Health and Welfare Sector
Education and Training Authority
HWSETA

Sector Skills Plan Update

for the Health and Social Development Sector in South Africa

HWSETA SSP UPDATE 2013-2014

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

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Health and Welfare Sector
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HWSETA

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

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FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is extremely pleased to present its annual update of the Sector Skills Plan (SSP). It is an honour to compile the Foreword to this report. In particular, a publication that seeks, as one of its aims, to contribute towards achieving performance goals set for the Minister of Higher Education and Training and how the HWSETA can also contribute to the realisation of these goals. Thus, to achieve this a '*Respice, prospice'* (look back look forward) approach is important.

The Sector Skills Plan (SSP) Update is an annual report approved by the HWSETA board which is constituted by representatives from labour, employers and government (Department of Social Development, Department of Health). The annual update is aimed at providing current sector skills development needs initially set out in the Five Year Sector Skills Plan. Furthermore, it is aimed at aligning sector-based skills needs and programmes with government's economic and social development priorities enshrined in the New Growth Path (hereafter NGP) and Medium Term Strategic Framework (hereafter MTSF). It also grapples with requirements set out by the Department of Higher Education and Training in the National Skills Development Strategy III (hereafter NSDS III). That said, it is assuring that this journal will provide a useful source of information for the HWSETA, stakeholders and wider audience, moving forward.

Comprehensive Sector Skills Plans contribute to the enhancement of the goals of a developmental state and democratisation of education and training. It is also a mechanism to diversify learning pathways, and at the same time opening learning and training spaces in the public service sector and the private sector.

For the Health and Welfare sector to achieve a skilled workforce and growth in general, the need to work together with employers, public education institutions [Further Education and Training (FET) colleges, universities and universities of technology], private training providers, and other SETAs, and use research to achieve NSDS III goals is vital to the economic growth as indicated in this report.

To proceed, "barriers to articulation are associated with structural and organisational components of the system, and other kinds of issues such epistemological, perceptual barriers" (Blom, 2012). Thus, for SSPs to capture sustainable development learning pathways, they should analyse systems components as Blom assets. In the final analysis, let us continue to '*Respice, prospice'* (look back look forward) in order to address skills shortages in perspective in South Africa.

May this publication help us to reminisce about the original vision of the SSPs as encapsulated in the NSDS.

Ms. Nozipho January-Bardill

HWSETA Board Chairperman

Ms. Yvonne Mbane

HWSETA Chief Executive Officer

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

ABET	Adult Basic Education and Training
AgriSETA	Agricultural Sector Education and Training Authority
AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ARC	Agricultural Research Council
ART	Anti-Retroviral Therapy
ATR	Annual Training Reports
BEE	Black Economic Empowerment
CBO	Community-Based Organisation
CCW	Community Care Worker
CCWMPF	Community Care Worker Management Policy Framework
CDA	Central Drug Authority
CDP	Community Development Practitioner
CDW	Community Development Worker
CESM	Classification of Education Study Material
CHE	Council on Higher Education
CHIETA	Chemical Industries Education and Training Authority
CHW	Community Health Worker
CPD	Continuous Professional Development
CSDH	Commission on the Social Determinants of Health
CSO	Civil Society Organisation
CYCW	Child and Youth Care Worker
DAFF	Department of Agriculture, Forestry and Fisheries
DBE	Department of Basic Education
DBSA	Development Bank of South Africa
DENOSA	Democratic Nursing Organisation of South Africa
DG	Director-General
DHET	Department of Higher Education and Training
DoA	Department of Agriculture
DoH	Department of Health
DSD	Department of Social Development
DBSA	Development Bank of South Africa
DPSA	Department of Public Service and Administration
DTI	Department of Trade and Industry
DWCPD	Department for Women, Children and Persons with Disabilities
ECD	Early Childhood Development
EMIS	Education Management Information System
EMS	Emergency Medical Services
EPWP	Expanded Public Works Programme
FAO	Food and Agricultural Organisation of the United Nations
FBO	Faith-Based Organisation
FET	Further Education and Training
FETC	Further Education and Training Certificate
GET	General Education and Training
GETC	General Education and Training Certificate
GDP	Gross Domestic Product
GHS	General Household Survey
GP	General Practitioner
HASA	Hospital Association of South Africa
HCBC	Home-Community-Based Care
HDSA	Historically Disadvantaged South Africans
HEI	Higher Education Institution
HEMIS	Higher Education Management Information System
HEQC	Higher Education Quality Committee
HET	Higher Education and Training
HIV	Human Immunodeficiency Virus
HOSPERSA	Health and Other Service Personnel Trade Union of South Africa
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
HWSETA	Health and Welfare Sector Education and Training Authority
ICT	Information Communication Technology
IDT	Independent Development Trust
INSETA	Insurance Sector Education and Training Authority
IP	Implementation Plan
ITHPCSA	Interim Traditional Health Practitioners Council of South Africa
LGSETA	Local Government SETA
MDG	Millennium Development Goals
MDR TB	Multiple Drug Resistant Tuberculosis
MLW	Mid-level Worker
MoU	Memorandum of Understanding
MRC	South African Medical Research Council
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NACCW	National Association of Child Care Workers
NACOSS	National Coalition of Social Services

NAMB	National Artisan Moderation Body
NAWONGO	National Association of Welfare Organisations and Non-Governmental Organisations
NC	National Certificate
NCV	National Certificate (Vocational)
NDA	National Development Agency
NEDLAC	National Economic Development and Labour Council
NEHAWU	National Education Health and Allied Workers Union
NGO	Non-Governmental Organisation
NGP	New Growth Path
NHA	National Health Act
NHI	National Health Insurance
NHIF	National Health Insurance Fund
NHLS	National Health Laboratory Service
NIP	National Implementation Plan
NPO	Non-Profit Organisation
NPSWU	National Public Service Workers Union
NQF	National Qualifications Framework
NRASD	National Religious Association for Social Development
NSDA	Negotiated Service Delivery Agreement for the Health Sector
NSDS	National Skills Development Strategy
NSF	National Skills Fund
NUPSAW	National Union of Public Service and Allied Workers
NWSSDF	National Welfare and Social Services Development Forum
OHSC	Office of Health Standards Compliance
OFO	Organising Framework for Occupations
OSD	Occupation Specific Dispensation
OVI	Onderstepoort Veterinary Institute
PAHC	Primary Animal Healthcare
PAWUSA	Public and Allied Workers Union of South Africa
PEPFAR	US President's Emergency Plan for AIDS Relief
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PIVOTAL programme	Professional, Vocational, Technical And Academic Learning Programme
PSA	Public Servants' Association
PSC	Public Service Contractor
PSETA	Public Service Sector Education Training Authority
QCTO	Quality Council for Trades and Occupations
QMS	Quality Management System
RAF	Road Accident Fund
RPL	Recognition of Prior Learning
SACCI	South African Chamber of Commerce and Industry
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
SANGOCO	South African National Non-Governmental Organisation Coalition
SAPC	South African Pharmacy Council
SAPSE	South African PostSecondary Education system
SARS	South African Revenue Service
SASSA	South African Social Security Agency
SAVC	South African Veterinary Council
SAW	Social Auxiliary Worker
SDA	Skills Development Act
SDF	Skills Development Facilitator
SDL	Skills Development Levy
SEDA	Small Enterprise Development Agency
SETA	Sector Education and Training Authority
SIC	Standard Industrial Classification
SIP	Strategic Integrated Project
SSP	Sector Skills Plan
TB	Tuberculosis
THO	Traditional Healers Organisation
UIF	Unemployment Insurance Fund
UCT	University of Cape Town
UMALUSI	Council for Quality Assurance in General and Further Education and Training
W&RSETA	Wholesale and Retail Sector Education Training Authority
WHO	World Health Organization
WSP	Workplace Skills Plan
XDR TB	Extensively Drug-resistant Tuberculosis

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 and the White Paper for Social Welfare.

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 priority 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.

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 FET 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) identi-

fies 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. 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.

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 FET 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 March 2013 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 typicaly 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 managers, general medical practitioners, specialist professional nurses and social workers) to mid-level skills (e.g.enrolled nurses, ambulance officers, boilers and pressure vessels inspectors and community workers) to low-level skills (e.g. emergency service and rescue officials and healthcare cleaners).

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. 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 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 social and development services on behalf of the state, NGOs require skills in governance and organisational management.

In the veterinary 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 FET 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 HW SETA'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.

	Sub-programme	No	Performance indicator	Five-year target	2014/2015 target	2014/2015 budget	NSDS III Objectives
ADMINISTRATION	Research, Information, Monitoring and Evaluation	5	Percentage artisans and unemployed learners funded by HWSETA find employment within 6 months of completion	80%	80%	Research budget	1
		12	Number of applied research reports completed and signed off that inform planning	25	5	R 534 000	1
		13	Number of post graduate research students funded in the health and welfare field	380	90	R 2.369 mil	1, 2
	Corporate Services	15	Number of learners reached through HWSETA career development awareness programmes	43 500	11 000	R 500 000	8
		18	Percentage of filled positions in the HWSETA	94%	90%	R 894 000	
		20	Percentage of HWSETA processes automated and integrated	95%	50%	R 4 mil	
SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS	Projects	2	Number of employers participating in work-based training	480	50	Included in learnerships and skills projects budgets	2
		4	Number of apprentices funded and enrolled to become artisans through HWSETA funding	800	300	R 28.875 mil	2
		6	Number of HWSETA funded students in higher education institutions funded for high-level scarce skills	1340	225	R 11.65 mil	2
		7	Number of students enrolled for work-experience and experiential learning programmes funded by the HWSETA	4 644	325	R 23.250 mil	2, 3
		9	Number of cooperatives in the health and social development sector whose skills needs are funded by the HWSETA	90	15	R 750 000	6
		10	Number of small and emerging businesses funded	450	75	R 4.950 mil	6
		11	Number of skills development projects funded to support NGOs, Cobs and trade unions	755	150	R 6 mil	6
		22	Number levy-exemp organisations funded by the HWSETA	510	110	R 10 mil	
		17	Number of learners in FET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses funded by the HWSETA	6 650	1 000	R 5.6 mil	3
		14	Number of projects funded through discretionary grant aimed at the public sector education and training	14	4	R3.3 mil	7
	Learning programmes	1	Number of programmes funded through grants to develop and address middle level skills	18	6	R 6.6 mil	2
		3	Number of learners registered in learnership training programmes	18 350	2 800	R 81.55 mil	2, 5
		8	Number of employed and unemployed learners in skills programmes funded by the HWSETA	12 680	5 800	R 11.600 mil	2, 3, 8
		21	Number of learners registered for AET programmes funded by the HWSETA	3 000	700	R 1.75 mil	4
		23	Number of partnership agreements signed through MoUs outlining areas of collaboration	50	7	R 2.984 mil	2, 3
QUALITY ASSURANCE AND QUALIFICATION DEVELOPMENT		19	The number of skills development training providers accredited to offer full qualifications	240	40	R3.3 mil	

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 2014 to 31 March 2019 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 for the Minister 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 two government departments and academic articles relevant to skills development in the sector, were used. The Department of Social Development's 2013 *Annual Performance Plan 2013/14* and the Department's *Strategic Plan 2012-2015* as well as the *Annual Performance Plan 2011/12-2013/14* of the Department of Health (DoH) were considered. 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 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 March 2013.

In October 2012 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 2013 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 MEDpages[1] database. 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. MEDpages, a comprehensive private database of health service providers in the private sector, was used to analyse employment in the private healthcare sector. The current update reflects the data that became available during 2013, including the WSP information submitted in June 2013.

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 tracksectoral 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 2012/2013 financial year a total of 5 362 organisations paid SDLs to the HWSETA

The databases referred to in Chapter 1 provided information on almost 588 300 people who are formally employed in the health and social development sector. Of these, 262 500 (45%) are employed in private sector organisations (referred to later as the “private sector”) and levy-paying public sector organisations, while 325 700 (55%) 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 (AHPCSA) and the South African Dental Technicians Council (SADTC). Members of the veterinary and para-veterinary professions are registered with the South African Veterinary Council (SAVC) and practitioners using indigenous African healthcare techniques and medicines will soon be required to register with the Interim Traditional Health Practitioners Council of South Africa (ITHPCSA). Professionals (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 various 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 3% of total employment and in the private sector 4%. Professionals comprise 41% of employees in the Public Service and 39% in the private sector. 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 (69%) of the professionals employed in the total sector are African, 16% are white, 12% coloured, and 4% are Indian. Among technicians and associate professionals, 51% in the private sector and 76% in the Public Service are Africans. Women constitute 73% of the health workforce and 79% of the professionals in the public sector. One-third of health and social development workers in the public sector are younger than 35 years. More than half (57%) are between 35 and 55 and 10% are older than 55. A relatively large percentage (15%) of managers in the Public Service is under the age of 35. Fewer than 10% of the professionals (9%) and technicians and associate professionals (7%) who work in the public sector are older than 55 years. Less than 1% of the people employed in the sector were living with disabilities. Information on the age distribution of people working in the private sector component of the health and social development sector is not available.

Professionals and practitioners in the sector are organised in numerous voluntary organisations that generally promote the interests of specific fields of medical 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 2012, a total of 85 248 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 (34 130 or 40%) deliver social services, a total of 16 817 of registered NPOs (20%) provide development and housing, and 11% provide healthcare services. NPOs involved in veterinary services, animal protection and welfare are classified in the environmental category and in 2012 a total of 1 036 organisations (or 1% of NPOs) were registered in this category, with 384 indicating that they provide veterinary-, animal protection-, animal welfare-, or wildlife-preservation services.

Civil Society Organisations (CSOs) 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, including child care and protection; youth care and development, including programmes to divert juvenile delinquents; specialised services for the disabled; crime prevention and 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 their own health insurance arrangements with medical schemes, or incur out-of-pocket expenses. In 2012, more than 43 million people relied on the public health system and 8.5 million people were covered by medical insurance. About 24% to 30% of

the uninsured population consulted private practitioners, but used public hospital services.

Many inequalities are entrenched in South Africa's public-private healthcare mix. In 2013 healthcare expenditure was estimated to be above R274 billion, with 48% of this 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.

Public sector spending on health services more than doubled in real terms over the period 1996 to 2011, representing an increase of around R60 billion. Government spending on public healthcare grew at an average annual rate of 5.6% in real terms from 2007/08 to 2013/14. Per capita public sector health spending amounted to R2 667 in 2010/11, i.e. 48% higher in real terms than in 1995/96. By comparison, gross contributions to medical schemes per average principal member reached R18 972 in 2012, up from R8 168 in 2000 for the average beneficiary.

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 public 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 Department of Social Development (DSD) increased from R85.3 billion in 2009/10 to R112.1 billion in 2012/13, at an average annual rate of 9.3%. 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 increase by 7.5% per annum between 2011/12 and 2014/15 while the bed occupancy rate at district hospitals is expected

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, faculties of health sciences, statutory councils and professional associations:

- Theme I: the supply (and distribution) of health professionals and equity of access to appropriate trained 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.

Regulation of the health and social development system

Almost every aspect of the health system is regulated by the national Department of Health (DoH), while the 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 redesignated 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.

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; perform-

ance outcomes; and the minimum range of services to be provided at different levels of care.

A new public entity, the National Health Insurance Fund (NHIF) will administer the scheme. According to the DoH the policy proposals are subject to on-going stakeholder and community consultations during 2012 and 2013, and a White Paper with final policy proposals is expected in 2013/14. Implementation will extend over a period of 14 years between 2012 and 2025 and piloting commenced in ten health districts in 2012. Adequate numbers of health-care 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, 13 of 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.

Implementation of these policies drives the need for more professional and technical healthcare, leadership and management skills, as well as skills development interventions to enhance the skills content. 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. Such programmes offer skills development, awareness training and support services to women, the youth and families and aim to provide food security and achieve social behaviour change to mitigate the social and economic impact of HIV/AIDS and other diseases.

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 interdependence 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 use (and uncontrolled) 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 2014, 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.

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 30 June 2013 there were 325 763 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 22 976. The total number of filled positions in public health and social development is 348 739.

In June 2013 the filled positions in the private sector were 262 503 while there were 7 090 vacancies. This brings the total number of positions in the private sector to 269 593 and the total number of positions (filled and vacancies) in the sector to 618 332. 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 2013, 60% of the organisations that submitted WSPs 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 indicate that a total of 22 976 people (7% of total employment) is reported as scarce skills shortages in the Public Service. Of the scarce skills vacant positions in the Public Service, 77% are for professionals. In the private health sector, a total of 7 090 people (3% of total employment) 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. In the private health sector, skills shortages are the most severe among professionals and 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..

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 another 16 000 social workers were needed in 2012 to implement services under the Children's Act. Of the 16 740 registered social workers in March 2012, just under 56% were employed by Government and NPOs, leaving 45% that were either working in the private sector or were no longer in practice. 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 2010 the public sector had 162 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 current 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) by almost three times will have a major impact on the demand for skills. More specifically, the public sector will need additional doctors, medical specialists, nurses, 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 and community health workers are needed to monitor adherence to treatment regimes for HIV/AIDS and TB. Skills interventions should also target PHC nurses involved in health monitoring programmes for children. 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 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 staff nurses, GPs, medical professionals trained in PHC, and community health workers. Professional nurses are needed in 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 to staff PHC teams at community level. A recent DoH audit found that the roles, responsibilities and functions fulfilled by the CHWs vary across provinces and organisations, and that there needs to be standardisation of services offered by these cadres. Education and training of CHWs is also varied and diverse, ranging from a few weeks to four years. For this reason considerable variation exists in the range of their knowledge, skills and competence. It will be necessary to transition this diverse informal workforce into formal positions as part of PHC outreach teams.

The expansion of PHC services over the next few years will aim to eliminate the transmission of malaria by 2018 and to manage non-communicable diseases through a chronic care model in 20% of health districts by 2015. Cataract surgery rates will also be increased almost threefold in the period 2012 to 2015. The DoH intends to increase the number of ward-based PHC outreach teams from 54 in 2012 to 2 000 teams by 2015. These interventions will require the skills of trained community health workers (CHWs), nurses and specialist nurses, environmental health practitioners, nutritionists, ophthalmologists and PHC supervisors.

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

Vacancies for social workers in the HWSETAamount to6 203 in 2013.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. 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 geriatric care will grow. Community caregivers who provide personal care services to the elderly are required to undergo prescribed training before they may render such services.

Among the other categories of social services workers required are social work professionals, social auxiliary workers, community development practitioners, community development workers, and community care givers. Social workers with specialist qualifications such as probation officers are needed for anti-substance abuse programmes, one of the major focal areas of the DSD until 2016. 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.

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 staff nurses, emergency medical care practitioners and technicians. New occupations are emerging as a result of the need to change the way social development services are delivered, such as in the field of 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.

The number of Grade 12 learners who sat for examinations decreased from 533 561 in 2008 to 496 090 in 2011 and the number of learners who wrote mathematics decreased annually over the same period by 9.3%. Fewer candidates in 2011 (n=67 541) achieved 40% or more for mathematics than in 2008 (n=91 796). The number of learners who achieved 40% or more in physical sciences also decreased annually by 1.8% from 64 538 in 2008 to 61 109 in 2011.

Quality standards of education in mathematics, physical sciences and life sciences are major supply-side constraints impacting on the skills of the health sector. Substandard 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.

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.

Social service professionals obtain qualifications in social work from higher education institutions. A total of 19 institutions of higher learning train social workers and offer four-year degree programmes at NQF Level 8. The successful completion of the qualification enables the graduate to be registered with the SACSSP and practise as a social worker. Social work graduates increased from 468 in 1999 to 1 671 in 2012. The number of social work students, excluding first-years, registered with the SACSSP increased from 976 in 2004 to 5 605 by May 2010.While the availability of bursaries has boosted the numbers of social work graduates, screening or selection processes to identify candidates with the desired attributes for social services appear inadequate. As a result, the retention rate of new professionals in the sector is too low.

Nursing colleges play an important role in the training of nurses. Total output from nursing colleges reached 19 143 in 2012 and has increased on average by 7.4% per year since 2002, while the number of pupil nurses has risen sharply from 2 771 in 2002 to 7 732 in 2012.

Professional registration

Growth in registrations of health professionals with their respective professional councils was slow from 2002 and 2012. The total number of registered dentists grew by 2.2% per year, medical interns by 3.8%, medical practitioners by 2.5%, and registered nurses by 2.7%. The ranks of registered pharmacists grew on average by 2.3% per year from 2006 to 2013 and pharmacist interns by 6.4%.Over the same period, registration figures in the pharmacy support staff categories showed higher growth.From 2010 to 2013, the number of veterinarians registered with the SAVC grew by 2.8% from 2 769 in 2010 to 3 006 in 2013.

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 5.9% from 2003 to 2012, or from 10 515 to 17 583. Registered social auxiliary workers increased at an average annual rate of 11.8% from 1 297 in 2003 to 3 533 in 2012.

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 2011/12 more than 9 400 learners successfully completed learnerships 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, ABET, partnerships with other role-players, and small-enterprise development.

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 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.

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- (FET) 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.

Delays in establishing effective regulatory frameworks for several professions and evolving occupational categories have also impacted on skills formation for the sector, especially in nursing and social services 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 skills development and training.

Skills development of CHWs and community care workers 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.

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 2013/14 to 2015/16 has been adjusted to R 783.6 million.

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 for the Minister 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, four 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; and
- Capacity building for the public sector.

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. 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.

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. A specific focal area will be to develop capacity in the HWSETA to conduct sector relevant research, development and innovation. Research partnerships with university faculties and other stakeholders will be concluded.

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. 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. 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. Discretionary grant funding will be used to train unemployed learners in occupationally-directed programmes aimed at developing the mid-level skills needed for the sector while work-ready unemployed graduates of middle level qualifications will also be supported to gain work experience. The formal partnerships already established with FET 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 FET college system that is responsive to the sector, local, regional and national skills needs and priorities

The HWSETA recognises that the public FET college system is central to the government's programme of skilling and re-skilling youth and adults. The National Development Plan views efforts to strengthen the FET college system as a national priority, and a number of HWSETA interventions support this goal. Parnerships with FET colleges have already been established and these will be expanded. The HWSETA will, among other things, focus on building the capacity of the FET colleges to offer the NCV in primary healthcare. 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

Through its discretionary budget the HWSETA will support unemployed adults to undergo literacy and ABET training.

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 will support NPOs and cooperatives with skills training and development relevant for the sector. 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. Specific projects will be funded to support and develop cooperative organisations and to establish further cooperatives.

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, and 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 2014 to 31 March 2019was 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 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 for the Minister of Higher Education and Training and how the HWSETA will contribute to attaining them. Attention is given to key pillars of the NSDS III,[2] namely:

a) Professional, vocational, technical and academic learning (PIVOTAL) programmes[3] 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.

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 *2013 Annual Performance Plan 2013-2014* and the *Strategic Plan 2012-2015*of the DSD as well as the *Annual Performance Plan 2011/12-2013/14* 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. Budget- and expenditure reports published by the National Treasury for the 2013 Budget, including the *Estimates of National Expenditure* (for DSD, DoH and Department of Agriculture, Forestry and Fisheries) and the *2013 Budget Review*were also used. 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

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

Coordinating Commission. This SSP update also includes updated data and information from the *South African Health Review 2012-13 and the Child Gauge 2012*, 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 2013 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 MEDpages[4] 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 2013, including the WSP information submitted in June 2013.

During Phase 2 of theprevious update (2012 SSP update) a total of 27 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, 56 respondents provided 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. 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. Two large NGOs that are engaged in the provision of a range of social services and social development programmes and a private sector employer organisation were also approached for inputs.

The HWSETA Board also played an important role in the development of the SSP. The first Draft (dated 31 August 2013) was considered by the Skills Development Standing Committee of the Board. Feedback was incorporated in this current update of the SSP.Two Board members participated in the interviews (held in late 2012) in their capacities as senior officers involved with skills planning in the DoH and the DSD. Both these Board members also facilitated access to other key persons in the sector with whom the HWSETA could engage on skills needs and skills development priorities.

This document constitutes the second draft of the updated HWSETA SSP for the period 2014-2019 (i.e. the-HWSETA SSP update 2013-2014). The Skills Development Standing Committee (sub-committee of the Board) and finally the HWSETA Board have reviewed and approved this draft. The first draft was published andstakeholders and interested parties were invited to provide inputs. The stakeholder inputs were considered and incorporated into this second and final draft.

In the 2013 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.

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 tracksectoral 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, ageand 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

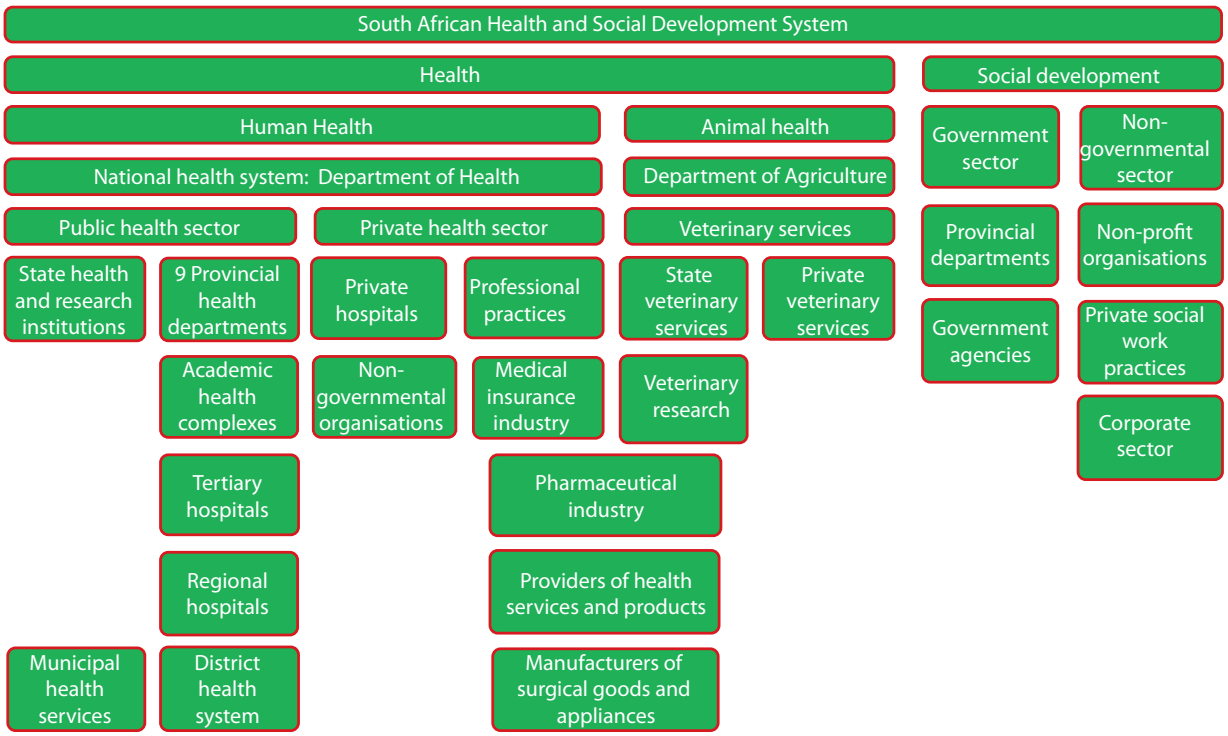


Figure 2-1 The South African health and social development system

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 control.[6]Many local authorities provide primary healthcare(PHC) services, which may either be financed from municipal revenues or by provincial health authorities.[7]

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*. Report on a process convened and facilitated by the DBSA.

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 August 2010).

The private health sector is made up of private hospitals, individual health service providers, NGOs and the medical insurance industry.[8]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 South African Social Security Agency* (SASSA). SASSA is responsible for the administration and payment of social grants[9](with 15.6million beneficiariesin 2012/13) as well as: processing of applications for social grants and social relief of distress; verification and approval of applications; disbursement and payment of grants to eligible beneficiaries; quality control by ensuring compliance with norms and standards; and fraud prevention and detection.[10]

b) *National Development Agency* (NDA). The NDA provides grant funding to civil society organisations for the purpose of meeting the development needs of poor communities and to bolster the institutional capacity of such civil society organisations.[11]

c) *The Independent Development Trust* (IDT).The IDT offers programme management and development advisory services for the eradication of poverty to government departments and other development partners. Emphasis is on the eradication of chronic intergenerational poverty, especially among the rural poor.[12]

d) *The Advisory Board on Social Development*. This board advises the Minister on social development and identifies, promotes, monitors and evaluates policy, legislation and programmes relating to social development.[13]

e) *TheCentral Drug Authority* (CDA). The CDA gives effect to the national drug master plan and promotes measures to prevent and combat the abuse of drugs.[14]

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 in South Africa and are key partners of national and provincial government in attaining socio-economic and developmental priorities.

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. September 2009. Vol. 374.Published at http://thelancet.com.(Accessed August 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, University of Cape Town.Published at http://www.web.uct.ac.za/depts/heu/SHIELD/reports/SouthAfrica1.pdf.(Accessed August 2010).

9 National Treasury. 2012 Budget Review.

10 South African Social Security Agency. 2010. *SASSA Annual Report 2009/2010,* p 13; National Treasury. 2011. "Vote 19: Social Development". *2011. Estimates of National Expenditure.*

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

12 Independent Development Trust. 2011. Corporate Plan 2011-2013. Published at http://www.idt.org.za/index.php?option=com_docman&task=cat_view&gid=7&Itemid=4.(Accessed 9 August 2011).

13 Department of Social Development. 2011. "Public Entities and Statutory Bodies". Published at http://www.dsd.gov.za/index.php?option=com_content&task=view&id=56&Itemid=101.(Accessed 18 August 2011).

14 Department of Social Development. 2011. "Public Entities and Statutory Bodies". Published at http://www.dsd.gov.za/index.php?option=com_content&task=view&id=56&Itemid=101.(Accessed 18 August 2011).

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 Act97 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 2012/2013financial year a total of 5 362 organisations paid SDLs to the HWSETA. These are organisations with payrolls in excess of R500 000 per year. Small practices may be excluded from this number.

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 Africa[15] (HPCSA), the South African Nursing Council[16] (SANC), the South African Pharmacy Council[17] (SAPC), the Allied Health Professions Council of South Africa[18] (AHPCSA), and the South African Dental Technicians Council[19] (SADTC). Members of the veterinary and para-veterinary professions are registered with the South African Veterinary Council (SAVC)[20] 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[21] (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.

Statutory provisions authorise the professional councils 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 controllingof standards for education and training, the registering of professionals, establishing what constitutes ethical and professional conduct, and enforcing compliance with standards.The councils also set requirements for the continuous professional development (CPD) of professionals and technicians in order for these people to retain their registration. 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 onHigher 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 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 closely involved in the SETA's activities and its substructures. An overview of the councils and the professionals and 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:

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

a) Dental Therapy and Oral Hygiene;

b) Dieteticsand 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 HearingProfessions.[22]

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 midwife.[23] A person undergoing education or trainingin nursing must apply to the SANC to be registered as a learner nurse or a learner midwife.[24]

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, leaner post basic basic and post basic) 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 SAPC.[25]

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 therapist.[26]Four professional boards within the AHPCSA provide that council with standards for specific allied health professions and contribute to policy development[27].

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 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 fields.[28]

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. These include the supplying, making, altering or repairing of artificial dentures or other dental appliances and any other work pertaining to such dentures or appliances. 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 is registered with the SADTC. A dental technologist holds a BTech degree in dental technology at NQF Level 7 from a recognised South African institution. The scope of practice of a dental technologist is broader than

22 HPCSA. 2013. Professional Boards.Published at http://www.hpcsa.co.za...overview.php.(Accessed 16 October 2013).
23 Section 31 of the Nursing Act 33 of 2005. Previously the professional categories were registered nurse, midwife, enrolled nurse and nursing auxiliary.
24 Section 32 of the Nursing Act 33 of 2005.
25 SAPC, 2013.http://www.pharmcouncil.co.za/B_Regs4_RegsPersons.asp(Accessed 16October 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 (Section 1 of the Allied Health Professions Act 63 of 1982).
27 AHPCSA. 2013. Council Structure. Published athttp://www.ahpcsa.co.za/council_struct.htm#Professional Boards(Accessed 24 October 2013).
28 SAVC. 2013. About Us. Published at http://www.savc.co.za/..(Accessed 16 October 2013).

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 patients.[29]

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 field.[30]The Council was also established to develop regulations under the Act. Regulations governing the appointment of the ITHPCSA were published by the Minister of Health in September 2011. 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 practice.[31] 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 (*ababelethis*i or *abazalis*i).Spiritual or faith healers are not included in the Traditional Health Practitioners Act.[32]

Among the objectives of the ITHPCSA are the promotion of public health awareness, ensuring the quality of services, and the promotion and maintenance of 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.

It was estimated that there were about 185 000 traditional health practitioners in South Africa in 2007.[33]By 2012, a new estimate put the number at 200 000, with affiliation spread across more than 100 separate organisations.[34]

At present the traditional healers operate outside a regulated environment and they do not form part of the formal public- or private health service. However, the Traditional Healers Organisation (THO) of South Africa, which claims a membership of 29 000 traditional healers, issues certificates of competence to practitioners who have completed training and passed assessment of ethical, safe, hygienic and competent practice. The THO certifies ten different specialists in traditional health practice.[35]The Natural Healers Association (NHA)estimates that there are 280 000 natural healers. This group includes professionals and practitioners with training in western medicine, traditional-, indigenous-, Eastern-, African- and European practices, and spiritual healing. The NHA seeks accreditation for training in natural healing with the Services Seta.[36]

The DoH acknowledges that traditional healers provide the first line of care in many communities and therefore play an important role in the healthcare system.[37]

h) *The South African Council for Social Service Professions*

The South African Council for Social Service Professions (SACSSP) recognises the occupation of "social worker" as a profession and also the para-profession of "social auxiliary worker". Recognition of the profession means that social workers have the right to practise in a particular field of expertise governed by the professional body.[38]One professional board is established under the auspices of the SACSSP; namely the Professional Board for Social Work, while preparatory work was underway in May 2012 to form the Professional Board for Child and Youth Care.[39] In 2008, a process was begun to establish a professional board for community development workers, but this has not been achieved.[40]

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. It is important to note that probation work is earmarked as a specialist area of social work. Child and youth care workers will only be able to register at auxiliary level once the status of this occupational category has been decided upon.[41]

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

30 Although the Traditional Health Practitioners Act, 22 of 2007 was enacted in Parliament, it has not come into operation. The date of its commencement will be published in the *Government Gazette*.

31 Section 1 of the Traditional Health Practitioners Act 22 of 2007.

32 Section 47(1)(f) of the Traditional Health Practitioners Act, 22 of 2007; Peltzer, K. 2009. "Traditional health practitioners in South Africa".Lancet. 19 September 2009. Vol.374. Published at http://www.thelancet.com. (Accessed August 2010).

33 Gqaleni, N., Moodley, I., et al. 2007. "Traditional and Complementary Medicine".South African Health Review. 2007. Published at http://www.hst.org.za/uploads/files/chap12_07.pdf. (Accessed 12 August 2011).

34 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation" in South African Health Review 2012/13.Published athttp://www.hst.org.za/publications/south-african-health-review-2012/13. (Accessed 13 July 2013).

35 Traditional Healers Organisation of South Africa. 2011. "Organisational profile". Published at http://traditionalhealth.org.za/t/documents/THO%20profile_2011.pdf.(Accessed 9 August 2011).

36 Natural Healers Association. 2010. Published at http://www.naturalhealersassociation...(Accessed August 2010).

37 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

38 SACSSP. 2010. Official Newsletter 2(2), December. Published at: ftp://ftp.sacssp.co.za/...pdf.(Accessed 12 August 2011).

39 SACSSP. 2012. SACSSP Newsletter May 2012. Published at http://www.sacssp.co.za... (Accessed 24 August 2012

40 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

41 Mahery, P. & Jamieson, L. 2009. Understanding the Social Service Occupations and Professions Bill, *Child and Youth Care Work* Vol. 27 No. 5 September/October 2009.

The Social Service Professions Act, 110 of 1978 is currently under review. Work is underway to develop a policy on social service professions and occupations for approval by Cabinet and to redraft the Social Service Professions and Occupations Bill of 2008 following public consultations on the policy framework.[42] The latter Bill distinguishes between social service professions and social service occupations such as the child and youth care occupations.

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 research.[43]The MRC conducts research in 39units 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 health.[44]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 sciences.[45]

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 providers.[46] The NHLS replaced the South African Institute for Medical Research, the National Institute for Virology, and the National Centre for Occupational Health, state-owned forensic chemistry laboratories, and provincial health laboratory services. 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 Antivenom Unit. With a network of 349 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. The NHLS employs approximately 6 700 people across all nine provinces and serves over 80% of the population.[47] Priority programmes of the NHLS address HIV and tuberculosis. These aim to make laboratory services accessible, functional and supported by well-trained health professionals.[48]

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 sciences[49] to teach at undergraduate and postgraduate levels. Subjects include anatomical pathology, haematology, microbiology, infectious diseases, immunology, human genetics, chemical pathology, epidemiology, tropical diseases, molecular biology, medical entomology, and human nutrition.

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 agencies.[50] 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 tuberculosis.[51] 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),

42 South African Council for Social Service Professions. 2012. SACSSP Newsletter May 2012. Published at http://www.sacssp.co.za/.. (Accessed 24 August 2012); South African Council for Social Service Professions. 2010. Official Newsletter 2(2), December. Published at: ftp://ftp.sacssp.co.za/... (Accessed 12 August 2011).

43 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.

44 MRC 2013.Our research. Published at http://www.mrc.ac.za/research/ourresearch.htm.. (Accessed 16October 2013).

45 MRC. 2005. *Research Strategy 2005-2010*. Published at http://www.mrc.ac.za/... (Accessed August 2010).

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

47 NHLS. 2013. About us.Published athttp://www.nhls.ac.za/?page=about_us&id=16(Accessed 16October 2013).

48 NHLS. 2011. Priority programmes.Published at http://www.nhls.ac.za/?page=priority_areas&id=11(Accessed 16October 2013).

49 These are the faculties of health sciences of the universities of Cape Town, Free State, KwaZulu-Natal, Limpopo (MEDUNSA Campus), Pretoria, Stellenbosch, Witwatersrand, Walter Sisulu University for Technology and the Science and the Oral Pathology Department of the University of the Western Cape.

