

Sector Skills Plan Update

for the Health and Social Development Sector in South Africa
HWSETA SSP Update 2014-2015 for the period 2015-2020



Submitted to the Department of Higher Education and Training
by the Health and Welfare Sector Education Training Authority (HWSETA)

Bridging the Skills Gap

www.hwseta.org.za



VISION

The creation of a skilled workforce to meet the health and welfare needs of all South Africans.

MISSION

The Health and Welfare Sector Education and Training Authority (HWSETA) aims to create an integrated approach to the development and provision of appropriately skilled health and welfare workers to render quality services that compare favourably with world-class standards

PHILOSOPHY

The HWSETA espouses the philosophy of a better life for all through people development.

OBJECTIVES

- Develop and implement the Sector Skill Plan
- Develop and administer Learnerships
- Support the implementation of the National Qualifications Framework (NQF)
- Implement ETQA responsibilities mandated by the South African Qualifications Authority (SAQA)
- Disburse levies collected from employers in the health and social development sectors
- Forge links with stakeholders and bodies in the health and social development sectors
- Account for the effective and efficient use of public monies received from levies collected from employers, in line with the provisions of the Public Finance Management Act
- Report to the Minister of Higher Education through the Director-General of the Department of Higher Education on matters related to the HWSETA

Head Office Contact Details

Tel: 011 607 6900

Email: sikhumbuzog@hwseta.org.za

Postal address: Private Bag x15 Gardenview 2047

Physical Address: 17 Bradford Road , Bedfordview Gauteng

FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its annual update of the HWSETA Sector Skills Plan (SSP).

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

This annual update seeks to provide current sector skills development needs initially set out in the HWSETA Five Year Sector Skills Plan. Its purpose is also to align sector-based skills needs and programmes with socio-economic development priorities of government and the country as stated in the New Growth Path (NGP), the National Development Plan (NDP) 2030 and the Medium Term Strategic Framework (MTSF).

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

This SSP is a valuable tool for HWSETA stakeholders and a useful source of

information for service providers and the community.

The HWSETA hopes that this comprehensive SSP will contribute to the enhancement of the goals of a developmental state and the 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 work with workers, employers and 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 and the youth.

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

Thank you.



Dr E.T. Confidence Moloko
Chairperson: HWSETA Board



Ms Yvonne Mbane
Chief Executive Officer: HWSETA

Originals signed and filed

Table of Contents

Abbreviations and Acronyms	5
SYNOPSIS	7
Key policy drivers	7
Major Shifts in Health and Social Development Sector	7
Methodology used to Identify Skills Needs	8
Overview of Skills Development Needs in the Sector	8
HWSETA Skills Development Priorities and Interventions	9
EXECUTIVE SUMMARY	14
Introduction	14
Profile of the Health and Social Development Sector	15
Factors Influencing the Labour Market for the Health and Social Development Sector	16
The Demand For Skills	19
Supply of Skills	21
Skills Development Priorities of The HWSETA	23
Areas of strategic focus for the NSDS III	24
In Conclusion	25
1 Introduction	26
1.1 Background	26
1.2 Preparation of the SSP update	26
1.3 Outline of the SSP	27
2 Profile of the Sector	28
2.1 Introduction	28
2.2 The South African Health and Social Development System	28
2.3 Employers in the Sector	29
2.4 Organisations in the Sector	29
2.5 Profile of Employees in the Sector	35
2.6 Conclusions	39
3 Factors Influencing the Labour Market for the Health and Social Development Sector	40
3.1 Introduction	40
3.2 Health and Social Development Spending	40
3.3 The Demand for Health and Social Development Services	42
3.4 Socio-Economic Realities	44
3.5 Economic Downturn	44
3.6 The Burden of Disease and Social Ills	45
3.7 The Mobility of Labour	46
3.8 Human Resources Challenges	46
3.9 Management of the Health and Social Development System	48
3.10 The National Development Plan	49
3.11 The Regulatory Environment	49
3.12 National Health Policies	51
3.13 Social Development Policies and Legislation	56
3.14 New Education Strategies	58
3.15 New Scopes of Practice, Occupations and Qualifications	59
3.16 Social Insurance and Social Security Reform	62
3.17 Veterinary Services	63
3.18 Conclusion	65

4	The Demand for Skills	68
4.1	Introduction	68
4.2	The Total Number of Positions in the Sector	68
4.3	Current Shortages	69
4.4	Future Demand	72
4.5	Demand for Skills Development Interventions by HWSETA	74
4.6	Factors That Impact on the Demand for Healthcare Workers	78
4.7	Factors That Impact on the Demand for Social Development Workers	81
4.8	Conclusions	83
5	The Supply of Skills	87
5.1	Introduction	87
5.2	The South African Secondary School System	87
5.3	Institutional Arrangements and Capacity to Train Health Workers	89
5.4	The Supply of New Graduates by the Higher Education System	92
5.5	The Supply of New Entrants Through Nursing Colleges	94
5.6	The Role of the HWSETA in the Supply of Skills	94
5.7	Professional Registration	100
5.8	Factors Influencing the Supply of Skills in the Health Sector	104
5.9	Factors Influencing the Supply of Skills in the Social Development Sector	110
5.10	Conclusions	112
6	Skills Development Priorities of the HWSETA	115
6.1	Introduction	115
6.2	The HWSETA's Skills Development Priorities	115
6.3	The HWSETA Strategic Business Plan	117
6.4	The National Development Plan and HWSETA Strategies	121
6.5	Sectoral Contribution to Strategic Areas of Focus for NSDS III	121
6.6	Sectoral Contribution to Government's MTSF Objectives	124
6.7	The New Growth Path and National Skills Accord	124
6.8	HWSETA Contribution to the Human Resources Development Strategy	125
6.9	HWSETA's Performance Agreement with DHET	125
6.10	Contribution to the Green Economy	126
6.11	Presidential Infrastructure Coordinating Commission	126
6.12	Conclusions	130
	References	131
	ANNEXURE A – HWSETA Budget 2011/12 to 2016/17	141
	ANNEXURE B – The Process of Updating 2013 Employment Data	143
	ANNEXURE C – Scarce Skills in the Health and Welfare Sector	146
	ANNEXURE D – Education and Training Needs Requested by HWSETA Stakeholders and Institutions of Higher Learning	149
	ANNEXURE E – Continuous Improvement Action Plan: Progress Report 2014	151
	ANNEXURE F – HWSETA's Pivotal Skills List	154
	ANNEXURE G – Synopsis	156
	ANNEXURE H – Covering Letter	163

List of Tables

Table 2 1	Total employment in the private sector and in Public Service, per occupational category	35
Table 2 2	Employment distribution in private and public health according to occupational-and population group	36
Table 2 3	Employment distribution in the private and public health sectors according to occupational group and gender	37
Table 2 4	Age distribution of employees in private and public health according to occupational group	37
Table 2 5	Disability in the private and public health sectors according to occupational- and population group	38
Table 3 1	Estimates of health expenditure in public and private sectors: 2009 to 2014	41
Table 3 2	Past and projected utilisation of public health services: 2010/11 to 2016/17	42
Table 3 3	Social grants beneficiaries by type, past and projected, 2010/11 to 2016/17	43
Table 3 4	Key resources per 10 000 of the population in public and private sectors: 2010	47
Table 3 5	Distribution of health professionals per 100 000 population in the public sector: 2012	47
Table 3 6	New nursing categories and qualifications framework	60
Table 4 1	Employment positions in the health and social development sector	69
Table 4 2	Vacant positions according to occupational group	69
Table 4 3	Occupations where more than 100 vacancies were reported	70
Table 4 4	Public sector vacancies and cost of filling key clinical professions, 2010	71
Table 4 5	Public sector staff needs to meet international in-hospital benchmarks	71
Table 4 6	Comparative benchmarks for health staff per 10,000 population and health outcomes	72
Table 4 7	Summary of needs gaps in key health professions and occupations: 2011 to 2025	73
Table 4 8	Skills development needs of specific occupations in the sector	85
Table 5 1	Grade 12 Statistics: 2008-2012	87
Table 5 2	Number of health-related qualifications awarded by the public higher education sector: 2010 to 2012	93
Table 5 3	Number of graduates at nursing colleges: 2003 to 2013 (with average annual growth)	94
Table 5 4	Qualification matrix of the HWSETA	95
Table 5 5	HWSETA learnerships	96
Table 5 6	Number of learners who completed learnerships in the health and social development sector by programme: 2005/06 to 2012/13	97
Table 5 7	Number of professionals registered with the HPCSA as at 31 December of 2003 to 2013 (selected professions) with average annual growth	101
Table 5 8	Number of nurses registered with the SANC: 2002 to 2013 (with average annual growth)	102
Table 5 9	Number of registrations with the SAPC: 2006 to 2014 (with average annual growth)	102
Table 5 10	Total registrations with the AHPCSA: 2010 to 2014 (with average annual growth)	103
Table 5 11	Number of registrations with the SAVC: 2010 to 2014 (with average annual growth)	103
Table 5 12	Social workers and social auxiliary workers registered with the SACSSP: 2004 to 2014	104
Table 5 13	Retention gap for professional graduates, 2002-2010	108
Table 6 1	HWSETA performance indicators and budget: 2015/16	118
Table 6 2	TVET colleges in partnership with the HWSETA, 2014/15	122

List of Figures

Figure 2 1	The South African health and social development system	28
Figure 2 2	Population group distribution of employees in the health and social development sector	36
Figure 4 1	Total Positions Available in the Health and Social Development Sectors according to Occupational Group	68
Figure 5 1	Grade 12 mathematics, life sciences and physical sciences achievement rates: 2008-2012	88
Figure 5 2	Number of passes in mathematics, life sciences and physical sciences: 2002-2012	88
Figure 5 3	Comparison of output in basic nursing training between public and private sectors: 2007 to 2013	91

Abbreviations and Acronyms

ACYCW	Auxiliary Child and Youth Care Worker	GDP	Gross Domestic Product
AET	Adult Education and Training	GHS	General Household Survey
AgriSETA	Agricultural Sector Education and Training Authority	GP	General Practitioner
AHPCSA	Allied Health Professions Council of South Africa	HASA	Hospital Association of South Africa
AIDS	Acquired Immune Deficiency Syndrome	HDSA	Historically Disadvantaged South Africans
AOP	Assessment Quality Partner	HEI	Higher Education Institution
ARC	Agricultural Research Council	HEMIS	Higher Education Management Information System
ART	Anti-Retroviral Therapy	HEQC	Higher Education Quality Committee
ATR	Annual Training Reports	HET	Higher Education and Training
CBO	Community-Based Organisation	HIV	Human Immunodeficiency Virus
CCG	Community Caregiver	HOSPERSA	Health and Other Service Personnel Trade Union of South Africa
CDA	Central Drug Authority	HPCSA	Health Professions Council of South Africa
CDP	Community Development Practitioner	HSRC	Human Sciences Research Council
CDW	Community Development Worker	HWSETA	Health and Welfare Sector Education and Training Authority
CESM	Classification of Education Study Material	ICT	Information Communication Technology
CHE	Council on Higher Education	IDT	Independent Development Trust
CHW	Community Health Worker	INSETA	Insurance Sector Education and Training Authority
CPD	Continuous Professional Development	IP	Implementation Plan
CSDH	Commission on the Social Determinants of Health	ITHPCSA	Interim Traditional Health Practitioners Council of South Africa
CSO	Civil Society Organisation	LGSETA	Local Government SETA
CYC	Child and Youth Care	MDG	Millennium Development Goals
CYCW	Child and Youth Care Worker	MDR TB	Multiple Drug Resistant Tuberculosis
DAFF	Department of Agriculture, Forestry and Fisheries	MLW	Mid-level Worker
DBE	Department of Basic Education	MoU	Memorandum of Understanding
DBSA	Development Bank of South Africa	MRC	South African Medical Research Council
DENOSA	Democratic Nursing Organisation of South Africa	MTEF	Medium Term Expenditure Framework
DHET	Department of Higher Education and Training	MTSF	Medium Term Strategic Framework
DoH	Department of Health	NACCW	National Association of Child Care Workers
DSD	Department of Social Development	NACOSS	National Coalition of Social Services
DBSA	Development Bank of South Africa	NAMB	National Artisan Moderation Body
DPSA	Department of Public Service and Administration	NAWONGO	National Association of Welfare Organisations and Non-Governmental Organisations
DTI	Department of Trade and Industry	NC	National Certificate
ECD	Early Childhood Development	NCV	National Certificate (Vocational)
EMIS	Education Management Information System	NDA	National Development Agency
EMS	Emergency Medical Services	NEDLAC	National Economic Development and Labour Council
EPWP	Expanded Public Works Programme	NEHAWU	National Education Health and Allied Workers Union
FAO	Food and Agricultural Organisation of the United Nations	NEI	Nursing Education Institution
FBO	Faith-Based Organisation	NGO	Non-Governmental Organisation
FET	Further Education and Training	NGP	New Growth Path
FETC	Further Education and Training Certificate	NHA	National Health Act
GET	General Education and Training		
GETC	General Education and Training Certificate		

NHI	National Health Insurance	SANGOCO	South African National Non-Governmental Organisation Coalition
NHIF	National Health Insurance Fund	SAPC	South African Pharmacy Council
NHLS	National Health Laboratory Service	SAPSE	South African Post-Secondary Education system
NIP	National Implementation Plan	SARS	South African Revenue Service
NPO	Non-Profit Organisation	SASSA	South African Social Security Agency
NPSWU	National Public Service Workers Union	SAVC	South African Veterinary Council
NQF	National Qualifications Framework	SAW	Social Auxiliary Worker
NSCA	National Senior Certificate for Adults	SDA	Skills Development Act
NSDA	Negotiated Service Delivery Agreement for the Health Sector	SDF	Skills Development Facilitator
NSDS	National Skills Development Strategy	SDL	Skills Development Levy
NSF	National Skills Fund	SEDA	Small Enterprise Development Agency
NSFAS	National Student Financial Aid Scheme	SETA	Sector Education and Training Authority
NUPSAW	National Union of Public Service and Allied Workers	SIC	Standard Industrial Classification
OECD	Organisation for Economic Cooperation and Development	SIP	Strategic Integrated Project
OHSC	Office of Health Standards Compliance	SSACI	Swiss South African Cooperation Initiative
OFO	Organising Framework for Occupations	SSP	Sector Skills Plan
OSD	Occupation Specific Dispensation	TB	Tuberculosis
OVI	Onderstepoort Veterinary Institute	TVET	Technical and Vocational Education and Training
PAHC	Primary Animal Healthcare	UIF	Unemployment Insurance Fund
PAWUSA	Public and Allied Workers Union of South Africa	UCT	University of Cape Town
PBSW	Professional Board for Social Work	UMALUSI	Council for Quality Assurance in General and Further Education and Training
PBCYC	Professional Board Child and Youth Care	W&RSETA	Wholesale and Retail Sector Education Training Authority
PEPFAR	US President's Emergency Plan for AIDS Relief	WHO	World Health Organisation
PFMA	Public Finance Management Act	WSP	Workplace Skills Plan
PHC	Primary Healthcare	XDR TB	Extensively Drug-resistant Tuberculosis
PIVOTAL	Professional, Vocational, Technical And Academic Learning programme		
PSA	Public Servants' Association		
PSC	Public Service Contractor		
PSETA	Public Service Sector Education Training Authority		
OCTO	Quality Council for Trades and Occupations		
QDP	Quality Development Partner		
RAF	Road Accident Fund		
RPL	Recognition of Prior Learning		
SACSSP	South African Council for Social Service Professions		
SADA	South African Dental Association		
SADNU	South African Democratic Nurses Union		
SADTC	South African Dental Technicians Council		
SAHARA	Social Aspects of HIV/AIDS Research Alliance		
SAMA	South African Medical Association		
SANC	South African Nursing Council		
SANDF	South African National Defence Force		

SYNOPSIS

This synopsis highlights key national policies that impact the health and social development sector as well as factors that constitute major shifts in the sector. The synopsis sets out skills needs for the sector and briefly outlines the methodology used to determine skills development needs. Finally, the skills development priorities for the HWSETA are identified together with the interventions and resources to be allocated to address those priorities.

Key policy drivers

A multitude of national policies and Constitutional principles impact strategic planning and service delivery in the health and social development sector, and thus delineate the skills sets required for the sector. Key policy drivers include the Constitution of the Republic of South Africa, 1996; the National Development Plan 2030, the National Health Insurance Scheme; the White Paper for Social Welfare and the White Paper for Post-school Education and Training.

The National Development Plan (NDP) addresses South Africa's vast socio-economic challenges and provides a multi-dimensional framework with priorities to eliminate poverty, reduce inequality and create a decent living standard for all. Prominence is given to three vital areas: economic growth and job creation; education and skills; and building a capable and developmental state. Two of the central priorities of the NDP are to improve the quality of education, skills development and innovation, and to build the capability of the state to play a developmental role. For this purpose specific interventions are needed to build human capital and service capacity through education, vocational training and work experience.

According to the NDP, the health system as a whole requires strengthening and the human capacity to provide care and manage services must be developed. A key goal is the introduction of National Health Insurance (NHI) to provide universal healthcare coverage and primary healthcare teams to care for families and communities. The NDP envisages a social development system that provides social protection and adequate social welfare services for

vulnerable groups, children and the elderly. Social protection services to children will focus on improving access to nutrition, healthcare, education, social care and safety. Early childhood development is of national importance. The NDP conceives of an effective social development system that delivers better results for families and marginalised communities. Another goal is to provide income support to unemployed persons in the form of public works programmes, community development and labour market incentives that offer training and skills development. The NDP recognises that these goals can only be attained if the skills deficit in the social welfare sector is addressed.

The White Paper for Social Welfare of 1997 reshaped welfare policies and moved the delivery of social services to a rights-based approach. Almost two decades on the White Paper continues to give direction to a developmental and preventive family-centred and community-based approach for social welfare interventions. New legislation which became operational since 2010 such as the Children's Act, 2005 and the Older Persons Act, 2006 commands the provision of social welfare services that acknowledges and protects human rights, improves the quality of life and enables human development. The NDP also supports the provision of developmental social services to advance human dignity and to create human capability to participate fully in the economic, social and political life of the country.

In the animal health sector, policy goals to expand agricultural production, maintain food security and improve livelihoods are driving the demand for veterinarians, veterinary technologists, veterinary health

technicians and primary animal healthcare workers.

The 2013 White Paper for Post-school Education and Training outlines strategies to create an integrated post-school education and training system that meets the country's developmental needs as well as those of workplaces in the public- and private sector. A core objective is to strengthen cooperation between education and training institutions and the workplace. In future more prominence will be given to work-integrated learning to better prepare learners for the labour market. The roles of SETAs are re-defined to "mediate between education and work", with their main focus on developing the skills of the existing workforce and to provide the skills pipeline to existing workplaces. SETAs will support training programmes that lead to qualifications and awards recognised by industry, rather than on short courses. Work-based learning such as learnerships and internships in the non-artisan fields will also be expanded, and SETAs will be expected to facilitate work-based partnerships between employers and educational institutions.

The National Skills Development Strategy (NSDS III) sets eight strategic goals for skills planning and skills development, namely, credible skills planning; increased access to occupationally focused training; growth of the public TVET college system to respond to the country's skills needs; improved literacy and numeracy skills amongst youth and adults; better use of workplace-based skills development; training and development support for cooperatives, small enterprises, NGOs and workers; building public sector capacity for improved service delivery and to adopt a professional, developmental role; and building career and vocational guidance.

Major Shifts in Health and Social Development Sector

Adjustments are being made to the way health and social services are delivered with the introduction of mid-level workers and changes to the scope of practice of many health professionals. Increasingly the focus is on community-based care to treat the ill and maintain the health of the healthy and on support to families and persons in

need. Social welfare services are becoming more development directed and the service-delivery platform is being broadened. Non-Governmental organisations (NGOs) are vital delivery partners of government to provide a range of social development services, but often lack the capacity to serve communities, train workers and meet the required standards of corporate governance.

The 2011 Green Paper on the National Health Insurance Scheme confirms a major shift in national healthcare policies, away from hospital-based care to a range of primary healthcare services delivered in health districts via home-based services, school-based services and agents in municipal wards. The Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17 sets targets for the production and deployment of health professionals and health workers to enhance access to services and improve quality in the health system. The Department of Health (DoH) identifies seven key foundations to improve health outcomes: to deploy community health workers (CHWs) in primary health care teams; to enhance nursing capacity and provide for a predominantly nurse-based health system; to plan for skilled mid-level workers to address the acute shortage of health professionals; to increase the number of general health professionals; to increase the number of selected specialist doctors; to increase the number of public health specialists; and to develop more academic clinicians. The strategy recommends that stakeholders such as the DoH, statutory councils, faculties of health sciences and SETAs focus their actions in three thematic areas: improving the supply of health professionals and equity of access to trained health workers; education, training and research; and improving the working environment of the health workforce.

Various reports by the Department of Social Development (DSD) confirm the severe shortage of social workers and social auxiliary workers to deliver the comprehensive social services envisioned by legislation for children, the elderly, youth, families, children in conflict with the law, and communities affected by social crime. Despite a substantial Government-funded scholarship programme to boost the ranks of registered social workers, the absorption of graduates in the public sector has been disappointing, mainly due to budget and structural constraints. The NDP

underscores the need to boost the numbers of social service professionals and sub-professionals in five categories in particular: social workers, auxiliary or assistant social workers, community development workers, child and youth care workers and early childhood development (ECD) practitioners. Efforts are underway to establish the various the emerging social service professions and occupations; to outline scopes of practice; to set qualification frameworks; and to regulate them.

A major shift taking place in the health and social development sector pertains to education, training and skills development. Globally, and also in South Africa, it is recognised that health professionals and social services workers need to be trained across multiple health and social contexts so as serve the needs of local populations. Higher-level qualifications required for entering several fields in health sciences and social welfare services are under development. Several entry-level qualifications in the field of nursing, pharmacy, pre-hospital emergency medical services and social auxiliary work are moving away from the TVET level to a higher education platform. This development has implications for training capacity at HEIs and the skills development needs of the current workforce.

The recent introduction of generic norms and standards for social services will identify skills gaps among current social work professionals and drive the need for greater access to workplace-based learning and for the development of occupation-specific technical skills.

Methodology used to Identify Skills Needs

Information and data on skills development needs were obtained from various sources. Strategic documents, including strategic plans of the DoH and DSD, as well as academic articles relevant to skills development in the sector, were used. Budget- and expenditure reports published by the National Treasury and a number of strategic documents that became available after the submission of the SSP in January 2014 were used. Feedback received from interviews held with sectoral- and industry experts and role-players in the sub-sectors for human health, animal health and social development was incorporated in this SSP update.

Various data sources were used to analyse and construct a profile of the health and social development sector. Data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the Public Service SETA (PSETA) and used to determine the scarce skills list. MEDpages, a comprehensive private database of health service providers in the private sector, was used to analyse employment in the private healthcare sector. Numbers from the MEDpages database were used for professionals who typically operate from small independent practices in the private sector. Data extracted from the registers of social service professionals, health professionals and para-professionals maintained by the statutory councils were analysed.

Information from the Education Management Information System (EMIS) and the Higher Education Management Information System (HEMIS) kept by the Department of Basic Education and the Department of Higher Education respectively was also used. Extensive desktop research was conducted on various aspects of the South African health and social development sector and incorporated into the SSP.

Overview of Skills Development Needs in the Sector

The demand for skills exists at all levels in the health and social development sector: from high-level specialist skills (e.g. community development professionals, general medical practitioners, specialist professional nurses, environmental health practitioners and social workers) to mid-level skills (e.g. enrolled nurses, emergency care workers, pharmacy mid-level workers, non-clinical technicians and artisans) to low-level skills (e.g. community health workers, community caregivers and ancillary health workers).

Primary and secondary research by the HWSETA indicates a significant need to expand workplace-based training and to provide experiential learning opportunities in the sub-sectors for health, social welfare and veterinary services. In the health sector, capacity in clinical training platforms is severely strained and more health academics and health educators

are needed to train and guide learners in the health sciences. With the introduction of new qualification frameworks set in higher education, bridging programmes are required to elevate the skills base of the current workforce in areas such as nursing, emergency care and pharmacy.

More students in the various social services fields require access to better quality workplace training and for this purpose the ranks of workplace supervisors, assessors and moderators need to be strengthened.

In the social development sector the most pressing skills development need is for supervision training of social workers. More social workers require occupation-specific technical training to supervise and guide lesser experienced colleagues and social auxiliary workers (SAWs). Another priority is improving the skills base of SAWs and for the HWSETA to strengthen quality assurance processes to ensure that the training of these mid-level workers is of the required standard. Further education and training interventions are needed to improve the skills base and professionalism of the current social services workforce, especially with regard to occupation-specific technical skills, specialisation and work-readiness.

In the health sector, vastly improved management and leadership skills are needed to provide functional services across all levels of facilities and to manage the health workforce. In particular, skills development is needed in the areas of leadership and general management, quality and performance management, resource utilisation, information technology, managing facilities, financial management, procurement and accountability (including the ability to hold staff accountable).

In order to deliver effective social and development services on behalf of the state, NGOs require skills in governance and organisational management.

In the animal health sector, veterinarians and para-veterinary professionals are needed. Veterinary professionals need “day one skills” to be ready for general animal health practice, while large numbers of animal health technicians need to be trained in primary animal healthcare.

HWSETA Skills Development Priorities and Interventions

The HWSETA will adopt strategies to improve corporate governance and service delivery to stakeholders. Effective financial controls will be put in place to support timely and automated reporting in accordance with regulatory and Board requirements.

In accordance with the developmental and transformation priorities of the NSDS III, the HWSETA will give preference to skills development for disadvantaged learners who lack the relevant technical, reading, writing and numeracy skills to access employment. The HWSETA’s interventions are specifically linked to the NSDS III objectives, namely:

1. Establishing a credible institutional mechanism for skills planning.
2. Increasing access to occupationally directed programmes.
3. Promoting the growth of a public TVET college system that is responsive to the sector, local, regional and national skills needs and priorities.
4. Addressing the low level of youth and adult language and numeracy skills to enable additional training.
5. Encouraging better use of workplace-based skills development.
6. Encouraging and supporting cooperatives, small enterprises, worker initiated, NGO and community training initiatives.
7. Increasing public sector capacity for improved service delivery and supporting the building of a developmental state.
8. Building career and vocational guidance.

The table below summarises the HWSETA’s projects and programmes and their linkages to NSDS III. The HWSETA will continue to assess the success and impact of these skills development interventions and engage with stakeholders so as to contribute to the training and development needs of the sector.

				Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives	
Sub-programme	No	Indicator title	Precise Definition					
ADMINISTRATION	5	Percentage artisans and unemployed learners funded by HWSETA find employment within 6 months of completion	This is an enumerator indicator to indicator 4 and 1 for unemployed learners. It measures the number of artisans and unemployed learners, after going through training, who obtains employment. It seeks to establish the needs for artisans and other critical skills in South Africa based on the principle of supply and demand. A qualified artisan is a person who has been awarded a certificate of competency. The ILO defines 'decent work' as productive work which generates an adequate income, in which workers' rights are protected, and where there is adequate social protection providing opportunities for men and women to obtain productive work in conditions of freedom, equality, security, and human dignity. This indicator also measures the number of months an unemployed learner takes to obtain a decent job. Obtaining employment will be measured from the day an employment offer is made.	80% (11365)	80% (1380)	Admin budget	1	
	12	Number of applied research reports completed and signed off that inform planning	A research activity is defined as any perusal of materials related to skills development and HWSETA, such as desk review, surveys, etc. Applied research is a form of systematic inquiry involving the practical application of science. It accesses and uses some part of the research communities' (the academia's) accumulated theories, knowledge, methods, and techniques, for a specific, often state-, business-, or client-driven purpose. Applied research is compared to pure research (basic research) in discussion about research ideals, methodologies, programs, and projects. Evaluation of training includes research reports on areas such as dropout rate and analysis and impact analysis.	31	5	R 563 000	1	
	13	Number of post graduate research students funded in the health and welfare field	This indicator measures the number of post graduate research students funded by HWSETA. This indicator also measures the number of support programmes funded to support develop and expansion of research in the sector. Counting from this indicator will commence upon the implementation of the programme. Lastly this indicator will also measure the number of post graduate students with access to employment opportunities after graduation. New post graduate research students refer to registered students in higher education institutions for higher degrees that have a research component in the curriculum and have registered for the first time. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	540	75	R 4.770 mil	1, 2	
	Corporate Services	15	Number of learners reached through HWSETA career development awareness programmes	This indicator measures the number of career awareness drives and documents created and distributed with information on the labour market to guide learners on career opportunities in specified areas of work. This indicator also measures the number of learners who are undergoing the career development/guidance programme. Career guides will be mapped to qualifications for all sectors. Reached in this context refers to learners recorded in the register of career fairs or career exhibitions.	79 000	11 500	R 500 000 Admin. budget	8
		18	Percentage of filled positions in the HWSETA	This indicator measures the fraction of jobs in the HWSETA that are open but have not been filled. Vacancy rate is defined as the number of job vacancies to the sum total of employment and job vacancies.	94% (84)	94% (81)	R850 000 Admin budget	
		20	Percentage of HWSETA processes automated and integrated	This indicator measures the fraction of work processes that are automated and integrated. It includes the efficiencies derived from the use of the document management system and the creation of a paperless environment. Automation and integration refers to the development and deployment of the ERP system as approved by the HWSETA board	95% (111)	70% (36)	R 2 mil	

Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives	
SKILLS DEVELOPMENT PROGRAMMES AND PROJECTS	Projects	2	Number of employers participating in work-based training	This indicator measures the number of employers (all organisations working with HWSETA to implement skills development programmes) who are implementing employee development programmes. This includes private and public entities. Evaluation and participation means workplace has been validated and the learners allocated as per the approval schedule and the Memorandum of Agreement signed.	755	140	Included in learnerships and skills projects budgets	2
		4	Number of apprentices funded and enrolled to become artisans through HWSETA funding	This indicator measures the number of artisans trained with HWSETA funding. (The artisan is a technically skilled person. Whilst he/she will mainly do manual work, these skills require a fairly high degree of scientific and engineering knowledge and a considerable amount of experience in the electrical trade).The tasks of the artisan in the workplace could entail: installation, maintenance, repairs, and servicing and operating of, for example, control systems, generators, transformers, power lines, etc .Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Enrolled refers to registration with both the training institution and HWSETA Seta Management System	1000	100	R 6.500 mil	2
		6	Number of HWSETA funded students in higher education institutions funded for high-level scarce skills	This indicator measures the number of learners who graduate in courses listed as scarce skills. Scarce Skills refers to those occupations in which there is a scarcity of qualified and experienced people, currently or anticipated in the future, either because (a) such skilled people are not available or (b) they are available but do not meet employment criteria. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	1735	280	R 11.4 mil	2
		7	Number of students enrolled for work-experience and experiential learning programmes funded by the HWSETA	Experiential learning refers to a spectrum of meanings, practices, and ideologies which emerge out of the work and commitments of policy makers, educators, trainers, change agents, and 'ordinary' people all over the world. This indicator seeks to collect data on a number of learners who are practicing the theory learnt in class or at an organisation to which they are attached as a partial fulfilment of the requirements of their course. Enrolled refers to registration with both the training institution and HWSETA Seta Management System Workplace experience and experiential learning refers a course, or a portion of a course, requiring students to participate in a supervised workplace experiential learning, directed field study, internship, cooperative, or cooperative work term course that is related to their program of study or training. It is also viewed as having four basic elements of learning in the workplace: experience, practice, conversations and reflection where at least 70% of workplace learning is through on-job experiences and practice 20% of workplace learning is through others (coaching, feedback and personal networks) 10% of workplace learning is through formal off-job training (Jennings, C: 2009).	4084	400	R 9.6 mil	2, 3
		9	Number of cooperatives in the health and social development sector whose skills needs are funded by the HWSETA	This indicator measures the number of co-operatives whose skills development needs are assessed for the purposes of closing the gaps. It also measures the number of co-operatives linked with trainings programmes meant to benefit their members for its development and growth. Lastly this indicator measures the number of projects supported by the NSF for the benefit of the co-operatives and small businesses. The National Skills Framework provides the basis for high quality, flexible, nationally consistent vocational education and training which meets industry needs and which employers can trust. Co-operatives are defined as an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly owned and democratically controlled enterprise. Co-operatives are those organizations established in terms of the co-operatives Act, 2005 (Act 14 of 2005). Funding in respect of these organizations includes start-up funding and skills development funding linked to worker initiated training.	145	20	R 1 mil	6

Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
	10	Number of small and emerging businesses funded	This indicator measures the number of small and emerging businesses that have undergone skills needs inventory for the purposes of expanding developmental support. The indicator also measures the number of projects identified and designed to help small and emerging businesses to develop and grow. A small or emerging business is a business that is privately owned and operated, with a small number of employees and relatively low volume of sales. Small businesses are normally privately owned corporations, partnerships, or sole proprietorships. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	685	100	R 1.3 mil	6
	11	Number of skills development projects funded to support NGOs, Cobs and trade unions	This indicator measures the number of skills development projects meant to benefit NGOs, CBOs, and Trade Unions. The scope will be limited by the number of users who can access the projects, the people affected, the partners involved, or other restrictions as appropriate. Pilot projects could be initiated in new areas whose purpose is to test whether the projects are working as they were designed.	1145	175	R 4. 725 mil	6
	22	Number levy-exempt organisations funded by the HWSETA	This indicator measures the number of workers who benefit from funding earmarked to non-levy paying organisations. Levy paying employers who submit Workplace Skills Plans and Annual Training reports qualify to receive mandatory grants based on their submission having been made by the 30 April 2014. This submission must be compliant in all respects as determined by the HWSETA.	760	120	R 5. 042 mil	
	17	Number of learners in TVET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses funded by the HWSETA	This indicator measures the number of TVET colleges and other public colleges offering vocational training. TVET colleges include the former Technical Colleges although Colleges of Education, Manpower and Skills centres, and some former community colleges were also merged during the restructuring process with Technical Colleges to form the new TVET colleges. Vocational training will be defined as an organised educational programme that is directly related to the preparation of individuals for employment. The system prepares learners for careers or professions that are traditionally non-academic and directly related to a trade, occupation, or 'vocation' in which the learner participates. Public colleges include public nursing colleges and other colleges reporting to a Government Department or State Institutions. Enrolled refers to registration with both the training institution and HWSETA Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	9450	1 000	R 9 mil	3
	14	Number of projects funded through discretionary grant aimed at the public sector education and training	This indicator measures the number of funded projects focused on improving the institutional framework for public education and training so as to improve delivery of services in those areas. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	29	5	R4.1 mil	7
Learning programmes	1	Number of programmes funded through grants to develop and address middle level skills	Programmes will be defined to mean strategies and combination of activities to meet identified needs. Middle level skills are those above routine skills but below professional skills. This includes, but is not limited to Pharmacist assistants, Medical assistants, and Auxiliary Social Workers etc.	32	4	R 4.4 mil	2
	3	Number of learners registered in learnership training programmes	This indicator measures the number of learners enrolled in learnership training programmes funded by the HWSETA. This indicator includes employed and unemployed learners. Registered means learner, employer and training provider details captured in the Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	21500	2450	R 64.679 m	2, 5

Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
	8	Number of employed and unemployed learners in skills programmes funded by the HWSETA	This indicator measures learners on skills programmes or projects developed to benefit employed workers and unemployed by developing their work skills. HWSETA will only count when programmes are being implemented. Unemployed and employed workers undergoing training on skills programmes will be counted when an employer selects and registers them with the HWSETA in order to improve their skills. Skills programmes are defined as per SAQA definition and include short courses for the employed workers	19150	6100	R 3.2 mil from discretionary grant, Balance funded from mandatory grants	2, 3, 8
	21	Number of learners registered for AET programmes funded by the HWSETA	This indicator measures the number of learners registered for Adult Education and Training that is funded by the HWSETA. This indicator includes those learners funded through partnerships with employers or partnerships with training institutions who are registered examination centres. Registered means learner, employer and training provider details captured in the Seta Management System.	5954	1440	R5.76 mil	4
	16	Number of TVET College lectures placed in work experience with employers in the reporting period	This indicator measures the number of public TVET college lecturers exposed to the workplace in the health and welfare sector. The objective of the exposure is to ensure that these lecturers are updated on the latest developments and innovations by employers so that they impact this practical knowledge to their students. Placement refers to temporal visitation to employer premises to gain work related experience in the aspect of work that relates to the training programme the lecturer is engaged in.	190	30	R75 000	
QUALITY ASSURANCE AND QUALIFICATION DEVELOPMENT	23	Number of partnership agreements signed through MoUs outlining areas of collaboration	This indicator measures the number of collaborating partners who have signed a Memorandum of Understanding or a service level agreement to collaborate with HWSETA. A collaborating partner is a person, institution, or association that has signed a service level agreement with HWSETA. Partnerships herein include Universities, TVET Colleges, Councils, Statutory bodies, employer bodies, communities of practice, etc	79	10	R 5 mil	2,3
	19	The number of skills development training providers accredited to offer full qualifications	This indicator measures the number of new training providers accredited and current training providers re-accredited by the HWSETA in the reporting period. This includes the process of approving learning programmes, evaluating the QMS and conducting site visits. For re-accreditation we would also have conducted successful verification of the learners' achievements. Assessors and moderators will have to be currently registered against the qualifications against which the training providers are accredited or re-accredited. Skills Development Training Providers refers those as defined by the SAQA Act and the HWSETA policy. Accreditation refers to meeting the criteria as set in the SAQA Act and the QCTO Act and policies/regulations and the HWSETA accreditation policies.	280	40	Admin. budget	

EXECUTIVE SUMMARY

Introduction

The Health and Welfare Sector Education and Training Authority (HWSETA) prepared this Sector Skills Plan (SSP) in accordance with the requirements set out by the Department of Higher Education and Training (DHET) in the National Skills Development Strategy (NSDS) III framework document. A skills development plan for the period 1 April 2015 to 31 March 2020 is included. Together with the HWSETA Strategic Plan and Budget, this SSP update will be submitted to the DHET for approval.

This SSP update aims to align the sector-based skills needs and programmes with government's economic and social development priorities set out in the National Development Plan, New Growth Path (NGP) and the Medium Term Strategic Framework (MTSF). Reference is also made to performance goals set by the Department of Higher Education and Training and how the HWSETA will contribute to attaining them. Attention is given to key pillars of the NSDS III:

- Professional, vocational, technical and academic learning (PIVOTAL) programmes, which lead to occupationally directed qualifications;
- Interventions to address shortages of priority skills in professional fields needed to implement national social development and economic growth strategies;
- Incentives for training and skills development among cooperatives and non-governmental organisations (NGOs), and especially in rural communities; and
- Initiatives to develop capabilities in the public sector to meet the strategic priorities of the South African developmental state.

Preparation of the SSP

Information and data for the SSP update were obtained from various sources. The most recent information available at the time of compiling the SSP was used. Strategic documents, including strategic plans of three government departments and academic articles relevant to skills development in the sector, were used. The Department of Social Development's Annual Performance Plan 2014-2015 and the Department's Strategic Plan 2014-

2019 were considered. High-level plans of the Department of Health (DoH) to guide healthcare service provision in the medium to longer term were reviewed, including the Strategic Plan 2014/15-2018/19 and Annual Performance Plan 2014/15-2016/17. Extensive reference was made to another strategic document of the DoH, namely Human Resources for Health South Africa – HR Strategy for the Health Sector 2012/13-2016/17. Also considered were the Strategic Plan 2013/14-2017/18 of the Department of Agriculture, Forestry and Fisheries, budget- and expenditure reports published by the National Treasury and the White Paper on Post-school Education and Training, as well as a number of other strategic documents that became available after the submission of the SSP in January 2014.

In October 2012 and July 2014 interviews held with sectoral- and industry experts and role-players in the sub-sectors for human health, animal health and social development. The respondents provided valuable perspectives on the changes taking place in the labour market for the sector, as well as skills development challenges, and the priority areas for skills development.

Various data sources were used to analyse and construct a profile of the health and social development sector. For the 2014 SSP update, data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the Public Service SETA (PSETA) as well as data furnished to the HWSETA from the private MEDpages¹ database, a comprehensive private database of health service providers in the private sector.

Data extracted from the registers of social service professionals, health professionals and para-professionals maintained by the statutory councils were analysed. Information from the Education Management Information System (EMIS) and the Higher Education Management Information System (HEMIS) kept by the Department of Basic Education and the DHET respectively was also used in the preparation of the SSP update. The MEDpages database was used to analyse employment in the private healthcare sector. The current update reflects the data that became available during 2013 and 2014, including the WSP information submitted in June 2014.

Limitations

During the preparation of this SSP update, the HWSETA again encountered significant difficulties with the lack of data, gaps in and quality of information, as well as inconsistencies in the data of the sector's human resources. The 2012 HRH Strategy reported similar difficulties, with a large discrepancy between national DoH and PERSAL data, and a margin of error in the region of 30% in some cases. These difficulties are beyond the control of the HWSETA and it has to place reliance on multiple employers and bodies in the sector to collate data. The development of reliable, integrated time-series data that will enable the SETA to accurately describe its sector and to track sectoral changes over time remains a challenge.

All occupational data used in this SSP update were coded according to the Organising Framework for Occupations (OFO) version 2013.

1. Database of healthcare professionals and organisations: <http://www.medpages.co.za>

Profile of the Health and Social Development Sector

Scope of sector

The sector served by the HWSETA is extensive and spans portions of the human and animal health systems in South Africa, as well as portions of the social development and social services systems. 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. For example, the national and provincial departments of health submit WSPs to the PSETA.

The economic activities that fall within the scope of the health component of the HWSETA range from all healthcare facilities and services, pharmaceutical services and the distribution of medicine, medical research, non-governmental organisations, to veterinary services. The social development component of the sector consists of the government and NGOs. The government organisations include national and provincial departments of social development, some of which have merged with health to form one department, public entities, and the social service components of the South African Police Service, and of the departments of justice and correctional services. The private or non-governmental part of the social development sector includes non-profit organisations (NPOs), private social work practices and the corporate-social-responsibility- and employee-wellness services offered by large organisations in the private sector.

Employment

The health and social development sector is a heterogeneous sector falling mainly under the Sector Industrial Classification (SIC) category 93. The HWSETA has jurisdiction over 60 SIC codes and employers belonging to the 60 SIC sectors are grouped into five groups:

- Community services;
- Complementary health services;
- Doctors and specialists;
- Hospitals and clinics; and
- Research and development institutions

In the 2013/2014 financial year a total of 5 945 organisations paid SDLs to the

HWSETA.

The databases referred to above provided information on almost 586 800 people who are formally employed in the health and social development sector. Of these, 276 500 (47%) are employed in private sector organisations (referred to later as the “private sector”) and levy-paying public sector organisations, while 310 500 (53%) work in the public service departments. The private sector figures are underestimates of the total number of employees in the sector and exclude professionals not listed on any of the databases used, the non-professional support staff employed in the private professional practices, and employees in the non-levy-paying NPOs. Medical personnel employed by the South African National Defence Force (SANDF) are excluded from the public service figures.

Organised professions

A large portion of the workers in the health and social development sector are registered with statutory professional councils that regulate the various professions. In the health sector these councils are the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC), the South African Pharmacy Council (SAPC), the Allied Health Professions Council of South Africa (AHPSCSA) and the South African Dental Technicians Council (SADTC). Members of the veterinary and para-veterinary professions are registered with the South African Veterinary Council (SAVC) and practitioners using indigenous African healthcare techniques and medicines will soon be required to register with the Interim Traditional Health Practitioners Council of South Africa (ITHPCSA). Professionals (i.e. social workers) and sub-professionals (i.e. social auxiliary workers) in the social development field are registered with the South African Council for Social Service Professions (SACSSP).

In many instances these councils determine the scope of practice for professions and occupational categories and enforce rules of ethical and professional conduct. The professional councils are actively involved in skills development through the setting and controlling of standards for education and training, the registration of professionals, and continuous professional development (CPD).

Profile of workforce

Available data relate to formally employed workers in the sector. No data are available on the substantial number of informally employed health and social services workers deployed by NGOs.

In the Public Service managers constitute 2% of total employment and in the private sector 5%. Professionals comprise 40% of employees in both the Public Service the private sectors. Professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, and other health-related occupations such as occupational therapists and psychologists, as well as social workers. Technicians and associate professionals in the Public Service constitute 21% and in the private sector 25% of total employment in each sector. In the Public Service this category mainly comprises enrolled nurses, ambulance officers, office supervisors and ambulance paramedics. In the private sector enrolled nurses, ancillary health care workers, medical laboratory technicians and office administrators make up this category.

Most (66%) of the professionals employed in the total sector are African, 20% are white, 9% coloured, and 5% are Indian. Among technicians and associate professionals, 51% in the private sector and 78% in the Public Service are Africans. Women constitute 72% of the health workforce and 79% of the professionals in the Public Service. Thirty-one per cent of health and social development workers in the Public Service are younger than 35 years. More than half (58%) are between 35 and 55 and 11% are older than 55.

In the private sector women constitute 70% of the workforce and 75% of professionals. Thirty-seven per cent of workers in the private sector are younger than 35 years, 54% are between 35 and 55 and 9% are older than 55.

Professionals and practitioners in the sector are organised in numerous voluntary organisations that mostly advance the interests of specific fields of healthcare practice, welfare- or social development services. In general these organisations promote their members’ interests, including their educational and economic interests, and also aim to enhance their professional development. Labour and trade unions are well organised and mobilised within the sector. Trade unions play a formative role

in shaping labour market policies, labour relations practices, and human resources management in the sector.

Research institutions

A number of institutions conducting research in human- and animal health, human and social development and the socio-economic impact of disease play a prominent role in the sector. In addition to their research activities, the Medical Research Council (MRC), the National Health Laboratory Service (NHLS), the Human Sciences Research Council (HSRC) and the Onderstepoort Veterinary Institute (OVI) are specifically mandated to advance the training and development of researchers, health professionals and technicians for the sector.

Non-profit organisations

Increasingly, NPOs play an essential part in service delivery and expanding the labour market for the health and social development sector. In 2013, a total of 102 297 NPOs were registered with the Department of Social Development in terms of the provisions of the Non-profit Organisations Act, 71 of 1997. The vast majority of registered NPOs (95%) are voluntary associations. The largest group of registered NPOs (40 078 or 39.2%) deliver social services, a further 20 964 NPOs (20.5%) provide development and housing, and 10 582 (10.3%) provide healthcare services. NPOs involved in veterinary services, animal protection and welfare are classified in the environmental category, and 1 228 organisations (1%) were registered in this category in 2013.

NPOs and Community-based organisations (CBOs) are major providers of care services for vulnerable persons and disadvantaged communities in South Africa and service more than 70% of social development clients. Therefore, they are key partners of national and provincial government in attaining socio-economic and developmental priorities. These organisations provide a range of services spanning the human lifecycle, including child care and protection; youth care and youth development; specialised services for the disabled; crime prevention and victim support; treatment and rehabilitation of persons suffering from substance abuse; care for older persons; shelters for women and families; material assistance, as well as support services to patients and households affected by HIV/

AIDS. Even though these organisations, their workers and volunteers fall outside the sector's formal structures, they require special attention in the SSP.

Factors Influencing the Labour Market for the Health and Social Development Sector

Socio-economic realities

South Africa is confronted by difficult socio-economic conditions that impact on the health and social development system and its workforce. Challenges such as poverty, unemployment, HIV/AIDS, maternal and child mortality, teenage pregnancy, low levels of literacy and education, high levels of violence, abuse and neglect, poor housing and poor public health, and high levels of crime provide the focus for policy frameworks and implementation. Constitutional imperatives compel the state to take progressive measures to grant everyone access to healthcare services, sufficient food and water, and social security, and to be development oriented. Measures introduced to achieve these objectives necessitate changes to the skills base and skills content of available human resources in the health and social development sector.

The public-private healthcare mix

South Africans access medical care through the public health system, through private health insurance arrangements with medical schemes, or incur out-of-pocket expenses. In 2014, more than 43 million people rely on the public health system and approximately 8.5 million people are covered by medical insurance. About 24% to 38% of the uninsured population use private services provided by doctors, dentists and pharmacists, but use public hospital services.

Many inequalities are entrenched in South Africa's public-private healthcare mix. In 2014 healthcare expenditure was estimated to be above R293 billion, with 48% attributable to public sector spending and 52% to private and donor financing. Over the period 2010 to 2012, medical scheme contributions paid on behalf of 16% of the population were only 1% to 5% below the combined health expenditure of the nine provincial governments.

It is not only the numbers and skills mix of health workers that are of concern but also their distribution between the public and private sectors, as well as geographically. Significantly higher numbers of health professionals serve healthcare users in the private sector than the public sector population. The challenge to provide healthcare services to rural areas is evident in the fact that an estimated 43.6% of the South African population live in rural areas but are served by only 12% of the doctors and 19% of nurses.

From 1995 onwards the public sector moved from a hospital-based approach to a primary healthcare (PHC) approach. This is also reflected in public sector spending, with about 43.5% of provincial health funds allocated to district health services, which include PHC clinics and community health centres, district hospitals and AIDS interventions. In contrast, private sector spending has moved away from PHC towards funding major medical benefits such as hospitals, specialists, and chronic diseases.

In the social development sector, expenditure by the DSD increased from R94 billion in 2010/11 to R117.8 billion in 2013/14, at an average annual rate of 7.8%. The rise is mainly as a result of expansion of social assistance programmes.

Demand for health and social development services

Both the health and social development sectors are experiencing increased demand for services, and this applies to both the public and private sector components. Demand for PHC services is projected to grow by nearly 5% per annum between 2012 and 2016. Admissions to public hospitals have risen to above 4 million per annum, and both the national average length of stay and the bed occupancy rates at district hospitals have increased over the last decade. The large private hospital groups reported increases in admissions, patient days and average length of stay, mainly due to the rising prevalence of lifestyle diseases.

Social welfare services are becoming more development orientated, with a focused strategy to serve vulnerable people in families and in communities. By March 2017, the number of grant beneficiaries is expected to reach 16.2 million. Foster care beneficiaries increased exponentially from 215 765 in 2000 to 421 883 in 2007 (or by

96%), and the number is projected to grow to 563 000 by 2017, mainly as the result of the growing numbers of AIDS orphans and the strengthened capacity of courts to provide oversight under the Children's Act 38 of 2005. The Department of Social Development has identified the need to promote national adoptions as a preferred mode of permanent placement of children, which entails an increase in the demand for social service professionals. The health and social development sectors are experiencing a growing need for services in the form of home- and community-based care for persons infected with and affected by HIV/AIDS, as well as care services for older persons.

Global factors

At the same time South Africa is also affected by the worldwide shortages of health workers and an exodus of social workers. As highly mobile health professionals migrate to more developed economies, valuable skills are lost and local health services are adversely impacted. Similar experiences in the veterinary profession continue to cause skills shortages in the public sector, where the vacancy rate at national-, provincial- and laboratory levels remains high.

The global economic crisis and economic downturn impacted the health and social development sector on several levels. As tax revenues decline as a result of economic contraction, health and social services budgets and allocations for human resources and training are directly affected. Demand for public health services is likely to increase due to job losses (and loss of employment-linked medical insurance cover). This will add further pressure on health professionals and workers in the public sector.

The burden of disease and social crime

South Africa is encumbered by a quadruple burden of disease attributable to diseases of poverty, the HIV/AIDS pandemic, a high incidence of communicable diseases and tuberculosis infection, as well as high levels of chronic diseases and inter-personal violence. This disease burden is four times larger than in developed countries and is generally double that of other developing countries. The public sector bears the brunt of the problems.

Management challenges

It is widely recognised that care levels, outcomes and management of the public health system are under strain partly because of significant staff shortages, a mal-distribution of skills between urban and rural areas, and an inadequate skills base. Management of the health system is under strain at almost all levels. Widespread inefficiencies result in services that are unresponsive to health and patient needs, and a lack of accountability exists on a large scale.

Provincial governments lack the capacity to plan for and implement social development services that meet the needs of the most vulnerable people. Most state-driven social development services are rendered by NPOs contracted for this purpose. While these NPOs generally rely on government for their core funding, payment delays by provinces for social development services continue to hamper service provision. It is acknowledged that most NPOs have limited financial and management expertise and operate in an uncertain state of sparse funding, job insecurity and well-worn facilities. Often NPOs lack the institutional capacity to meet donor stipulations about business and governance practices, and also lack the means to acquire the requisite competencies and skills.

Many workers in the social development sector earn low salaries, have no employment benefits, face poor working conditions and encounter on-going insecurity associated with community projects and employers' sustainability. Staff turnover rates are high at all levels – for social work professionals, auxiliary workers, supervisors, and managers.

The National Development Plan

The National Development Plan (NDP) describes critical areas where the country needs to progress to reduce poverty and inequality, and improve living standards by 2030. Three priority areas are: economic growth and job creation; education and skills; and building a capable and developmental state. The NDP offers a long-term strategy to increase employment and expand opportunities through education, vocational training and work experience; strengthen health and nutrition services; and expand social protection and community development. Both the DSD and DoH have aligned strategies and service delivery targets with objectives of the NDP.

Human Resources for Health Strategy 2012 to 2017

A revised strategy for the development of human resources in health was published by the DoH in January 2012 under the title Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. The strategy focuses on three thematic areas to guide future actions of the multiple stakeholders, including the DoH, provincial health departments, and faculties of health sciences, statutory councils and professional associations:

- **Theme I:** the supply (and distribution) of health professionals and equity of access to health workers
- **Theme II:** education, training and research
- **Theme III:** the working environment of the health workforce.

The strategy contains short-, medium-, and long term objectives to strengthen human resources to meet service demands, enable appropriate planning and build capacity in the health sector. The National Treasury will make available R7.3 billion in conditional grants to provinces for health professional training and development over the three years from 2015 to 2017.

Regulation of the health and social development system

Almost every aspect of the health system is regulated by the national Department of Health (DoH), and statutory professional councils regulate the quality of the country's health workers. As from 2014, the DoH will also control the quantity and distribution of healthcare services. Newly proclaimed statutory licensing provisions empower the DoH to determine where, by whom and which healthcare services may be provided. Statutory professional councils regulate the quality of the country's health workers.

Responsibility for developing human resources in the public sector is split between the national and provincial levels. The DoH has to promote adherence to norms and standards for the training of human resources, while the nine provincial departments of health are responsible for planning, managing and developing human resources to render health services.

The social development system is driven by the national Department of Social Development (DSD) and services are delivered by provincial government, public entities and NPOs.

Health policies

The National Health Insurance (NHI) policy document of August 2011 envisages a universal health system that will provide adequate healthcare at affordable costs. All South Africans and legal permanent residents will receive universal coverage for a defined, comprehensive benefit package of healthcare services. The PHC package will include personal care, rehabilitative care, health prevention, and health promotion services. Membership of the scheme will be mandatory. All the PHC services will be delivered via the district health system, and in three streams – district-based clinical specialist support teams, school-based services, and PHC agents in each municipal ward. Community health workers will play a key role in health promotion and prevention services at the community and household level.

To ensure continuity of care, a defined referral process will be used to give patients access to care at secondary-, tertiary- and quaternary levels. Hospitals will be re-designated in the following categories: district-, regional-, tertiary-, central-, and specialised hospital. Remedial strategies will focus on the development of a service model for hospital services. Standards and staffing norms for district-, regional- and academic tertiary hospitals will be set to achieve a balanced health system. Adjusted norms will also be agreed for service sites where healthcare professionals are trained. Other initiatives will focus on the development of new team- and clinical role functions of the hospital workforce, including strategies to adjust the skills mix in hospitals to enable cost-effective staffing. Each level of hospital designation will provide different medical services based on standardised care and areas of specialist care. Appropriately qualified and skilled healthcare workers and healthcare professionals will be deployed according to the designated hospital level.

A new public entity, the National Health Insurance Fund (NHIF) will administer the scheme. All providers of healthcare services will be required to meet statutory quality standards, and only accredited providers will be permitted to deliver healthcare for

the NHI scheme. A new statutory body, the Office of Healthcare Service Standards will set norms and standards for the rendering of health services, conduct inspections of all health facilities, and license and certify facilities. Accreditation criteria will cover standards of access and safety; service elements; management systems; performance outcomes; and the minimum range of services to be provided at different levels of care.

A White Paper with final policy proposals is expected in 2014/15. Implementation will extend over a period of 14 years between 2012 and 2025 and piloting commenced in ten health districts in 2013 and will extend to 26 districts by 2019. Adequate numbers of healthcare workers and a well-balanced skills mix of health professionals, practitioners, managers, mid-level workers and auxiliary health workers are critical for the success of the NHI scheme.

Current national health policies focus on: the provision of primary care and community-based health services; expanded HIV/AIDS and TB treatment; improving the health of mothers, babies and children; improving management and governance of the health system; and improving human resources planning.

Social development policies

Multiple policy initiatives and legislative changes to align welfare and social security arrangements with Constitutional principles and a more developmental approach are driving the demand for a range of social development skills. In the Children's Act of 2005, comprehensive arrangements are made for the delivery of social services to children in the areas of alternative care, early childhood development, prevention and early intervention, protection, foster care, adoption, and child and youth care centres. The provisions have a major impact on the obligations, duties and skills of the social development workforce.

The Older Persons Act, 2006 came into operation on 1 April 2010 and establishes a framework aimed at the empowerment and protection of elderly people. A major change involves the shift from institutional care (old age homes) towards community- and home-based care, and the development of care and support programmes to enable the independent living of older persons in their community. The protection of the elderly involves statutory processes that may be

initiated by social workers and health professionals. Home-carers need to be trained and social and health workers need to be registered practitioners.

Community development policies focus on vulnerable communities, who are supported with programmes to alleviate poverty, to generate their own income and to create sustainable livelihoods. Typically, poor communities are assisted to plan and implement activities that will improve their economic, social, cultural and environmental conditions. Some programmes offer skills development, awareness training and support services to women, the youth and families, while other interventions are directed at providing food security and achieving social behaviour change to mitigate the social and economic impact of HIV/AIDS and other diseases.

New education and training strategies

Since 2010 Government and the statutory councils have set new requirements for education and training which impact the workforce in the health and social development sector and also the HWSETA.

The 2013 White Paper for Post-school Education and Training outlines strategies to create an integrated post-school education and training system that meets the country's developmental needs as well as those of workplaces in all sectors. Public TVET colleges will be re-positioned and improved to function as technical and vocational education and training (TVET) colleges. These colleges will be required to re-establish a good artisan training system capable of producing 30 000 artisans annually by 2030. New training institutions, i.e. community colleges will train youth and adults with incomplete or no schooling. Learning programmes will lead to the General Education and Training Certificate (GETC) and the new National Senior Certificate for Adults (NSCA), and SETA-funded occupational programmes will also be offered. The aim is to enrol one million learners in community colleges by 2030. Access to universities will be expanded to 1.6 million students by 2030 and academic teaching capacity and training platforms will be strengthened at the same time.

Cooperation between education and training institutions and the workplace will be stepped up. More prominence will be given to work-integrated learning to ensure that

learners are better prepared for the labour market.

The roles of SETAs are re-defined: to focus on skills development for the existing workforce and to provide the skills pipeline to current workplaces. SETAs will support training programmes that lead to qualifications and awards recognised by industry, rather than short courses. Work-based learning such as learnerships and internships in the non-artisan fields will be expanded, and SETAs will be expected to facilitate work-based partnerships between employers and educational institutions.

New qualification frameworks set in the higher education band have been introduced for several professions and related occupations, including in nursing, pharmacy, emergency medical care, environmental health, child and youth care, and community development.

Veterinary services

Veterinary services are delivered by a veterinary team and so the traditional veterinary profession has expanded to include a range of para-professionals such as animal health technicians, veterinary nurses, veterinary technologists and laboratory animal technologists. Veterinary skills are in demand globally, especially in Africa, and in South Africa skills shortages are experienced in both the public and private sectors. In 2012, a total of 2 113 registered veterinarians worked in private practice, another 271 worked overseas and only between 185 and 200 were employed in the public sector.

Veterinary professionals and para-professionals play a critical role in the treatment of diseases that affect and pose a risk to animal- and human health and in the promotion of food safety and food security required for economic growth. Veterinarians are key drivers of the “One Health Concept”, which recognises the inter-dependence of humans, animals and the environment. In South Africa a shortage of veterinary skills and veterinary controls pose a risk to human health in that the incorrect (and uncontrolled) use of veterinary medicines and farm feeds may contaminate meat and milk produced for human consumption.

Particular challenges pertaining to the provision of veterinary services include the need to improve access for all users of veterinary services in rural areas; to ensure

that state veterinary services are adequate and comply with international standards; and specifically to maintain national animal health and veterinary public health systems. Shortages of veterinary professionals exist in the public sector and amongst previously disadvantaged groups.

A key government priority is to strengthen rural development by growing rural income, improving food security and enabling sustainable job creation. Mismanagement of livestock by small-scale farmers is having an adverse economic impact. Veterinary services need to be extended country-wide to small-scale livestock owners to give them access to the knowledge, skills and technical support necessary for good animal health and profitable production. Given the shortage of veterinarians, there is a need to train more animal health technicians who should also be equipped with the skills for providing basic primary animal healthcare and veterinary extension services.

Harsh economic conditions for farmers and animal owners have led to a reduced demand for private veterinary services and this has contributed to an exodus of veterinarians in private practice from rural areas. Limited clinical training platforms to train veterinary professionals and para-professionals are hampering supply. Compulsory community service for veterinarians will be introduced in 2015 or 2016, and for para-veterinarians, within a few years after that, and this will relieve skills shortages in the state veterinary services in the short term.

The Demand For Skills

The health and social development sector is a personal services industry where services are both resource- and time intensive. Effective delivery of these services depends upon the availability of skilled human resources with the appropriate skills. The growing demand for health and social development services and the introduction of changes in the way these services are delivered to the public drive the demand for skills. Such demand continues to outstrip supply.

Current employment

By 2014 there were 310 256 filled positions in the Public Service health and social development departments. Vacancy rates are quite high and the total number of vacancies indicated as scarce skills amount

to 15 969. The total number of positions (filled and vacancies) in the Public service is 326 225.

In 2014 the filled positions in the private sector were 276 513 while there were 5 099 vacancies. This brings the total number of positions in the private sector to 281 612 and the total number of positions in the Health and Social Development sector to 607 837. However, components of the sector are still excluded from these calculations; e.g. some of the professionals in private practice, the professional and administrative support staff working in these practices, the medical personnel employed by the SANDF and the majority of people working in non-levy-paying NPOs.

Current shortages

In 2014, 64% of the organisations that submitted WSPs to the HWSETA reported difficulties in filling certain vacancies, while the national DoH – as well as most of the provincial departments of health and social development – reported skills shortages. Analysis of the WSP applications indicated that 82% vacant positions in the Public Service were for professionals. In the private health sector, a total of 5 099 people is required to fully alleviate the skill shortages. Skills shortages are the most severe among professionals and technicians and associate professionals.

In the Public Service Scarcity were frequently related to geographic location and replacement demand. Most organisations indicated a lack of skilled people combined with attractive career opportunities outside SA as reason for the scarcity of professionals.

The shortage of nursing skills is acute and post-basic training for nurses in specialised fields must be stepped up. Nurse specialists are needed in advanced midwifery, post-natal care, intensive care, trauma care, operating-theatre, PHC, paediatrics, psychiatry and other specialist areas. More health academics, health educators and preceptors are needed, especially in the nursing field.

According to the DoH, the gap in critical health professionals in the public sector reached 83 043 in 2011. In other words, had the public sector maintained the desired ratio of health staff to population, another 83 043 health professionals, practitioners and home-based care workers would have

been required. The largest shortages were for nurses (22 352 professional nurses, 19 805 staff nurses and 6 434 enrolled nursing assistants); medical specialists (7 471), general medical practitioners (4 294); emergency service medical practitioners (4 914); post-basic pharmacy assistants (8 288); home-based care workers (9 655) and community health workers (14 651).

In the social development sector, the most critical challenge impeding rapid budget growth and expanded service delivery continues to be the shortage of social work practitioners. The DSD estimates that 16 500 social workers were needed in 2012 to implement statutory services under the Children’s Act. That figure represents 91 % of all registered social workers in 2014, leaving just 9% to deliver other much-needed social development services. Considering that only an estimated 55% of social workers are employed by Government or the NPO sector, the demand for social service professionals is acute. The national ratio of social worker to population falls below international benchmarking norms. Demand also exists for specific skills sets so that social workers may be better prepared for working in a community context and for being work-ready- and productive professionals. In particular, there is a need for intensive “on-boarding programmes” and thorough occupational-specific training for the current corps of social workers.

Demand for healthcare skills in terms of comparative benchmarks

Employment of doctors and nurses in the public sector falls short of international benchmarks for in-hospital care and the minimum guidelines of the World Health Organization (WHO). According to the WHO, countries with fewer than 230 doctors, nurses and midwives per 100 000 population generally fail to achieve adequate coverage rates of care to attain the health-related Millennium Development Goals (MDGs). These goals relate to reducing child mortality, improving maternal health and combating HIV/AIDS and other diseases. In 2012 the public sector had 181 doctors and professional nurses per 100 000 of the population.

A recent comparison with peer countries (Brazil, Argentina, Chile, Colombia, Costa Rica and Thailand) shows that South Africa has significantly fewer health professionals per 10 000 population and also has poorer

health outcomes. Although South Africa has a higher ratio of nurses than five of its peers (except for Brazil), the local infant mortality and maternal mortality rates are significantly worse than those of its peers. South Africa had one pharmacist per 3 849 population in 2010, well below the WHO recommendation of one per 2 300 population. To meet the WHO targets by 2030, South Africa will need to deploy 24 000 pharmacists and 72 000 pharmacy support personnel.

Future demand for health workers

In a recent strategy document entitled Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17, the national DoH sets targets for the production and deployment of health professionals, health practitioners and health workers to ensure better access to services and to improve quality in the health system.

Among the key targets set are to increase the ratio of medical practitioners in the public sector from the 2.82 per 10 000 population to 3.66. The number of general practitioners (GPs) in the public sector needs to increase from the 13 829 the public sector had in 2011 to 21 508 by 2025. Annual intake of GPs from training will have to grow from an estimated 1 394 in 2011 to 1 843 by 2025, while the intake of new medical students will have to grow by 60% from 2011 levels to 2 199 by 2025. Between 2011 and 2025, an additional 8 289 GPs will have to be sourced from the private sector or through foreign recruitment. The future demand for medical specialists in the public sector is particularly acute. Production of medical specialists will have to be more than doubled from the 872 graduates of 2011 to 1 729 graduates by 2025.

Factors driving demand for healthcare skills

Programmes to accelerate HIV testing and increase the number of patients on anti-retroviral treatment (ART) six-fold between 2010 and 2019 will have a major impact on the demand for skills. More specifically, the public sector will need additional doctors, medical specialists, nurses, pharmacists, administrative support staff (to order, collect and distribute drugs) and skilled health managers to implement and oversee operations. Demand for similar skills is triggered when key programmes to fight TB

are rolled out. More lower-level skills are needed to monitor adherence to treatment regimes for HIV/AIDS and TB. Specialised training on a large scale is required in TB management and infection control.

Strategies to improve the health of mothers, children and women aim to provide universal access to reproductive services. Specialised skills are needed in midwifery, advanced midwifery, neonatology, paediatrics and integrated management of childhood diseases, while doctors and midwives need to be trained in the management of obstetric emergencies. Skills interventions should also target PHC nurses involved in health monitoring programmes for mothers and children.

Skills requirements to implement the NHI – including the extension of PHC services to communities and schools and measures to improve service delivery in all levels of public hospitals – are daunting. This will drive demand for a range of medical and nursing specialists, professional and registered staff nurses, GPs, medical professionals trained in PHC, and community health workers. Professional nurses are needed to lead 7 500 PHC outreach teams, and also for all areas of post-basic care including midwifery, intensive care, operating-theatre-related work and psychiatry. The DoH estimates that 45 000 CHWs are needed initially to staff PHC outreach teams at community level, while the NDP estimates that 700 000 should be trained by 2030. Environmental health practitioners and nutritionists are also needed for all the health districts.

In the public sector and in the district health system in particular, leadership skills and professional management skills are required to manage complex systems and to improve operational efficiency. Skills in the planning and implementation of programmes, as well as the monitoring and evaluation of service and quality of care, are required. On the people side, skills are needed to manage human resources and their performance. More particularly, managers require skills to lead and guide subordinates, improve their productivity and instil accountability for service to patients. Other areas for managerial development include planning and time utilisation, use of information technology, and financial- and capital-resources management. Extensive, intensive and purposive skills development is needed in all these areas.

Public health specialists and public health professionals are needed to lead public health policy and monitor public health strategy, while academic clinicians are required in all disciplines to ensure a platform for health professional training and development.

Demand for social development workers

Expansion of social development services and the introduction of new services for children, persons with disabilities, older persons and vulnerable members of society propel demands for a range of occupational groups to implement developmental social welfare programmes. According to the NDP, the ranks of social services professionals should be boosted to 55 000 to meet the demand for appropriate basic social welfare services.

Plans to grant young children universal access to early childhood development for two years are driving the demand for skilled Early Childhood Development (ECD) practitioners. An estimated 10 000 child- and youth care workers need to be trained to expand supervision services at home and give psychosocial support to 1.3 million orphans and vulnerable children. As the population ages and the elderly become a larger proportion of the population, the need for social- and care services to older persons care will grow. Role-players in the sector have identified the need to regulate and train community caregivers and care workers employed by agencies and residential facilities.

Among the other categories of social services workers required are social work professionals, social auxiliary workers, community development practitioners, community development workers, and community caregivers. Social workers with specialist qualifications such as probation officers are needed for anti-substance abuse programmes. Stakeholders confirmed the need to improve the skills base of the current corps of social auxiliary workers so that they may be fully functional assistant workers to achieve the aims of social work.

Extensive skills development is needed for current corps of social workers, who require support to strengthen occupationally-specific technical skills and to develop post-graduate level skills in one or more of the recognised specialisation areas of social work, as well as the emerging areas

of specialisation. The need for training in supervision and management is acute, while a broader skills base should be developed to deal with cases involving substance abuse and mental health.

Demand for new skills

Shifting service demands and technological progress necessitate changes to the scopes of practice of many professions and occupations. As a result, practitioners will require new skills sets to close current skills gaps – e.g. pharmacists, pharmacy technicians, registered nurses and enrolled nurses, emergency medical care practitioners and technicians. New professions and occupations are emerging as a result of the need to change the way social development services are delivered, such as in the field of child and youth care and community development.

Demand for skills development interventions by the HWSETA

Stakeholders in the health and social development sector expect of the HWSETA to create an enabling environment for skills development. In this regard the SETA's quality assurance functions, service delivery and responsiveness need to improve, and the capacity for practical- and workplace training must be expanded, with more technical- and occupational supervisors made available to teach and guide learners.

Supply of Skills

The supply of skills can be correlated directly with outputs from the school system, graduation trends, professional registration, and the role that the HWSETA plays in skills development. A combination of complex factors influences the supply of skills to the health sector.

The secondary school system

At the heart of the supply problem is the quantity and quality of learners who complete high school. The secondary school system is producing fewer candidates with the combination of mathematics, physical sciences and/or life sciences required to enter tertiary level studies in the health sciences.

In 2012, a total of 511 152 learners sat the NSC examination. Of these, 377 847 (74%) passed the examination, while only 152 881 learners fulfilled the requirements for admission into diploma courses and 136

047 for admission into a bachelor's degree. From 2008 to 2012 the number of passes (40% and more) in life sciences and physical sciences increased but decreased in the case of mathematics.

Quality standards of education in mathematics, physical sciences and life sciences are major supply-side constraints impacting on the skills of the health sector. Sub-standard levels of literacy and numeracy skills of school leavers and their poor level of readiness for tertiary studies further reduce the supply pool for the health and social development sector.

Institutional capacity to train health and social development workers

Long lead times required for developing health professionals and the lack of coordinated planning for health professional training between the health sector and education sector impact on the supply of skills. Existing institutional arrangements and regulatory provisions regarding the training of health professionals restrict the supply of skills to the sector. Most of the health professionals who are required to register with the HPCSA, the SANC, the SAPC and the SAVC are trained by universities and universities of technology, and undergo practical training in state-owned academic health complexes. Production levels at these institutions are limited because of: constraints in clinical training platforms; the inadequate numbers of health educators and academics; poor infrastructure and equipment; and low budgets. However, the strengthening of academic medicine and health training platforms is a key strategic area for the DoH, and measures will be taken to improve academic resources. In terms of policy documents such as the NDP and the 2013 White Paper for Post-school Education and Training, SETAs are required to support these goals.

Opportunities to train healthcare professionals in the private sector are also limited as private HEIs appear to be challenged in meeting the extensive accreditation requirements for the training of health professionals set by the professional councils and the HEQC, or are restricted by government policy.

Generally, NGOs offer non-accredited training to volunteers and CHWs, as the organisations lack capacity to

seek accreditation to offer the formal qualifications registered on the NQF. The HWSETA's capacity to facilitate skills development for NGOs is hampered by funding constraints because the NGOs are levy-exempt organisations.

Educational infrastructure to accommodate social work students is under great pressure. Factors such as budget constraints, limited training capacity at academic institutions, and challenges in placing students in fieldwork for practical training continue to hamper the output of social work graduates. Social services organisations also have limited resources to accommodate undergraduate students in suitable workplace training. Stakeholders identified an urgent need to provide supervision capacity and boost the ranks of practice supervisors for social work interns.

Supply of new graduates from the higher education system

Owing to recent changes made to the manner in which the number of graduates in various higher education programmes are grouped and recorded, it is difficult to compare the supply of graduates from higher education institutions (HEIs) in health-related fields over the medium- to longer term. From 2010 to 2012 the total output from the Higher Education and Training (HET) sector in the health-related fields of study grew on average by 3.9% at first three-year B Degree level and by 6.0% at first four-year B Degree level. However, over the same period the growth in supply of new professionals in fields of study such as medicine (1.8%), nursing (2.0%) and veterinary biomedical and clinical sciences (0.9%) has been well below the average. By contrast, the growth in supply of social workers reached 19.5%.

Nursing colleges play an important role in the training of nurses. Total output from nursing colleges reached 20 764 in 2013 and has increased on average by 7.1% per year since 2003, while the number of pupil nurses has risen sharply from 3 158 in 2003 to 8 954 in 2013.

Professional registration

Growth in registrations of health professionals with their respective professional councils was slow from 2003 to 2013. The total number of registered dentists grew by 2.5% per year, medical interns by 4.6%, medical practitioners by 2.8%, and

registered nurses by 2.8%. The ranks of registered pharmacists grew on average by 2.3% per year from 2006 to 2014 and pharmacist interns by 6.4%. Over the same period, registration figures in the pharmacy support staff categories showed higher growth. From 2010 to 2014, the number of veterinarians registered with the SAVC grew by 2.9% from 2 769 in 2010 to 3 102 in 2014.

In some instances the annual growth rate in professional registrations has been lower than the growth rates in graduates produced for the particular health professional category.

The total number of registered social workers increased on average by 5.5% from 2004 to 2014, or from 10 645 to 18 213. Registered social auxiliary workers increased at an average annual rate of 13.7% from 1 455 in 2003 to 5 239 in 2014.

Role of the HWSETA in the supply of skills

The HWSETA also contributes to skills formation in the health and social development sector. Since 2002 more than 25 000 learners have enrolled on health-related learnerships. Over the period 2005/06 to 2012/13 more than 10 800 learners successfully completed learnerships in the health and social development sector and were recorded on the HWSETA's electronic system. Many more learners completed learnerships that are quality-assured by professional councils and learners' achievements are recorded by the councils and not by the HWSETA. For this reason a considerable number of learners who have successfully completed learnerships in the sector are not recorded on the HWSETA's system. The SETA also supports skills development through internships and workplace training programmes, skills programmes, scholarships, AET, and partnerships with public TVET colleges, universities and employers, as well as small-enterprise development. Recently the HWSETA also cooperated with DoH, DSD and the SACSSP to develop qualifications required for the sector.

Factors influencing the supply of skills in the sector

The supply of skills to the health sector is not only determined by capacity at training institutions and the scope of training activities on clinical platforms. Structural barriers in the public sector

also impact on the supply of skills. Newly qualified health professionals are often not absorbed in the public sector due to the non-availability of posts and budget constraints. Health workers and community caregivers risk exposure to HIV/AIDS and TB in the workplace and face increased risks of contracting the disease compared with workers in other sectors. As a result of HIV/AIDS, skilled workers leave the sector prematurely, either because they fear infection, become ill themselves, or need to care for others who fall ill.

Public health policies and skills planning by various role-players have lagged behind demand for mid-level skills. Considerable uncertainty prevails about the scopes of practice of mid-level workers (MLWs), their roles in healthcare teams, and the responsibility for their supervision. The production of MLWs may remain low until these issues are addressed and provision is made for their training and career progression. Positive progress is expected in the near future as the HPCSA has identified the need to develop occupational frameworks that include MLWs in most of the professional fields regulated by the respective professional boards. However, it may take a number of years to prepare and furnish the training platforms.

In order to provide better skilled practitioners to the sector, several of the health professions are elevating healthcare qualifications and training requirements to higher education platforms. The direct implications are that current training providers such as Further Education and Training (TVET) and nursing colleges will have to meet different (and perhaps more stringent) accreditation requirements and be declared HEIs. Delays in authorising and accrediting the new training platforms will limit graduate output and hamper the supply of more competent, better-skilled health practitioners.

Migration of professionals and challenges to retain their services (or even deploy them) in the public sector continue to impact on the skills available to the health system. For example, 11 700 doctors graduated between 2002 and 2010, and yet the number of public sector posts for doctors increased by only 4 403. Low absorption rates are also noted for dentists and the therapeutic sciences (physiotherapy and occupational therapy) as a result of the lack of public sector posts.

Skills development of CHWs is required on an extensive scale to incorporate them into PHC teams. However, the supply of skilled workers in these categories is hampered by uncertainty about: their roles and scope of work; the training and supervision framework required; and their employment status as volunteers or partially paid helpers.

Recently enacted statutory provisions to licence healthcare practices, -facilities and -services may have a major impact on the supply and distribution of skills. While these provisions will soon permit Government to manipulate the quantity and allocation of skills across provinces, the extent of the impact on skills provision for the sector will not be known for some time.

Many factors constrain the supply of skills to the social development sector. While number of social work graduates and registered professionals has grown over the last five years, mainly due to the Government-funded scholarship programme, the supply of new skills has not met the enormous demand for services. The supply of skills to the sector has been hampered by policy gaps. The expanding statutory framework for social services demands services from occupational groups that are not yet formally organised, recognised or regulated, and policy makers have been slow to identify which cadres of workers should be deployed. There is also uncertainty whether certain services (and the workforces that deliver them) resort with in the social development sector or other sectors, e.g. CCGs and ECD practitioners could also operate in the health- or education sector respectively.

Delays in establishing effective regulatory frameworks for several professions and evolving occupational categories have impacted on skills formation for the sector, especially in fields such as ECD and child and youth care. Capacity- and budget constraints at HEIs restrict output of social work graduates to lower levels than those required. Placing undergraduate students in suitable workplace training is becoming increasingly challenging, mainly because of limited resources in social services organisations. Access to learnerships in the social development sector is also hampered, as NPOs – which are the main delivery channel for social services – lack the infrastructure, funds and human resources to accommodate learners. The introduction

of generic norms and standards for social welfare services will drive demand for further skills development and training.

Although social services programmes under the EPWP are training many unemployed persons, the levels of skills developed are low and are often not retained in the sector, especially if salaried employment is not available to them.

The supply-side analysis presented in Chapter 5 of this SSP shows that 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 various institutional problems such as weak management systems, sub-functional working environments and poor human resources practices. The analysis also leads to the conclusion that unless major improvements in the leadership and management of the health and social development system at all levels are made, migration of health and social development professionals and workers is likely to drain the supply of skills for the considerable future.

Responsible regulatory bodies in the sector also need to speed up processes to recognise emerging occupational categories and professions and institute the required regulating frameworks for such professions and occupations. For as long as these arrangements are not in place, efforts to supply critical skills for healthcare and social development will be hamstrung.

Skills Development Priorities of The HWSETA

Given the nature and magnitude of the skills development challenges in the health and social development sector, an integrated effort is required in partnership with the national DoH, DSD, DHET, the higher education sector, private education and training providers, public and private health facilities, NPOs, and the HWSETA. As one of several institutions tasked with funding and facilitating skills development for the sector, the HWSETA will focus its attention in a number of priority areas in the five-year period covered by NSDS III.

The HWSETA will allocate mandatory grants and discretionary grants to finance skills development projects and programmes that are aligned with the Annual Performance Plan. Budget provision for grant funding for the period 2014/15 to 2016/17 has been

adjusted to R 743 296 000.

Specific skills development priorities

Skills development priorities for the sector are aligned with five cross-cutting skills development objectives. These are strategic focus areas for the NSDS III; support of government's MTSF objectives, the National Development Plan, the National Skills Accord to achieve the New Growth Path goals, the Human Resource Development Strategy for South Africa and the Presidential Infrastructure Coordinating Commission. Consideration is also given to attaining the high-level performance targets set by the Executive Authority and the Department of Higher Education and Training.

The HWSETA realises that it should not train people for the sake of training. Rather, training must have value, meet sector needs and enable a learner to have dignity and find employment. The main goal of the HWSETA skills development programmes and projects is to provide skills to learners in the workplace in scarce and critical areas within the health and social development sector.

Following the analysis of the skills situation in the sector and the needs identified by stakeholders, five skills development priorities have been identified for the health and social development sector:

- Occupationally directed programmes;
- Workplace-based skills development;
- Training initiatives for cooperatives, small enterprises, workers, NGOs and the community;
- Capacity building for the public sector; and
- Special Project: Post-school education and training priority areas.

Skills development programmes and projects that increase access to occupationally directed programmes will focus on the development of mid-level skills, high-level national scarce skills, artisans and pre-apprenticeship skills. The HWSETA will encourage the better use of workplace-based skills development by directing discretionary grant funding to train employed workers in critical skills, and interventions to enhance the ability of the workforce to adapt to change in the labour market. Specific projects will enable

learners and graduates to gain relevant workplace experience. The HWSETA will support training initiatives to develop the capacity of NGOs, CBOs, and cooperatives to be more self-sustaining. Projects to train skills development facilitators and labour representatives of trade unions will also be provided and their impact measured. The HWSETA will cooperate with the DoH and the DSD to revise training plans and funding to support interventions that build the developmental state and increase efficiency in the public sector. Resources will be allocated via a special HWSETA programme to strengthen training infrastructure in the post school education and training system.

Sectoral contribution to government policies

The HWSETA's contribution to government's objectives set out in the NDP, NSDS III and other policies will centre on close cooperation with the DoH and the DSD, support for health and social development strategies through skills development and – within mandate and budget parameters – enabling the supply of larger numbers of workers equipped with the skills necessary to improve healthcare and social services in South Africa. However, these initiatives may be hampered by a disjuncture between the different ministries involved in the planning of health and social development services.

Current shortages of skills in the public health sector lead to massive inequalities in terms of access to proper healthcare and the perpetuation, and even the intensification, of inequalities in the South African society. Therefore, the HWSETA's activities will aim to alleviate skills shortages and develop new skills that can serve the poorest segments of the population and under-resourced areas. Skills development support will give preference to historically disadvantaged individuals.

Areas of strategic focus for the NSDS III

Establishing a credible institutional mechanism for skills planning

The HWSETA will conduct research and sectoral analysis in accordance with acceptable academic standards to produce SSPs and consult with stakeholders on skills development needs and strategies. Monitoring and evaluation of programmes and projects and impact assessments

of skills development interventions will be undertaken by the HWSETA. Through support given to postgraduate research students, the HWSETA will build research capacity in the sector. Research partnerships with university faculties and other stakeholders will be concluded and strengthened.

Increasing access to occupationally directed programmes

Several strategies will be introduced to develop intermediate and mid-level skills. The HWSETA will cooperate with employers to develop mid-level skills through work-based training opportunities. Targeted funding will be made available to register employed and unemployed learners on learnerships. Partnerships will be established to take on apprentices and support the development of artisans for the health and social development sector and learners on pre-apprenticeships and N-courses will be supported to develop vocational skills. The HWSETA will support measures to enable the employment of artisans and unemployed learners in their respective trades and occupations after completing the SETA-funded programmes. Projects will be put in place to advance entry into priority programmes for high-level national scarce skills. The HWSETA will support access to PIVOTAL programmes, i.e. “professional, vocational, technical and academic learning” programmes that meet the critical needs for economic growth and social development. Work-ready unemployed graduates of middle level qualifications will be supported to gain work experience. The formal partnerships already established with TVET colleges, universities of technology, universities, and other stakeholders to enable workplace-based training in mid-level skills and scarce high-level skills will continue and will be broadened.

Promoting the growth of a public TVET college system that is responsive to the sector, local, regional and national skills needs and priorities

The HWSETA recognises that the public TVET college system is central to the government's programme of skilling and re-skilling youth and adults. It also recognises that Government will take positive measures to strengthen and re-position these institutions as Technical and

Vocational Education and Training (TVET) colleges as a matter of national priority. A number of HWSETA interventions support this goal. Partnerships with TVET colleges have already been established and these will be expanded.

Partnerships will be established between the HWSETA, and various role-players, employers and public TVET colleges to offer vocational training and courses for social services needed in the sector. The HWSETA will, among other things, focus on building the capacity of the TVET colleges to courses that are relevant to the health and social development sector. The training of lecturers and building of workplace experience of lecturers are focal areas that will receive funding in the planning period.

Addressing the low level of youth and adult language and numeracy skills to enable additional training

Although the responsibility for training in basic literacy and numeracy now lies with the Department of Basic Education, special projects will be launched to promote and fund AET.

Encouraging better use of workplace-based skills development

Funding will be allocated for particular projects and quality programmes that address sector-specific skills gaps in the current workforce. Cross-sectoral health and social skills development projects will be supported in nine provinces to strengthen local skills and enable local economic development. Programmes that stimulate economic growth and the ability of the workforce to adapt to change in the labour market will also be supported. The HWSETA will also introduce incentives to employers to encourage improvements to the funding of training and the use of training funds.

Encouraging and supporting cooperatives, small enterprises, worker initiated, NGO and community training initiatives

The HWSETA endorses one of the key “job-drivers” in the National Growth Plan which is to leverage the social economy and support NPOs and civil society organisations. The HWSETA will support NPOs and cooperatives with skills training and development relevant for the sector. Specific projects will be established

to support and develop cooperative organisations. To advance employment opportunities and growth, training will focus on unemployed persons, youth, women, and people with disabilities. The SETA will also engage in partnership projects to provide training and development support to small businesses in the sector, especially in the area of business skills development. Education programmes to support levy exempt organisations and trade unions will be funded as well as small and emerging businesses.

Increasing public sector capacity for improved service delivery and supporting the building of a developmental state

Many of the significant challenges faced by the public sector to deliver quality services in healthcare and social development can be attributed to serious skills gaps of public service managers, officials and workers. The NDP recognises that the state should take steps to professionalise the public service and the HWSETA will contribute to this goal.

The HWSETA will engage with national and provincial departments of health and social development to determine their capacity needs. Skills development plans and funding arrangements will be agreed on between the various departments, the HWSETA, the PSETA and other relevant SETAs. These strategies will enable the HWSETA to contribute to the revision of education and training plans for the public sector and the implementation of capacity-building programmes.

Building career and vocational guidance

The HWSETA will create awareness of the occupations in the health and social development sector at all levels. Special attention will be given to scarce skills and new mid-level occupations. Career guides with relevant labour-market information will be developed for all the health and social development sub-sectors. Career paths will be mapped to qualifications and the career guides will be updated annually. Career development interventions will be directed at a targeted number of school learners across all nine provinces.

In Conclusion

The skills development priorities and interventions outlined above will be implemented within the available funding of the SETA. The success and impact of these strategies will be assessed on an on-going basis and the overall strategy and business plan will be revised annually. Concerted efforts will be made to improve service delivery and governance. Regular engagement with stakeholders will take place on skills development strategies and outcomes of the skills development interventions.

We hope that readers and fellow researchers will find the information useful in shaping their own strategies and research-based work in time to come.

1 Introduction

1.1 Background

Section 10 (1) (a) of the Skills Development Act No 97 of 1998 (as amended) requires each Sector Education and Training Authority (SETA) to develop a five-year Sector Skills Plan (SSP) within the framework of the National Skills Development Strategy (NSDS). SSPs are reports aimed at identifying skills needs (including skills shortages), as well as opportunities and constraints in utilising and developing skills aligned with government's skills development priorities. Specific aims of an SSP, as stated by the Department of Higher Education and Training (DHET), in its original guidelines are to:

- a) Determine the skills development priorities following an analysis of the skills demand and trends and the supply issues within sectors;
- b) Identify a set of sector-specific objectives and goals that will meet sector needs, skills needs related to economic or industrial growth strategies, and scarce and critical skills needs;
- c) Identify strategies to address these objectives and goals for the sector;
- d) Identify activities that will support these strategies; and
- e) Resource these activities.

SETAs are required to update SSPs annually to cover the next five-year period. The updating of the SSP for the period 1 April 2015 to 31 March 2020 was done in phases and involved extensive desktop research and quantitative analysis of several databases. Personal interviews with key experts with in-depth sectoral knowledge were held in mid-2014 and late 2012 and their views are incorporated herein.

1.2 Preparation of the SSP update

1.2.1 Alignment with NSDS III and other government policies and strategies

This SSP aims to align the sector-based skills needs and programmes with government's economic and social development priorities set out in the National Development Plan (NDP), New Growth Path (NGP), the Skills Accord and the Medium Term Strategic Framework (MTSF). Reference is also made to performance goals set by the Executive Authority and the Department of Higher Education and Training and how the HWSETA will contribute to attaining them. Attention is given to key pillars of the NSDS III², namely:

- a) Professional, vocational, technical and academic learning (PIVOTAL) programmes³ that provide an occupationally directed qualification;
- b) Interventions to address shortages of priority skills in professional fields needed to implement national social-development- and economic-growth strategies;
- c) Incentives for training and skills development among cooperatives and Non-Governmental Organisations (NGOs) and especially in rural communities so that adults, especially women, and young people may overcome poverty and create a livelihood for themselves; and
- d) Initiatives to develop capabilities in the public sector to meet the strategic priorities of the South African developmental state.

² Department of Higher Education and Training, 2011. *National Skills Development Strategy III*. Published at <http://www.dhet.gov.za>. (Accessed 9 Aug 2011).

³ A PIVOTAL programme is a professional, vocational, technical and academic programme that equips a candidate with the knowledge, skills, competencies, judgment, behavioural patterns and values required for a specialised vocation. Such programmes lead to an occupationally directed qualification comprising academic and supervised practical learning in the workplace. In some instances such programmes may start in the workplace and then move to course work at a college or university. In other instances, PIVOTAL courses may commence at an academic institution, and include supervised work and learning in an enterprise before culminating in a qualification.

1.2.2 The process of updating the SSP 2013-2018

Very important to this SSP are the strategic plans of the two government departments involved in this sector: the Department of Health (DoH) and the Department of Social Development (DSD). The latest Annual Performance Plan 2014-2015 and the Strategic Plan 2014-2019 of the DSD as well as the Annual Performance Plan 2014/15-2016/17 and the Strategic Plan 2014/15-2018/19 of the DoH were considered in this SSP update. Extensive reference was made to another strategic document of the Department of Health, namely Human Resources for Health South Africa – HR Strategy for the Health Sector 2012/13-2016/17. Policy and strategy documents that impact on the skills base of the workforce in the health and social development sector were also studied. Pertinent aspects relating to veterinary health were sourced from the Strategic Plan 2013/14-2017/18 of the Department of Agriculture, Forestry and Fisheries (DAFF). Budget- and expenditure reports published by the National Treasury for the 2014 Budget, including the Estimates of National Expenditure (for DSD, DoH and DAFF) and the 2014 Budget Review were also used. The White Paper on Post-School Education and Training and its relevance for the HWSETA's skills development initiatives was also considered. Reference is also made to a number of strategic documents that became available after the submission of the previous SSP update.

Desktop research conducted over several months focused on identifying factors that affect the demand and supply of skills for the sector. Information was also gathered on government strategic plans and priorities – e.g. the National Development Plan 2030, the Green Paper on the National Health Insurance and the Strategic Integrated Projects (SIPs) driven by the Presidential Infrastructure Coordinating Commission. This SSP update also includes updated data and information from the South African Health Review 2012-13 and the Child Gauge 2013, published by the Children's Institute of the University of Cape Town.

Various data sources were used to analyse and construct a profile of the health and social development sector. For the 2014

SSP update, data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the Public Service SETA (PSETA) as well as data furnished to the HWSETA from the private MEDpages⁴ database (see Annexure B). Data extracted from the registers of social service professionals, health professionals and para-professionals maintained by the statutory councils were analysed. Information from the Education Management Information System (EMIS) and the Higher Education Management Information System (HEMIS) kept by the Department of Basic Education and the DHET respectively was also used in the preparation of the SSP update. The current update reflects the data that became available during 2014, including the WSP information submitted in June 2014.

In preparation of this SSP update, interviews were held with sectoral and industry experts and role-players in the sub-sectors for human health, animal health and social development. In all, 30 respondents were interviewed in June-July 2014 and another 56 respondents in October and November 2012. In this manner the HWSETA obtained valuable perspectives on the changes taking place in the labour market for the sector, as well as skills development needs and challenges, and the priority areas for skills development. A number of the respondents were senior officers in the DoH and the DSD who are tasked with human resources planning at a national level. Respondents from three provincial departments were also interviewed in 2012. Representatives responsible for professional development at five statutory professional councils were also consulted. Interviews were also held with academics involved in the training of healthcare practitioners, health sector managers, social workers and veterinary and para-veterinary professionals. Three large NGOs that are engaged in the provision of a range of social services and social development programmes, one umbrella organisation responsible for lobbying on behalf of NGOs and a private sector employer organisation were also approached for inputs.