50 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.

51 HSRC. 2011. About the HSRC. Published at: http://www.hsrc.ac.za/index... (Accessed 13 August 2011).

established to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate its severe impact in sub-Saharan Africa.[52]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 form.[53]

d) *Onderstepoort Veterinary Institute*

The Onderstepoort Veterinary Institute (OVI) has been engaged in veterinary research for more than a century.[54]Today it is one of several research institutes of the Agricultural Research Council (ARC), established to undertake research, development and technology transfer in the use and improvement of agricultural resources.[55]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 (especially for foot and mouth and tick-borne diseases) 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 animal diseases in Africa.[56]

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 livelihoods. 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 way.[57]

52 HSRC 2011.HIV/AIDS, STIs and TB.Published at http://www.hsrc.ac.za/HAST.phtml.(Accessed 13 August 2011).
53 HSRC. 2011. About the HSRC. Published at: http://www.hsrc.ac.za/..(Accessed 13 August 2011).
54 The OVI was founded in 1908 by Sir Arnold Theiler.
55 The ARC is established by the Agricultural Research Act 86 of 1990. Published at http://www.arc.agric.za/home.asp?pid=1118&sec=792 (Accessed 16October 2013).
56 ARC. 2013. *ARC - Onderstepoort Veterinary Institute*. Published at http://www.arc.agric.za/home.asp?pid=373

(Accessed 16October 2013).
57 Department of Agriculture, Forestry and Fisheries. 2012. *Strategic Plan 2012/13 - 2016/17 for the Department of Agriculture, Forestry and Fisheries.*Published at http://www.nda.agric.za/. (Accessed 5 September 2012)

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 independentlyowned private hospitals in the country. HASA is a key roleplayer 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). As the official mouthpiece of the private hospital industry, it 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 support 218 000 jobs, or 1.8% of total South African employment. Seventy-eight percent of these jobs are held by previously disadvantaged individuals.[58]

b) *The National Welfare Forum*

The National Welfare Forum is a national coalition of non-governmental organisations (NGOs), community based organisations (CBOs), provincial and local networks and academic institutions that serves affiliate member organisations that work in the development field.[59]It advocates and promotes the development of an effective social welfare system by engaging role-players and decision-makers on social policy, legislation and programmes.

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 lobbying.[60]

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

58 HASA. 2013. *Facts about HASA*. Published at http://www.hasa.co.za/about/facts-about-hasa/.(Accessed 16 October 2013).
59 NAWONGO. 2012. What is the National Welfare Forum?Published at http://www.nwf.org.za/vision-mission-goals-and-objectives.(Accessed 24 August 2012).
60 South African National Non-Governmental Organisation Coalition. 2012. About. Published at http://sangocoonline.wordpress.com/about/.(Accessed 26 September 2012).

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 effectiveness.[61]

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 capacity.[62]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).[63]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 clients.[64]

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 2012, a total of85 248 NPOs were registered with the DSD, up from 49 827 in 2007/08, and this represents an annual increase of about 14%.[65] 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 (34 130 of registered NPOs or 40%), and development and housing (16 817 NPOs or 20%). This is followed by religion (9 856 or 12%), health (9 145or 11%), and education and research (6 241 or 7%).[66]

Patel identifies four categories of NPOs that operate in the social development sector:[67]

a) Public service contractors (PSCs) are NPOs that deliver services on behalf of government. PSCs are largely formally organised and 80% of them have been in existence for between 21 and 80 years. These contractors provide a wide range of services, including professional social services, and mostly support 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.

c) Faith-based organisations (FBOs) tend to be a hybrid of the first two types.

d) Community-based organisations (CBOs) are informally organised and are partners with intermediary NPOs to deliver services. Many CBOs are delivery- or implementing agencies for government, PSCs, donor-funded NPOs and FBOs. Generally, CBOs are small locally-based organisations with limited access to skills and funding, and do not employ staff but use unpaid volunteers. Many are rooted in local communities and associated with religious and traditional structures. Although the size of this NPO sub-set is not known, it is estimated that just more than 50% of NPOs fall in this category.[68]

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. Other organisations provide material assistance (e.g. food and clothing), income support and maintenance, and temporary shelter to refugees and vulnerable persons.[69]

61 NAWONGO. 2009. NAWONGO condensed policy document. Published at www.nawongo.co.za/UserFiles/... (Accessed 14 August 2011).
62 National Treasury. 2009. *Provincial Budgets and Expenditure Review* 2005/06 – 2011/12.
63 DSD. 2011. "All about non-profit organisations". Published at http://www.dsd.gov.za/npo/...(Accessed 9 August 2011).
64 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/.. (Accessed 14 August 2011).
65 DSD. 2012 State of South African Registered Non-profit Organisations. Published at http://www.dsd.gov.za/npo/... (Accessed 9 November 2012).
66 DSD. 2012 State of South African Registered Non-profit Organisations. Published at http://www.dsd.gov.za/npo/... (Accessed 9 November 2012).
67 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).
68 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).
69 DSD. 2012 State of South African Registered Non-profit Organisations. Published at http://www.dsd.gov.za/npo/... (Accessed 9 November 2012).

More than 9 800 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. As such, NPOs play crucial roles in the healthcare sector. They contribute to research, education, policy advocacy, development and care, in areas such as HIV/AIDS, tuberculosis, mental healthcare, 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 programmes.70 A number of NGOs are involved in the recruitment, training and orientation of health professionals for deployment in the public sector.71

NPOs involved in veterinary services, animal protection and welfare are classified in the environmental category and by 31 March 2012 a total of 1 036 organisations (or 1% of NPOs) were registered in that category.[72].Of those, 384 indicated that they provide veterinary-, animal protection-, animal welfare-, or wildlife-preservation services.

2.4.5 Professional associations

The health sector accommodates numerous voluntary organisations and associations that generally promote the interests of specific healthcare professions, specialised fields of professional practice, and their members. More specifically, 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. Membership of these voluntary organisations also entitles practitioners to gain access to conferences, seminars, lectures and international associations in the same field of medical practice. 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 profession. Voluntary organisations also keep social workers abreast of professional matters and network with other associations at a local, national and global level.73 Examples of these voluntary organisations in the social development sector 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 Institutions. A number of umbrella organisations such as the National Welfare Social Service & Development Forum engage in lobbying, advocacy and monitoring of social policies, the delivery of social development programmes, and legislation. These associations also build capacity to enable their member organisations to deliver more effective, accessible and sustainable social development services.74

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

70 DoH. "Partnerships for Primary Health Care". Published at http://www.doh.gov.za/pdphcp/.... (Accessed August 2010); Burger D. 2009.South Africa Yearbook 2009/10.Published at http://www.gcis.gov.za/...yearbook/2009-10.htm.(Accessed August 2010); Department of Social Development. 2011. State of Registered Non-profit Organisations 2010-2011. Published at http://www.dsd.gov.za/npo... (Accessed 14 August 2011).

71 Africa Health Placements. 2010. Published at http://www.ahp.org.za. (Accessed August 2010).

72 DSD. 2012 State of South African Registered Non-profit Organisations. Published at http://www.dsd.gov.za/npo/.... (Accessed 9 November 2012).

73 SACSSP. 2011. Official Newsletter 1(1), July. Published at: http://www.sacssp.co.za/...pdf.(Accessed 12 August 2011).

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

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 for health professionals, 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 hearings.[75]

Among the larger unions in the health and social development sectorsare 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 588 300 people who are formally employed in the health and social development sector. Of these, 262 500 (45%) are employed in private sector organisations (referred to later as the "private sector") and levy-paying public sector organisations, while 325 700 (55%) work in the public service departments. 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 3% of total employment and in the private sector 4%. Professionals comprise 41% of employees in the Public Service and 39% 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.

75 NEHAWU. 2013. NEHAWU member services. Published at http://www.nehawu.org.za/NEHAWU%20members%20services.html (Accessed 17 October 2013);

DENOSA. 2013. Membership services. Published at http://www.denosa.org.za/DENOSA.php?id=17 (Accessed 17 October 2013);

SADNU. 2013. Contacts. Published at http://www.cosatu.org.za/contact.php?id=16 (Accessed 17 October 2013);

HOSPERSA.2013Principals and objectives.Published athttp://www.hospersa.co.za/Principlesandobjectives_3.ca. (Accessed 17 October 2013);

SAMA. 2013. Member benefits. Published at https://www.samedical.org/membership.html.(Accessed 17 October 2013).NUPSAW. 2013. Vision and Mission. Published at http://www.nupsaw.co.za/index.php/en/objectives (Accessed 17 October 2013);

NPSWU. 2013. About NPSWU. Published at http://npswu.org/index.php?option=com_content&view=article&id=51&Itemid=27.(Accessed 17 October 2013).

PAWUSA. 2013. Benefits. Published at http://www.pawusa.org.za/benefits/member-benefits.html. (Accessed 17October 2013);

PSA 2013.Objectives.Published at http://www.psa.co.za/objectives (Accessed 17October 2013).

Table 2-1 Total employment in the private sector and in Public Service according to occupational category

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	8 861	3	11 652	4	20 513	3
Professionals	132 433	41	101 190	39	233 623	40
Technicians and Associate Professionals	68 674	21	64 515	25	133 189	23
Clerical Support Workers	35 043	11	41 017	16	76 060	13
Service and Sales Workers	37 325	11	26 914	10	64 239	11
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 402	0	1 975	1	3 377	1
Plant and Machine Operators and Assemblers	4 626	1	4 702	2	9 328	2
Elementary Occupations	37 399	11	10 538	4	47 937	8
Total	**325 763**	**100**	**262 503**	**100**	**588266**	**100**

Sources: Calculated from HWSETA and PSETA WSP applications 2013, MEDpages database, October 2013.

c) *Population group*

Most (68%) of the workers employed in the health and social development sector are African, 16% are white, 12% coloured, and 4% are Indian (Figure 2-2).

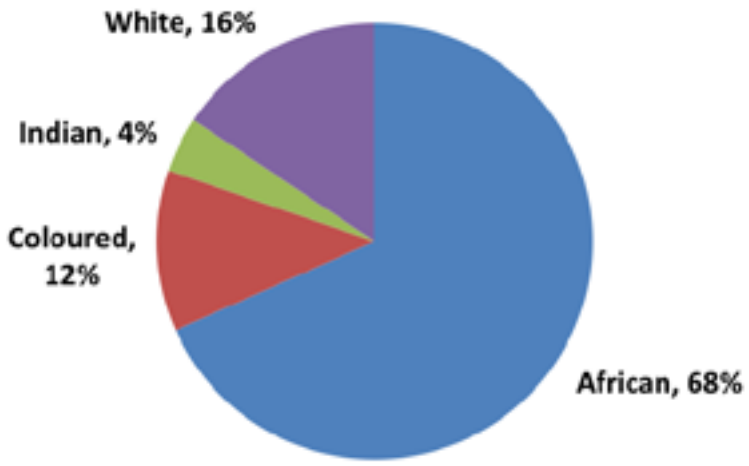


Figure 2-2 Population group distribution of employees in the health and social development sector

Table 2-2 shows the population group distribution of people in the different occupational groups. The majority (73%) of managers in the Public Service are Africans, followed by whites at 10%, coloureds at 12%, and Indians at 5%. In the private sector 53% of the managers are white, 27% are African, 11% coloured and 9% Indian. The majority of professionals in the Public Service (79%) are African, while respectively 76% and 51% of technicians and associate professionals in the Public Service and private sector are African. In the total sector 68% of employees are African, 16% white, 12% 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 Sector				
	African	Coloured	Indian	White	Total	African	Coloured	Indian	White	Total	African	Coloured	Indian	White	Total
	%					%					%				
Managers	73	12	5	10	100	27	11	9	53	100	47	12	7	34	100
Professionals	79	8	4	10	100	43	11	7	38	100	67	9	5	19	100
Technicians and Associate Professionals	76	15	2	7	100	51	15	7	26	100	64	15	5	16	100
Clerical Support Workers	77	14	3	6	100	49	17	6	28	100	62	16	5	18	100
Service and Sales Workers	92	5	2	1	100	63	21	3	14	100	80	12	2	6	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	76	12	4	8	100	58	15	6	21	100	66	14	5	16	100
Plant and Machine Operators and Assemblers	88	8	3	1	100	68	23	2	7	100	78	15	3	4	100
Elementary Occupations	91	7	0	2	100	76	17	2	6	100	88	9	1	3	100
Total	**80**	**10**	**3**	**7**	**100**	**50**	**15**	**6**	**29**	**100**	**68**	**12**	**4**	**16**	**100**

Sources: Calculated from HWSETA and PSETA WSP applications 2013.

d) *Gender*

The gender distribution of employees in the total health and social development sector can be seen in Table 2-3. Most (73%) of the employees in this sector are women. All the occupational categories are dominated by women, 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	40	60	100	45	55	100	43	57	100
Professionals	21	79	100	21	79	100	21	79	100
Technicians and Associate Professionals	30	70	100	22	78	100	26	74	100
Clerical Support Workers	35	65	100	27	73	100	31	69	100
Service and Sales Workers	27	73	100	24	76	100	26	74	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	82	18	100	72	28	100	76	24	100
Plant and Machine Operators and Assemblers	77	23	100	91	9	100	84	16	100
Elementary Occupations	32	68	100	35	65	100	33	67	100
Total	**28**	**72**	**100**	**27**	**73**	**100**	**27**	**73**	**100**

Sources: Calculated from HWSETA and PSETA WSP applications 2013.

e) *Age distribution*

The age distribution of employees in the Public Service can be seen in Table 2-4. Most of the employees in the sector (57%) fall in the age group 35 to 55, while a third of employees are younger than 35. However, 26% of Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers are older than 55.Most managers in the Public Service (72%) fall in the age group 35 to 55.

Information on the age distribution of people working in the private sector component of the health and social development sector is not available.[76]

Table 2-4 Age distribution of employees in the Public Service according to occupational group

Occupational Group	Age category			Total
	<35	35 - 55	55+	
	%			
Managers	15	72	14	100
Professionals	34	57	9	100
Technicians and Associate Professionals	37	55	7	100
Clerical Support Workers	41	51	8	100
Service and Sales Workers	30	59	11	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	18	57	26	100
Plant and Machine Operators and Assemblers	25	64	11	100
Elementary Occupations	24	59	16	100
Total	**33**	**57**	**10**	**100**

Source: Calculated from WSPs submitted to the PSETA, 2013.

f) *Disability*

Only a small percentage of the people employed in the sector were living with disabilities (Table 2-5). Of the 802 disabled employees in the public service, 369 were employed as clerical suppport workersand 131 as professionals and of the 1 065 employees in the private sector, 302were employed as clerical suppport workers, 284 as technicians and associate professionals and 217 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	27	7	1	19	54	0.6	18	16	1	31	66	0.6
Professionals	85	15	7	24	131	0.1	38	19	25	135	217	0.2
Technicians & Associate Professionals	50	17	3	11	81	0.1	138	47	19	80	284	0.4
Clerical Support Workers	257	32	28	52	369	1.1	108	49	20	125	302	0.7
Service & Sales Workers	60	9	0	4	73	0.2	51	38	4	39	132	0.5
Skilled Agricultural, Forestry, Fishery, Craft &Related Trades Workers	9	1	0	4	14	1.0	3	1	0	5	9	0.5
Plant &Machine Operators &Assemblers	4	2	0	1	7	0.2	5	0	0	1	6	0.1
Elementary Occupations	51	10	0	12	73	0.2	25	9	1	14	49	0.5
Total	543	93	39	127	802	0.2	386	179	70	430	1 065	0.4

Sources: Calculated from HWSETA and PSETA WSP applications 2013.

76 The HWSETA doesn't ask for information on age in their WSP submissions.

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. 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 civil society 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 588 300, 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 apartheidera. 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-1990s.[77]

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-oriented.[78] 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 environmentare 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 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.

77 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care" in *South African Health Review 2008*.Published at www.hst.org.za.(Accessed August 2010); Harrison, D. 2009. An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Department of Health. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.

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

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 payments.[79] The public sector is underresourced relative to the burden of disease and the user population served. South Africa spends about 8.5% of its GDP on health, higher than the 5% recommended by the World Health Organization (WHO).[80]Health expenditure as a percentage of total government spending is projected to reach 14.6% in 2013.[81]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 8.5 million people (16%) are entitled to medical scheme benefits.[82]However, a larger proportion of the population (estimated between 24% and 30%) use some private services provided by general practitioners and pharmacists.[83]

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 2012healthcare expenditure was estimated to be above R255 billion, with 50.3% of this attributable to public sector spending and 49.7% to private financing. Over the three financial years 2010 to 2012, medical scheme contributions paid on behalf of 16% of the population was only 1% to 5% below the combined health expenditure of the nine provincial governments.[84]

79 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011).

80 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011).

81 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" South African Health Review 2011.Published at:http://www.hst.org.za/publications/south-african-health-review-2011. (Accessed 27 August 2012).

82 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011); Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/.... (Accessed 10 November 2012).

83 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011(Accessed 27 August 2012).

84 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing" *South African Health Review 2011*. Published athttp://www.hst.org.za/publications/south-african-health-review-2011.(Accessed 27 August 2012).

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

	Rand million				
Public sector	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
National Department of Health core	1645	1736	1784	1864	1961
Provincial departments of health	88593	98066	110014	119003	126831
Defence	2483	2770	2961	3201	3377
Local government (own revenue)	1829	1865	1977	2096	2221
Education	2350	2503	2653	2812	2981
Other (Correctional services & social insurance funds) [1]	2946	3451	3720	3905	4110
Total public sector health	***99848***	***110391***	***123110***	***132881***	***141473***
Private sector					
Medical schemes	84863	96482	104008	112120	120866
Out-of-pocket	16200	17172	18202	19294	20452
Medical insurance	2660	2870	3094	3336	3596
Employer private	1271	1372	1479	1594	1718
Total private sector health	***104994***	***117896***	***126783***	***136344***	***146632***
Donors or NGOs	6319	5787	5308	5574	5852
TOTAL	**211161**	**234074**	**255201**	**274799**	**293957**

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" in *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, ofthe 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 more than doubled in real terms over the period 1996 to 2011, representing an increase of around R60billion.Government spending on public healthcaregrew at an average annual rate of 5.6% in real terms from 2007/08 to 2013/14. Per capita public sector health spending amounted to R2,667 in 2011; i.e. 48% higher in real terms than in 1995/96.[85]Over the last 17 years the public sector has moved from an in-hospital approach to a primary healthcare (PHC) approach.[86] This is also reflected in public sector spending. About 43.5%[87] 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 sector.[88]

Government recognises that given competing demands for resources, it is unlikely to absorblarge increases inhealth budgets.For this reason the sector will have to improve efficiencies and human resources management to improve services and coverage.[89]

85 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011.(Accessed 27 August 2012).
86 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.Published at http://thelancet.com.(Accessed August 2010).
87 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 August 2012).
88 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published athttp://www.doh.gov.za.(Accessed 10 August 2012); Blecher, M., Kollipara, A., De Jager, P. et al. 2011."Health Financing".South African Health Review 2011. Published at http://www.hst.org.za/....(Accessed 27 August 2012).
89 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

b) *Private sector spending*

Private sector spending as a percentage of total health expenditure declined from 52.5% in 2007/08 to 49.7% in 2011, partly due to recent increases in public spending and lower estimated out-of-pocket expenditure.[90]By 2012 gross contributions to medical schemes per average principal memberreached R18 972 compared to R8 168 in 2000 for the average beneficiary. This represents a growth of 43.3% over the period.[91]Per capita expenditure through private medical schemes was R11 084 in 2011, or more than four times the level in the public sector.[92]

Medical schemes spent R93.2 billion on healthcare benefits in 2011, an increase of 10% from 2010. Hospital expenditure accounted for R34.1 billion (37%).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).[93]Payments to medical specialists amounted to R21.3 billion or 22.8% of benefits paid, with a resulting year-on-year increase of 13.5%.[94]

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 healthcare.[95]This affects the nature of labour demand in the two sectors.

According to the Development Bank of South Africa (DBSA), South Africa's public health expenditure is slightly below that of comparable middle-income countries, but its per capita expenditure is above the median level. However, when health outcomes are compared with those of peer countries, South Africans are worse off. It could therefore be said that the health system is underperforming in relation to its financing levels.Reasons for this under-performance are, in part, related to the quality of healthcare management, the allocation of resources, and technical inefficiencies, all of which in turn may be related to the availability of managerial skills in the sector.[96]

3.2.2 Spending on social development

The social development sector primarily focuses on social assistance, social security, welfare services and community development by targeting poor and vulnerable groups. Information on social development expenditure from donor organisations is not readily available.Transfers by national and provincial social development departments to the NGO sector 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 2015/16.[97]

Expenditure by the DSD grew from R85.3 billion in 2009/10 to R112.1 billion in 2012/13, at an average annual rate of 9.3%.[98]The rise is mainly as a result of increases to social assistance programmes, which extended the child support grant to all children to the age of 18, and lowered the qualifying age for men to 60 years to access the old-age grant.[99] The medium term expenditure estimate for 2013/14 is R120.4 billion and increases to R137.6 billion for 2015/16, or by 7.3% per annum.[100]Expenditure on social assistance grants is projected to increase at an annual rate of 7.3% between 2013/14 and 2015/16, or from R113 billion to R129.4 billion.[101] In 2012/13approximately 93.8% of the DSD budgetwastransferred to social assistance programmes for the payment of social grants.[102]

Since many NGOs face financial difficulties due to increased demand for services and a decline in donor funding, the 2013 Budget provides for additional funding.[103]

90 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011.(Accessed 27 August 2012).
91 Calculated from Council for Medical Schemes. 2012. Annual Report 2011-2012Published at http://www.medicalschemes.com/.... (Accessed 10 November 2012);Calculated from Council for Medical Schemes. 2011. Annual Report 2010-2011. Published at http://www.medicalschemes.com/.... (Accessed 24 August 2012).
92 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).
93 Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/.... (Accessed 10 November 2012 and 15 July 2013).
94 Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/.... (Accessed 10 November 2012 and 15 July 2013).
95 Day, C. and Gray, A. 2008."Health and Related Indicators". South African Health Review.Published at http://www.hst.org.za/uploads/files/chap16_08.pdf.(Accessed August 2010).
96 Development Bank of South Africa. 2008. A Roadmap for the Reform of the South African Health System; McIntyre, D. 2011. "(Dis) agreements in South African health system reform debates". Symposium on health reform, Stellenbosch, Published at http://uct-heu.s3.amazonaws.com/wp-content/uploads/2011/07/DiMcIntyre-1.pdf (Accessed 14 August 2011).
97 National Treasury.*2013 Budget Review.*
98 National Treasury. "Vote 19: social Development". *2013 Estimates of National Expenditure*.
99 Department of Social Development. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013); National Treasury. 2012. "Vote: 19: Social Development". *2012 Estimates of National Expenditure.*
100 National Treasury. "Vote 19: social Development". *2013 Estimates of National Expenditure.*
101 National Treasury. "Vote 19: social Development". *2013 Estimates of National Expenditure.*
102 Department of Social Development. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013):National Treasury. 2012. "Vote: 19: Social Development". *2012 Estimates of National Expenditure.*
103 National Treasury.*2013 Budget Review.*

3.3 THE DEMAND FOR HEALTH AND SOCIAL DEVELOPMENT SERVICES

3.3.1 Demand for health services

Table 3-2 shows the use of public and private facilities as measured by the General Household Survey of 2010.The majority of households (60.5%) in 2010 first sought medical help at public clinics. Nearly one-quarter (24.1%) initially consulted private medical practitioners while 9.3% approached public hospitals first. Access to medical insurance continues to determine whether people mostly access medical care in the private or public sector: 83.1% of households where at least one member had such cover usually consulted the private sector compared to only 14.6% of uninsured households.[104]

104 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators".South African Health Review 2011.Published at http://www.hst.org.za/publications/south-african-health-review-2011.(Accessed 27 August 2012).

Table 3-2 Place usually consulted by households (%), by medical insurance cover of household: 2010

Place usually consulted		At least one person belongs to medical scheme	No medical scheme cover or unknown	Total
Public sector	Hospitals	4.5	10.6	9.3
	Clinic	11.6	73.7	60.5
	Other in public sector	0.2	0.4	0.3
	Total public sector	16.4	84.7	70.1
Private sector	Hospital	9.0	0.7	2.4
	Clinic	5.0	0.8	1.7
	Private doctor/specialist	68.1	12.2	24.1
	Traditional healer	0.0	0.2	0.2
	Spiritual healers workplace/church	0.0	0.3	0.2
	Pharmacist/Chemist	0.5	0.3	0.3
	Health facility provided by employer	0.3	0.1	0.1
	Alternative medicine e.g. homeopath	0.0	0.0	0.0
	Other in private sector	0.2	0.0	0.1
	Total in private sector	83.1	14.6	29.2
Total		**100.0**	**100.0**	**100.0**

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

An estimated 64% to 68% of the population is entirely dependent on public sector care.[105]Research by the Health Economics Unit at UCT found that 16% of the population pays for private healthcare out of pocket (with average annual spending amounting to R2,806 per capita) and uses the public sector for specialist and in-patient care (on a tax-funded basis).[106]

a) *The demand for public healthcare*

Table 3-3shows that utilisation of public services increased in several categories between 2007/08 and 2010 and it is projected to increase until 2014.

105 HEU Information Sheet 3. 2009. "The public-private health sector mix in South Africa". Health Economics Unit, UCT. Published at http://www.heu-uct.org.za (Accessed August 2010); Coovadia, H., Jewkes, R. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet. September 2009. Vol. 374.

106 McIntyre, D. 2011. "(Dis)agreements in South African health system reform debates". Symposium on health reform, Stellenbosch, July. Published at http://uct-heu.s3.amazonaws.com/wp-.../07/DiMcIntyre-1.pdf (Accessed 14 August 2011).

Table 3-3 Past and projected utilisation of public health services: 2007/08 to 2013/1

Healthcare service area	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Bed utilisation rate: district hospitals	65.2%	67.8%	66.9%	54.4%	70%	75%	75%
PHC utilisation rate: Ave number of visits per person p.a.	2.4	2.4	2.5	2.5	2.6	2.8	3
Tuberculosis treatment defaulter rate	7%	8.5%	7.9%	7%	6%	5%	5%
Number of new patients put on antiretroviral treatment p.a.	483 084	781 907	539 819	440 000	625 000	650 000	675 000
National immunisation coverage (children under age of 1 year)	87% 899 256	92.1% 926 168	97.4% 955 485	95% 1 066 401	95% 1 066 401	95% 1 066 401	95% 1 066 401
Measles immunisation coverage rate (2nd dose)	71.2% 736 098	78% 797 617	90% 900 347	95% 1 066 401	95% 1 066 401	95% 1 066 401	95% 1 066 401

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

Although the bed utilisation in district hospitals declined to 2010/11, it is projected to increase sharply until 2014. Demand for PHC services will continue to increase. PHC visits increased from 82 million to 122 million during the decade 2001 to 2010.[107] The DoH envisages that demand for PHC services will increase to 3.2 visits per person per annum by 2014/15, which represents an increase of 7.5% per annum over a four-year period.[108]

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.

Demand for hospital services has also increased between 2000/01 and 2009/10.[109] Overall hospital admissions increased from 3.5 million to above 4 million per annum. Although the number of inpatient days declined from 24.6 million to 22.5 million, the average length of stay appeared to increase. Analysis by the Health Systems Trust shows that the national average length of stay at public sector health facilities was 5.3 days in 2010, notably higher than 4.0 days for district hospitals in 2001.[110]. Outpatient visits increased from 17 million to 26 million during the period.[111]

Demand for healthcare services in the public sector continues to rise and exceeds supply. Reports about lack of medicines and equipment, as well as backlogs in payments for goods and services procured, remain fairly common.[112]Not everyone requiring HIV/AIDS medication can be treated because of resource constraints.[113]Recent research has shown that the rise in the child mortality rate in South Africa since 1990 can be attributed to constraints in the availability of healthcare services (the coverage of care) and the quality of care due to staff shortages. Specifically,the available financial and human resources are insufficient to meet the demands for care of mothers, babies and children.[114]Low-quality care in the neo-natal stage may result in complications such as cerebral palsy and blindness (retinopathy of prematurity) which have a long-term impact on the demand for specialist care. Demand for healthcare among the urban poor population is also increasing due to the growing prominence of non-communicable and chronic diseases such as diabetes, hypertension and kidney disease, and certain types of cancer.[115]

A comprehensive revitalisation programme for public hospitals and public healthcare facilities is underway. New hospitals are under construction and existing facilities are being upgraded, renovated and repaired.[116]As the number of hospital beds is increased, so will the demand for medical professionals and staff increase as well.

107 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 August 2012).

108 Department of Health 2012.Annual Performance Plan 2012/13 – 2014/15.Published at http://www.health.gov.za.(Accessed 10 August 2012). Percentage growth was calculated from DoH figures.

109 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011 (Accessed 27 August 2012).

110 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators".South African Health Review 2011.Published at http://www.hst.org.za/publications... (Accessed 27 August 2012); Day, C and Gray, A. 2010."Health and Related Indicators".South African Health Review 2010. Published at http://www.hst.org.za/recently-updated-.... (Accessed 10 August 2011).

111 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011(Accessed 27 August 2012).

112 National Treasury. 2009. "Health". In *Provincial Budgets and Expenditure Review* 2005/06 – 2011/12.

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

114 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. September 2009. Vol. 374.Published at http://thelancet.com.(Accessed August 2010).

115 Chopra, M., Lawn, J.E., Sanders, D. et al. 2009. "Achieving the health Millennium Development Goals for South Africa: challenges and priorities". Lancet. September 2009. Vol. 374.Published at http://thelancet.com.(Accessed August 2010).

116 National Treasury. 2010. "Vote 15: Health". *Estimates of National Expenditure 2010.*

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. It is estimated that medical scheme coverage varied between 14.5% and 17.1% of the population between 1985 and 2010.[117] The number of hospital beds in the private sector increased from 20 908 in 1998 to 31 067 in 2010 or by 3.4% per yearover the period.[118]Membership of medical schemes increased from about 6.7 million in 2000 to 8.5 million in 2011 – i.e. by 26.9%.[119] 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 2011.[120]Recent research by Econex found that hospital utilisation (patient days) per beneficiary increased by 12.5% between 2006 and 2010, or from 753 private hospital days per 1 000 beneficiaries to 847 days per 1 000 beneficiaries.[121] However, the average length of stay in private hospital per beneficiary per annumdecreased from 3.8 days in 2006 to 3.2 days in 2011.[122]More older people are being admitted to hospital more often and beneficiaries with chronic diseases are increasing the utilisation of private hospital services.[123]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.[124]

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 staff.[125]Growing numbers of people from the poorest households prefer to pay for private care, which increases the demand for private providers and GPs in particular.[126]

3.3.2 Demand for social development services

Demand for social development services continues to expand. By 2012/13, the recipients of social grants totalled 16 million people, more than double the beneficiary total of 7.9 million people in 2004.[127]. The table below shows the growth in social grant beneficiary numbers by grant category since 2009/10. By March 2015, the number of grant beneficiaries is expected to reach 16.9 million and will climb to 17.1 million by March 2016.[128]Demand for social assistance to children is increasing faster than in other categories. Recipients of the child support grant (i.e. 11.7 million children) account for 71% of the social grant beneficiaries in 2013/4. By 2015/16 the number of children qualifying for the child support grant should increase to 12.1 million. The number of foster care beneficiaries is projected to grow by 4.4% per annum between 2009/10 and 2015/16, mainly as the result of the growing numbers of AIDS orphans and the enhanced capacity of courts to provide oversight under the Children's Act 38 of 2005.[129] The DSD has identified the need to promote national adoptions as a preferred mode of permanent placement of children.[130]

117 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

118 Calculated from Day, C., Gray, A. et al. 2011."Health and Related Indicators".South African Health Review 2011. Published at http://www.hst.org.za/publ...review-2011.(Accessed 27 August 2012); Day, C and Gray, A. 2010."Health and Related Indicators".South African Health Review 2010.Published at http://www.hst.org.za/...(Accessed 10 August 2011).

119 Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/...aspx. (Accessed 10 November 2012).

120 Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/...aspx. (Accessed 10 November 2012).

121 Econex.2012 "Medical Scheme Expenditure on Private Hospitals".Published at http://www.hasa.co.za/wp-content/uploads/2012/12/Medical-expenditure-on-private-hospitals_Aug20121.pdf.(Accessed 20 July 2013).

122 Council for Medical Schemes. 2010. Annual Report 2009 - 2010. Published at http://www.medicalschemes.com/...pdf.(Accessed 14 August 2011); Council for Medical Schemes. 2011. Annual Report 2010-2011. Published at http://www.medicalschemes.com/...aspx. (Accessed 24 August 2012); Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/...aspx.(Accessed 10 November 2012 and 15 July 2013).

123 Econex.2012 "Medical Scheme Expenditure on Private Hospitals".Published at http://www.hasa.co.za/wp-content/uploads/2012/12/Medical-expenditure-on-private-hospitals_Aug20121.pdf.(Accessed 20 July 2013).

124 Council for Medical Schemes. 2009. Annual Report 2008-2009. Published at http://www.medicalschemes.com/...aspx. (Accessed 24 August 2012); Council for Medical Schemes. 2011. Annual Report 2010-2011. Published at http://www.medicalschemes.com/...aspx.(Accessed 24 August 2012); Council for Medical Schemes. 2012. Annual Report 2011-2012. Published at http://www.medicalschemes.com/Public...aspx.(Accessed 10 November 2012).

125 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).

126 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011); Van der Berg, S., Burger, R., Theron, N. et al. 2010.Financial Implications of a National Health Insurance Plan for South Africa.

127 National Treasury.*2013 Budget Review*. National Treasury.*2008 Budget Review.*

128 National Treasury.*2013 Budget Review;* Medium-term Budget Policy Statement by Minister of Finance, October 2012.

129 National Treasury. 2013*Budget Review;* Department of Social Development. 2011. *Annual Performance Plan2011/12.*

130 Department of Social Development. 2011. *Annual Performance Plan2011/12.*

Table 3-4 Social grants beneficiaries by type, past and projected, 2009/10to 2015/16

Type of grant	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Older persons (old-age)	2 490	2 647	2 711	2 851	2 931	3 013	3 096
War veterans*	1	1					
Disability	1 299	1 212	1 172	1 179	1 180	1 181	1 181
Foster care	489	490	518	529	569	604	633
Care dependency	119	121	122	130	135	140	146
Child support	9 381	10 154	10 675	11 406	11 699	11 937	12 116
Total	**13 779**	**14 625**	**15 198**	**16 059**	**16 514**	**16 875**	**17 172**

* Included with old age beneficiaries from 2011/12.

Sources: National Treasury. *2012Budget Review*;National Treasury.*2013 Budget Review.*

The sector is experiencing a growing need for service delivery 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 disabilities.[131] NGOs also report an increased demand for residential services over the last decade.[132]

An increasing number of NPOs is formalising their activities. Registration of NPOs with the DSD totalled 85 248 at the end of March 2012, up from 49 826 in 2008 (an increase of almost 14% p.a.). Reasons for the increase in registrations include funding requirements set by donor agencies and government departments, and conditions imposed by financial institutions for NPOs to operate a bank account.[133]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 unemployment.[134] NGOs also report an increase in demand for social relief, poverty eradication interventions, income-generation projects, and skills development programmes.

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. Although the government has no single official poverty line, a measure of R524 per person per month in 2008 prices (updated to 2010) is applied.[135]Based on this indicator, 48% of the population lived below the poverty line in 2008.

More than 60% of employed persons earn less than the tax threshold of about R5 000 per month.[136]

Only 13.1 million people out of a population of 51 million are employed (or 41% of the working age population) and about 50% of working-age youths below 25 years are unemployed. Long-term joblessness increased to 68% of the total unemployed persons.[137]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 stability.[138] Women face a higher unemployment rate than men and many women remain vulnerable by depending on survivalist activities.[139]Statistics SA found that 20% of households had inadequate or severely inadequate access to food in 2009.[140] Malnutrition is widespread and up to 20% of children may suffer from chronic malnutrition as evidenced by stunted growth.[141]

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,

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

132 Patel, L., Hochfeld, T. et al. 2008. The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

133 DSD. 2012 State of South African Registered Non-profit Organisations.Published at http://www.dsd.gov.za/npo/... (Accessed 9 November 2012).

134 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 athttp://www.uj.ac.za/...csda.(Accessed 10 September 2012).

135 National Planning Commission. 2011. Diagnostic Human Conditions. Published at http://www.npconline.co.za/...

136 National Treasury.*2013 Budget Review*.

137 National Treasury. 2011. "Employment". *2011 Budget Review.*

138 National Planning Commission. 2011. Diagnostic Human Conditions. Published at http://www.npconline.co.za/....(Accessed 27 August 2012).