The HWSETA Board also play an important role in the development of the SSP. The first Draft (dated 01 August 2014) will

be considered by the Skills Development Standing Committee of the Board. Feedback will be incorporated in the second update of the SSP and the final version of this update will be reviewed and approved by the Board prior to submission to the DHET. Two Board members, while serving in their capacities as senior officers involved with skills planning in the DoH and the DSD, facilitated access to key persons in the sector with whom the HWSETA could engage on skills needs and skills development priorities.

Previous updates of the SSP were reviewed and approved by The Skills Development Standing Committee (sub-committee of the Board) and finally the HWSETA Board, and were also published for stakeholders interested parties to provide inputs. The stakeholder inputs were considered and incorporated into the final versions of previous updates. The HWSETA will adopt a similar approach in finalising the SSP update for 2015 to 2020.

In the 2014 SSP update all occupational data are reported according to OFO version 2013. Data that was originally reported according to other classification systems were coded to OFO 2013 during the 2013 update.

1.2.3 Limitations

During the preparation of every SSP update the HWSETA encountered significant difficulties with the lack of data, gaps in and quality of information, as well as inconsistencies in the data of the sector's human resources. The 2012 HRH Strategy reported similar difficulties, with a large discrepancy between national DoH and PERSAL data, and a margin of error in the region of 30% in some cases. These difficulties are beyond the control of the HWSETA and it has to place reliance on multiple employers and bodies in the sector to collate such data. The development of reliable, integrated time-series data that will enable the SETA to accurately describe its sector and to track sectoral changes over time remains a challenge.

1.3 Outline of the SSP

The Synopsis Chapter required by the DHET was incorporated before the Executive Summary of this SSP update. Chapter 2 of the SSP provides a profile of the health and social development sector in South Africa and specifically those components of the sector served by the HWSETA. In Chapter

3 the most important factors that impact on the sector's labour market are discussed. Chapter 4 deals with the demand for skills in the sector and Chapter 5 with the supply of skills. In Chapter 6 the strategic areas of focus for the HWSETA are outlined.

⁴ Database of healthcare professionals and organisations. <http://www.medpages.co.za>.

2 Profile of the Sector

2.1 Introduction

Any sectoral skills development strategy needs to be based on a sound understanding of employment in the sector, the environment in which services are delivered, and the changes taking place in that sector. In this chapter of the SSP the health and social development sector is described and discussed from various perspectives.

First, the sector served by the HWSETA forms part of the South African health and social development system and this chapter starts with a short description of the national system, a description of standard industrial classification (SIC) codes included in the scope of the HWSETA, and the

identification of points of contact with other SETAs. This is followed by a description of the organisations that are major role players in the sector.

The chapter then continues with a description of the employees in the sector. This section starts with an estimate of total

employment, followed by a description of employees according to occupation, population group, gender, age and disability. In the conclusion to this chapter the most salient implications of the profile of the sector for skills development are highlighted.

2.2 The South African Health and Social Development System

Figure 2 1 The South African health and social development system

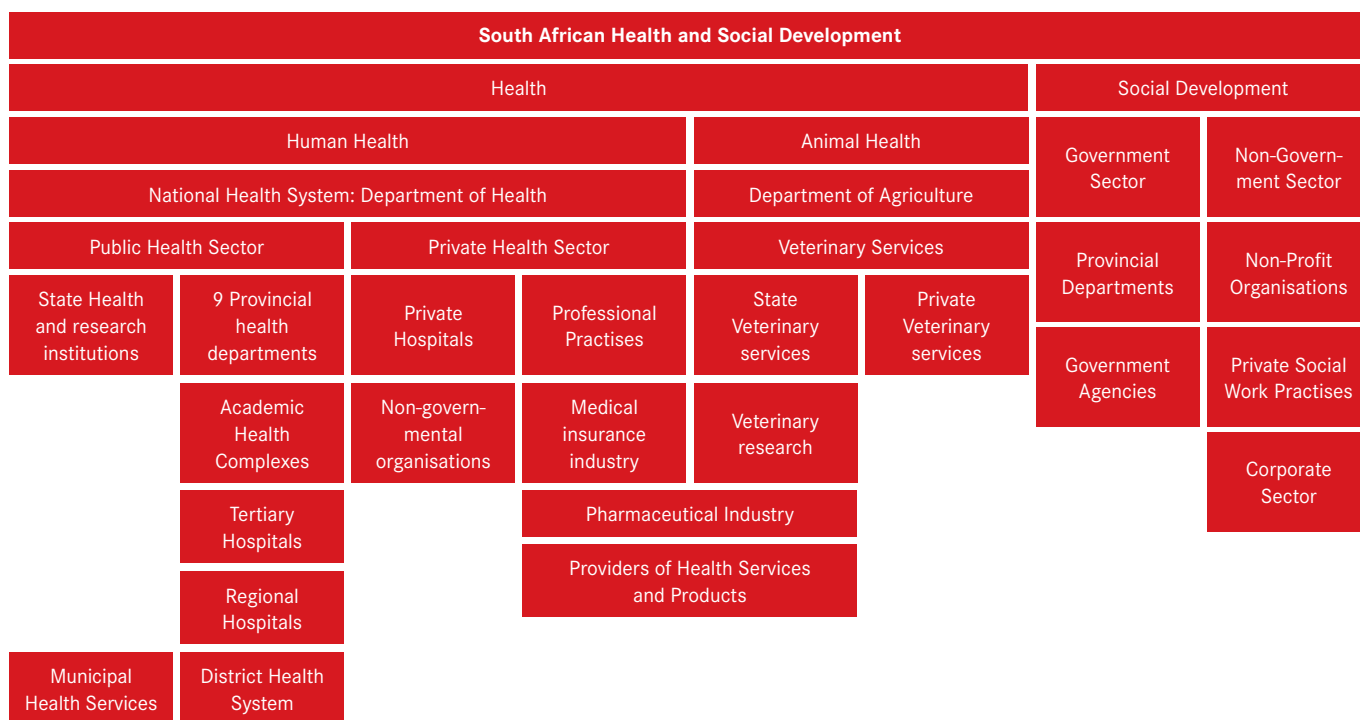


Figure 2-1 provides a graphical representation of the South African health and social development system. The South African health system spans the economic sectors for human and animal health. The national Department of Health (DoH) ⁵ is responsible for the national human health system, which comprises both public and private health sectors.

Key entities in the public health sector are the nine provincial departments of health, state health and research institutions, and municipalities. Provincial health departments are responsible for public service delivery and for planning and managing human resources for health. Academic health complexes (where health sciences learners are trained) are financed and administered at provincial level. Provincial hospitals operate at three tiers: tertiary-, regional-, and district

levels. The district health system consists of 52 districts. Ambulance and other emergency services, occupational health and primary care services are delivered at district level. Municipal health services encompass environmental issues such as water quality, waste management, pollution control, surveillance and prevention of communicable diseases and food control⁶. Many local authorities provide primary

⁵ Established by the National Health Act, 2003, to provide equitable healthcare services.

⁶ Development Bank of South Africa, 2008. A Roadmap for the Reform of the South African Health System.

healthcare (PHC) services, which may either be financed from municipal revenues or by provincial health authorities⁷.

The private health sector is made up of private hospitals, individual health service providers, NGOs and the medical insurance industry⁸. Extending across the human and animal health sectors are the pharmaceutical industry, providers of health services and products, and manufacturers of surgical goods and appliances. On the animal health side the Department of Agriculture, Forestry and Fisheries (DAFF) oversees veterinary services, which comprise state- and private veterinary services and veterinary research.

Not all the entities in the South African health system form part of the HWSETA sector and there is considerable overlap with several other SETAs. The national and provincial departments of health submit WSPs and Annual Training Reports (ATRs) to the PSETA, while municipalities are more closely aligned with the Local Government SETA (LGSETA). The medical insurance industry, which comprises medical schemes and other bodies, forms part of the Insurance Sector Education and Training Authority (INSETA). Even though pharmacists and pharmacies are allocated to the HWSETA, many employers pay skills development levies to the Wholesale and Retail SETA (W&RSETA). Although the HWSETA is responsible for skills development in animal health, many veterinarians in private practice pay their SDL to the Agricultural Sector Education and Training Authority (AgriSETA) and are more closely affiliated with this SETA.

The social development component of the sector consists of government- and non-government organisations. The government organisations include national and provincial departments of social development – some of which have merged with health to form one department – and the social service components of the

South African Police Service and of the departments of justice and correctional services.

The government organisations also include public entities and statutory bodies such as those listed under a) to e) below.

- a) The National Development Agency (NDA): provides grant funding to civil society organisations to meet the development needs of poor communities and to bolster the institutional capacity of such organisations⁹.
- b) The South African Social Security Agency (SASSA): is responsible for the administration and payment of social grants¹⁰ (with 16.8 million beneficiaries in 2013/14) as well as: processing of applications for social grants and social relief of distress¹¹;
- c) The Independent Development Trust (IDT): offers programme management and development advisory services for the eradication of poverty to government departments and other development partners¹².
- d) The Advisory Board on Social Development: advises the Minister on social development and identifies, promotes, monitors and evaluates policy, legislation and programmes relating to social development¹³.
- e) The Central Drug Authority (CDA): gives effect to the national drug master plan and promotes measures to prevent and combat the abuse of drugs¹⁴.

The private or non-governmental part of the social development sector includes non-profit organisations (NPOs) and civil society organisations, private social work practices, and the corporate social responsibility and employee wellness services offered by large organisations in the private sector. In the health and social development sector NGOs and NPOs are major providers of care services for particular target groups and are key partners of national and provincial

government in attaining socio-economic and developmental priorities.

2.3 Employers in the Sector

The health and social development sector is a heterogeneous sector falling mainly under the Sector Industrial Classification (SIC) category 93. Schedule 2 of Regulation No. R.316, published on 31 March 2005 in terms of section 9(1) of the Skills Development Act 97 of 1998, gives the HWSETA jurisdiction over 60 SIC codes. The employers belonging to the 60 SIC sectors are grouped into five groups:

- a) Community services;
- b) Complementary health services;
- c) Doctors and specialists;
- d) Hospitals and clinics; and
- e) Research and development institutions.

In the 2013/2014 financial year a total of 5 945 organisations paid SDLs to the HWSETA, notably more than the 5 362 organisations in 2012/13. These are organisations with payrolls in excess of R500 000 per year. Small practices may be excluded from this number.

2.4 Organisations in the Sector

2.4.1 Regulators and professional bodies

A large number of the workers in the health and social development sector are registered with statutory councils that control and regulate the various professions. In the health sector these councils are the Health Professions Council of South Africa¹⁵ (HPCSA), the South African Nursing Council¹⁶ (SANC), the South African Pharmacy Council¹⁷ (SAPC), the Allied Health Professions Council of South Africa¹⁸ (AHPSCSA), and the South African Dental Technicians Council¹⁹ (SADTC). Members of the veterinary and para-veterinary professions are registered with the South African Veterinary Council²⁰ (SAVC) and practitioners using indigenous African

¹⁵ Established in terms of the Health Professions Act 56 of 1974.

¹⁶ Established by the Nursing Act 33 of 2005, and previously by the Nursing Act 50 of 1978.

¹⁷ Established in terms of the Pharmacy Act 53 of 1974

¹⁸ Established by the Allied Health Professions Act 63 of 1982.

¹⁹ Established by the Dental Technicians Act 19 of 1979.

²⁰ Established by the Veterinary and Para-Veterinary Professions Act 19 of 1982.

⁷ Burger, D. 2009. *South Africa Yearbook 2009/10. Government Communication and Information System. Published at http://www.gcis.gov.za/resource_centre/sa_info/yearbook/2009-10.htm. (Accessed Aug 2010).*

⁸ Coovadia, H., Jewkes, R., Barron, P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet. Sept 2009. Vol. 374. Published at <http://thelancet.com>. (Accessed Aug 2009); McIntyre, D., Thiede, M., Nkosi, M. et al. 2007. SHIELD work package 1 report: A critical analysis of the current South African health system. Health Economics Unit, UCT. Published at <http://www.web.uct.ac.za/depts/heu/.../SouthAfrica1.pdf>. (Accessed Aug 2010).*

⁹ National Development Agency. 2011. "About the NDA"; National Treasury. 2011. "Vote 19: Social Development". 2011. *Estimates of National Expenditure*

¹⁰ National Treasury. 2012 *Budget Review*.

¹¹ SASSA. 2010. *SASSA Annual Report 2009/2010; National Treasury. 2011. "Vote 19: Social Development". 2011. Estimates of National Expenditure*

¹² IDT. 2011. *Corporate Plan 2011-2013. Published at <http://www.idt.org.za/>....(Accessed 9 Aug 2011).*

¹³ DSD. 2011. "Public Entities and Statutory Bodies". Published at <http://www.dsd.gov.za/>....(Accessed 18 Aug 2011).

¹⁴ DSD. 2011. "Public Entities and Statutory Bodies". Published at <http://www.dsd.gov.za/>.... (Accessed 18 Aug 2011).

healthcare techniques and medicines will soon be required to register with the Interim Traditional Health Practitioners Council of South Africa²¹ (ITHPCSA). These councils regulate the various health and allied health professions and practices.

Professionals and para-professionals working in the social development field are registered with the South African Council for Social Service Professions (SACSSP), which obtains its mandate from the Social Service Professions Act 110 of 1978, as amended.

Professional councils are authorised to demarcate the scope of practice of each category of profession (i.e. stipulate the types of services permitted and not permitted). Among the statutory functions of all the councils are the setting and controlling of standards for education and training, the registering of professionals, establishing what constitutes ethical and professional conduct, and enforcing compliance with standards. The councils set requirements for the continuous professional development (CPD) of professionals and practitioners in order for these people to retain their registration (and the right to practice). As such, these councils are major role players in the sector and contribute to skills development and ensure on-going professional competence. By setting and upholding the relevant standards, the councils promote and protect the rendering of services to the broader public and enhance the quality of these services. All these councils are authorised to: receive, investigate and deal with complaints of unprofessional conduct against persons registered with them; hold disciplinary enquiries; and sanction practitioners with cautions, fines, suspension or de-registration (i.e. expulsion from the profession).

Each council exercises jurisdiction over the categories of practitioners described in its founding statutes. The professional councils together with the Higher Education Quality Committee (HEQC) of the Council on Higher Education (CHE) and UMALUSI accredit the training institutions to offer professional training programmes that lead to attaining recognised qualifications. Several of the professional councils also accredit clinical and workplace facilities where learners serve internships and undergo

practical training, and set the standards for structured workplace experience and internships served by aspirant professionals.

Professional councils and voluntary associations from the health and social development sector are also represented on the HWSETA Board and are involved in the SETA's activities and its substructures. An overview of the councils and the practitioners falling under their jurisdiction is set out below.

a) The Health Professions Council of South Africa

The Health Professions Council of South Africa (HPCSA) is an overarching statutory body supported by 12 professional boards dealing with oversight of and matters pertaining to the professions required to register with the HPCSA. The 12 boards established for specific professions are:

- a) Dental Therapy and Oral Hygiene;
- b) Dietetics and Nutrition;
- c) Emergency Care;
- d) Environmental Health;
- e) Medical and Dental and Medical Science;
- f) Medical Technology;
- g) Occupational Therapy and Medical Orthotics/Prosthetics and Arts Therapy;
- h) Optometry and Dispensing Opticians;
- i) Physiotherapy, Podiatry and Biokinetics;
- j) Psychology;
- k) Radiography and Clinical Technology; and
- l) Speech, Language and Hearing Professions²².

b) The South African Nursing Council

The South African Nursing Council (SANC) is a statutory body established to regulate the nursing profession. The SANC sets standards and exercises control over all matters relating to the education and training of the nursing profession and also determines and controls the scope of practices pursued by the five registration categories of nurses. These categories are professional nurse, midwife, staff nurse, auxiliary nurse, and auxiliary midwife²³. A person undergoing education or training in nursing must apply to the SANC to be registered as a learner nurse or a

learner midwife²⁴.

c) The South African Pharmacy Council

The South African Pharmacy Council (SAPC) is a statutory body established to regulate the pharmacy profession and practice, as well as pharmacy support personnel and pharmacy premises. All persons trained as pharmacists are required to register with the SAPC before they are permitted to practise as such. Registration categories include pharmacist, pharmacist in community service, specialist pharmacist, authorised pharmacist prescriber, pharmacist intern, student pharmacist, pharmacist's assistant (Basic, learner basic, learner post basic and post basic), pharmacist technician and pharmaceutical sales representatives. Enterprises operating as pharmacies (including community-, hospital-, wholesale-and-distribution-, and manufacturing pharmacies) and as organisations offering pharmacy education and training are required to register with the SAPC²⁵.

d) The Allied Health Professions Council of South Africa

The Allied Health Professions Council of South Africa (AHPCSA) is a statutory body charged with the control and registration of professions contemplated in the Allied Health Professions Act 63 of 1982. Among these professions are: Ayurveda, Chinese medicine and acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy, and therapeutic reflexology. In the allied health professions a distinction is made between a practitioner and a therapist²⁶. Four professional boards within the AHPCSA provide that council with standards for specific allied health professions and contribute to policy development²⁷.

e) The South African Veterinary Council

The South African Veterinary Council (SAVC) is the regulatory body for the veterinary and para-veterinary professions. The SAVD

²⁴ Sec 32 of the Nursing Act 33 of 2005.

²⁵ SAPC, 2013. http://www.pharmacouncil.co.za/B_Regs4_RegsPersons.asp. (Accessed 16 Oct 2013).

²⁶ A practitioner may diagnose, and treat or prevent physical and mental disease, illness or deficiencies in humans; prescribe or dispense medicine; or provide or prescribe treatment for such conditions. Therapists may only provide treatment for diagnosed diseases, illnesses or deficiencies, or prevent such conditions (Sec 1 of the Allied Health Professions Act 63 of 1982).

²⁷ AHPCSA, 2013. Council Structure. Published at http://www.ahpcca.co.za/...Professional_Boards. (Accessed 24 Oct 2013).

²² HPCSA, 2013. Professional Boards. Published at <http://www.hpcsa.co.za...overview.php>. (Accessed 16 Oct 2013).

²³ Sec 31 of the Nursing Act 33 of 2005. Previously the professional categories were registered nurse, midwife, enrolled nurse and nursing auxiliary.

²¹ Established by the Traditional Health Practitioners Act 22 of 2007.

determines the scientific and ethical standards of professional conduct and education and is responsible for the registration of persons practising these professions. The SAVC keeps registers for the veterinary professions (veterinarians and veterinary specialists) and the para-veterinary professions (animal health technicians, laboratory animal technologists, veterinary nurses and veterinary technologists), as well as students in the respective fields²⁸.

f) The South African Dental Technicians Council

The South African Dental Technicians Council (SADTC) is a statutory body established by the Dental Technicians Act, 19 of 1979. The SADTC regulates the profession and acts as a public protector for persons using the services of dental technicians and technologists and controls all matters relating to the education and training of technicians and technologists and their practices. Although the scope of practice for dental technologists and dental technicians is very similar, the SADTC distinguishes between the professions. A dental technician holds an NQF Level 6 qualification in dental technology from a recognised institution and a dental technologist holds a BTech degree in dental technology at NQF Level 7 from a recognised institution. The scope of practice of a dental technologist is broader than that of a dental technician. For example, dental technologists may supervise dental laboratories, employ dental technicians and dental laboratory assistants, review cases in dental laboratories and make decisions, and they may work with dental clinicians or clinical professionals on treatment planning and the design of customised devices or appliances for patients²⁹.

g) The Interim Traditional Health Practitioners Council of South Africa

The Interim Traditional Health Practitioners Council of South Africa (ITHPCSA) is a statutory body established to regulate the registration, training and practices of traditional health practitioners and students engaged in learning in that field³⁰. Sections of the Traditional Health Practitioners Act that establish the Council and provide a regulatory framework for the provision of

traditional care services were enacted on 1 May 2014³¹. Among the primary goals of the ITHPCSA will be to establish a register of traditional healers and to advise the Minister of Health on integrating traditional medicine into the proposed National Health Insurance (NHI) system³².

The Act provides a regulatory framework to safeguard the safety and quality of traditional health services and norms and standards on traditional medicine³³. Specific objectives of the ITHPCSA are to promote public health awareness and maintain appropriate ethical and professional standards in the practice of traditional health and medicine. The interim council is further required to promote and develop interest in the field by encouraging research, education and training.

Traditional health practice involves the performance of a function, activity, process or service based on a traditional philosophy and uses indigenous African techniques, principles, medication and practice³⁴. Every person who renders services as a traditional health practitioner will be required to register as such. Various categories of practitioners will register with the Council, including herbalists (izinyanga or amaxhwele), diviners (izangoma or amagqirha), traditional surgeons (iingcibi) and traditional birth attendants (ababelethisi or abazalisi). Spiritual or faith healers are not included in the Traditional Health Practitioners Act³⁵.

It was estimated that there were about 185 000 traditional health practitioners in South Africa in 2007³⁶. By 2012, a new estimate put the number at 200 000, with affiliation spread across more than 100 separate organisations³⁷. The DoH acknowledges that traditional health practitioners provide

the first line of care in many communities and therefore play an important role in the healthcare system³⁸. It is recognised that primary healthcare facilities have cooperated with these practitioners to contain childhood diseases, HIV/AIDS and TB, and mental illness³⁹.

h) The South African Council for Social Service Professions

Two professional boards are established under the auspices of the South African Council for Social Service Professions (SACSSP), i.e. the Professional Board for Social Work (PBSW) and the Professional Board for Child and Youth Care⁴⁰ (PBCYC). The SACSSP recognises the occupation of social worker as a profession and also the para-profession of social auxiliary worker (SAW). Recognition of the profession means that social workers have the right to practise in a particular field of expertise governed by the statutory body⁴¹. At the time of writing, the new profession of child and youth care worker (CYCW) and new mid-level occupation of auxiliary child and youth care worker (ACYCW) were being established. Regulations to control the registration and acts of these occupational categories, as well as students in the field were published for public comment⁴². Once the regulations take effect in 2014/15, the profession of CYCW and mid-level occupation of ACYCW will be recognised, and these occupational categories will be able to register with the PBCYC⁴³. Currently only social workers, student social workers, social auxiliary workers, and social auxiliary work learners can register with the SACSSP. Probation officers are registered as social workers and assistant probation officers are registered as social auxiliary workers. Probation work, adoption work and occupational social work are earmarked as specialist areas of social work.

In 2008, a process was begun to establish a professional board for community

28 SAVC. 2013. *About Us*. Published at <http://www.savc.co.za/>... (Accessed 16 Oct 2013).

29 SADTC. 2013. <http://www.sadtc.org.za/index.php/about-us/mega-menu>. (Accessed 16 Oct 2013).

30 Although the Traditional Health Practitioners Act, 22 of 2007 was enacted in Parliament, it has not come into full operation.

31 Republic of South Africa, South African Government News Agency, 4 May 2014.

32 Medical Chronicle. 2013 "Traditional healers to be integrated into NHI". *Medical Chronicle*, 5 March 2013. Published at: <http://www.medicalchronicle.co.za/traditional-healers...nhi>. (Accessed 18 July 2014).

33 Medical Chronicle. 2013 "Traditional healers to be integrated into NHI". *Medical Chronicle*, 5 March 2013.

34 Sec 1 of the Traditional Health Practitioners Act 22 of 2007.

35 Sec 47(1)(f) of the Traditional Health Practitioners Act, 22 of 2007; Peltzer, K. 2009. "Traditional health practitioners in South Africa". *Lancet*. 19 Sept 2009. Vol.374. Published at <http://www.thelancet.com>. (Accessed Aug 2010).

36 Ggaleni, N., Moodley, I., et al. 2007. "Traditional and Complementary Medicine". *South African Health Review* 2007.

37 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation". *South African Health Review* 2012/13.

38 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

39 Medical Chronicle. 2013 "Traditional healers to be integrated into NHI". *Medical Chronicle*, 5 March 2013.

40 Interviews with SACSSP in July 2014.

41 SACSSP. 2010. *Official Newsletter 2(2), December*. Published at: <ftp://ftp.sacssp.co.za/...pdf>. (Accessed 12 Aug 2011).

42 SACSSP. 2014. *Board Notice 56 of 2014 of South African Council of Social Services Professions. Government Gazette No 37689, 29 May 2014*. Published at <http://www.sacssp.co.za/website/wp-content/uploads/...pdf>. (Accessed 18 July 2014).

43 Interviews with SACSSP in July 2014.

development workers, but this has not been achieved⁴⁴. The Social Service Professions Act, 110 of 1978 is under review and work is underway to develop an occupational framework for the social service professions⁴⁵.

2.4.2 Academic and research institutions

A number of institutions conducting research in human and animal health and the socio-economic impact of disease play a prominent role in the health and social development sector. In addition to their research activities, several institutions are specifically mandated to advance the training and development of researchers, health professionals and technicians for the sector.

a) The South African Medical Research Council

The South African Medical Research Council (MRC) is a statutory body established to promote the improvement of the nation's health and quality of life through promoting and conducting relevant and responsive health research⁴⁶. The MRC conducts research into the burden of disease in South Africa (including HIV/AIDS; cardiovascular disease and diabetes; infectious disease; tuberculosis; cancer; and crime, violence and injury), public health and policy matters, environmental health issues, health promotion, nutrition, African traditional medicines, and aspects concerning female-, maternal- and child health⁴⁷. Among the core tasks of the MRC are to promote the training of researchers and related personnel and, for that purpose, it may grant study bursaries and loans and pay grants for training and research in the health sciences⁴⁸.

b) The National Health Laboratory Service

The National Health Laboratory Service (NHLS) is a statutory body that provides public health laboratory services to all state clinics and hospitals and, on request, to private sector providers⁴⁹. The NHLS consists of four specialised divisions – the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry, and the South African Vaccine Producers, which houses the anti-venom unit. With a network of more than 300 laboratories throughout South Africa, the NHLS provides diagnostic laboratory services, research, teaching and training, and production of serums for the anti-snake venom and reagents. Nationally, the NHLS employs 6 700 people and serves over 80% of the population⁵⁰. Priority programmes of the NHLS address HIV, tuberculosis and the human papillomavirus (HPV) diseases⁵¹. With its strong training mandate, the NHLS trains medical technologists in association with universities of technology. It cooperates with the pathology departments of all nine faculties of health sciences⁵² to teach at undergraduate and postgraduate levels.

c) The Human Sciences Research Council

The Human Sciences Research Council (HSRC) is a national social science council and conducts large-scale social-scientific projects for the public sector, NGOs and international development agencies⁵³. Among the HSRC's main research areas are human and social development; population health, health systems and innovation; and HIV/AIDS, sexually transmitted infections and tuberculosis⁵⁴. Research in human and social development assesses social conditions and identity markers that

impact on people's life opportunities, while research activities in the field of population health focus on social and environmental determinants of health, health systems and financing of healthcare. The research programme for HIV/AIDS, sexually transmitted infections and tuberculosis concentrates on surveillance in general populations and intervention research, as well as the socio-economic, cultural and behavioural aspects of the diseases. This programme also includes an Africa-wide research network, the Social Aspects of HIV/AIDS Research Alliance (SAHARA), established to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate its severe impact in sub-Saharan Africa⁵⁵. Healthcare programmes are also evaluated and their impact assessed. Research by the HSRC is used to influence the development of national health policies and strategies.

The HSRC employs almost 500 people and the organisation's publishing arm, the HSRC Press, is an open-access publisher of social-science research publications in print and electronic form⁵⁶.

d) Onderstepoort Veterinary Institute

The Onderstepoort Veterinary Institute (OVI) has been engaged in veterinary research for more than a century⁵⁷. Today it is one of several research institutes of the Agricultural Research Council (ARC), established to undertake research and technology transfer in the use of agricultural resources⁵⁸. Specific research is undertaken in viral diseases that have a major economic impact, such as foot and mouth disease, rabies, African swine fever, blue tongue, lumpy skin disease, African horse sickness and Rift Valley fever. Research activities focus on the development and improvement of vaccines and diagnostic tests, and on applying the latest molecular biological techniques. As a collaborating office for the World Organisation for Animal Health, the OVI is responsible for surveillance and control of animal diseases in Africa. The OVI also serves the Food and Agriculture Organisation (FAO) of the United Nations in emergency preparedness for trans-boundary

44 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*. CSDA.

45 SACSSP. 2012. *SACSSP Newsletter May 2012*. Published at <http://www.sacssp.co.za/>.... (Accessed 24 Aug 2012); SACSSP. 2010. *Official Newsletter 2(2)*, Dec. Published at: <ftp://ftp.sacssp.co.za/>.... (Accessed 12 Aug 2011).

46 *The MRC was established by the South African Medical Research Council Act, 19 of 1969 and continues to exist under the South African Medical Research Council Act, 58 of 1991.*

47 MRC. 2014. *Who we are*. Published at <http://www.mrc.ac.za/about/>.... (Accessed 30 June 2014); MRC 2013. *Our research*. Published at <http://www.mrc.ac.za/research/>.... (Accessed 16 Oct 2013).

48 MRC. 2005. *Research Strategy 2005-2010*. Published at <http://www.mrc.ac.za/>.... (Accessed Aug 2010).

49 *Established by the National Health Laboratory Service Act 37 of 2000*. Published at <http://www.nhls.ac.za/>.... (Accessed Aug 2010); *National Treasury 2010. "Vote 15: Health". Estimates of National Expenditure 2010*.

50 NHLS. 2013. *About us*. Published at http://www.nhls.ac.za/?page=about_us&id=16. (Accessed 16 Oct 2013).

51 NHLS. 2011. *Priority programmes*. Published at <http://www.nhls.ac.za/>.... (Accessed 16 Oct 2013 and 30 June 2014).

52 *These are the faculties of health sciences of the universities of Cape Town, Free State, KwaZulu-Natal, Limpopo (MEDUNSA Campus), Pretoria, Stellenbosch, Witwatersrand, Western Cape and the Walter Sisulu University.*

53 *Established by the Human Sciences Research Act 23 of 1968. The new Human Sciences Research Council Act 17 of 2008 has been adopted by Parliament, but was not yet in operation by 10 November 2012.*

54 HSRC. 2011. *About the HSRC*. Published at: <http://www.hsrc.ac.za/index...> (Accessed 13 Aug 2011).

55 HSRC 2011. *HIV/AIDS, STIs and TB*. Published at <http://www.hsrc.ac.za/HAST.phtml>. (Accessed 13 Aug 2011).

56 HSRC. 2014. *About the HSRC*. Published at: <http://www.hsrc.ac.za/>.... (Accessed 30 June 2014).

57 *The OVI was founded in 1908 by Sir Arnold Theiler.*

58 *The ARC is established by the Agricultural Research Act 86 of 1990.*

animal diseases in Africa⁵⁹.

e) Onderstepoort Biological Products

This state enterprise is involved in the research and production of veterinary vaccines to prevent and control animal diseases that impact on food security, human health and livelihoods⁶⁰. Bio-technical research and the manufacturing of vaccines and animal health products are critical to grow the livestock sector and enable rural economic development in this way⁶¹.

2.4.3 Employer organisations

a) The Hospital Association of South Africa

The Hospital Association of South Africa (HASA) is an industry association that represents the interests of the majority of private hospital groups and independently owned private hospitals in the country. HASA is a key role-player in the health sector and represents more than 80% of the private hospital industry including the following groups: Mediclinic, Life Healthcare, Netcare and the National Hospital Network (NHN). The association promotes entrepreneurship and free market economic principles, engages with government on proposed legislation and policy matters, represents the industry at commissions and institutions, and markets the industry and its services to the public. In total, HASA members employ 64 000 persons and support 218 000 jobs, or 1.8% of total employment in South Africa. Seventy-eight percent of these jobs are held by previously disadvantaged individuals⁶².

b) The National Coalition of Social Services

The National Coalition of Social Services (NACOSS) is a voluntary coalition of NGOs operating at national and provincial level and exists to share information and expertise. NACOSS engage in lobbying with the DSD to improve funding arrangements for and service delivery by NGO's. In addition, the organisation aims to influence the policy agenda for social development.

c) The South African National Non-Governmental Organisation Coalition

The South African National Non-governmental Organisation Coalition (SANGOCO) is a large umbrella body for civil society organisations and it exists to strengthen the NGO sector and to advocate for the rights of the poor. The main areas of work include organisational development and capacity building of member organisations; networking; influencing of development policy; engaging and lobbying⁶³.

d) The National Association of Welfare Organisations and NGOs

The National Association of Welfare Organisations and Non-governmental Organisations (NAWONGO) represents more than 700 social development and welfare organisations and aims to create an enabling environment for member organisations by influencing policy, legislation and practice that impact on the delivery of social services. NAWONGO seeks to strengthen social service delivery partnerships with government, set minimum conditions of service in the sector and establish benchmarks for cost efficiency and professional effectiveness⁶⁴.

2.4.4 Non-Profit organisations

In the social development sector, NPOs are the major providers of care services for particular target groups and they work in partnership with provincial governments to expand service-delivery capacity⁶⁵. Non-governmental organisations (NGOs) and community based organisations (CBOs) are collectively known as non-profit organisations (NPOs), and are also referred to as "civil society organisations" (CSOs)⁶⁶. Such organisations provide a range of services, including child care and protection, youth care and development, crime prevention and support, treatment and rehabilitation of persons suffering from substance abuse, care for older persons and the disabled, and material assistance, as well as support services to patients and households affected by HIV/AIDS. By 2009 NPOs managed 98% of the social development facilities

such as protective workshops, homes for older persons and persons with disabilities, children's homes, and places of safety and shelters, and serviced almost 72% of social development clients⁶⁷.

NPOs are encouraged to register on a voluntary basis with the Department of Social Development (DSD) in terms of the Non-Profit Organisations Act, 71, of 1997 and to give an annual account of their financial affairs and activities. The DSD holds information on NPOs in custody for purposes of public access. Failure to comply with statutory reporting requirements results in de-registration. By 31 March 2013, a total of 102 297 NPOs were registered with the DSD, up from 49 827 in 2007/08⁶⁸. The vast majority of registered NPOs (95%) are voluntary associations, while not-for-profit companies represent 3% and non-profit trusts comprise 2%. NPOs are classified according to the International Classification of Non-profit Organisations, in accordance with the sector in which they predominantly operate. In South Africa, the leading sectors are social services (40 078 of registered NPOs or 39.2%), and development and housing (20 964 NPOs or 20.5%). This is followed by religion (11 791 or 11.5%), health (10 582 or 10.3%), and education and research (8 039 or 7.9%)⁶⁹.

Patel identifies four categories of NPOs that operate in the social development sector⁷⁰:

- a) Public service contractors (PSCs) are NPOs that deliver services on behalf of government and are largely formally organised to provide a wide range of services, including professional social services, support of children and families, and care for the elderly. PSCs rely on state funding and operate with strict public sector mandates, bureaucratic procedures and accountability systems, and offer training and skills development.
- b) Donor-funded NPOs are not reliant on government for their main source of funding.

⁶⁷ National Treasury. 2009. *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*; DSD. 2011. *State of Registered Non-profit Organisations 2010-2011*. Published at [http://www.dsd.gov.za/npo/...](http://www.dsd.gov.za/npo/) (Accessed 14 Aug 2011).

⁶⁸ DSD. 2013. *State of South African registered Non-Profit Organisations 2012/13*; DSD. 2012 *State of South African Registered Non-profit Organisations*. Published at [http://www.dsd.gov.za/npo/...](http://www.dsd.gov.za/npo/) (Accessed 9 Nov 2012 and 6 June 2014).

⁶⁹ DSD. 2013. *State of South African registered Non-Profit Organisations 2012/13*.

⁷⁰ Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*. CSDA.

⁵⁹ ARC. 2014. *ARC - Onderstepoort Veterinary Institute*. Published at [http://www.arc.agric.za/...](http://www.arc.agric.za/) (Accessed 30 June 2014).

⁶⁰ OBP. 2014. *About Us*. Published at <http://www.obpvaccines.co.za/about-us>. (Accessed 30 June 2014).

⁶¹ DAFF. 2012. *Strategic Plan 2012/13 - 2016/17 for the Department of Agriculture, Forestry and Fisheries*.

⁶² HASA. 2014. *Facts about HASA*. Published at <http://www.hasa.co.za/about/facts-about-hasa/>. (Accessed 30 June 2014).

⁶³ South African National Non-Governmental Organisation Coalition. 2012. *About*. Published at <http://sangocoonline.wordpress.com/about/>. (Accessed 26 Sept 2012).

⁶⁴ NAWONGO. 2009. *NAWONGO condensed policy document*. Published at [www.nawongo.co.za/...](http://www.nawongo.co.za/) (Accessed 14 Aug 2011).

⁶⁵ National Treasury. 2009. *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*.

⁶⁶ DSD. 2011. "All about non-profit organisations". Published at [http://www.dsd.gov.za/npo/...](http://www.dsd.gov.za/npo/) (Accessed 9 Aug 2011).

- c) Faith-based organisations (FBOs) tend to be a hybrid of the first two types.
- d) Community-based organisations (CBOs) are informally organised, local organisations with limited access to funding and skills development. Many CBOs are delivery- or implementing agencies for government, larger and donor-funded NPOs. Many are rooted in local communities and do not employ staff, but rely on unpaid volunteers⁷¹.

Social services rendered by NPOs include homes and specialised services for handicapped persons; geriatric care, in-home services, recreation and meal programmes for senior citizens; specialised youth services, youth centres, job programmes and youth welfare programmes to prevent delinquency. The services also include specialised services for children – such as child development interventions and alternative care; and family care services such as family life/parent education and family violence shelters and services. Some organisations provide material assistance (e.g. food and clothing), income support and maintenance, and temporary shelter to refugees and vulnerable persons⁷².

More than 10 500 registered NPOs operate within the health sector and participate in, and support, various health programmes at national and provincial levels. Many NGOs and NPOs have entered into partnerships with provincial health departments and district municipalities to improve the organisation and management of health systems and monitor the delivery of health services. In the health sector NPOs contribute to research, education, policy advocacy, development and care, in areas such as HIV/AIDS, tuberculosis, mental healthcare, public health promotion, emergency care, rehabilitation, cancer, disability, women's health, family planning, orphans and vulnerable children, palliative care, and PHC. Their activities include directly observed treatment support for tuberculosis patients, home-based- and community care and voluntary counselling and testing for HIV/AIDS, nursing care, and public health and wellness programmes⁷³. A number of NGOs are involved in the recruitment, training and orientation of health professionals for

deployment in the public sector⁷⁴.

NPOs involved in veterinary services, animal protection and welfare are classified in the environmental category and by 31 March 2013 a total of 1 228 organisations (or 1% of NPOs) were registered in that category. In 2012, a total of 384 indicated that they provide veterinary-, animal protection-, animal welfare-, or wildlife-preservation services⁷⁵.

2.4.5 Professional associations

The health sector accommodates numerous voluntary organisations that generally promote the interests of specific healthcare professions, specialised fields of professional practice, and their members. These associations aim to protect and promote the professional, educational and economic interests of their members and the public image of their respective professions. Through advocacy, lobbying and negotiating the organisations seek to advance their members' positions and integrity as well as the standing and sustainability of their particular profession. Typically these voluntary organisations provide information to their members on the state of the profession and updates on regulatory changes, ethical matters, employment relations, and practice news. Several of the associations act as mouthpieces to influence health legislation and policies. A number of associations publish clinical and scientific journals and technical newsletters to keep their members abreast of technological advancements and the latest medical research in their field. Some also support their members to record and meet requirements for CPD set by their respective regulatory professional councils.

Examples of these voluntary associations in the health sector are: the South African Medical Association (for medical practitioners), the South African Veterinary Association, the South African Dental Association, the Ophthalmological Society of South Africa, the South African Society of Physiotherapy, the Pharmaceutical Society of South Africa, the Veterinary Nurses Association of South Africa, the Chiropractic Association of South Africa and the Homeopathic Association of South Africa.

In the social development sector a number of voluntary organisations aim to enhance the professional development of the social work

labour force and contribute to the development of the social work profession. This is pursued through training and by promoting standards of ethical practice, and by seeking greater recognition of social work as a profession⁷⁶. Examples of these voluntary organisations are: the National Association of Social Workers of South Africa, the National Association of Child and Youth Care Workers, the South African Association of Social Workers in Private Practice and the Association of South African Social Work Education Institutions⁷⁷.

2.4.6 Labour unions

Labour and trade unions are well organised and mobilised within the formal health and social development sector. However, this is not the case in the NGO/NPO sector largely due to its semi-formal nature. Trade unions play a formative role in shaping labour market policies, labour relations practices and human resources management in both the health and welfare sectors. Acting on behalf of their members, labour unions engage with employers over better employment conditions, better contractual benefits, and safer working environments. Trade unions also collectively bargain and negotiate for better wages, monetary allowances, working hours, and workplace benefits. In addition, trade unions provide their members with a range of benefits such as access to medical insurance schemes, group benefit schemes, provident funds and funeral cover. Most provide legal advice and representation at labour disputes, grievance procedures and disciplinary hearings⁷⁸.

⁷⁶ SACSSP. 2011. *Official Newsletter 1(1), July*. Published at: <http://www.sacssp.co.za/...pdf>. (Accessed 12 Aug 2011).

⁷⁷ National Welfare Social Service & Development Forum. 2011. *What is the Forum?* Published at <http://www.forum.org.za/...> (Accessed 10 Aug 2011); Forum Network Partner. Published at <http://www.forum.org.za/...NACOSS>. (Accessed 10 Aug 2011); National Association of Welfare Organisations and NGOs. Published at <http://www.nawongo.co.za>. (Accessed 10 Aug 2011).

⁷⁸ NEHAWU. 2013. *NEHAWU member services*. Published at <http://www.nehawu.org.za/...> (Accessed 17 Oct 2013); DENOSA. 2013. *Membership services*. Published at <http://www.denosa.org.za/...> (Accessed 17 Oct 2013); SADNU. 2013. *Contacts*. Published at <http://www.cosatu.org.za/...> (Accessed 17 Oct 2013); HOSPERSA. 2013 *Principals and objectives*. Published at <http://www.hospersa.co.za/...> (Accessed 17 Oct 2013); SAMA. 2013. *Member benefits*. Published at <https://www.samedical.org/...> (Accessed 17 Oct 2013); NUPSAW. 2013. *Vision and Mission*. Published at <http://www.nupsaw.co.za/...> (Accessed 17 Oct 2013); NPSWU. 2013. *About NPSWU*. Published at <http://npswu.org/...> (Accessed 17 Oct 2013); PAWUSA. 2013. *Benefits*. Published at <http://www.pawusa.org.za/...> (Accessed 17 Oct 2013); PSA 2013. *Objectives*. Published at <http://www.psa.co.za/objectives>. (Accessed 17 Oct 2013).

⁷¹ Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*. CSDA.

⁷² DSD. 2012 *State of South African Registered Non-profit Organisations*.

⁷³ DoH. "Partnerships for Primary Health Care". Published at <http://www.doh.gov.za/pdphcp/...> (Accessed Aug 2010); Burger D. 2009. *South Africa Yearbook 2009/10*. Published at <http://www.gcis.gov.za/...> (Accessed Aug 2010); DSD. 2011. *State of Registered Non-profit Organisations 2010-2011*.

⁷⁴ Africa Health Placements. 2010. Published at <http://www.ahp.org.za>. (Accessed Aug 2010).

⁷⁵ DSD. 2013. *State of South African registered Non-Profit Organisations 2012/13*; DSD. 2012 *State of South African Registered Non-profit Organisations*.

Among the larger unions in the health and social development sectors are the National Education Health and Allied Workers Union (NEHAWU), the Democratic Nursing Organisation of South Africa (DENOSA), the

South African Democratic Nurses Union (SADNU), the Health and Other Service Personnel Trade Union of South Africa (HOSPERSA), the National Public Sector Workers Union (NPSWU), the National

Union of Public Service and Allied Workers (NUPSAW), the Public and Allied Workers Union of South Africa (PAWUSA), and the Public Servants' Association (PSA).

2.5 Profile of Employees in the Sector

2.5.1 Estimate of total employment

a) Total employment

The three databases referred to in Chapter 1 provided information on almost 587 000 people who are formally employed in the health and social development sector. Of these, 276 500 (47%) are employed in private sector organisations (referred to later as the “private sector”) and levy-paying public sector organisations, while 310 300 (53%) work in the public service departments⁷⁹. The private sector figures are still underestimates of the total number of employees in the sector. Definitely excluded from the private sector figures are: professionals not listed on any of the databases used; the non-

professional support staff employed in private professional practices; and employees in the non-levy-paying NPOs. Excluded from the public service figures are the medical personnel employed in the South African National Defence Force (SANDF).

b) Occupational distribution of employment

Table 2 1 shows a breakdown of total employment according to the main occupational groups of the OFO. In the Public Service managers constitute 2% of total employment and in the private sector 5%. Professionals comprise 40% of employees in the Public Service and in the private sector. Professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, veterinarians and other health-related occupations such as

occupational therapists and psychologists as well as social workers. The group also includes allied health professionals such as homoeopaths. Professionals in support functions such as human resource professionals, financial professionals and scientists also form part of the group.

Technicians and associate professionals in the Public Service constitute 21% and in the private sector 25% of total employment in each sector. In the Public Service this category mainly comprises enrolled nurses, ambulance officers, office supervisors and ambulance paramedics and in the private sector enrolled nurses, ancillary health care workers, medical laboratory technicians and office administrators. Clerical support workers include general clerks and admissions clerks.

⁷⁹ No WSP's were received from the Western and the Northern Cape Department of Health in 2014. Their 2013 employment figures were used for calculations.

Table 2 1 Total employment in the private sector and in Public Service, per occupational category

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	7 656	2	13 134	5	20 790	4
Professionals	123 117	40	109 924	40	233 041	40
Technicians and Associate Professionals	66 413	21	68 125	25	134 538	23
Clerical Support Workers	34 236	11	42 197	15	76 433	13
Service and Sales Workers	33 591	11	23 608	9	57 199	10
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 575	1	2 223	1	3 798	1
Plant and Machine Operators and Assemblers	4 561	1	4 707	2	9 268	2
Elementary Occupations	39 107	13	12 595	5	51 702	9
Total	310 256	100	276 513	100	586 769	100

Sources: Calculated from HWSETA and PSETA WSP applications 2014, MEDpages database, July 2014.

c) Population group

Most (67%) of the workers employed in the health and social development sector are African, 16% are white, 13% coloured, and 4% are Indian (Figure 2.2).

Figure 2 2 Population group distribution of employees in the health and social development sector

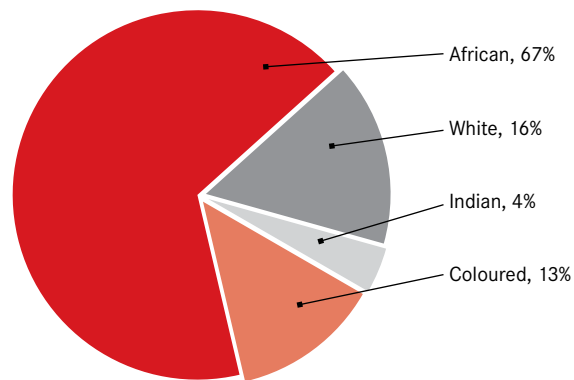


Table 2 2 shows the population group distribution of people in the different occupational groups. The majority (68%) of managers in the Public Service are Africans, followed by coloureds at 15%, whites at 11%,

and Indians at 7%. In the private sector 58% of the managers are white, 22% are African, 12% coloured and 7% Indian. The majority of professionals in the Public Service (79%) are African, while respectively 78% and 51%

of technicians and associate professionals in the Public Service and private sector are African. In the total sector 67% of employees are African, 16% white, 13% coloured and 4% Indian.

Table 2 2 Employment distribution in private and public health according to occupational-and population group

Occupational Group	Public Service					Private Sector					Total				
	African	Coloured	Indian	White	Total	African	Coloured	Indian	White	Total	African	Coloured	Indian	White	Total
	%	%	%												
Managers	68	15	7	11	100	22	12	7	58	100	39	13	7	41	100
Professionals	79	8	4	9	100	42	11	7	40	100	66	9	5	20	100
Technicians and Associate Professionals	78	15	3	4	100	51	15	7	27	100	64	15	5	16	100
Clerical Support Workers	79	14	2	5	100	45	20	6	29	100	60	17	4	18	100
Service and Sales Workers	89	7	2	1	100	67	23	2	8	100	80	14	2	4	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	77	10	4	9	100	56	15	5	25	100	64	13	4	18	100
Plant and Machine Operators and Assemblers	88	8	4	1	100	60	31	4	6	100	74	19	4	3	100
Elementary Occupations	92	7	0	1	100	76	18	1	5	100	88	10	1	2	100
Total	81	10	3	6	100	49	16	6	29	100	67	13	4	16	100

Sources: Calculated from HWSETA and PSETA WSP applications 2014

d) Gender

The gender distribution of employees in the total health and social development sector can be seen in Table 2 3. Most (72%) of the employees in this sector are women. In all the occupational categories women are in the majority, with the exception of the categories skilled agricultural, forestry, fishery, craft and related trades workers (which includes artisans), and plant and machine operators and assemblers (which includes occupations such as drivers).

Table 2 3 Employment distribution in the private and public health sectors according to occupational group and gender

Occupational Group	Public Service			Private Sector			Total		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
	%	%	%	%	%	%	%	%	%
Managers	42	58	100	48	52	100	46	54	100
Professionals	19	81	100	25	75	100	21	79	100
Technicians and Associate Professionals	28	72	100	25	75	100	26	74	100
Clerical Support Workers	35	65	100	27	73	100	30	70	100
Service and Sales Workers	28	72	100	29	71	100	28	72	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	74	26	100	72	28	100	73	27	100
Plant and Machine Operators and Assemblers	74	26	100	87	13	100	81	19	100
Elementary Occupations	30	70	100	42	58	100	33	67	100
Total	27	73	100	30	70	100	28	72	100

Sources: Calculated from HWSETA and PSETA WSP applications 2014

e) Age distribution

The age distribution of employees in the sector can be seen in Table 2 4. Most of the employees in public health (58%) fall in the age group 35 to 55, while 31% of employees are younger than 35. However, 28% of Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers are older than 55. Most managers in the Public Service (70%) fall in the age group 35 to 55.

Most of the employees in private health (54%) fall in the age group 35 to 55, while 37% of employees are younger than 35. However, excluded from the private sector are professionals not listed on the HWSETA database.

Table 2 4 Age distribution of employees in private and public health according to occupational group

Occupational Group	Public service				Private sector			
	Age category			Total	Age category			Total
	<35	35 - 55	55+	%	<35	35 - 55	55+	%
	%	%	%	%	%	%	%	%
Managers	14	70	16	100	19	67	14	100
Professionals	30	60	10	100	33	56	11	100
Technicians and Associate Professionals	35	56	9	100	46	47	7	100
Clerical Support Workers	39	54	7	100	32	60	7	100
Service and Sales Workers	25	62	13	100	42	51	7	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	12	60	28	100	34	58	9	100
Plant and Machine Operators and Assemblers	23	63	13	100	29	55	16	100
Elementary Occupations	29	57	15	100	35	55	11	100
Total	31	58	11	100	37	54	9	100

Sources: Calculated from HWSETA and PSETA WSP applications 2014.

f) Disability

Only a small percentage of the people employed in the sector were living with disabilities (Table 2-5). Of the 778 disabled employees in the public service, 366 were employed as clerical support workers and 135 as professionals and of the 1 169 employees in the private sector, 346 were employed as clerical support workers, 319 as technicians and associate professionals and 231 as professionals.

Table 2 5 Disability in the private and public health sectors according to occupational and population group

Occupational Group	Public Service						Private Sector					
	African	Coloured	Indian	White	Total	% of total employment	African	Coloured	Indian	White	Total	% of total employment
Managers	30	5	0	12	47	0.6	10	5	2	42	59	0.4
Professionals	93	10	7	25	135	0.1	60	26	24	121	231	0.4
Technicians & Associate Professionals	51	14	5	12	82	0.1	186	36	23	74	319	0.5
Clerical Support Workers	266	26	15	59	366	1.1	141	50	22	133	346	0.8
Service & Sales Workers	47	9	6	1	63	0.2	32	12	1	32	77	0.3
Skilled Agricultural, Forestry, Fishery, Craft & Related Trades Workers	1	2	2	2	7	0.4	5	1	0	8	14	0.6
Plant & Machine Operators & Assemblers	4	3	0	0	7	0.2	6	1	0	2	9	0.2
Elementary Occupations	57	10	1	3	71	0.2	51	42	1	20	114	0.9
Total	549	79	36	114	778	0.3	491	173	703	432	1 169	0.5

Sources: Calculated from HWSETA and PSETA WSP applications 2014.

2.6 Conclusions

The health and social development sector served by the HWSETA is extensive and spans sections of the human- and animal health systems in South Africa, as well as sections of the social development- and social services systems. Considerable overlap exists between the HWSETA and other SETAs, making it difficult to distinguish accurately and describe the sector served by the HWSETA.

Labour and trade unions are well organised and mobilised within the formal health and social development sector.

A unique feature of the health sector is that a majority of the healthcare professionals, sub-professionals and specialised workers are regulated by a number of professional councils. One professional council in the social development sector regulates the social work profession and the social auxiliary para-profession, and will soon also regulate the new profession of child and youth care worker. These statutory bodies play a formative role in determining the scope of practice for professionals and specialist occupations, and also regulate the education and training standards required

for work as healthcare practitioners and social workers. By controlling and enforcing standards of quality, ethical conduct and CPD, these councils promote the rendering of quality health and social services to the broader public. Thus the professional councils, together with the organised voluntary professional associations, perform important functions in the health and social development sector labour market and are involved in the HWSETA's skills development initiatives.

Academic and research institutions conducting research in human and animal health and the socio-economic impact of disease play a prominent role in the health and social development sector. Several institutions are specifically charged with advancing training and development of researchers, human-and animal health professionals, and technicians for the sector.

Increasingly, NPOs play an essential role in service delivery and in the labour market for the health and social development sector. NPOs are major providers of care services for particular target groups in South Africa and service more than 70% of

social development clients. Therefore they are key partners of national and provincial government in attaining socio-economic and developmental priorities. These organisations provide a range of services, including child care and protection, youth care and development, crime prevention and support, treatment and rehabilitation of persons suffering from substance abuse, care for older persons and the disabled, material assistance, and support services to patients and households affected by HIV/AIDS. Even though these organisations, their workers and volunteers, fall outside the sector's formal structures, they require special attention in the SSP.

Formal employment in the health and social development sector is estimated at approximately 586 700, with professionals and technicians and associate professionals respectively forming 40% and 23% of the total workforce. The majority of people working in the sector are women and the vast majority are black. Only a small percentage of the people employed in the sector were living with disabilities.

3 Factors Influencing the Labour Market for the Health and Social Development Sector

3.1 Introduction

South Africa is confronted by difficult economic conditions and severe social problems that provide the focus for its health and social development system. These challenges include poverty, unemployment, HIV/AIDS, infant mortality and teenage pregnancy, low levels of literacy and education, high levels of violence, abuse and neglect, poor housing and public health, high levels of crime, and inequalities born of the apartheid era. Health sector analysts comment that gains made since 1994 to improve access to healthcare, rationalise health management and attain more equitable health expenditure have been mostly eroded as a result of the rampant AIDS crisis, disparities in spending and allocation of staff, and weak health-systems management. As a result, health outcomes are poor relative to health expenditure and the health sector workforce is substantially weaker than in the mid-1990s⁸⁰.

The South African Constitution compels the state to take progressive measures to grant everyone access to healthcare services, sufficient food and water and social security, and to be development-oriented⁸¹. Measures introduced to achieve these imperatives necessitate changes to the skills base and skills content of available human resources in the health and social development sector.

As a point of departure, the chapter examines health and social development spending and the demand for health and social services. The impact of the

global economic downturn, pertinent socio-economic factors and the burden of disease and social realities that shape the service environment are also considered. Global influences on the sector's labour supply and challenges relating to the sector's human resources are outlined. Management issues that constrain effective provision of health and social services are highlighted. The strategic importance of the National Development Plan (NDP) in relation to health and social development policies is considered. Since existing and new legislation has a bearing on human resources and skills needs, the chapter outlines key statutory provisions influencing the sector. Various national policies pertaining to health and social development services and the anticipated impact of skills development needs are discussed as well. Reference is made to the White Paper for Post-school Education and Training as well as new approaches to education and changes affecting key occupations in the sector. The chapter concludes with an overview of factors affecting the delivery of veterinary services.

3.2 Health and Social Development Spending

3.2.1 Health spending

Healthcare expenditure comes from three sources: general tax revenues finance the public sector, and private sector expenditure is financed by medical schemes and out-of-pocket payments⁸². The public sector is under-resourced relative to the burden of disease and the user population served. South Africa spends on average 8.2% of its GDP on health, higher than the 5% recommended by the World Health

Organization (WHO), but in line with most OECD countries⁸³.

South Africans access medical care either through the public health system or through private health insurance arrangements with medical schemes, or incur out-of-pocket expenses. About 84% of the population (an estimated 43.2 million people) is served in the public sector, while 8.7 million people (16%) are entitled to medical scheme benefits⁸⁴. However, a larger proportion of the population (estimated between 24% and 38%) use some private services provided by general practitioners, dentists and pharmacists⁸⁵.

Levels of healthcare spending in the private and public sectors for the period 2009/10 to 2013/14 are shown in Table 3.1. In 2014 healthcare expenditure was estimated to be above R293 billion, with 48% of this attributable to public sector spending, 50% to private financing and 2% to donors⁸⁶.

80 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care" in *South African Health Review 2008*; Harrison, D. 2009. *An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*; DoH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

81 Sec 27 and sec 28 and sec 195 of the Constitution of the Republic of South Africa, Act 108 of 1996.

82 DoH. 2011. *National Health Insurance in South Africa: Policy Paper*. Published at <http://images.businessday.co.za/NHL.pdf>. (Accessed 12 Aug 2011).

83 DoH. 2011. *National Health Insurance in South Africa: Policy Paper*; Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*. Published at <http://www.econex.co.za>. (Accessed 7 June 2014).

84 DoH. 2011. *National Health Insurance in South Africa: Policy Paper*; Council for Medical Schemes. 2013. *Annual Report 2012-2013*. Published at <http://www.medicalschemes.com/...> (Accessed 5 June 2014).

85 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". *South African Health Review 2011*. Published at <http://www.hst.org.za/...> (Accessed 27 Aug 2012); Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*.

86 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". *South African Health Review 2011*.

Table 3 1 Estimates of health expenditure in public and private sectors: 2009 to 2014

Public sector	Rand million				
	2009/10	2010/11	2011/12	2012/13	2013/14
National Department of Health core	1 645	1 736	1 784	1 864	1 961
Provincial departments of health	88 593	98 066	110 014	119 003	126 831
Defence	2 483	2 770	2 961	3 201	3 377
Local government (own revenue)	1 829	1 865	1 977	2 096	2 221
Education	2 350	2 503	2 653	2 812	2 981
Other (Correctional services & social insurance funds) ¹	2 946	3 451	3 720	3 905	4 110
Total public sector health	99 848	110 391	123 110	132 881	141 473
Private sector					
Medical schemes	84 863	96 482	104 008	112 120	120 866
Out-of-pocket	16 200	17 172	18 202	19 294	20 452
Medical insurance	2 660	2 870	3 094	3 336	3 596
Employer private	1 271	1 372	1 479	1 594	1 718
Total private sector health	104 994	117 896	126 783	136 344	146 632
Donors or NGOs	6 319	5 787	5 308	5 574	5 852
TOTAL	211 161	234 074	255 201	274 799	293 957

1. Social insurance funds are the Compensation Fund for workmen's injuries on duty and the Road Accident Fund. Costs of private and public healthcare providers are included in the amounts paid.

Source: Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". South African Health Review 2011.

There is a direct relationship between health spending (in the public and private sectors) and the demand for health workers. In the public sector health budgets are major determinants of both the number of positions created and salary levels and, consequently, of the ability of institutions to attract and retain staff. In the private sector the linkages are somewhat more complex, but equally significant.

a) Public sector spending

Public sector spending on health services will increase from R99.4 billion in 2009/10 to a projected R154.1 billion in 2014/15⁸⁷. Public healthcare expenditure is projected to grow at an average annual rate of 7% in real terms from 2014/15 to 2016/17⁸⁸. Over the last 20 years the public sector has moved from an in-hospital approach to a primary healthcare (PHC) approach⁸⁹. This is also reflected in public sector spending. About 43.5%⁹⁰ of public health spending at provincial level flows to district health services, which include primary care clinics and community health centres, district

hospitals, and AIDS interventions.

Salaries and wages comprise the greatest portion of the health budget, an average 57.8% of the total budget over the period 2011 to 2014. Growth in public sector expenditure on the health workforce doubled from R28.7 billion in 2006/07 to R58.9 billion in 2010/11, largely due to the introduction of the Occupation Specific Dispensation (OSD), an increase of 37 000 health workers between 2008/09 and 2010/11, and above-inflation salary increases in the public sector⁹¹. From 2014/15 additional funding is available to public health facilities to contract the services of general practitioners in private practice⁹².

Government recognises that given competing demands for resources, it is unlikely to absorb large increases in health budgets. For this reason the sector will have to improve efficiencies and human resources management to improve services and coverage⁹³.

b) Private sector spending

By 2012 gross contributions to medical schemes per average principal member reached R18 972 compared to R8 168 in 2000 for the average beneficiary. This represents a growth of 43.3% over the period⁹⁴. Per capita expenditure through private medical schemes was R11 084 in 2011, or more than four times the level in the public sector⁹⁵. Medical schemes spent R103.3 billion on healthcare benefits in 2012, an increase of 10% from 2011. Hospital expenditure accounted for R37.9 billion (36.7%). Medical scheme expenditure on private hospitals increased in real terms by 129.9% between 2000 and 2010 (from R14.7 billion to R33.8 billion)⁹⁶.

In contrast to the public sector, private sector spending has moved away from PHC towards funding major medical benefits such as hospital-, specialist- and chronic-disease benefits. Comparison in spending shows that the private and public sectors are on divergent paths in their respective approaches to healthcare⁹⁷. This affects the nature of labour demand in the two sectors.

87 National Treasury. 2012 Budget Review; National Treasury. 2014 Budget Review.

88 National Treasury. 2014 Budget Review.

89 Coovadia, H., Jewkes, R., Barron, P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet. Sept 2009. Vol. 374. Published at <http://thelancet.com>. (Accessed Aug 2010).

90 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". South African Health Review 2011.

91 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; Blecher, M., Kollipara, A. et al. 2011. "Health Financing". South African Health Review 2011.

92 National Treasury. 2014 Budget Review.

93 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

94 Calculated from Council for Medical Schemes. 2012. Annual Report 2011-2012 and. Annual Report 2010-2011..

95 Day, C. and Gray, A. 2013. "Health and Related Indicators" in South African Health Review 2012/13.

96 Council for Medical Schemes. 2012. Annual Report 2011-2012.

97 Day, C. and Gray, A. 2008. "Health and Related Indicators". South African Health Review 2008.

3.2.2 Spending on social development

The main focus of the social development sector is on social assistance, social security, welfare services and community development for poor and vulnerable groups. Information on social expenditure from donor organisations is not readily available. Transfers by national and provincial social development departments to NGOs for welfare services delivered on behalf of the state grew from R3 billion in 2008/09 to R5 billion in 2012/13 and will increase to R6.5 billion in 2015/16⁹⁸.

Expenditure by the DSD grew from R94 billion in 2010/11 to R117.8 billion in 2013/14, at an average annual rate of 7.8%, and will increase to R146.2 billion by 2016/17⁹⁹. The rise is mainly as a result of

98 National Treasury. 2013 Budget Review.

99 National Treasury. 2014. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

increases to social assistance programmes, which extended access to social grants for children and older men¹⁰⁰. Expenditure on social grants is projected to increase by 7.6% per annum and will account for 94% of the DSD budget until 2016/17. In view of increased service demands and declining donor funding, the 2014 Budget allocates R233 million in subsidies to NGOs over the medium term¹⁰¹.

3.3 The Demand for Health and Social Development Services

3.3.1 Demand for health services

According to the South African Health

100 DSD. 2013. Annual Performance Plan 2013/2014; National Treasury. 2012. "Vote: 19: Social Development". 2012 Estimates of National Expenditure.

101 National Treasury. 2014. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

Review 2012/13 data on the utilisation of health facilities and health services are not readily available. The 2011 General Household Survey conducted by StatsSA reported that when persons fall ill or have accidents, 70.7% would seek care from a public sector facility and 24.3% would consult a private medical practitioner¹⁰². It is anticipated that the demand for and utilisation of health services will continue to grow in the next decade as Government adopts more measures to make the health sector work for everyone.

a) The demand for public healthcare

Table 3 2 shows that utilisation of public services increased in several categories between 2010/11 and 2014 and it is projected to increase until 2017.

102 Day, C. and Gray, A. 2013. "Health and Related Indicators". South African Health Review 2012/13.

Table 3 2 Past and projected utilisation of public health services: 2010/11 to 2016/17

Healthcare service area	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
PHC utilisation rate: Ave number of visits per person p.a.	2.4	2.5	2.5	2.8	2.9	3	3
Tuberculosis (new pulmonary) cure rate	71.1%	73.1%	73.8%	85%	85%	85%	85%
Tuberculosis treatment defaulter rate	7.1%	6.8%	6.1%	5%	5%	5%	5%
Number of new patients put on antiretroviral treatment p.a.	418 677	617 147	612 118	500 000	500 000	500 000	500 000
Antenatal first visit before 20 weeks	37.5%	40.2%	44%	60%	65%	68%	70%
National immunisation coverage (children under age of 1y)	89.4%	95.2%	94%	90%	90%	90%	90%
Measles immunisation coverage rate (2nd dose)	81%	85.3%	82.7%	90%	90%	90%	90%
Cervical cancer screening coverage	52.2%	55%	55.4%	56%	58%	60%	62%

Source: National Treasury. 2014. "Vote 16: Health". 2014 Estimates of National Expenditure.

Demand for PHC services will continue to increase. The DoH projects that demand for PHC services will increase to 3 visits per person per annum by 2015/16, representing an annual increase of 4.7% over four years¹⁰³. The anticipated decline in the tuberculosis treatment defaulter rate may be linked to increased efforts by health workers to prevent patients from discontinuing the prescribed courses of medication. The body of patients on antiretroviral treatment will continue to grow, and every year more patients will require timely access to medicines and health monitoring.

Demand for hospital services has also increased between 2000/01 and 2009/10¹⁰⁴.

103 National Treasury. 2014. "Vote 16: Health". 2014 Estimates of National Expenditure. Percentage growth was calculated.

104 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". South African Health Review 2011.

Although the number of public hospitals increased from 375 in 2001 to 410 in 2011, the ratio of usable beds per 1 000 population nationally decreased from 1 to 0.7¹⁰⁵. Overall hospital admissions increased from 3.5 million to above 4 million per annum and so did the average length of stay. Analysis by the Health Systems Trust shows that the national average length of stay at public sector health facilities was 5.6 days in 2011, higher than 4.0 days for district hospitals in 2001. Over the period the occupancy rate at district hospitals increased from 57% to 73 nationally¹⁰⁶ and outpatient visits increased from 17 million

105 Day, C. and Gray, A. 2013. "Health and Related Indicators" South African Health Review 2012/13; Day, C and Gray, A. 2010. "Health and Related Indicators". South African Health Review 2010.

106 Day, C. and Gray, A. 2013. "Health and Related Indicators" South African Health Review 2012/13; Day, C and Gray, A. 2010. "Health and Related Indicators". South African Health Review 2010.

to 26 million¹⁰⁷.

A comprehensive revitalisation programme for public hospitals and public health facilities is underway, and an amount of R16.281 billion will be allocated for this purpose over three years until 2017¹⁰⁸. New hospitals are under construction and existing facilities are being upgraded and renovated¹⁰⁹. As the number of hospital beds increase, so too does the demand for medical professionals and staff.

107 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". South African Health Review 2011.

108 National Treasury. 2014 Budget Review.

109 National Treasury. 2010. "Health". Estimates of National Expenditure 2010; National Treasury. 2014 Budget Review.

b) The demand for private healthcare services

The private sector has also experienced an increase in demand for healthcare, as evidenced by higher medical scheme membership, higher hospital occupancy rates, the growth in the percentage of people consulting health workers, as well as increasing levels of concern about the quality of healthcare. By 2013, the number of private hospitals and day clinics reached 314, and provided 34 572 beds, up from 20 908 in 1998. This represents an average annual increase of 3.2% over the period¹¹⁰. Membership of medical schemes increased by 24% between 2000 and 2012, and this provided coverage within the range of 14.5% to 17% of the population¹¹¹. Expenditure by medical schemes for provincial hospital care declined from 27% of scheme expenditure in 1989 to 0.324% in 2012/13 – yet another indicator of the rising demand for private healthcare¹¹².

According to the Council for Medical Schemes, the utilisation rate of beneficiaries admitted to private hospitals increased from 173.7 per 1 000 beneficiaries in 2006 to 178.8 per 1 000 beneficiaries in 2011¹¹³. Older people are being admitted to hospital more often and beneficiaries with chronic diseases are increasing the utilisation of private hospital services, as the prevalence of lifestyle diseases appears to rise¹¹⁴. For example, Econex

analysed in-patient admissions for chronic diseases at the three largest private hospital groups for the period 2005 to 2010 and found a 47.2% increase in admissions, a 68.5% increase in patient days and a 14.5% increase in average length of stay¹¹⁵. The number of visits to a medical doctor (GP) per medical scheme beneficiary remained at between 2.9 and 3.0 over the period 2007 to 2011, but increased to above 3.6 in 2012¹¹⁶.

Several studies over the last decade found that users of public health facilities remain concerned about the quality of care, citing long queues, lack of equipment and medication, disrespect for patients, and rude staff¹¹⁷. Growing numbers of people from the poorest households prefer to pay for private care, which increases the demand for private providers and GPs in particular¹¹⁸.

3.3.2 Demand for social development services

Demand for social development services continues to expand.

One of the main strategies to combat poverty is the provision of social assistance to vulnerable persons in the form of monthly social grants paid from tax revenues. Six categories of persons who meet prescribed eligibility criteria may benefit¹¹⁹. A child support grant is paid to a primary caregiver of a child and a care dependency grant is paid to a parent, foster parent or primary

caregiver of a child who requires permanent care due to a physical or mental disability. A foster care grant is paid to any person (except the parent of the child) in whose custody a foster child is placed by a court. Persons unfit for employment and unable to provide for their maintenance owing to a mental or physical disability may qualify for a disability grant. The old-age grant is paid to persons who are 60 years and older with annual incomes of less than R61 320 (single) or R122 640 (married) and a war veterans grant is paid to a person of 60 years and older who served in the armed forces during World War II or the Korean War. A grant-in-aid is paid to a person with a physical or mental disability and who requires regular attendance by another person. Social relief of distress is a temporary grant of assistance in the form of food or money to persons who are experiencing a crisis following the death of a breadwinner, with insufficient means, following a disaster, or who have been found medically unfit to work.

By 2013/14, the recipients of social grants totalled 15.8 million people, double the number of 7.9 million people in 2004¹²⁰. The table below shows the growth in beneficiary numbers by grant category since 2010/11. By March 2017 income support should reach 16.5 million persons¹²¹. The projected number of beneficiaries is lower than reported in the 2013/14 SSP update due to measures taken by the DSD to remove ineligible persons from the grant system¹²². Recipients of the child support grant (i.e. 11 million children) account for 66% of the social grant beneficiaries in 2013/4. Income support for older persons will be extended to reach 3.3 million beneficiaries (20% of social assistance beneficiaries) by 2016/17¹²³.

¹²⁰ National Treasury. 2014 Budget Review. National Treasury. 2008 Budget Review.

¹²¹ National Treasury. 2014 Budget Review; Medium-term Budget Policy Statement by Minister of Finance, October 2012.

¹²² National Treasury. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

¹²³ National Treasury. 2014 Budget Review.

¹¹⁰ Calculated from Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*; Day, C., Gray, A. et al. 2011. "Health and Related Indicators". *South African Health Review 2011*; Day, C and Gray, A. 2010. "Health and Related Indicators". *South African Health Review 2010*.

¹¹¹ Day, C. and Gray, A. 2013. "Health and Related Indicators". *South African Health Review 2012/13*; Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*.

¹¹² Council for Medical Schemes. 2013. *Annual Report 2012-2013*; Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*.

¹¹³ Council for Medical Schemes. 2012. *Annual Report 2011-2012*.

¹¹⁴ Econex. 2012. "Medical Scheme Expenditure on Private Hospitals"; Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*.

¹¹⁵ Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*.

¹¹⁶ Council for Medical Schemes. *Annual Report 2008-2009*; *Annual Report 2010-2011*; *Annual Report 2011-2012*; *Annual Report 2012-2013*. Published at <http://www.medicalschemes.com/Public...aspx>. (Accessed 5 June 2014).

¹¹⁷ McIntyre, D., Goudge, J., Harris, B. et al. 2009. "Prerequisites for National Health Insurance in South Africa: Results of a national household survey". *South African Medical Journal*. October 2009. 99 (10).

¹¹⁸ DoH. 2011. *National Health Insurance in South Africa: Policy Paper*; Van der Berg, S., Burger et al. 2010. *Financial Implications of a National Health Insurance Plan for South Africa*.

¹¹⁹ Social Assistance Act, 13 of 2004; National Treasury. 2014. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

Table 3 3 Social grants beneficiaries by type, past and projected, 2010/11 to 2016/17

Type of grant	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Older persons (old-age)	2 648	2 711	2 846	2 946	3 074	3 188	3 308
Disability	1 212	1 172	1 154	1 179	1 116	1 114	1 113
Foster care	490	518	515	519	534	549	563
Care dependency	121	122	129	132	135	139	144
Child support	10 154	10 675	11 213	11 050	11 194	11 319	11 392
Total	14 625	15 198	15 857	16 765	16 052	16 309	16 520

Sources: National Treasury. 2014 Budget Review.

Child protection services will expand by growing the number of children adopted by 10% per annum between 2014 and 2017. Policy development work is underway to expand social security and support for unemployed youth and orphaned children cared for by relatives¹²⁴. With the projected annual growth of the elderly population at 3%, there is increasing demand for social services to promote and protect the rights of older persons¹²⁵. The sector is experiencing a growing need for service in the form of home- and community-based care for persons infected with and affected by HIV/AIDS. Owing to the impact of HIV/AIDS and other pressures on communities, it is becoming more challenging for government to provide residential care for children, frail older persons and people with severe physical and mental disabilities¹²⁶.

NGOs report an increase in demand for statutory services – i.e. social services that require a professional to give effect to legislation or a court order, such as child protection. This increase in individual case work is attributed to the growth in foster care placements and a surge in the number of orphans and vulnerable children as a result of HIV/AIDS, poverty and unemployment¹²⁷. NGOs also report an increase in demand for social relief, poverty eradication interventions, income-generation projects, and skills development programmes. Government will expand the Expanded Public Works Programme (EPWP) that employs poor and unemployed persons to deliver public and community service in every municipality. The aim is to create 6 million jobs of short- and medium term duration by 2016/17¹²⁸.

3.4 Socio-Economic Realities

Socio-economic realities drive the need for health and social services. Large sections of South African society are beset by high levels of chronic poverty. By 2011 only

13.1 million people out of a population of 51 million were employed (or 39.7% of the working age population). About 50% of working-age youths below 25 years were unemployed. Long-term joblessness increased to 68% of the total unemployed persons¹²⁹. Close to one-quarter (22.3%) of households listed social grants as their main income source¹³⁰. The National Planning Commission fears that up to 60% of an entire young generation may never hold a formal job, constituting a huge risk to social stability¹³¹. Women face a higher unemployment rate than men and many women remain vulnerable by depending on survivalist activities¹³². Statistics SA found that 21% of households had inadequate or severely inadequate access to food in 2011¹³³. Malnutrition is widespread and up to 20% of children may suffer from chronic malnutrition as evidenced by stunted growth¹³⁴.

Increasingly, policy makers recognise that social and economic factors influence people's health status and have instituted action plans over the last decade to address the so-called social determinants of health. Factors such as income, education, social safety nets, employment and working conditions, unemployment and job security, early childhood development, gender, race, food insecurity, housing, social exclusion, access to health services and disability are regarded as social determinants of health¹³⁵. According to the Commission on the Social Determinants of Health (CSDH), health and illness follow a social gradient: the lower the socio-economic position, the worse the health¹³⁶. Since disease rates vary according to economic status, the relationship between

poverty, hunger and diseases such as HIV/AIDS and TB underscores the need for social development interventions.

The social development and health needs of children are particularly critical. In South Africa it is common for children to live separately from their biological parents due to orphaning, labour migration, financial factors, care arrangements, and cultural practices¹³⁷. Of the country's 18.5 million children in 2011, an estimated 3.8 million (21%) had lost one or both parents. Between 2002 and 2011 the number of orphaned children increased by 853 000, while the number of double orphans more than doubled from 350 000 to 950 000. An estimated 82 000 children were living in a total of 47 000 child-only households. Children in child-only households are particularly vulnerable to poverty, crime and abuse. According to the Children's Institute, nearly 10.8 million children (58%) lived below the poverty line (with a per capita income of less than R604 per month) in 2011. Over 6.5 million children (35%) lived in households where no adults were employed¹³⁸.

3.5 Economic Downturn

The enduring global economic outlook and the downturn in South Africa since 2008 have impacted on the health and social development sector on several levels. Firstly, the delivery of health and welfare services is highly dependent upon tax revenues. During periods of economic contraction, tax revenues decline, which affects budgets, allocation of human resources and provision for training¹³⁹. Secondly, many NPOs depend on international and local donor funding, and these sources of income may dip substantially or be plugged altogether. As a result, the sustainability of these organisations has been compromised¹⁴⁰. Reduced funding (and even termination) by international donors¹⁴¹ has had a severe impact on national health and social

124 National Treasury. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

125 National Treasury. 2012 "Vote 19: Social Development". 2012 Estimates of National Expenditure.

126 National Treasury. 2009. "Social Development". Provincial Budgets and Expenditure Review 2005/06 – 2011/12.

127 Patel, L., Hochfeld, T. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*; Schmid, J. 2012. *Trends in South African Child Welfare Reform*. Published at <http://www.uj.ac.za/...csda>. (Accessed 10 Sept 2012).

128 National Planning Commission. 2011. *Diagnostic Human Conditions*. Published at <http://www.npconline.co.za/...>; National Treasury 2014 Budget Review.

129 StatsSA. 2012. *Census 2011 Statistical Release P0301.4*. Published at <http://www.statssa.gov.za/...> (Accessed 10 Nov 2012); National Treasury. 2011 *Budget Review*; StatsSA. 2012. *Census 2011 Fact Sheet*. Published at <http://www.statssa.gov.za/...> (Accessed 10 Nov 2012).

130 <http://www.southafrica.info/about/social/food-access-310812.htm#>. (Accessed 6 June 2014).

131 National Planning Commission. 2011. *Diagnostic Human Conditions*.

132 Department of Social Development. 2012. *Annual HRD Implementation Plan*.

133 <http://www.southafrica.info/about/social/food-access-310812.htm#>. (Accessed 6 June 2014).

134 National Planning Commission. 2011. *Diagnostic Human Conditions*.

135 Rispel, L. and Nieuwoudt, S. 2013. "Mainstreaming the Social Determinants of Health in South Africa: Rhetoric or reality?" in *South African Health Review 2012/13*; National Planning Commission. 2012. *National Development Plan 2030, Our Future: Make it Work. "Executive Summary"*. Published at <http://www.npconline.co.za/...> (Accessed 16 July 2013).

136 Lutge, E. and Friedman, I. 2010. "The Cycle of Poverty, Hunger and Ill-health". *South African Health Review 2010*.

137 Hall, K. and Posel, D. 2012. "Inequalities in children's household contexts: Place, parental presence and migration". *South African Child Gauge 2012*. Published at <http://www.ci.org.za/depts/ci/...> (Accessed 18 July 2013).

138 Berry, L., Biersteker, L., et al. (eds). "Children Count – The Numbers". *South African Child Gauge 2013*.

139 Such concerns were raised during the baseline study of the health sector undertaken for the HWSETA.

140 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Published at <http://www.uj.ac.za/...>; Coalition on Civil Society Resource Mobilisation. 2012. "Critical Perspectives on Sustainability of the South African Civil Society Sector".

141 National Treasury. 2013. "Vote 16: Health". 2013 Estimates of National Expenditure.

development programmes. For example, over the period 2014-2016 the National Treasury will provide additional resources to off-set the decline in funding from international donors. Thirdly, economic recessions led to retrenchments, and the loss of medical insurance offered by some employers, which situation adds to the demand for public health services and social security to alleviate poverty. Fourthly, while funding resources may stagnate or weaken during periods of economic downturn, the demand for health- and social development services will grow. These economic factors are likely to put further pressure on professionals and workers in the social development and health sectors¹⁴².

3.6 The Burden of Disease and Social Ills

Research shows that South Africa has substantially larger numbers of sick people who are sicker than those in other countries. This high burden of disease is four times larger than for developed countries and generally double that of other developing countries. This “quadruple burden of disease”¹⁴³ is attributable to the scale of the HIV/AIDS pandemic; the high incidence of tuberculosis (TB), malaria, inter-personal violence and trauma; poor maternal and child health; and chronic conditions such as alcohol abuse, diabetes, lung- and heart disease¹⁴⁴. By 2013, it was estimated that 6.4 million people were living with HIV and that the HIV prevalence rate among persons aged 15-49 was 15.9%¹⁴⁵. StatsSA estimated the percentage of deaths due to AIDS in 2013 at 32%¹⁴⁶. Studies show that more than 300 000 South Africans are infected every year¹⁴⁷. HIV/AIDS poses developmental challenges as the diseases are driven by poverty and social factors such as gender inequality and behaviour¹⁴⁸.

142 National Treasury. *Budget Review 2010; National Treasury. 2011 Budget Review.*

143 Coovadia, H., Jewkes, et al. 2009. “The health and health system of South Africa: historical roots of current public health challenges”. *Lancet*. Sept 2009.

144 Van der Berg, S., Burger, R. et al. 2010. *Financial Implications of a National Health Insurance Plan for South Africa*; Harrison, D. 2009. *An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains.*

145 DoH. 2014. *Strategic Plan 2014/15-2018/19*; Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy.*

146 DoH. 2014. *Strategic Plan 2014/15-2018/19.*

147 Venter, F. 2013. “HIV Treatment in South Africa: The challenges of an increasingly successful antiretroviral programme”. *South African Health Review 2012/13*. Published at <http://www.hst.org.za/.../health-review-2012/13>. (Accessed 13 July 2013).

148 Department of Social Development. 2012. *Annual HRD Implementation Plan.*

The country’s TB epidemic is amongst the worst and most serious globally, with an estimated annual incidence rate of 993 per 100 000 population¹⁴⁹ and a prevalence rate of 795 per 100 000 population in 2011¹⁵⁰. TB is a major cause of death and the co-infection rate with HIV is about 60%¹⁵¹. Inappropriate and ineffective treatment of TB results in multiple-drug-resistant TB, which is placing a huge burden on the national health system¹⁵².

Even though South African maternal and infant mortality rates declined between 2009 and 2011, the rates are higher than in comparable developing countries. Although HIV/AIDS is a contributing factor in 30% to 60% of child deaths¹⁵³, many deaths are attributed to care failures and are thus preventable¹⁵⁴. In rural areas the infant mortality is on average 62% higher in comparison with urban areas¹⁵⁵. Child mortality remains a major and complex public health challenge. The under-five mortality per 1 000 live births decreased from 56 in 2009 to 42 in 2011, but it is far from the 2015 target of 20¹⁵⁶. High mortality is linked to health, social and environmental risks such as a poor immunisation rate, poverty and malnutrition, as well as inadequate access to clean water and sanitation¹⁵⁷. Decreasing child and maternal mortality is a key government objective¹⁵⁸.

Non-communicable diseases such as high blood pressure, diabetes, chronic heart disease, chronic lung diseases, stroke and

149 Day, C. and Gray, A. 2013. “Health and Related Indicators” in *South African Health Review 2012/13*; Karim, S.S.A, Churchyard, G.J. et al. 2009. “HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response”. *Lancet*. Sept 2009. Vol. 374; DoH. 2011. *National Health Insurance in South Africa: Policy Paper.*

150 Day, C. and Gray, A. 2013. “Health and Related Indicators”. *South African Health Review 2012/13*.

151 DoH. 2014. *Strategic Plan 2014/15-2018/19*.

152 Medical Research Council. 2006. *Policy Brief, No1, Jan 2006*. Published at <http://www.mrc.ac.za/.../Accessed August 2010>.

153 Bamford, L. 2013. “Maternal, newborn and child health” in *South African Health Review 2012/13*.

154 DoH. 2014. *Strategic Plan 2014/15-2018/19*; DoH. 2011. *National Health Insurance in South Africa: Policy Paper*; Day, C., Gray, A. et al. E. 2011. “Health and Related Indicators”. *South African Health Review 2011*.

155 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

156 Bamford, L. 2013. “Maternal, newborn and child health” in *South African Health Review 2012/13*. DoH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

157 Macheke, C. 2010. *HWSETA Health Sector Baseline Study*.

158 Day, C., Gray, A. and Budgell, E. 2011. “Health and Related Indicators”. *South African Health Review 2011*.

cancer contribute to 33% of the disease burden, and are major causes of premature death¹⁵⁹. Public health specialists estimate that up to 2 million South Africans are affected by type 2 diabetes which can cause blindness and amputation of limbs¹⁶⁰. Primarily four risk factors are identified, namely alcohol, smoking, poor diet, and lack of exercise.

High levels of social crime, particularly violence against women and children, and injuries associated with road accidents and inter-personal crime also contribute to the country’s health and social burden. The injury death rate is 158 per 100 000 population, or twice the global average¹⁶¹. Research has shown that violence, alcohol abuse and mental disorders are interlinked, and that the lifetime prevalence of mental illness amongst South African adults may be as high as 30.3%¹⁶². Poor access to mental health and substance misuse services adds to the burden. In future more social- and health interventions will be directed at behaviours that correlate with the risks of non-communicable diseases, social crime, and injury¹⁶³.

Arguably, many of the driving factors in the disease burden are linked to social and economic inequalities and are not primarily caused by poor health-and social services¹⁶⁴. The scope and complexity of these health threats are creating increased demands on the services and workforce in the sector¹⁶⁵. Training and skills development must provide for a wide spectrum of conditions and equip the workforce to address the social determinants of health and well-being¹⁶⁶.

159 DoH. 2014. *Strategic Plan 2014/15-2018/19*; Day, C., Gray, A. and Budgell, E. 2011. “Health and Related Indicators”. *South African Health Review 2011*.

160 Child, K. “Plan to fight lifestyle diseases.” *The Times*. 13 May 2014. <http://www.timeslive.co.za/.../Accessed 2 June 2014>.

161 DoH. 2014. *Strategic Plan 2014/15-2018/19*.

162 Corrigan, J. and Matzopoulos, R. 2013. “Violence, Alcohol Misuse and Mental Health: Gaps in the health system’s response”. *South African Health Review 2012/13*.

163 Day, C., Gray, A. and Budgell, E. 2011. “Health and Related Indicators” *South African Health Review 2011*.

164 Harrison, D. 2009. *An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains.*

165 Lehmann, U. 2008. “Strengthening Human Resources for Primary Health Care”. *South African Health Review 2008*.

166 DoH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

3.7 The Mobility of Labour

The effects of globalisation and the migration of skilled labour from emerging to developed economies continue to affect the health sector. Job opportunities in better resourced countries that offer more attractive working conditions, better prospects for professional advancement, and general quality of life advantages attract trained healthcare professionals from less developed countries to work elsewhere¹⁶⁷. This mobility of health professionals not only depletes the skills base in developing countries but also adversely affects healthcare services, as well as the workloads of and working conditions for the remaining workforce¹⁶⁸. Conservative estimates place the attrition rate of health professionals in South Africa due to emigration at about 25%¹⁶⁹.

The social development sector has also experienced a departure of social workers, from the welfare- to the corporate sector, and also from NPOs to government departments. Research has found that low salaries and unfavourable working conditions contribute to the exodus of skills¹⁷⁰. This results in significant skills shortages in the NGO sector which constitutes the major delivery channel for social services¹⁷¹. South African social workers have also been recruited internationally¹⁷².

167 WHO. 2010. *Migration of Health Workers. Factsheet 301*. Published at <http://www.who.int/...> (Accessed 15 Aug 2011); Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance". *South African Health Review* 2010.

168 WHO. 2006. *The World Health Report 2006 - working together for health*.

169 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.x*

170 Patel, L., Hochfeld, T., et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*.

171 South African Council for Social Service Professions. 2011. *Official Newsletter 1(1)*, July.

172 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*.

3.8 Human Resources Challenges

3.8.1 Problem statement

Market forces, working conditions and career advancement opportunities are all factors that determine where and for how long people work in a particular workplace. This is also true of the labour market in the health and social development sector. While this SSP looks at the availability of skills and the demand and supply of the skills in more detail in the following chapters, it is useful to sketch key issues at this stage.

Decision makers, operational managers and analysts of the health sector have expressed concerns about the quantity and quality of healthcare professionals available in the country. It is widely recognised that care levels, outcomes and management of the public health system are under strain, partly because of significant staff shortages and an inadequate skills base¹⁷³. According to public health academics, the record of human resources planning and management is not good. Among the key weaknesses is the failure to produce adequate numbers of health professionals and ineffective strategies to retain health workers in the public health system, especially in rural and under-resourced areas. Of the approximately 1 200 medical doctors graduating every year, only about 35 remain working in rural areas in the longer term¹⁷⁴. Staff turnover for health professionals in some provinces is as high as 80%¹⁷⁵. District hospitals are often poorly staffed and under-equipped¹⁷⁶.

173 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance". *South African Health Review* 2010; Coovadia, H., Jewkes, R. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet*. Sept 2009. Vol. 374. Chopra, M., Daviaud, E. et al. 2009. "Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?" *Lancet*. Sept 2009. Vol 374.

174 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

175 DOH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

176 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in *South African Health Review* 2010.

3.8.2 Human Resources for Health Strategy 2012 to 2017

A new strategy, Human Resources for Health – South Africa 2030, was published by the DoH in October 2011, with a further revision published in January 2012 under the title Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17¹⁷⁷. The strategy focuses on three thematic areas to guide actions of the multiple stakeholders in the sector, including the DoH, provincial health departments, and faculties of health sciences, statutory councils and professional associations:

- Theme I: the supply (and distribution) of health professionals and equity of access to appropriately trained health workers;
- Theme II: education, training and research; and
- Theme III: the working environment of the health workforce.

The strategy contains short-, medium-, and long-term objectives to strengthen human resources to meet service demands, enable appropriate planning and build capacity in the health sector¹⁷⁸. Conditional grants to provinces for the education, training and development of health professionals between 2015 and 2017 will total R7.3 billion¹⁷⁹. Core aspects of the HRH Strategy will be highlighted throughout this SSP.

3.8.3 Distribution of health workers in private and public sectors

It is not only the numbers and skills mix of health workers that are of concern but also their distribution between the public and private sectors, as well as geographically. Generally, there are more health professionals per 10 000 population in the private sector than in the public sector. Estimates on the distribution of resources across the sectors vary, depending on the approach adopted and the interpretation of available (and often uncertain) data. Nevertheless, Table 3 4 compares the allocation of GPs, dental practitioners, pharmacists and nurses per 10 000 of the population in the public and private sectors.

177 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

178 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

179 National Treasury. 2014 *Budget Review*.

Table 3 4 Key resources per 10 000 of the population in public and private sectors: 2010

	Medical practitioners	Dental practitioners	Pharmacists	Nurses* ¹⁸⁰
Public sector	3.66	0.20	0.78	25.5*
Private sector	3.76	5.63	10.20	50.0*
Total SA	3.70	1.09	2.33	30.0*

*Nurses: 2009 figures from Van der Berg, S., Burger, R., Theron, N. et al. 2010. *Financial Implications of a National Health Insurance Plan for South Africa, Econex report.*

Source: DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

¹⁸⁰ Private sector nurses include those employed at private hospitals (about one-third) while the bulk work for NGOs, pharmacy clinics, mining hospitals and other private sector employers.

Although the ratio of GPs per population in the public and private sectors (for the total country) are more even than reported in previous HWSETA SSPs (2011 and 2012), this is not the case for the majority of the health professions. For example, the ratio of dental practitioners and pharmacists in the private sector by far outnumber the professional to population ratio in the public sector. The distribution of general practitioners in the public sector improved further between 2011 and 2013, and the majority are now active in that sector. While 59% of medical specialists work in the

private sector, it is estimated that 5% to 10% of specialists work in both sectors¹⁸¹.

3.8.4 Geographical distribution—the urban/rural dilemma

An estimated 43.6% of the South African population live in rural areas but are served by only 12% of the doctors and 19% of nurses¹⁸². Human resources are also

unevenly distributed between provinces in the public sector, as staff favour working near urban medical schools, and doctors prefer working in hospitals rather than in PHC facilities¹⁸³. Table 3 5 shows the skewed distribution of different categories of health professionals in 2012 as a ratio of the estimated population in each province that depends on the public sector¹⁸⁴.