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

140 Day, C. and Gray, A. 2010."Health and Related Indicators". South African Health Review 2010.

141 National Planning Commission. 2011. Diagnostic Human Conditions. Published at http://www.npconline.co.za/....

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 health.[142] 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 health.[143] 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 practices.[144]Of the country's 18.6 million children in 2010, an estimated 3.8 million children (21%) had lost one or both parents.Between 2002 and 2010 the number of orphaned children increased by 28% (or by 845 000).An estimated 90 000 children were living in a total of 50 000 child-only households in 2010. Children in child-only households are particularly vulnerable to poverty, crime and abuse.Only one-third of all children live in a household together with both their parents, and nearly a quarter lives with neither parent. Children in the poorest households are most disadvantaged – only 19% of children living in the poorest 20% of households live with both parents.[145]

According to the Children's Institute, more than 11 million children (61%) lived below the poverty line (with a per capita income of less than R575 per month) in 2010. Over 6.5 million children (35%) lived in households were no adults were employed.[146]

With the projected annual growth of the elderly population at 3% until 2015, there is increasing demand for social services to promote and protect the rights of older persons.[147]

One of the main strategies to combat poverty is the provision of social assistance to vulnerable persons in the form of social grants paid from tax revenues.[148] Monthly social grants are paid to the following categories of persons who meet prescribed eligibility criteria:[149]

a) A child support grant is paid to the primary caregiver of a child who earns less than R34 800 (single) and R69 600 (married) per annum from 1 April 2013, and R36 000 (single) and R72 000 (married) a year from 1 October 2013;

b) 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, and who earn less than R151 200 (single) or R302 400 (married) a year;

c) A foster care grant is paid to any person (except the parent of the child) in whose custody a foster child has been placed in terms of applicable legislation;

d) A disability grant is paid to persons who are, owing to a mental or physical disability, unfit for employment and unable to provide for their maintenance and who have an annual income of less than R49 920 (single) or R99 840 (married) a year, and whose assets do not exceed prescribed limits;

e) The old-age grant is paid to persons who are 60 years and older with annual incomes of less thanR49 920(single) or R99 840(married) a year;

f) A war veterans grant is paid to a person of 60 years and older who served in the armed forces during the Second World War or Korean War; and

g) A grant in aid is paid to a social grant recipientwith 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.[150]

Other anti-poverty strategies include the Expanded Public Works Programme (EPWP) that employs poor and unemployed persons through the delivery of public and community service. Further expansion of the EPWP will enable the creation of 2 million jobs of short and longer duration by 2014, while community work programmes

142 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.Published at http://www.hst.org.za/...health-review-2012/13.(Accessed 13 July 2013); National Planning Commission. 2012. National Development Plan 2030, Our Future: Make it Work. "Executive Summary".Published at http://www.npconline.co.za/.../.../Executive...Summary-NDP%...pdf.(Accessed 16 July 2013).

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

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

145 Hall, K. and Lake, L. 2012. "Introducing Children Count – AbantwanaBabalulekile" in South African Child Gauge 2012. Children's Institute, UCT. Published at http://www.ci.org.za/depts/ci/pubs/...child_gauge2012.pdf.(Accessed 18 July 2013).

146 Hall, K. and Lake, L. 2012. "Introducing Children Count – AbantwanaBabalulekile" in South African Child Gauge 2012. Children's Institute, UCT. Published at http://www.ci.org.za/depts/ci/pubs/.../...child_gauge2012.pdf.(Accessed 18 July 2013).

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

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

149 Social Assistance Act, 13 of 2004; DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013); National Treasury. 2013. *"Vote 19: Social Development". 2013 Estimates of National Expenditure.*

150 Western Cape Government Information and Services. 2011. "Social Relief of Distress". Published at http://www.capegateway.gov.za/eng/directories/services/11586/201147.(Accessed 18 August 2011).

aim to provide minimum income in poor communities (daily wages of R60 for at least 8 days per month).[151]By facilitating public employment programmes for the social cluster, the DSD aims to create 255 000 job opportunities by 2013/14.[152]

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 training.[153] 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 many civil society organisations has been compromised.[154]A significant reduction in funding by international donors (and even termination in some instances) has had a severe impact on national health and social development programmes. For example, over the period 2014-2016 the National Treasury will have to provide additional resources to off-set the decrease in funding from the US President's Emergency Plan for AIDS Relief (PEPFAR).[155]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 (especially for primary healthcare, direct income support to individuals and social relief of distress). These economic factors are likely to put further pressure on professionals and workers in the social development and health sectors.[156]

3.6 THE BURDEN OF DISEASE AND SOCIAL ILLS

Recent 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 disease burden is attributable to the scale of the HIV/AIDS pandemic; the high incidence of tuberculosis (TB), malaria, interpersonal violence and trauma; poor maternal and child health; and chronic diseases such as alcohol abuse, diabetes and heart disease.[157],[158]

By 2011, it was estimated that 5.6 million people were living with HIVand that the HIV prevalence rateamong persons aged 15-49 was 17%.[159]This is 22 times the global average.[160]According to StatsSA, the percentage of deaths due to AIDS was 43.6% in 2011.[161]The Minister of Health informed Parliament in March 2010 that amongst women in the age group 15 to 24 years, the prevalence rate was nearly 22% and the mother-to-child transmission rate was 10%.[162]Recent studies demonstrate that more than 300 000 South Africans are infected every year.[163]HIV/AIDS poses developmental challenges as the diseases are driven by poverty and social factors such as gender inequality and behaviour.[164]

The country's TB epidemic is amongst the worst and most serious in the world, with an estimated annual incidence rate of 993 per 100 000 population in 2011, or 23 times the global average.[165] The Global TB databaseestimated

151 National Planning Commission. 2011. Diagnostic Human Conditions. Published at http://www.npconline.co.za/... .

152 National Treasury. 2013. *"Vote 19: Social Development". 2013 Estimates of National Expenditure.*

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

154 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Published at http://www.uj.ac.za/...(Accessed 10 September 2012); Coalition on Civil Society Resource Mobilisation. 2012. "Critical Perspectives on Sustainability of the South African Civil Society Sector". Published at http://www.ngopulse.org/press...(Accessed 20 September 2012).

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

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

157 Van der Berg, S., Burger, R., Theron, N. 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. Published at www.doh.gov.za. (Accessed February 2010).; Bateman, C. 2009. "Incompetent, unaccountable managers paralysing health care". South African Medical Journal. October 2009. 99 (10).

158 It is referred to as the "quadruple burden of disease" which includes diseases of poverty (maternal, infant and child mortality), non-communicable diseases, HIV/AIDS and TB, and violence/personal injury. (See 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.Published at http://thelancet.com.(Accessed August 2010).

159 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

160 WHO. 2011. World Health Statistics 2011. Published at http://www.doh.gov.za/list..Profile.(Accessed 17 August 2011).

161 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

162 Portfolio Committee on Health. 2010. "Health plans major increase in vaccination and HIV work". Published at http://sabinetlaw.co.za/health/articles.(Accessed August 2010).

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

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

165 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.

the prevalence of TB at 795 per 100 000 population in 2011.[166] TB is a major cause of death and the co-infection rate with HIV is about 73%.[167] Inappropriate and ineffective treatment of TB results in multiple-drug-resistant TB, which is placing a huge burden on the health system in all nine provinces.[168] Malaria is endemic in low-lying areas of Limpopo, Mpumalanga and north-eastern KwaZulu-Natal. About 10% of the population in South Africa lives in malaria-risk areas.[169]

South African maternal and infant mortality rates are higher than in comparable developing countries. Although HIV/AIDS is a contributing factor in 30% to 60% of child deaths,[170] many deaths are attributed to care failures and are thus preventable.[171] Statistics from the WHO put maternal mortality rates at 410 per 100 000 live births in 2009, significantly worse than the global average of 260.[172]In rural areas the infant mortality is on average 62% higher in comparison with urban areas.[173]Child mortality remains a major and complex public health challenge. Although the under-five mortality per 1 000 live births decreased from 56 in 2009 to 42 in 2011, it is far from the 2015 target of 20.[174]Infant mortality remains at between 30 to 40 per 1 000 live births, also far off the target of 18. High mortality is linked to health, social and environmental risks such as under-weight births, a poor immunisation rate, poverty and malnutrition, as well as inadequate access to clean water and sanitation.[175] Decreasing child and maternal mortality is a key government objective.[176]

Non-communicable diseases such as high blood pressure, diabetes, chronic heart disease, chronic lung diseases, strokeand cancer are major causes of premature death.[177] 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. Social crime is aggravated by widespread social ills such as the abuse of alcohol and illicit substances and culturallydriven behaviour associated with gender inequality.[178]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%.[179] 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 injury.[180]

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 services.[181]The scope and complexity of these health threats are creating increased demands on the services and workforce in the sector.[182] 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-being.[183]

National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011); Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/..,(Accessed 13 July 2013).

166 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

167 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011).

168 Medical Research Council. 2006. Policy Brief, No1, Jan 2006. Published at http://www.mrc.ac.za/..(Accessed August 2010).

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

170 Bamford, L. 2013. "Maternal, newborn and child health" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

171 DoH. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf. (Accessed 12 August 2011); Day, C., Gray, A. et al. E. 2011."Health and Related Indicators".South African Health Review 2011. Published at http://www.hst.org.za/public....(Accessed 27 August 2012).

172 WHO. 2011. World Health Statistics 2011. Published at http://www.doh.gov.za/list...Profile.(Accessed 17 August 2011).

173 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

174 Bamford, L. 2013. "Maternal, newborn and child health" in South African Health Review 2012/13. Published at http://www.hst.org.za/.... (Accessed 13 July 2013); DoH. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za.(Accessed 23 March 2012).

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

176 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" South African Health Review 2011.Published at http://www.hst.org.za/publications/south-african-health-review-2011. (Accessed 27 August 2012).

177 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" South African Health Review 2011.Published at http://www.hst.org.za/publications/south-african-health-review-2011. (Accessed 27 August 2012).

178 DoH. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf. (Accessed 12 August 2011); Department of Social Development. 2011. Strategic Plan 2011/12 – 2013/14.

179 Corrigall, J. and Matzopoulos, R. 2013. "Violence, Alcohol Misuse and Mental Health: Gaps in the health system's response" in South African Health Review 2012/13. Published at http://www.hst.org.za/pub../..review-2012/13.(Accessed 13 July 2013).

180 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" South African Health Review 2011.Published at http://www.hst.org.za/publications/south-african-health-review-2011. (Accessed 27 August 2012).

181 Harrison, D. 2009. An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Published at www.doh.gov.za.(Accessed February 2010).

182 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".South African Health Review 2008.Published at www.hst.org.za/publications/841.(Accessed August 2010).

183 Department of Health. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za.(Accessed 23 March 2012).

3.7 THE MOBILITY OF LABOUR

In 2006 the WHO estimated the global shortages of health workers at almost 4.3 million, with the combined shortage of doctors, nurses and midwives estimated at 2.4 million.[184] Across Africa the shortage was estimated at one million, with the most acute shortage experienced in sub-Saharan African countries.[185] 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, betterprospects for professional advancement, and general quality of life advantages attract trained healthcare professionals from less developed countries to work elsewhere.[186]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 workforce.[187] Conservative estimates place the attrition rate of health professionals in South Africa due to emigration at about 25%.[188]

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 skills.[189] This results in significant skills shortages in the non-government sector which constitutes a major delivery channel for social services.[190] South African social workers have also been recruited internationally.[191]

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.

Decisionmakers, 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 base.[192] 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 term.[193]Staff turnover for health professionals in some provinces is as high as 80%.[194]District hospitals are often poorly staffed and under-equipped.[195]

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: 2012/13-2016/17*.[196] The strategy focuses on three thematic areas to guide actions

184 WHO. 2006. The World Health Report 2006 - working together for health. Published at http://www.who.int/whr/2006/...pdf.(Accessed August 2010); HWSETA. 2010. Sectoral Analysis for the Health Sector.

185 WHO. 2008. "New task force launched to address health workforce financing". Published at http://www.who.int/mediacentre/news/../2008/np02/en/.(Accessed 15 August 2011).

186 WHO. 2010. Migration of Health Workers. Factsheet 301. Published at http://www.who.int/...factsheets/fs301/en/. (Accessed 15 August 2011); Lloyd, B., Sanders, D. and Lehmann, U. 2010."Human resource requirements for National Health Insurance".South African Health Review 2010.

187 WHO. 2006. The World Health Report 2006 - working together for health. Published at http://www.who.int/.(Accessed August 2010).

188 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

189 Patel, L., Hochfeld, T. Graham, L. and Selipsky, L. 2008. The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

190 South African Council for Social Service Professions. 2011. Official Newsletter 1(1), July. Published at: http://www.sacssp.co.za/UserFiles/File/...Newsletter....pdf.(Accessed 12 August 2011).

191 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

192 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in *South African Health Review 2010*; Harrison, D. 2009. *An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains*; 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*. September 2009. Vol 374.

193 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

194 Department of Health. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za.(Accessed 23 March 2012).

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

196 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

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 sector.[197] Core aspects of the HRH Strategy will be highlighted throughout this SSP.

197 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

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 3-5compares the allocation ofGPs, dental practitioners, pharmacists and nurses per 10 000 of the population in the public and private sectors.

Table 3-5 Key resources per 10 000 of the population in public and private sectors: 2010

	Medical practitioners	Dental practitioners	Pharmacists	Nurses*
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.*

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.

3.8.4 Geographical distribution—the urban/rural dilemma

An estimated 43.6% of the South African population live in rural areas butare served by only 12% of the doctors and 19% of nurses.[198]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 facilities.[199]Table 3-6shows the skewed distribution of different categories of health professionals in 2012 as a ratio of the estimated population in each provincethat depends on the public sector.[200]

198 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published athttp://www.doh.gov.za.(Accessed 10 August 2012).

199 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.Published at http://thelancet.com.(Accessed August 2010).

200 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

Table 3-6 Distribution of health professionals per 100 000 population in public sector: 2012

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
	Professionals per 100 000 population									
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*.

For example, in 2012the Western Cape had 33.2medical specialists per 100 000 population compared with 1.6in Limpopo and 3.2in North West Province. In KwaZulu-Natal the number of enrolled nurses per 100 000 population wasalmost 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. Such imbalances affect access to care.

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.

In this sector, the most critical challenge impeding rapid budget growth and expanded service delivery continues to be the shortage of social work practitioners. These include social service professionals, social auxiliary workers, child and youth care workers, ECD practitioners, and community development practitioners, community development workers and community care givers.[201] Research in 2008 indicated that in order to meet government norms, South Africa required another 7 631 social workers immediately – significantly more than the 5 076 who were employed in the sector at the time. It was also projected that another 13 313 social work professionals would be required in direct social development work by 2015 to meet government norms.[202]Social workers registered with the SACSSP numbered 16 740 in March 2012. Of those, only 6 655 (40%) were employed by Government and 2 634 by NPOs. Thus 7 451 (45%) were either employed in the private sector or not practicing.[203] Given the acute shortage of social workers, social auxiliary workers (SAWs) are used, but those cadres are often poorly trained, and lack knowledge and capacity to serve so that managers are placed under strain.[204]

A 2008 study amongst NGOs found that 50% of the organisations could not meet service demand because of insufficient staff.NGOs engaged in home- and community-based programmes rely on volunteers to deliver the services. Recent 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 careers.[205]Volunteers' motivation levels are also

201 DSD. 2011. Strategic Plan 2011/12 – 2013/14; National Treasury. 2009. "Social Development". Provincial Budgets and Expenditure Review 2005/06 – 2011/12; Patel, L., Hochfeld, et al. 2008.The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../.../csda/publications. (Accessed 20 August 2011).

202 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds).Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

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

204 Schmid, J. 2012. Trends in South African Child Welfare Reform. Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

205 Schmid, J. 2012. Trends in South African Child Welfare Reform. Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

affected by differences in funded stipends; e.g. in 2008 the DoH contributed between R1,000 and R1,250 per month, while the DSD paid between R500 and R750 per month.[206] Some volunteers receive transport or food allowances rather than stipends. 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 2019/20.[207]

3.9 MANAGEMENT OF THE HEALTH AND SOCIAL DEVELOPMENT SYSTEM

3.9.1 Management challenges in the health system

Numerous challenges exist at managerial and operational levels in the public health system. Health sector experts report on widespread inefficiencies that result in services that are unresponsive to health and patient needs and a lack of accountability on a large scale. Health economists highlight challenges relating to resource allocation, technical efficiency, management, accountability and governance.[208] Government has acknowledged these and other challenges relating to service quality, including the availability of health services at convenient hours and professional staff; cleanliness; safety and security of staff and patients; non-availability of drugs; long waiting times; infection control; and staff attitudes towards patients.[209]

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 understaffing have been attributed to weak management and leadership of the health system.[210]A health sector audit in 2009 commissioned by the Minister of Health documented significant inefficiencies in the management of the public health system. Some of these challenges include the lack of: efficient and effective human resources management; training, support and supervision; and performance management. Complaints of absenteeism, moonlighting, poor discipline and incompetence are frequent.[211] The DoH has acknowledged these and other management challenges, and has embarked on a comprehensive strategy to improve the resources and management of the health system.[212]

Greater accountability is needed at all levels. Managers require skills in the management of time and resources, in planning, in performance- and financial management, in procurement of supplies, and in leadership and innovation.[213] A particular need for planning and management skills exists at district level in the public health sector. Research has shown that the skills of middle- and senior management in the district health system remain weak, despite intensive training interventions. It has been suggested that a need exists for more comprehensive and nationally standardised training for primary healthcare and for the development of district health systems.[214]

According to the DoH, management challenges in the private sector involve the costs and utilisation of services – e.g. private hospital costs have increased by 121% in a decade, and medical scheme contribution rates have doubled in seven years, 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 basis.[215] Further, the private sector is criticised for using disproportionately more of the available human resources in comparison to the service that it provides.[216]

3.9.2 Management challenges in the social development system

Institutional challenges in the administration of welfare servicesalso hamper effective delivery. The gap between government's social development policy objectives and policy execution to improve the quality of lives remains problematic.[217]Provincial governments lack the capacity to

206 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

207 DSD. 2012. Strategic Plan 2012-2015. Published at http://www.dsd.gov.za.(Accessed 10 August 2012).

208 DBSA. 2008. A Roadmap for the Reform of the South African Health System; McIntyre, D. 2011. "(Dis)agreements in South African health system reform debates". Symposium on health reform, Stellenbosch. Published at http://uct-heu.s3.... (Accessed 14 August 2011).

209 Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011).

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

211 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; Rispel, L. 2011. "Understanding demand and supply of health services: managing the health workforce". Presentation to ERSA Symposium on health reform, Stellenbosch.

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

213 National Treasury. 2009. "Health". In *Provincial Budgets and Expenditure Review* 2005/06 – 2011/12; Harrison, D. 2009. *An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains.*Coovadia, H., Jewkes, R. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". *Lancet*. September 2009. Vol. 374; 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*. September 2009. Vol. 374.

214 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care" *South African Health Review*.

215 Department of Health. 2011. *National Health Insurance in South Africa: Policy Paper*.

216 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" South African Health Review 2010. Published at http://www.hst.org.za/publications/...-review-2010. (Accessed 19 August 2011).

217 Patel, L., Hochfeld, T. Graham, L. et al. 2008. The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

plan for and implement social development services that meet the needs of the most vulnerable people.[218]Welfare services and community-based health services have been outsourced to NPOs that often face limited and unreliable financial and logistical support. Many NPOs involved in social development services rely on government for their core funding.[219] However, irregular and inadequate payment by government has a negative impact on service delivery.[220] Government has acknowledged that the funding of its service delivery partners remains a major challenge.[221]

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 CSOs is also hampered by the ineffective disbursement of funds from the NDA and National Lotteries Distribution Trust Fund.[222]

Most NPOs have limited financial and management expertise and operate in an uncertain state of scarce funding, job insecurity, and well-worn facilities.[223] 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 workers.[224] A 2009 study found that government funding arrangements for NPOs do not provide for capacity building and administrative functions. Yet the Non-Profit Organisations Act places an obligation on every organ of state to promote, support and enhance the capacity of NPOs to perform their functions.[225]

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 offered, and sub-standard service quality.[226] 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' sustainability.[227] A 2008 research report found staff turnover rates in the NGO sector of above 40% at general social worker level, and at above 16% at managerial and supervisory levels.[228]

NGOs involved with social development face significant management challenges. Governance challenges amongst more established NPOs include areas of review of organisational mission and effectiveness; monitoring of cost-efficiency and taking steps to ensure financial sustainability; and adapting and aligning with stakeholder needs. 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 purpose.[229]

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 workers.[230]

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 demands.[231]Government and donor agencies are insist-

218 National Treasury. 2009. "Social Development". Provincial Budgets and Expenditure Review 2005/06 – 2011/12.Schmid, J. 2012. Trends in South African Child Welfare Reform. Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

219 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

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

221 National Treasury. 2011. "Vote 19: Social Development. *2011 Estimates of National Expenditure.*

222 Coalition on Civil Society Resource Mobilisation. 2012. Critical Perspectives on Sustainability of the South African Civil Society Sector. Published at http://www.ngopulse.org/press-release/...-african-civil-society.(Accessed 20 September 2012).

223 NGOConnect Africa. 2009. "NGOs in South Africa". Published at http://ngopedia.org/wiki/NGOs...challenges.... (Accessed 19 August 2011); Schmid, J. 2012.Trends in South African Child Welfare Reform. Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/.../.../csda/research/.(Accessed 10 September 2012).

224 Patel, L., Hochfeld, T. Graham, L. et al. 2008. The implementation of the White Paper for Social Welfare in the NGO sector. Published at http://www.uj.ac.za/EN/..././csda/publications.(Accessed 20 August 2011); 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.

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

226 Patel, L., Hochfeld, T. Graham, L. et al. 2008. The implementation of the White Paper for Social Welfare in the NGO sector. Published at http://www.uj.ac.za/.../csda/.(Accessed 20 August 2011); Coalition on Civil Society Resource Mobilisation. 2012. Critical Perspectives on Sustainability of the South African Civil Society Sector. Published at http://www.ngopulse.org/press-release/...-sustainability-south-african-civil-society.(Accessed 20 September 2012).

227 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. Published at http://www.ci.org.za/.(Accessed 21 August 2011); Patel, L. 2009.The gendered character of social care in the non-profit sector in South Africa. Published at http://www.uj.ac.za/.(Accessed 20 August 2011).

228 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

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

230 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

231 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/

ing on more sustainable social development and pressurise NGOs to improve management, monitoring and governance. NGOs are expected to change long-standing informal approaches and to adopt business models for their operations, but many lack the institutional capacity to acquire the requisite competencies and skills to meet donor stipulations.[232]

CSOs generally lack the understanding, capacity and tools (e.g. information technology) to measure and track service provision. 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

In September 2012 Cabinet approved the National Development Plan (NDP)which addresses South Africa's vast socio-economic challenges.[233] The NDP provides a multi-dimensional framework with priorities to eliminate poverty and reduce inequality by 2030. The plan identifies specific elements that determine a decent standard of livingand areas where the country needs to progress. Critical capabilities needed to transform the economy and society are described.Prominence is given to three priority areas: 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.[234].

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".[235]The NDP envisages a health system that raises life expectancy, reduces infant mortality and the incidence of HIV and 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 to phase in a National Health Insurance scheme, which is considered in paragraph 3.12 below. The NDP recognises that the health system as 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 and benefits aimed at facilitating access to nutrition, health care, 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 that affect physical growth and cognitive development, especially among children must be addressed. Thirdly, the unemployed should access income support such as public works programmes and labour market incentives that provide training and 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 sub-professionals in five categories in particular: social workers, auxiliary or assistantsocial workers, community developmentworkers, early childhood development practitioners and child and youth care workers.[236]

Both the DSD and DoH have aligned strategies and service delivery targets with objectives of the NDP.

3.11 THE REGULATORY ENVIRONMENT

3.11.1 Fundamental changes

Constitutional imperatives[237] 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 provided direction to move away from remedial welfare services based on remedial and institutional care delivered by specialists towards a family-centred- and community-based approach. In this developmental approach (rather than a curative or case-based approach), the emphasis is on integrated community development through prevention, early interventions, strengthening of communities and preservation of families.[238]Essentially, in social development services there is less emphasis on hand-outs and more focus on self-help.[239]During the same period public health services have moved from a hospital-centred

EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

232 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa. Published at http://www.uj.ac.za/../csda..(Accessed 20 August 2011); NGOConnect Africa. 2009. "NGOs in South Africa". Published at http://ngopedia.org/wiki/NGOs....challenges...NGOs_face.(Accessed 19 August 2011).

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

234 National Planning Commission. 2012. National Development Plan 2030, Our Future: Make it Work. "Executive Summary".Published at http://www.npconline.co.za/MediaLib/....pdf.(Accessed 16 July 2013)

235 National Planning Commission. 2012. National Development Plan 2030. Chapter 10: Promoting Health. Published at http://www.npconline.co.za/.../..NDP...%20health.pdf.(Accessed 16 July 2013).

236 National Planning Commission. 2012. National Development Plan 2030 Published at: http://www.npconline.co.za/...pdf.(Accessed 16 July 2013).

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

238 Schmid, J. 2012. Trends in South African Child Welfare Reform. Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

239 Personal interview with Family Life (Division of FAMSA), October 2012.

approach to a PHC approach.[240] These policy and regulatory changes have had a profound effect on the skills content needed in the sector.[241]

3.11.2 The social development system

The social development system is driven by the DSD and 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. Schedule 4 of the Constitution determines that welfare services, population development and disaster management are functional areas of concurrent national and provincial legislative competence. 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 assistance.[242]At local government level, municipalities are responsible for child care facilities.[243]

The role of provincial social development departments (some of which are integrated with health) is to provide social welfare and community development services in the following areas:[244]

a) *Prevention and promotion services* aim to strengthen communities, families and individuals by addressing potential problems and preventing escalation, e.g. programmes for ECD, 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 in children, the elderly, women or 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, especially children, into their families and/or society, e.g. through family counselling, life skills and parenting programmes, and other support services to aid self-reliance and social functioning;

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 HBCB 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 courts.[245] 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 intervention.[246]Community development is emerging as a separate area of specialised work to empower communities to implement income-creating programmes towards attaining sustainable livelihoods.[247] This is further discussed in paragraph3.15.6.

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".[248]However, the critical responsibility to "plan, manage and develop human resources for the rendering of health services" lies with all nine provincial departments of health and it is not a national responsibility.[249]The NHA empowers the Minister of Health to make regulations to ensure adequate

240 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".South African Health Review. Health Systems Trust. Published at www.hst.org.za/publications/841.(Accessed August 2010).

241 National Planning Commission. 2012. Summary and key issues of the National Development Plan 2030. Published at http://www.info.gov.za/issues/national-development-plan/index.html (Accessed 19 September 2012).

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

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

244 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.

245 Patel, L., Hochfeld, T. et al. 2008. The implementation of the White Paper for Social Welfare in the NGO sector. Published at http://www.uj.ac.za/.... (Accessed 20 August 2011); National Treasury. 2009. "Social Development". Provincial Budgets and Expenditure Review 2005/06 – 2011/12.

246 Patel, L., Hochfeld, T. Graham, L. and Selipsky, L. 2008. The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

247 Interviews with DSD, October 2012.

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

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

resources are available to educate and train health personnel; create new categories of health personnel; identify key skills shortages; recruit foreign health worker; and ensure that there are adequate human resources, planning, and development structures across all levels of the national health system.[250]

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 services.[251]Government and the statutory bodies referred to in Chapter 2 are the main regulators on matters pertaining to the skills base of the workforce.

3.11.4 Regulation of quantity and distribution

The NHA introduces provisions aimed at regulating the number and distribution of public and private facilities and providers of healthcare. Although that aspect of the NHA has not been implemented as yet, implementation will have implications for the distribution of skills available in the sector, as well as for providers trying to enter the sector. The NHA empowers the Director-General (DG) of the national DoH to issue licences or a "certificate of need" to private hospitals and private practices of health professionals and technologists for a prescribed period.[252]Before issuing or renewing such a certificate, the DG must consider the need to promote an equitable distribution and rationalisation of health services and resources, as well as other factors. The NHA empowers the Minister of Health to determine the range of health services that may be offered at a public health establishment.[253]In this way the DoH can regulate the allocation and distribution of healthcare skills.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 allowed 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 are permitted and those that are not. 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 the skills development legislation. The councils furthermore determine the standards for the CPD that professionals require in order to retain their registration. Generally healthcare- and socialservices professionals may engage in a range of activities to update their skills – including organisational activities, self-study and group-study, usage of information from latest research publications, teaching, and the acquisition of additional qualifications.[254]

The NHA establishes academic health complexes[255] where health workers are trained in primary-, secondary- and tertiary healthcare facilities and are exposed to peripheral facilities serving communities. The intention is to better prepare staff to work in a range of facilities, including PHC.

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.

South Africa endorsed three health-related Millennium Development Goals (MDGs), which are to: reduce child mortality; improve maternal health; and combat HIV/AIDS, malaria and other diseases.[256]The Minister of Health signed the Negotiated Service Delivery Agreement (NSDA) for the Health Sector in October 2010. Four strategic outputs are featured: increasing life expectancy; decreasing maternal and child mortality; combatting HIV/AIDS and reducing the burden of disease from TB; and strengthening the effectiveness of the health system.[257]Apart from the National Development Plan, several national health policies aim to achievethese goals and to improvethe health profile of all South Africans. Key priorities in the *Health Sector Strategic Framework: The 10 Point Plan*[258]

250 Section 52 of the National Health Act 61 of 2003.
251 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 August 2010).
252 Section 36 of the National Health Act 61 of 2003.
253 Section 41 of the National Health Act 61 of 2003.
254 Macheke, C. 2010. *HWSETA Health Sector Baseline Study.*
255 Section 51 of the National Health Act 61 of 2003.
256 Day, C. and Gray, A. 2008."Health and Related Indicators". *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*.
257 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.Published athttp://www.hst.org.za/... (Accessed 13 July 2013).
258 DoH. 2010. "Health Sector Strategic Framework: The 10 Point Plan" in the *Strategic Plan 2010/11-2012/13*.

of the DoHarealso aligned to the NDP. Among these are:[259]

a) Implementation of National Health Insurance (NHI);

b) Re-engineering of PHC services to focus on community outreach services;[260]

c) Accelerated implementation of TB controls and HIV/AIDS policies (including expanded prevention strategies and access to ART);

d) Greater focus on improving maternal, perinatal and child health;

e) Promoting the prevention of lifestyle diseases and better nutrition;

f) Strategicleadership, and improved management and governance of the health system; and

g) Improvements in human resources planning and development – including recruitment and retention of professionals and training of PHC staff, nurses and mid-level health workers.[261]

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 and will be subject to on-going stakeholder and community consultations during 2012 and 2013.[262]According to government, "the rationale for introducing NHI is to eliminate the current tiered system wherein those with the greatest need have the least access and have poor health outcomes". Thus the aim is to improve access to health services and improve cross-subsidisation between rich and poor and the healthy and sick in the entire health system.[263]Another key objective is to strengthen the under-resourced public sector to enhance performance in the health system.[264] The phasing in of NHI is one of the main pillars of the National Development Plan.[265]

b) Proposals

In essence the NHI is a financing system for providing healthcare to all citizens.[266] All South Africans and legal permanent residents will receive universal coverage[267] 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. Refugees and asylum seekers will be covered under the Refugees Act, 130 of 1998, which entitles them to the same basic health services as legal inhabitants of South Africa.[268]

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 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 andpiloting commenced in 10under-serviced health districts in 2012. While the pilot districts focus on improving the management of health facilities, medical infrastructure and supplies, and service quality, the key aim is to develop and test systems that will enable implementation of the NHI.[269]

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.[270]Medical services in the defined package of services will be free of charge and no

259 DoH. 2013. "Health Priorities". Published at http://www.doh.gov.za/National Health Insurance.(Accessed 9 July 2013).
260 DoH. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf. (Accessed 12 August 2011).
261 DoH. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.
262 DoH. 2012. *Annual Performance Plan 2012/13 – 2014/15*.
263 DoH. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf. (Accessed 12 August 2011).
264 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months"in *South African Health Review 2012/13.* Published at http://www.hst.org.za/publications/south-african-health-review-2012/2013.(Accessed 11 July 2013).
265 National Planning Commission. 2012. National Development Plan 2030, Our Future: Make it Work. "Executive Summary".Published at http://www.npconline.co.za/..../Executive%20Summary-NDP%...pdf.(Accessed 16 July 2013)
266 DoH. 2011. Media statement by Minister of Health – Release of Green Paper on National Health Insurance. August, 2011.
267 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".
268 Sec 27(g) of the Refugees Act, 130 of 1998.
269 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13. (Accessed 13 July 2013).
270 In 2010, total provincial health expenditure amounted to R90.4 billion and medical scheme contributions amounted to R76.3 billion in 2009. (See: Day, C. and Gray, A. 2010. "Health and Related Indicators" in *South African Health Review 2010).*

co-payments or out-of-pocket expenses will be required from patients. However, co-payments will be required 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 abolished. [271]A pre-payment financing mechanism will be used; i.e. payments for health services will be made in advance. A single fund will be created to purchase services on behalf of the entire population.

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-players.[272]

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 promotion.[273]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 at district hospitals will include 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 platform for training of 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 practitioners[274]

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. The support teams will be expected to provide specialist care closer to patients' homes, integrate working practices between GPs and the hospital-based specialists, and improve the quality of care. Emergency care workers will back up PHC teams who require rapid transfer to more advanced clinical care.[275]Environmental health officers will be part of new PHC teams to address social and environmental health risks associated with sewerage, refuse, vermin, food handling, and waste management to prevent diseases such as pneumonia and diarrhoea.[276]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.

271 Boyle, B. 2010."SA to import thousands of docs".Sunday Times, 26 September.
272 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation" in South African Health Review 2012/13.; Day, C. and Gray, A. 2013. "Health and Related Indicators" in South African Health Review 2012/13. Published at http://www.hst.org.za/....(Accessed 13 July 2013).
273 DoH. 2011. Media statement by Minister of Health – Release of Green Paper on NHI. August, 2011.
274 DoH 2012. National Health Insurance—presentation on NHI pilot district selection. Published at http://www.doh.gov.za.(Accessed 10 August 2012).
275 DoH. 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.
276 DoH. 2011. Human Resources for Health for South Africa 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za.(Accessed 16 August 2011).

The new national Integrated School Health Policy was launched in October 2012 and targets the most disadvantaged schools.[277]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 practitioners.[278]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.

PHC agents in each municipal ward will work with families and vulnerable persons to identify health problems and behaviour that place people at risk of injury or disease. At least ten PHC agents will be deployed per ward. Depending on availability, a health professional will head each ward team.

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. Providers' performance will be assessed in relation to treatment outcomes. Providers will also need to adhere to treatment protocols for all conditions covered under the defined package of care. In this way the DoH hopes to ensure that services are rendered at the appropriate level of care and that expenditure may be controlled.

f) *Payment of providers and co-payments*

Payment mechanisms and payment levels for providers will be determined by the NHI. Providers of PHC services will be reimbursed by a risk-adjusted capitation system,[279] which will be linked to providers' performance. A uniform amount will be paid for defined levels of providers. The annual capitation amount will be linked to the size of the registered population, target utilisation, cost levels and the health-related status of users. At the hospital level, accredited and contracted facilities will be reimbursed initially using global budgets.[280] Over time a system of case mix reimbursement or diagnosis related groups[281] will be implemented. Public emergency services will be paid initially from global budgets allocated to public hospitals, and a case-based approach will be introduced later. Contracted private providers of emergency care will be reimbursed on a case-based approach.

g) *Management of the NHI*

A new public entity, the National Health Insurance Fund (NHIF), which is anticipated to be launched in 2014/15,will administer the system. Within the NHI, the functions of purchasing and provision of services will be separated. 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. These authorities will be involved with purchasing decisions for health services; manage contracts with accredited providers in conjunction with the NHIF; andmonitor performance of contracted providers. The DoH will be responsible for infrastructure development and health planning, and will give direction in health worker training and planning.Hospital boards will be strengthened to improve oversight and accountability, esp. for central hospitals.[282]

h) *Health information management*

The *National e-Health Strategy for South Africa 2012/13 -2016/17* provides a roadmap to develop a national health information system that prioritises the patient and supports management of the public health system.A core

277 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.* Published at http://www.hst.org.za/publications/south-african-health-review-2012/2013.(Accessed 11 July 2013).

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

279 This is a payment method for health care services. Usually accredited and contracted providers are paid a fixed and predetermined fee to cover all the health needs of each person registered with them, regardless of the number or nature of services provided in terms of a defined package of services. The fee paid is adjusted to take account of the patient profiles of each provider. Risk-adjustment factors include patient gender, age and epidemiological (state of health) profile. The fee is usually fixed for at least one year.

280 A global budget is a fixed maximum expenditure for a defined set of health services. Providers are given a fixed budget and are required to deliver services within them. A global budget intends to constrain both the level and rate of increase in health care cost by limiting them. Providers of health care services that face global budgets have incentives to control costs and operate efficiently. If the risk arises that providers may exceed their budgets, they may delay or withhold treatment ("rationing by waiting"), which creates problems in terms of access to healthcare. (Mathematica Inc. undated)."Global Budgets for Health Care".Published at http://www.mass.gov/...Global_Budgets_final-C5.pdf.(Accessed 16 August 2011).

281 This is a case mix reimbursement system that bundles diseases or treatment interventions into homogenous cost groups. An average treatment cost for the intervention or disease is then calculated. Case-based payment systems are often used to reimburse hospitals. It is a health care financing intervention aimed at controlling costs and encouraging efficiency.

282 MatsotsoM.P.andFryatt, R. 2013 "National Health Insurance: The first 18 months"inSouth African Health Review 2012/13. Published athttp://www.hst.org.za/publications/south-african-health-review-2012/2013.(Accessed 11 July 2013).

objective is to develop an integrated national patient-based information system in accordance with scientific standards.[283] 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 services.[284]

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 surveys.[285].

i) Challenges for the skills base

Government acknowledges that there are many challenges to be addressed before the NHI can be implemented successfully. Among these is the need to improve the quality of services in the public hospitals.[286] The availability of adequate human resources will be critical for the success of the NHI.[287]

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 facility.[288]

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 autonomy.[289]It will also be necessary to fill the large numbers of vacant public sector posts and provide additional nursing and healthcareskills.[290]

j) Implications for human resources and the skills base

The NHI proposals introduce a new health service delivery model and will thus 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. Although the proposals are still under development and subject to change, the HWSETA should take into account the implications for skills needs, especially considering the long leadtime required for training healthcare professionals, specialists, clinicians and mid-level workers.[291]

According to the DoH, the required human resource interventions will have to focus on:

a) Increasing the numbers and expanding the skills of general practitioners and selected medical specialists to work in teams in community health settings;

b) Producing more professional nurses, specialist nurses in selected areas, and PHC-trained nurses, and extending the scope of practice of current enrolled nurses;

c) Expanding mid-level workers (MLWs) such as clinical associates, pharmacy technicians, rehabilitation assistants and laboratory assistants;d) Incorporating CHWs who are well-trained in a core set of competencies into the PHC system;

d) Training and developing managers, especially in the areas of finance; health services and operations; human resources; information technology; procurement and contract management; quality and performance management; and facility and clinical management against mandatory standards;

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

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

285 MatsotsoM.P.andFryatt, R. 2013 "National Health Insurance: The first 18 months"inSouth African Health Review 2012/13. Published at http://www.hst.org.za/publications/south-african-health-review-2012/013.(Accessed 11 July 2013).