¹⁸¹ Econex. 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy.*

¹⁸² DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

¹⁸³ Coovadia, H., Jewkes, R., Barron, P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet*. September 2009. Vol. 374.

¹⁸⁴ Day, C. and Gray, A. 2013. "Health and Related Indicators" in *South African Health Review 2012/13.*

Table 3 5 Distribution of health professionals per 100 000 population in the public sector: 2012

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
Dental practitioners	1.96	2.87	2.65	1.20	3.10	3.29	2.57	1.74	2.91	2.31
Dental therapists	0.19	0.08	0.49	0.85	1.53	0.66	0.89	0.59	0.05	0.61
Enrolled nurses	54.4	30.9	67.2	115.0	88.6	51.7	21.7	24.5	55.2	69.9
Environmental health practitioners	1.89	3.28	1.56	1.98	3.24	5.10	2.27	1.38	0.12	2.12
Medical practitioners	24.9	27.2	34.6	33.9	21.6	23.1	38.8	20.2	34.7	29.4
Medical specialists	3.8	14.9	21.1	7.9	1.6	2.1	1.9	3.2	33.2	11.2
Nursing assistants	100.6	84.1	80.9	68.6	119.3	59.3	91.5	89.5	97.4	86.4
Occupational therapists	2.1	3.1	2.8	1.5	3.7	2.3	4.0	1.1	3.2	2.4
Pharmacists	6.2	10.7	11.8	6.4	7.9	6.3	11.9	5.8	18.4	9.2
Physiotherapists	2.26	3.40	2.59	2.54	2.88	2.06	4.84	2.07	3.31	2.66
Professional nurses	160.1	91.2	132.3	154.8	172.1	132.0	130.1	122.1	114.4	140.8
Radiographers	6.1	8.1	7.8	5.7	3.1	2.9	8.3	3.2	10.2	6.1
Student nurses	17.6	-	62.8	23.0	12.9	30.2	-	21.8	-	25.3

Source: Day, C. and Gray, A. 2013. "Health and Related Indicators". *South African Health Review 2012/13.*

In 2012 the Western Cape had 33.2 medical specialists per 100 000 population compared with 1.6 in Limpopo and 3.2 in North West Province. In KwaZulu-Natal the number of enrolled nurses per 100 000 population was almost four- and five times greater than in the Free State and Northern Cape respectively. Also, Gauteng had almost twice the number of pharmacists per 100 000 population than the Eastern Cape and KwaZulu-Natal. These imbalances affect access to and quality of healthcare.

3.8.5 Human resources challenges in the social development sector

Workers in the social development sector are tasked with: providing support, protection and access to social services for vulnerable persons; addressing poverty and social ills; and facilitating community development to attain sustainable livelihoods. Government maintains that the shortage of social work practitioners impedes service delivery and that a range of skills in social work, community development, child and youth care and early

childhood development is needed¹⁸⁵. The most recent cost projections by DSD showed that 16 500 social workers were needed to implement the Children's Act, 2005¹⁸⁶. In 2012, only 16 164 social workers were registered with the SACSSP, with about 40% of them employed by Government¹⁸⁷. Although scholarship funding from the National Treasury boosted the number of

¹⁸⁵ National Planning Commission. 2012. *National Development Plan 2030; DSD. 2014. Strategic Plan 2014-2019.*

¹⁸⁶ DSD. 2013. *Scholarship Programme: Presentation to HR consultative Forum*

¹⁸⁷ SAIRR. 2012. "Social worker shortage undermines effectiveness of social welfare legislation". Press release, 14 Aug 2012.

registered social workers by nearly 4 000 between 2009 and 2014¹⁸⁸, almost 50% of the graduates in 2011 and 2012 were not absorbed into public sector posts in the year after graduation¹⁸⁹. However, it is not only skills shortages but also the skills mix (and deficiency of critical skills) that present challenges, as discussed in Chapter 4.

Social auxiliary workers (SAWs) are used to compensate for the shortage of social workers, but those cadres are often poorly trained, and lack knowledge and capacity to serve, so that further strain is placed on managers and systems¹⁹⁰. NGOs are challenged to meet service demand because of insufficient staff and reliance on volunteers. Research found that once volunteers are trained and have acquired skills, they leave to seek better opportunities. Role-players have remarked that it is problematic to maintain a workforce of volunteers in the context of poverty, as they have aspirations to build better careers¹⁹¹. Volunteers' motivation levels are also affected by differences in funded stipends by the DSD and DoH¹⁹², and difference between provinces. Turnover of volunteers due to low or no remuneration is high – and when people secure paid jobs, they leave. Women volunteers often leave to take care of their own families.

The DSD is currently assessing human capital challenges in the sector and intends to publish, approve and implement a Sector Human Capital Strategy and Plan 2013/14 to 2019/20¹⁹³.

3.9 Management of the Health and Social Development System

3.9.1 Management challenges in the health system

Multiple weaknesses in the health system such as inferior healthcare outcomes, unacceptably high numbers of neonatal deaths, poor planning, reports of catastrophic management of hospitals, over-expenditure and under-staffing have been attributed to weak management

188 SACSSP Register;

189 DSD. 2013. *Calculated from Presentation to HR Consultative Forum on Scholarship Programme.*

190 Schmid, J. 2012. *Trends in South African Child Welfare Reform. Centre for Social Development in Africa.*

191 Schmid, J. 2012. *Trends in South African Child Welfare Reform. Centre for Social Development in Africa.*

192 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa.*

193 DSD. 2012. *Strategic Plan 2012-2015. Published at <http://www.dsd.gov.za>. (Accessed 10 Aug 2012).*

and leadership of the health system¹⁹⁴. Some of these challenges include the lack of: efficient and effective human resources management; training, support and supervision; and performance management¹⁹⁵. Government has acknowledged these and other challenges relating to service quality; the availability of professional staff, medication and health services; cleanliness; safety and security of staff and patients; long waiting times; infection control; and poor staff attitudes towards patients¹⁹⁶. The DoH has embarked on a comprehensive strategy to improve the resources and management of the health system¹⁹⁷.

According to the DoH, management challenges in the private sector involve the costs and utilisation of services – e.g. in a decade, private hospital costs have increased by 121%, and medical scheme contribution rates have more than doubled, while increased access to services has been disproportionate. The private sector is also accused of over-servicing patients since it largely operates on a fee-for-service basis¹⁹⁸. Further, the private sector is criticised for using disproportionately more of the available human resources in comparison to the service that it provides¹⁹⁹.

3.9.2 Management challenges in the social development system

Institutional challenges in the administration of welfare services also hamper effective delivery. The gap between government's social development policy objectives and policy execution to improve

the quality of lives remains problematic²⁰⁰. Provincial governments lack the capacity to plan for and implement social development services and so welfare- and community-based services have been outsourced to NPOs. Many NPOs involved in social development services rely on government for their core funding²⁰¹. However, irregular and inadequate payment by government has a negative impact on service delivery²⁰². Government has acknowledged this challenge²⁰³.

Research commissioned by the Coalition for Civil Society Organisations found that the “enabling environment”, i.e. the legislative platform established for NGOs, is dysfunctional. The study found that the DSD experiences capacity constraints and has not implemented its responsibilities in terms of the Non-Profit Organisations Act, 71 of 1997. Service delivery by NPOs is also hampered by the ineffective disbursement of funds from the NDA and National Lotteries Distribution Trust Fund²⁰⁴.

Most NPOs have limited financial and management expertise and operate in an uncertain state of scarce funding, job insecurity, and well-worn facilities²⁰⁵. Services contracted by government are not funded at full cost and subsidies for professionals' salaries are low compared to the public sector, especially for social workers²⁰⁶. Research has shown that both the lack of and restrictive nature of government funding impacts on NPOs and social services directly, especially with regard to low salaries, high staff turnover, the limited nature and volume of services

200 Patel, L., Hochfeld, T. Graham, L. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*; Ross, E. 2012. “Social Work in South Africa”. *Social Dialogue* 3 2013.

201 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa.*

202 Lloyd, B., Sanders, D. and Lehmann, U. 2010. “Human resource requirements for National Health Insurance”. *South African Health Review* 2010; *Interviews with NGOs in October 2012; Interviews with NGOs and NACOSS in July 2014.*

203 National Treasury. 2011. “Vote 19: Social Development. 2011 Estimates of National Expenditure.”

204 Coalition on Civil Society Resource Mobilisation. 2012. *Critical Perspectives on Sustainability of the South African Civil Society Sector*; Ross, E. 2012. “Social Work in South Africa”. *Social Dialogue* 3 2013.

205 NGOConnect Africa. 2009. “NGOs in South Africa”. Published at <http://ngopedia.org/wiki/NGOs...challenges...> (Accessed 19 Aug 2011); Schmid, J. 2012. *Trends in South African Child Welfare Reform.*

206 Patel, L., Hochfeld, et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*; Loffel, J., Allsopp, M., et al. 2008. “Human resources needed to give effect to children's right to social services” in *South African Child Gauge 2007/08: Interviews with NGOs in Oct 2012 and July 2014.*

offered, and sub-standard service quality²⁰⁷. Insecure funding and wide discrepancies in remuneration lead to high staff turnover and an exit of skills. Many workers in the sector earn low salaries, have no employment benefits, face poor working conditions and encounter on-going insecurity associated with community projects and employers' sustainability²⁰⁸.

NGOs involved with social development face significant management and governance challenges. Since welfare activities tend to drain, rather than generate resources, the level of self-sustainability of NPOs tends to be low. More donors adopt short-term funding strategies, which affect the ability of NPOs to engage in longer-term planning. Some national network organisations engage in income-generating activities to supplement declining donor income, but this diverts attention from their purpose²⁰⁹.

Individuals in the public sector carry heavy workloads and professionals are often reduced to office clerks to deal with backlogged cases and paperwork²¹⁰. Other recent research revealed that middle management in the social development sector often lacked the depth of experience and an adequate foundation to guide and supervise young social workers²¹¹.

Differing norms across government departments and provinces for the payment of stipends of volunteers and community caregivers cause problems. Various donors also impose conflicting conditions for funding. As a result NPOs are stretched to reconcile diverging demands²¹². Government and donor agencies are insisting on more sustainable social development and pressurise NGOs to improve management, monitoring and governance. However,

many NGOs lack the institutional capacity to acquire the requisite competencies, information technology and skills to meet donor stipulations²¹³. Capacity constraints also affect communication and service coordination among NPOs, so that many promote their causes in isolation and without a clear understanding of the wider socio-economic environment.

3.10 The National Development Plan

The National Development Plan (NDP) addresses South Africa's vast socio-economic challenges and provides a multi-dimensional agenda to eliminate poverty and reduce inequality by 2030²¹⁴. Specific factors that determine a decent living standard and areas where the country needs to progress are explained. Prominence is given 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 development²¹⁵.

According to the NDP, "health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyles"²¹⁶. The NDP envisages a health system that raises life expectancy, reduces infant mortality and the incidence of HIV/AIDS and lowers the burden of disease. Two key goals are the provision of universal healthcare coverage and dedicated primary healthcare teams to care for families and communities. These goals are linked to proposals for the National Health Insurance scheme, which is considered in paragraph 3.12. The NDP recognises that the health system as a whole will need strengthening and that human capacity to provide care and manage services must be developed.

The NDP envisages a social development

system that provides social protection and adequate social welfare services for vulnerable groups, children and the elderly. Multiple avenues will be used to attain social protection. Firstly, services aimed at facilitating access to nutrition, healthcare, education, social care and safety must be provided for all children. In this regard early childhood development is a critical vehicle. Secondly, problems such as hunger, malnutrition and substance abuse that affect physical growth and cognitive development must be addressed. Thirdly, the unemployed should access income support via public works programmes and labour market incentives that provide skills development. Fourthly, an effective social welfare system must deliver better results for vulnerable groups. To attain these goals, it is essential to address the skills deficit in the social welfare sector and to boost the numbers of social service professionals and mid-level skills in five categories in particular: social workers, auxiliary social workers, community development workers, early childhood development practitioners and child and youth care workers²¹⁷.

Both the DSD and DoH have aligned strategies and service targets with objectives of the NDP, and have adopted measures to build management capacity and expand the skills base of the workforce²¹⁸.

3.11 The Regulatory Environment

3.11.1 Fundamental changes

Constitutional imperatives²¹⁹ faced by the state to improve access to healthcare and social security services and to care for vulnerable people continue to drive the regulatory environment in the sector. Since 1994, South Africa has adopted a developmental approach to social welfare. The 1997 White Paper for Social Welfare directs services away from remedial services and institutional care delivered by specialists towards a family-centred and community-based approach. In this developmental mode (rather than a curative or case-based approach), the emphasis is on development through prevention, early interventions, strengthening of communities

207 Patel, L., Hochfeld, T. Graham, L. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector; Coalition on Civil Society Resource Mobilisation. 2012. Critical Perspectives on Sustainability of the South African Civil Society Sector.*

208 Loffel, J., Allsopp, M. et al. 2008. "Human resources needed to give effect to children's right to social services". *South African Child Gauge 2007/08*; Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*; Earle-Malteson, N. 2008. "Social workers". *Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*

209 Wyngaard, R. and Hendricks, P. 2010. *Governance Practices of National Non-Profit Bodies and National Network Organisations.*

210 Ross, E. 2012. "Social Work in South Africa". *Social Dialogue 3* 2013.

211 Schmid, J. 2012. "Trends in South African Child Welfare Reform". *Centre for Social Development in Africa.*

212 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa.*

213 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*; NGOConnect Africa. 2009. "NGOs in South Africa". Published at http://ngopedia.org/wiki/NGOs...challenges...NGOs_face. (Accessed 19 Aug 2011).

214 National Planning Commission. 2013. Published at <http://www.npconline.co.za/>. (Accessed 16 July 2013).

215 National Planning Commission. 2012. *National Development Plan 2030, Our Future: Make it Work. "Executive Summary".*

216 National Planning Commission. 2012. *National Development Plan 2030. Chapter 10: Promoting Health.*

217 National Planning Commission. 2012. *National Development Plan 2030.*

218 National Treasury. "Vote 16: Health" and "Vote 19: Social Development". *2014 Estimates of National Expenditure.*

219 Sections 27 and 28 of the Constitution of South Africa, Act 108 of 1996.

and preservation of families²²⁰. These policy and regulatory changes have had a profound effect on the skills content needed in the sector²²¹.

3.11.2 The social development system

The social development system is driven by the DSD, while services are delivered by provincial government, public entities and NPOs. The DSD derives its mandate from the Constitution, which grants anyone access to appropriate social assistance and sets out children's rights to care, nutrition, shelter, basic social services and healthcare. Nationally, the DSD is responsible for developing policy frameworks and protocols for the delivery of social services; providing support to provinces; monitoring and evaluating provincial service delivery; and for the budgeting and oversight of social assistance²²². At local government level, municipalities are responsible for child care facilities²²³.

Provincial social development departments (some of which are integrated with health) provide social welfare and community development services in the following areas²²⁴:

- a) Prevention and promotion services aim to strengthen communities, families and individuals by addressing problems and preventing escalation, e.g. ECD programmes, drug awareness, youth development, and campaigns against abuse of women and children;
- b) Social assistance and relief services target persons temporarily unable to care for themselves;
- c) Social support services aim to stabilise individuals, families and communities by enabling people to overcome challenges, e.g. through counselling and probation services;
- d) Protection services or statutory intervention address cases of

abandonment, neglect and abuse of vulnerable persons (esp. children, women, the elderly and disabled persons) and are rendered against a legislative or policy framework;

- e) Therapeutic/rehabilitative and restorative services address impairment and improve social functioning to reintegrate individuals into their families and society, e.g. through family counselling, life skills- and parenting programmes, and support services to aid self-reliance;
- f) Continuing care involves caring for persons whose families are unable to care for them or who have been removed from situations of abuse or neglect; such persons are often placed in the state's care by court order and become wards of the state. Services include home-based care for older persons, the disabled and people with HIV/AIDS, and foster care for children;
- g) Reintegration and aftercare services aim to develop self-reliance, independence and optimal social functioning in the family and community.

Many of these services, particularly where statutory assessment and prescribed intervention are required, must be performed by appropriately qualified and registered social service professionals who work in conjunction with the courts²²⁵. Statutory interventions are specialised, remedial in nature, expensive services and they are usually focused on an individual. Such services are labour intensive and have a low impact in relation to the numbers of people reached in a single intervention²²⁶.

3.11.3 The health system

The National Health Act (NHA), 61 of 2003 establishes a national health system comprising the public and private sectors, and sets out the rights and duties of healthcare providers, health workers, establishments and users. Responsibilities regarding the development of human resources for health are split between national and provincial levels. The national DoH is obliged to "promote adherence to norms and standards for the training of

human resources for health"²²⁷. However, the critical responsibility to "plan, manage and develop human resources for the rendering of health services" lies with the provincial departments of health and it is not a national responsibility²²⁸. The NHA empowers the Minister of Health to make regulations to ensure adequate resources are available to educate and train staff; create new categories of health personnel; identify key skills shortages; recruit foreign health workers; and ensure that there are adequate human resources, planning, and development structures across all levels of the national health system²²⁹.

An extensive legislative framework is in place to regulate almost all aspects of the health sector. The main areas of regulation relate to the quantity and distribution of resources; the quality of resources (infrastructure and the workforce); and the price of products and services²³⁰. Government and the statutory councils are the main regulators on matters pertaining to the skills base of the workforce.

3.11.4 Regulation of quantity and distribution

Provisions in the NHA aimed at regulating the number and distribution of healthcare facilities and healthcare providers came into operation in April 2014²³¹. Healthcare professionals and –facilities in the private sector have until April 2016 to obtain a "certificate of need" to continue to deliver health services²³². Before issuing or renewing such a certificate, the DG must consider, among other factors, the need to promote an equitable distribution and rationalisation of health services and resources; the need to correct inequities with reference to demographic factors; and the need to promote an equitable mix of public and private health services. These provisions permit the state to manipulate the quality and allocation of healthcare skills and the nature of healthcare services available across the country. At the time

220 Schmid, J. 2012. *Trends in South African Child Welfare Reform*. Centre for Social Development in Africa.
 221 National Planning Commission. 2012. *Summary and key issues of the National Development Plan 2030*.
 222 National Treasury. 2009. "Social Development". *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*.

223 Section 155 (6) and (7) and Schedule 4B of the Constitution of the Republic of South Africa, Act 108 of 1996.

224 National Treasury. 2009. "Social Development". *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*; Department of Social Development. 2011. *DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services*.

225 Patel, L., Hochfeld, T. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*; National Treasury. 2009. "Social Development". *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*.

226 Patel, L., Hochfeld, T. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*.

227 Section 21(2)(c) of the National Health Act 61 of 2003.

228 Section 25(2)(i) of the National Health Act 61 of 2003.

229 Section 52 of the National Health Act 61 of 2003.

230 McIntyre, D., Thiede, M. et al. 2007. *SHIELD work package 1 report: A critical analysis of the current South African health system*. Health Economics Unit. Published at <http://www.web.uct.ac.za/SHIELD/reports/>... (Accessed Aug 2010).

231 Child, K. 2014. "Docs to be told where to work". *The Times*. 24 May 2014. Published at <http://www.timeslive.co.za/>... (Accessed 24 May 2014).

232 Section 36 of the National Health Act 61 of 2003.

of this SSP update, the publication of draft regulations was awaited to assess the impact of the provisions²³³. While this licencing regime may hold significant implications for the distribution of skills in the health sector, the extent of the impact on skills provision and skills formation for the country may not be known for some time.

3.11.5 Regulation of quality

Strict regulatory controls are in place to control standards for entry into the healthcare professions. Statutory provisions require health professionals to be registered as such in their respective fields. As discussed in Chapter 2, the HPCSA, AHPCSA, SANC, SAPC, and SADTC control the respective registers entrusted to them by statute. Registration as a healthcare professional or technician only takes place once the applicant has obtained the required qualifications and has served an internship or has completed practical training. Several categories of healthcare professionals are required to serve one year of community service in the public health services before they are permitted to register for independent practice. The professional bodies also determine the scope of practice for the various categories of healthcare professionals, which amounts to them controlling the services and treatment that a profession is permitted to give. Although the professional councils do not control or influence the supply of skills, they do control the quality of skills available in the health sector. As such, the councils set standards for practice, education and training and ensure that the training programmes offered meet the specifications of registered qualifications. The councils also assess and accredit training providers entrusted with delivering accredited programmes and perform quality assurance functions required in terms of skills development legislation. The councils furthermore determine the standards for the CPD that professionals require in order to retain their registration.

3.12 National Health Policies

With the introduction of several new far-reaching health policies, the demands for service delivery change and, as a result, more human resources and a different skills

mix are required. This section considers key policy developments that impact on skills needs in the health sector.

Core aspects of present health policies have been assimilated in the development agenda of the NDP. Nine health goals address the health services required to improve the health of the population and the systems needed to deliver healthcare. The goals are to²³⁴:

- a) Increase life expectancy at birth through broad treatment and prevention services for HIV/AIDS;
- b) Reduce the TB infection rate and improve treatment outcomes;
- c) Reduce maternal, infant and child mortality;
- d) Significantly reduce the prevalence of non-communicable chronic diseases²³⁵;
- e) Reduce injury, accidents, inter-personal violence and violent crime;
- f) Complete health system reforms (provide infrastructure and IT system to manage diseases);
- g) Provide universal health coverage and implement the National Health Insurance (NHI) scheme
- h) Establish PHC teams to care for families; communities and schools; and
- i) Improve human resources through better planning, development and management.

The DoH has outlined multiple strategies to strengthen the health system and improve health information systems. Health facility planning will be addressed and norms and standards will be set. Improvements will be made to the financial management of the health system. A health management information system will be developed. Quality of care and clinical governance will be stepped up, and national norms and standards for healthcare provision will be introduced. Specific measures are already directed at addressing the social determinants affecting health and disease; health promotion; and reducing the disease burden. Management will be improved and accountability measures will be strengthened²³⁶.

234 National Development Plan 2030 Chapter 10: Promoting Health.

235 Lifestyle diseases such as cardiovascular diseases, diabetes, cancer and chronic respiratory disease will be addressed.

236 DoH. 2014. Strategic Plan 2014/15-2018/19.

3.12.1 National Health Insurance system

a) Purpose of the scheme

Proposals for an NHI scheme are contained in a Green Paper released on 12 August 2011. Key policy objectives of the scheme are to improve access to health services and improve cross-subsidisation between rich and poor and the healthy and sick in the entire health system²³⁷. Another objective is to strengthen the under-resourced public sector to enhance performance in the health system²³⁸. The phasing in of NHI is one of the main pillars of the National Development Plan²³⁹.

b) Proposals

In essence the NHI is a financing system for providing healthcare to all citizens²⁴⁰. All South Africans and legal permanent residents will receive universal coverage²⁴¹ for a defined, comprehensive benefit package of healthcare services. The package will include personal care, rehabilitative care, health-prevention services and health-promotion services. Membership of the scheme will be mandatory. Short-term residents and tourists will need to purchase compulsory travel insurance.

New service delivery models will be developed to take account of the local context and respond to local needs. The model will be based on a structured referral system rendered via a revised PHC approach. A defined package of PHC services will focus mainly on health promotion and preventive care while appropriate curative and rehabilitative services will be available at the PHC level. Community Health Workers (CHWs) will play a key role in health promotion and prevention services at the community and household levels. Referral systems will be in place to give individuals access to further levels of care; e.g. hospital or specialist care. Members of the NHI (i.e. the South African

237 DoH. 2011. National Health Insurance in South Africa: Policy Paper.

238 Matsoto M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months". South African Health Review 2012/13.

239

240 DoH. 2011. Media statement by Minister of Health – Release of Green Paper on National Health Insurance. August, 2011.

241 According to the Green Paper: "Universal coverage as defined by the WHO 'is the progressive development of a health system including its financing mechanisms into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services'".

233 Child, K. 2014. "Docs to be told where to work". The Times. 24 May 2014. Published at [http://www.timeslive.co.za/...](http://www.timeslive.co.za/) (Accessed 24 May 2014).

population) will be entitled to a defined comprehensive package of health services at all levels of care – primary, secondary, tertiary and quaternary – with guaranteed continuity of healthcare benefits. Accredited and contracted public and private providers will deliver the PHC services.

The NHI scheme will be implemented over a period of 14 years. Piloting projects commenced in 10 under-serviced health districts in 2012/13 and will extend to 26 districts by 2018/19²⁴². While the pilot districts focus on improving the management of health facilities, medical infrastructure and supplies, and service quality, the main aim is to develop systems that will enable implementation of the NHI²⁴³.

Preliminary estimates (in 2010 financial terms) cost the scheme at R125 billion in 2012, increasing to R214 billion in 2020 and R255 billion in 2025. Medical services in the defined package of services will be free of charge and no co-payments will be required from patients. However, co-payments will be made for treatment or goods not included in the prescribed service package. Proposals to finance the NHI are under development, and include the pooling of general tax revenues from the fiscus, a payroll tax levied on employers, and contributions by individuals. New taxes may be introduced and tax rebates for medical scheme premiums will be abolished²⁴⁴. A pre-payment financing mechanism will be used; i.e. payments for health services will be made in advance.

At the time of updating this SSP, the publication of a final policy document, i.e. a White Paper and also a discussion paper on financing of the NHI, were eagerly awaited by industry role-players²⁴⁵. It is the aim of the DoH to promulgate legislation for the NHI by 2018/19²⁴⁶.

c) Changes to the health system

According to the Minister of Health, the present healthcare system places undue focus on curing of disease and performance of procedures when people have developed

complications. More emphasis is required on prevention of disease and health promotion²⁴⁷. Major changes to the health system are proposed. Hospitals will be re-designated in the five categories: district-, regional-, tertiary-, central-and specialised hospitals. Each designated hospital level will provide differing medical services based on standardised care and areas of specialist care. Appropriately qualified and skilled healthcare workers and professionals will be deployed according to the designated hospital level.

District hospitals will provide generalist medical services and specialist care in four basic areas – obstetrics and gynaecology; paediatrics and child health; general surgery; and family medicine. The package of care will cover trauma and emergency care; in-patient care; out-patient visits; rehabilitation services; geriatric care; laboratory and diagnostic services; and paediatric and obstetric care.

Regional hospitals will receive referrals from district hospitals and offer a range of general specialist services in eight areas: general surgery; orthopaedics; general medicine; paediatrics; obstetrics and gynaecology; psychiatry; radiology; and anaesthetics. Tertiary hospitals will provide super-specialist and sub-specialist care, and also serve as the main training platform for health workers and research. Care provided in tertiary hospitals will be more complex and will require the expertise of teams led by experienced specialists. Central hospitals are national referral hospitals attached to a medical school where health professionals are trained and research is undertaken. Here highly specialised tertiary and quaternary services will be rendered for cases referred from other hospitals. Therefore, health workers at central hospitals must be highly trained and have access to high-quality technology. Specialised hospitals will generally offer services in a specialised field such as psychiatry, spinal injuries, urology, maternity, infectious diseases, or orthopaedics.

d) Delivery of primary healthcare

Central to the NHI policy is the intention to “re-engineer” PHC to focus mainly on community outreach services. The aim is to provide a defined, comprehensive PHC package that reaches communities and households through home-based services.

All the PHC services will be delivered via the district health system, and in three streams – which are district-based clinical specialist support teams, school-based services, and PHC agents in each municipal ward. The delivery of PHC services will be supported by sessional general practitioners²⁴⁸.

At district level, a team of clinical specialists in the four basic areas of care will provide clinical support and oversight, particularly in districts with a high disease burden. Team members will comprise a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal PHC professional nurse. Emergency care workers will back up PHC teams to transfer patients to more advanced clinical care. The district health package will deal with the major sources of the disease burden, namely HIV/AIDS and TB; maternal, infant and child mortality; non-communicable diseases; and injury and violence. It is envisaged that PHC will be delivered in the public and private sector.

The new national Integrated School Health Policy was launched in October 2012 and targets the most disadvantaged schools²⁴⁹. School-based health programmes will be offered in partnership by three national departments: the DoH, DSD and Department of Basic Education (DBE). School health service teams will be headed by a professional nurse and be staffed by nurses and health promotion practitioners²⁵⁰. Mobile clinics will support school nurses. Services will include health promotion, prevention, immunisation, oral health, vision screening and curative health interventions required by school-going children. Developmental health services will include programmes on child and sex abuse, eradication of parasites, nutritional services, substance abuse, HIV/AIDS, and sexual and reproductive health rights, including family planning services.

Ward-based PHC outreach teams will provide health promotion and disease prevention services. The teams will include six CHWs, a health promoter, and an environmental health officer. Professional

242 DoH. 2014. *Strategic Plan 2014/15-2018/19*.

243 Gray, A., Vawda, Y. and Jack, C. 2013. “Health Policy and Legislation” in *South African Health Review 2012/13*.

244 Boyle, B. 2010. “SA to import thousands of docs”. *Sunday Times*, 26 September.

245 Gray, A., Vawda, Y. and Jack, C. 2013. “Health Policy and Legislation” in *South African Health Review 2012/13*. National Treasury. 2014 Budget Review.

246 DoH. 2014 *Annual Performance Plan 2014/15-2016/17*.

247 DoH. 2011. *Media statement by Minister of Health – Release of Green Paper on NHI*. August, 2011.

248 DoH 2012. *National Health Insurance—presentation on NHI pilot district selection*. Published at <http://www.doh.gov.za>. (Accessed 10 Aug 2012).

249 Matsotso, M.P. and Fryatt, R. 2013 “National Health Insurance: The first 18 months”. *South African Health Review 2012/13*.

250 DoH. 2012. *Annual Performance Plan 2012/13-2014/15*.

nurses with skills in maternal-and child health will serve as team-leaders²⁵¹. Environmental health officers will work in PHC teams to prevent diseases by addressing social and environmental health risks associated with sewerage, refuse, vermin, food handling, and waste management²⁵².

e) Accreditation of providers

Providers of healthcare services will be assessed and accredited by a statutory body, the Office of Health Standards Compliance (OHSC). All health establishments will have to meet prescribed standards of quality. The OHSC will set norms and standards for the rendering of health services; conduct inspections of all health facilities; and license and certify facilities. Accreditation criteria will cover standards of access and safety; service elements; management systems; performance outcomes; and the minimum range of services to be provided at different levels of care. All providers will be required to comply with prescribed referral procedures to ensure the continuity of care and contain costs.

f) Management of the NHI

A new public entity, the National Health Insurance Fund (NHIF) will administer the system. The NHIF will purchase health services on behalf of the entire population and will be a single payer entity of health services. The NHIF will also manage nationally negotiated contracts with contracted providers. The Minister of Health will exercise oversight of the NHIF. District health authorities will be established to plan health services for each health district and manage contracts with accredited providers in conjunction with the NHIF and monitor performance of contracted providers. Hospital boards will be strengthened to improve oversight and accountability, esp. for central hospitals²⁵³.

g) Health information management

The National e-Health Strategy for South Africa 2012/13 -2016/17 describes the need for a national health information system that prioritises the patient and supports management of the public health system. A core objective is to develop an integrated national patient-based information system in accordance with scientific standards by 2019²⁵⁴. The national health information system will be developed to manage health facilities; improve the referral of at-risk patients; track diseases; monitor clinical care; facilitate research and produce key indicators required to monitor and manage the health services²⁵⁵. A national health information repository and database is also under development to provide up-to-date information on national indicators and key data sets. It will serve as data warehouse for national health surveys; HIV counselling and testing campaigns; financial records from accounting systems; service access; social determinants of health and demographic surveys²⁵⁶.

h) Challenges for the skills base

Government acknowledges that there are many challenges to be addressed before the NHI can be implemented successfully. The need to improve the quality of services in the public hospitals²⁵⁷ and the availability of adequate human resources will be critical for the success of the NHI²⁵⁸. While it is expected that utilisation of services will grow, the DoH says that it is difficult to plan for increases in terms of capacity (facilities and health professionals) and financing. Public health infrastructure, including facilities, technology and management capacity, will have to be strengthened. This applies particularly to structures and management at district level. Improvements in the quality of service delivery are also required. Human resources planning and development and management must be made effective. These challenges are more acute in view of current skills shortages in the health

system. The DoH recognises that reforms in hospital management are necessary, particularly with regard to governance, financial management, accountability and the decentralisation of authority. Managers of different categories of hospitals will require appropriate qualifications, skills and competencies to oversee the levels of care provided at their facility²⁵⁹.

The introduction of such extensive reforms is complex and exacerbated by the massive disparities in the private-public sector mix referred to earlier. Observers have commented that before any NHI system can be introduced, significant improvements will be required in public hospital services, public perceptions of such institutions, management and governance, and operational autonomy²⁶⁰.

i) Implications for human resources and the skills base

The new health service delivery model will have a significant impact on the human resources and skills required to service the scheme. Resource planning is needed to meet increased service demands and to change the skills mix of the health workforce. Provision of professional and occupational skills will have to be stepped up and the skills base of the current workforce be strengthened. It will be necessary to review the scopes of practice of all healthcare professionals and apply task-shifting – i.e. assign tasks to a different category of health worker who is trained to do the work more efficiently²⁶¹. The HWSETA should take into account the implications for skills needs, especially considering the long lead-time required for training healthcare professionals, specialists, clinicians and mid-level workers²⁶².

The demand for skills to serve the country's healthcare needs are more fully considered in Chapter 4.

259 DoH. 2011. *National Health Insurance in South Africa: Policy Paper*; DoH. 2011. *Media statement by Minister of Health – Release of Green Paper on NHI*. August, 11.

260 McIntyre, D. and Van den Heever, A. 2007. "Social or National Health Insurance" in *South African Health Review 2007*.

261 DoH. 2011. *Human Resources for Health for South Africa 2030 : Draft HR Strategy for the Health Sector: 2012/13- 2016/17*.

262 As a minimum, it takes 14 years to train a medical specialist, 8 to 9 years to train a medical doctor for independent practice, 6 years to train a dentist, 5 years to train a pharmacist, 5 years to train a professional nurse, and 5 years to train an occupational therapist, and 4 years to train a clinical (medical) assistant. The periods include one year of compulsory community service required before the practitioners acquire full registration status at their respective professional councils.

251 Interview with DoH, HR Directorate: Health Policy and Planning in July 2014.

252 DoH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

253 Matsotso, M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months". *South African Health Review 2012/13*.

254 National Treasury. 2013. "Vote 16: Health". *2013 Estimates of National Expenditure*; DoH. 2014. *Annual Performance Plan 2014/15-2016/17*.

255 DoH. 2012. *National e-Health Strategy for South Africa, 2012/13-2016/17*. Published at [http://www.doh.gov.za/...](http://www.doh.gov.za/) (Accessed 11 July 2013).

256 Matsotso, M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months". *South African Health Review 2012/13*.

257 DoH. 2011. *Media statement by Minister of Health – Release of Green Paper on NHI*. August, 11.

258 Khan, T. 2011. "New health staff plan 'key to NHI'". *Business Day*, Aug 15; DoH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

3.12.2 Primary healthcare policies

The re-engineered PHC model will adopt a preventive approach to health to improve the health of the population and identify at-risk persons and families²⁶³. More specialist PHC-trained nurses and skilled CHWs are required for these teams²⁶⁴. Mental health services will be expanded and specialised mental health teams aided by registered counsellors will help PHC outreach teams²⁶⁵. Patient access to occupational health services at district hospitals will also be improved by expanding such services in the public sector, thereby increasing the need for occupational therapists, physiotherapists and rehabilitation practitioners²⁶⁶.

3.12.3 Community health workers and care givers

Owing to the HIV/AIDS pandemic and TB epidemic, the health and social development sector has experienced a sharp growth in a range of community care givers (CCGs) and community health workers (CHWs) who are mostly affiliated to NPOs. By 2010, their numbers were estimated at 65 000²⁶⁷. These generalist workers provide primary care and social services, but their mandates and conditions of service are poorly defined²⁶⁸. Many have been deployed to do the tasks in hand but they have not been integrated into the wider health system²⁶⁹. Working on the periphery of the public health system, they face challenges such as poor and irregular payment, as well as difficult and uncertain working conditions. Some are paid a stipend by provincial health departments via designated NGOs²⁷⁰. According to the DSD, a lack of resources continues to constrain government efforts to pay stipends or the

minimum daily wage²⁷¹.

The majority of CHWs and CCGs are volunteers and lay persons drawn from local communities and, without adequate training, they could compromise outcomes in healthcare and social development programmes. Some workers are trained informally, on-the-job and via generic short course programmes, or in very limited areas only, while some may have no training²⁷². Since NPOs lack the capacity to become accredited training providers, these workers are not receiving accredited training²⁷³. A DoH audit found that the roles and responsibilities of these workers vary across provinces and NGOs, and that their services should be standardised.

The DoH and DSD distinguish between CHWs and CCGs. According to the DoH, community health workers provide health promotion and prevention services to improve access to care in communities. CHWs will be an integral part of ward-based PHC outreach teams²⁷⁴, as discussed in paragraph 3.12.1. In contrast, CCGs are home-based care workers who render personal care services to and perform household chores for the elderly and sick. CCGs also administer medication, deliver food parcels and attend to patients' personal needs around the home. Many also work in social sector programmes of the EPWP. An estimated 18 000 CCGs were active in communities during 2014²⁷⁵. Skills development for CCGs is challenging due to low literacy levels, while formal training is needed at NQF levels 2 and 3, i.e. above basic the literacy level. No qualifications exist for CCGs²⁷⁶.

Neither CCGs nor CHWs are regulated and both categories of workers fall outside an occupational framework. The HPCSA has declined requests to regulate CHWs due to concerns that their range of services overlap with the scopes of practice of nearly all healthcare professions, including the nursing profession²⁷⁷. The DoH is working to incorporate CHWs into formal positions

in the public sector and will start to train 45 000 of these cadres at its regional training centres from 2015²⁷⁸. While the DoH recognises the need to standardise services and to provide clarity on the scope of CHWs' functions and service conditions, major interventions are needed to improve their skills base and competencies, and to provide for their supervision²⁷⁹.

3.12.4 HIV/AIDS policies

A national HIV testing campaign was launched in April 2010 and by the end of 2012 between 1.7 and 2 million people were using ART²⁸⁰. The DoH aims to target 5 million patients by 2019²⁸¹. Efforts are also underway to strengthen prevention of mother-to-child HIV transmission (PMTCT) programmes. Additional human resources will be required if the ART population is to increase more than six-fold between 2010 and 2019. The scale of the programme will require the appointment of more administrative support staff (to order, collect and distribute drugs) and more skilled health managers to oversee services. Social welfare support staff will be needed to ensure that people who undergo testing receive appropriate help²⁸².

3.12.5 Strategy to fight tuberculosis

In a 2012-2016 national strategic plan for HIV, sexually transmitted infections and tuberculosis, the DoH set TB control targets to advance access to treatment and improve the cure rate²⁸³. Strategies to fight TB require increased surveillance for MDR-TB, active case management, and monitoring of treatment completion²⁸⁴. Infection control in hospitals and clinics will need to improve to

263 DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17*.

264 DoH. 2011. *Human Resources for Health for South Africa 2030: HRH Strategy for the Health Sector: 2012/13 - 2016/17*.

265 Day, C., Gray, A. and Budgell, E. 2011. "Health and Related Indicators" *South African Health Review 2011*.

266 DoH. 2014. *Annual Performance Plan 2014/15-2016/17*.

267 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance". *South African Health Review 2010*.

268 Harrison, D. 2009. *An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*; Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care". *South African Health Review 2008*; Interviews with HPCSA in October 2012 and July 2014.

269 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*.

270 Coovadia, H., Jewkes, R., Barron, P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet*. Sept 2009. Vol. 374.

271 DSD. 2011. *Strategic Plan 2011/12 - 2013/14*.

272 Interviews with DoH, October and November 2012.

273 HWSETA. 2009. *HWSETA Sector Skills Plan 2005-2010: Annual Update August 2009*.

274 Interviews with the DoH in October 2012 and July 2014; DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17*.

275 Interview with DSD, Directorate HIV/AIDS Community Caregivers, July 2014.

276 Interview with DSD, Directorate HIV/AIDS Community Caregivers, July 2014.

277 Interviews with managers of professional boards of the HPCSA in October 2012 and July 2014.

278 Interview with DoH, November 2012.

279 DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17*; Lloyd, B., Sanders, D. et al. 2010. "Human resource requirements for National Health Insurance". *South African Health Review 2010*.

280 Day, C., Gray, A. and Budgell, E. 2011. "Health and Related Indicators" *South African Health Review 2011*.

281 Venter, F. 2013. "HIV Treatment in South Africa: The challenges of an increasingly successful antiretroviral programme". *South African Health Review 2012/13; National Treasury*. 2014. "Vote 16: Health." 2014 Estimates of National Expenditure; DoH. 2012. *Annual Performance Plan 2012/13-2014/15*.

282 DSD. 2011. *Strategic Plan 2011/12 - 2013/14*.

283 National Treasury. 2014. "Vote 16: Health". 2014 Estimates of National Expenditure.

284 Karim, S. S. A., Churchyard, G. J., Karim, Q. A. et al. 2009. "HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response". *Lancet*. Sept 2009.

prevent further outbreaks²⁸⁵. Clearly, skills will be required at primary and secondary levels, including health professionals, microbiologists, mid-level workers, laboratory technicians, and infection control officers.

3.12.6 Maternal and child health

Decreasing maternal deaths is a national priority and several programmes aim to improve reproductive and maternal health. By 2019 the DoH intends to reduce the maternal mortality ratio to 215 per 100 000 live births; reduce the infant mortality rate to 24 per 1 000 live births²⁸⁶; and to reduce the under-five mortality rate to below 34 per 1 000 live births. To achieve these targets, the quality and productivity of existing skills must be improved and the skills base expanded, especially in the public sector²⁸⁷. Vaccination programmes for children will also be stepped up to improve immunisation coverage²⁸⁸. More emphasis is given to nutrition and the NDP calls for nutrition interventions for all pregnant women and young children²⁸⁹. The skills of more GPs, medical specialists (gynaecologists and paediatricians), professional nurses, midwives, birth attendants and nurses trained in intensive care, nutritionists and clinical associates will be required, while the clinical skills of health workers in obstetric care and comprehensive emergency obstetric care also require upgrading²⁹⁰.

3.12.7 Non-communicable diseases

Provincial departments of health will increase the monitoring of chronic diseases and run campaigns for the early detection of conditions such as diabetes and hypertension. Specific measures will focus on preventing and managing non-

communicable diseases through a chronic care model and a long-term care model for diabetes²⁹¹. Plans are under development to screen all men above 40 years for prostate cancer, and to increase screening and treatment for mental health problems by 30% by 2020²⁹².

3.12.8 Pre-hospital care and hospital services

The DoH recognises the need to improve access to emergency medical services. The PHC system will require the back-up of a well-trained ambulance and pre-hospital care service. Plans to roll out a national emergency number have been impeded by a low skills base, especially in the public sector²⁹³.

According to the DoH, prioritisation of PHC caused hospital services at secondary and tertiary level to become de-prioritised, leading to reduced quality and capacity. Remedial strategies will focus on the development of a service model for hospital services. Standards and staffing norms for district-, regional- and academic tertiary hospitals will be set to achieve a balanced health system. Adjusted norms will also be agreed for service sites where healthcare professionals are trained. Other initiatives will focus on the development of new team- and clinical role functions of the hospital workforce, including strategies to adjust the skills mix in hospitals to enable cost-effective staffing²⁹⁴.

3.12.9 The national environmental health policy

The DoH published a draft national environmental health policy in 2011 to expand environmental health services to all South Africans. Such services are directed at the surroundings in which humans exist and are critical to prevent the outbreak of diseases. Environmental health issues are multi-sectoral and involve areas such as water quality; waste management; surveillance of premises; pollution control; chemical safety and hazardous substances; air quality; and the control of communicable diseases and malaria. Environmental health practitioners (EPHs) will be deployed in

PHC teams at municipal level in accordance with the national norm of one per 15 000 people²⁹⁵.

3.12.10 Strategic priorities for human resources for health

National objectives to improve access to healthcare involve measures to develop new professionals and health workers; to improve ways of working, productivity and retention; and to regenerate key facets of health education and training. Eight strategic priorities will drive the interventions needed to improve the provision and service delivery of the sector's human resources²⁹⁶:

- a) Leadership, governance and accountability;
- b) Health workforce information and planning systems to provide intelligence and information for oversight and leadership;
- c) Re-engineering of the workforce to meet service needs;
- d) Expansion of education, training and research by growing capacity of higher education institutions (HEIs) and rural campuses, and reviving clinical research and innovation;
- e) Creation of infrastructure for the development of the workforce and health services, academic health complexes and nursing colleges;
- f) Professionalising the management of human resources and prioritising health workforce needs;
- g) Strengthening and improving oversight, regulation and CPD; and
- h) Improving access to health professionals in rural and remote areas.

285 DoH. 2012. *Management of Drug-Resistant Tuberculosis: Policy Guidelines*. Published at <http://www.doh.gov.za/...> (Accessed 30 Aug 2012); Harrison, D. 2009. *An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*.

286 National Treasury. 2014. "Vote 16: Health". 2014 *Estimates of National Expenditure*.

287 Chopra, M., Daviaud, E., Pattinson, R. et al. 2009. "Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?" *Lancet*. Sept 2009. Vol. 374.

288 National Treasury. 2010. "Vote 15: Health". *Estimates of National Expenditure 2010*; Day, C., Gray, A. and Budget, E. 2011. "Health and Related Indicators" *South African Health Review 2011*.

289 National Planning Commission. 2012. *Summary and key issues of the National Development Plan 2030*.

290 DOH. 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*; DoH. 2012. *Annual Performance Plan 2012/13 – 2014/15*.

291 National Treasury. 2011. "Vote 16: Health". 2011 *Estimates of National Expenditure*.

292 DoH 2012. *Annual Performance Plan 2012/13–2014/15*.

293 Interview DoH in November 2012.

294 DoH. 2011. *Human Resources for Health for South Africa 2030: Draft HR Strategy for the Health Sector: 2012/13-2016/17*.

295 DoH 2011. *National Environmental Health Policy*. *Government Gazette No 34499*. 3 Aug 2011; Gray, A., Vawda, Y. and Jack, C. 2011. "Health Policy and Legislation" *South African Health Review 2011*.

296 DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17*.

3.13 Social Development Policies and Legislation

3.13.1 Overview

The NDP and White Paper for Social Welfare, 1997 are the key policy documents shaping legislation and delivery of social- and community services. The White Paper reformed welfare policies and moved the delivery of social services to a rights-based approach, while the NDP introduces a shift towards a developmental approach. An in-depth review of the White Paper is expected by March 2016, and it is expected to guide future policies and programmes²⁹⁷.

Improving the quality of life and enabling human development remain primary national objectives. The DSD is tasked with providing comprehensive social services to the poor and creating an enabling environment for sustainable development. The strategic priorities of the DSD for the period 2014 to 2019 are to²⁹⁸:

- a) Reduce income poverty by providing social assistance to eligible persons;
- b) Increase food security by providing 300 000 households with access to food by 2019²⁹⁹;
- c) Improve service delivery by standardising social welfare services by 2016;
- d) Address the social causes of HIV and tuberculosis, and mitigate the impact of the diseases;
- e) Create an enabling and supportive environment for NGOs to operate by 2016;
- f) Improve access to and the quality of ECD services for children aged 0-4 years;
- g) Strengthen child protection services;
- h) Protect and promote the rights of older persons and persons living with disabilities;
- i) Reduce social crime, esp. gender-based violence and reduce the demand for drugs; and
- j) Facilitate social change and sustainable development by targeting the youth, adults and vulnerable families in communities³⁰⁰.

297 National Treasury. 2014. "Vote 19: Social Development". 2014 Estimates of National Expenditure.

298 DSD. 2014. Strategic Plan 2014-2019; DSD. 2014. Annual Performance Plan 2014-2015.

299 With the Departments of Agriculture, Forestry and Fisheries (DAFF) and Rural Development and Land Reform.

300 National Treasury. "Vote 19: Social Development". 2013 Estimates of National Expenditure; DSD. 2014. Strategic Plan 2014-2019.

The DSD aims to deliver developmental social services that build human capacity and self-reliance in a caring and enabling environment. Such services are rendered in partnership between various public sector entities, the private sector, civil society, training institutions, donors and development agencies. A range of policies and legislative changes are driving the delivery of social services. These initiatives have major impact on the human resources and amalgam of skills needed in the social development sector, and are outlined in this section of the SSP.

3.13.2 Social and development services to children

a) The Children's Act

The Children's Act, 38 of 2005 became operational on 1 April 2010 and gives effect to the constitutional rights of children to family- and parental care or appropriate alternative care³⁰¹. Statutory social services to children are comprehensive and span alternative care; ECD; prevention and early intervention; protection from maltreatment; foster care; adoption; and child and youth care centres. A broad definition of care covers the promotion of the social, emotional, physical and intellectual development of children; guidance of their education, upbringing, and behaviour; material maintenance; protection from harm and abuse; providing for special needs; and ensuring the best interests of a child³⁰².

The Act establishes children's courts and determines matters that the courts may adjudicate. Social workers must process court applications for alternative care such as foster- and institutional care. Extensive provisions deal with the health and protection of children. Child protection organisations need to meet prescribed criteria, deliver defined services and register with the DSD. A range of social development- and health professionals and workers are authorised to report child abuse or neglect to a designated child protection organisation. Every child and youth centre must offer therapeutic programmes for children with behavioural, psychological or emotional problems as well as interventions for abused children. Norms and standards are set for prevention and early intervention programmes aimed at preserving family structures, and strengthening the skills and

301 Sec 2 of the Children's Act 38 of 2005: DSD. 2013. Policy for Social Service Practitioners, 5th Draft.
302 Sec 1 of the Children's Act 38 of 2005.

capacity of parents and caregivers to deal with problems that could give rise to state intervention.

Adoptions are strictly regulated and social workers in private practice performing adoption work are required to have a speciality in adoption services and must be accredited to practise as such. Social workers employed by child protection organisations also require accreditation. The DSD is promoting adoption as a preferred approach to place children in permanent family care and is working to increase the number of adoptions by 10% per year until 2016/17³⁰³.

The Act assigns functions to a range of social services practitioners beyond the scope of social workers, and in particular to: adoption social workers, auxiliary social workers, probation officers, child and youth care workers, community development workers and youth workers³⁰⁴. Researchers working in the social development field have expressed concern that the sector lacks the human resources and skills to deliver the full spectrum of services provided for in the legislation³⁰⁵.

b) The Child Justice Act

The Child Justice Act, 75 of 2008 establishes a criminal justice system for children who are in conflict with the law or are accused of committing criminal offences. Children's cases are managed in a rights-based approach and juveniles are assisted to turn their lives around and become productive members of society. Probation officers are required to assess alleged child offenders to determine their need for care and protection and for referral to a children's court. Such assessments also inform decisions on the release or detention and placement of children. Provision is made to divert matters away from the formal criminal justice system. Such diversion arrangements focus on holding children accountable for harm caused and promoting reconciliation with the persons harmed; reintegrating child offenders into their families and communities; and reducing the potential for re-offending.

303 DSD. 2014. Annual Performance Plan 2014-2015; National Treasury. 2014 Estimates of National Expenditure.

304 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

305 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.

c) Early childhood development

Early childhood development (ECD) is a top national priority to improve the foundation phase of development and education so that babies, toddlers, and young children make a good start in life. The DSD is responsible for expanding access to ECD to children under five years³⁰⁶. There is a vast need for competent ECD practitioners who are also skilled to serve children in non-formal settings. The DSD intends to build the human resources capacity to deliver a comprehensive package of ECD services³⁰⁷.

d) Child and youth care

Expanded welfare services support vulnerable children in their homes (and life space) to counter the de-stabilising effects of the loss of a parent or both parents³⁰⁸. Child and youth care workers train children and youth in life skills, guide them through everyday life events and provide support at community level in accordance with the DSD's Isibindi-model. Special development needs of children and adolescents are also addressed³⁰⁹. The DSD plans to expand this support nationally³¹⁰.

3.13.3 Aged persons and the Older Persons Act

Older persons (65+ years) in South Africa constituted 2.77 million (or 5.4% of the population) during the 2011 population census and are expected to increase to 5.23 million (or 10.5% of the population) by 2025. Older persons' roles have evolved over the past 20 years from care-receivers to caregivers, mainly due to the mortality rate of young adults, high youth unemployment, and out-migration of young people. The impact of HIV/AIDS alters family structures – when young adults die, grandparents and the elderly become the heads of households and care for orphaned children. The majority of older caregivers are women who face serious financial, physical and emotional stress due to their belated caregiving responsibilities. The growing HIV/AIDS pandemic has resulted in the loss of the middle generation, leaving the elderly more vulnerable to a lack of care. The WHO recommends that the impact of these challenges on older people may be

306 DSD. 2013. *Annual Performance Plan 2013/2014*.

307 DSD. 2013. *Annual Performance Plan 2013/2014*.

308 DSD. 2012. *Annual HRD Implementation Plan; Interviews with DSD in Oct 2012*.

309 DSD. 2013. *Policy for Social Service Practitioners, 5th Draft*.

310 DSD. 2014. *Strategic Plan 2014-2019*; DSD. 2013. *Annual Performance Plan 2013/2014*.

mitigated by training social service workers in gerontological issues and by providing psychosocial and medical support to older people.

The Older Persons Act, 13 of 2006 came into operation on 1 April 2010 and established a framework to empower and protect elderly people by promoting their well-being, rights, safety and security, and welfare³¹¹. A major change involves the shift from institutional care (old age homes) towards community- and home-based care³¹². Specific provisions promote the independent living of older persons and home-based care for frail older persons through a range of integrated social services within their communities³¹³.

The Act contains several provisions that impact on the skills base of the social services workforce. The protection of the elderly involves statutory processes that may be initiated by social workers and health professionals³¹⁴. The occupation of caregiver is recognised as a person who may provide care or home-based care to the elderly. Provision is made for a code of conduct to be prescribed for caregivers. The Act also regulates the registration and management of community-based care services and residential facilities for older persons and contains measures aimed at preventing the abuse of older persons.

3.13.4 Prevention of and Treatment for Substance Abuse Act

The Prevention of and Treatment for Substance Abuse Act, 70 of 2008 adopts an integrated approach to combat substance abuse through demand reduction (i.e. measures to discourage abuse), and harm reduction (i.e. the treatment of users and their families and reducing the social-, psychological- and health impacts abuse), and supply reduction. The Act controls the registration of treatment centres, the committal of persons to such centres, and for their rehabilitation and skills development. Medical and social work interventions need to address the physiological and psychiatric needs of users.

The DSD plans to lead anti-substance abuse programmes nationally to lessen the risk of family disintegration and reduce crime

311 Sections 2, 5 and 6 of the Older Persons Act, 13 of 2006.

312 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*.

313 DSD. 2011. *Strategic Plan 2011/12 – 2013/14*.

314 Patel, L. 2009. *The gendered character of social care in the non-profit sector in South Africa*.

expressed in domestic abuse and violence³¹⁵. Four new substance abuse centres will be established and staffed by 2017³¹⁶. Service providers in this field must be multi-skilled and recognise the educational, social, cultural, economic and physical needs of users and persons affected by substance abuse. According to the DSD and SACSSP, the workforce in this service area require specialist skills in the holistic management of substance abuse and the mental health challenges that are often associated with such abuse³¹⁷.

3.13.5 Policy on People with Disabilities

In 2010 an estimated 6.3% of the population lived with a moderate to severe disability that limited one or more activities of daily living such as seeing, hearing, communicating, moving, and getting around, daily life activities, learning, and intellectual and emotional interaction³¹⁸. The aim of the Policy on People with Disabilities (2009) is to ensure that persons with disabilities who are poor, vulnerable, and marginalised receive adequate economic and social protection, and attain access to social welfare programmes. The implications for skills planning are that the state must deploy resources to improve the physical and social environment for disabled persons, while social services workers must be equipped to enhance disabled persons' personal mobility and independent living³¹⁹.

3.13.6 Community development policies

Community development policies aim to build the capabilities of poor communities to generate their own income and create sustainable livelihoods. Typically, poor communities are assisted to plan and implement activities that will improve their economic, social, cultural and environmental conditions. The DSD will introduce a range of programmes from 2014 to 2017 that aim to³²⁰:

315 National Treasury. 2012 *Estimates of National Expenditure*; DSD. 2012. *Annual HRD Implementation Plan*.

316 National Treasury. 2014. "Vote 19: Social Development". 2014 *Estimates of National Expenditure*.

317 Interviews with DSD in October 2012 and SACSSP in July 2014.

318 Health Systems Trust. 2011. *Health indicators. Published at <http://www.hst.org.za/recently...>* (Accessed 10 Aug 2011).

319 United Nations. 2006. *Convention on the Rights of Persons with Disabilities*.

320 DSD. 2014. *Annual Performance Plan 2014-2015*; DSD. 2014. *Strategic Plan 2014-2019*.

- a) Mobilise communities to create employment and develop sustainable livelihoods;
- b) Strengthen families;
- c) Promote personal development and social awareness amongst the youth;
- d) Provide food security and assist poor households in rural communities to access food;
- e) Improve the capacity and competence of community development practitioners and CBOs;
- f) Achieve behavioural change to reduce new HIV/AIDS infections;
- g) Provide psychosocial support to 1.9 million beneficiaries;
- h) Train home and community based care givers; and
- i) Train community development facilitators, community care givers and their supervisors.

3.13.7 Policies to combat social crime

In view of high levels of social crime, particularly violence against women and children, the DSD developed empowerment and social crime prevention strategies, which are delivered in partnership with CBOs and NPOs³²¹. Specific skills development needs to combat social crime include training for³²²:

- a) Probation officers in social crime prevention and administration of the Child Justice Act, 2008 to ensure that youth offenders access special support and diversion programmes;
- b) Service providers on social crime prevention, the application of minimum norms and standards and the accreditation of diversion services for youth offenders;
- c) Social workers and lay counsellors to implement the Domestic Violence Act 116 of 1998; and
- d) Social services workers involved in the prevention of human trafficking.

321 DSD. 2012. *Strategic Plan 2012-2015*; DSD. 2014. *Strategic Plan 2014-2019*.

322 National Treasury. 2012. "Vote 19: Social Development". 2012 Estimates of National Expenditure; DSD. 2012. *Annual HRD Implementation Plan*; DSD. 2013. *Annual Performance Plan 2013/2014*.

3.13.8 Professionalisation and regulation of practices

Policy initiatives of the DSD aim to address the inconsistent delivery of social welfare services, to regulate practices and to enhance the professional level of social services. Norms and standards for minimum service levels were published to improve access to and delivery of social welfare services. Criteria will be used to measure the quality of a range of social services to children; the youth; women; families; older persons; people with disabilities; and persons in substance abuse programmes, as well as AIDS prevention, and care and support programmes. Service specifications and criteria have been set for crime prevention services and victim empowerment³²³. A monitoring and evaluation system for home-based care and standards for community-based care and support to older persons were also designed³²⁴. The DSD will aim to develop a regulatory and capacity building agenda for NPOs by 2016³²⁵. Policy development by the SACSSP and DSD will culminate in regulations on the supervision of social workers, student social workers, social auxiliary workers and learners³²⁶.

3.14 New Education Strategies

3.14.1 White Paper for post-school education and training

The White Paper for Post-school Education and Training of 2013 outlines strategies to create an integrated post-school education and training system that meets national developmental needs as well as those of workplaces in the public- and private sector³²⁷. Government's objective is to create a single, coordinated post-school education and training system with expanded access, better quality and greater diversity of provision. A focal area in the policy is the strengthening of cooperation between education and training institutions and the workplace. More prominence will be given to work-integrated learning to ensure that learners are better prepared for the labour market.

323 DSD. 2011. *DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services*; DSD. 2013.

324 DSD. 2012. *Annual HRD Implementation Plan*.

325 DSD. 2014. *Strategic Plan 2014-2019*.

326 SACSSP. 2012. *SACSSP Newsletter. May 2012. Vol.1 (1)*.

327 DHET. 2013. *White Paper for Post-School Education and Training*. Published at <http://www.che.ac.za>. (Accessed 10 June 2014).

Public TVET colleges will be re-positioned and improved to function as technical and vocational education and training (TVET) colleges. Private TVET colleges and private HEIs will be re-named TVET colleges. These colleges will be tasked to re-establish a good artisan training system that produces 30 000 artisans annually by 2030. Partnerships between employers and colleges to enhance work-integrated learning and workplace exposure for teaching staff will be encouraged. In this regard SETAs will have a pivotal role to promote and facilitate links between TVET colleges and employers.

A new type of institution known as a community college will be established to cater for youth and adults with incomplete or no schooling. Existing public adult learning centres will be grouped with community colleges to offer formal and non-formal vocational and skills programmes. Learners will be able to obtain a General Education and Training Certificate (GETC) and the proposed new National Senior Certificate for Adults (NSCA). SETA-funded occupational programmes will also be on offer. Government aims to enrol one million learners in community colleges by 2030.

All public colleges will have to meet the requirements of SAQA, education and training quality assurance (ETQA) institutions and the national qualifications framework (NQF). Measures will be introduced to improve articulation between HEIs and between universities and other post-school institutions. Policies will be developed so that learners may articulate between the three sub-frameworks for qualifications³²⁸, and so reduce unfair barriers to further skills development.

Access to universities will be expanded over the next 15 years to grow admissions from 937 000 in 2011 to 1.6 million students by 2030. Specific interventions will aim to improve student performance and throughput, and to develop scarce and critical skills needed for economic development. Institutions will be supported to recruit and retain academics and to attract teaching staff from abroad. Academics will be assisted to improve their qualifications and conditions of service. Universities will be required to build partnerships with

328 The three sub-frameworks are: the General and Further Education and Training Qualifications Sub-framework; the Higher Education Qualifications Sub-framework; and the Trades and Occupations Qualifications Sub-framework.

other post-school institutions, in particular TVET colleges, and with employers to expand workplace training required for qualifications and professional registration.

In future SETAs will focus on developing the skills of the current workforce and providing the skills pipeline for the workplace. The emphasis will be on training programmes that lead to qualifications and awards recognised by industry, rather than on short courses. Work-based learning such as learnerships and internships in the non-artisan fields will also be expanded, and SETAs will be required to facilitate work-based partnerships between employers and educational institutions. In essence, the focus of SETAs will be streamlined to “mediate between education and work”.

3.14.2 New approaches to education of health practitioners

Health systems worldwide are challenged to keep pace with service demands as new infections, environmental and behavioural risks emerge amidst changing demographic patterns and growing inequities (especially access to healthcare). Internationally, there is a growing concern that health professional training has not kept pace with the health needs of the population, and that practitioners are ill-equipped to meet those needs. Several factors are attributed to inadequate health professional education: narrow technical focus without broader contextual understanding; predominant hospital orientation at the expense of primary care; episodic curative encounters rather than continuous care; and mismatch of competencies to patient and population needs³²⁹.

Public health specialists agree that healthcare practitioners need new and different skills sets to address the health needs of local populations³³⁰. It is recognised that health professionals should be trained in tertiary hospitals and in networks of secondary and primary health centres to gain exposure to a range of practice environments in community and remote settings. The Medical and Dental Professional Board of the HPCSA is reviewing the core competencies that practitioners require to provide optimum

329 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*.

330 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*.

patient-centred care in a multiplicity of health and social contexts³³¹. It is re-defining the role of healthcare practitioners to be enlightened change agents and to integrate profession-specific knowledge, clinical skills and professional attitudes. As such, healthcare practitioners will need to integrate the core competencies of a professional, communicator, collaborator, health advocate, scholar, and a manager of resources and leader in a community.

To achieve these outcomes, changes will be made to curricula and instructional methods. Clinical training will expand from academic centres to span the entire health system. In future, more health professionals will be trained in rural settings and health education will have a more pertinent socio-economic and multi-cultural focus. Specific skills interventions will be necessary to equip academics, educators and clinical facilitators to assimilate these developments in health professional education.

3.14.3 Education and training for social services professionals

The social services workforce has expanded beyond the scope of social workers to include other professions such as child and youth care worker (CYCW) and emerging occupations such as community development practitioner, ECD practitioner, youth worker and caregiver³³². One of the main challenges in educating and training is to prepare social services practitioners for the complexities of misfortunes faced by vulnerable groups and to address multiple needs in varied settings. Work-integrated learning is becoming more critical to produce work-ready workers³³³. Education and training focus on a rights-based and developmental approach, rather than merely on interventions, treatment and rehabilitation. At the same time the education and training of social services practitioners are reaching across multiple sectors and disciplines. Role-players identify a growing need to provide postgraduate level education and training in a range of specialist areas which are not yet recognised

331 HPCSA. 2012. “Core competencies for Undergraduate students in the Clinical Associate, Dentistry and Medical Teaching and Learning Programmes in South Africa”.

332 According to the DSD’s 2013 Policy on Social Service Practitioners (5th draft), the term “caregiver” refers to someone who takes care of six or more children, and also to a person who cares for the elderly as envisaged by the Older Persons Act, 2006.

333 Interviews with academics in the social services field in Oct 2012 and July 2014; Interviews with SACSSP in October 2012 and July 2014.

as such by the SACSSP. These areas include: forensic social work, school social work, specialised counselling and behavioural management, mental health, drug abuse, gerontology and supervision³³⁴.

3.15 New Scopes of Practice, Occupations and Qualifications

Policy changes initiated by several statutory councils are impacting the labour market for health and social welfare workers. Shifting service demands and technological progress necessitate changes to the scopes of practice of some professions and occupations. As a result, practitioners require new skills sets to close current skills gaps. New occupations are emerging to due to changing goals in social services; e.g. in the community development field, and new qualifications are under development.

3.15.1 Pharmacy profession

The roles of pharmacists and their support staff are changing owing to advancements in biotechnology; the increased use of technology in the supply of medicine; expanding ART and the NHI proposals. The SAPC has revised the scope of practice for pharmacy assistants and identified new specialist areas for pharmacists. Two new categories of mid-level workers (MLWs), i.e. the pharmacy technical assistant (NQF level 5) and pharmacy technician (NQF level 6) will be introduced. These new workers will be trained on a higher education platform and will have a broader scope of practice than the current categories of pharmacy support personnel (i.e. pharmacy assistant basic and pharmacy assistant post basic)³³⁵. Training of the current pharmacy assistant categories will be phased out in 2015 (basic) and 2016 (post-basic) and the register for these categories will cease to exist from January 2030³³⁶.

The first intake of pharmacy technical assistant was in 2013 and training of pharmacy technicians will commence once the SAPC has accredited learning

334 Interviews with SACSSP in July 2014; interviews with the DSD in Oct 2012; interviews with academics in social services field in Oct 2012 and July 2014; DSD.2013. Policy for Social Service Practitioners, 5th Draft.

335 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

336 SAPC. 2013. *Pharmacie 21(2). 4th Quarter. Published at <http://www.e2.co.za/emags/pharmacie...> (Accessed 18 July 2014)*.

programmes³³⁷. Pharmacy technician graduates will perform an internship of six months prior to registration as semi-professionals, while the pharmacy technical assistant will undergo practical workplace training at an accredited pharmacy for three months. Once qualified, pharmacy technicians will be able to work under the direct supervision of a pharmacist in any category of pharmacy³³⁸, and under indirect supervision in PHC clinics³³⁹. Subject to regulatory amendments, pharmacy technicians will also be able to dispense prescribed PHC medicines.

Pharmacy assistants (basic and post basic) who do not study towards the new qualifications will be converted to a new category of pharmacist assistant³⁴⁰. A new qualification for pharmacy general assistant will be developed at NQF level 4 and submitted for registration to the Quality Council for Trades and Occupations (QCTO). Pharmacy general assistants will be able to work with inventory in hospitals, wholesalers and pharmaceutical distributors³⁴¹.

337 SAPC. 2014. "For Professionals: Education". Published at http://www.sapc.za.org/B_Edu_Acc... (Accessed 18 July 2014).

338 The Pharmacy Act identifies five categories of pharmacies (manufacturing, wholesale, community, institutional (public and private) and consultant) and prescribes the range of services that may be performed in each.

339 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

340 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

341 Interview with SAPC in October 2012.

A new health professional, the authorised pharmacist prescriber will strengthen the provision of PHC services in community pharmacies. Pharmacist prescribers will provide preventive health services, by immunising children, treating minor conditions, and screening and managing patients with lifestyle diseases. The scope of practice and qualification has been developed and different providers will offer learning programmes. A Master's degree is required to register in one of the three pharmacy specialisation areas: clinical pharmacy (includes the radio pharmacist and pharmacokineticist), pharmaceutical public health and management pharmacist and industrial pharmacy³⁴².

According to the SAPC, pharmacy schools will be challenged to train and re-train the number of pharmacists and the pharmacy MLWs required to meet the health needs of the population³⁴³. By mid-2014, the DoH was still evaluating the need to upgrade its current workforce in the pharmacy field³⁴⁴.

3.15.2 Nursing profession

The DoH and SANC are addressing a range of strategic issues to strengthen the nursing profession, including a new regulatory framework for nursing practice, and education and training in accordance

342 Interview with SAPC in October 2012.

343 Interview with SAPC in October 2012.

344 Interview with the DoH in July 2014.

with the Nursing Act, 2005. The scope of practice of nurses is split into new categories – professional nurse/registered nurse³⁴⁵, professional midwife, registered staff nurse, and auxiliary nurse³⁴⁶. Table 3 6 summarises the new qualifications framework required for the nursing and midwifery professions.

From 2016 onwards nursing education will be placed in higher education. This has implications for public and private nursing colleges which currently serve as the primary training platform, as more stringent accreditation requirements apply to HEIs³⁴⁷. The SANC will develop and implement an accreditation framework for Nursing Education Institutions (NEIs) and nursing education will undergo major reforms to ensure that qualifications correspond with the revised scopes of practice and regulatory requirements. The need to develop more and better qualified educators to conduct higher-level training and to re-establish clinical teaching units is particularly acute.

345 A professional nurse has completed a four-year programme with training in community nursing, midwifery, psychiatric nursing and general nursing; A registered nurse is qualified in general nursing only and typically, enrolled nurses complete a two-year bridging programme to qualify as registered nurses. The categories of enrolled nurse and registered nurse will be phased out.

346 Categories under the Nursing Act of 1978: registered nurse, registered midwife, enrolled nurse and enrolled midwife.

347 DoH. 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17*.

Table 3 6 New nursing categories and qualifications framework

New SANC category	New qualification	NQF level	Duration	Current (legacy) qualification and level
Registered auxiliary nurse	Higher certificate	5	1 year	Certificate Enrolled Nursing Auxiliary (NQF 3)
Registered staff nurse	Diploma	6	3 years	Certificate in Enrolled Nursing (NQF 4): phase out
Registered midwife	Advanced diploma	7	1 year	
Registered professional nurse and midwife	Professional degree	8	4 years	Comprehensive Diploma in Nursing (General, Psychiatry, Community and Midwife) (NQF 6)
Specialist nurse	Postgraduate Diploma	8	1 year	
Advance specialist nurse	Master's degree	9	1 year	
Doctorate in nursing	PhD	10	3 years	

Source: DoH. 2013. *The National Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17*.

3.15.3 Health professionals registered with the HPCSA

Recently more emphasis is given to environmental health as a means for disease prevention. A higher education qualification framework was designed to professionalise the field and a new professional category of environmental health practitioner (EHP) will be introduced. Training under the new B.Sc. Degree in Environmental Health, (NQF level 8) will commence in 2015 and will incorporate compulsory work-integrated learning. Graduates will have the requisite skills to improve the health of communities and the environment, and to contribute to sustainable development³⁴⁸. Over time the older occupational categories of health and sanitary inspectors will be phased out. A new MLW category of environmental health assistant will be recognised to provide PHC services. Guidelines for academic qualifications, skills training, work experience and registration of this occupation have been set³⁴⁹.

A new professional degree in the field of medical technology, the Bachelor of Health Science: Medical Laboratory Science (NQF 8) will be introduced. This qualification will eventually replace the National Diploma: Biomedical Technology (NQF level 6). The new register for medical laboratory scientists will open at the end of 2014 and qualified medical technologists will be able to transfer to the new register following an approved articulation process³⁵⁰. The Professional Board for Medical Technology will develop a scope of practice for forensic pathology assistants (previously known in the public sector as morticians) and work with DoH to design a new qualification at NQF level 6. This cadre works at crime scenes and in mortuaries, and assists pathologists, and is in demand in the public sector³⁵¹.

Two new registration categories for psychology are recognised, namely neuropsychology and forensic psychology. The HPCSA has also revised the qualifications framework for registered counsellors who are trained to provide primary psychological services focusing on prevention, promotion, community-based care and referral services. Registered counsellors serve as “emotional paramedics” for traumatised persons and promote wellbeing in a socio-cultural setting. Training requirements include completion of an accredited BHons Psych Degree (NQF 8) and a practicum over six months in the public healthcare sector³⁵².

Changes are also underway in the field of pre-hospital emergency medical services (EMS) to improve the skills base and to meet the dire need for intermediate- and advanced life support-skills (i.e. paramedical skills). Entry into the public sector EMS has been slow in recent years because of low output from EMS colleges, competition with the private sector, and emigration. Many of the existing EMS training programmes are short course-based and the qualifications are not NQF-aligned³⁵³. A new qualifications framework set in higher education provides for two mid-level categories: emergency care assistant (NQF 5) and emergency care technician (NQF 6). The current BTech degree in emergency medical care will be converted into a professional degree for emergency care practitioners (NQF 8)³⁵⁴.

3.15.4 Mid-level workers

Many developing countries are expanding scarce healthcare resources by introducing mid-level and ancillary health workers³⁵⁵. In South Africa there is a growing demand for MLWs to widen access to healthcare, especially in under-serviced areas. MLWs have worked in the nursing and pharmacy fields for years (enrolled nurses and pharmacy assistants). A MLW for the medical field, the clinical associate, was introduced in 2004 to improve coverage of PHC and service delivery in under-

resourced areas³⁵⁶. Clinical associates work under the supervision of doctors and assist them with emergency care, routine procedures and in-patient care in district hospitals³⁵⁷. To enter practice, clinical associates complete a three-year Bachelor of Medical Clinical Practice degree and serve one year of community service. The DoH has called for the training of another 4 000 to work in district hospitals³⁵⁸.

A small number of MLWs are trained at universities of technology to work as emergency medical care technicians, radiographer assistants and forensic pathology assistants. Analysts have commented that progress with the development of these mid-level skills has been slow and that graduation numbers are too low to offset the shortage of professionals³⁵⁹. There is uncertainty about the roles of MLWs³⁶⁰ and career mobility is hampered in the absence of articulation opportunities into higher-level qualifications or professions³⁶¹. No national policy exists to develop MLWs and their training at HEIs has neither been planned nor formalised³⁶². Recently the HPCSA resolved to develop a mid-level occupation for each professional field³⁶³.

Clinical training for MLWs is very expensive and so training platforms are absent for a number of categories. According to the HPCSA, the funding structures at traditional HEIs favour full-time study in longer courses, while training of MLWs is very practically orientated and often conducted on a part-time basis. Government’s subsidy system for HEIs may also favour courses over three and four years, rather than

348 HPCSA. 2014. “Chairperson’s note”. *Environmental Health News. Newsletter of PBEHP*. Published at <http://www.hpcsca.co.za/.../newsletters/...pdf>. (Accessed 2 June 2014); HPCSA. 2012. “Environmental Health Profession and the new Higher Education Qualification Framework (HEQF)”. *Environmental Health News. Newsletter of PBEHP*. Published at <http://www.hpcsca.co.za/.../newsletters/...pdf>. (Accessed 2 June 2014);

349 HPCSA. 2012. “Chairperson’s note”. *Environmental Health News. Newsletter of PBEHP*. Published at <http://www.hpcsca.co.za/.../newsletters/...pdf>. (Accessed 2 June 2014); Interview with the HPCSA in July 2014.

350 HPCSA. 2012. *Medi Tech News 2012. Newsletter of PBMT*. Published at <http://www.hpcsca.co.za/.../newsletters....> (Accessed 2 June 2014).

351 Interviews with HPCSA and DoH in July 2014.

352 HPCSA. 2013. *Psychology News, August 2013. Newsletter, PBP*. Published at <http://www.hpcsca.co.za/.../newsletters/>. (Accessed 2 June 2014).

353 Interview with the DoH in Nov 2012.

354 Interview with the DoH in Nov 2012; Interview with the HPCSA in July 2014.

355 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*.

356 Lehmann, U. 2008. “Strengthening Human Resources for Primary Health Care”. *South African Health Review 2008*.

357 Faculty of Health Sciences. 2010. *Faculty of Health Sciences Prospectus 2010*. Mthatha: Walter Sisulu University. Published at <http://www.wsu.ac.za/academic/...> (Accessed Aug 2010); University of the Witwatersrand. Published at <http://web.wits.ac.za/Prospective/...htm>. (Accessed Sept 2010).

358 Interviews with stakeholders held in October and November 2012.

359 Coovadia, H., Jewkes, R. et al. 2009. “The health and health system of South Africa: historical roots of current public health challenges”. *Lancet*. Sept 2009. Vol. 374; Lloyd, B., Sanders, D. et al. 2010. “Human resource requirements for National Health Insurance”. *South African Health Review 2010*.

360 Hugo, J. 2005. “Midlevel health workers in South Africa – not an easy option”. *South African Health Review 2005*; Lehmann, U. 2008. “Strengthening Human Resources for Primary Health Care”. *South African Health Review 2008*.

361 Interview with HPCSA, Oct 2012.

362 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

363 Interviews with HPCSA, July 2014.

two-year courses designed for MLWs. As a result some HEIs have stopped the training of rehabilitation technicians in the fields of occupational therapy and physiotherapy³⁶⁴. A further constraint is that the public health sector may not have funded (or created) the posts for these MLWs.

3.15.5 Child and youth care workers

In the social services sector, child and youth care (CYC) is an emerging field of practice focusing on young people in crisis. CYC practice offers preventive and therapeutic interventions in the life space of children, youth and families. CYC programmes focus on normal and special development needs and primarily address emotional and behavioural issues in orphaned and vulnerable children; disabled and developmentally challenged youngsters; and juveniles in trouble with the law³⁶⁵.

To coincide with the recognition of the profession by the Professional Board for Child and Youth Care (PBCYC) of the SACSSP, a new qualification at professional degree level (NQF 8) was developed³⁶⁶. A new mid-level qualification, FETC: Child and Youth Care (NQF 4) was developed to train auxiliary child and youth care workers (ACYCWs)³⁶⁷. Once the regulatory framework is proclaimed, the PBCYC will benchmark skills gaps between the new NQF 8 qualification and the existing NQF 6 and NQF 7 qualifications. A RPL articulation mechanism will be provided so that current workers may qualify to register. It is anticipated that assessors and moderators will have to be trained for this purpose³⁶⁸.

3.15.6 Community development practitioners

Community development projects aim to alleviate poverty, generate income, stimulate employment and sustain households and communities³⁶⁹. Community development practitioners (CDPs) use consultative processes to mobilise the economic- and

environmental resources, values, and social structures of communities. Interventions are usually planned and rolled out in a multi-sectoral context³⁷⁰. CPDs require appropriate skills to engage a range of different parties (e.g. government departments, local- and tribal authorities, NGOs, civic organisations, donor organisations and various organised community structures). Typical projects are multi-disciplinary in nature and so practitioners need to be trained in the regulatory environment; human settlements, infrastructure and services; community profiling; community health; rural development; agriculture and the environment; procurement; project management; adult learning; entrepreneurship; and monitoring and evaluation.

A skills audit by the DSD found that workers in the field lacked appropriate qualifications, skills and competencies to implement community development plans. Since training levels of the workforce vary from no- or very basic training to auxiliary level- and professional training (as social workers), community development is practised in a fragmented manner³⁷¹. Together the DSD and Department of Cooperative Governance and Traditional Affairs (CoGTA) have taken steps to professionalise the field³⁷². Three qualifications were developed: FETC: Community Development (NQF 4), NC: Community Development (NQF 5) and a professional degree, Bachelor of Community Development (NQF 8). Academic programmes towards the professional degree will commence in 2015. Learnerships have been developed for the mid-level qualifications³⁷³. According to the DSD, potentially thousands of community development workers (CDWs) and government officials need to enter the NC: Community Development (NQF 5), which will be on offer at public TVET colleges and HEIs from 2016 or 2017. Norms and standards for the provision of community development are being set³⁷⁴. It is anticipated that, the field will evolve into a regulated profession some time the future.

3.16 Social Insurance and Social Security Reform

Current social insurance arrangements provide conditional income support or compensation to workers who are injured at work or find themselves out of work, as well as road users who are injured in traffic accidents. These contributory social security funds include the Unemployment Insurance Fund (UIF), the Compensation Funds (for injuries and diseases contracted in the workplace) and the Road Accident Fund (RAF). New policy developments in the social insurance arena will also impact on the human resources and skills base of the sector.

A policy document for a new no-fault Road Accident Benefit Scheme was published in 2010. The scheme provides for a more equitable, affordable and sustainable benefit system that enhances access to social security and healthcare. Greater emphasis will be placed on rehabilitation to enable injured road users to return to their social and economic activities, and life-long care for those seriously injured³⁷⁵. Draft legislation for the new scheme was published for public comment. Government anticipates that the health-related benefits provided by the RAF and the Compensation Funds will be aligned with the NHI funding arrangements at some time in the future³⁷⁶.

High administrative costs of social assistance delivered by SASSA and the separate statutory social security funds are consuming resources intended for beneficiaries. In 2010 the inter-ministerial committee on social security reform and health financing called for the greater coordination of policies, alignment of social insurance benefits and unification of administrative functions³⁷⁷. Proposed changes will include standard death and disability benefits and a basic retirement pension, financed through an earnings-related contribution³⁷⁸. Achieving these aims will require high-level skills in risk analysis, financial management, social insurance operations, IT, and in the legal field.

An interdepartmental government task team for social security is developing proposals for new compulsory social insurance to

364 Interview with HPCSA, Oct 2012; Interviews with HPCSA in July 2014.

365 DSD. 2013. Policy for Social Service Practitioners, 5th Draft; Interview with PBCYC of the SACSSP in July 2014.

366 Interview with PBCYC of the SACSSP in July 2014.

367 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

368 Interview with PBCYC of the SACSSP in July 2014.

369 DSD. 2009. "Towards Sustainable Livelihoods: a Toolkit for Community Development Practitioners in South Africa"; DSD. 2013. Policy for Social Service Practitioners, 5th Draft; Interviews with academics in October 2012 and July 2014.

370 DSD. 2012. Draft policy for social service practitioners. (Working document).

371 Loffel, J., Allsopp, M., et al. 2008. "Human resources needed to give effect to children's right to social services". South African Child Gauge 2007/08.

372 Interviews with the Department of Social Development in Oct 2012.

373 Interviews with DSD in October 2012 and July 2014.

374 DSD. 2013. Policy for Social Service Practitioners, 5th Draft; Interviews with the SACSSP and DSD in July 2014.

375 National Treasury. 2011 Budget Review.

376 National Treasury. 2012. "Social security and national health insurance". 2012 Budget Review.

377 National Treasury. 2011 Budget Review.

378 National Treasury. 2013 Budget Review.

provide for retirement, disability and survivor benefits. At this stage the impact that these proposals may have on skills needs is still uncertain. It is possible that the financial services sector will be more directly affected rather than the health and social development sector.

3.17 Veterinary Services

3.17.1 Veterinary professionals and para-professionals

Veterinary professionals play a critical role in the treatment of diseases that affect and pose a risk to animal and human health, and in the promotion of food safety and food security required for economic growth. As such, these professionals fulfil a crucial function in preventing the spread of trans-boundary diseases, reducing hunger, monitoring food quality, performing biomedical research, and controlling infectious diseases in animals that can be transmitted to humans³⁷⁹.

Veterinary services are delivered by a veterinary team and so the traditional veterinary profession has expanded to include a range of para-professionals such as animal health technicians, veterinary nurses, veterinary technologists and laboratory animal technologists³⁸⁰. Animal health technicians are involved in surveillance and inspection of livestock; disease prevention through vaccination and parasite control programmes; the analysis of specimens and samples; and the provision of primary animal healthcare³⁸¹. They are employed by state veterinary services and require professional supervision. In private practice, veterinary nurses attend to patient care, administration of medicines, basic laboratory procedures, stock control and merchandising, and in the NGO sector, they provide primary animal healthcare. Veterinary technologists render laboratory diagnostic services, in this way assisting veterinarians to determine the cause of diseases, conduct quality control of veterinary products, work in vaccine production and assist with research³⁸².

379 SAVC. 2011. "Celebrating World Veterinary Year 2011 in South Africa". Published at <http://www.savc.co.za/...> (Accessed 22 Aug 2011).

380 Interviews with SAVC in October 2012 and June 2014.

381 Government Gazette No 32298, Notice R 867, June 12. Published at <http://www.savc.co.za/...pdf>. (Accessed 22 Aug 2011).

382 SAVA. 2012. Career information. Published at: <http://www.vetassociation.co.za/...> (Accessed 4 Sept 2012); Interviews with respondents from the veterinary professions in Oct 2012.

Recently, the SAVC agreed to recognise the role of veterinary welfare assistants (previously animal welfare assistants) and to acknowledge the skills of animal handlers at veterinary practices, kennels and NGOs involved in animal care. Generally, this category of worker has no formal qualifications, but has received in-service training and gained experience and skills needed in the animal health sector. By October 2012, a total of 194 of the animal health assistants were authorised by the SAVC to perform basic animal care services under supervision of a veterinarian. However, this occupational group has no scope of practice and is not formally registered. Unisa developed a new qualification, the HC: Animal Welfare (NQF 5), to be offered as a one-year distance learning programme³⁸³. Other emerging animal health occupations are veterinary physiotherapist (for which the SAVC approved a scope of practice and required skills sets), animal rehabilitation- and equine dental technician³⁸⁴.

3.17.2 Factors driving the demand for skills in animal healthcare

Veterinary skills are in demand globally, especially in Africa³⁸⁵. International migration is common³⁸⁶ and the immigration rate of the country's newly qualified veterinarians remains high³⁸⁷. In South Africa skills shortages are experienced in both the public and private sectors. This is particularly acute in the public sector where the vacancy rate for veterinarians remains elevated, at around 40%³⁸⁸. However, the high vacancy rate is not necessarily a true reflection of skills shortages and could be attributed to recruitment, management, remuneration and promotion policies applied in the public sector³⁸⁹. In the absence of an epidemiological study that considers multiple factors driving the demand for animal health services, it is not possible to give an accurate picture of skills

383 Interviews with SAVC and veterinary academics, Oct 2012 and June/July 2014.

384 Interviews with SAVC in Oct 2012 and June 2014.

385 Interviews with SAVC in Oct 2012 and June 2014; Interviews with veterinary academics, Oct 2012.

386 Paterson, A. 2008. "Veterinary Skills". Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

387 DAFF. 2012. Memorandum to the Veterinary and Para-Veterinary Professions Amendment Bill, 2012.

388 Interviews with SAVC and veterinary academics, Oct 2012; Interview with SAVC in June 2014.

389 Interviews with SAVC and veterinary academics, Oct 2012.

shortages³⁹⁰. Challenges pertaining to the provision of veterinary services are the need to³⁹¹:

- a) Enable emerging black and subsistence farmers to gain access to veterinary services;
- b) Improve access for all users of veterinary services in rural areas across South Africa;
- c) Ensure that state veterinary services comply with international standards set by the World Organisation for Animal Health, and to maintain national animal health and veterinary public health systems across the entire country;
- d) Produce the required skills to meet service demands, sustain safe food production, ensure food security, and protect animal- and human health; and
- e) Address the shortage of veterinary professionals from previously disadvantaged groups.

Expansion of the world population to 9 billion by 2050 is driving the need to increase agricultural production by 70%. Globalisation and increased cross-border trade in livestock and animals have increased the risks for the spread of animal-borne diseases³⁹². To address these challenges, the DAFF will take measures to increase livestock production and improve animal-disease risk-management programmes³⁹³. The advancement of food security strategies will require the strengthening of meat inspection systems and veterinary public health services³⁹⁴. Regulatory interventions such as inspections, quarantine services and audits will be increased to advance animal health and veterinary public health³⁹⁵. The successful implementation of these interventions will depend on the availability of skilled veterinary professionals and para-professionals.

390 Interview with SAVC in Oct 2012.

391 Inputs by the SAVC in 2011 following a consultative process initiated by the HWSETA.

392 DAFF. 2014. Strategic Plan 2013/14 -2017/18 for the Department of Agriculture, Forestry and Fisheries.

393 National Treasury. 2014. "Vote 26: Agriculture, Forestry and Fisheries". 2014 Estimates of National Expenditure; DAFF. 2014. Strategic Plan 2013/14 -2017/18 for the Department of Agriculture, Forestry and Fisheries.

394 DAFF. 2012. Strategic Plan 2012/13 -2016/17 for the Department of Agriculture, Forestry and Fisheries.

395 National Treasury. 2012. "Vote 26: Agriculture, Forestry and Fisheries". 2012 Estimates of National Expenditure.

One of South Africa's challenges is to strengthen rural development by growing rural income, improving food security and enabling sustainable job creation³⁹⁶. Production losses stemming from mismanagement of livestock by small-scale farmers is having an adverse economic impact. Annual production losses are estimated at almost R3 billion at farm gate value³⁹⁷. Of particular concern is that about 1 000 000 small-scale livestock owners manage 50% of the country's livestock but contribute less than 10% to national red meat production³⁹⁸. This is mainly the result of low levels of exposure to and uptake of recognised livestock health and production management practices. The animal health sector faces a significant challenge to transfer knowledge and skills to emerging farmers, and to provide on-going veterinary support services until appropriate and proven livestock management practices are adopted. More veterinary and para-veterinary skills are needed to improve production practices, reduce mortalities, and increase calving percentages.

The DAFF adopted the Primary Animal Healthcare Policy in South Africa to broaden access to veterinary services in rural communities in a cost-effective manner and to improve the health status and production of animals. However, implementation is proving to be challenging because the limited veterinary public resources are mostly located in urban centres³⁹⁹.

The University of Pretoria (UP)⁴⁰⁰ established a chair in primary animal healthcare to develop the concept, methodology and training material needed for primary animal healthcare (PAHC)⁴⁰¹. The DAFF and the Faculty of Veterinary Science of UP introduced specific measures to advance access to PAHC for small-scale livestock owners by enabling them to access the knowledge, skills and technical

support necessary for good animal health and profitable production⁴⁰². The aim is to train all 1 000 registered animal health technicians in basic PAHC and production management. In turn, these para-veterinary professionals will initially train 50 000 small-scale livestock owners to establish skills on the ground and the technical support systems required for effective disease surveillance, disease prevention (vaccination awareness and dip tank management) and disease treatment. Veterinary professionals from the private and public sector are involved in the "train the trainer" programme. Technical support services for the PAHC programme focus on disease surveillance and reporting; production management programmes designed for local conditions; and vaccination awareness campaigns. In addition, animal health assistants are trained as dip-tank managers and to keep the prescribed registers, while veterinary professionals and para-professionals offer clinical services to improve livestock owners' confidence in the technical capability of veterinary services⁴⁰³.

In South Africa, the state's commitments to veterinary services are directed at measures to provide food safety, public health, and community animal services. Para-professionals, e.g. veterinary nurses and technicians often render such services under professional supervision. A shortage exists of animal health technicians in the public sector to perform disease control and a range of prescribed statutory functions⁴⁰⁴. The SAVC has expressed concerns to the DAFF about food safety, especially about high levels of residues detected in milk and meat resulting from the incorrect (and uncontrolled) use of veterinary medicines and farm feeds. This may be attributed to the absence of adequate veterinary controls and expertise to monitor medicine use and to provide scientific advice to stock owners. As a result, these risk factors could serve as a catalyst for a crisis in human health⁴⁰⁵.

Veterinary services are also in demand in public entities such as the ARC, Onderstepoort Biological Products, and the Perishable Products Export Control

Board. Such services are also required for teaching positions at HEIs and in corporate research and development⁴⁰⁶. According to the SAVC there is a shortage of veterinary educators in the fields of PAHC, veterinary technology and veterinary specialisation. More veterinary specialists are needed in veterinary public health; aquaculture; epidemiology; poultry; wildlife; and production animal studies, especially in the context of rural development. Researchers with veterinary qualifications are also needed⁴⁰⁷.

3.17.3 New roles and responsibilities for animal health professionals and technicians

Internationally, the roles of veterinarians and para-professionals working in animal public health services are expanding to recognise the inter-dependence of humans, animals and the environment. The so-called "One Health Concept" considers the transmission of diseases and recognises that the health of humans, animals and the environment is so interconnected that efforts to address the one component impact on the other two. In essence, good health in animals is the foundation of good human health⁴⁰⁸.

The rapid spread of animal diseases due to global transport, emerging zoonoses (i.e. infectious diseases transmitted from animals to humans, and vice versa) and climate change pose real challenges, and the animal health workforce need to be up-skilled to produce safe food without compromising the environment⁴⁰⁹.

The focus of veterinary services is changing from a reactionary approach with reliance on clinical services to a more preventive approach delivered by para-veterinary professionals and via extended veterinary services (i.e. health promotion through advice to and education of owners). More emphasis is placed on PAHC, with activities focused on surveillance and reporting, disease prevention and proven production

396 This is aligned to Strategic Infrastructure Project (SIP) 11 of the Presidential Infrastructure Coordinating Commission.

397 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

398 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

399 Paterson, A. 2008. "Veterinary Skills". Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

400 At the Faculty of Veterinary Science, Onderstepoort.

401 University of Pretoria. Faculty of Veterinary Science. 2012. Chair in Primary Health Animal Healthcare (PAHC) Programme. Published at <http://web.up.ac.za/default.asp?ipkCategoryID=18032>. (Accessed 5 Sept 2012).