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

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

288 DoH. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf. (Accessed 12 August 2011); DoH. 2011. Media statement by Minister of Health – Release of Green Paper on NHI. August, 11.

289 McIntyre, D. and Van den Heever, A. 2007."Social or National Health Insurance" in South African Health Review 2007. Health Systems Trust. Published at www.hst.org.za/uploads/files/chap5_07.pdf.(Accessed August 2010).

290 Van Niekerk, J. P. de V. 2010. "National Health Insurance Exposed". *South African Medical Journal*. January 2010. 100 (1).

291 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.

e) Training and deploying more public health specialists; and

f) Employing data capturers and information communication and technology graduates[292].

In addition, 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 efficiently.[293]

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 families.[294]CHWs will be incorporated in the public health service to deliver primary healthcare. The focus will be on families and communities.Family health teams consisting of nurses, doctors and CHWs will support home-based care and educate communities on health.[295] More specialist PHC-trained nurses are required for these teams.[296]Mental health services will also be expanded and specialised mental health teams will support PHC outreach teams.[297]Patient access to occupational health services at district hospitals will also be improved by increasing the number of occupational health units to 100 by 2012, thereby increasing the need for occupational therapists, physiotherapists and rehabilitation practitioners.[298]

3.12.3 Community health workers

Owing to the rapid spread in the HIV/AIDS pandemic and TB epidemic, the health and social development sector has experienced a sharp growth in a range of community care workers (CCWs) and CHWs who are mostly affiliated to NPOs and CSOs. The CHWs are generalist workers who provide primary care and social services, but their mandates and conditions of service are not well defined.[299]Many CHWs have been deployed to do the tasks in hand but they have not been integrated into the wider health system.[300]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 NGOs.[301] According to the DSD, a lack of resources continues to constrain government efforts to pay stipends or the minimum daily wage.[302]

The majority of CHWs are volunteers and lay persons drawn from local communities and, without adequate skills development, they could compromise outcomes in major healthcare and social development programmes. By 2010, their numbers were estimated at 65 000 and the majority undertake limited activities, mainly in HIV and TB programmes.[303]Some CHWs are trained informally, on-the-job and via generic short course programmes, or in very limited areas only, while some may have no training.[304] Since NPOs lack the capacity to become accredited training providers, these workers are not receiving accredited training.[305]A recent DoH audit found that the roles, responsibilities and functions fulfilled by the community-based workers vary across provinces and organisations, and there needs to be standardisation of their services. Education and training of CHWs is also varied and diverse, ranging from a few weeks to four years. For this reason there is considerable variation in the range of their knowledge, skills and competence.[306]

With the view of strengthening maternal health and child care and improving access to care at community level, the DoH has been working to incorporate CHWs into jobs in the public sector, and specifically in ward-based outreach teams.[307] It is envisaged that CHWs will be an integral part of PHC outreach teams and work at a household level to strengthen health promotion and prevention. Their role will be to identify at-risk individuals and families who require further interventions, and to improve population health.The DoH recognises the need to standardise its services and to provide clarity on the scope of CHWs' work, role and responsibilities, qualification requirements, and conditions.[308]Major steps are needed to

292 Matsotso M.P and Fryatt, R. 2013 "National Health Insurance: The first 18 months"in*South African Health Review 2012/13.* Published at http://www.hst.org.za/publications/south-african-health-review-2012/2013.(Accessed 11 July 2013).
293 DoH. 2011. Human Resources for Health for South Africa 2030 : Draft HR Strategy for the Health Sector: 2012/13- 2016/17.
294 DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17.*
295 National Treasury. 2011. "Vote 16: Health". 2011 Estimates of National Expenditure.
296 DoH. 2011. *Human Resources for Health for South Africa 2030: HRH Strategy for the Health Sector: 2012/13 – 2016/17.*
297 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011. (Accessed 27 August 2012).
298 National Treasury. 2011. "Vote 16: Health". *2011 Estimates of National Expenditure.*
299 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.*
300 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*. Cambridge, Massachusetts: Harvard University Press.
301 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.Published at http://thelancet.com.(Accessed August 2010).
302 DSD. 2011. Strategic Plan 2011/12 – 2013/14.
303 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010. Published at http://www.hst.org.za/publications/.... (Accessed 19 August 2011).
304 Interviews with DoH,October and November 2012.
305 HWSETA. 2009. *HWSETA Sector Skills Plan 2005-2010: Annual Update August 2009*.
306 DoH. 2012. *Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17.*
307 Interview with DoH, November 2012.
308 DoH. 2012. Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17.

improve training and supervision of CHWs and to provide career opportunities for them to ensure that they are integrated into PHC teams with the required competencies.[309]

3.12.4 HIV/AIDS policies

By 2010 the number of hospital or clinic visits associated with HIV/AIDS approached 30 million per annum.[310] Only 41.6% of the population with advanced HIV had access to antiretroviral treatment (ART) in 2009,[311] or an estimated 740 000 patients. A national HIV counselling and testing (HCT) campaign was launched in April 2010 and the South African National Aids Council (SANAC) reported that 13 million HIV tests and 14.8 million counselling sessions had been completed by June 2011.[312]By the end of 2012between 1.7 and 2 million people (adults and children) were using ART, and the number of users is expected to increase to 2.5 million by 2015.[313]Scaling up of access to ART forms part of SANAC's National Strategic Plan for HIV/AIDS, STIs and TB, 2012-2017.Efforts are also underway to strengthen prevention of mother-to-child HIV transmission (PMTCT) programmes. However, the state of public health systems in terms of service delivery and medicine supply jeopardise the scale-up and success of ART programmes.[314]Additional human resources will be required if the ART population is to increase more than three-fold between 2010 and 2015.

Health economists predict that more than 25% of current public health resources will be required for ART over the next eight years, and by 2020 the resource needs will be 40% of resources currently available.[315] The DoH plans to equip more than 4300 sites to administer the treatment (or almost four times the number of police stations in South Africa) and to train 4800 nurses and lay counsellors to initiate and manage AIDS treatment.[316]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 implement and oversee operations. Social welfare support staff will also be needed to ensure that people who undergo testing receive appropriate help.[317]

3.12.5 Strategy to fight tuberculosis

Approximately 74% of TB cases are not managed appropriately – 44% of cases treated are not cured and 30% of cases are not reported, as per the DBSA. Poor case management contributes to the increased incidence of TB and MDR-TB and XDR-TB.[318]Specific TB control targets have been set to advance access to treatment and improve the cure rate. However,the South African National Tuberculosis Management Guidelines of 2010 recognised specific skills challenges – e.g. inadequate human and financial resources; poorly trained or supervised healthcare workers; and inadequate health systems. These challenges resulted in low case detection, poor continuity of care, and high levels of treatment interruption.[319] Successful strategies to fight TB require increased surveillance for MDR-TB, active case management, and monitoring of treatment completion.[320]Infection control in hospitals and clinics will need to improve to prevent further outbreaks.[321] Clearly, skills will be required at primary and secondary levels, including doctors, nurses, pharmacists, microbiologists, mid-level workers, laboratory technicians, and infection control officers.

3.12.6 Maternal and child health

Mortality rates for mothers and babies have increased since the baselines for the MDGs were set. Preventable maternal and neo-natal deaths have been attributed to failures in the health system, such as a lack of staff, inadequate skills and weak health management systems.[322]Decreasing maternal deaths is a national priority and several programmes aim to improve reproductive and maternal health.A target has also been set to reduce the child mortality rate to 20 (or lower) per 1 000 live births by 2014.[323] To achieve this, the quality and pro-

309 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010.Published at http://www.hst.org.za/publications/.....review-2010.(Accessed 19 August 2011).
310 National Treasury.*Budget Review 2010.*
311 Day, C. and Gray, A. 2010."Health and Related Indicators". South African Health Review 2010.
312 Steinberg, J. "The state wants our blood, to stop the three-letter plague". *Sunday Times* 2 May 2010, p. 9; Day, C., Gray, A. and Budgell, E. 2011. "Health and Related Indicators" *South African Health Review 2011*.
313 Venter, F. 2013."HIV Treatment in South Africa: The challenges of an increasingly successful antiretroviral programme" in South African Health Review 2012/13; National Treasury.2013 Budget Review; DoH. 2012. Annual Performance Plan 2012/13–2014/15. Published at http://www.health.gov.za.(Accessed 10 August 2012).
314 Venter, F. 2013. "HIV Treatment in South Africa: The challenges of an increasingly successful antiretroviral programme" in South African Health Review 2012/13. Published at http://www.hst.org.za/...(Accessed 13 July 2013).
315 HEU Information Sheet 1. 2009. "Public sector health care spending in South Africa". Health Economics Unit, UCT. Published at http://www.heu-uct.org.za.(Accessed August 2010).
316 Steinberg, J. "The state wants our blood, to stop the three-letter plague". *Sunday Times* 2 May 2010, p. 9.
317 DSD. 2011. *Strategic Plan 2011/12 – 2013/14*.
318 DBSA. 2008. *A Roadmap for the Reform of the South African Health System;* Day, C., Gray, A. and Budgell, E. 2011. "Health and Related Indicators" *South African Health Review 2011.*
319 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" *South African Health Review 2011.*
320 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. Published at http://thelancet.com.(Accessed August 2010).
321 DoH. 2012. Management of Drug-Resistant Tuberculosis: Policy Guidelines. Published at http://www.doh.gov.za/list.php.. (Accessed 30 August 2012); Harrison, D. 2009. An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains.
322 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; 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 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17.
323 Day, C., Gray, A. and Budgell, E. 2011."Health and Related Indicators" *South African Health Review 2011.*

ductivity of existing skills must be improved and the skills base expanded, especially in the public sector.[324] Vaccination programmes will also be stepped up to improve immunisation coverage and more emphasis will be placed on nutrition.[325]In 2012 the National Planning Commission called for nutrition interventions for all pregnant women and young children.[326]The skills of more GPs, medical specialists (gynaecologists and paediatricians), professional nurses, midwifes, birth attendants and nurses trained in intensive care, dieticians, nutritionists and clinical associates will be required, while the clinical skills of existing workers in areas such as obstetric care and comprehensive emergency obstetric care also require upgrading.[327]

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 diabetes.[328] Plans are under development to screen all men above 40 years for prostate cancer by 2020, and to increase screening and treatment for mental health problems by 30% by 2020.[329]

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 sector.[330]

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 staffing.[331]

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 waterquality; waste management; surveillance of premises; pollution control; chemical safety and hazardous substances;air quality;and the control of communicable diseases and malaria. The DoHaims to deploy environmental health practitioners(EPHs) in accordance with the national norm ofoneper 15 000 people. Another key objective is to ensure that provincial health departments monitor municipal health servicesrendered by metropolitan and district municipalities.[332]The policy also recognises the need to build the capacity of EHPs to support the integration of primary and preventivehealthcare into municipal health services.

3.12.10 Strategic priorities for human resources for health

Government's objective to improve access to healthcare will involve measures to develop new professionals and health workers; to increase flexibility in the workforce; to improve ways of working, productivity and retention; and to regenerate key facets of education and training. Eight strategic priorities will drive the interventions needed to improve the planning, provision, management, and service delivery of the sector's human resources. These priorities are:[333]

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;

324 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. September 2009. Vol. 374.Published at http://thelancet.com.(Accessed August 2010).

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

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

327 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. Published athttp://www.health.gov.za.(Accessed 10 August 2012).

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

329 DoH 2012.Annual Performance Plan 2012/13–2014/15.

330 Interview DoH in November 2012.

331 DoH. 2011. Human Resources for Health for South Africa 2030: Draft HR Strategy for the Health Sector: 2012/13-2 016/17..

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

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

e) Creation of infrastructure for the development of the workforce and health services, academic health complexesand nursing colleges;

f) Professionalising the management of HR 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.

3.13 SOCIAL DEVELOPMENT POLICIES AND LEGISLATION

3.13.11 Overview

The NDP and White Paper for Social Welfare, 1997 arethe key policy documents shaping legislation and delivery of social- and community services. The White Paper reshaped welfare policies and moved the delivery of social services to a rights-based approach, while the NDP makes introduces a shift towards a developmental approach. Improving the quality of life and enabling human development remain primary objectives of Government. For this purpose the DSD has the task of providing comprehensive social services to the poor and creating an enabling environment for sustainable development.The strategic priorities of the DSD for the period 2013 to 2016 are to:[334]

a) Reduce income poverty by providing social assistance to eligible persons;

b) Increase food security by providing 900 000 households with access to food by 2015;[335]

c) Improve service delivery by standardising social welfare services;

d) Prevent new HIV infections by addressing 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;

f) Improve access to and the quality of ECD to shape young children's social, cognitive and emotional skills, so as to give them a better start in life;

g) Strengthen child protection services;

h) Protect and promote the rights of older persons and persons living with disabilities;

i) Reduce social crime, especially violence against women and children;reduce demand for addictive substances in communities;and

j) Facilitate social change and sustainable development by targeting the youth, adults and vulnerable families in communities[336].

According to the DSD, the delivery of developmental social services aims to 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. The DSD has driven a range of policies and legislative changes to align welfare and social security arrangements with Constitutional principles and a more developmental approach. Key policy initiatives and legislative changes that have an impact on the human resources and amalgam of skills needed in the social development sector are outlined in this section of the SSP.

3.13.12 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 rights of children as contained in the Constitution, while it also aims to strengthen and preserve families.[337]Comprehensive provision is made for the delivery of social services to children in the areas of alternative care; ECD; prevention and early intervention; protection; foster care; adoption; and child and youth care centres. These provisions have a major impact on the social development workforce.

The Act sets out principles relating to the care, protection and well-being of children and defines parental responsibilities and rights. A broad definition of care refers to the promotion of the social, emotional, physical and intellectual development of children; guidance of their education, upbringing, and behaviour; material maintenance; protecting them from harm and abuse; providing for special needs; and ensuring the best interests of a child.[338] "Caregivers" include foster parents, heads of shelters and youth centres, and youth and childcare workers.

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 stipulations deal with the protection of children and their health. Child protection organisations need to meet prescribed criteria, deliver defined services and register with the

334 DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013); National Treasury. 2013. "Vote 19: Social Development". *2013 Estimates of National Expenditure*.

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

336 National Treasury. "Vote 19: Social Development". *2013 Estimates of National Expenditure*; Department of Social Development. 2012. *Annual Performance Plan 2012/2013*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).

337 Sec 2 of the Children's Act 38 of 2005.

338 Sec 1 of the Children's Act 38 of 2005.

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. A national child protection register also records the names of persons who are found unsuitable by a court to work with children.

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 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 careand is working to increase the number of adoptions by 10% per year until 2016.[339]

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 legislation.[340]The DSD is working towards the implementation of the Act between 2011 and 2014.[341]Amendments to the Children's Act will be developed and published during 2015/16.

b) The Child Justice Act

The Child Justice Act, 75 of 2008 seeks to establish a criminal justice system for children who are in conflict with the law or are accused of committing criminal offences. The Act ensures that children's cases are managed in a rights-based approach and assists juvenile delinquents to turn their lives around and become productive members of society. The Act provides for the assessment of alleged child offenders by a probation officer to determine their need for care and protection and for referral to a children's court. The assessment also informs decisions on the release or detention and placement of the child. Provision is made for the holding of preliminary inquiries to determine how cases may be handled – e.g. 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. The successful implementation of the Act will depend on the availability of appropriate skills to make it possible to entrench restorative justice in respect of child offenders. During 2011/12 further work will focus on the accreditation of diversion programmes to usher child and youth offenders out of the criminal justice system. The DSD has developed a strategy on the prevention of social crime and this work will be extended to 2014 to accredit prevention programmes under the Act and to train practitioners and service providers.[342]

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. ECD is supported by legislation, the NDP and other policies, and a dedicated subsidy. The DSD is entrusted with the responsibility of expanding access to ECD to children under five years.[343] There is a vast need for competent ECD practitioners who are also skilled to serve children in non-formal settings. During the period 2013/14 to 2015/16 the DSD will develop a policy and national plan for ECD. The DSD also intends to build the human resources capacity to deliver a comprehensive package of ECD services.[344]

d) Child and youth care

Expanded welfare services to orphans and vulnerable children aim to support children in their homes (and life space) to counter the de-stabilising effects of the loss of a parent or both parents.[345]Child and youth care workers train children and youth in life skills and provide support at community level. This approach follows the *Isibindi*model, which the DSD plans to roll-out across the country.[346]Youth leadership development and youth programmes to influence social change will also be stepped up. During 2012/14specific training programmes will target child care givers and supervisors to improve services in HIV/AIDS home-community-based-care (HCBC).[347]

3.13.13 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

339 DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).
340 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../.../csda/publications.(Accessed 20 August 2011).
341 National Treasury. 2011. "Vote 19: Social Development". *2011 Estimates of National Expenditure*.
342 National Treasury. 2012. "Vote 19: Social Development". *2012 Estimates of National Expenditure*.
343 DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).
344 DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).
345 DSD. 2012. *Annual HRD Implementation Plan;* Department of Social Development: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.
346 DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).
347 DSD. 2012. *Annual HRD Implementation Plan;* DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).

have evolved over the past 20 years from care-receivers to caregivers, propelled mainly by the increase in mortality 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. Inadequate retirement provision, poverty, lack of access to basic services, healthcare, food insecurity, and a lack of affordable accommodation are some of the challenges facing older persons. 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 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 welfare.[348] A major change involves the shift from institutional care (old age homes) towards community- and home-based care.[349] 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 communities.[350] 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.[351]

Over the period 2013-16the DSD will take measures to improve access to social welfare services for older persons. Specific attention will be given to promoting and protecting the rights of older persons, reducing abuse and providing HCBC services to older persons.The Older Persons Act will also be reviewed.[352]

3.13.14 Prevention of and Treatment for Substance Abuse Act

ThePrevention of and Treatment for Substance Abuse Act, 70 of 2008 requires an integrated approach to combat substance abuse through demand reduction (i.e. measures to discourage abuse), and harm reduction by providing holistic treatment of users and their families, mitigating the social- psychological- and health impacts of substance abuse, and supply reduction. Medical interventions are needed to address the physiological and psychiatric needs of users. Provision is made for the registration of treatment centres, the committal of persons to such centres and for their treatment, and for rehabilitation and skills development in such centres. Service providers must be multi-skilled and recognise the educational, social, cultural, economic and physical needs of users and persons affected by substance abuse.The Central Drug Authority (CDA) is established to oversee the National Drug Master Plan; i.e. a national strategy to control and manage the supply of and demand for drugs. Provincial substance abuse forums and local drug action committees at municipal level will be set up.It is anticipated that the Act will become operational in 2013/14.[353]

The DSD plans to lead anti-substance abuse programmes nationally to reduce social ills and crime expressed in domestic abuse and violence. The aim is to educate communities on the dangers of drug- and alcohol abuse, and to rehabilitate and re-integrate drug users into society.[354]Other strategies will aim to alter the unhealthy use of alcohol[355] and to reduce substance abuse.

3.13.15 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 interaction.[356]The *Policy on People with Disabilities (2009)* aims to ensure that all people with disabilities who are poor, vulnerable, and marginalised receive adequate economic and social protection, and attainaccess to social welfare programmes to enhance social functioning. The implications for skills planning are that policy developers need to understand the state's obligations 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 living.[357]

The DSD introduced a new disability-assessment tool to ensure that beneficiaries of the disability grant are being targeted correctly. Adraft policy and bill on social development services for disabled personswill be published during2013/2014. Officials will also be trained to ensure that disability programmes are incorporated in departmental planning, budgeting and implementation processes.[358]

348 Sections 2, 5 and 6 of the Older Persons Act, 13 of 2006.
349 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).
350 DSD. 2011. *Strategic Plan 2011/12 – 2013/14.*
351 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).
352 DSD. 2013. *Annual Performance Plan 2013/2014*; National Treasury. 2013. "Vote 19: Social Development". *2013 Estimates of National Expenditure*.
353 DSD. 2013. *Annual Performance Plan 2013/2014.*
354 National Treasury.2012 Estimates of National Expenditure; DSD. 2012. *Annual HRD Implementation Plan.*
355 DSD. 2011. *Strategic Plan 2011/12 – 2013/14.*
356 Health Systems Trust. 2011. Health indicators. Published at http://www.hst.org.za/recently-.. (Accessed 10 August 2011).
357 United Nations. 2006. Convention on the Rights of Persons with Disabilities. Published at http://www.un.org/disabilities/convention/conventionfull.shtmlNations.(Accessed 17 August 2011).
358 DSD. 2013. *Annual Performance Plan 2013/2014*; National Treasury. *2012 Estimates of National Expenditure*.

3.13.16 Community development policies

Community development policies aim to build the capabilities of poor communities to generate their own incomeand create sustainable livelihoods. Typically, poor communities are assisted to plan and implement activities that will improve their economic, social, cultural and environmental conditions.[359]The DSDwill introduce a range of programmes from 2012 to 2016that aim to:[360]

a) Mobilise communities, esp. youth and women 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 improve nutrition by assisting poor households in rural communities to access diverse, nutritious and affordable 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 440 000 households and 980 000 orphaned children;
h) Strengthen the capacity of CBOs to govern and to comply with the requisite norms and standards to deliver HCBC;
i) Train community development facilitators, community care givers and their supervisors.

According to the National Planning Commission, community safety centres will be developed to prevent crime and involve youth in community development.[361]Youth service programmes and new community-based programmes will offer training to young people in life-skills and entrepreneurship.

3.13.17 Policies to combat social crime

In view of high levels of social crime, particularly violence against women and children, the DSDdeveloped empowerment and social crime prevention strategies, which are delivered in partnership with CBOs.[362]Specific skills development needs to combat social crime include training for:[363]

a) Probation officers in social crime prevention and administration of the Child Justice Act, 2008to 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 accreditation of diversion servicesfor youth offenders;
c) Social workers and lay counsellors to implement the Domestic Violence Act 116 of 1998;
d) NPOs to run effective youth development programmes;
e) Persons working to prevent human trafficking.

3.13.18 Professionalisation and regulation of practices

Policy initiatives of the DSD aim toaddress inconsistencies in the 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. Specific sets of 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, care and support programmes. Service specifications and criteria were also set for crime prevention services and victim empowerment.[364]A monitoring and evaluation system for home-based care and standards for community based care and support to older persons were also designed.[365]

Anotheraim is develop governance and delivery skills of 25 000 CBOs and NPOs by 2014.[366]A framework for the supervision of social workers, student social workers, social auxiliary workers and learners was jointly developed by the DSD and SACSSP, and regulations will be developed once consultation workshops have been held.[367]During 2013/4to 2015/6the DSD intends to:[368]

a) Develop a regulatory framework for social services practitioners and a draft Bill on social service practitioners;
b) Introduce a regulatory system for NPOs;

359 DSD 2012. Draft policy for social service practitioners. (Working document).
360 National Treasury.*2012 Estimates of National Expenditure*; DSD. 2012. *Strategic Plan 2012-2015*; DSD. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).
361 National Planning Commission. 2012. Summary and key issues of the National Development Plan 2030. Published at http://www.info.gov.za/issues/national-development-plan/index.html(Accessed 19 September 2012).
362 DSD. 2012. Strategic Plan 2012-2015.
363 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*.
364 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services; Department of Social Development. 2013. Website. Published at http://www.dsd.gov.za/.. (Accessed 19 July 2013).
365 DSD. 2012. *Annual HRD Implementation Plan.*
366 DSD. 2011. *Strategic Plan 2011/12 – 2013/14*.
367 SACSSP. 2012. SACSSP Newsletter. May 2012. Vol.1 (1). Published at: http://www.sacssp.co.za/... (Accessed 24 August 2012).
368 DSD. 2013. *Annual Performance Plan 2013/2014*; National Treasury. *2011 Estimates of National Expenditure*; National Treasury.*2012 Estimates of National Expenditure*; DSD. 2012. Annual Performance Plan.

c) Assess whether residential care facilities and home-based care for older persons comply with prescribed norms and standards;

d) Implement training and capacity-building programmes for social development workers to help disabled persons better enter mainstream society;

e) Develop an occupational framework for community development practice;

f) Implement protocols and guidelines on foster care to improve alternative care for children; and

g) Establish an inspectorate for social security to enforce policy and regulatory compliance, reduce leakages and strengthen controls, and curb misconduct and abuse.

3.14 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 practitionersare 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 needs.[369]

Public health specialists agree that healthcare practitioners need new and different skills sets to address the health needs of local populations.[370] 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 patient-centred care in a multiplicity of health and social contexts.[371] 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.

3.15 NEW SCOPES OF PRACTICE, OCCUPATIONS AND QUALIFICATIONS

Policy changes initiated by several of the 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 will require new skills sets to close current skills gaps. New occupations are emerging to due to the need to change the way social development services are delivered; e.g. in the field of community development. New qualifications are also under development.

3.15.19 Pharmacy profession

The roles of pharmacists and their support staff are changing as a result of 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 MLWs, the pharmacy technical assistant (NQF level 5) and pharmacy technician (NQF level 6) will be introduced in the near future. They 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).[372] The current categories will be phased out by 2015.

According to the SAPC, the first intake of pharmacy technical assistant and pharmacy technicians is expected in 2013. 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 work under the direct supervision of a pharmacist in any category of pharmacy,[373] and

369 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*. Cambridge, Massachusetts: Harvard University Press.

370 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*. Cambridge, Massachusetts: Harvard University Press.

371 HPCSA. 2012. "Core competencies for Undergraduate students in the Clinical Associate, Dentistry and Medical Teaching and Learning Programmes in South Africa".

372 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

373 The Pharmacy Act identifies five categories of pharmacies (manufacturing, wholesale, community, institutional (public and

under indirect supervision in PHC clinics.[374] Subject to amendments to the Medicines and Related Substances Control Act, 1965 pharmacy technicians will also be able to dispense prescribed PHC medicines.

The current categories of pharmacy assistants (basic and post basic) who do not study towards the new qualifications will be converted to a new category of pharmacist assistant.[375]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) during 2013. Pharmacy general assistants will be able to work with inventory in hospitals, wholesalers and pharmaceutical distributors.[376]

A new category of health professional, the authorised pharmacist prescriber, has been created to strengthen the provision of PHC services in community pharmacies. These professionals will assist with preventive health services, by immunising children, treating minor conditions, and screeningand managingpatients with lifestyle diseases. The scope of practice and qualification has been developed and different providers will offer learning programmes.Three areas for specialisation in pharmacy have been identified: clinical pharmacy (which includes the radio pharmacist and pharmacokineticist), public health and industrial pharmacy. Further planning and dedicated budgets are required to implement these specialities and develop qualifications at Master's degree level.[377]

The SAPC has acknowledged that pharmacy schools will be challenged to train and re-train the numberof pharmacists and the pharmacy MLWs required to meet the health needs of the population.[378]

At the time of writing this update, deliberations on qualification development and collaboration with strategic partners in the implementation of this MLW category in the pharmacy sector (mentioned in the previous paragraphs), were at the advanced stage. SAPC had approached the HWSETA to assist in the production of these cadres. The HWSETA, SAPC as well as employers, have been identified as strategic partners in the production of these mid-level skills category. The HWSETA has committed its support in the following areas of collaboration:

- Support and increase the number of accredited training providers that offer MLW training as determined by the SAPC
- Identify and capacitate FET Colleges in partnership with the SAPC to offer level 4 learnerships
- Conclude an MoU with SAPC as a Qualification Development Partner (QDP)
- Support the SAPC to build and increase its capacity as a Qualification Assurance Partner (QAP)
- Foster strong relationships with employers and fund Workplace Experience Grant (WEG)
- Provide career and vocational guidance in partnership with the SAPC and employers in the sector

The HWSETA extended its support by offering its services to participate in the Committee for Human Resources in Pharmacy. The HWSETA will also increase the production of mid-level skills by:

- Providing bursaries in critical occupations
- Registering and funding learnerships
- Placing interns in the workplace and providing incentives to employers
- Training lecturers in institutions of learning including FET colleges; and

Providing mentorship support to employers

3.15.20 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 with the Nursing Act, 2005. The scope of practice of nurses is divided into new categories – professional nurse/registered nurse[379], professional midwife, staff nurse, and auxiliary nurse.[380]Table 3-7summarises the new qualifications framework required for the nursing and midwifery professions.

Currently nursing colleges serve as the primary training platform for new entrants to the profession. The revised qualification framework is set on a higher education platform. This has implications for public and private nursing colleges, as more stringent accreditation requirements apply to HEIs. The DoH has recommended that nursing colleges be declared HEIs and that the training capacity of these institutions be improved.[381] The need to develop more and better qualified educators to conduct higher-level training is particularly acute.

private) and consultant) and prescribes the range of services that may be performed in each.

374 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

375 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

376 Interview with SAPC in October 2012.

377 Interview with SAPC in October 2012.

378 Interview with SAPC in October 2012.

379 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.

380 Categories under the Nursing Act of 1978: registered nurse, registered midwife, enrolled nurse and enrolled midwife.

381 DoH. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.

Table 3-7 New nursing categories and qualifications framewo

New SANC category	New qualification	New 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)
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: Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.

3.15.21 Health professionals registered with the HPCSA

During 2011 and 2012 the HPCSA initiated regulatory changes to the scopes of practice in the professions of psychology, audiology and environmental health.Regulatory changes to qualifications for several professions, including speech therapists, audiologists, environmental health officers, dental assistants, and biokineticistswere also published.[382]

3.15.22 Mid-level workers

Many developing countries are expanding scarce healthcare resources by introducing mid-level and ancillary health workers.[383]In South Africa there is a growing demand for MLWs or para-professionals 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).[384]

A new category of MLW for the medical field, known as the "clinical associate", was introduced in 2004 to improve coverage of PHC and service delivery in under-resourced areas.[385]Clinical associates work under the supervision of doctors and assist them with emergency care, routine procedures and in-patient care in district hospitals.[386] They enter practice after completing a three-year Bachelor of Medical Clinical Practice degree and after serving one year of community service. Both the HPCSA and DoH view clinical associates as key health workers in district hospitals and the DoH has called for the training of another 4 000.[387]

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 the graduation numbers are too low to offset the shortage of professionals.[388]According to a number of authors there still appears to be uncertainty about the roles of MLWs[389] and the HPCSA remains cautious about them. Career mobility is a significant challenge due to the lack of articulation opportunities into higher-level qualifications or professions.[390]

No national policy exists to develop MLWs and their training at HEIs has neither been planned nor for-

382 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13. (Accessed 13 July 2013).

383 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*. Cambridge, Massachusetts: Harvard University Press.

384 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".*South African Health Review 2008*.

385 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".*South African Health Review 2008*.

386 Faculty of Health Sciences. 2010. Faculty of Health Sciences Prospectus 2010. Mthatha: Walter Sisulu University. Published at http://www.wsu.ac.za/academic/... (Accessed August 2010); University of the Witwatersrand. Published at http://web.wits.ac.za/Prospective/.../Health/UndergraduateDegrees....htm.(Accessed September 2010).

387 Interviews with stakeholders held in October and November 2012.

388 Coovadia, H., Jewkes, R. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet. September 2009. Vol. 374; Lloyd, B., Sanders, D. et al.. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010. Published at http://www.hst.org.za/.. (Accessed 19 August 2011).

389 Hugo, J. 2005. "Midlevel health workers in South Africa – not an easy option" in South African Health Review 2005.Published at http://www.hst.org.za/up...sahr05_chapter11.pdf.(Accessed August 2010); Lehmann, U. 2008."Strengthening Human Resources for Primary Health Care".South African Health Review 2008.

390 Interview with HPCSA, October 2012.

malised.[391] 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. As a result some HEIs have stopped the training of rehabilitation technicians and rehabilitation assistants in the fields of occupational therapy and physiotherapy.[392] A further constraint is that the public health sector may not have funded (or created) the posts for these MLWs.

3.15.23 Allied health professions

A new occupation of a health promotion officer is under development. Once the scope of practice and education and training requirements are finalised, this category will be temporarily registered with the Environmental Health Practitioners Board of the HPCSA.[393]

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.para-medical 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 existingEMS training programmes are shortcourse-based and the qualifications are not NQFaligned.[394]The Emergency Care Professional Board of the HPCSA and the DoH are developing a new qualifications framework to be set on a higher education platform. New qualifications provide for two mid-level categories – emergency care assistant(NQF 5) and emergency care technician (NQF 6).The currentBTech degree in emergency medical care will be converted into a professional degree for emergency care practitioners (NQF 8). Training under the qualifications of emergency care assistant and emergency care practitioner will commence in 2014.[395]

3.15.24 Community development

The need for community development stems from the constitutional principle that South Africa is a developmental state. Community development interventions aim to alleviate poverty, generate income, stimulate employment and sustain households and communities. The aims are to empower vulnerable communities to participate in issues that affect their daily lives; develop their human capacity; enhance their self-reliance; redress social injustice and enablethem to invoke their human rights.[396]The DSD has adopted a"sustainable livelihoods" approach to community development.

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 context.[397]CPDs require appropriate skills to engage a range of different parties (e.g. national and provincial 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 recent skills audit by the DSD found that workers in the field lacked appropriate qualifications, skills and competencies to successfully undertake and implement community development programmes. 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 way.[398] Together the DSD and Department of Cooperative Governance and Traditional Affairs (CoGTA) are driving processes to establish an occupational framework and to develop standards against which CDPs and workers may be trained.[399] Three qualifications are under development and will be submitted to the QCTO in 2013.[400] According to the DSD, potentially thousands of community development workers and government officials need to enter the NC: Community Development (NQF 5),which will be offered by FET colleges and universities of technology. The two lower-level qualifications will also be registered as learnerships.

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

391 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).
392 Interview with HPCSA, October 2012.
393 Interview with HPCSA, October 2012.
394 Interview with the DoH in November 2012.
395 Interview with the DoH in November 2012.
396 DSD. 2009. "Towards Sustainable Livelihoods: a Toolkit for Community Development Practitioners in South Africa". Interview, Prof Antoinette Lombard, Head of Social Work Department, University of Pretoria.
397 DSD. 2012. Draft policy for social service practitioners. (Working document).
398 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. Published at http://www.ci.org.za/depts/ci.../general/gauge...pdf.(Accessed 21 August 2011).
399 Interviews with the Department of Social Development during October 2012.
400 These are a FETC: Community Development (NQF level 4), NC: Community Development (NQF level 5) and a professional degree, Bachelor of Community Development (NQF level 8). These qualifications have been registered by SAQA, but a task team is busy re-scoping them to apply for registration via the QCTO.

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 injured.[401]During 2013 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 future.[402]

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 functions.[403]Proposed changes will include standard death and disability benefits and a basic retirement pension, financed through an earnings-related contribution.[404]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 provide for retirement, disability and survivor benefits. Government is aiming to establish the National Social Security Fund by 2013.[405]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 EMPLOYMENT EQUITY AND BEE

The Health Charter of 2006 was developed by the private and public health sectors to promote access, equity and quality in health services, and to foster black economic empowerment (BEE). Among the core strategies are to:[406]

a) Enhance access by involving doctors from the private to provide care in the public sector;

b) Create more equity by: developing a basic package of care available to all patients, irrespective of their ability to pay; improving the profile of the health workforce to represent the population demographic (with the aim that 60% be black and 50% be women by 2010);

c) Improve quality by training personnel on patients' rights and dignity, by implementing quality assurance programmes and learning from complaints of users of health services; and

d) Advance BEE through increased levels of black ownership of companies (35% by 2010 and 51% by 2014) and preferential procurement from black firms (60% by 2010 and 80% by 2014).

An advisor to the DoH noted that targets in the Health Charter resulted in a number of black empowerment deals with the three major hospital groups and a number of smaller ones. While those deals met the BEE objectives of the Health Charter, they failed to address the other objectives of access, equity and quality in health service provision.[407]

3.18 VETERINARY SERVICES

3.18.1 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 humans.[408]

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.[409]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

401 National Treasury.*2011 Budget Review*.
402 National Treasury.*2012. "Social security and national health insurance".2012 Budget Review.*
403 National Treasury.*2011 Budget Review.*
404 National Treasury.*2013 Budget Review.*
405 National Treasury.*2012. "Social security and national health insurance".2012 Budget Review.*
406 McIntyre, D., Thiede, M. et al. 2007. A critical analysis of the current South African health system. Health Economics Unit, UCT. Published at http://www.web.uct.ac.za/./SHIELD/reports/.(Accessed August 2010); Harrison, D. 2009. An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains.
407 Harrison, D. 2009. An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Published at www.doh.gov.za.(Accessed February 2010).
408 SAVC. 2011. "Celebrating World Veterinary Year 2011 in South Africa". Published at http://www.savc.co.za/pdf_docs/World...%20final.pdf.(Accessed 22 August 2011).
409 Interview with SAVC in October 2012.

healthcare[410]. They are often employed by state veterinary services and require professional supervision.In private practice, veterinary nurses attend to patient care, client liaison, administration of medicines, basic laboratory procedures, stock control and merchandising, and in the NGO sector, they provide primary animal healthcare and educate pet owners.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 research.[411]

Recently, the SAVC agreed to recognisethe role of animal welfare assistants in order to acknowledge the skills of animal handlers at veterinary practices and kennels. Generally, this category of worker has no formal qualifications, but hasreceived in-service training and gained relevant experience and skills sets 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, the para-veterinary group is notformally registered by the SAVC and a scope of practice has not been developed.Unisamay develop a new qualification, the HC: Animal Welfare, to be offered as a one-year distance learning programme for this emerging category.[412] Other emerging animal health occupations are animal rehabilitation- and equine dental technician.[413]

3.18.2 Factors driving the demand for skills in animal healthcare

Veterinary skills are in demand globally, especially in Africa.[414] International migration is common[415]and the immigration rate of the country's newly qualified veterinarians remains high.[416]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%.[417]However, the high vacancy rate is not necessarily a true reflection of skills shortages and could be attributed to specific recruitment, management, remuneration and promotion policies applied inthe public sector.[418]In the absence of an up-to-date epidemiological study that considers multiple factors driving the demand for animal health services, it is not possible to give an accurate picture of skills shortages in the veterinary and para-veterinary fields.[419]

Specific challenges pertaining to the provision of veterinary services arethe needto:[420]

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.

One of Government's key challenges is to strengthen rural development by growing rural income, improving food security and enabling sustainable job creation.[421]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 value.[422]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 production.[423]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.