402 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

403 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

404 SAVC. 2011. SAVC Review 2007-2010. Published at <http://www.savc.org.za/>. (Accessed 13 Aug 2011).

405 Interview with SAVC in October 2012.

406 Paterson, A. 2008. "Veterinary Skills". Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

407 Interview with SAVC in Oct 2012.

408 Interview Faculty of Veterinary Science, University of Pretoria, October 2012.

409 McCrindle, C.M.E. 2010. "Veterinary education for global animal and public health". *Journal of the South African Veterinary Association*, Vol 81 (2).

management⁴¹⁰. As a result of this emerging approach, veterinary professionals need to develop new skills sets that support collaborative abilities, and develop a consciousness about socio-economic issues, cultural diversity, and different value systems⁴¹¹.

3.17.4 Supply of animal healthcare skills

In 2012, a total of 2 113 registered veterinarians worked in private practice, another 271 worked overseas and only between 185 and 200 were employed in the public sector⁴¹². The supply of veterinary skills to the public sector is hampered by a number of factors. While the SAVC has lobbied state veterinary services to enter into partnerships with private veterinarians, there is a perception that contributions of private practitioners are neither appreciated nor utilised⁴¹³. According to the SAVC, state veterinary services are fragmented and in need of improved governance. Varying remuneration policies between provinces are affecting the supply of skills, as veterinary professionals and workers constantly migrate to secure better benefits⁴¹⁴. Language barriers are also constraining factors in service delivery to emerging stockowners. For example, it is preferable to deploy animal health technicians in their “home” province where they are able to communicate in local languages and respect local cultures and practices⁴¹⁵. Further, existing training institutions produce insufficient numbers of veterinary- and para-veterinary professionals to meet public sector service targets⁴¹⁶.

Harsh economic conditions for farmers and animal owners have led to a reduced demand for private veterinary services and this has contributed to an exodus of veterinarians in private practice from rural areas. According to the SAVC, foreign graduate professionals who wish to practise in South Africa face numerous bureaucratic obstacles to do so⁴¹⁷.

Limited clinical training platforms to train veterinary professionals and para-professionals are also hampering supply. It is challenging to secure placements for students in work-integrated learning settings. For example, third-year veterinary technology students serve their internships in private sector laboratories, as the state laboratories lack the resources required – e.g. equipment, technology and supervision capacity⁴¹⁸. While state facilities should serve all the diagnostic disciplines, private laboratories tend to render services only in one or two disciplines, e.g. virology, or haematology, or biochemistry, or histology or parasitology. As a result, learners receive limited practical exposure. The curriculum for experiential training may have to be adjusted to expose learners to all the specialisation areas, and this will increase pressure on the clinical platforms.

To enable skills provision, more attention is paid to articulation opportunities in skills planning for the animal health sector. For example, the new NC: Veterinary Welfare Assistant (NQF level 5) will enable learners to articulate to the courses for animal health technician and the veterinary nurse.

A number of strategies have been mooted in order to improve access to veterinary services and alleviate skills shortages in the public sector and in rural areas. Firstly, the DAFF may introduce a “zoning” policy when licensing veterinarians so that they are compelled to establish practices in under-served areas⁴¹⁹. Secondly, compulsory community service for persons registering for the first time as veterinarians will be introduced by 2015 or 2016 and for para-veterinarians within a few years⁴²⁰. The DAFF had intended to commence with the compulsory community service by 2014, but experienced implementation challenges such as access to workplace facilities, supervision and mentorship for the graduates⁴²¹. Thirdly, the state could enter into contracts with rural-based veterinarians in private practice to provide public animal

healthcare services⁴²². However, these professionals will need training to perform regulatory work for the state in areas such as surveillance and disease control⁴²³. The DAFF also provides bursary funding to train veterinarians⁴²⁴.

The Faculty of Veterinary Science of UP has increased the intake of veterinary students from 140 per year to 190 from 2014 and will specifically increase the intake of black students from rural provinces. Graduates will also be encouraged to enter rural practice and state veterinary services⁴²⁵. The Faculty experienced a drop in applications for veterinary nurses and the training programme will be converted from a two-year diploma course into a three-year degree in 2015/16 in the hope of attracting more candidates. The last intake of students for the Veterinary Nursing Diploma course will be in 2014/15⁴²⁶.

The SAVC and Faculty of Veterinary Science of UP are also driving the development of “Day One Skills” for newly qualified veterinarians when they enter the labour market⁴²⁷. The objective is to ensure that veterinary graduates are work-ready and equipped with the skills and competences to serve the needs of all communities, animal populations and the country as a whole.

3.18 Conclusion

Difficult socio-economic conditions and multiple challenges triggered by poverty, unemployment, HIV/AIDS, high maternal and infant mortality, low levels of literacy and education, social crime and high levels of violence, abuse and neglect, as well as poor housing provide the focus for the health and social development sector. Demand for healthcare and social development services – particularly in the public sector – continues to rise in the midst of a growing burden of disease, swelling social hardship and the enduring shortages of health- and social

410 University of Pretoria, Faculty of Veterinary Science. 2011. *Primary Animal Healthcare Implementation Plan*.

411 Faculty of Veterinary Science. UP. 2012. “Curriculum principles”. Published at <http://web.up.ac.za/>. (Accessed 2 Nov 2012).

412 Interview with SAVC in October 2012.

413 Interview with SAVC in October 2012.

414 Interview with SAVC in October 2012.

415 Interview with SAVC in October 2012.

416 South African Veterinary Council. 2011. *Annual Report 2011*.

417 Interview with SAVC in October 2012.

418 Interview with Department of Biomedical Sciences, Tshwane University of Technology, November 2012.

419 Paterson, A. 2008. “Veterinary Skills”. *Human Resources Development Review 2008: Education, Employment and Skills in South Africa*.

420 DAFF. 2014. *Strategic Plan 2013/14–2017/18 for the Department of Agriculture, Forestry and Fisheries*; DAFF. 2013. *Draft regulations relating to the performance of compulsory community service*. Published at <http://www.savc.co.za/...pdf>. (Accessed 20 July 2013).

421 Interviews with SAVC in October 2012 and July 2014; DAFF. 2014. *Veterinary Public Health*. Published at: http://www.nda.agric.za/vetweb/community.../CCS_...pdf. (Accessed 3 July 2014).

422 Paterson, A. 2008. “Veterinary Skills”. *Human Resources Development Review 2008: Education, Employment and Skills in South Africa*.

423 Interview with SAVC in October 2012.

424 National Treasury 2012. “Vote 26: Agriculture, Forestry and Fisheries”. *2012 Estimates of National Expenditure*.

425 UP. 2014. *Undergraduate Faculty Brochure: Veterinary Science 2014/15*; SAVC. 2012. “Veterinary training in South Africa-Strategic policy statement”. Published at <http://www.savc.org.za/...> (Accessed 20 July 2013).

426 UP. 2014. *Undergraduate Faculty Brochure: Veterinary Science 2014/15*; Interview, Faculty of Veterinary Science, University of Pretoria, October 2012.

427 SAVC. 2013. “Latest news”. Published at <http://www.savc.org.za>. (Accessed 20 July 2013).

services professionals. The scope, complexity and diversity of the disease burden and social development needs present mounting challenges for service delivery and the workforce.

Numerous policy initiatives and a progressive legislative agenda are advancing human rights and access to social services and healthcare. Government's preference for a developmental approach for social welfare services is driving the demand for a range of social development skills. New skills sets that integrate occupation-specific knowledge and technical ability with professional attitudes and socio-cultural awareness are needed to build communities, support at-risk families, protect children, nurture the young, enable the vulnerable, uplift victims of social crime, and care for the sick and elderly. Among the social services workers required are social work professionals, social auxiliary workers, child and youth care workers, ECD practitioners, community development practitioners, community development workers, and community caregivers as well as specialists in various service areas.

Healthcare financing in the public and private sectors remains disproportionate to the number of users served and this affects the existing skills base. Poor health outcomes, however, can be linked to inefficiencies in the health system, and not only to resource constraints or skills shortages. Government spending on social development continues to grow above inflation rates, mainly as a result of social assistance provided to vulnerable groups. Transfers to NPOs and delivery partners for social development services maintain their upward trend but problems with timely payment to NPOs adversely affect service delivery and the retention of scarce skills.

Multiple socio-economic factors impact on the availability and distribution of health and social development workers. Attrition and a growing population with an increasing disease burden have reduced the patient/health worker ratios in the public sector. The social development sector has also experienced a departure of social workers and from the NPO-sector in particular, mainly due to low salaries, unfavourable working conditions and multiple sustainability- and capacity challenges experienced by less formally organised NPOs. Efforts to develop mid-level workers to compensate for the shortage of

professionals have been frustrated by factors such as the poor alignment of policies for human resource planning; uncertainty about their roles, and structural problems with subsidies provided for post-school education.

Institutional difficulties and failures in management of the health system also have an impact on the availability and effectiveness of skills. In order to maintain reasonable patient/health worker ratios and to provide acceptable levels of service, the health sector will have to replace skills lost due to attrition. Many social services delivered for the protection of persons, as well as services requiring statutory assessment and prescribed intervention, must be performed by appropriately qualified and registered social service professionals. Concerted efforts are underway to increase the number of social work professionals. However, their effective deployment in the sector has been hampered by budget constraints, limited availability of public sector posts and countless sustainability challenges that confront NPOs. Nevertheless, additional, extensive skills development interventions are needed for the social services sector to meet the demand for diverse services.

The successful implementation of the proposed NHI scheme over a period of 14 years from 2012 to 2025 will depend on comprehensive efforts to grow, further develop, and maintain an appropriate skills mix for the South African health sector. Several healthcare policies currently under development and in the process of implementation will increase the demand for a wide range of skills, including those of CHWs, clinical associates, environmental health practitioners, emergency care assistants, professional nurses, specialist nurses, registered staff nurses, pharmacists and pharmacy MLWs, medical practitioners and medical specialists, as well as occupational- and physiotherapists. New mid-level occupations such as pharmacy technician, emergency care technician and environmental health assistant are emerging to address changing service- and technology needs.

Education and training provision for the sector will also undergo major changes in the next decade and impact on the mandate of the HWSETA. Work-integrated learning will gain more prominence to ensure that learners combine technical knowledge and real-world skills to achieve acceptable

service outcomes. In future, SETAs will focus on developing the skills of the existing workforce and to provide a skills pipeline to workplaces in their sectors. Increasingly, the HWSETA will support training programmes that lead to qualifications and awards demanded in the sector, rather than short courses. More work-based partnerships between employers and educational institutions will also have to be facilitated. Given the substantial growth expected in admissions to universities and the TVET colleges, the HWSETA will have to increase its provision for scholarships.

At the same time training for healthcare practitioners in the fields of nursing, pharmacy and emergency medical care is moving to a higher education platform. This has major implications for the provision of healthcare education, and the formation of clinical skills, as well as the expansion of skills of educators and academics. Statutory councils and various organised professions have taken steps to professionalise their fields of practice by setting new scopes of practice and more stringent requirements for education and training, e.g. in the fields of medical technology, nursing, child and youth care and community development.

The implementation of strategies to strengthen the health system and to develop health information systems will only be successful if the skills base of operational managers is developed. Similarly, to achieve the goals for improved financial management and in the health system, leadership skills and management capability at all levels will have to be cultivated. Both the health and welfare sector require management skills at strategic and operational levels to enhance quality, performance and accountability, as well as capable financial and resource management. As much as there is a need for more professional skills, there is also a need for leadership and management skills to improve efficiencies in service delivery.

Veterinarians work at the interface of animal- and human health and the environment. As such veterinary professionals and para-professionals play a critical role in the treatment of diseases that affect and pose a risk to animal- and human health, and in the promotion of food safety and food security required for economic growth. Particular challenges pertaining to the provision of veterinary services include the need to: improve access for all users of

veterinary services in rural areas; ensure that state veterinary services are adequate and comply with international standards; and, specifically, to maintain national animal health and veterinary public health systems across the entire country.

Shortages of veterinary professionals and other members of the veterinary services team exist in both the public and private sectors. A key government priority is to enable the vast number of small-scale livestock owners and emerging farmers to gain access to veterinary extension services. An ambitious project is underway to make primary animal healthcare services available to support good animal health and profitable production. It remains challenging to produce the required number of veterinary professionals and -practitioners to meet demands for safe food production and food security, and to protect animal- and human health. The planned introduction of compulsory community service for young veterinary graduates in 2015 or 2016 (and for para-veterinary professionals sometime in the future) will relieve some skills shortages in the public sector.

In a resource-constrained environment with enormous demands for healthcare and social services, the country needs to develop skills to deliver cost-effective healthcare and social development interventions. Government policies and national agendas such as the National Development Plan are changing the way social services and human- and animal healthcare are accessed and delivered. Increasingly, government is looking at primary and community-based services to help vulnerable persons and to treat the ill and maintain the health of the healthy. The needs and service expectations of the primary healthcare and social development systems are expanding rapidly, and will necessitate changes to the composition and skills base of the workforce. The HWSETA has a responsibility to respond to skills gaps in the current workforce brought about by changes in policy and service delivery as well as skills shortages driven by legislative changes and the human rights-based socio-economic development agenda.

4 The Demand for Skills

4.1 Introduction

The health and social development sector is a personal services industry and such services are both resource- and time-intensive. Effective health and social welfare services can only be rendered if the sector has adequately skilled human resources with the appropriate skills content. As the demand for such services increases, so too does the demand for human resources in the sector.

In a resource-constrained environment with enormous demands for healthcare, social development and welfare the country needs to develop skills to deliver services cost effectively. Adjustments are being made to the way services are delivered with the introduction of mid-level workers and changes to the scope of practice of many

health professionals. Increasingly the focus is on community-based care to treat the ill, maintain the health of the healthy and support to families and persons in need. Social welfare services are becoming more development directed and the service-delivery platform is being broadened. These developments will impact directly on the

quantitative demand for people in specific occupations and professions and on the skills required of them.

This chapter looks at the demand for skills in the health and social sector from various perspectives. It starts with an analysis of the current positions available in the sector – those that are filled as well as vacancies. Current skills shortages and future demand for skills are considered with reference to benchmarks and various targets. Stakeholders’ demands for skills development interventions by the HWSETA are also discussed. The chapter also looks at changes in the skills required of workers in the sector and the factors that influence the demand for skills.

4.2 The Total Number of Positions in the Sector

As indicated in Chapter 2, in April 2014 there were approximately 310 200 filled positions in the Public Service. The total number of vacancies that are indicated as scarce skills amounts to nearly 16 000. This figure is an under estimate as a number of departments did not submit vacancy data⁴²⁸. The total number of positions in the public health and social development sector is therefore approximately 326 000⁴²⁹ (Table 4 1).

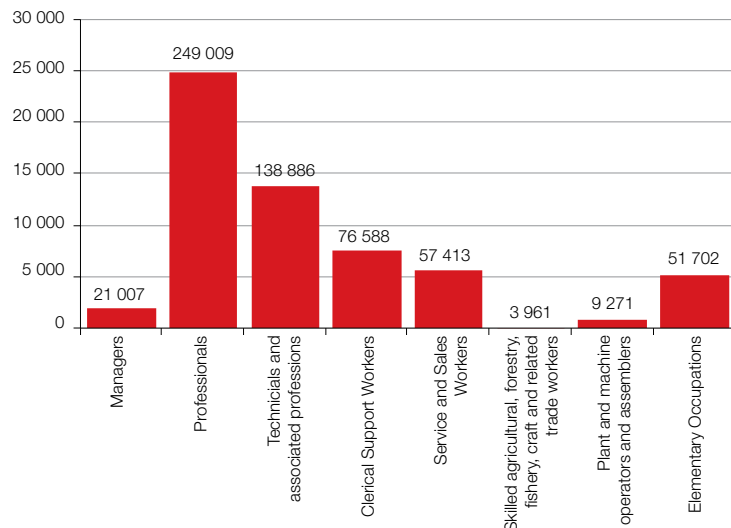
The total number of posts in the private sector was also estimated by adding the vacancies reported in the WSPs submitted to the HWSETA in June 2014 to the estimates of total employment in each occupation. The filled positions in the private sector numbered 276 513 while there were 5 099 vacancies. This brings the total number of positions in the private sector to 281 612 and the total number of positions in the sector to 607 837. As mentioned earlier in this report, there are still components of the sector that are excluded from these calculations – for example some of the professionals in private practice, the professional and administrative support

staff working in these practices, the medical personnel employed by the SANDF and the majority of people working in non-levy-paying NPOs.

Whether the total number of positions in the health and social development sector is enough to service the growing population is a topic that has been debated by various analysts in recent years. The 2008 DBSA

Roadmap for the Reform of the South African Health System considered human resources and skills needs in the health component of the sector⁴³⁰. According to the Roadmap process, staff headcount in the public sector health departments declined from around 251 000 to around 215 000 from 1997/98 onwards and only regained the previous level by 2007/08; i.e. 11 years later. No increases in health professionals and workers occurred,

Figure 4 1. Total Positions Available in the Health and Social Development Sectors according to Occupational Group



⁴²⁸ No vacancy data were received from the Department of Health, Western Cape; the Department of Health, Free State; the Department of Health, Gauteng (national); the Department of Health, North West; the Department of Social Development, Mpumalanga and the Department of Social Development, Northern Cape.

⁴²⁹ The extent to which these reported vacancies are currently funded is not clear.

⁴³⁰ DBSA. 2008. A Roadmap for the Reform of the South African Health System.

despite the growing population requiring public health services and the increasing burden of disease mainly due to HIV/AIDS. Had staff levels been adjusted to allow for population growth, another 64 087 posts (or a staff complement of 315 087) were required by 2008. If further allowance was made for the disease burden, the total public sector staff complement in health had to be 330 791 in 2008 just to retain the status quo of 1997/98. The shortfall at that stage was

79 791 posts. Significant efforts were made to increase the total number of healthcare personnel in the provincial departments of health to 303 531 by May 2011⁴³¹.

The occupational distribution of positions in the health and social development

431 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011. "Health Financing". South African Health Review 2011. Published at <http://www.hst.org.za/publications/south-african-health-review-2011>. (Accessed 27 Aug 2012).

sector is shown in Figure 4 1. The sector employs mainly professionals (41% of the total number of positions in the sector) and technicians and associate professionals (23% of the total number of positions).

Table 4-1 shows the total demand in the health and development sector (including vacant positions for scarce skills). Of the vacant positions in the sector, 76% are for professionals.

Table 4 1 Employment positions in the health and social development sector

Occupational Group	Public Service			Private Sector			Total Sector		
	Filled positions*	Vacant positions	Total positions	Filled positions	Vacant positions	Total positions	Filled positions	Vacant positions	Total positions
Managers	7 656	120	7 776	13 134	97	13 231	20 790	217	21 007
Professionals	123 117	13 094	136 211	109 924	2 874	112 798	233 041	15 968	249 009
Technicians and Associate Professionals	66 413	2 283	68 696	68 125	2 065	70 190	134 538	4 348	138 886
Clerical Support Workers	34 236	120	34 356	42 197	35	42 232	76 433	155	76 588
Service and Sales Workers	33 591	204	33 795	23 608	10	23 618	57 199	214	57 413
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 575	148	1 723	2 223	15	2 238	3 798	163	3 961
Plant and Machine Operators and Assemblers	4 561	0	4 561	4 707	3	4 710	9 268	3	9 271
Elementary Occupations	39 107	0	39 107	12 595	0	12 595	51 702	0	51 702
Total	310 256	15 969	326 225	276 513	5 099	281 612	586 769	21 068	607 837

*Differences in the number of filled manager and professional positions reported in the public sector are noted from year to year. This is largely because health professionals also have managerial responsibilities and vice versa. Sources: Vacancies calculated from HWSETA and PSETA WSP applications 2014.

4.3 Current Shortages

4.3.1 Skills shortages reported by organisations in the sector

Skills shortages or scarce skills are monitored by the SETAs in the WSPs submitted to them on an annual basis. For the purposes of this SSP the WSPs submitted to the HWSETA and those submitted by the health and social development departments to the PSETA were combined to provide an overview of the shortages experienced in the sector.

In 2014, 64% of the organisations that submitted WSPs to the HWSETA reported certain vacancies, while most of the provincial departments of health and social development⁴³² reported skills shortages. A total of 15 969 people (5% of total

432 Scarce skills information could not be obtained from the the Department of Health, Western Cape; the Department of Health, Free State; the Department of Health, Gauteng (national); the Department of Health, North West; the Department of Social Development, Mpumalanga and the Department of Social Development, Northern Cape.

employment) is reported as scarce skills shortages in the Public Service. Of the scarce skills vacant positions in the Public Service, 82% are for professionals.

In the private health sector, a total of 5 099 people (2% of total employment) is required to fully alleviate the skill shortages. Skills shortages are the most severe among professionals and technicians and associate professionals (Table 4-2).

Table 4 2 Vacant positions according to occupational group

Occupational Group	Public Service Vacant positions		Private Sector Vacant positions	
	N	% of employment	N	% of employment
Managers	120	2	97	1
Professionals	13 094	11	2 874	3
Technicians and Associate Professionals	2 283	3	2 065	3
Clerical Support Workers	120	0	35	0
Service and Sales Workers	204	1	10	0
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	148	9	15	1
Plant and Machine Operators and Assemblers	0	0	3	0
Elementary Occupations	0	0	0	0
Total	15 969	5	5 099	2

Sources: Calculated from HWSETA and PSETA WSP applications, 2014.

The occupations with the highest numbers of unfilled positions (>100) are listed in Table 4 3. Clearly the needs are, especially in the public service, social workers, registered nurses, medical practitioners, community workers and hospital pharmacists. However, the DoH

warns against the use of vacancy rates to determine skills shortages and conduct workforce planning. According to the DoH, it is preferable to set staffing norms for professional categories based on the workload, productivity and skills mix⁴³³.

433 DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

Demand for specialist nurses remains high, especially in view of decreased production between 1996 and 2010 of post-basic nurses in clinical specialisations such as advanced psychiatry, advanced midwifery, intensive care and paediatric nursing⁴³⁴.

434 DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.

Table 4 3 Occupations where more than 100 vacancies were reported

OFO Code	OFO description	Number of vacancies		
		Public Service	Private sector	Total
263507	Social Worker	6 933	150	7 083
222108	Registered Nurse (Medical and Surgical)	1 193	156	1 349
221101	General Medical Practitioner	1 278	40	1 318
341201	Community Worker	1 166	117	1 283
332208	Pharmacy Sales Assistant	9	1 215	1 224
226203	Retail Pharmacist	5	779	784
222112	Registered Nurse (Surgical)	4	720	724
226201	Hospital Pharmacist	569	24	593
222104	Registered Nurse (Community Health)	538	52	590
321101	Medical Diagnostic Radiographer	313	155	468
222105	Registered Nurse (Critical Care and Emergency)	179	279	458
226401	Physiotherapist	365	6	371
222101	Clinical Nurse Practitioner	289	22	311
341204	Auxiliary Child and Youth Care Worker	258	0	258
532903	Nursing Support Worker	201	5	206
325802	Intensive Care Ambulance Paramedic / Ambulance Paramedic	169	6	175
222201	Midwife	162	13	175
322101	Enrolled Nurse	118	47	165
222116	Nurse Manager	97	54	151
341203	Social Auxiliary Worker	0	146	146
321201	Medical Laboratory Technician	7	131	138
221210	Specialist Physician (General Medicine)	126	11	137
222107	Registered Nurse (Disability and Rehabilitation)	124	0	124
222113	Paediatrics Nurse	82	42	124
422901	Admissions Clerk	120	0	120
226902	Occupational Therapist	96	23	119

Sources: Calculated from HWSETA and PSETA WSP applications, 2014.

In 2012 the DoH published details of public sector vacancies (for 2010) in 14 key clinical professions as well as the cost of filling them (Table 4 4). These are vacancies in the staff establishment, but they were not necessarily funded at the time. It was

estimated that almost R40 billion was required to fill the listed vacancies when provision was made for the Occupational Specific Dispensation. According to the DOH, this is an unattainable target. Rural provinces reported the highest number of

vacancies (Limpopo 39 653, Eastern Cape 27 267, and KwaZulu-Natal 14 359)⁴³⁵.

435 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

Table 4 4 Public sector vacancies and cost of filling key clinical professions, 2010

Clinical profession	Number of public sector		
	vacancies	Ave. cost per worker	Cost to fill vacancies
Medical practitioner	10 860	R 796,822	R 8 653 486 920
Medical specialist	3 491	R 1 052 236	R 3 673 355 876
Nursing assistant	20 943	R 127 939	R 2 679 426 477
Professional nurse	44 780	R 393 591	R 17 625 004 980
Staff nurse and pupil nurse	16 202	R 166 925	R 2 704 518 850
Dental practitioner	921	R 538 904	R 496 330 584
Dental specialist	155	R 1 052 236	R 162 096 580
Dental therapist	287	R 284 592	R 81 677 904
Pharmacist	3 747	R 411 516	R 1 541 127 420
Radiographer	1 621	R 126 316	R 201 758 236
Environmental health practitioner	443	R 284 592	R 126 758 236
Occupational therapist	1 260	R 284 592	R 358 585 920
Physiotherapist	1 074	R 284 592	R 305 651 808
Psychologist and vocational counsellor	699	R 284 592	R 198 929 808
TOTAL	106 518		R 38 812 025 619

Source: DoH 2012. HRH Strategy for the Health Sector 2012/13 – 2016/17.

Although the public sector vacancy data indicate the need for human resources, the DoH warns that there are problems with the data⁴³⁶.

In 2010 the DoH estimated that the needs gap for medical specialists in the public sector was 7 590 while private sector hospitals reported a shortage of 280⁴³⁷.

Organisations are also required to explain in their WSPs why they found it difficult to fill

436 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

437 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

the positions that they identified as scarce skills. In the Public Service, scarcity was frequently related to geographic location and replacement demand. In the private health sector, skills shortages are the most severe among professionals, technicians and associate professionals. Most organisations indicated a lack of skilled people combined with attractive career opportunities outside SA as reason for the scarcity of professionals.

4.3.2 Benchmarking and comparisons

Another way of looking at skills shortages in the health sector is to compare employment

figures with international benchmarks. Health economists applied the ratios used in the DBSA Roadmap report to calculate how many medical officers (GPs), nurses and medical specialists the public sector hospitals would have required in 2009/10 to function according to international benchmarks. The results given in Table 4 5 below show that public hospitals needed an extra 5 352 GPs and 150 591 nurses in 2010⁴³⁸. These calculations did not take into account any additional staff that would be needed for the NHI.

438 Van der Berg, S., Burger, R. et al. 2010. Financial Implications of a National Health Insurance Plan for South Africa.

Table 4 5 Public sector staff needs to meet international in-hospital benchmarks

	Staff actual (per Econex calculations)	Employed in public hospital	International benchmark (hospital)	Difference
Medical officer (GP)	8 027	6 075	11 427	5 352
Nurse	104 000	63 035	213 626	150 591
Medical specialist	4 026	4 202	3 846	n.a.

Source: Econex. Van der Berg, S. et al. 2010. Financial Implications of a National Health Insurance Plan for South Africa.

The WHO stated that countries with fewer than 230 doctors, nurses and midwives per 100 000 population generally fail to achieve adequate coverage rates of care to attain the health-related MDGs. Those goals relate to reducing child mortality, improving maternal health and combating HIV/AIDS and other diseases⁴³⁹. If South Africa's situation in the Public Service is compared to this benchmark, we fall short: in 2012 the public

439 World Health Organisation. 2006. The World Health Report 2006 - working together for health.

sector had only 181 doctors and professional nurses per 100 000 of the population that depends on public services⁴⁴⁰.

A recent comparison with peer countries shows that South Africa has significantly fewer health professionals per 10 000 population and also has poorer health outcomes. South Africa was compared with six peer countries with similar population

440 Calculated from Day, C. and Gray, A. 2013. "Health and Related Indicators" in South African Health Review 2012/13.

size, per capita gross domestic product (GDP), Gini co-efficient and GDP growth⁴⁴¹. Health outcomes were compared in terms of infant mortality rate per 1 000 live births and maternal mortality rate per 100 000 live births. The results are shown in Table 4 6.

441 GDP represents the total market value of all officially recognised goods and services produced in a country. The Gini coefficient is a statistical measure of income inequality.

Table 4 6 Comparative benchmarks for health staff per 10,000 population and health outcomes

Indicator	Peer countries						
	Brazil	Chile	Costa Rica	Colombia	Thailand	Argentina	South Africa
Population	193.7 m	17 m	4.6m	45.7 m	67.8m	40.3 m	49.3 m
GDP per capita(USD)	4,399	6,083	5,043	3,102	2,567	9,880	3,689
%GDP for health	9.05	8.18	10.47	6.42	4.31	9.53	8.51
GDP growth (% p.a.)	-0.64	-1.53	-1.50	0.83	-2.25	0.85	-1.78
GINI index	53.9	52.06	50.31	58.49	53.57	45.77	57.77
Staff per 10,000							
Doctors	17.31	15.71	20.42	19.43	8.72	31.96	5.43
Nurses	65.59	10.45	22.19	5.83	33.21	4.87	36.1
Pharmacists	5.81	3.72	5.34	0	2.92	5.08	2.29
Oral health	13.69	7.44	4.85	8.26	1.73	9.28	1.2
Total	102.39	37.32	52.8	33.52	46.59	51.19	45.02
Health outcomes							
IMR (per 1 000 live births)	17.3	7.0	9.6	16.2	12.0	13.0	43.1
MMR (per 100 000 live births)	75	18.2	26.7	75.6	12.2	40	165.5

Source: DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

South Africa has a nurse-based healthcare system, similar to Brazil and Thailand. On the other hand, Argentina and Colombia have doctor-based systems while the doctor/nurse balance in Chile and Costa Rica is more even. South Africa has notably fewer doctors, pharmacists and oral health professionals per 10 000 population than its peer countries. Although the ratio of nurses is higher than five peer countries (except for Brazil), the local infant mortality and maternal mortality rates are much worse.

According to the SAPC, South Africa had one pharmacist per 3 849 population in 2010, well below the WHO recommendation of one per 2 300 population⁴⁴². Health experts emphasise that health outcomes do not only depend on the numbers of available health professionals, but also on the competence, type of skills available and the overall management of the health system⁴⁴³. By 2010 the country required another 2 931 environmental health practitioners to meet the WHO international standard and 1 265 to meet the national norm⁴⁴⁴.

According to the DSD, South Africa falls below the international benchmarking norm for social workers of 1 per 5 000 population. Nationally the ratio is 5 446 persons per

social worker⁴⁴⁵. While the national norm may appear to be within reasonable range of the international norm, South Africa has a significant socio-economic and disease burden.

4.4 Future Demand

4.4.1 Skills development targets set by the Department of Health

In a strategy document entitled *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*, the national DoH set targets for the production and deployment of health professionals, practitioners and workers to ensure better access to services and to improve quality in the health system. The *HRH Strategy for the Health Sector: 2012/13 – 2016/17*, published in 2012, is an updated version of the initial policy document.

A workforce planning model was used to plan and forecast growth in human resources needs. Different scenarios with variable timelines, costs and outcomes were developed, but further work is needed before the model could be used to plan staff needs for the NHI. The DoH projects that it will be possible to close gaps in human resources over a period of 15 to 25 years at a constant annual GDP growth rate of 3.5% and an annual growth in personnel spending of 3% to 5%. The model incorporates seven key foundations to improve health outcomes.

These are: to deploy CHWs at community level; to grow nurse capacity and provide for a predominantly nurse-based health system; to plan for MLWs; to increase the number of general health professionals; to increase the number of selected specialist doctors; to increase the number of public health specialists; and to develop more academic clinicians. The model provides high-level projections for more than 100 registered health professions but excludes non-clinical professionals needed in the health sector – e.g. health economists, medical physicists and clinical engineers. The workforce planning model provides for changes in the production of health professionals at training institutions to remain consistent with workforce targets, and also projects the affordability of human resources targets based on public sector remuneration. The model is designed to accommodate inputs in respect of four discretionary policy areas⁴⁴⁶:

- The target minimum health professionals to population ratio for each critical profession;
- The required years to achieve the target;
- The plan to manage exits from the public health sector (due to retirement, death, emigration);
- The number of additional entrants required in the system over and above the maximum potential output of the educational system in South Africa.

442 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

443 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

444 DoH 2011. *National Environmental Health Policy*. Government Gazette No 34499. 3 August 2011.

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

446 DoH 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

Among the key targets set is to increase the ratio of medical practitioners in the public sector from the current 2.82 per 10 000 population to 3.66. The number of GPs in the public sector needs to increase from 13 829 in 2011 to 21 508 in 2025. Annual intake of GPs from training will grow from an estimated 1 394 in 2011 to 1 843 in 2025, while the intake of new medical students will have to grow by almost 60% from 2011 levels to 2 199 by 2025. Between 2011 and 2025, an additional 8 289 GPs will have to be sourced from the private sector or through foreign recruitment⁴⁴⁷.

447 DoH 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

The future demand for medical specialists in the public sector is particularly acute. Production of medical specialists will have to be more than doubled from 872 graduates in 2011 to 1 729 graduates in 2025. This target appears to be very ambitious, given that it takes 14 to 15 years to train a medical specialist. Over the period 2011 to 2025 another 9 202 medical specialists will have to be sourced from abroad and the private sector to meet public sector needs. The greatest demand exists in the specialist fields of anaesthesiology, medicine, obstetrics and gynaecology, family medicine, orthopaedics, paediatrics and sub-specialist areas of paediatrics, otorhinolaryngology,

diagnostic radiology, general surgery and neurosurgery⁴⁴⁸.

Based on the more conservative scenario employed to set human resources targets, the following needs gaps (shortages) in priority health professions and health occupations existed in 2011. In some fields the gaps are projected to continue into 2020 and 2025, even though education and training will be scaled up and professionals are to be sourced from elsewhere. The needs gaps projected by the DoH are summarised in Table 4 7 below.

448 DoH 2011. *Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17*.

Table 4 7 Summary of needs gaps in key health professions and occupations: 2011 to 2025

Profession or occupation	2011	2015	2020	2025
Staff nurse	19 805	15 380	8 990	1 357
Professional nurse	16 675	17 131	11 527	898
Professional nurse: PHC	4 270	4 128	2 404	16
Professional nurse: advanced midwife	1 407	863	371	No needs gap
Medical practitioner (GP)	4 294	3 800	2 109	525
Medical specialists	7 471	5 677	3 158	583
Emergency medical services practitioner	4 914	3 650	No needs gap	No needs gap
Medical technologist	3 984	No needs gap	No needs gap	No needs gap
Pharmacist	557	No needs gap	No needs gap	No needs gap
Pharmacy assistant post basic	8 288	3 513	No needs gap	No needs gap
Pharmacy assistant (basic)	1 365	552	No needs gap	No needs gap
Community health worker	14 651	14 279	3 006	No needs gap
Home-based care worker	9 655	9 874	2 079	No needs gap

Source: Summarised from *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

4.4.2 Other skills targets for health sector

In 2011 the SAPC set targets to increase the production of pharmacy human resources over a 20-year period. By 2010 the eight pharmacy schools produced an average of 476 pharmacy graduates per year, and to meet service demand, this must increase to 1 200 graduates⁴⁴⁹. To meet the WHO targets by 2030, South Africa will need to deploy 24 000 pharmacists and 72 000 pharmacy support personnel. Given that an average of 1 000 pharmacy support personnel are produced each year, another 1 500 MLWs must be added every year to reach a ratio of three support workers per pharmacist⁴⁵⁰. Several thousand current cadres of pharmacy assistants (basic and post-basic) have to be up-skilled to the new

449 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

450 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

categories of pharmacy technician and pharmacy technical assistant.

The DoH set a target to train 45 000 CHWs for PHC outreach teams over a period of five to eight years; i.e. between 2012 and 2019⁴⁵¹. According to the NDP, a total of 700 000 CHWs should be recruited, trained and deployed by 2030 to implement community-based healthcare services⁴⁵². It is estimated that between 9 000 to 12 000 emergency care workers will need training to qualify in the new mid-level categories of emergency care assistants and emergency care technicians⁴⁵³.

451 Interviews DoH in October and November 2012, and in July 2014.

452 National Planning Commission. 2012. *Summary of Objectives and Actions*.

453 Interviews DoH in October and November 2012.

4.4.3 Skills requirements in the social development sector

In 2007 Government acknowledged a critical need to accelerate the training of social workers at professional and auxiliary level in order to deliver socio-economic programmes⁴⁵⁴. A scholarship programme for undergraduate social work students was launched to boost professional development. To enable the state to meet the “demand for appropriate basic social welfare services”, the NDP sets a target to increase the supply of social services professionals to 55 000 in four occupational categories. These are: social work, auxiliary social work, community development, and child and youth care⁴⁵⁵. There is a dire need for male social professionals to work in traditional communities and to lead male-

454 Earle-Mallesson, N. 2008. “Social workers”. *Human Resources Development Review 2008: Education, Employment and Skills in South Africa*.

455 National Planning Commission. 2012. *Summary and key issues of the National Development Plan 2030*.

targeted youth development projects⁴⁵⁶. Given the shortage of social workers, it is not uncommon for NGOs and government to deploy SAWs “illegally” in service areas beyond their scope of practice⁴⁵⁷.

Demand also exists for specific skills sets. Role-players in the sector say that newly trained social workers are not ready for work and require skills to deal with the many complexities of working in a community context. These skills include: diversity and cultural awareness; facilitation skills in small and large groups; and building trust⁴⁵⁸. The DSD is calling for intensive “on-boarding” orientation programmes to enable new graduates to be work-ready- and productive professionals. Social workers also need more thorough occupation-specific training to conduct assessments (i.e. to correctly “diagnose” the problem); to understand the diverse intervention options; to select the appropriate route, and to evaluate its effectiveness⁴⁵⁹. Social work professionals also need postgraduate training to develop into well-rounded professionals who are able to provide a diverse range of social welfare services. Training at postgraduate level is needed to improve interventions in cases of substance abuse; victim empowerment; child abuse and exploitation, forensic social work (i.e. knowledge of the criminal justice system); probation work; adoptions and other emerging areas of specialisation. Training for social workers is also needed in trauma counselling-, mental health- and rehabilitation services. Social workers also require stronger generic skills to improve their office-bound duties.

The demand for skilled social work professionals to supervise, monitor and guide junior social workers, and oversee the work of SAWs, is acute, and particularly for technical- and occupational supervision of case management. According to the DSD, there is a real risk that social welfare services at district level could collapse without adequate technical supervision⁴⁶⁰.

Stakeholders are concerned about the

poor quality of training for SAWs who generally lack understanding about their roles and functions. Although many providers are skilled in social work, they are not necessarily skilled educators, and so SAWs have emerged from learning programmes with sub-standard skills. As a result, SAWs are often ill-prepared for the complexities of social assistance work. Workplace providers report that student SAWs often arrive unprepared for workplace training and present with inappropriate attitudes. In addition, many learners lack the ability to integrate theoretical and practical training⁴⁶¹. Many SAWs have poor communication skills and don’t speak English, and so NGOs find it challenging to deploy them. It is critical that SAWs be up-skilled to perform the statutory work entrusted to them, e.g. in certain areas of child care⁴⁶².

Caregivers need training to work with persons infected with and affected by HIV/AIDS, the elderly and persons with disabilities. In particular, caregivers need training in the rendering of psychosocial support to and supportive supervision of vulnerable children, as well as in cultural diversity⁴⁶³. The DSD estimates that 18 000 community caregivers “work for” NGOs and in the EPWP in the social sector. While their ranks must expand to reach more persons in need, present cadres need formal training at above basic literacy levels⁴⁶⁴. The ranks of the CCGs will soon be depleted as the DoH will draw upon those resources to train CHWs to render health promotion and prevention services in the ward-based PHC outreach teams⁴⁶⁵.

NGOs rely heavily on volunteers who are often illiterate or have low levels of basic education. Before these volunteers can work as functional units, they need training in areas such as life skills, basic hygiene, and risk behaviour and child abuse. The need for counselling skills in areas such as grief- and trauma counselling, and psychosocial support is also critical. Since NGOs report a high turnover of volunteers through illness and death, pregnancy and better employment opportunities, they have on-

going training needs⁴⁶⁶.

NGOs are very challenged to offer learnerships – they lack staff and resources to supervise learners and lack the resources required to manage the burden of paperwork associated with learnerships⁴⁶⁷. For the same reasons, NGOs are also challenged to provide adequate supervision to guide new social workers. Demand exists to strengthen the capacity of NGOs to supervise and train social workers⁴⁶⁸.

4.5 Demand for Skills Development Interventions by HWSETA

The recent HWSETA case study published by the HSRC highlights stakeholders’ views about the SETA’s role in skills formation⁴⁶⁹. As part of the process to develop this SSP, the HWSETA engaged with stakeholders in the health and social welfare sector to understand their needs for skills development. Many of the stakeholders asked the HWSETA to develop a better understanding of the sector itself. Further, a request was made that the skills developed match the skills demands of the labour market, entailing the SETA to be responsive to skills needed in the country and also in a specific community and market. Apart from the content of learning programmes, the manner that the SETA implements skills development is also important. It is evident from responses that stakeholders have expectations about the HWSETA’s role in the design, planning, and management of learnerships and skills programmes.

4.5.1 Expectations about learnerships and skills programmes

Stakeholders expect that skills programmes and learnerships should facilitate a smooth transition into the health and social development sectors. Theoretical learning and the structured workplace experience must be linked in such a way that learners acquire the appropriate knowledge, skills and competencies and enter employment.

456 Personal interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSAs).

457 Interviews with experts in social services professions held in June-July 2014; Schmid, J. 2012. Trends in South African Child Welfare Reform.

458 Personal interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSAs).

459 Personal interviews with DSD: Directorate Service Standards, October 2012.

460 Interviews with the DSD and experts in social services professions held in October 2012 and June-July 2014.

461 Interviews with experts in social services professions and NGOs held in June-July 2014.

462 Interviews with experts in social services professions and NGOs held in June-July 2014.

463 Interviews held in October 2012 with NGOs and DSD; Interviews held with nursing academics and NGOs in July 2014.

464 Interviews held with DSD: Directorate Community Caregivers HIV/AIDS, October 2012 and July 2014.

465 Interview with DoH held in July 2014.

466 Interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSAs).

467 Interviews held with Family Life (division of FAMSAs) and Child Welfare SA in October 2012.

468 Interviews with NGOs held in October 2012 and July 2014.

469 Wildschut, A. 2012. “HWSETA Case Study 2011: Skills development for the Health and Social Development Sectors”. Assessing the impact of learnerships and apprenticeships under NSDS II.

Learnerships should be developed to provide a structured and clear career pathway with relevant exit points to enter employment. These elements are important and impact directly on the commitment of employers and the ability of training providers to guarantee employment for the learners. SETAs are also expected to provide more clarity about what the qualifications entail and what learners will be able to do upon attaining them.

In an effort to improve health services, the DoH requested that all new qualifications should contain a module on core service standards that address matters such as patients' rights and safety; hygiene, cleanliness and infection control; and staff values and attitudes. The DoH also identified the need for learners to attain the new qualification of Diploma in Forensic Pathology via a learnership. Provincial health departments, the HPCSA and biomedical science academics confirmed that the HWSETA should continue to support the learnership for radiography. The need for new learnerships in the form of bridging courses in the fields of pharmacy and nursing was identified to transition the current MLWs to the new qualifications – e.g. enrolled nurses to the new registered staff nurse category⁴⁷⁰, and pharmacy assistants to pharmacy technicians. Learnerships aligned to the new mid-level qualifications in emergency care are needed, esp. for emergency care technicians⁴⁷¹. According to the HPCSA, more dental assistants must be trained and a learnership at NQF level 5 should be developed.

The social development sector identified the need for accessible training programmes with a stronger rural perspective. It was suggested that the HWSETA enter into partnerships with NGOs and TVET colleges to facilitate access to such programmes. Concerns were raised that the registration period for unit standards and qualifications was too short and that frequent changes had significant costs implications. Role-players in the social welfare field called for the development of new learnerships for caregiving, substance abuse and family

preservation for families in crisis.

The HWSETA was asked to support skills programmes for social workers and CYCWs. Technical skills of social workers must be improved in the recognised specialisation areas, as well as in forensic-, clinical-, and school social work; management and supervision; social policy and planning; mental health and drug abuse; social work in education; and social work in healthcare. Social workers' skills in report-writing, minute-taking and drafting of legal documents must be developed, as their work is used in court processes⁴⁷². Skills programmes for CYC should address supervision; administration and management; youth justice and probation; advanced behavioural management; and communication⁴⁷³. Better-trained ECD practitioners are needed to work with pre-school children aged 3 to 5 years. A qualification (at NQF 6 or 7) which is linked to a learnership should be developed, and the SETA should also support skills development in child behaviour and psychosocial support.

Caregivers who work with older persons must be trained in the statutory standards of care for older persons, geriatric care, cultural diversity and caring for persons with dementia⁴⁷⁴. The skills base of CCGs providing home-based care should also be developed.

According to the DSD, skills development for CDPs and CDWs should address occupation-specific areas, including social research; project management; financial management and corporate governance; youth development; community facilitation; and facilitation skills to build capacity in CBOs.

4.5.2 Expanded provision for workplace training

Stakeholders in the social welfare sector emphasised the need to expand the ranks of accredited workplace providers to facilitate experiential training and work-integrated learning. TVET colleges require the capacity to provide practical training for SAWs. There are concerns that the majority of providers are accredited to train in soft skills, yet the real skills development needs are in occupational-specific fields. SAWs also

require more supportive supervision in the workplace to develop their skills.

The ranks of assessors and moderators for occupational-specific training should broaden. Accredited providers are challenged to find qualified assessors and moderators for SAW learning programmes. Requests were put that the HWSETA should permit academics and experienced practitioners to serve as assessors and moderators, even if they have not completed the SETA-approved courses⁴⁷⁵.

Respondents asked that NGOs be enabled to provide work-integrated learning in the fields of ECD, nursing, CYC and social work. It was suggested that the HWSETA to enter into partnerships with NGOs to give social work students access to relevant practical training in the workplace. Since NGOs often lack capacity to supervise interns (and thus do not meet criteria for workplace providers), the SETA could provide funding to appoint experienced external practice supervisors to monitor the students'.

In the health sector, the SAPC requested the HWSETA to assist with resources to strengthen the internship programmes for pharmacists and pharmacy support personnel. The HPCSA emphasised that all the health professions require funding for clinical training in the workplace. A specific request was made that the HWSETA grow the capacity of supervisors and mentors at places of clinical training, as these practitioners are so over-worked and have limited time to guide trainees.