410 Statutory duties of animal health technicians are set out in Government Gazette No 32298, Notice R 867, June 12. Published at http://www.savc.co.za/pdf_docs/ahtrules.pdf. (Accessed 22 August 2011)).

411 South African Veterinary Association. 2012. Career information. Published at: http://www.vetassociation.co.za/..php?.... (Accessed 4 September 2012); Interviews with respondents from the veterinary professions in October 2012.

412 Interviews with SAVC and veterinary academics, October 2012.

413 Interview with SAVC in October 2012.

414 Interviews with SAVC and veterinary academics, October 2012.

415 Paterson, A. 2008. "Veterinary Skills", in Kraak, A. and Press, K. (eds).*Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*

416 Department of Agriculture, Forestry and Fisheries.2012. Memorandum to the Veterinary and Para-Veterinary Professions Amendment Bill, 2012. Published at http://www.pmg.org.za/bill/20120613-.....-b25-2012.(Accessed 6 September 2012).

417 Interviews with SAVC and veterinary academics, October 2012.

418 Interviews with SAVC and veterinary academics, October 2012.

419 Interview with SAVC in October 2012.

420 Inputs by the SAVC in 2011 following a consultative process initiated by the HWSETA.

421 This is aligned to Strategic Infrastructure Project (SIP) 11 of the Presidential Infrastructure Coordinating Commission.

422 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

423 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

The DAFF adopted the *Primary Animal Healthcare Policy in South Africa* in 2000 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 resources in government are mostly located in urban centres.[424]In April 2011 the University of Pretoria (UP)[425] established a chair in primary animal healthcare to develop the concept, methodology and training material needed for primary animal healthcare (PAHC).[426]

More recently 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 production.[427] The aim is to train all 1 000 registered animal health techniciansin 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. Each animal health technician receives a comprehensive PAHC toolkit with the material to train stock owners and to demonstrate treatment and disease prevention techniques. 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 services.[428]

In South Africa, Government'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 functions.[429]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 health.[430]

The DAFF set policy objectives and delivery targets to improve livestock production and animal-disease risk-management programmes over the period 2012 to 2017.Production improvement schemes will be rolled out in all provinces and interventions to control animal diseases will be better coordinated. The advancement of food security strategies will require the strengthening of meat inspection systems and veterinary public health services.[431]Regulatory interventions such as inspections, quarantine services and audits will be increased to advance animal health and veterinary public health.[432] The successful implementation of these interventions will depend on the availability of skilled veterinary professionals and para-professionals.

There are increasing calls to make veterinary services more accessible to low-income communities at local government level, as these communities may not have the means to afford private veterinary treatment for vaccination, sterilisation, and advice and disease control.[433]According to the South African Veterinary Association (SAVA) the need remains high for primary veterinary healthcare in disadvantaged communities where animal owners are unable to access services offered by private veterinary practitioners.[434]Recently the SAVC also called upon veterinarians to participate in social responsibility programmes to enable poor rural communities to gain access to veterinary services.[435]

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 development.[436] According to the SAVC there is a shortage of veterinary educators in the fields of PAHC, veterinary technology and veterinary

424 Paterson, A. 2008. "Veterinary Skills", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*

425 At the Faculty of Veterinary Science, Onderstepoort.

426 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 September 2012).

427 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

428 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.

429 SAVC. 2011. SAVC Review 2007-2010. Published at http://www.savc.org.za/.(Accessed 13 August 2011).

430 Interview with SAVC in October 2012.

431 Department of Agriculture, Forestry and Fisheries. 2012. *Strategic Plan 2012/13 -2016/17 for the Department of Agriculture, Forestry and Fisheries.*Published at http://www.nda.agric.za/. (Accessed 5 September 2012).

432 National Treasury. 2012 "Vote 26: Agriculture, Forestry and Fisheries". *2012 Estimates of National Expenditure.*

433 Paterson, A. 2008. "Veterinary Skills", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa*.

434 SAVA. 2012. "Community Vet". Published at http://vw.communityvet.co.za/.(Accessed 4 September 2012).

435 SAVC. 2011. SAVC Review 2007-2010. Published at http://www.savc.org.za/...(Accessed 13 August 2011).

436 Paterson, A. 2008."Veterinary Skills", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*

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 needed.3.18.3
New roles and responsibilities for animal health professionals and technicians

Internationally, the roles of veterinarians and para-veterinarians working in veterinary 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 health. As the only professionals that routinely operate at the interface of these components, veterinarians are well placed to drive the One Health Concept.[437]

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 to animal health workers who require skills to produce safe food for the anticipated nine billion people on the Earth by 2050, without compromising the environment.[438]

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 through 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 management.[439]As a result of thisemerging approach, veterinary professionals need to develop new skills sets that support collaborative abilities, and develop their consciousness about socio-economic issues, cultural diversity, and value systems.[440]

3.18.4 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 200were employed in the public sector.[441]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 utilised.[442] 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 benefits.[443]Language barriers are also constraining factors in service delivery to emerging stock-owners. 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 practices.[444]Further, existing training institutions produce insufficient numbers of veterinary- and para-veterinary professionals to meet public sector service targets.[445]

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 so and no assistance is available to them to prepare for the registration examination.[446]

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 capacity.[447]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.

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-serviced areas.[448] Secondly, compulsory community service for personsregistering for the first time as veterinarianswill be introduced in 2014, and for para-

437 Interview Faculty of Veterinary Science, University of Pretoria, October 2012.
438 McCrindle, C.M.E. 2010."Veterinary education for global animal and public health".Journal of the South African Veterinary AssociationVol 81 (2) Published at http://www.jsava.co.za/index...view/126/109. (Accessed 4 September 2012).
439 University of Pretoria, Faculty of Veterinary Science. 2011. Primary Animal Healthcare Implementation Plan.
440 Faculty of Veterinary Science.University of Pretoria. 2012. "Curriculum principles". Published at http://web.up.ac.za/.(Accessed 2 November 2012).
441 Interview with SAVC in October 2012.
442 Interview with SAVC in October 2012.
443 Interview with SAVC in October 2012.
444 Interview with SAVC in October 2012.
445 South African Veterinary Council. 2011. *Annual Report 2011*.
446 Interview with SAVC in October 2012.
447 Interview with Department of Biomedical Sciences, Tshwane University of Technology, November 2012.
448 Paterson, A. 2008. "Veterinary Skills", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*

veterinarians, within a few years.[449] Plans are underway to finalise a framework for community service by 2013[450] and legislative amendments to provide for such compulsory community service will be tabled in Parliament.[451]Thirdly, the state could enter into contracts with rural-based veterinarians in private practice to provide public animal healthcare services.[452]However, these professionals will need training to perform regulatory work for the state in areas such as surveillance and disease control.[453]. The DAFF also provides bursary funding to train veterinarians.[454]

The Faculty of Veterinary Science of UP will increase the intake of veterinary students from 140 per year to 190 from 2013and specifically increase the intake of black students from rural provinces. Graduates will also be encouraged to enter rural practice and state veterinary services.[455]

The Faculty experienced a drop in applications for veterinary nurses and the training programme will be converted from a diploma course into a degree in 2014 in the hope of attracting more candidates.[456]

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 market.[457] 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.

3.19 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 grow in the midst of a growing burden of disease and enduring shortages of health and social services professionals. The scope, complexity and diversity of the disease burden presents mounting challenges for service delivery and the workforce. These realities are driving the need for new skills sets that integrate occupation-specific knowledge and technical ability with professional attitudes and socio-cultural awareness.

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, while transfers to NPOs and delivery partners for social development services maintain their upward trend.

Multiple socio-economic factors impact on the availability and distribution of health and social development workers. Attrition and a growing population 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.

Institutional problems 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. In addition, more skilled health workers are required to meet the demands of the growing population and the disease burden. 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, but additional, extensive skills development interventions are needed for the social services sector.

449 Interview with SAVC in October 2012; DAFF. 2013. Draft regualtions relating to the performance of compulsory community service. Published at http://www.savc.co.za/pdf_docs/...pdf.(Accessed 20 July 2013).
450 Department of Agriculture, Forestry and Fisheries. 2012. Strategic Plan 2012/13 -2016/17 for the Department of Agriculture, Forestry and Fisheries.Published at http://www.nda.agric.za/. (Accessed 5 September 2012).
451 Department of Agriculture, Forestry and Fisheries. 2012. General Notice 491 of 2012. Government Gazette No. 35440 11 June 2012. Published at http://www.nda.agric.za/.(Accessed 5 September 2012).
452 Paterson, A. 2008. "Veterinary Skills", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa.*
453 Interview with SAVC in October 2012.
454 National Treasury 2012. "Vote 26: Agriculture, Forestry and Fisheries".*2012 Estimates of National Expenditure.*
455 SAVC. 2012 "Veterinary training in South Africa-Strategic policy statement". Published at http://www.savc.org.za/pdf_docs/...policy_statement_vet_recruitment_UP.pdf.(Accessed 20 July 2013).
456 Interview, Faculty of Veterinary Science, University of Pretoria, October 2012.
457 SAVC.2013 "Latest news".Published at http://www.savc.org.za.(Accessed 20 July 2013).

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 professional nurses, staff nurses, pharmacists, medical practitioners and medical specialists. New occupations such as pharmacy technician and emergency care technician are emerging to address changing service- and technology needs. Training for healthcare practitioners in the fields of nursing, pharmacy and emergency medical care is moving to a higher education platform, and this has major implications for the provision of healthcare education and the development of clinical skills.

At the same time the health and welfare sector requires management skills at strategic and operational levels to enhance quality, performance and accountability, as well as financial and resource management within the health system. 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.

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. 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 care givers.

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 2014 (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 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 2013there were approximately 325 700 filled positions in the Public Service, that vacancy rates are quite high and that the Public Service's total establishment is considerably larger than is reflected in the current employment figures. The total number of vacancies that are indicated as scarce skills amounts to more than 30 000.[458]. This means that the total number of positions in the public health and social development sector is approximately 349 000[459] (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 2013 to the estimates of total employment in each occupation. The filled positions in the private sector numbered 262 503 while there were 7 090vacancies. This brings the total number of positions in the private sector to 269 593 and the total number of positions in the sector to 618 332.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 are excluded.

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 sector.[460] 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, 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 2011.[461]

The occupational distribution of positions in the sector is shown in Figure 4-1. The sector employs mainly professionals (36% of the total number of positions in the sector) and technicians and associate professionals (24% of the total number of positions).

458 No vacancies were reported by the Department of Social Development in Mpumalanga and Department of Health, Northern Cape.

459 The extent to which these reported vacancies are currently funded is not clear.

460 DBSA. 2008. *A Roadmap for the Reform of the South African Health System*.

461 Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. 2011."Health Financing".South African Health Review 2011.Published athttp://www.hst.org.za/publications/south-african-health-review-2011.(Accessed 27 August 2012).

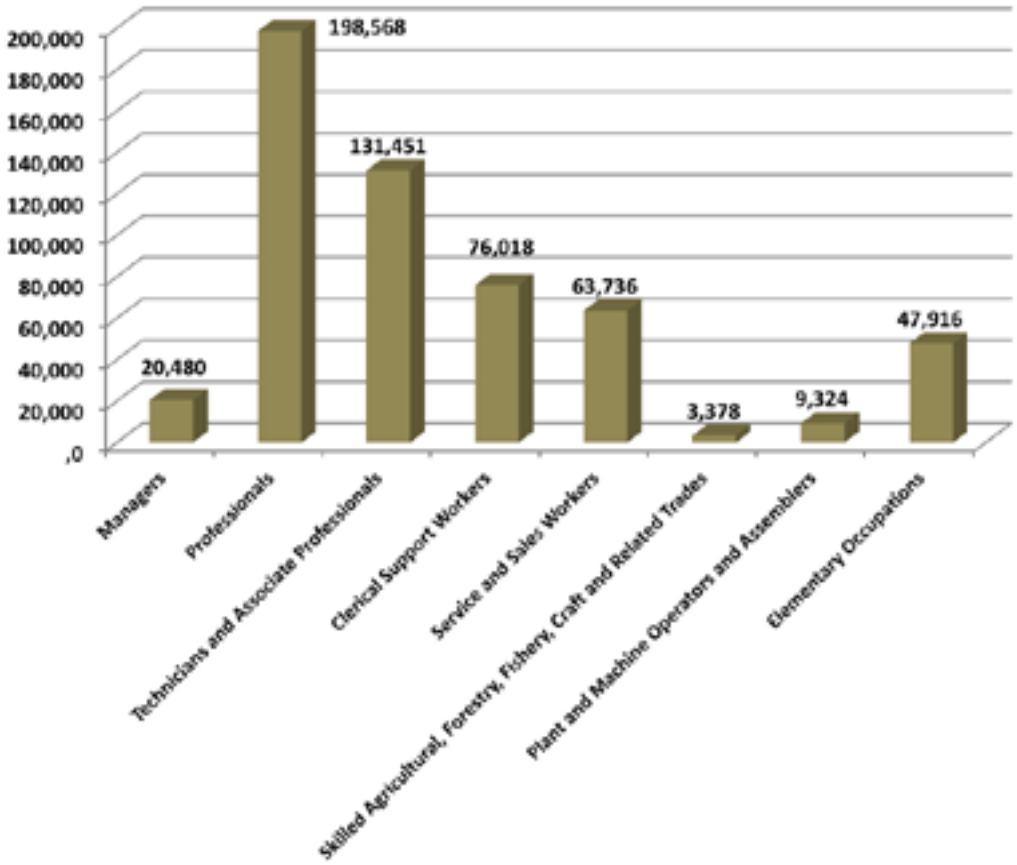


Figure 4-1 Total positions available in the health and social development sector according to occupational group

Sources: Calculated from HWSETA and PSETA WSP applications 2013, MEDpages database, October 2013.

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	8 861	1 283	10 144	11 652	131	11 783	20 513	1 414	21 927
Professionals	132 433	17 611	150 044	101 190	5 289	106 479	233 623	22 900	256 523
Technicians and Associate Professionals	68 674	2 392	71 066	64 515	1 315	65 830	133 189	3 707	136 896
Clerical Support Workers	35 043	389	35 432	41 017	36	41 053	76 060	425	76 485
Service and Sales Workers	37 325	585	37 910	26 914	52	26 966	64 239	637	64 876
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 402	163	1 565	1 975	14	1 989	3 377	177	3 554
Plant and Machine Operators and Assemblers	4 626	17	4 643	4 702	187	4 889	9 328	204	9 532
Elementary Occupations	37 399	536	37 935	10 538	66	10 604	47 937	602	48 539
Total	**325 763**	**22 976**	**348 739**	**262 503**	**7 090**	**269 593**	**588 266**	**30 066**	**618 332**

*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 2013.

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 2013, 60% of the organisations that submitted WSPs to the HWSETA reported certain vacancies, while the national DoH as well as most of the provincial departments of health and social development[462] reported skills shortages. A total of 22 976 people (7% of total employment) is reported as scarce skills shortages in the Public Service. Of the scarce skills vacant positions in the Public Service, 77% are for professionals.

In the private health sector, a total of 7090 people (3% 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).

462 Scarce skills information could not be obtained from the Mpumalanga Department of Social Development and the Northern Cape Department of Health.

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	1 283	14	131	1
Professionals	17 611	13	5 289	5
Technicians and Associate Professionals	2 392	3	1 315	2
Clerical Support Workers	389	1	36	0
Service and Sales Workers	585	2	52	0
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	163	12	14	1
Plant and Machine Operators and Assemblers	17	0	187	4
Elementary Occupations	536	1	66	1
Total	**22 976**	**7**	**7 090**	**3**

Sources: Calculated from HWSETA and PSETA WSP applications, 2013.

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 pharmacists.

Table 4-3 Occupations where more than 100 vacancies were reporte

		Number of vacancies		
OFO Code	OFO description	Public Service	Private sector	Total
263507	Social Worker	6 121	82	6 203
222112	Registered Nurse (Surgical)	3 687	69	3 756
222101	Clinical Nurse Practitioner	980	1 146	2 126
221101	General Medical Practitioner	1 964	32	1 996
222108	Registered Nurse (Medical and Surgical)	847	320	1 167
226201	Hospital Pharmacist	966	178	1 144
322101	Enrolled Nurse	868	124	992
134402	Community Development Manager	812		812
222105	Registered Nurse (Critical Care and Emergency)	58	751	809
222111	Registered Nurse (Preoperative)	41	724	765
222109	Registered Nurse (Medical Practice)	277	302	579
222201	Midwife	132	410	542
222102	Registered Nurse (Aged Care)	422	95	517
311502	Boilers and Pressure Vessels Inspector		500	500
226203	Retail Pharmacist	114	325	439
811202	Healthcare Cleaner	431		431
341201	Community Worker	410	2	412
222104	Registered Nurse (Community Health)	300	77	377
134201	Medical Superintendent	351	2	353
325801	Ambulance Officer	275	31	306
541902	Emergency Service and Rescue Official	280		280
321301	Pharmaceutical Technician	5	249	254
441601	Human Resources Clerk	242		242
341203	Social Auxiliary Worker	210	20	230
222116	Nurse Manager	30	197	227
321101	Medical Diagnostic Radiographer	176	39	215
732101	Delivery Driver	17	185	202
221207	Pathologist	147	35	182
226401	Physiotherapist	158	15	173
325802	Intensive Care Ambulance Paramedic / Ambulance Paramedic	134	30	164
226501	Dietician	156	1	157
226102	Dentist	131	1	132
263508	Child and Youth Care Worker	100	29	129
532902	Hospital Orderly	125		125
642601	Plumber	125		125
221210	Specialist Physician (General Medicine)	115	2	117
226902	Occupational Therapist	96	12	108
812101	Laundry Worker (General)	105	3	108

Sources: Calculated from HWSETA and PSETA WSP applications, 2013.

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 nursing.[463]

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 are not necessarily currently funded. 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).[464]

463 DoH. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*

464 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

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 data.[465]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 280.[466]

Organisations are also required to explain in their WSPs why they found it difficult to fill the positions that they identified as scarce skills. In the Public Service Scarcity were frequently related to geographic location and replacement demand. In the private health sector, skills shortages are the most severe among professionals and 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 2010.[467]These calculations did not take into account any additional staff that would be neededfor the NHI.

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

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

467 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 diseases.[468] If South Africa's situation in the Public Service is compared to this benchmark, we fall short: in 2010 we had only 162 doctors and professional nurses per 100 000 of the population that depends on public services.[469]

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 size, per capita gross domestic product (GDP), Gini co-efficient and GDP growth[470]. 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.

468 World Health Organisation. 2006. The World Health Report 2006 - working together for health. Published at http://www.who.int/whr/2006/06_chap1_en.pdf.(Accessed August 2010).

469 Calculated from Day, C. and Gray, A. 2010."Health and Related Indicators" in *South African Health Review 2010*.

470 Gross domestic product 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 populations 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. It is clear that South Africa has notably fewer doctors, pharmacists and oral health professionals per 10 000 population than its peer countries. 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 much worse than those of peer countries. 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 population.[471]

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 system.[472]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 worker.[473]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. The DSD estimates that another 16 000 social workers were needed in 2012 to implement services under the Children's Act.[474]

By 2010 the country required another 2 931 environmental health practitioners to meetthe WHO international standard and 1 265 to meet the national norm.[475].

4.4 FUTURE DEMAND

4.4.1 Skills development targetsset by the Department of Health

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 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 planning model could be used as a tool to plan staff needs for the NHI.TheDoH projects that it will be possible to close gaps in human resources over a period of 15 to 25 years at a constant annualGDP 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 enhance nurse capacity and provide for a predominantly nurse-based health system; to plan forMLWs; 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 furthermore 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 areas:[476]

a) The target minimum health professionals to population ratio for each critical profession;
b) The required years to achieve the target;
c) The plan to manage exits from the public health sector (due to retirement, death, emigration);
d) The number of additional entrants required in the system over and above the maximum potential output of the educational system in South Africa.

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 recruitment.[477]

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

471 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011.*
472 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
473 South African Institute of Race Relations. 2012. "Social worker shortage undermines effectiveness of social welfare legislation". Press release 14 August 2012.
474 Personal interview, DSD, Directorate Human Capital Management—Sector Education and Training on 1 October 2012.
475 DoH 2011.National Environmental Health Policy.*Government Gazette* No 34499. 3 August 2011.
476 DoH 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.
477 DoH 2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.

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 neurosurgery.[478]

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.

478 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 graduates.[479]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 pharmacist.[480]Several thousand current cadres of pharmacy assistants (basic and post-basic) have to be up-skilled to the new 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 2019.[481]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 technicians.[482]

479 SAPC. 2011. Pharmacy Human Resources in South Africa 2011.
480 SAPC. 2011. Pharmacy Human Resources in South Africa 2011.
481 Interviews DoH in October and November 2012.
482 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 family social workers at professional and auxiliary level to implement socio-economic programmes.[483] The uneven geographical distribution of social workers is also challenging. Past studies have indicated that the more urbanised provinces had higher ratios of social work professionals per 100 000 population than poorer rural provinces.[484] A study conducted in 2008 estimated that the country would need between 13 300 to 19 000 social work professionals by 2015 to meet the norms set by the DSD– i.e. the ratio of social worker per population unit.[485]An exercise to determine the costs and human resources needs to implement the Children's Act, 2005, revealed that at the lowest level of implementation at least 16 504 social workers would be needed by 2011 to deliver services to children alone. At the higher level of implementation, 66 329 social workers would be required

483 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). *Human Resources Development Review 2008: Education, Employment and Skills in South Africa*.
484 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). Human Resources Development Review 2008: Education, Employment and Skills in South Africa.
485 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

in 2011.[486]There is also a critical need for male social professionals to work in traditional communities and to lead male-targeted youth development programmes.[487]

Demand also exists for specific skills sets.Role-players in the sector say that newlytrained social workers are not ready for work and need 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 trust.[488]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); tounderstand the diverse intervention options; to select the appropriate route, and to evaluate its effectiveness.[489]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. Postgraduate training is needed to improve interventions in cases of substance abuse, victim empowerment, child abuse and exploitation, as well as forensic social work (i.e. knowledge of the criminal justice system).Social workers also need generic skills to improve their office-bound duties, e.g. report writing, document management, and recording of work activities in their cases.

Stakeholders are concerned about the poor quality of training for SAWs who lack understanding about their roles. Many have poor communication skills and don't speak English, and so NGOs find it challenging to deploy them. 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.[490]

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 needs.[491]The DSD estimates that 15 000 caregivers "work for" NGOs and while their ranks must expand to reach more persons in need, present cadres need training.[492]

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 learnerships.[493] 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 workers.

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 formation.[494]As part of the process to develop this SSP, the HWSETAengaged with stakeholders and role-players in the health and social development sector to understand their needs for skills development.The majority of 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 SETAto 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 implementsskills development is also important to stakeholders. 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

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. 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

486 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. Published at http://www.ci.org.za/depts/ci/.../gauge...pdf.(Accessed 21 August 2011).
487 Personal interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSA).
488 Personal interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSA).
489 Personal interviews with DSD: Directorate Service Standards, October 2012.
490 Personal interviews held in October 2012 with NGOs and DSD.
491 Personal interviews held in October 2012 with Child Welfare SA and Family Life (division of FAMSA).
492 Personal interview with DSD: Directorate Capacity Building HIV/AIDS, October 2012.
493 Interviews with Family Life (division of FAMSA) and Child Welfare SA in October 2012.
494 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*.

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 staff nurse level and pharmacy assistants to pharmacy technicians. Learnerships aligned to the new mid-level qualifications for emergency medical care 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 FET 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.

4.5.2 Expanded provision for workplace training

Several stakeholders in the social development sector emphasised the need to increase the number of accredited workplace training providers. More providers are also needed to facilitate experiential training in different social services fields. The ranks of moderators and assessors for occupational-specific training also require strengthening. FET 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, while the real skills development needs are in occupational-specific fields. The SETA is requested to grow provider capacity to deliver accredited CPD programmes and to accredit more training providers to deliver the three core skills programmes for community caregivers.

Several respondents called upon the HWSETA to enter into partnerships with NGOs in order 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 practical training at the NGOs.

Stakeholders from the social welfare sector accentuated the acute need for skilled social work professionals to supervise, monitor and guide junior social workers. In particular, there is need 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 supervision. SAWs also require more workplace training and supportive supervision to develop their skills.Several respondents expect the HWSETA to provide funding for experiential learning and to publish the availability of such funding. Specific attention should also be given to customised induction programmes for newly qualified social workers to better orientate them for service.

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, asthese 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 monitortraining providers, training facilities and curricula. There are concerns that delays in evaluating training programmes hamper skills development. It was suggested that the HWSETA ETQA should be more proactive in monitoring social development programmes offered at FET colleges. In particular, there are urgent calls for improved 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 experiential learning to ensure that learners receive the appropriate workplace training.They also highlighted the need to improve the HWSETA's processes and timeframes to verify learnership qualification results and to issue certificates to learners. Several respondents called for more direct HWSETA support to capacitate and support training providers to meet quality standards.

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 learnerships.[495]In interviews conducted for this SSP, role-

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*.

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.

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 and PHC while post-basic nursing skills are also needed in neonatology, operating theatre, critical care, trauma care, psychiatry, paediatrics, orthopaedic, oncology, ophthalmology and nephrology. According to public sector respondents, the SETA should set aside funding for enrolled nurses employed by provinces to complete the bridging course to qualify as registered nurses. There is also a need for more enrolled nurses and enrolled nursing auxiliaries in rural health facilities. SETA funding forCDP for nurses is also required, while many need to be trained in computer skills.

According to the SAPC, the current cadres of pharmacy assistants need further skills to meet the requirements of the new occupations of pharmacy technician and pharmacy technical assistant. HWSETA funding should also be made available to train learners in the new higher education pharmacy qualifications.Provincial health departments agreed with the SAPC and stressed the need to deploy the new pharmacy MLWs so as to meet service demands in clinics and at district level.

Private and public sector respondents identified the need for more MLWs and the development of more qualifications for MLWs. Respondents also asked the HWSETA to facilitate engagement between various professional bodies to address problems relating to the roles, scopes of practice, and supervision of MLWs. Clinical associates are needed in district hospitals and the HWSETA is specifically requested to make available bursaries for this purpose. Officers responsible for human resources planning in the public sector indicated the need for MLWs in the categories of clinical associate, 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.

Several of the provinces asked for the development of appropriate learnerships for CHWs and care workers to enable them to provide a complete range of PHC services. The HWSETA was requested to provide funding for this purpose, even before a learnership was in place.

As discussed in paragraph3.14 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 HWSETAprovide 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.Respondents also asked the HWSETA to enable more providers to gain accreditation. The need to develop more health educators and preceptors, especially in the nursing field is particularly acute. Funding is also required for assessor courses for nurse educators in both the public and private sectors. In future, nurses involved in the clinical accompaniment of learners will require an educational qualification in addition to their clinical qualifications.

Respondents also identified the need for more allied health professionals (such as occupational therapists, physiotherapists, nutritionists, speech therapists,orthotists/prosthetists, phlebotomists, perfusionists, radiographers, medical coders and neurophysiologists). According to the HPCSA, there will is a significant 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 injuredby 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 support officers (formerly known as morticians).

The need for bursary funding for especially rural students to qualify as medical doctors, clinical associates, pharmacy technicians and comprehensively trained nurses was also identified. Funding conditions should be set to re-connect the students back to rural communities once they complete their studies. The need for bursaries for health science training was emphasised, even if the funding is only made available from the second year of study.

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 equipment such as life support machines (ventilators, incubators, anaesthetic-, dialysis-, and heart-lung machines); diagnostic equipment (imaging and ultrasound machines); and medical monitors, sterilising- and laboratory equipment.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. More social workers require occupation-specific training to supervise and guide lesser experienced colleagues and social auxiliary workers. Another priority is improving the skills base of SAWs and for the HWSETA to strengthen quality assurance processes to ensure that SAWs are competent.Training is needed to improve the collaborative skillsof social workers and SAWs in order to jointly achieve the aims of social work. Social workers need training in delegation, task-sharing and supervision oftheir assistant workers. SAWs 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 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. New social workers require structured induction programmes to prepare them for work while many need to improve their occupation-specific technical skills in the areas of assessment, intervention options and evaluation. Several stakeholders identified the need for work readiness training.

A need also exists to train social workers at postgraduate level to develop specialistskills in areas of forensic social work, probation services, adoption, occupational social work, mental health, victim empowerment, rehabilitation, childcare and youth care, substance abuse interventions, and trauma counselling.It was suggested that the HWSETA should provide bursary funding for this purpose. According to the DSD, funding is needed for community-based caregivers to be trained on the three registered skills programmes in psychosocial support, child protection and supportive supervision.

Respondents requested the HWSETA to support training for community development practitioners and community development workers once the new qualifications are registered and HEIs have developed accredited learning programmes for these emerging occupations. Social workers and CDPs also need skills to analyse social data to perform community- and family profiling in order to determine real needs and facilitate appropriate development interventions.

More funding should be provided towards organisational development of NGOs to strengthen their skills in governance, financial management, project management, and monitoring and evaluation.

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. HWSETA funding is needed to expand the ranks of animal health technicians and 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 supervised training. Veterinary support staff in private practices also need 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.

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:

a) The impact of skills programmes and learnerships on learners and communities served by those trained;
b) The role of MLWs, and to understand areas where they may be deployed as well as practices concerning MLWs in other countries;
c) The need for new qualifications and learnerships for the sector;
d) Assessing how the HWSETA could contribute to building a rural clinical platform for training of health professionals;
e) Assessing how the HWETA can contribute to skills development as part of larger initiatives driven by provincial health departments or the DoH;
f) 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;
g) Developing norms and standards of practice for community development practitioners and community development workers.

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:

4.6.8 HIV/AIDS treatment policies

Expanding the access to ART will impact largely 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. Since there are not enough doctors to do so, the bulk of the work is expected to shift to nurses – a professional group already in short supply and under pressure in the public sector.[496] This may necessitate the fast-tracking of changes to the legal and regulatory frameworks governing the nursing profession, as nurses may be required to prescribe ART. Because the delivery of ART is regarded as a complex health intervention, nurses will require additional training in this area. Additional higher-level skills such as those of doctors and experienced PHC-trained nurses will also be needed to support the front-line nurses and to accept referral of more complex cases.[497] As more medication will be dispensed to patients requiring daily life-long care, pharmacists may be under pressure and their ranks (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 hospitals.[498]Plans to improve the nutritional status of HIV- and TB-infected persons by providing access to nutritional services at PHC facilities will drive the demand for dieticians and nutritionists.[499]

4.6.9 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

496 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. 100 (4).
497 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. 100 (4).
498 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. 99 (8).
499 DoH 2012.Annual Performance Plan 2012/13 – 2014/15.

stage.[500] By implication, more appropriately trained and skilled professional nurses and doctors are required at district level to ensure that more patients are screened sooner.

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 disease.[501] To combat the risk of infection the DoH has identified the need to train 3 500 health professionals per year in TB management control.[502] In addition, more lower-level health workers such as nursing auxiliaries and CHWs are needed to support and monitor patient adherence to treatment regimes, and to increase treatment completion rates. Mid-level environmental health practitioners such as infection control officers are needed to prevent the risks of infectious outbreaks in hospitals and clinics. Another concern is that training in infection prevention and control does not form part of the undergraduate training programme of nurses and other health workers. There is an urgent need for such training to broaden the skills base in infection prevention and control so that it may be practised all the time.[503]In South Africa, policy currently focuses on children from pre-school age, and a shift in focus to earlier developmental stages would be in line with the United Nations Millenium Development goal of improve,ent in maternal and infant health. The above mentioned information warrants for more research support around this topic.

4.6.10 Maternal, child and women's health programmes

The provision of universal access to reproductive health services is a key national target.[504]The programme to improve the health of mothers, children and women (which is linked to South Africa's commitment to achieve its MDGs) aims to avert maternal deaths and stillbirths and improve infant mortality rates. This programme involves improvements to the coverage and quality of care of mothers, babies and children in the antenatal-, post-natal- and ECD stages. Special focus on infant mental health is needed even though it is still a failey new and groeing area in South Afria. Research findings from western countries indicates a need to focus more on mental health policy and on developmentally crucial period of 0-3 years. Research is showin that 90% of brain development occurs in the first three years of life, and the the quality of parent-child relationship during these years determines future relational capacity (i.e. empathy for others) and future potential for learning.[505]The above-mentioned information warrants for research support in this area of infant mental health.

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 emergencies.[506]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.[507]

The aim to test 100% of pregnant women for HIV at hospitals, community clinics and PHC facilities[508] will drive the demand for nurses and CHWs with counselling skills. Efforts to prevent and to improve the diagnosis, monitoring and management of birth defects require the skills of nurses and medical practitioners trained in human genetics care. More nursing skills are required at PHC level where immunisation and vaccination coverage of babies, infants and young children will be increased. Many PHC facilities will require healthcare providers trained in the integrated management of childhood illnesses.[509] At the tertiary level of care, the demand for nursing skills in neonatal care and intensive care is high. A 2008 study conducted by the Critical Care Society of South Africa found that only 3.8% of nurses had neo-natal intensive care training.[510]

Healthcare professionals may be needed to support the statutory therapeutic programmes required in terms of the Children's Act, 2005. It is mandatory for child and youth centres to provide interventions for children with behavioural, psychological or emotional problems.

500 Harrison, D. 2009. An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Published at www.doh.gov.za.(Accessed February 2010).

501 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" in South African Health Review 2012/13. Published athttp://www.hst.org.za/..(Accessed 13 July 2013);Jordan, B. 2010. "Health workers besieged with drug-resistant TB". Sunday Times, 12 September 2010.

502 Department of Health.2010. *National Department of Health Strategic Plan 2010/11-2012/13*.

503 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" South African Health Review 2010. Published at http://www.hst.org.za/publications/south-african-health-review-2010.(Accessed 19 August 2011).

504 Department of Health 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).

505 Notes from Dr Katherine Bain, Clinical Psychologist/Senior Lecturer, University of Witwatersrand.

506 Department of Health 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/...Africa.pdf.(Accessed 11 July 2013).

507 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.

508 Department of Health.2010. *National Department of Health Strategic Plan 2010/11-2012/13*.

509 Department of Health.2010. *National Department of Health Strategic Plan 2010/11-2012/13*.

510 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". South African Medical Journal. August 2009. 99 (8).Published at http://www.scielo.org.za/pdf/samj/V99n8. (Accessed August 2009).

4.6.11 Skills requirements for the NHI and new health service policies

It is recognised that 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 needed.[511]

a) Re-engineering of primary healthcare

Primary healthcare will be delivered through family health teams consisting of nurses, doctors and CHWs, similar to the approach in Brazil.[512] In the Brazilian model multi-professional teams consisting of a doctor, dentist, nurse, assistant nurses and six CHWs serve between 1 000 to 2 000 families (or 4 000 to 10 000 people) in PHC clinics or in communities. Nurse supervisors support and guide the approximately 250 000 CHWs employed in the Brazilian health system. The success of PHC in that country depends on large investments in training and capacity development.[513]

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 technician.[514] More professional nurses are needed while specialist nurses, in school health, PHC and advanced midwifery are in demand.[515]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 are needed to manage medicines in the PHC system for home-based care, clinics and other health centres. Additional pharmacy assistants will be needed for the new PHC specialist teams while the current pharmacy assistants require training to assume an expanded scope of work in a semi-professional role.[516] 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). A new category of health professional, the authorised pharmacist prescriber, 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 par. 3.15.

The expansion of PHC services over the next few years will aim to eliminate the transmission of malaria by 2018 and to manage non-communicable diseases through a chronic care model in 20% of health districts by 2015. Cataract surgery rates will also be increased almost threefold in the period 2012 to 2015. The DoH also intends to increase the number of ward-based PHC outreach teams from 54 in 2012 to 2 000 teams by 2015.[517] These interventions will require the skills of trained CHWs, nurses and specialist nurses, environmental health practitioners, nutritionists, ophthalmologists and PHC supervisors.

Health prevention services and policies to address the social and environmental determinants of health drive the need for environmental health officers.[518] Supervision of PHC services must also be strengthened to improve health outcomes.[519]

b) Ancillary healthcare workers and community health workers

In view of the shortage of nursing staff, ancillary healthcare workers and caregivers are often required to perform tasks that fall within the scope of practice of a qualified nurse. Some stakeholders attributed this to financial considerations in the private sector, where caregivers are employed at lower salaries than enrolled nursing auxiliaries and enrolled nurses to provide basic patient care. A clear need was expressed for the regulation of the caregivers, ancillary health workers and CHWs, to define their roles and set scopes of practice that are linked to standards and accredited qualifications.

Community health workers are needed to promote health and prevent illness (e.g. by aiding referrals of pregnant women to antenatal care, and babies for immunisation and minor conditions to clinics). Currently the majority of the estimated 65 000 CHWs do not work for the state

511 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.* Published at http://www.hst.org.za/...(Accessed 11 July 2013); Lloyd, B., Sanders, D. and Lehmann, U. 2010."Human resource requirements for National Health Insurance" in *South African Health Review 2010*).

512 National Treasury."Social Security and Healthcare Financing".*2011 Budget Review*.

513 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010.Published at http://www.hst.org.za/.../...health-review-2010.(Accessed 19 August 2011).

514 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010.Published at http://www.hst.org.za/publications/...review-2010.(Accessed 19 August 2011).

515 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.

516 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; Interview with SAPC in October 2012.

517 Department of Health 2012.Annual Performance Plan 2012/13 – 2014/15.

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

519 Naledi, T., Barron, P. and Schneider, H. 2011."Primary Health Care in SA since 1994 and implications of the new vision for PHC re-engineering".*South African Health Review 2011*; Stakeholder interviews in October and November 2012.

and perform only limited services with mixed levels of training.[520] According to stakeholders in the sector, there is general confusion between CHWs, ancillary healthcare workers and home-based carers.[521] The fact that HWSETA learnerships are also offered at different levels adds to the confusion.[522] There is a need to gain clarity on the roles and responsibilities of CHWs in relation to other health and social development professionals and to train CHWs to deliver a range of PHC services.[523]

c) A tiered hospital system

District hospitals will need medical specialists and nurses in general surgery, obstetrics and gynaecology, paediatrics and family medicine, primary healthcare 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 in district hospitals. The DoH estimates that 1 350 clinical associates are needed in the public sector (at least five per district hospital).[524]

Skills needed at regional hospitals span the aforementioned categories, as well as specialist medical skills in orthopaedics, psychiatry, radiology and anaesthetics.[525] The DoH aims to deploy district specialist teams in 20 out of a possible 52 districts by 2013/14.[526] 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 acute.[527]

d) Changes to the utilisation of healthcare services

The introduction of an NHI benefits package with no co-payments to the whole population will impact on the demand for healthcare services and personnel. Demand for services will be driven by an increased rate of utilisation of healthcare (as there will be no co-payments) and greater demand for higher levels of care. A 2010 study by Econex shows that, based on the assumptions used in the study, a larger proportion of the population will use higher levels of medical care offered by general practitioners and medical specialists, and steer away from nurse-led PHC. Therefore, more GPs and medical specialists will be required to meet the increased demand for service. It is projected that South Africa will require between 5 800 to 10 000 more GPs and another 7 000 to 17 000 medical specialists to serve healthcare demand under the NHI. On the other hand, the demand for nurses is expected to drop, as the public will move away from public clinics and choose a higher level of care.[528] However, another study projected that the private sector would require 3 700 nurses to maintain 2009 nursing ratios if 2 million more patients are treated in the private sector under the NHI scheme.[529] The Econex study concluded that rationing of healthcare services under the NHI would be required in view of the scarcity of resources.

e) 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 efficiency.[530] Skills will be needed in clinical supervision and support and in procurement, resource management and governance.[531]

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 and supply chain.[532] Problem-solving skills at all levels are severely under-developed.[533] 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

520 Lloyd, B., Sanders, D. and Lehmann, U. 2010. "Human resource requirements for National Health Insurance" in South African Health Review 2010.Published at http://www.hst.org.za/.../south....-2010.(Accessed 19 August 2011).

521 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: Three case study reports.

522 Ancillary healthcare is registered at NQF level 1 and Community Health Worker is pitched at NQF level 3.

523 Interview with Directorate: Workforce Planning of national Department of Health in October 2012.

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

525 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months" in South African Health Review 2012/13. Published at http://www.hst.org.za/.../.(Accessed 11 July 2013); Department of Health. 2011. National Health Insurance in South Africa: Policy Paper. Published at http://images.businessday.co.za/NHI.pdf.(Accessed 12 August 2011).

526 Department of Health 2012.Annual Performance Plan 2012/13 – 2014/15.

527 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in *South African Health Review 2010*.

528 Van der Berg, S., Burger, R..et al. 2010. *Financial Implications of a National Health Insurance Plan for South Africa.*

529 Ramjee, S. and McLeod, H. 2010."Private sector perspectives on National Health Insurance" in South African Health Review 2010. Published at http://www.hst.org.za/publications/south-....health-review-2010.(Accessed 19 August 2011).

530 Crisp, N. 2011. "Some management challenges in the health sector". ERSA Symposium on health reform, Stellenbosch. Published at http://econrsa.org/home/.... (Accessed 20 August 2011); 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.

531 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. Published athttp://www.hst.org.za/....(Accessed 27 August 2012).

532 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in South African Health Review 2010. Published at http://www.hst.org.za/publications/south-african-health-review-2010.(Accessed 19 August 2011).

533 Interviews with stakeholders in October 2012.

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 management.[534] A need exists to improve the stewardship, governance and monitoring capacity in national and provincial departments of health to leverage improved performance at hospital level.[535] Soft skills development is needed to improve the attitudes of health staff and to nurture an appropriate, and genuine, caring attitude.[536]

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 programmes.[537]

f) 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 to prescribed standards.[538]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.

g) 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. It is therefore not yet possible to project with certainty the numbers of professionals that will be needed to implement NHI. The Green Paper proposals have also been subjected to further examination, and the final policy document may adopt a different approach. In addition, much work must still be done by the various professional councils to review the scope of work for professional categories while curricula will also have to 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.

According to the DoH[539] 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 teams;[540]

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;
   - 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 a new 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;

534 Harrison, D. 2009. An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Published at www.doh.gov.za.(Accessed February 2010); Chopra, M., Lawn, J.E., Sanders, D. et al. 2009."Achieving the health Millennium Development Goals for South Africa: challenges and priorities".Lancet. September 2009.

535 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in South African Health Review 2010. Published at http://www.hst.org.za/publications/south-african-health-review-2010.(Accessed 19 August 2011).

536 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in South African Health Review 2010. Published at http://www.hst.org.za/publications/south-african-health-review-2010.(Accessed 19 August 2011).

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

538 Ramjee, S. and McLeod, H. 2010."Private sector perspectives on National Health Insurance" South African Health Review 2010. Published at http://www.hst.org.za/publications/south-...-health-review-2010.(Accessed 19 August 2011).

539 DoH. 2011. National Health Insurance in South Africa: Policy Paper; DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

540 DoH. 2012. Annual Performance Plan 2012/13 – 2014/15.

- 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; and
- 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) Academic clinicians are required in all disciplines to ensure a platform for health professional development, as well as nurse educators.

A need also exists to train non-clinical professionals for the health sector such as health economists, health actuaries, healthcare managers, clinical engineers, data capturers, data analysts, biostatisticians, epidemiologists, information technology professionals, medical physicists, and medical scientists.[541]

4.6.12 The nursing population

Nurses are viewed as the backbone of health service delivery. South Africa's nursing population is aging fast, as more than 40% of nurses are older than 50 and approaching retirement, and only 3% are younger than 30 years. Current demand for nursing skills remains high in order to provide for the replacement of retiring nurses and population growth. Expansion of PHC services to clinics in communities is also driving demand. Some rural provinces face such acute shortages of nurses that new PHC clinics remain closed. Most nursing training is still hospital-based and not delivered in a PHC setting and one province is "re-training" nurses to skill them for PHC services.

Health sector stakeholders confirmed that there is a need for more enrolled nurses, especially for the public sector. This is driven by the shortage of registered nurses and because enrolled nurses are the skills pipeline for registered nurses (i.e. via a two-year learnership (bridging programme)). Specialist nurses are also trained from the ranks of the registered nurses.

4.6.13 Expansion of the public health infrastructure

Health workers and facility managers need to track services and the quality of care, and monitor procurement. 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 performance.[542]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 such as doctors and nurses, and MLWs, as well as support staff.

4.6.14 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 facilities.[543] New 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, psychologists, and psychiatrists.[544] 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 functioning.[545]

541 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" in South African Health Review 2012/13. Published at http://www.hst.org.za/publications/south-african-health-review-2012/2013. (Accessed 11 July 2013).

542 National Treasury. 2009. "Health". In *Provincial Budgets and Expenditure Review* 2005/06 – 2011/12.

543 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" in *South African Child Gauge 2007/08*.

544 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. Published at http://www.ci.org.za/... (Accessed 21 August 2011).

545 Section 9 of the Older Persons Act, 13 of 2006.

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. Although social work has been declared a critical skill, the shortage of social workers remains acute.Occupational skillsand 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 cope.[546]

South Africa's social development system is based on a statutory model of protecting and promoting human rights. The model requires social workers to make micro-interventions at individual and family level and this is demanding in terms of human resources, skills and budgets. [547]Measures to improve access to social welfare services for communities utilising such services are also driving the demand for skills. 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 with specialist qualifications such as probation officers are needed for anti-substance abuse programmes, one of the major focal areas of the DSD until 2016.

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 several new social services. Human resources capacity must increase to deliver these services. Specific objectives of the DSD are to:

a) Expand services to 1.3 million orphans and vulnerable children who will be given direct supervision at home and psychosocial support[548] and for this purpose 10 000 CYCWs will require training between 2012 and 2015;[549]

b) Increase the availability of foster care and the number of children who access child and youth care centres;

Many of the challenges in implementing these deliverables 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 them.[550] 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.[551]

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 are such services labour intensive, but effective delivery will depend on the availability of skilled practitioners in various disciplines, such as social workers, SAWs, probation officers, assistant probation officers, CYCWs, auxiliary child and youth care workers, and ECD practitioners. As this diversified workforce develops further, many of the categories require social workers as supervisors.[552]

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, designated social workers need to manage cases brought before the Children's Court and a court may refer a child to a designated social worker to determine whether there is a need of care and protection. 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 to deliver such services.

According to the DSD, 16 504 social workers are required just to deliver the statutory services to children in terms of the Children's Act, 2005. That figure represents 99% of all social workers, leaving just 1% to services related to substance abuse, older people, community development, and people with disabilities, crime prevention and support, and HIV/AIDS, among many other demands

546 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). Human Resources Development Review 2008: Education, Employment and Skills in South Africa.

547 Patel, L., Hochfeld, T. Graham, L. and Selipsky, L. 2008. The implementation of the White Paper for Social Welfare in the NGO sector.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).

548 DSD. 2012. Strategic Plan 2012-2015. Published at http://www.dsd.gov.za.(Accessed 10 August 2012).

549 DSD: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.

550 DSD: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.

551 Interviews with DSD, October 2012.

552 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

highlighted in Chapter 3. Considering that only 55% of social workers are employed by Government or the NPO sector, the demand for social service professionals is acute.[553] Higher-level skills (i.e. at postgraduate level) are needed in forensic social work, a field that combines social work and legal knowledge required to draft expert socio-legal reports, interface with the judicial system, and give evidence in court.[554]

b) New roles for occupations

The child welfare workforce is expanding beyond the social work profession. Demand exists for CYCWs, ECD practitioners, SAWs, community developers and generic community facilitators.[555]Several HWSETA stakeholders identified the need to up-skill SAWs to assist and support social work professionals. One respondent remarked that many SAWs "perform the work of security guards by directing traffic" (i.e. referring queries to specific desks) while they should be able to provide administrative supportto alleviate the social worker's burden.

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 model, 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. Currently CYCWs are social workers and undergo four years of training at an HEI.

Demand exists for probation officers to provide intervention services to children who are in conflict with the law by assessing their circumstances, determining their need for care and protection, and acting in their best interests. It may need to address problems underlying children's criminal behaviour and work with children to reintegrate them into families and society. Probation officers are social work professionals with a specialisation in a particular field of social work.

c) Early childhood development

Expanding access to ECD and partial care services will require more skilled persons to promote the holistic development of young children. 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.Government views ECD programmes as of strategic importance, including within the EPWP. A national survey carried out in 2000 by the Department of Education identified 54 503 ECD workers from a range of backgrounds. The survey found that 88% of ECD workers had no training, inadequate training, or unrecognised training. The National Development Plan aims to grant young children universal access to ECD for two years by 2030[556] and Government has set targets to provide ECD programmes to almost 790 000 children by 2015.[557]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 the NPO sector has provided training, but 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 conduct.[558]

4.7.3 Youth development

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 in their communities.The proportion of youths (aged 14 to 35) in South Africa is expected to increase to 41.5% by 2014. Given this and the challenges of youth unemployment, the DSD will facilitate skills development among the youth and the creation of work opportunities. Community development practitioners, youth workers and CYCWs require appropriate training for youth development work.[559]

4.7.4 Community development

Government policies to build sustainable livelihoods in poor communities are driving the need for professional community development practitioners (CDPs) and community development workers (CDWs). Social workers and community development workers require skills to move households and communities from a "state of dependence to a state of independence".[560] Thus practitioners and workersneed the knowledge, skills and capabilities to seek cooperation and foster partnerships to enable marginalised communities to become more self-reliant, access external resources and maintain sustainable livelihoods. CDPs require professional skills to identify, initiate, facilitate

553 South African Institute of Race Relations. 2012. "Social worker shortage undermines effectiveness of social welfare legislation". Press release dated 14 August 2012.
554 Interviews with the DSD, SACSSP and academics in the fielf of social work during October 2012.
555 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).
556 National Planning Commission. 2012. Summary and key issues of the National Development Plan 2030. Published at http://www.info.gov.za/issues/national-development-plan/index.html. (Accessed 19 September 2012).
557 Department of Social Development 2012. Strategic Plan 2012-2015. National Treasury.*2012 Budget Review.*
558 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
559 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
560 Interview with Prof Antoinette Lombard, Head of Department of Social Work, University of Pretoria.

and implement integrated development projects by involving diverse communities and multiple resources and stakeholders. CDWs are needed to work in a supportive role as change agents to assist communities to develop plans, to provide information to communities, and maintain the cooperation of all parties involved in projects.[561]

Over the period 2013 to 2016 the DSD will support the implementation of community development programmes aimed to improve access to diverse and affordable food. The Food for All programme aims to provide food security for 900 000 households by 2014/2015.Another aspect of community development involves the strengthening of the capacity of CSOsto implement community development programmes.In total 1 500 organisations will be supported to strengthen governance and 234 will be trained in community development practices.[562]These interventions will require skilled trainers, managers and mentors.

According to the DSD, there is a pressing need to train CPDs and CDWs in formal programmes. University courses aligned to the new professional degree for CDPs should commence in 2014, or soon thereafter, while training programmes for the community development worker should also be on offer at FET colleges and universities of technology in the next few years.[563]

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 persons.[564] 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. Statutory provisions require that such caregivers undergo prescribed training[565], register with the DSD, and be regulated in terms of a code of conduct.[566]

Improved protection and quality of life for older persons is a specific strategic objective of the DSD during the planning period 2012-2015. 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 needed.[567]

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 governance.[568] 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.

A need also exists to improve the professional conduct of social workers and to equip them with the right skills mix to provide appropriate social welfare services in different situations. Well-rounded social work professionals are needed, with networking- and problem-solving skills,the ability to manage complex cases, and the capacity for delivering suitable interventions for vulnerable persons and their families.[569]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 practitioners.[570]

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 of social development plans and welfare programmes 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 because project proposals lacked adequate assurances and risk-control measures.[571]As service providers NPOs will be obliged to improve business planning, financial management, internal controls, and accounting practices. Should funding be made available to NGOs, it will still be necessary to have on-going monitoring and evaluation of business plans and organisational performance.[572]NPOs will require the capacity to comply with norms and standards for programme development to ensure alignment with policies, strategic priorities and funding.

561 SAQA Registered Qualification: Bachelor in Community Development and National Certificate: Community Development.
562 National Treasury.*2012 Estimates of National Expenditure*; DSD. 2012. *Strategic Plan 2012-2015*.
563 Interview with DSD, October 2012.
564 Department of Social Development 2012.*Draft policy for social service practitioners.* (working document).
565 Section 14 of the Older Persons Act, 13 of 2006.
566 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
567 DSD. 2012. Strategic Plan 2012-2015. Published at http://www.dsd.gov.za.(Accessed 10 August 2012.
568 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).
569 DSD: Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.
570 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
571 DSD. Personal interview: Directorate Human Capital Management – Sector Education and Training on 1 October 2012.
572 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

In view of these and other challenges CSOs face (as discussed in paragraph 3.9.2), skills development needs exist in the following areas: 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

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. 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 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 staff nurses) and to low-level skills (community care caregivers, and CHWs).

In 2012 there were approximately 332 400 filled positions in the Public Service Health and Social Development Departments and more than 21 500 vacancies for scarce skills, bringing the total number of positions in the public health and social development sector to approximately 354 000.The total number of positions in the private sector was an estimated 218 350 and the total number of positions in the sector as a whole 577 224. The sector uses mainly the services of professionals, who fill 36% of the positions in the sector. This is followed by positions for technicians and associate professionals, which constitute 24% of all positions in the sector.

This sector is affected by skills shortages which in 2012 resulted in 26 439unfilled positions. The situation is much worse in the Public Service than in the private sector. Public Service vacancies constitute 6% of total employment. In the professionals category the vacancies constitute 13% of total employment. Of the vacant positions in the sector, 85% 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”, 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. 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. More lower-level workers and community health workers are needed to provide a complete range of PHC services and home-based care, and 45 000 CHWs will need training between 2012 and 2019. 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 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, 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 professionallytrained 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, CCWs, and ECD practitioners. Processes are underway to define and possibly regulate these occupational groups. Supply-side constraints are considered in next chapter

Stakeholders in the health and social development sector expect 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.

The most pertinent skills development needs of key occupational groups as they emerged from the preceding analyses are summarised below.

Skills development needs of specific occupations in the sector

Target groups and occupational categories	Skills development needs
Social workers	Social development, including social services and support to communities, children, families, child-headed households, persons affected by social crime
	Probation work and child and youth care work
	Social services to rehabilitate and develop skills of persons who abuse substances and provide support to their families
	Supervision of social workers and social auxiliary workers
Social auxiliary workers	Early childhood development
	Child and youth care work, assistant probation work
	Community development and HIV/AIDS support
	Basic counselling
	Social and support services to persons abusing substances and their families
Community development practitioners	Comprehensive community development approaches and enterprises to fight poverty and establish sustainable livelihoods in vulnerable communities
Community development workers	Mid-level skills to support practitioners, inform and mobilise communities to generate their own income
Doctors	General practitioners and GPs trained to supervise PHC teams and community health services
Medical specialists in selected areas	Anaesthesiology, critical care, community health, dermatology, diagnostic radiology, emergency medicine, medicine, geriatric medicine, family medicine, neurosurgery, obstetrics and gynaecology, occupational health, oncology, orthopaedics, oto-rhinolaryngology, paediatrics, pathology (in all areas of specialisation), psychiatry, surgery and urology
Nurses	Comprehensively trained professional nurses
	Specialist fields: PHC, infection control, neo-natal care, critical care, trauma care, operating theatre, midwifery, advanced midwifery, obstetric care, paediatric care, orthopaedic care, psychiatry
	Home-community-based care for the sick, disabled and elderly, and school outreach
Occupational therapist and physiotherapy assistants	Rehabilitation and promoting independent living of disabled persons and the elderly

Target groups and occupational categories	Skills development needs
Early childhood development practitioners	Early childhood development for children aged 0 to 5 years
Youth development practitioners	Youth development, project management, supervision of community workers
Community health workers and community care workers	Promotive and preventive care in community settings Home-community-based care for the sick, disabled and elderly and psycho-social support to families HIV/AIDS awareness and basic counselling PHC services in basic health promotion and prevention, nutrition and substance abuse Monitoring of STIs, TB, other diseases and directly observed treatment of TB and HIV patients; monitoring of immunisation Occupational hygiene and safety
Emergency medical services practitioners	Dealing with emergencies at home and in communities and assisting with transfer of patients to clinical care environment
Environmental practitioners	Part of new PHC teams to address social and environmental health risks associated with sewerage, refuse, vermin, food handling, waste management to prevent diseases such as pneumonia, diarrhoea and malaria
Clinical associates	Required at district level to share tasks with/take over tasks from doctors in different units – emergency, outpatient, medical and surgical and maternity, and work as assistants to surgeons in operating theatres
Advanced pharmacy assistants or pharmacy technicians	Managing supply chain of medicines to PHC level (clinics, health centres and chronic medicines used at home) and working in PHC specialist teams
Public health professionals and public health specialists	Public health leadership, strategy and planning, epidemiology and statistical analysis, disease control, monitoring and evaluation of health programmes and health services
Managers of health hospitals and health facilities	Finance, health services and operations, human resources, information technology, procurement and contract management, quality and performance management, facility and clinical management against mandatory standards, soft leadership skills, succession planning
Information technology professionals	Information technology, systems engineering, systems integration; data warehousing, data analysis
Engineers & technicians	Clinical engineers, hospital engineers, biomedical equipment technicians to maintain and repair medical and diagnostic equipment
Artisans	Electricians, plumbers, welders to service hospital infrastructure
Managers and supervisors of NPOs and NGOs	Leadership and general management, financial management, human resources management, internal administration, operations and service delivery, management of external environment
Veterinarians	Comprehensive training with “day one skills” for practice
Veterinary para-professionals and workers	Training of animal health technicians in primary animal healthcare Animal welfare assistants

5

The Supply of Skills

5.1 INTRODUCTION

The previous chapters have clearly indicated that the health and social development sector (and specifically the public sector) is in crisis as a result of skills shortages. Demand for skills by far exceeds their supply. In this chapter the supplyside of the labour market is considered. The different elements of supply are described, supply figures are presented (in as far as they are available), and supply-side constraints that contribute to the current shortages are highlighted.

The chapter starts with a discussion of the output from the secondary school system, which underlies the supply of skills to the sector. This is followed by a discussion of the institutional arrangements and capacity for skills development. The output from the higher education system comes next, followed by a short description of the output from nursing colleges and the role of the HWSETA in skills development in the sector. As the majority of employees in this sector are only allowed to practise if registered with relevant professional councils, these registration figures are presented in this chapter. The chapter concludes with a discussion of some of the most important factors that impact on the supply of skills – both positively and negatively.

5.2 THE SOUTH AFRICAN SECONDARY SCHOOL SYSTEM

5.2.1 Entry from secondary school into the health sector

The results of the Senior Certificate examination are key factors in determining the supply of skills to the health sector. Grade 12 mathematics is an entry requirement for most of the tertiary-level study programmes providing access to the sector. In addition, most of the tertiary institutions require prospective health sciences students to have studied either Grade 12 physical sciences or Grade 12 life sciences (previously referred to as “biology”).The subject life sciences (biology) isnot necessarily a prerequisite. However, life sciences at school level could spark learners’ interest in study fields relating to health, while health support workers will most probably be sourced from candidates with at least Grade 12 in life sciences.

In 2011, a total of 496 090 learners sat the NSC examination. Of these, 348 117 (70.2%) passed the examination, while 141 584 learners fulfilled the requirements for admission into diploma courses and 120 767 (24.3% of those who wrote the examination) for admission into a bachelor’s degree. The Western Cape had the highest pass rate in the country of 82.9% (N=33 110), while Gauteng and North West provinces were second and third with pass rates of 81.1% and 77.8% respectively.

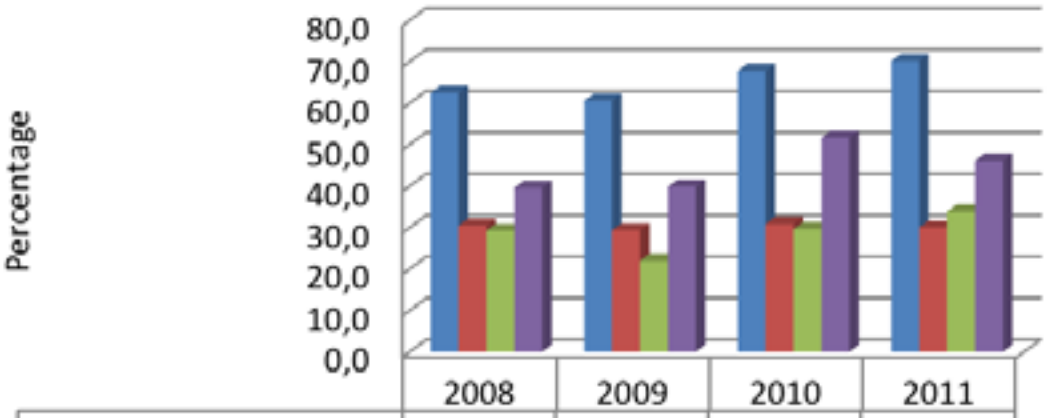
The number of Grade 12 learners who sat for examinations decreased from 533 561 in 2008 to 496 090 in 2011 and the number of learners who wrote mathematics decreased annually over the same period by 9.3% (Table 5-1). Fewer candidates in 2011 (n=67 541) achieved 40% or more for mathematics than in 2008 (n=91 796). The number of learners who achieved 40% or more in physical sciences also decreased annually by 1.8% from 64 538 in 2008 to 61 109 in 2011.

Table 5-1 Grade 12 Statistics: 2008-2011

Number of matriculants who -	2008 N	2008 % of total who wrote Grade 12	2009 N	2009 % of total who wrote Grade 12	2010 N	2010 % of total who wrote Grade 12	2011 N	2011 % of total who wrote Grade 12	AG p/a %
Wrote Grade 12	533 561	100.0	552 073	100.0	537 543	100.0	496 090	100.0	-2.4
Achieved Grade 12	333 604	62.5	334 718	60.6	364 513	67.8	348 117	70.2	1.4
Wrote Mathematics	300 829	56.4	301 654	54.6	263 034	48.9	224 635	45.3	-9.3
Achieved Mathematics (40% and higher)	91 796	17.2	90 699	16.4	81 374	15.1	67 541	13.6	-9.7
Wrote Physical Sciences	220 164	41.3	225 102	40.8	205 364	38.2	180 585	36.4	-6.4
Achieved Physical Sciences (40% and higher)	64 538	12.1	49 524	9.0	60 917	11.3	61 109	12.3	-1.8
Wrote Life Sciences	297 417	55.7	298 683	54.1	285 496	53.1	264 819	53.4	-3.8
Achieved Life Sciences (40% and higher)	117 787	22.1	119 069	21.6	147 601	27.5	122 302	24.7	1.3

Source: Department of Basic Education.

From 2008 to 2011 the achievement rates in the Grade 12 examination, in physical sciences and life sciences increased but the rate of achievement in mathematics remained constant. Per annum only approximately 30% of those who wrote Grade 12 mathematics from 2008 to 2011 achieved 40% or more in their examination. Of those who sat for Grade 12 physical sciences in 2008, 29.3% achieved 40% or more in the subject, while 33.8% achieved 40% or more in 2011.

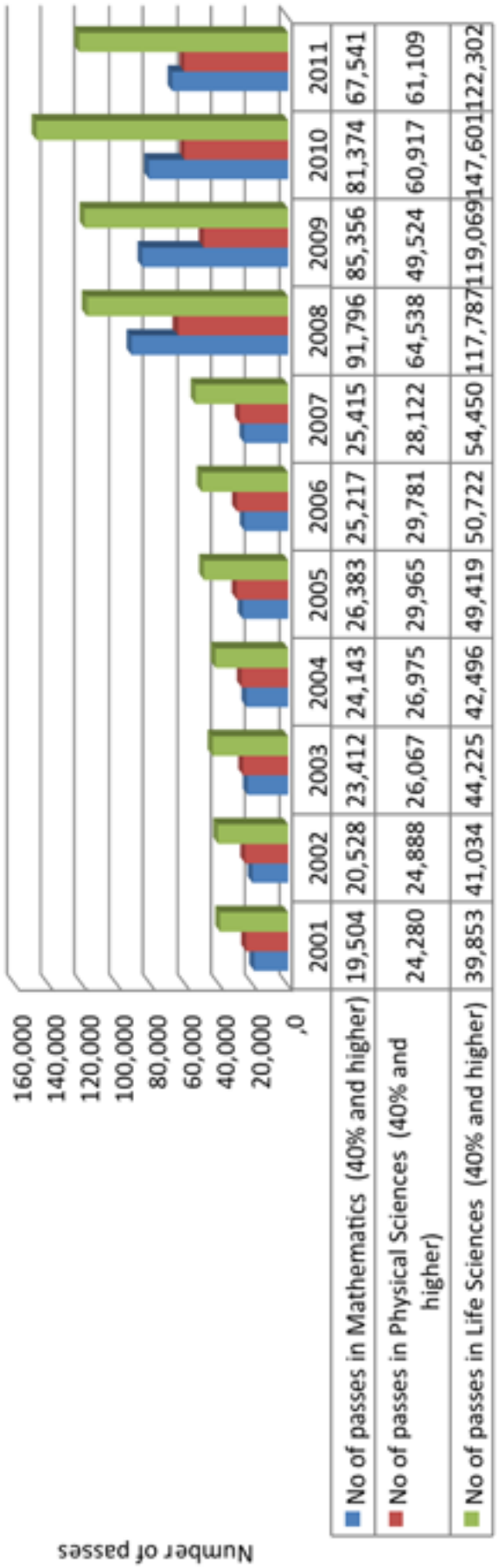


	2008	2009	2010	2011
Achieved Grade 12	62,5	60,6	67,8	70,2
Achieved Mathematics (40% and more)	30,5	29,4	30,9	30,1
Achieved Physical Sciences (40% and more)	29,3	22,0	29,7	33,8
Achieved Life Sciences (40% and more)	39,6	39,9	51,7	46,2

Figure 5-1 Grade 12 mathematics and physical sciences achievement rates: 2008-2011

Figure 5-2 shows the trend in mathematics, physical sciences and life sciences passes from 2001 to 2011 for entry into tertiary studies. The number of passes in mathematics increased from 19 504 in 2001 to 67 541 in 2011 at an average annual growth rate of 13.2%. However, from 2001 to 2007 the number of mathematics passes comprised only higher grade mathematics but from 2008 the Department of Education did away with higher and standard grade mathematics. With the new qualification, the number of passes in mathematics increased dramatically from 25 415 (higher grade mathematics) in 2007 to 91 796 in 2008. Since then (2008 to 2011) a negative annual growth rate (9.7%) in mathematics passes (40% or more) was reported (Table 5-1).

The number of passes in physical sciences increased annually from 24 280 in 2001 to 61 109 in 2011, at an average annual growth rate of 9.7%. In 2008 the number of passes in physical sciences more than doubled from 28 122 (higher grade science) in 2007 to 64 538 (physical science). Since then (2008 to 2011) the number of physical sciences passes (40% or more) decreased annually by 1.8% (Table 5-1).



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
No of passes in Mathematics (40% and higher)	19,504	20,528	23,412	24,143	26,383	25,217	25,415	91,796	85,356	81,374	67,541
No of passes in Physical Sciences (40% and higher)	24,280	24,888	26,067	26,975	29,965	29,781	28,122	64,538	49,524	60,917	61,109
No of passes in Life Sciences (40% and higher)	39,853	41,034	44,225	42,496	49,419	50,722	54,450	117,787	119,069	147,601	122,302

Figure 5-2 Number of passes in mathematics, physical sciences and life sciences: 2001-2011[1]

Source: Department of Basic Education

Analysis of the statistics cited above shows that the secondary school system is producing fewer candidates with the combination of subjects required for entering tertiary-level studies in the health sciences. Apart from the issue of insufficient numbers, there are serious concerns about the quality ofmatriculants.Education experts have found that the levels of literacy and numeracy in South Africa are considerably lower than those of other developing countries and several African countries. According to the DBSA Roadmap, in a comparison with developed countries the top 6% to 10% of South African students were at the same level as the top 75% of students in the advanced countries.[573]These realities confirm prevailing concerns about poor student readiness for tertiary studies. Nursing colleges report an oversupply of under-qualified learners who do not meet the academic entrance criteria.[574]These colleges also experience dropout rates of around 75%, which is an indication that prospective nurses are not properly prepared for training at post-school level.[575]

5.2.2 Entry from school into social development labour market

Although mathematics and science at Grade 12 level are not barriers to entry into the social development sector, the personal characteristics of learners are important in respect of well-developed communication skills, personal trustworthiness, and a desire to serve others.

A large number of workers in the sector enter into the labour market after school without any further education or training. These are mostly volunteer workers, many of whom may not have completed their schooling. Many of these workers enter the sector via government's EPWP. According to the DSD, 41 908 community caregivers received accredited training in terms of NQF levels 1 to 4 through NGOs in 2008/09.[576] These programmes provide unemployed individuals and volunteers with a stipend, on-the-job experience, and training for a period. This programme culminates in an NQF-aligned qualification or skills programme, and provides the individual with longer-term income-earning opportunities.[577]

5.3 INSTITUTIONAL ARRANGEMENTS AND CAPACITY TO TRAIN HEALTH WORKERS

Post-school training for the nearly 100 registered health professions takes place at public and privateHEIs, provincial training colleges, and nursing- and ambulance colleges. Factors impacting on the supply of health professionals by the different institutional streams are discussed in the following paragraphs.Apart from physical infrastructure, the training of health professionals also requires a clinical health service teaching platform to develop clinical skills, patient care, and delivery of care services.It takes many years to train and equip health professionals with the required knowledge, skills and competencies.[578]

5.3.1 Academic healthcomplexes

Most prospective health professionals are trained in academic health complexes established under the National Health Act that aim to provide comprehensive training in primary-, district- and tertiary-level care. Each of these academic health complexes consists of health facilities at all levels of the national health system, including peripheral facilities and one or more educational institutions.[579]By providing the platform for clinical- and in-service training, as well as clinical research, academic health complexes play an important role in the development of healthcare and the health system.[580]

Although there are many calls for increased output from the academic health complexes, training capacity is limited as a result of constraints related to infrastructure, restrictions on the number of clinician posts, bed count, laboratories, and other resources. Despite the high demand for placement in healthcare educational programmes, the annual intake remains restricted.

Leading health academics, in a presentation to the Parliamentary Portfolio Committee on Health, warned that the academic health complexes are in a state of crisis because of the lack of a national governance structure and an appropriate funding framework. According to these academics, although provincial health departments are responsible for funding the complexes, very little money is allocated to them. These complexes compete with other priorities in the provincial budgets, such as PHC and district healthcare.[581] As a result, fewer healthcare workers are produced and the quality of tertiary-level healthcare

573 Development Bank of South Africa. 2008. Education Roadmap: Focus on the Schooling System. Published at http://www.dbsa.org/Research/Roadmaps1/Education%20Roadmap.pdf. (Accessed August 2010).
574 Breier, M.,Wildschut, A. et al. 2009. *Nursing in a New Era – The Professional Education of Nurses in South Africa*.
575 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". South African Medical Journal. August 2009. 99 (8).Published at http://www.scielo.org.za/pdf/samj/V99n8. (Accessed August 2009).
576 Department of Social Development. 2009. *Annual Report 2008/09*.
577 Plaatjies, D. and Nicolaou-Manias, K. 2005 *Government employment opportunities: Budgeting for job creation in social welfare services – exploring EPWP opportunities*.
578 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).
579 Section 51 of the National Health Act, 61 of 2003.
580 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).
581 Bateman, C. 2010. "Academic health complexes bleeding in 'no man's land'".*South African Medical Journal*. January 2010. 100 (1). DBSA. 2008. *A Roadmap for the Reform of the South African Health System*.

and training is reduced. Central hospitals are experiencing resource challenges in particular.[582]There are fears that some academic hospitals may lose their accreditation as teaching institutions unless funding is made available to maintain infrastructure, provide adequate standards of service, and supply medication. There is a real risk that the numbers of undergraduate medical students may be cut and intern training posts may be reduced.[583] Owing to budget constraints the bed count in several tertiary hospitals has dropped, and this has resulted in a diminished capacity to train health professionals.

Historically, integrated planning on the development of health professionals between the health sector and education sector has been lacking. Such training has not necessarily been linked to actual healthcare needs and adequate financing mechanisms. Furthermore, a trend emerged over the last 15 years to retrench academic clinicians and clinical supervisors and to freeze their posts. As a result, growth in the training of doctors, medical specialists, nursing specialists and the therapeutic sciences was significantly affected. The quality of all undergraduate and postgraduate training is also affected.[584]The HWSETA baseline study reported that the brain drain of academic and experienced personnel leads to deficiencies within training institutions. These deficiencies impact on the professional attachment and supervision of new graduates and the production of future health personnel.

Government acknowledges the above-mentioned realities as factors that constrain the education and development of health professionals and recognises that the infrastructure for clinical training and service development (i.e. the academic health complexes, nursing colleges and other training platforms) must be better managed, strengthened, and organised.[585]

Teaching capacity in pharmacy schools and nursing colleges is also under strain due to the ageing of academics and educators, and the closure of nursing colleges in the past.[586] Since the new qualifications in nursing, pharmacy support personnel and emergency medical care services are based on a higher education platform, the capacity of training institutions to meet new accreditation requirements and the ranks of current academics who train at the FET level will have to be strengthened.

For many years the annual intake of veterinary science students has been limited to 140 and the selection process is structured to reflect government policy and the veterinary needs of the country. Owing to the recent restructuring of the veterinary science programme into a core-elective six-year single-degree structure, there was no intake of first-year students in 2011.[587]Owing to the acute shortage of skills and increasing pressure to train more veterinarians, the annual intake will be increased to 190 in 2013.[588]

5.3.2 Private higher education and training institutions

Although South Africa has dynamic and well-established private HEIs they may be challenged in meeting the extensive accreditation requirements for the training of health professionals set by the professional councils and the HEQC of the CHE. Many private providers argue that for the training of health professionals accreditation requirements are not the constraining factors but, rather, the restrictions placed by government on the private sector.[589]

Role players in the private health sector have expressed concerns that the private higher education sector is, to a large extent, barred from producing certain health professionals.[590]They observed that even though the DoH acknowledges skills shortages in almost all categories of healthcare professionals, the national Human Resources of Health Plan of 2006 neither addresses strategies to include the private sector in trainingnor plans for the increased intake of learners at tertiary academic institutions.[591]

The 2011 national strategy, *Human Resources for Health for South Africa 2030*, indicates government's intention to investigate cooperation with the private sector to ensure that the academic sector grows, is sustainable, and produces quality health professionals and academics. For this purpose the DoH is evaluating mechanisms by which the private sector can contribute to health professional development.[592]

Several private HEIs are accredited to train in qualifications required for registration with the AHPCSA. In November 2012 the accredited training providers in the

582 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published athttp://www.doh.gov.za.(Accessed 10 August 2012).
583 Bateman, C. 2010. "Academic health complexes bleeding in 'no man's land'".South African Medical Journal. January 2010. 100 (1).Published at http://www.scielo.org.za/pdf/samj/V100n1.(Accessed August 2010).
584 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
585 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
586 Interviews with the SAPC and SANC in October 2012; SAPC, 2011.*Pharmacy Human Resources in South Africa 2011*.
587 University of Pretoria. 2011. Faculty Brochure: Veterinary Science 2011/12. Published at http://web.up.ac.za/sitefiles/file/...Brochures/FB%20-%20Vet%20Science%202011-2012.pdf.(Accessed 26 August 2010).
588 Interview with academics at Faculty of Veterinary Science, University of Pretoria, October 2012.
589 Worrall-Clare, K. 2009."Partnering Sectors" in Private Hospital Review 2009.Hospital Association of South Africa. Published at: http://www.hasa.co.za/.... (Accessed August 2010); Life Healthcare Company. 2010. "Commentary on the Draft 2011 – 2016 Sector Skills Plan".
590 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care". South African Health Review 2008.. Published at www.hst.org.za/publications..(Accessed August 2010).
591 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care". *South African Health Review 2008.* Health Systems Trust.
592 DoH. 2011. Human Resources for Health for South Africa 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za.(Accessed 16 August 2011).

allied health professions of therapeutic aromatherapy, therapeutic reflexology and therapeutic massage therapy were all private HEIs.[593] The South African Faculty of Homeopathy offers an accredited programme that leads to the Postgraduate Diploma in Homeopathy, which is aimed at medical practitioners already registered with the HPCSA who wish to specialise in homeopathy.[594]

The Foundation for Professional Development (FPD) is a private HEI established by the South African Medical Association (SAMA). The FPD offers a comprehensive curriculum of training and development courses aimed at health professionals, practitioners, allied workers, health sector managers, and non-medical professionals. It offers programmes that lead to undergraduate- and post-graduate qualifications, and short courses. Among key focus areas are leadership and management in a health environment,and clinical and multi-disciplinary courses, some of which are designed to meet the needs of health professionals and practitioners working in rural areas. Community engagement is sought via the development of grassroots NGOs.The FPD also develops institutional capacity within the public sector.[595]

5.3.3 Private further education and training institutions

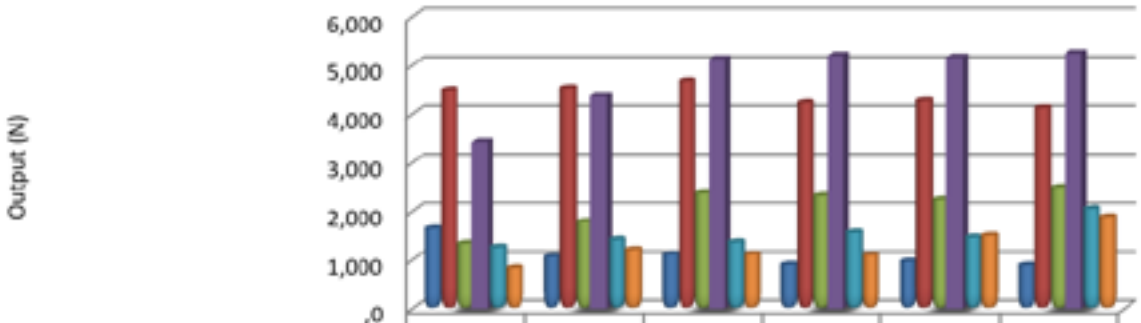
Private FET institutions produce nursing auxiliaries (NQF Level 3), enrolled nurses (NQF Level 4), and pharmacy assistants (basic level) at NQF Level 3, and pharmacyassistants post-basic at NQF Level 4. The nursing schools of several of the large private hospital groups and independent private nursing schools are accredited by the Department of Higher Education as FET providers.