4.5.3 Quality assurance functions

Several stakeholders requested the HWSETA to strengthen quality assurance functions to monitor training providers, training facilities and curricula. There are concerns that delays in evaluating training programmes hamper skills development. It was suggested that the HWSETA should be more proactive in monitoring social development programmes offered at TVET colleges, and in particular, improve quality assurance in the training of SAWs. Many stakeholders are concerned that SAWs are so poorly skilled that they are neither able to assist social workers with basic administrative tasks nor able to complete documents required for social grant applications.

Stakeholders called for more effective and more regular monitoring and evaluation of

470 The enrolled nurse category will not be accommodated in the new nursing qualifications framework. Enrolled nurses work under supervision and are not regulated by a scope of practice. Registered staff nurses will adhere to a prescribed scope of practice. Skills programmes or a learnership should be developed to bridge the current contingent of enrolled nurses into the new category of registered staff nurse. (Interviews with nurse educators in July 2014).

471 Interviews with DoH, July 2014

472 Interviews with NGOs and SACSSP in July 2014.

473 Interviews with the PBSW and PBCYC of the SACSSP in July 2014.

474 Interviews with NGOs and academics in the nursing field in July 2014.

475 Interview with PBSW of SACSSP in July 2014.

experiential learning to ensure that learners receive the appropriate workplace training. They highlighted the need to improve the HWSETA's processes and timeframes to verify learnership qualification results and to issue certificates to learners so that they may secure employment. Respondents called for more direct HWSETA support to capacitate and support training providers to meet quality standards and to make provision for learners who complete accredited programmes, but are denied certificates due to non-compliance by providers.

4.5.4 Service delivery and responsiveness

The HSRC impact study identified the need for the HWSETA to work with all role-players to improve provider capacity, to support training and to remove obstacles to skills development. More particularly, employers and providers of experiential training expect SETAs to be responsive and participate in the implementation of learnerships⁴⁷⁶. In interviews conducted for this SSP, role-players called on the HWSETA to streamline, improve and simplify internal processes in order to speed up the registration of learners and to release funding more timely. All the stakeholders require pro-active communication and a facilitative approach from the HWSETA.

Of particular concern was that the HWSETA should be more accessible to and supportive of the NGO sector where many social work students are trained and the bulk of welfare services are rendered – often in a hostile and very under-resourced environment. There are specific calls for the HWSETA to enable NGOs to deliver accredited skills programmes and become accredited workplace providers.

Another area of concern relates to the quality of information provided by public sector employers in WSPs about occupational-specific skills needed. The main focus appears to fall on generic type skills. It was suggested that the HWSETA could amend the reporting format of its WSP to extract more information on training needs related to specific occupational areas.

476 Wildschut, A. 2012. "HWSETA Case Study 2011: Skills development for the Health and Social Development Sectors". Assessing the impact of learnerships and apprenticeships under NSDSII.

4.5.5 Skills development priorities identified by HWSETA stakeholders

a) Health sector

Health sector stakeholders identified the shortage of nursing skills, particularly specialist nurses, as the most critical skills development priority. One health sector expert described the immediate shortage of nurses as "acute and alarming". Respondents asked the HWSETA to expand the scope of specialist nursing fields targeted for skills development and to provide funding for all specialist areas. The most pressing needs appeared to be for advanced midwifery, midwifery, child care, advanced psychiatry and PHC while post-basic/specialist nursing skills are also needed in neonatology, operating theatre, critical care, trauma care, psychiatry, paediatrics, orthopaedic, oncology, ophthalmology and nephrology. In future specialist nurses will need to complete a postgraduate diploma in a specialist field of nursing (after attaining a professional degree)⁴⁷⁷. The DoH requires professional nurses trained in maternal- and child health to serve as PHC outreach team leaders for 7 500 PHC teams. SETA funding for CDP for nurses and nurse educators is also required. In future nursing practice will be enabled by ICT and many nurses require training to develop computer skills and apply electronic tools.

Respondents from provincial health departments affirmed the on-going need for HWSETA funding in the bridging course that enables enrolled nurses to qualify as registered nurses (general)⁴⁷⁸, while more enrolled nurses and enrolled nursing auxiliaries should be trained for rural health facilities. However, the HWSETA takes note that some of these legacy qualifications will be phased out by the SANC from 2016 onwards, including the categories of enrolled nurses and registered nurse (general)⁴⁷⁹.

The DoH identified the need to develop nurse managers who are trained in multi-

477 DoH. 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17; Interviews with academics in the nursing field in July 2014.*

478 It should be noted that the bridging course equips learners with general nursing skills and unlike the comprehensively trained nurse, these learners are not trained in midwifery, community nursing and psychiatric nursing.

479 DoH. 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17; Interviews with academics in the nursing field in July 2014.*

and inter-disciplinary skills for all levels of the health system⁴⁸⁰.

Given the scope of training needed in the new pharmacy qualifications which are set in the HE band, the SAPC requested the HWSETA to enable current pharmacy MLWs to meet the requirements of the new occupations of pharmacy technician and pharmacy technical assistant via bridging programmes.

Private and public sector respondents identified the need for more MLWs and the development of more qualifications for MLWs. Clinical associates are needed in district hospitals and the HWSETA is specifically requested to make available bursaries for this purpose. Further, officers responsible for human resources planning in the public sector indicated the need for MLWs in the categories of physiotherapy-, occupational therapy-, rehabilitation-, speech therapy-, ophthalmology-, nutrition-, mental health- and dental assistant, as well as for forensic pathology- and radiation technicians. The need for rehabilitation assistants trained in palliative care was emphasised.

Emergency care workers need to be up-skilled to meet the higher education standards set in the new qualification framework. Emergency care colleges and their educators require support to build the required capacity to offer training programmes set in the higher education band⁴⁸¹. Several of the provinces asked that appropriate learnerships be developed for CHWs to qualify them to provide a complete range of PHC services.

As discussed in paragraph 3.14 changes to core competencies required of health practitioners highlight the need for new learning models and clinical training platforms. There are specific requests that the HWSETA provide strategic funds to enable health academics and educators to align curricula with the revised core competencies and to research how new rural training platforms should be planned. Funding is also needed to support health academics to nurture new skills sets to teach across the revised core competencies and on expanded clinical platforms. The need to develop more health educators and preceptors, especially in the nursing field is particularly acute as nursing education

480 DoH 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.*

481 Interviews with DoH and HPCSA in July 2014.

will be set in higher education. As a minimum, nurse educators will require a Master's Degree in nursing (NQF 9) to train undergraduates and the HWSETA is requested to provide bursaries to nurse educators for postgraduate studies⁴⁸². Future SANC requirements for registration as a nurse educator will include competence in a clinical speciality, teaching, learning and research methodologies, learner supervision and assessment methods, as well as knowledge of technology in education⁴⁸³. Funding is also required for assessor and moderator courses for healthcare educators in both the public and private sectors.

Respondents from the public, private and NGO sectors identified the need for more allied health professionals (such as occupational therapists, physiotherapists, nutritionists, speech therapists, orthotists/prosthetists, psychologists, phlebotomists, perfusionists, radiographers, medical coders and neurophysiologists). According to the HPCSA, there is a large demand for rehabilitation professionals at district level. With greater importance being placed on health promotion, there is a need to train health promotion officers and to re-orient all other categories of health workers who have largely been trained from a curative perspective.

A number of respondents identified the need for forensic skills. Health professionals who work with medico-legal cases (e.g. patients injured by assault, abuse, rape, violence and other trauma) require skills to manage the legal requirements attached to managing those patients and to give evidence in court. In particular, there is a need for specialist forensic nurses and forensic pathology officers.

Scholarships are needed to enable rural students to qualify as health professionals, and the funding conditions should re-connect the students back to rural communities once they complete their studies.

Respondents from the private and public sectors warned that the HWSETA should not only allocate funding to employees in the clinical health fields. More clinical engineers, hospital engineers and biomedical equipment technicians are

needed to maintain and repair medical-, diagnostic -, sterilising-, and laboratory equipment, as well as medical monitors. Artisans (electricians, plumbers and welders) are needed for deployment in both the private and public health sectors.

A vast number of managers in the public health system lack core management skills in areas such as performance management, resource utilisation, managing facilities, financial management, procurement and accountability (including the ability to hold staff accountable). The need for health management skills to provide functional services across all levels of facilities remains urgent. This need also applies to the smallest health facilities and clinics – e.g. if a nurse is promoted to head a clinic, she requires new skills to manage staff, resources, service quality and performance.

Health management training should develop a range of management skills and enable the development of management capacity. Programmes should be pitched at postgraduate level with strong practical components in the form of problem-based learning and case studies. There is a specific need to address problem-solving skills, effective communication, and capacity development and to provide for mentoring. Management development training should provide for sustained maintenance interventions through mentoring and peer support long after the formal coursework is completed. The private sector identified the need to develop more hospital managers while the heads of hospital units require stronger financial skills.

b) Social development sector

For stakeholders in the social development sector, the most pressing skills development need is for supervision training of social workers. Social workers also require occupation-specific training to supervise and guide lesser experienced colleagues and SAWs. Respondents identified multiple skills development needs for social workers and these are outlined in paragraph 4.4.3. It was suggested that the HWSETA should provide bursary funding for postgraduate studies in social work.

Another priority is improving the skills base of SAWs. These cadres need training to be functional support workers for the tasks at hand and require generic skills in networking, office administration, computer work, and making and managing

enquiries on behalf of social workers. Stakeholders also requested the HWSETA to provide funding for interventions aimed at improving professionalism and service delivery in the social welfare sector. It was stressed that intensive, on-going CPD and training is needed to strengthen core competencies and maintain professional skills.

HWSETA initiatives in the field of child and youth care, as well as community development should aim to up-skill the current workforce and to support training against the new qualifications frameworks. Assessors and moderators will require training to evaluate the RPL applications submitted for professional registration in the field of child and youth care. The need for specific skills programmes in the community development field was outlined in paragraph 4.5.1.

More funding should be provided towards organisational development of NGOs to strengthen governance, financial management, bookkeeping, project management, human resource management and monitoring and evaluation. Training is needed for the local management and volunteer committees of NGOs, esp. in rural areas, and should address the statutory obligations of NGOs as managers may be held legally responsible for the actions and failures of volunteers and staff⁴⁸⁴.

c) Animal health sector

Respondents requested the HWSETA to support CPD training for all the veterinary and para-veterinary professions. The sector is also challenged to find placements for students in clinical skills training and work-integrated learning and HWSETA funding is needed to facilitate more practical learning opportunities for all the professional categories. HWSETA funding is needed to expand the ranks of veterinary technologists and animal health technicians. The SETA should support training interventions to make primary animal healthcare services available to more small scale livestock owners. Veterinarians in private practice need to be trained to perform regulatory work for the state and HWSETA funding should be made available for this purpose. Newly qualified veterinarians in community service will need adequate supervision and mentoring to strengthen their technical and professional skills. The HWSETA should make funding available for such

⁴⁸² Interviews with academics in nursing field in July 2014; DoH 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17*.

⁴⁸³ DoH 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17*.

⁴⁸⁴ Interviews with NGOs held in July 2014.

supervised training. Veterinary support staff in private practices also needs training in animal handling, electronic ICT, and office administration.

4.5.6 HWSETA funding model

Respondents in the public and private sector requested the HWSETA to review its funding model and to align funding more closely to the actual costs of training. Learnership funding only covers a portion of the actual training costs. In the past NGOs (i.e. non-profit entities with pressing budget constraints) have been required to co-finance large amounts so that learners could complete training.

4.5.7 Research and innovation needs

Stakeholders were asked to identify areas pertaining to skills planning that require specific research. It appears that most of the research areas identified would be better served by national government departments or one of the professional councils. The following areas for research were mentioned:

- The impact of skills programmes and learnerships on learners and communities served by those trained;
- The role of MLWs, and to understand areas where they may be deployed as well as practices concerning MLWs in other countries;
- The need for new qualifications and learnerships for the sector;
- Assessing how the HWSETA could contribute to building a rural clinical platform for training of health professionals;
- Assessing how the HWETA can contribute to skills development as part of larger initiatives driven by provincial health departments or the DoH; and
- Assessing how the HWSETA could enter into social compacts (with provincial governments, traditional leaders, local communities, trade unions, development agencies and NGOs) in rural provinces to develop rural-based skills.

One respondent said that the HWSETA should be the central repository of information for the sector and must be able to access academic and postgraduate research relevant to the sector.

4.6 Factors That Impact on the Demand for Healthcare Workers

In Chapter 3 several changes and challenges were discussed that will have an impact on the number of healthcare workers needed in the country, the occupational mix needed, and the actual skills required of people within specific occupations. The most important of these are summarised below:

4.6.1 HIV/AIDS treatment policies

Expanding the access to ART to 5.1 million patients by 2018/19 will impact largely on the health workforce at the district level. Patients will have to be introduced to ART, advised of the risks of non-compliance with the treatment regime, followed up for risks, and monitored for side-effects. Given the shortage of doctors, the bulk of the work is expected to shift to nurses – a professional group already in short supply in the public sector. This may necessitate changes to the regulatory frameworks governing the nursing profession, as nurses may be required to prescribe ART and medication on the essential drug list for PHC services⁴⁸⁵. Because the delivery of ART is regarded as a complex health intervention, nurses will require additional training in this area. Doctors and experienced PHC-trained nurses will be needed to support the front-line nurses and to accept referral of more complex cases⁴⁸⁶. As more medication will be dispensed to patients requiring daily life-long care, the ranks of pharmacists (and pharmacy support staff) in the public sector will require strengthening.

Research has shown that expansion of ART will increase the number of patients who develop complications from ART-drug toxicity, side effects, opportunistic infections, and syndromes of the immune system. This will potentially increase the demand for specialist medical care at secondary-level hospitals⁴⁸⁷. Plans to improve the nutritional status of HIV- and TB-infected persons by providing access

485 Colvin, C. J., Fairall, L., Lewin, S. et al. 2010. "Expanding access to ART in South Africa: the role of nurse initiated treatment". *South African Medical Journal*. April 2010; Interview with academic in nursing field in July 2014.

486 Colvin, C. J., Fairall, L., Lewin, S. et al. 2010. "Expanding access to ART in South Africa: the role of nurse initiated treatment". *South African Medical Journal*. April 2010.

487 Kevany, S. Meintjes, G. et al. 2009. "Clinical and financial burdens of secondary level care in a public sector antiretroviral roll-out setting (GF Jooste Hospital)". *South African Medical Journal*. August 2009.

to nutritional services at PHC facilities will drive the demand for dieticians and nutritionists⁴⁸⁸.

4.6.2 Policies to control tuberculosis

Preventing the development of MDR-TB and XDR-TB requires a heightened response from nursing professionals to detect signs of these diseases and from medical practitioners to correctly diagnose patients at an earlier stage⁴⁸⁹. More appropriately trained professional nurses and doctors are required at district level to ensure that more patients are screened sooner and adhere to treatment. Health workers experience a high TB infection rate themselves, are six times more likely to develop drug-resistant TB, and may inadvertently be spreading the disease⁴⁹⁰. To combat the risk of infection, mid-level skills in infection control are needed⁴⁹¹. Broad-based training in infection control is needed for the workforce in the health sector⁴⁹². In addition, more lower-level health workers are needed to monitor patient adherence to treatment regimes, and to increase treatment completion rates.

4.6.3 Maternal, child and women's health programmes

The provision of universal access to reproductive health services is a key national goal⁴⁹³. The programme to improve the health of mothers, children and women targets the coverage and quality of care of mothers, babies and children in the antenatal-, post-natal- and ECD stages. Specialised skills are needed. Education and training for midwives must be stepped up, while doctors and midwives need to be trained in the management of obstetric

488 DoH. 2012. *Annual Performance Plan 2012/13–2014/15*.

489 Harrison, D. 2009. *An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*.

490 Adams, S., Ehrlich, R. et al. 2013. "Occupational Health Challenges Facing the Department of Health: Protecting employees against tuberculosis and caring for former mineworkers with occupational health disease". *South African Health Review 2012/13*. Jordan, B. 2010. "Health workers besieged with drug-resistant TB". *Sunday Times*, 12 Sept 2010.

491 DoH. 2010. *National Department of Health Strategic Plan 2010/11-2012/13*.

492 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" *South African Health Review 2010*.

493 DoH. 2012. *South Africa's national strategic plan for a campaign on accelerated reduction of maternal and child mortality in Africa (CARMMA)*. Published at <http://www.doh.gov.za/docs/...pdf>. (Accessed 11 July 2013).

emergencies⁴⁹⁴. According to stakeholders in the health sector, the need for skills in midwifery and advanced midwifery (which includes neonatology) is particularly acute. The shortage is related to structural factors: many universities no longer offer the comprehensive four-year degree programme while the private sector does not offer training leading to the comprehensive qualification in nursing⁴⁹⁵.

The expansion of HIV-testing to all pregnant women, drive the demand for nurses and counselling skills. Measures to prevent, monitor and manage birth defects depend on skilled nurses and medical practitioners trained in human genetics care. PHC facilities will need health professionals who are trained in the integrated management of childhood illnesses⁴⁹⁶. At the tertiary level of care, the demand for nursing skills in neonatal care and intensive care is high⁴⁹⁷.

4.6.4 Skills requirements for the NHI and new health service policies

The successful introduction of the NHI will require the overhaul of present service delivery structures, administrative and management systems, for which skills and motivated health workers are needed⁴⁹⁸.

a) Re-engineering of primary healthcare

Demand for skills to provide services in the re-engineered PHC model spans many professions, occupations and skills sets. Public health academics indicate that a PHC clinic serving a population of 10 000 people should comprise a multi-disciplinary team consisting of a doctor (who visits regularly), four to eight nurses (comprising a clinical nurse practitioner, professional nurses, enrolled nurses and enrolled nursing assistants), several CHWs, and a

MLW such as a pharmacy technician⁴⁹⁹. The DoH envisages that PHC outreach teams will each serve 1 500 families. Each team will include a professional nurse, registered staff nurse, an enrolled nursing assistant, six CHWs, a PHC nurse practitioner, an EHP and a part-time doctor⁵⁰⁰. The DoH also intends to increase the number of ward-based PHC outreach teams from 54 in 2012 to 2 000 teams by 2015⁵⁰¹, and ultimately to 7 500⁵⁰². Expansion of school health services requires the skills of post-basic nurses to provide health education, impart life skills, screen children for diseases, disabilities and immunisation status, and other healthcare needs.

More pharmacists and MLWs are needed to manage medicines in the PHC system for home-based care, clinics and other health centres⁵⁰³. According to the SAPC, almost 10 000 pharmacy assistants must be up-skilled to the new mid-level qualifications of pharmacy technical assistant (NQF 5) and pharmacy technician (NQF 6). Authorised pharmacist prescribers, a new professional category, must also be trained to strengthen the provision of medication prescription services at PHC level.

Additional emergency care workers will be needed to transfer patients to higher levels of clinical care (e.g. from homes or clinics to hospitals) and the current workforce must be skilled under the revised scopes of practice, and attain the new higher level qualifications, referred to in paragraph 3.15

The DoH aims to reduce obesity and to screen and counsel five to ten million patients for high blood pressure and raised blood glucose levels by 2018/19⁵⁰⁴. Strategies to manage non-communicable diseases are driving the need for nurses, specialist nurses, CHWs, dieticians and nutritionists⁵⁰⁵.

b) A tiered hospital system

District hospitals will need medical specialists and nurses in general surgery, obstetrics and gynaecology, paediatrics and family medicine, PHC and trauma- and emergency care; occupational therapists and physiotherapists for rehabilitation services; and laboratory technicians. Specific training is required to re-orientate clinicians to deliver services in a community setting rather than a hospital-oriented setting and to work in teams where task shifting will take place to MLWs and CHWs. Clinical associates are needed to reduce the workload of medical doctors and to assist doctors with basic procedures. The DoH estimates that 1 350 clinical associates are needed in the public sector⁵⁰⁶.

Skills needed at regional hospitals span the aforementioned categories, as well as specialist medical skills in orthopaedics, psychiatry, radiology and anaesthetics⁵⁰⁷. The DoH aims to deploy district specialist teams in 20 out of a possible 52 districts by 2013/14⁵⁰⁸. Highly specialised medical-, nursing- and therapeutic skills will be needed at tertiary and central hospitals where specialist care will be delivered. Skills shortages in the medical specialist fields of histopathology, cytology, anaesthetics and forensic medicine are also acute⁵⁰⁹.

c) Managing the health system

In the public sector and in the district health system in particular, leadership skills, professional management skills and supervision skills are required for managing complex systems and improving operational efficiency⁵¹⁰. Management capacity of hospital managers is of particular concern as they manage large budgets and complex environments. Skills development is required to improve bidding processes for financial resources, purchasing mechanisms

494 DoH. 2012. *South Africa's national strategic plan for a campaign on accelerated reduction of maternal and child mortality in Africa (CARMMA)*.

495 Wildschut, A. 2012. "HWSETA Case Study 2011: Skills development for the Health and Social Development Sectors". *Assessing the impact of learnerships and apprenticeships under NSDSII; Interviews with stakeholders in October 2012*.

496 DoH. 2010. *National Department of Health Strategic Plan 2010/11-2012/13*.

497 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". *South African Medical Journal*. Aug 2009. 99 (8).

498 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months". *South African Health Review 2012/13*; Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance". *South African Health Review 2010*.

499 Lloyd, B., Sanders, D. and Lehmann, U. 2010.

"Human resource requirements for National Health Insurance". *South African Health Review 2010*.

500 DoH. 2013. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17; Interviews with DoH in July 2014*.

501 DoH. 2014. *Strategic Plan 2014/15-2018/19*; DoH.

2012. *Annual Performance Plan 2012/13 – 2014/15*.

502 Interview with DoH in July 2014.

503 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; Interview with SAPC in October 2012*.

504 DoH. 2014. *Strategic Plan 2014/15-2018/19*.

505 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

506 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*.

507 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months". *South African Health Review 2012/13*; DoH. 2011. *National Health Insurance in South Africa: Policy Paper*.

508 DoH 2012. *Annual Performance Plan 2012/13 – 2014/15*.

509 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". *South African Health Review 2010*.

510 Crisp, N. 2011. "Some management challenges in the health sector". *ERSA Symposium on health reform, Stellenbosch; Coovadia, H., Jewkes, R., Barron, P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet*. Sept 2009.*

and supply chain⁵¹¹, while skills are also needed in clinical supervision.

Problem-solving skills at all levels are severely under-developed⁵¹². Skills in the planning and implementation of programmes, as well as in the monitoring and evaluation of service and quality of care, are required to strengthen management of health operations. On the people side, skills are needed in the management of human resources and their performance. More particularly, managers require skills to lead and guide subordinates, improve their productivity, and instil accountability for service to patients. Other areas for managerial development include IT, finance for non-financial managers, planning and time utilisation and financial- and capital-resources management⁵¹³. A need exists to improve the stewardship, governance and monitoring capacity in national and provincial departments of health to leverage improved performance at hospital level⁵¹⁴. Soft skills development is needed to improve the attitudes of health staff and to nurture an appropriate, caring attitude⁵¹⁵.

Changes to the delivery of public health services also drive the demand for public health specialists and public health professionals who work to prevent disease and promote healthy behaviour. Public health specialists also develop and implement health policy; monitor and evaluate services; and control diseases; and manage health programmes⁵¹⁶.

d) Quality assurance measures

Considerable expertise and skills will be required in the Office of Healthcare Standards Compliance to conduct the accreditation of hospitals, clinics and medical practices and to monitor whether the facilities continue to adhere

511 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". *South African Health Review 2010*; Naledi, T., Barron, P. et al. 2011. "Primary Health Care in SA since 1994 and implications of the new vision for PHC re-engineering". *South African Health Review 2011*.

512 Interviews with stakeholders in October 2012.

513 Harrison, D. 2009. *An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*; Chopra, M., Lawn, J.E., Sanders, D. et al. 2009. "Achieving the health Millennium Development Goals for South Africa: challenges and priorities". *Lancet*. Sept 2009.

514 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". *South African Health Review 2010*.

515 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". *South African Health Review 2010*.

516 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13–2016/17*.

to prescribed standards⁵¹⁷. Managers of hospitals and healthcare facilities will require training in the scope and application of the national core standards for health establishments. All health professionals and managers in a clinical environment will require skills in the use of the treatment guidelines and protocols that will be introduced. Managers of healthcare facilities at provincial- and national level will also require training in quality assurance processes and the standards to be used to certify and accredit facilities.

e) Changes in healthcare service delivery

Currently there is no clarity about the basic package of healthcare, the referral system, or the treatment to be offered at secondary and tertiary levels of the proposed NHI scheme. Neither have the responsibilities of the family health teams, school teams and PHC agents in municipal wards been defined. The Green Paper proposals have also been subjected to further examination, and the final policy document may adopt a different approach. Much work must still be done by the various professional councils to review the scope of work for professional categories while curricula will also be revised. Even though much preparatory work is still required before the NHI will be implemented, it is an area that needs to be closely monitored and incorporated in future updates of the SSP.

f) Overview of skills needed for NHI

According to the DoH and key stakeholders with whom the HWSETA engaged to prepare this SSP, skills development is required in the following areas:

- a) CHWs require a common set of core competencies to deliver preventive and promotive healthcare in the areas of maternal, child and women's health and basic household and community hygiene. An estimated 45 000 CHWs are needed to staff PHC teams⁵¹⁸;
- b) With respect to nursing professionals and nursing practitioners there is a need to:
 - Expand the number of professional nurses and increase their clinical competencies in accordance with a revised scope of work;

517 Ramjee, S. and McLeod, H. 2010. "Private sector perspectives on National Health Insurance" *South African Health Review 2010*.

518 DoH. 2012. *Annual Performance Plan 2012/13 – 2014/15*.

- Train professional nurses to manage nursing care in all levels of hospitals and in PHC services as well as to supervise community services;
- Train professional nurses at post-basic level in specialist areas of PHC, advanced midwifery, paediatrics, intensive care, integrated management of childhood illnesses, critical care, operating theatre, ophthalmology, and psychiatry;
- Convert the bulk of enrolled nurses to the registered staff nurse category aligned to the revised scope of work, and to increase their community-based clinical competencies to work with CHWs in district teams.

c) Introducing and significantly expanding MLWs in the following categories:

- Clinical associates to share or take-over some tasks performed by medical doctors;
- Advanced pharmacy assistants must be trained as pharmacy technicians and pharmacy technical assistants to acquire competencies to manage medicines and pharmaceutical products in district facilities and PHC services;
- Rehabilitation assistants are needed to support occupational therapists and physiotherapists;
- Forensic pathology officers to work at crime scenes and assist pathologists; and
- Emergency care assistants, dental assistants, nutrition assistants, ophthalmic assistants and mental health assistants are needed.

d) The ranks of GPs at PHC- and hospital levels must be expanded, as well as those of generalist health professionals such as pharmacists, physiotherapists and dieticians.

e) Planned expansion for specialist doctors in prioritised areas such as anaesthesiology, critical care, community health, dermatology, diagnostic radiology, emergency medicine, medicine, geriatric medicine, family medicine, neurosurgery, obstetrics and gynaecology, occupational health, oncology, orthopaedics, otorhinolaryngology, paediatrics, pathology (in all areas of specialisation), psychiatry, surgery and urology.

- f) Public health specialists and public health professionals are needed to lead public health policy and monitor public health strategy
- g) Leadership and management skills must be improved at all levels of the public health system.
- h) Academic clinicians are required in all disciplines to support and expand the platform for health professional development, as well as educators in the fields of nursing and emergency care.

A need also exists to train non-clinical professionals for the health sector such as health economists, health actuaries, clinical engineers, data capturers, data analysts, biostatisticians, epidemiologists, information technology professionals, medical physicists, and medical scientists⁵¹⁹.

4.6.5 Expansion of the public health infrastructure

It is anticipated that health information systems in the public sector will be upgraded in the next five years to support decision making, budgeting, monitoring and evaluation of performance⁵²⁰. Such a national health information management system will have to be supported by a range of information technology professionals, analysts and data capturers. Major training interventions may be required to facilitate effective application and use of such new systems, as well as the tools to extract and analyse data. The current public hospital revitalisation programme will increase the number of usable beds, leading to an increase in demand for health professionals and support staff.

4.6.6 Social development legislation

A new generation of social development legislation prescribes the types of services that need to be available for communities and families and at institutions of care or residential facilities⁵²¹. Legislation such as the Children's Act, 2005 and

the Older Person's Act, 2006 promote the holistic development of children and the delivery of integrated services to the elderly. Statutory provisions for the referral and care of children and older persons drive the demand for healthcare professionals such as nurses, occupational therapists, physiotherapists, psychologists, and psychiatrists⁵²². For example, care services for the elderly must recognise their multi-dimensional needs and ensure their rehabilitation so as to enable them to reach and maintain their optimum levels of physical-, sensory-, intellectual-, psychiatric and social functioning⁵²³. NGOs that serve the older persons highlight the need for these professional skills. The skills of carers employed at homes for the disabled and elderly must also be developed⁵²⁴.

4.7 Factors That Impact on the Demand for Social Development Workers

It is evident from the discussion in Chapter 3 that the country has huge demands for social and developmental services. Typically social workers work with other professionals and occupational groups and community members to provide a range of protective, preventive and developmental services to children and families, and help them to improve their social functioning. In the past social work was declared a critical skill by Government, but the decision was revised during 2014⁵²⁵. The SACSSP made representations to Government to review the scarce skills list and contends that the shortage of social workers remains acute. Occupational skills and the blend of skills required for social development services are summarised below.

4.7.1 Socio-economic development policies

Policy objectives to fight poverty, unemployment, HIV/AIDS, substance abuse and social crime and to develop families and communities drive the demand for social development workers. Capacity problems to implement these policies have endured for several years. Recently government has introduced more legislative

measures and stepped up the delivery of social services. Demand for such services is almost overwhelming and the available human resources are unable to cope⁵²⁶. As indicated in paragraph 4.4.3, the NDP targets the development of 55 000 social services professionals in social work, CYC and community development to meet the demand for basic social welfare services.

South Africa's social development system is based on a statutory model of protecting and promoting human rights. The model requires social services professionals to make micro-interventions at individual and family level and this is demanding in terms of human resources, skills and budgets⁵²⁷. The DSD will introduce additional service points that should be staffed by a registered social worker; a qualified SAW; one child youth care worker and a CDW. Social workers who are specialised probation officers are needed for anti-substance abuse programmes, one of the major focal areas of the DSD.

4.7.2 Social services to children

a) New social services

New legislation, e.g. the Children's Act, 2005 and the Child Justice Act 2008, is shifting service delivery to a broader developmental approach and identifies new social services areas. Human resources capacity must increase to deliver these services. The DSD intends to expand child and youth care services to 1.3 million orphans and vulnerable children. Child-headed households will be given direct supervision at home and psychosocial support⁵²⁸. For this purpose 10 000 CYCWs will require training between 2012 and 2016⁵²⁹, and access to foster care and child and youth centres will be increased.

Many of the challenges in implementing these basic services are related to the unavailability of skills; e.g. a backlog of foster care cases is building due to a shortage of social workers to process

519 DoH. 2011. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17*; Matsotso M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months". *South African Health Review* 2012/13.

520 National Treasury. 2009. "Health". In *Provincial Budgets and Expenditure Review 2005/06 – 2011/12*.

521 See sec 17 of the Older Persons Act, 13 of 2006 ;Loffel, J., Allsopp, M., et al. 2008. "Human resources needed to give effect to children's right to social services". *South African Child Gauge* 2007/08.

522 Loffel, J., Allsopp, M. et al. 2008. "Human resources needed to give effect to children's right to social services". *South African Child Gauge* 2007/08.

523 Section 9 of the Older Persons Act, 13 of 2006.

524 Interviews with academics in the nursing field, NGOs and SACSSP held in July 2014.

525 Interviews with SACSSP in July 2014; interviews with academics in the social work field in June 2014.

526 Earle-Mallesen, N. 2008. "Social workers". *Human Resources Development Review 2008: Education, Employment and Skills in South Africa; Experts in the social services field and officers of Government Departments confirm the state of affairs*.

527 Patel, L., Hochfeld, T. et al. 2008. *The implementation of the White Paper for Social Welfare in the NGO sector*. CSDA.

528 DSD. 2014 *Strategic Plan 2014-2019*; DSD. 2012. *Strategic Plan 2012-2015*.

529 DSD: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012; DSD. 2013. *Policy for Social Service Practitioners, 5th Draft*.

them⁵³⁰. With more emphasis placed on child protection and diversion programmes for youth offenders, more social workers, probation officers and child and youth care workers (CYCWs) are needed.⁵³¹ Probation officers are social work professionals with a specialisation in a particular field of social work who are skilled in addressing problems underlying children's criminal behaviour; researching matters referred to them by a court; and reintegrating children into families and society.

Expansion of social services to children will require a range of social services practitioners to deliver services in partial care; ECD; prevention and early intervention; protection; monitoring of long-term foster care; adoption; and child and youth centres. Not only is such services labour intensive, but effective delivery will depend on the availability of skilled practitioners in multiple disciplines. As this diversified social services workforce develops further, many of the categories require professionals (i.e. CYCWs and social workers) as supervisors⁵³².

Specific statutory services must be delivered by "designated" social workers who are employed by the DSD or a provincial department of social services, a municipality, or a designated child protection organisation. For example, expansion of national adoption services will require statutory services including screening and assessment by social workers who are adoption specialists—i.e. social workers who have been accredited by the DSD to deliver such services.

According to the DSD, 16 504 social workers are required just to deliver statutory services to children in terms of the Children's Act, 2005. That figure represents 91 % of all registered social workers in 2014, leaving just 9% to services related to substance abuse, older persons, community development, and people with disabilities, crime prevention and support, and HIV/AIDS, among many other demands. Considering that an estimated 55% of social workers are employed by Government or the NPO sector, the demand for social

service professionals is acute⁵³³. However, many newly trained social workers are not absorbed into public sector posts due to budget constraints.

b) New roles for occupations

New social development legislation created the need for social services to be provided by occupations that have not been formally organised or are only emerging. Demand exists for CYCWs, auxiliary CYCWs, ECD practitioners, CDPs and generic CDWs⁵³⁴. Legislative changes expanded the traditional role of CYCWs from offering residential care to children to providing prevention and early intervention services at community level. In the Isibindi model⁵³⁵, CYCWs are increasingly becoming involved in providing developmental and therapeutic services to children – e.g. psychosocial support; teaching them life-skills to cope with the de-stabilising effects of the death of parents; and referring children for rehabilitation and medical care. As a result of these changing roles, new skills sets are required.

c) Early childhood development

One of the main goals of the NDP is to grant young children universal access to ECD for two years by 2030⁵³⁶. Expanding access to ECD and improving the quality of such services will require a better skilled workforce⁵³⁷. Government views ECD programmes as of strategic importance, including within the EPWP, and has set targets to provide ECD to almost 790 000 children by 2015⁵³⁸.

ECD practitioners require a range of skills and competencies. These include resourcing skills to gain access to food banks; child nutrition; role-playing and use of training aids to stimulate the development of toddlers' cognitive and motor skills; and management skills to meet the criteria to secure funding of ECD centres. A national survey carried out in 2000 by the Department of Education found that 88% of ECD workers had no training, inadequate

training, or unrecognised training. The DSD is responsible for the provision of ECD to children between birth and five years.

Currently there is no regulatory framework for the professional recognition, training or skills development of ECD practitioners. The public sector has limited capacity to train ECD candidates and while the NPO sector has trained, the scope and quality of this training is not certain. In future the DSD will require ECD workers to be trained, registered and regulated in terms of a code of conduct⁵³⁹, and hold SAQA-accredited qualifications. At the time of writing, there was uncertainty about the levels of qualifications required. The need was noted for a Bachelors degree (with a special focus on the developmental needs of children aged 0 to 4 years)⁵⁴⁰. NGOs have identified the need for a qualification at NQF level 6 or 7, and to train assistants for ECD practitioners/teachers⁵⁴¹.

4.7.3 Youth development

The proportion of youths (aged 14 to 35) in South Africa is expected to increase to 41.5% of the population by 2014. Youth development work has not evolved into a formal occupation or profession and the DSD views it as a component of community development⁵⁴². Youth development aims to cultivate the spiritual, emotional, social and political awareness of young people in a holistic way and to empower them through skills development. Given the challenges of youth unemployment, the DSD will facilitate skills development to create work opportunities. To combat the spread of HIV/AIDS, social behavioural change programmes will aim to reach 700 000 youths, while psychosocial support programmes will target 2.3 million persons by 2016/17⁵⁴³. CDPs, youth workers, registered counsellors and CYCWs require appropriate training for youth development work⁵⁴⁴.

4.7.4 Community development

Government policies to build sustainable livelihoods in poor communities are driving the need for professional CDPs and CDWs.

530 DSD: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.

531 Interviews with DSD, October 2012; Interviews with SACSSP in July 2014.

532 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa.

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

534 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa; Interview with the PBCYC of the SACSSP in July 2014.

535 The Isibindi model provides for on-going interventions and support in households, families and communities

536 National Planning Commission. 2012. Summary and key issues of the National Development Plan 2030.

537 DSD. 2014. Strategic Plan 2014-2019.

538 DSD. 2012. Strategic Plan 2012-2015. National Treasury. 2012 Budget Review.

539 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

540 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

541 Interviews with NGOs in July 2014.

542 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

543 DSD. 2014. Annual Performance Plan 2014-2015.

544 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

Together with social workers, these new cadres require skills to move households and communities from a “state of dependence to a state of independence”⁵⁴⁵. CDPs and CDWs need the knowledge, skills and capabilities to enable marginalised communities to become more self-reliant and maintain sustainable livelihoods. CDPs require professional skills to identify, initiate, facilitate and implement integrated development projects by involving diverse communities and multiple resources and stakeholders. CDWs are needed to work in supportive roles as change agents, and to maintain the cooperation of all parties involved in projects⁵⁴⁶.

Over the period 2014 to 2019 the DSD will implement community development programmes so that 200 000 households access nutritious food. This programme drives the demand for nutritionists who are development-oriented health professionals skilled to work in and with communities to meet their nutritional needs⁵⁴⁷. Skilled CDWs are needed to conduct extensive profiling of vulnerable households to inform planning for future programmes⁵⁴⁸. Another aspect of community development involves the strengthening of the capacity of NPOs to implement community development programmes⁵⁴⁹. These interventions will require skilled trainers, managers and mentors in the field.

According to the DSD, there is a pressing need to train CPDs and CDWs in formal programmes aligned to the new occupational and qualifications framework⁵⁵⁰.

4.7.5 Community-based care and social services to older persons

The provision of care to people with disabilities, terminally ill persons, and frail and elderly persons has moved from an institutional model to a community-based model. As a result, a new category of worker has emerged. Community caregivers provide personal care services to vulnerable and

home-bound persons⁵⁵¹. Many are untrained and do not meet the ethical standards required of workers who provide home-based care services to the public. Caregivers who work with the elderly may no longer be untrained volunteers. It is anticipated that this occupational category will be made subject to regulation but it is still uncertain whether the service area falls within health- or social services⁵⁵².

Improved protection and quality of life for older persons is a specific strategic objective of the DSD during the period 2013-2016. In order to expand community-based care and support services to the elderly, the skills of social workers, community development workers and caregivers will be needed⁵⁵³.

4.7.6 Improving social welfare delivery

As international donors impose more stringent criteria to the monitoring and evaluation of social development programmes, so the demand increases for social workers who are skilled supervisors and able to comply with principles of good governance⁵⁵⁴. The DSD also intends to step up measures to monitor and evaluate the effectiveness of social welfare service delivery. Providers of social welfare services such as NPOs and NGOs will be required to evaluate whether their services comply with national norms and standards, as well as with legislation and policies. In the longer term, policies will be devised to deliver social services according to a benchmarked workload, with reference to population ratios, manageable caseloads, and complexity of interventions, as well as the experience levels of social service practitioners⁵⁵⁵. The DSD anticipates that the demand for skills of social services professions will increase once such workload assessments are finalised⁵⁵⁶.

4.7.7 Governance and organisational management of CSOs and NPOs

CSOs and NPOs deliver the bulk of social- and development services on behalf of the provincial governments. Potential funders are so concerned about the lack of governance and organisational skills that submissions by NPOs to secure financing for social development projects are often rejected. In 2012 it was estimated that the National Lottery Fund had R300 billion available for social development projects, but that funding was held back due to the lack of adequate assurances and risk-control measures in project proposals⁵⁵⁷. As service providers that rely on external funding, NPOs will be obliged to improve business planning, financial management, governance, internal controls, and accounting practices. Further, NPOs require the capacity to comply with norms and standards imposed for the development and delivery of social services programmes to ensure alignment with policies, strategic priorities and funding. Skilled managers are needed to monitor and evaluate progress against project plans and operational budgets.

In view of institutional and management challenges CSOs that face (as discussed in paragraph 3.9.2), skills development needs exist in many areas, including: leadership and general management; governance; supervision and internal controls; human resources management; business administration; financial resources management; strategic planning; project planning; service delivery and technical skills; and management of the external environment.

4.8 Conclusions

In view of the state’s expanding agenda to improve access to adequate healthcare and social development services, the demand for skills to deliver such services continues to rise. Changes in the way health- and social development services are delivered to the public, further drive the demand for new and different skills mixes. The information reported in this chapter confirms that the demand for skills in the health and social development sector continues to outstrip supply.

The demand for skills exists at all levels in

⁵⁵⁷ DSD. Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.

⁵⁴⁵ Interview with Prof Antoinette Lombard, Head of Department of Social Work, University of Pretoria.

⁵⁴⁶ SAQA Registered Qualification: Bachelor in Community Development and NC: Community Development.

⁵⁴⁷ DSD. 2014. Strategic Plan 2014-2019; Interview with HPCSA in July 2014.

⁵⁴⁸ DSD. 2014. Strategic Plan 2014-2019; Interviews with DSD in July 2014.

⁵⁴⁹ National Treasury. 2012 Estimates of National Expenditure; DSD. 2014. Strategic Plan 2014-2019.

⁵⁵⁰ Interviews with DSD in October 2012 and July 2014.

⁵⁵¹ DSD. 2012. Draft policy for social service practitioners. (Working document).

⁵⁵² DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

⁵⁵³ DSD. 2012. Strategic Plan 2012-2015.

⁵⁵⁴ Schmid, J. 2012. “Trends in South African Child Welfare Reform”. Centre for Social Development in Africa.

⁵⁵⁵ DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

⁵⁵⁶ DSD. 2013. Presentation to HR consultative Forum (internal document).

the health and social development sector: from high-level specialist skills (e.g. medical specialists, specialist professional nurses, and community development practitioners) to mid-level skills (pharmacy technicians, community development workers, emergency care assistants, and ECD practitioners and registered staff nurses) and to low-level skills (CCGs, and CHWs).

In 2014 there were approximately 310 300 filled positions in the Public Service and nearly 16 000 vacancies for scarce skills, bringing the total number of positions in the Public Service to approximately 326 000. The total number of positions in the private sector was an estimated 276 500 and the number of vacancies 5 100.

The number of filled positions in the entire Health and Social Development sector is an estimated 586 800. The sector uses mainly the services of professionals, who fill 40% of the positions in the sector. This is followed by positions for technicians and associate professionals, which constitute 23% of all filled positions in the sector.

The sector is affected by skills shortages which in 2014 resulted in 21 068 unfilled positions. The situation is worse in the Public Service than in the private sector. Public Service vacancies constitute 5% of total employment. Of the vacant positions in Public Service, 82% are for professionals. Some of the reasons for this situation are discussed in the next chapter.

Skills development targets for the health sector set by the DoH in 2012 indicate the scope of demand for skills and acknowledge the significant supply-side constraints to produce and deploy health professionals, practitioners and workers to ensure better access to services and to improve quality in the health system. Budget provision is a major constraint that impedes the deployment of more health professionals. The cost to fill public sector vacancies in key clinical professions is almost R40 billion and this is prohibitively high. Some of the other constraints are considered in the next chapter.

With health sector experts describing the immediate shortage of nursing skills as “acute and alarming”, training of professional nurses must be stepped up. Post-basic training for nurses in specialised fields must receive more prominence. Nurse specialists are needed in advanced midwifery, post-natal care, intensive care,

trauma care, operating-theatre, PHC, paediatrics, psychiatry and other specialist areas. Skills interventions should also target nurses involved in integrated management of childhood illnesses and health monitoring programmes for children. Current cadres with legacy qualifications should access bridging programmes to register under the new nursing qualifications framework. More health academics, health educators and preceptors are needed, especially in the nursing field.

Skills requirements to implement the NHI, including the extension of PHC services to communities and schools and measures to improve service delivery at all levels of public hospitals, are daunting. The effective rollout of key public health programmes to fight HIV/AIDS and TB and to improve the health of mothers, children and women will only be achieved by developing the clinical skills of existing health workers and employing more doctors, medical specialists and professional nurses. Specialised training on a large scale is required in TB management and infection control. Initially an estimated 45 000 CHWs are needed to provide a complete range of PHC services, and 18 000 CCGs should be adequately skilled for home-based care. However, higher estimates of the NDP that 700 000 CHWs will have to be trained and deployed by 2030, demonstrate the extent of the demand for skills development.

However, meeting this demand will be challenging because of substantial supply-side constraints, which are considered in the next chapter.

Pharmacy professionals are also in high demand, and higher skilled cadres of pharmacy technicians must be trained to work in PHC clinics. A range of allied health professionals (e.g. occupational therapists, speech and hearing therapists, and physiotherapists), technicians to service biomedical equipment and artisans are needed in both the public and private sectors, while the public sector needs mid-level skills in every domain of healthcare.

In the animal health sector, strong economic imperatives drive the need for more veterinarians and animal health technicians (who are also trained to provide veterinary extension services and primary animal healthcare).

Extensive, intensive and purposive skills development is required 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 in NPOs also require training in leadership and management of financial resources, human resources, governance, service delivery, and the external environment.

Expansion of social development services and the introduction of new services for children, persons with disabilities, older persons and vulnerable members of society propel demands for a range of occupational groups to implement developmental social welfare programmes. In the past, demand scenarios tended to focus on social workers only and further research and work is needed within the sector to include all other categories of social service occupations and professions that make up the ‘social welfare workforce’. Apart from the need to train more social workers for the social development and health sector, the current skills base needs strengthening through occupational-specific and technical training, while extensive “on-boarding” programmes must prepare work-ready professionals for service. Social auxiliary workers must be up-skilled as fully-fledged social service support workers.

Given the immense and complex work required to reduce poverty and to uplift vulnerable communities into developing sustainable livelihoods, the public sector needs professionally trained community development practitioners and mid-level skills. With reference to current and proposed legislation and social development policies, demand exists for social service professionals and a range of other occupational groups. These occupational categories include social auxiliary workers, probation officers, assistant probation officers, child and youth care workers, auxiliary child and youth care workers, CDWs, and ECD practitioners. Processes are underway to define and possibly regulate these occupational groups. In view of the comprehensive and far-reaching national development agenda, the NDP estimates that the ranks of social services professionals need to be increased to 55 000.

Stakeholders in the health and social development sector expect the HWSSETA to create an enabling environment for skills development. In this regard the SETA’s quality assurance functions, service delivery