5.3.4 Private hospitals

Private hospitals are permitted to train nurse practitioners but constraints in meeting regulatory and accreditation requirements limit their ability to produce certain qualifications and,therefore, the required number of nurses. Private hospitals mainly train nursing auxiliaries and enrolled nurses and offer a two-year bridging programme towards full registration as a professional nurse for general nursing functions. Because the private sector offers limited clinical experience to trainee nurses, it has not been successful in attaining accreditation to offer comprehensive training for registered nurses. Even larger private hospitals are not able to offer access to chronic psychiatric care, community-based nursing, or midwifery – all of which are required to complete a comprehensive four-year programme.[596]The private sector does offer specialist training in intensive care, neo-natal care and operating theatre units. Role players in the private hospital sector dispute general allegations that such hospitals offer limited clinical experience and maintain that valuable learning opportunities can be provided, including in midwifery and psychiatric care.[597]

The private sector has assumed a prominent role in contributing to the output of enrolled nursing auxiliaries and enrolled nurses, and in bridging programmes to upgrade enrolled nurses to be registered as nurses (Figure 5-3). In 2012, compared to the public sector, the private sector trained most enrolled nursing auxiliaries (82%) and enrolled nurses (68%). From 2007 to 2012 the number of enrolled nurses trained by the private sector increased annually by 9% from 3 419 to 5 243, while the number of nurses on bridging programmes provided by the private sector increased annually by 13% over the same period.

593 AHPCSA. 2012. Published at http://www.ahpcsa.co.za/... (Accessed 12 November 2012).
594 South African Faculty of Homeopathy. 2012. Published at http://www.homeopathysouthafrica.co.za/. (Accessed 12 November 2012).
595 Foundation for Professional Development. 2012. Published at http://www.foundation.co.za/. (Accessed 12 November 2012).
596 Breier, M., Wildschut, A. et al.. 2009. *Nursing in a New Era – The Professional Education of Nurses in South Africa*.
597 Life Healthcare Company. 2010. "Commentary on the Draft 2011 – 2016 Sector Skills Plan"; Worrall-Clare, K. 2009. "Partnering Sectors" in Private Hospital Review 2009. Johannesburg: Hospital Association of South Africa. Published at: http://www.hasa.co.za/media/uploads/news/.../Private_Hospital_Review_2009.pdf (Accessed August 2010).



	2007	2008	2009	2010	2011	2012
Enrolled Nursing Auxiliaries Public Sector	1,641	1,061	1,106	,899	,955	,887
Enrolled Nursing Auxiliaries Private Sector	4,495	4,532	4,673	4,226	4,267	4,122
Enrolled Nurses Public Sector	1,339	1,788	2,365	2,314	2,233	2,489
Enrolled Nurses Private Sector	3,419	4,366	5,128	5,197	5,158	5,243
Bridging programme Public Sector	1,261	1,419	1,366	1,563	1,465	2,048
Bridging programme Private Sector	,832	1,209	1,109	1,092	1,499	1,881

Figure 5-3 Comparison of output in basic nursing training between public and private sectors: 2007 to 2012
Source: SANC, 2013.

Currently, private hospitals are not accredited to train doctors and, in an article, HASA expressed concerns about this situation – especially with respect to capacity constraints at academic health complexes.[598]

5.3.5 Provision of Continuous Professional Development

Health professionals are obliged to undergo CPD in order to retain their registered status with their respective regulatory councils. Increasingly CPD is viewed as an opportunity to update the knowledge and skills of social workers and health professionals in their respective professional fields.[599]Policy makers in both the health and welfare sectors are calling on the statutory councils to strengthen the requirements for and monitoring of CPD. Therefore CPD plays an important role in skills formation in the sector. Most of the professional bodies accredit providers to offer CPD and various voluntary organisations within the organised profession facilitate access to CPD and keep members' records of CPD participation. Government has recommended that CPD for the health workforce should take place in line with a national competence framework that sets out priority competencies.[600] The SAPC will introduce mandatory CPD for pharmacists and pharmacy support personnel in the near future, while the SANC aims to do the same for the nursing profession.In 2012 the DoH recommended that a CPD system for all nurses and midwives, linked to registration and professional progression, be introduced urgently. Training in professionalism and ethics must be a compulsory component of the CPD system.[601]The DoH also urged the SANC to design a national framework for the education and training of nurse educators and nurse managers and to set standards for their CPD.

5.3.6 Non-profit organisations

Generally, NGOs offer non-accredited training to volunteers, CHWs and community caregivers, 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. Participants in the baseline study acknowledged the HWSETA's role in financing skills development for NGOs and called for increased support and capacity building in rural areas and CBOs. As discussed in paragraph 4.5.2, respondents from NGOs and academics whom the HWSETA interviewed in October 2012, emphasised the urgent need to support and capacitate NGOs to supply skills to the health and social development sector. A specific suggestion is that the HWSETA should provide funding to appoint external, experienced practice supervisors to oversee experiential learning.

598 Worrall-Clare, K. 2009."Partnering Sectors" in Private Hospital Review 2009.Published at: http://www.hasa.co.za/media/uploads/news/.../Private_Hospital_Review_2009.pdf.(Accessed August 2010).
599 Interviews with stakeholders in October and November 2012.
600 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
601 DoH. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*

5.4 THE SUPPLY OF NEW GRADUATES BY THE HIGHER EDUCATION SYSTEM

5.4.1 Higher education and training

As indicated above, health professionals mostly receive their academic education from the public higher education sector. The analysis of the supply of skills at HET level is based on information obtained from the Department of Education's Higher Education Management Information System (HEMIS). This database contains data required for quality assurance, national and institutional higher education planning, and the allocation of Government funds to HEIs.After its inception in 2000, HEMIS used the subject matter classifications of the old South African Post-Secondary Education (SAPSE) system. In 2008, the system was revised and the broad subject matter category "Health Care and Health Sciences" with 10 second-order categories was replaced by the broad category "Health Professions and Related Clinical Sciences" with 25 second-order categories. From 2010 HEMIS collected data according to the revised Classification of Education Study Material (CESM) categories. In the absence of official information on correspondence between the two systems (mapping) only 2010 to 2012 output from the HEIs in health-related fields of study are shown in Table 5-2.

If all the health-related fields of study are considered, the total output from the higher education and training (HET) sector grew on average from 2010 to 2012 by 3.9% at first three-year B Degree level and at 6.0% at first four-year B degree level. Medicine (1.8%), nursing (2.0%), pharmacy, pharmaceutical sciences and administration (9.7%) and social work (19.5%) have been fields with positive average annual growth in professional (four-year) degrees since 2010. In contrast, output in the fields of dentistry, advanced dentistry and oral sciences (2.6%), and medical clinical sciences (0.8%) showed negative growth from 2010 to 2012.

Table 5-2 Number of health-related qualifications awarded by the public higher education sector: 2010 to 2012

CESM* Category	Qualification Type	2010	2011	2012	AAG**
Chiropractic	First Bdegree (3 years)				
	First Bdegree (4 years)	48	44	52	4.1
Communications Disorders Sciences and Services	First Bdegree (3 years)				
	First Bdegree (4 years)	114	153	141	11.1
Dentistry, Advanced Dentistry and Oral Sciences	First Bdegree (3 years)	50	38	52	2.0
	First Bdegree (4 years)	212	157	201	-2.6
Dental Support Services and Allied Professions	First Bdegree (3 years)				
	First Bdegree (4 years)	46	36	24	-27.8
Health and Medical Administrative Services	First Bdegree (3 years)	200	179	230	7.3
	First Bdegree (4 years)	258	290	270	2.3
Medicine	First Bdegree (3 years)	1	25	40	628.0
	First Bdegree (4 years)	637	704	660	1.8
Medical Clinical Sciences	First Bdegree (3 years)	55	65	102	36.0
	First Bdegree (4 years)	1 015	936	999	-0.8
Nursing	First Bdegree (3 years)	302	271	278	-4.0
	First Bdegree (4 years)	891	958	927	2.0
Optometry	First Bdegree (3 years)	1			
	First Bdegree (4 years)	127	115	90	-15.9
Pharmacy, Pharmaceutical Sciences and Administration	First Bdegree (3 years)	1			
	First Bdegree (4 years)	466	509	561	9.7
Podiatric Medicine/Podiatry	First Bdegree (3 years)				
	First Bdegree (4 years)	6	16	3	-29.3

CESM* Category	Qualification Type	2010	2011	2012	AAG**
Public Health	First Bdegree (3 years)	20	23	63	75.8
	First Bdegree (4 years)	172	201	210	10.4
Rehabilitation and Therapeutic Professions	First Bdegree (3 years)	57	52	41	-15.2
	First Bdegree (4 years)	526	555	578	4.9
Veterinary Medicine	First Bdegree (3 years)	25	25		
	First Bdegree (4 years)	32”	29”	32	-0.4
Veterinary Biomedical and Clinical Sciences	First Bdegree (3 years)	25	25	0	
	First Bdegree (4 years)	97”	86”	95	-0.9
Dietetics and Clinical Nutrition Services	First Bdegree (3 years)	16	24	20	11.5
	First Bdegree (4 years)	110	127	118	3.5
Alternative and Complementary Medicine and Medical Systems	First Bdegree (3 years)	10	6	7	-14.2
	First Bdegree (4 years)	24	26	28	9.2
Somatic Bodywork and Related Therapeutic Services	First Bdegree (3 years)	10	5	8	-8.2
	First Bdegree (4 years)	47	42	40	-7.9
Movement and Mind-Body Therapies And Education	First Bdegree (3 years)	0	14	20	
	First Bdegree (4 years)	7	6	6	-7.4
Medical Radiologic Technology/Science (Radiography)	First Bdegree (3 years)	29	41	33	5.9
	First Bdegree (4 years)	77	106	98	13.1
Health Professions and Related Clinical Sciences, Other	First Bdegree (3 years)	7	0	0	
	First Bdegree (4 years)	11	45	47	107.7
Social Work	First Bdegree (3 years)	65	85	48	-14.1
	First Bdegree (4 years)	1 169	1 297	1 671	19.5
TOTAL	**First Bdegree (3 years)**	872	878	941	3.9
	First Bdegree (4 years)	6 091	6 436	6 850	6.0

*Classification of Education Study Material
**Average annual growth.
Postgraduate Baccalaureus degree.
Source: Calculated from DHET, HEMIS.

5.5 THE SUPPLY OF NEW ENTRANTS THROUGH NURSING COLLEGES

Public and private nursing colleges play an important role in the supply of nurses to the health sector. According to the SANC, there were 97 active accredited private nursing education institutions and 140 public institutions in August 2013.[602] The accredited institutions comprised: public sector institutions (attached to provincial- and military hospitals); universities and universities of technology; private hospital academies; private hospitals; training academies of mining companies; private academies and colleges; and institutional care facilities for the elderly and handicapped persons. Gauteng and KwaZulu-Natal had the most private training institutions while most public training institutions can be found in KwaZulu-Natal and Limpopo. No training institution is registered in the Northern Cape.

602 SANC. 2013. Published at http://www.sanc.co.za/neis.htm(Accessed 7 October 2013).

The number of nurses who qualified at the various levels can be seen in Table 5-3. In 2012 a total of 19 143 nurses qualified at the nursing colleges. The total output of the colleges increased on average by 7.4% per year over the period 2002 to 2012. The highest average growth in output was in the pupil nurse category (10.3% per annum). From 2002 to 2012 the output of nurses who had done four-year programmes increased from 1 252 to 2 473 at an average annual growth rate of 6.6%.

Table 5-3 Number of graduates at nursing colleges: 2002 to 2012

Programme	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	AAG
Four-year Programme	1 252	1 100	1 288	1 058	1 493	1 628	1 701	1 967	2 337	2 376	2 473	6.6
Bridging Course*	1 679	1 841	2 103	2 352	2 364	2 093	2 628	2 475	2 655	2 964	3 929	5.8
Pupil Nurses	2 771	3 158	4 273	4 565	4 816	4 758	6 154	7 493	7 511	7 391	7 732	10.3
Pupil Auxiliaries	3 078	4 390	6 698	6 754	5 422	6 136	5 593	5 779	5 125	5 232	5 009	5.4
Total	**8 780**	**10 489**	**14 362**	**14 729**	**14 095**	**14 615**	**16 076**	**17 714**	**17 628**	**17 963**	**19 143**	7.4

*Bridging into professional nurse category.
Source: SANC, 2013. Published a thttp://www.sanc.co.za/stats.htm(Accessed 4October 2013).

Production of registered nurses in nursing colleges dropped significantly between 2001 and 2008, and only started to regain 1996 levels by 2010.Output of enrolled nurses from public training colleges grew from a low base of 70 in 1996 to 2 489 in 2012 while output from private institutions increased exponentially from 33 to 5 243 over the same period.[603]According to the DoH, outputs of nursing education institutions do not match the health and service demands for nurses and midwives in South Africa.[604]

Analysis of data from the SANC shows that specialist nursing output in areas such as intensive care, operating theatre, advanced midwifery, paediatric nursing and psychiatry has declined and led to reduced capacity for service in tertiary hospitals.[605]

603 SANC. 2013. Published athttp://www.sanc.co.za/stats.htm(Accessed 4October 2013).
604 DoH. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*
605 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

5.6 THE ROLE OF THE HWSETA IN THE SUPPLY OF SKILLS

5.6.1 Changes in the skills development landscape

An important change in the skills development landscape was brought about by the The National Qualifications Framework Act (Act 67 of 2008) which came into effect in December 2010. The Act provides (among others) for a third sub-framework to the National Qualifications Framework (NQF), namely the the Occupational Qualifications Framework (OQF). This sub-framework co-exists with the General and Further Education and Training Qualifications Framework (GFETQF, overseen by Umalusi) and the Higher Education and Training Qualifications Framework (HETQF, overseen by the Council on Higher Education (CHE)) and is overseen by a new quality council, the Quality Council for Trades and Occupations (QCTO).

The QCTO is ultimately responsible for the development and quality assurance of occupational qualifications and currently it works with the SETAs on the quality assurance of existing qualifications that fall within their respective scopes and on the development of new occupational qualifications according to the QCTO specifications.

5.6.2 The registration of qualifications and learnerships

Before the establishment of the QCTO the HWSETA had registered 26 qualifications in the health and welfare sector (Table 5-4). The SETA remains responsible for the quality assurance of these qualifications under the auspices of and in collaboration with the QCTO.

Table 5-4 Qualification matrix of the HWSETA

SAQA ID	Qualification title	NQF level	Credits
49606	GETC Ancillary Healthcare	1	134
73250	GETC ABET Ancillary Healthcare	1	120
64749	NC Community Health Work	2	140
64149	NC Occupational Health, Safety and Environment	2	120
74289	NC Occupational Health, Safety and Environment: Health	2	120
74290	NC Occupational Health, Safety and Environment: Safety	2	120
74291	NC Occupational Health, Safety and Environment: Environment	2	120
48891	NC Theology and Ministry	2	120
49279	NC Victim Empowerment and Support	2	120
50062	NC Occupational Hygiene and Safety	3	144
64769	NC Community Health Work	3	140
49688	NC Victim Empowerment	3	127
60249	NC Primary Response in Emergencies	3	142
60209	FETC Child and Youth Care Work	4	165
64697	FETC Community Health Work	4	156
58396	FETC Community Development – HIV/AIDS Support	4	155
49256	FETC Counselling	4	140
49836	FETC Gender Practice	4	152
50063	FETC Occupational Hygiene and Safety	4	145
50041	FETC Probation Work	4	142
23993	FETC Social Auxiliary Work	4	180
48960	FETC Social Security Administration	4	140
49057	FETC Theology and Ministry	4	120
49872	FETC Victim Empowerment Coordination	4	146
74410	FETC Public Awareness Promotion of Dread Diseases and HIV/AIDS	4	166
58786	National Diploma: Occupational Safety	5	242

Source: HWSETA.

The HWSETA has entered into a memorandum of agreement with the QCTO to manage the development of a newSAW qualification (NQF Level 5). This qualification is awaiting evaluation by the QCTO. The HWSETA will continue to support to development of new qualifications to replace those that reach their registration end dates and for which there is still a need.

During 2012/13 the HWSETA engaged in discussions with professional bodies regarding the development of qualifications for the mid-level skills needed to support the implementation of the NHI and to strengthen professionalism in the social sector. Further discussions will be held in 2013/14.

The HWSETA has also registered several learnerships for the sector with the DoL (the registrations are now handled by the DHET) (Table 5-5).

Table 5-5 HWSETA learnerships

Learnership title	NQF level	DoL Registration Number
GETC Ancillary Healthcare	1	11 Q 110011 31 125 1
NC Theology and Ministry	2	11 Q 110017 30 120 2
Certificate Pharmacist Assistant (Basic)	3	11 Q 110002 13 120 3
Community Health Worker	3	11 Q 110016 27 120 3
Certificate in General Nursing (Auxiliary)	4	11 Q 110008 20 132 4
Certificate in General Nursing (Enrolled)	4	11 Q 110003 00 132 4
Certificate Pharmacist Assistant (Post Basic)	4	11 Q 110001 08 120 4
FETC Social Auxiliary Work	4	11 Q 110012 00 180 4
FETC Phlebotomy Techniques	4	11 Q 110006 28 134 4
FETC Child and Youth Care Work	4	11 Q 110014 35 155 4
FETC Counselling	4	11 Q 110018 69 140 4
FETC Community Development – HIV/AIDS Support	4	11 Q 110015 18 135 4
Diploma Medical Technology	5	11 Q 110005 00 120 5
Diploma in General Nursing (Bridging)	5	11 Q 110004 00 256 05
Post Basic Diploma in Medical / Surgical Nursing (Elective: Critical Care / Operating Theatre)	6	11 Q 110010 17 360 6
Diagnostic Radiography	6	11 Q 110031 00 360 6
Diploma in Primary Health Care (Post Basic)	6	11 Q 110009 23

Source: HWSETA.

In 2011/12 the HWSETA issued a total of 4 554 learner certificates for full qualifications achieved,and in 2012/13, another 3 579 such certificates were issued.However, in compliance with QCTO directives, the HWSETA does not print such certificates any longer.

5.6.3 Quality-assurance functions

During 2012/13 the HWSETA accredited 28 training providers. The fact that 80% of the learning programmes were not accredited impacted on the number of providers who qualified for accreditation. Many aspirant training providers appear to be challenged when drafting learning programmes. In an attempt to address this; the HWSETA made available learning programmes to be used as guidelines for Community Healthcare NQF Levels 2 and 4, Victim Empowerment NQF Level 2 and Theology NQF Level 2.

To speed up the evaluation of learning programmes for the sector, the HWSETA concluded contracts with the University of the Western Cape and Unisa. A total of 257 learning programmes were evaluated. Of those, 168 learning programmes aligned to full qualifications and 89 aligned to part qualifications which are offered as skills programmes. However, the evaluation outcomes were poor: only 52 (20%) of the learning programmes were approved.The HWSETA Board has given approval that learning programmes be made available for social auxiliary, occupational health and safety, HIV/ AIDS as well as child and welfare qualifications and part qualifications.

Only 31% of the sites visited for accreditation purposes complied with HWSETA requirements. Workshops to build capacity for training providers and to promote quality were held in eight provinces during 2012/13.

A total of 403 assessors and 180 moderators were registered during the 2012 financial year.These numbers increased notably to 1 514 assessors and 592 moderators during 2012/13. The results of 12 training providers were also endorsed and 183 monitoring and evaluation visits took place.The HWSETA experienced some challenges with the verification of learners' achievements. This is mainly because of the difficulties of providers to link learners to unit standards and full qualifications. Measures were taken to address the backlog in the certification of learners.

Several factors impacted on the HWSETA's ability to deliver education and training quality-assurance (ETQA) function over the past two years.Staff shortages as a result of disciplinary action taken by the HWSETA against former employees slowed down service delivery, and uncertainty prevailed about the role and operations of the QCTO.Slow turnaround times of ETQA bodies serving the sector hampered the recording of the completion of learning projects. The prescription for accredited training providers to upload learners with the ETQA only upon completion of their training added to the delays.Since the licence for the ETQA functions of the HWSETA expired on 30 September 2012, ithas entered into a partnership with the QCTO to assume the ETQA functions and responsibilities with effect from 1 October 2012. The HWSETA is participating in the development of a new and improved quality-assurance system and is awaiting a policy decision on the future functions of ETQA bodies in relation to the QCTO.[606]

The HWSETA is concerned about increased incidences of illegal training in the sector and will increase the capacity of its legal division.

5.6.4 Learners who qualified on learnerships

Learnerships remain the chief mechanism through which the HWSETA facilitates the disbursement of PIVOTAL and discretionary grants. Since learnerships enable learners to gain on-the-job competence and achieve a recognised qualification, the allocation of funding provides a tangible return on investment. In 2012/13 a total of 1 223 unemployed persons and 2 654 employed workers (of whom 1 792were black females) entered learnerships in the sector. Amongst the unemployed learners, 833 were black women, 252 black men and 111 persons living with disabilities.

Nursing learnerships are receiving particular support to boost the development of scarce and critical skills. Increased funding is provided to bridge enrolled nurses into the registered nurse category. In total 827 employed and 85 unemployed learners entered the nursing bridging learnership in 2012/13. Nurses are also supported in learnerships for specialised fields where skills shortages exist, such as post-basic PHC, critical care and operating theatre.The learnerships for pharmacist assistants are also in demand. A total of 560 employed and 154 unemployed learners registered for the basic pharmacist assistant learnership assistant learnership, while the post basic pharmacist assistant learnership attracted 221 employed learners.

The learnership in social auxiliary work is supported to increase the output of mid-level skills to the welfare sector. In 2011/12 a total of 403 unemployed learners and 202 employed workers entered this learnership.New registrations dropped to 115 unemployed learners and 37 employed workers in 2012/13.

The HWSETA changed its policy on learnership funding. For learnerships to have an impact, learners need to secure employment when they complete the training. Thus, the HWSETA now only supports learnerships where employment is guaranteed. This ensures placement of learners in the sector.

Table 5-6 gives and overview of the learnerships completed in the sector over the period 2005/2006 to 2012/2013. A total of 10 845 learners had completed learnerships. The numbers varied from year to year with no definite trend discernible. The learnership with the highest number of learners is the GET Certificate in Ancillary Healthcare.

606 HWSETA 2012.HWSETA Annual Report 2011/12.

Table 5-6 Number of learners who completed learnerships in the health sector by programme: 2005/06 to 2012/13

Programme	Financial year								Total
	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011 /12	2012/ 13	
Certificate in General Nursing: Auxiliary	509	174	238	233	83	1			1 238
Certificate in General Nursing: Enrolled	178	734	566	264	94	2		113	1 951
Certificate in Social Auxiliary Work Level 4	84	53	1	49	382		308		877
Certificate Pharmacist Assistant: Basic	121	224	92	153	67	21			678
Commercial and Financial Accountant Public Practice		1							1
Community Health Worker					19		25	7	51
Diagnostic Radiography	13	37	6	6			23	13	98
Diploma in General Nursing: Bridging	244	252	251	71	2	2	163	176	1 161
Diploma in Primary Healthcare: Post Basic	18	32	1	18	36	1		5	111
FET Certificate: Child and Youth Care Work					526		6	4	536
FET Certificate: Phlebotomy Techniques	51	14	39	36	34		67	32	273
First Line Manager					16				16
GET Certificate in Ancillary Healthcare	499	166	18	56	20	606	78	725	2 168
National Certificate: Community Development -HIV/AIDS Support		1		5	29				35
Post Basic Diploma in Medical/ Surgical Nursing (Elective: Operating Theatre Nursing)	8	22	14	12			1	4	61
Post Basic Diploma in Medical/ Surgical Nursing: Elective (Critical Care)	20	55	37	10		1	42	5	170
Post-basic Pharmacist Assistant Learnership	57	158	56	79	47	18	52	138	605
Certificate in Pharmacist Assistance: Post Basic							70	122	192
Community Development HIV/ AIDS support							11		11
Diploma in General Nursing : Auxillary							147	35	182
Diploma in General Nursing : Enrolled							140	290	430
Total	**1 802**	**1 923**	**1 319**	**992**	**1 355**	**652**	**1 133**	**1 669**	**10 845**

Source: HWSETA, October 2013.

5.6.5 Workplace skills plans and implementation reports

Out of 18 967 organisations registered with the HWSETA, a total of 907 submitted workplace skills plans and implementation reports (WSPIRs) in 2012/13, down from 948 in the previous year. A total of 490 levy-paying organisations qualified for the mandatory skills grant as their WSPIRs were approved. The levy-exempt sector submitted 264 WSPIRs, of which 217 were accepted.Organisations who wish to register learners on learnerships with the HWSETA are required to submit WSPs.

5.6.6 Scholarships and bursaries

In 2012/13 a total of 162 unemployed learners received support in the form of bursary funding to enter tertiary studies at universities and universities of technology. Of those, 102 were registered by early 2013 and another 60 persons were expected to enrol by June 2013. Bursaries were awarded for degrees in population studies, social work and nursing science. Bursary funding by the HWSETA also enabled another 120 black unemployed learners from the Eastern Cape to complete their training.

During 2011/12 bursaries were provided to 175 unemployed African learners. In terms of a formal agreement with the Eastern Cape provincial department of health, financing was provided to 121 undergraduate medical students at Walter Sisulu University in order to enhance the supply of high-level national scarce skills. However, this strategy was revised during 2013.

5.6.7 Support for work-based training

During 2012/13 the HWSETA entered into a partnership with the South African Chamber of Commerce and Industry (SACCI) to support the training of 100 unemployed persons as artisans for the sector. The intake of apprentices will take place during 2013/14. The National Artisan Moderation Body (NAMB) will assist the HWSETA to accredit workplaces in the sector for the implementation of apprenticeships. The HWSETA aims to register another 100 employed workers as apprentices once employers have been accredited as training sites.

The HWSETA set a target of supporting 125 work-ready unemployed graduates of middle level qualifications to gain work experience during 2012/13. Significant challenges were encountered with the implementation and only five unemployed graduates gained work experience. However a total of 300 social work graduates were supported in workplace experience. At the time of updating this SSP, the HWSETA was expecting the registration of these learners andwas working to sign a memorandum of understanding regarding the workplace training.

The work experience grant was made available for five postgraduates to access work opportunities. Further research is needed to determine the postgraduate learning areas relevant to the sector for which learners qualified but remain unemployed.

The HWSETA will meet with the Graduates Development Association to determine how the work experience grant may be made available to 500 learners of public FET colleges between 2013/14 and 2015/16.

The HWSETA engaged with 25 organisations to provide workplace experience to 145 disabled persons, and 73 persons were registered on the programme by the end of 2012/13. Approval was given to 120 levy exempt organisations in the sector to train employees in learning areas that fall outside the social and health sector.

During 2012/2013 a total of 170 employers spread across all nine provinces participated in work-based training.

5.6.8 Skills programmes

A total of 658 unemployed learners completed skills programmes during 2012/13. Of those, 626 were black women and 419 lived in Limpopo. Another 520 employed workers completed skills programmes. During 2012/13 no employed workers and only 41 unemployed learners (out of a target of 225) entered skills programmes, mainly due to insufficient numbers of training providers who were accredited against the unit standards which comprised the skills programmes. The HWSETA will draw a new set of skills programmes and work with the ETQA division to ensure that an adequate number of training providerswill be accredited against the chosen programmes.

The HWSETA Board approved financing for 300 labour representatives to attend training courses for skills development facilitators(SDFs). Due to the need for standardisation of the training and the scope of the project, the HWSETA embarked on a tender process in June 2013.

Provision is also made for skills training in scarce and critical skills needed by levy exempt organisations. During 2012/13, the HWSETA approved 120 organisations and concluded funding and training agreements with 61 such organisations.

5.6.9 Partnerships for skills development

By 2011/12 the HWSETA had formed partnerships with 10 FET colleges to offer vocational courses in ECD and preparatory courses in mathematics and science to enable learners to enter apprenticeships. During 2012/2013 the HWSETA approved nine FET colleges where 889 learners will be supported in pre-apprenticeship and N-courses. By March 2013 a total of 270 learners were registered and more will be registered at later intake dates during the 2013 academic year. The HWSETA is negotiating with four FET colleges to train learners from rural areas in ECD (NQF level 4). The HWSETA encountered challenges with the implementation of ECD (NQF level 5) programmes and will continue to address problems with the FET colleges during 2013/14.

The NC Vocational Health qualification was developed and curriculum books were compiled. A planning workshop was held for FET colleges to assist them with preparation on how to deliver the vocational programme in accordance with the qualification requirements that applied from January 2013. During 2012/13 capacity building interventions were conducted at ten FET colleges selected to offer the qualification were.

Two further partnerships with FET colleges were established in 2012/13 to offer NCV levels 2 to 4 qualifications. Four universities were approached to accept NCV qualifications to enable learners to access higher education in the health and social development fields. However, at the time of updating this SSP, none of the universities were willing to enter into a memorandum of understanding.

By mid-2013 the HWSETA identified 24 FET Colleges to work as its skills development partners and memoranda of understanding were finalised and awaited signing. Twelve FET colleges were identified as HWSETA partners to offer vocational courses, pending the finalisation of contracts.

During 2012/3 discussions with the DSD and FET Directorate of the DBE were underway to consider the possibility of developing a qualification NC Vocational Social Development.Discussions were also held with the DHET where it was disclosed that the number of programmes to be developed had been finalised and that no further programmes could be provided. During 2013/14 the HWSETA will review the programmes already developed and evaluate whether they may be aligned to meet DSD requirements.

The HWSETA is a member of a task team chaired by the DSD and CoGTA, which aims to establish the community development profession. As the DQP the HWSETA is contributing to the development of three new qualifications in the community development field.[607]

During 2012 the HWSETA also entered into negotiations with Unisa to assist it with the evaluation of learning programmes submitted for accreditation. Through a partnership between the HWSETA and Skills for Care, a social work exchange programme between South Africa and England was established. The programme enables social workers from both countries to share, compare and analyse current models of delivery in the two countries. The training and qualifications of social workers are also explored and opportunities are created for skills transfer.

Provincial offices have been established in four provinces (KwaZulu-Natal, Limpopo, Eastern Cape and the Western Cape) and the SETA is investigating the most cost effective way to increase its presence across the country, and also into rural areas. As part of the investigation, a feasibility study has been completed on the possibility of decentralising HWSETA functions as an attempt to improve service delivery and access for people in marginalised rural areas.

During 2012/13 the HWSETA held two workshops with the DSD to discuss skills development needs and agreed on a joint implementation plan to build capacity in the Department. Funding opportunities for the Western Cape DSD and Eastern Cape DSD were identified, and funding will be provided for bursaries in population studies at the Nelson Mandela Metropolitan University. Combined workshops with the DoH and DSD are planned for 2013/14.

5.6.10 Adult Basic Education and Training (ABET)

The HWSETA supports the implementation of Adult Basic Education and Training (ABET) through discretionary grants to increase literacy in the sector. More unemployed people need access to ABET than employed workers in the sector. Workers who need ABET are generally employed in outsourced functions such as cleaning, catering and general work, or as volunteers with NPOs and their employers are not registered with the HWSETA.Participants in the HWSETA survey and baseline study in 2009 agreed that the SETA was providing adequate funding for ABET and that enough ABET programmes are available. However there were some challenges in the delivery of ABET, such as the limited availability of trainers, and perceptions of too little funding per learner and of the training being imposed and not necessarily sought after.

In 2011/12 a total of 541 learners achieved ABET levels.

5.6.11 Skills development support to small enterprises

During 2011/12 the HWSETA launched a pilot project to support levy-paying small and micro enterprises (SMEs) to access funding for training. Organisations who used accredited training providers could apply for training vouchers once the HWSETA had concluded a formal agreement with the provider to offer the training that was applied for. Training vouchers were issued for project management, financial management, HR management, computer skills, research skills, management and life skills as well as HIV/AIDS awareness. A total of R2.8 million was distributed to 147 SMEs and 2 199 learners where supported through the voucher system.

The small medium enterprises grant was made available to 250 organisations during 2012/13 to train employed workers in priority skills areas identified in the SSP. Additional provision was made for employers training persons with disabilities.

The HWSETA allocated funding towards a new venture creation programme to develop emerging entrepreneurs. A project plan and expression of interest was developed during 2012 and will be revised and strengthened during 2013.

607 These qualifications are the FETC: Community Development (NQF level 4); NC: Community Development (NQF level 5) and Bachelor of Community Development (NQF level 8), a professional qualification for community development practitioners.

Funding was provided to 120 levy-exempt organisations including NGOs and NPOs to train employees in learning areas identified in the SSP.

At least 147 potential cooperatives, 80 from the social sector and 67 from the health sector, were identified for skills training from the Department of Trade and Industry (DTI) database for cooperatives. During 2013/14 the HWSETA will focus on supporting existing cooperatives and will assist with the establishment of newcooperatives in the future.

A survey of small firms listed on the MedPages database was conducted to identify their skills needs. Preliminary findings were completed early in 2013 and the final report will be ready for dissemination later in 2013/14.

5.6.12 Strengthening capacity for skills development

The HWSETA embarked on a number of strategies to strengthen the capacity for skills development in the sector. To improve the quality of training, the HWSETA provided capacity-building workshops for training providersduring the past two financial years. The HWSETA also intends to improve its quality-assurance service to training providers in 2013 and beyond.A total of 134 delegates attended a capacity building workshop for providers during 2012/13. Another 490 delegates attended workshops to train providers to upload learner achievement information in accordance with SAQA requirements.

5.6.13 Measures to support a green environment

A paperless process of applications for registration of assessors and moderators was introduced as part of the HWSETA's strategy to support a green environment. With further refinement of the facility, the HWSETA hopes that all future applications will be done electronically.

5.6.14 Career guidance and career paths

During 2011/12the HWSETA developed a career guide with labour market information and study guides for grade 11 and 12 learners. A total of 10 000 career guides were printed and distributed to learners from Grade 9 upwards. During the year the HWSETA attended 29 career exhibition events across the country, mostly at rural schools and in rural communities. This is also another attempt by the HWSETA to improve access for the South African rural-dwellers.

A new version of the career guide with updated career information on scarce skills was prepared in 2012/13. The HWSETA will reach out to learners in presidential/poverty nodal zone schools in partnership with relevant NGOs. These schools were identified and the costing of career guides and study guides completed by 31 March 2013. The updated career guide will be made available to these schools in 2013/14. During the previous financial year, the HWSETA supported 73 career development exhibitions across all the provinces, of which 19 were held in rural areas. A pilot project to provide post school youth with credible career guidance will also be launched in 2013/14 in partnership with a university and possibly also SAQA.

5.6.15 Research, monitoring and evaluation activities of the HWSETA

Research activities of the HWSETA focus on gathering and interpreting information from experts with sectoral knowledge, key stakeholders, databases;from specific SETA-initiated research projects; and fromthe work of researchers in fields relevant to the sector. Education and training provision in the sector is also monitored. During 2011/12 the conceptual framework with 28 indicators for monitoring and evaluation of training provision was revised and aligned with the NSDS III.In addition, the quality management system of the HWSETA is also maintained.

During 2011/12 anumber of descriptive research studies were undertaken to gain a better understanding of new areas of learning and skills development thatthe SETA is expected to support. Research projects undertaken were in mid-level skills, cooperatives and NPOs, while an evaluation study was done of the International Social Work Exchange Programme. Research projects in 2012/13 included a study of the feasibility of distance learning for the social auxiliary work qualification and advice on the best model for a distance learning programme; a tracer study on the training and learnership outcomes of HWSETA funded graduates; and primary research for the annual update of the SSP. Another focus area was the feasibility study on the decentralisation of HWSETA functions to enhance service delivery.

Work commenced in 2011/12 to create an alumni database and a register for job opportunities available in the sector. Further, a database containing labour market statistics for the sector is under development and will be expanded to meet requirements of the International Labour Organisation for a labour market information system. A database of registered cooperatives working within the health and social development sector and a similar database of NPOs registered with the DSD were created. These resources will assist the HWSETA with skills planning, programme implementation and capacitating interventions.

An impact evaluation study to assess the impact of the HWSETA's skills development projects and programmes under the NSDS II on employers, learners and the sector was undertaken in 2012/2013. Training provision for the community health qualification was also assessed through site visits and data collection.

During 2012/13 the HWSETA adopted measures to ensure that its research strategy is in place to support a credible institutional mechanism for skills analysis and planning across the health and social development sector. The research strategy was reviewed, and research standards were defined with reference to acceptable academic standards. A research agenda addressing partnerships with the University of the Western Cape and University of Fort Hare was also drafted. Both the research strategy and agenda were approved by the Skills Development Standing Committee of the Board. The research standards were communicated to contracted service providers. Considerable progress was also made to engage two other universities in potential partnerships for research and the development of innovation capacity relevant to the sector.The HWSETA Board also approved a project to support 65 emerging researchers. The support is linked to the HWSETA's research agenda and strategy. A call for emerging researchers to apply for bursaries was advertised by mid-2013.

Two staff members were trained in research methodology at tertiary institutions. A dedicated researcher and two research interns were also appointed.A research seminar was held with training providers of the community health worker qualification and in 2013/14 further seminars will be held to discussthe research reports of the tracer study, SMME study and feasibility study of the social auxiliary work qualification.

5.7 PROFESSIONAL REGISTRATION

As stated in Chapter 2, healthcare professionals have to register with their respective professional councils in order to have the right to practise or work in the health sector. Ideally, the professional registers should provide a fair reflection of the stock of professional skills available in the country. However, the registers don't keep track of professionals' movement out of the country and it is possible that people who are registered no longer offer their services to the South African health sector, or only work part-time. Some of the registered professionals may also be employed elsewhere in the economy or may be economically inactive.[608] Nevertheless, the professional registers do provide an indication of growth in the number of health professionals available.

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

The HPCSA offers registration in 89 registration categories and is by far the registration body with the largest number of categories of health professionals. At the end of December 2012 there were 167 842 people registered with the 12 Professional registration boards of the HPCSA. This figure has more than doubled since 2000, when there were 84 682 people on the registers. This increase was, however, mainly the result of the registration of new health workers who were not regulated in the past – e.g. basic ambulance assistants.

Table 5-7shows the registration figures for a number of key professions as on 31 December of each year from 2002 and 2012. The table also shows the average annual growth in the number of professionals registered. The total number of registered dentists grew by 2.2% per year, medical interns by 3.8%, and GPs by 2.5%. Clearly, this slow growth is the most important reason why the dire employment figures are not improving.

As many as 9 117 healthcare practitioners were suspended from the HPCSA register in November 2012 for failure to pay annual fees. Among those struck from the register were 1 360 medical and dental practitioners, 6 207 emergency care practitioners and 323 psychologists. These practitioners no longer enjoyed statutory recognition to practise their professions[609]. According to the Health Professions Act, it is a criminal offence to practise any of the health professions under the ambit of the Council when one has been suspended or erased from the register.

5.7.2 Registrations with the South African Nursing Council (SANC)

The number of nurses registered with the SANC over the period 2002 to 2012 can be seen inTable 5-8. In 2012 there were 248 736nurses registered with the Council. The number of registered nurses grew steadily from 2002 to 2012at an average annual rate of 2.7%. The average annual growth rate for all nurses was 3.7% over the period 2002 to 2012. Registration figures for pupil and student nurses grew from a low base (16 419 in 2002) to 37 344 in 2012 at an average annual rate of 8.6%.

In May 2012 about 9 300 nurse practitioners were removed from the SANC register for non-payment of their annual registration fees.[610]

There is a gap in numbers between nurses who complete their training in one year and those who register in the following year, and this attrition rate is estimated at 40%. Throughput of nurses (i.e. the number that enter training and actually qualify) is estimated at 50%, while about 18% of nurses on the SANC register may not be actively working.[611]

The proportion of registered nurses is decreasing and is estimated to decline from 50% in 2009 to 37% in 2020. Registered nurses are older than the other categories, with 44% being over 50 years old and retiring at a rate of 3 000 per year for the decade and beyond.[612]

608 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13.(Accessed 13 July 2013).

609 HPCSA, 10 October, 2013.

610 South African Nursing Council. 2012. News. Published athttp://www.sanc.co.za.(Accessed 24 August 2012).

611 Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*

612 Department of Health. 2012. *Strategic Plan for Nursing Edu-*

According to the DoH, the numbers of professional nurses with specialist qualifications registering with the SANC in intensive care, operating theatre care, advanced midwifery and psychiatry declined gradually between 1996 and 2010.[613]Representatives of private hospitals raised the need to recruit specialist nurses internationally and train operating theatre assistants.[614]

cation, Training and Practice 2012/13 -2016/17
613 Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*
614 Interview with HASA, October 2012.

Table 5-7 Number of professionals registered with the HPCSA as at 31 December of 2002 to 2012 (selected professions)*

Registration category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	AAG %*
Dentist	4 560	4 500	4 644	4 761	4 836	5 047	4 890	5 015	5 296	5 423	5 652	2.2
Medical Intern	2 306	2 157	2 479	2 899	3 275	3 760	3 645	3 006	3 619	3 862	3 338	3.8
Medical Practitioner	30 271	30 578	31 330	32 443	33 507	34 449	33 534	33 800	36 633	37 289	38 652	2.5
Medical Technologist	3 942	4 713	4 869	4 877	4 954	5 048	5 151	5 311	5 383	5 552	4 948	2.3
Occupational Therapist	2 563	2 511	2 819	2 808	2 922	3 159	2 946	3 156	3 490	3 668	3 945	4.4
Optometrist	2 173	2 218	2 401	2 516	2 633	2 733	2 915	3 023	3 083	3 168	3 342	4.4
Physiotherapist	4 360	4 400	4 785	4 760	4 915	5 240	5 081	5 261	5 773	5 954	6 328	3.8
Psychologist	5 064	5 401	5 774	5 878	6 130	6 391	6 532	6 684	6 914	7 073	7 245	3.6
Radiographer	4 295	4 789	5 221	5 237	5 433	5 624	5 562	5 800	6 208	6 500	6 225	3.8
Speech Therapist and Audiologist	1 321	1 345	1 397	1 391	1 396	1 441	1 222	1 296	1 388	1 426	1 448	0.9

*Average annual growth.
Source: HPCSA, 2013.

Table 5-8 Number of nurses registered with the SANC: 2002 to 2012

Registration category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	AAG %*
Registered	94 948	96 715	98 490	99 534	101 295	103 792	107 978	111 299	115 244	118 262	124 045	2.7
Enrolled	32 495	33 575	35 266	37 085	39 305	40 582	43 686	48 078	52 370	55 408	58 722	6.1
Auxiliaries	45 426	47 431	50 703	54 650	56 314	59 574	61 142	62 440	63 472	64 526	65 969	3.8
Total	**172 869**	**177 721**	**184 459**	**191 269**	**196 914**	**203 948**	**212 806**	**221 817**	**231 086**	**238 196**	**248 736**	**3.7**
Student	10 338	11 478	12 280	13 096	13 272	15 258	16 457	17 167	19 778	20 581	20 920	7.3
Pupil	6 081	7 245	8 300	8 096	8 483	9 528	11 179	13 052	16 836	16 428	16 424	10.4
Pupil Nursing Auxiliaries	4 685	4 938	6 577	6 289	6 169	4 812	5 058	37 53	6 711	5 744	5 910	2.3
Total	**21 104**	**23 661**	**27 157**	**27 481**	**27 924**	**29 598**	**32 694**	**30 219**	**43 325**	**42 753**	**43 254**	**7.4**

*Average annual growth.
Source: SANC, 2013. Published at http://www.sanc.co.za/stats.htm.(Accessed 4October 2013).

5.7.3 Registrations with the South African Pharmacy Council (SAPC)

From 2006 to 2012 the number of registered pharmacists grew by 2.3% per annum from 11 167 to 12 805 and pharmacist interns by 4.5% per annum from 474 to 619 (Table 5-9). The registration figures in the support staff categories showed higher growth, but from a low base. From 2006, basic pharmacist assistants (NQF Level 3) annually grew by 40.4% from 114 in 2006 to 867 in 2012 and post-basic pharmacist assistants (NQF Level 4) by 16.7% from 1 792 in 2006 to 4 533 in 2012.

In 2011 South Africa had 12813 registered pharmacists or 25.5 pharmacists per 100 000 population, which was significantly lower than the WHO recommended ratio of 45 per 100 000 population. Rural provinces fell short – in Limpopo the ratio was only 10.23, the Northern Cape 13.77, Mpumalanga 14.53 and the Eastern Cape had 15.94 pharmacists per 100 000 population.[615]According to the SAPC, approximately 96% of registered pharmacists were practising actively in 2011.

The proportion of pharmacists working in the public sector increased from 12% in 2004 to 29% in 2010, mainly as the result of the implementation of the public sector scarce skill and rural allowances, the OSD, as well as the creation of new posts to support the ARV programmes.[616]

615 South African Pharmacy Council. 2011. Pharmacy Human Resources in South Africa 2011. Published at http://www.e2.co.za/emgs/phrsa/pageflip.html.(Accessed 24 August 2012).
616 South African Pharmacy Council. 2011. Pharmacy Human Resources in South Africa 2011. Published at http://www.e2.co.za/emgs/phrsa/pageflip.html.(Accessed 24 August 2012).

Table 5-9 Number of registrations with the SAPC: 2006 to 2013

Registration category	2006	2007	2008	2009	2010	2011	2012	2013	AAG %
Basic Pharmacist Assistant	114	140	178	284	437	622	867	1 184	39.7
Learner Basic Pharmacist Assistant	2 191	2 657	2 766	3 146	3 637	3 858	3 807	4 372	10.4
Post-basic Pharmacist Assistant	1 792	2 257	2 443	2 768	3 457	4 159	4 533	5 371	17.0
Learner Post-basic Pharmacist Assistant	944	1 269	1 328	1 381	1 507	1 757	1 693	1 956	11.0
Pharmacist	11 167	11 365	11 905	12 109	11 939	12 346	12 805	13 119	2.3
Pharmacist Intern	474	480	489	372	566	625	619	732	6.4

Source: SAPC, 2013. Published at http://www.pharmcouncil.co.za/B_Statistics.asp(Accessed 3October 2013).

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

By October 2013a total of 2 766 people were registered with the AHPCSA (Table 5-10). Of these, 662 were registered as reflexologists, 647 as chiropractors, and 559 as homeopaths. From 2010 to 2013, the total number of registrations annually dropped by 4.3% from 3 160 in 2010 to the current 2 766. Generally, allied health professionals and complementary practitioners are not employed in the public sector, but they do hope to provide healing services in the NHI service delivery framework currently under development.[617]

617 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

Table 5-10 Total registrations with the AHPCSA: 2010 to 2013

Registration category	Number of persons registered				AAG
	2010	2011	2012	2013	
Acupuncture	130	118	113	99	-8.7
Ayurveda doctor	14	12	14	15	2.3
Chinese medicine	160	153	156	152	-1.7
Chiropractic	578	603	628	647	3.8
Homoeopathy	541	546	565	559	1.1
Naturopathy	92	91	95	89	-1.1
Osteopathy	46	48	49	47	0.7
Phytotherapy	32	39	40	38	5.9
Therapeutic aromatherapy	396	342	306	242	-15.1
Therapeutic massage therapy	194	174	163	146	-9.0
Therapeutic reflexology	900	783	735	662	-9.7
Unani-Tibb	77	81	79	70	-3.1
Total	**3 160**	**2 990**	**2 943**	**2 766**	**-4.3**

Source: AHPCSA, October 2013.

5.7.5 Registrations with the South African Veterinary Council (SAVC)

The number of veterinarians registered with the SAVC grew by 2.8% from 2 769 in 2010 to 3 006 in 2013 (Table 5-11.) Of the support staff registered, 1 039 were registered as animal health technicians, 589 as veterinary nurses, and 260 as veterinary technologists.

Table 5-11 Number of registrations with the SAVC: 2010 to 2013

Registration categories	Number of persons registered				
	2010	2011	2012	2013	AAG %
Veterinarians	2 769	2 842	2 902	3 006	2.8
Veterinary specialists	135	139	147	157	5.2
Animal Health Technicians		1 008	1 043	1 039	1.5
Laboratory Animal Technologists		21	21	21	0.0*
Veterinary Nurses		542	573	589	4.2*
Veterinary Technologists		210	246	260	11.3*
Professionals in training	650	1 693	1 926	2 077	47.3
Total	**3 554**	**4 762**	**6 858**	**7 149**	**26.2**

Source: SAVC, October 2013.
*Average annual growth from 2011.

5.7.6 Registration with the South African Council for Social Service Professions

The registration figures of social workers and SAWs can be seen inTable 5-12. The total number of registered social workers increased on average by 5.9% annually from 10 515 in 2003 to 17 583 in 2012. Registration figures dropped, however, to 15 254 in 2013.

The majority (87%) of currently registered social workers are women. Registered social auxiliary workers (NQF Level 4) increased from 1 297 in 2003 to 3 533 in 2012. This figure dropped slightly to 3 513 in 2013.

Table 5-12 Social workers and social auxiliary workers registered with the SACSSP: 2003 to 2013

Occupation	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Social Workers	10 515	10 645	11 111	11 762	12 252	14 072	14 266	14 904	16 164	17 583	15 254
Social Auxiliary Workers	1 297	1 455	1 591	2 065	2 132	2 577	2 323	2 729	6 648	3 533	3 513

Source: SACSSP, January 2013.

5.8 FACTORS INFLUENCING THE SUPPLY OF SKILLS IN THE HEALTH SECTOR

Apart from the institutional strengths and constraints described earlier in this chapter, a number of other factors also impact, or are set to impact, on the supply of skills in the future. These include poor workforce planning and the absence of an occupational framework for key health professions, government strategies and policy interventions, the management of public sector health facilities, the migration of South African health professionals, the recruitment of foreign professionals, and the socio-economic realities faced by many potential professionals.

5.8.1 Health workforce planning

Health workforce planning is very challenging because of the time required to train health professionals, especially doctors and medical specialists (i.e. 9 years and 14 to 15 years respectively). While the aim is to align supply, demand and need, this is not necessarily achievable; e.g. health professionals may be trained but not accommodated in the health system as a result of budget constraints or frozen posts.

According to the DoH, education and training for the health sector has not kept pace with health needs and requirements of the health system, and the supply of health professionals has not been adequately managed. This is attributed to the lack of planning between the health- and education sectors, as well as inadequate financing to develop and deploy health professionals.[618] A lack of clarity on the roles, responsibilities and scopes of practice in several occupational categories has also continued to affect supply – e.g. clinical associates, several nursing categories and CHWs – while the sector lacks data and information needed for planning of the professional health workforce.[619]

The DoH proposes to introduce a range of measures to improve health workforce planning. It intends to develop databases to support planning and monitoring of the health workforce.Staffing norms, standards and training requirements for clinical health professionals in the fields of physiotherapy, occupational therapy, clinical psychology, dietetics, environmental health, oral hygiene, medical technology, radiography, optometry and pharmacy will also be determined.[620]

5.8.2 Government strategies and policy interventions

Over the last few years government has introduced a number of strategies and plans to improve the supply of health workers. A few of these interventions are discussed below:

a) *Nursing*

Healthcare provision in South Africa is affected by the global shortage of nurses. Both the public and private sectors have suffered losses of experienced nursing professionals who are regarded as essential components in the overall healthcare delivery system. Cuts in provincial health budgets for training, the rationalisation of public nursing colleges (and the subsequent closure and merger of many), and reduced output of specialist nurses have had an adverse effect on the supply of nurses.[621]. The DoH has raised concerns about the clinical education and training of nurses. Many nurses apparently lack sufficient competence in PHC and midwifery. Clinical training departments are no longer in existence in health service institutions, while the supervision and management of learners is also inadequate.[622]

In response to these challenges the SANC and the DoH developed the *Nursing Strategy for South Africa* in 2008to "a*chieve and maintain an adequate supply of nursing professionals who are appropriately educated, distributed and deployed to meet the health needs of all South Africans"*.[623]As outlined in Chapter 3, new nursing categories aligned to revised scopes of practice for nurses were createdand a new qualification framework is under development. Work by a special Ministerial Task Team culmi-

618 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
619 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
620 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
621 Breier, M., Wildschut, A. et al. 2009.*Nursing in a New Era – The Professional Education of Nurses in South Africa;* Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*
622 Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.*
623 DoH. 2008. Nursing Strategy for South Africa. Published at http://www.sanc.co.za/...strategy.pdf.(Accessed August 2010).

nated in the *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*in October 2012. The document outlines strategies to augment the nursing profession to manage the country's healthcare needs.Important elements of this strategy are to re-position nursing education in higher education; develop nurse educators and nurse managers; run programmes to restore the professional ethos of nursing; and address governance, leadership, legislation and policy for the nursing profession. Other interventions will aim to develop positive practice environments[624], improve conditions of service and human resources planning, and set staffing norms.[625]The 2013 National Strategic Plan envisages that nursing colleges will be declared higher education institutions under the Higher Education Act, 2008, a development that will drive the demand for better qualified nurse educators and academics. Government will request the SANC to develop a new accreditation framework for nursing education institutions. Also, strategies will be adopted to strengthen clinical education and training of nurses.[626]

According to the SANC, training under the new qualifications will commence in 2016 and a teach-out period for the legacy qualifications will be provided.[627]Entry requirements for all the new nursing categories differ from those for older qualifications. This may restrict the pool of potential entrants, especially at the level of professional nurse, where a solid pass in Grade 12 mathematics is required.[628]Education and training requirements will be set to meet the new scope of practice and competency requirements for each category of nurse, and curriculum guidelines will be given. Nursing education institutions that offer revised and new nursing qualifications will be accredited, and their capacity will be strengthened to increase the production and quality of nursing graduates on a higher education platform.[629]Plans are underway to re-open nursing schools and colleges and Government has allocated funding to re-capacitate these institutions.[630]The ranks of nurse educators and clinical preceptorswill be developed to improve clinical nursing education and training.Long-term planning by the SANC includes the introduction of a professional licensing examination for all categories of nurses as a registration requirement to enter practice.[631]

Older-cadre nurses will require skills development interventions to upgrade their skills and develop the necessary competencies aligned to the revised scopes of practice.[632]The SANC has identified the need for a bridging course to transition enrolled nurses to the new staff nurse category.

b) *Community service for health professionals*

Compulsory community service in the public sector was introduced for 11 health professions between 1998 and 2007. Newly qualified health professionals serve one year of community service in under-resourced areas to enhance access to healthcare and also to develop their own clinical skills independently from their institutions of training.[633] Each year a number of these health professionals are allocated positions in the SA Military Health Services and the Department of Correctional Services.The creation of academic community service posts in faculties of health sciences are under consideration, while similar proposals have been made for pharmacy schools.[634]While community service alleviatessome skills shortages, public health services are still challenged to retain professionals, especially in rural areas. The attrition rate among community service professionals remains relatively high at around 23.1%. This constitutes a notable loss of trained professionals to the health system, as it is equivalent to the annual output of one medical school.[635]

Veterinarians will be required to perform mandatory community service in the public sector from 2014 onwards, and para-professionals will also do so within the next few years. These measures will address acute skills shortages in the animal health sector.[636]

c) *Salary adjustments*

A few years ago the DoH introduced rural and scarce skills allowances to attract and retain healthcare professionals in areas of greatest need.[637] The introduction of the occupational-specific dispensation (OSD) for health professionals in the public sector was aimed at eliminating salary differentials between the private and public sectors and retaining scarce skills. However the arrangements have been hampered by incapacity in provincial health departments.[638] Inadequate financial planning for OSD

624 According to the DoH "positive practice environments"are healthcare settings that support nursing excellence and decent work, enable quality patient care and improve patient satisfaction, outcomes, and staff retention.

625 Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.

626 Matsotso M.P. and Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.* Published at http://www.hst.org.za/publications/south-african-health-review.(Accessed 11 July 2013).

627 Interview SANC, October 2012.

628 Democratic Nursing Organisation of South Africa. 2010. "Skills development input". Written submission dated 14 December 2010 made to the HWSETA on the draft SSP for the health sector for the period 2011 to 2015.

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

630 DoH 2012.Annual Performance Plan 2012/13 – 2014/15; National Treasury.*2012 Budget Review*.

631 Interview with the SANC in October 2012.

632 Democratic Nursing Organisation of South Africa. 2010. "Skills development input". Written submission dated 14 December 2010 made to the HWSETA on the draft SSP for the health sector for the period 2011 to 2015.

633 DoH. 2006. "Community service to improve access to quality health care to all South Africans". Published at http://www.doh.gov.za (Accessed August 2010).

634 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.

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

636 SAVC. 2012. Interview in October 2012.

637 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".South African Health Review 2008. Health Systems Trust. Published at www.hst.org.za/publications/841. (Accessed August 2010).

638 Bateman, C. 2010. "Occupation-specific dispensation – a hapless tale".South African Medical Journal. May 2010. 100 (5).

resulted in problems: the scheme was under-funded and funds allocated to health services and goods were used to cover the shortfall, thus reducing service delivery.[639] Over-spending on budgets resulted in the non-filling of vacant posts. The DoH will review current OSD arrangements to ensure that appropriate incentives are in place to attract and retain health professionals.[640]

d) *The introduction of mid-level skills*

Supply constraints are hampering the provision of mid-level skills. According to the HPCSA, the training of clinical associates is viewed as a medium-term solution to overcome the acute shortage of doctors and to strengthen access to healthcare at district hospitals. In theory, their presence in the health system will make tasksharing possible and enable better utilisation of high-level medical skills. However, challenges in the health system have hampered the deployment of clinical associates. Theirrolerelative to other health professionals has not been finalised and they are not trained to prescribe medication.[641] Many have been unable to work, as public sector posts were not created or funded. Since clinical associates are required to work under the supervision of a doctor, it is not yet clear whether they will work in the private sector.Uncertainties remain about how the roles of doctors and nurses (especially in rural areas) may change when clinical associates are introduced. The current corps of health professionals will require re-orientation to practise tasksharing, while responsibility for supervision and areas of accountability will have to be delineated.Thus, as these mid-level skills are supplied to the health system, the need for further training and re-orientation across health professions will increase.

Two professions are planning to introduce more proficient MLWs at semi-professional level to better serve the health needs of the population. For this reason the legacy qualifications for enrolled nurses and pharmacy assistant will be replaced with the new staff nurse and pharmacy technician categories.

e) *Community health workers*

In the re-engineered PHC system, health promotion and prevention services will be delivered by CHWs who will be positioned to assist with alleviating the quadruple burden of disease. Their main roles will be to promote maternal-and child health, and to identify at-risk individuals and families who require further interventions, and to improve population health.[642] As outlined in Chapter 3, the ranks of CHWs are disorganised and their skills levels vary. It will be necessary to transition this diverse informal workforce into formal positions (and employment) as part of PHC outreach teams. This will require clarity on the scope of their work, their roles and responsibilities, job descriptions, qualification requirements, employment mechanisms and conditions of service.

At the time of preparation of this SSP, a new Level 3 qualification for CHWs was under development by the DoH, with the HWSETA as the development partner. Since it is structured as an occupational qualification with theoretical- and practical- and workplace learning components, it will be submitted to the QCTO for registration on the NQF. The DoH has developed curricula and approached the HPCSA to serve as the external assessment partner of the qualification. Plans are underway to develop and accredit providers to offer training towards the qualification. According to the DoH, it will also be necessary to structure the qualification as a learnership and to replace the current HWSETA learnerships in ancillary healthcare (NQF level 1) and community health work (NQF level 3).[643]

During the period 2013-2019 an estimated 45 000 CHWs must be re-trained in the new national approach to community-based PHC to serve in the outreach teams.[644]To address this urgent need, the DoH has put together orientation- and skills programmes to train 10 000 CHWs between 2011 and 2013. These programmes focus on maternal- and child health services and the core skills required for the PHC outreach teams. Because these skills programmes are closely aligned to the new occupational qualification, learners will be able to gain recognition for prior learning once they enter accredited courses for the qualification.[645]The DoH as specifically called upon the HWSETA fund these skills programmes in 2013, even though the occupational qualification is not registered yet.

However, skills provision for CHWs may be hampered by the continuing uncertaintyamongst important role-players in the health sector. According to the HPCSA, the occupation of CHW has not been registered and confusion remains about their roles and responsibilities. In particular, the range of services to be delivered by CHWs has neither been finalised and nor has their scope of practice. It appears that CHWs will need a spectrum of skills to monitor the use of complex medication regimes; provide psycho-social support; assist with rehabilitation

Published at http://www.scielo.org.za/pdf/samj/V100n5.(Accessed August 2010).

639 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in *South African Health Review 2010.* DoH. 2011. Human Resources for Health for South Africa 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17.

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

641 Doherty, J., Couper, I. and Fonn, S. 2012. "Will clinical associates be effective for South Africa?" South African Medical Journal. November 2012. 102 (11).Published at http://www.scielo.org.za/scielo... (Accessed 20 July 2013).

642 Interviews with DoH in October 2012; Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

643 Interviews with the DoH in October and November 2012.

644 Matsotso M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.* Published at http://www.hst.org.za/publications/south-african-health-review-2013.(Accessed 11 July 2013).

645 Interviews with the DoH in October and November 2012.

of victims of abuse and crime; provide advice on nutrition and infant care; and offer counselling for a range of conditions and interventions. To the HPCSA it seems that the CHW may have to be trained as "a jack-of-all-trades". Consequently the HPCSA has reservations about the level of the proposed new occupational qualification (i.e. NQF level 3) and suggests that a higher-level qualification (i.e. above NQF 4) may be more appropriate. Questions also remain about where CHWs will be trained since experiential training and supervision will be essential.

The nursing profession is particularly concerned about roleconfusion and roleconflict between CHWs and nurses. The profession maintains that CHWs are neither nurses nor trained in a nursing environment and, in the future, nurses may be required to supervise CHWs in the PHC teams. However, nurses have not been trained to supervise such workers.[646]Public health experts contend that primary care workers will only be effective if the health system attracts them into rewarding jobs.[647]

From a policy perspective, there is also uncertainty about the broader occupational framework where the CHW may be accommodated and whether the occupation will be linked to a profession. The DoH makes reference to the need to regulate CHWs in the context of strategic planning for nursing, but has approached the HPCSA (and not the SANC) to set the external assessments of learners upon completion of their training.[648]Another concern relates to the lack of career paths for CHWs. Stakeholders indicated the need to create clear and structured career pathways linked to qualifications and exit points from training for CHWs and caregivers.[649]It was suggested that CHWs could be trained while gaining work experience in the PHC system, and be enabled to enter the lower steps of the nursing profession, from where they could permeate to higher qualification levels.[650]

f) *Special grants*

Government will make available a number of grants to support the development of healthcare skills. The health professions training and development grant will be paid to provinces to fund operational costs associated with the training of health professionals while also strengthening undergraduate and postgraduate teaching and training processes in health facilities. Specific targets are set to train 38 149 undergraduate students and deploy 1 599 registrars (i.e. medical doctors receiving advanced training in a specialist field) and at least 125 specialists.[651]This grant will also provide for the development and recruitment of medical specialists in under-served areas.A dedicated nursing college/school grant will be allocated to maintain and re-open these training institutions.[652]

g) *Licensing of health professional practices*

The DoH has recommended that in the future health professionals themselves and the physical facility of their practice should be licensed for the professional and the service functions to be performed at the site.[653]Further details are not available, but such an intervention will enable Government to manipulate the supply of skills while also controlling the location of where health professionals may render their services.In addition, Government intends to develop regulatory strategies to improve access to health professionals in rural and remote areas.[654]The SAPC also called for a moratorium to be placed on the issuing of pharmacy licences to allow the Council and the DoH to map needs across all provinces, sectors and pharmacy categories.[655]

5.8.3 Education and training of health professionals

Education output of most health professions, and specifically of medical doctors, has remained stagnant over the past 15 years. As highlighted in paragraph 5.3.1, posts for academic clinicians have reduced as a result of budget cuts, and hence academic capacity for clinical training and clinical research has been reduced. In addition, registrar and sub-specialist training posts remain at 30% and 75% unfilled respectively, largely because of a lack of funding. This restricts the number of medical specialists that are trained.Similarly, budget cuts and the lack of public sector posts have limited the development of specialists in the therapeutic sciences. The training of MLWs is hampered by sub-optimal planning as this has not been integrated into the higher education platform.[656]

Another factor affecting supply is the cost and time to train health professionals who are trained on an academic-, clinical-, and workplace platform. The cost to the public sector of training health professionals is notably higher than for other education and training programmes. This is mainly due to the nature of clinical training, which requires a low academic clinician to student ratio, the time required in such training and availability of equipment, technology and clinical infrastructure.[657]Government has

646 Interview with the SANC in October 2012.
647 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*.
648 Interviews with DoH in October: Department of Health. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.
649 Interviews with HWSETA stakeholders held in October 2012 in preparation of this SSP.
650 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care" in Barron, P. and Roma-Reardon, J. (eds). *South African Health Review 2008.*Published at www.hst.org.za/publications/841.(Accessed August 2010).
651 Department of Health 2012.Annual Performance Plan 2012/13 – 2014/15.
652 Department of Health 2012.Annual Performance Plan 2012/13 – 2014/15.
653 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
654 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
655 SAPC. 2011. *Pharmacy Human Resources in South Africa 2011*.
656 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
657 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

pressurised all medical schools to increase their student intake, but has not provided the considerable resources needed to expand clinical training platforms.[658]It is also a slow process to increase the supply of health professionals. For example, to produce 1 053 extra MBChB graduates annually (in addition to the current 1 300) by 2025, requires increasing the enrolment of medical students from 8 589 to 15 549 (a doubling of the current medical training platform).[659]Training of South African medical students also takes place abroad through arrangements with the Cuban government.

According to the SAPC, limited resources in pharmacy schools hamper access to training. Since there are only a limited number of pharmacies and tutors available that are capable of training pharmacist interns, it may be necessary to develop a revised training model for pharmacists.[660]In the nursing field, nurse educators face several challenges. Their numbers have declined due to improved public sector remuneration while many have reached retirement age. Insufficient numbers of educators are required to train a growing student corps and to absorb a greater workload. Provision of CPD is inadequate and this impacts negatively on the quality of teaching, supervision of clinical training, and the skills needed to apply new technologies.[661]

The DoH has recognised the formative and essential role of health educators and academic clinicians. Measures will be introduced to strengthen the health education sector.[662]Short-term strategies include an assessment of HEI programmes at undergraduate and postgraduate levels in the clinical and non-clinical professions; the development of various databases to plan and monitor the employment of health academics and registrars;[663] the identification of additional financing for the education and training of health professionals; and the development of a national framework for academic clinicians who also provide clinical services at provincial hospitals.[664]Specific interventions will aim to strengthen academic health complexes, through additional financing for teaching, research and service. Local and foreign recruitment of academic clinicians will be stepped up and faculties of health sciences will be required to actively plan the development of academic clinicians. New campuses and service sites in rural and peri-urban areas will also be developed. Curriculum planning will be aligned to the re-engineered PHC model and reviewed to address the burden of disease and the use of new technology. Steps will be taken to standardise the quality of clinical training offered by HEIs and to set minimum requirements for output.Training infrastructure and career paths will also be developed for CHWs and MLWs. It will also be necessary to provide professionals with the requisite skills to work alongside non-professionals (e.g. ancillary and support workers) in integrated health teams.[665]

5.8.4 Migration of professionals

Emigration of professionals and their migration from the public sector to the private sector directly impact on healthcare delivery and outcomes. Research has identified a number of factors that contribute to increased emigration in the healthcare sector – including remuneration, working conditions, job satisfaction, medical infrastructure, safety and risk of disease, along with more general concerns about political instability, crime, and standards of service delivery.[666]

Lack of posts in the public sector as well as budget constraints to fill vacant public sector posts contribute to attrition and migration. Although the numbers of health professionals in the public sector have grown since 2002, both newly qualified and postgraduate health professionals have difficulty finding jobs in the sector.[667]When graduate output is compared with the increase in public sector posts for the period 2002 to 2010, it is evident that graduates from faculties of health sciences are not absorbed into the public health sector, as is illustrated in Table 5-13below:

658 Interview with HPCSA in October 2012.
659 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
660 South African Pharmacy Council. 2011. *Pharmacy Human Resources in South Africa 2011*. Published at http://www.e2.co.za/emgs/phrsa/pageflip.html(Accessed 24 August 2012).
661 Interviews with stakeholders in October 2012; DoH. 2012. *Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17*.
662 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17..
663 Registrars are medical doctors who are undergoing advanced training in a specialist field.
664 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
665 Frenk, J., Chen, L. et al. 2010. *Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world*. Cambridge, Massachusetts: Harvard University Press.
666 Ramjee, S. and McLeod, H. 2010. "Private sector perspectives on National Health Insurance" in South African Health Review 2010.;Macheke, C. 2010. *HWSETA Health Sector Baseline Study*.
667 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

Table 5-13 Retention gap for professional graduates, 2002-2010

Profession	Graduate output	Public sector post Increase	Retention gap	Retention gap
	N	N	N	%
Medical doctors	11 700	4 403	7 ,297	62.4
Dentistry	2 140	248	1 892	88.4
Pharmacy	3 645	1 960	1 685	46.2
Physiotherapy	2 934	497	2 437	83.1
Occupational therapy	1 827	410	1 417	77.6
Speech-language pathology and audiology	1 413	265	1 148	81.2
Dietetics	657	502	155	23.6

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

The analysis shows that while 11 700 doctors graduated between 2002 and 2012, the number of doctors employed in the public sector only increased by 4 403. Low absorption rates are noted for the therapeutic sciences (physiotherapy and occupational therapy) because of the lack of public sector posts.

Burnout due to a combination of workload, under-staffing, lack of resources, high-risk working conditions, poor local hospital management, and dysfunctional administration is another factor contributing to public-private sector migration.[668]Doctors and nurses are often ill-prepared to work in PHC facilities and complain of poor support while they work there.[669]In an attempt to address the difficult working conditions, two trade unions – DENOSA and Solidarity – are calling for the introduction of legally enforceable nurse/patient ratios to bring nurses back to practice and to boost training outputs.The implications are that if the nurse/patient ratio is reached, patients will either wait to be admitted, or be refused treatment, or wards in under-staffed hospitals and facilities will have to close in order to reach the prescribed nurse/patient ratios.[670]

South African health professionals are a sought-after resource.[671]By 2007 more than 20 foreign commercial recruitment agencies were working locally to recruit and place South African health professionals overseas.[672]As part of a broader strategy to address skills supply challenges, the DoH plans to establish a national recruitment and retention unit to ensure and oversee recruitment, retention and equitable distribution of professionals for the health sector.[673]

5.8.5 The impact of HIV/AIDS

Workers in the health sector are required to treat, counsel and care for patients infected with HIV/AIDS. Unlike workers in other sectors who risk HIV infection due to human and social behaviour, health workers are exposed to additional infection risks in the workplace daily. The nature of their work makes them more vulnerable to infection risks from HIV and tuberculosis. Surveys have found that as many as 46% of in-hospital patients in the public sector may be HIVpositive, while more than 36% of private sector patients are infected. Exposure to these conditions increases the risks of illness and premature death among staff and adversely affects worker morale.[674] In turn, service delivery in the health system is affected by absenteeism, loss of skills due to preventable deaths, and the risk of neglect as a result of increased patient load.[675] During interviews with NGOs serving the health and social development sector, respondents confirmed that large numbers of volunteers take ill, and that the organisations have to constantly train more people to replace those who leave.

By 2002 an estimated 15.7% of health workers employed in the public and private sectors were living with HIV/AIDS. Among younger health workers in the age group 18 to 35 years, the risk of infection was higher and the estimated HIV prevalence was 20%. Non-professionals had a higher HIV prevalence of 20.3% compared to professionals at 13.7%.Studies have recorded a high HIV prevalence among nurses at 16%. Of the total number of health workers who died between 1997 and 2001, it was estimated that 13% died from HIV/AIDS-related illnesses.[676],[677]

668 Bateman, C. 2007. "Slim Pickings as 2008 Health Staff Crisis Looms". *South African Medical Journal*. Nov 2007. 97(11).

669 Coovadia, H., Jewkes, R., et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet.September 2009; Day, C. and Gray, A. 2008."Health and Related Indicators".South African Health Review.Published at http://www.hst.org.za/... (Accessed August 2010).

670 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". South African Medical Journal. August 2009. 99 (8).Published at http://www.scielo.org.za/pdf/samj/V2009n8.(Accessed August 2009).

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

672 Bateman, C. 2007. "Slim Pickings as 2008 Health Staff Crisis Looms". *South African Medical Journal*. Nov 2007. 97 (11).

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

674 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".South African Health Review. Health Systems Trust. Published at www.hst.org.za/publications/841.(Accessed August 2010).

675 Shisana, O., Hall, E., Maluleke, J. et al. 2004. *The Impact of HIV/AIDS on the Health Sector – National Survey of Health Personnel, Ambulatory Patients and Health Facilities, 2002*.

676 Shisana, O., Hall, E., Maluleke, K.R. et al. 2004. *The Impact of HIV/AIDS on the Health Sector – National Survey of Health Personnel, Ambulatory Patients and Health Facilities, 2002*; Shisana, O. Hall, E., Maluleke R. et al. 2004. "HIV/AIDS prevalence among South African health workers.*South African Medical Journal* October 2004. Vol. 94 (10).

677 Macheke, C. 2010. *HWSETA Health Sector Baseline Study*; 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.

5.8.6 Recruitment of foreign health workers

Since 1994 the DoH has entered into bilateral agreements with foreign governments (including Cuba, Iran, Tunisia, Germany and the United Kingdom) to recruit and employ foreign doctors in the public health sector. Priority has been given to doctors from Cuba and by mid-2011 the agreements with the other countries had not been fully activated.[678]Concerns were raised recently that a substantial number of foreign-qualified doctors (about 300) are available to serve in the public sector, but that bureaucratic delays (specifically registration with the respective professional councils) are preventing their deployment.[679]

According to the DoH, the longer-term policy was to limit the recruitment of foreign doctors to 6% of the medical workforce, but that they comprised 10% of the medical workforce by 2011.[680] However, from 2012foreign recruitment of health professionalswasstepped up in the short term, especially for rural areas. Priority will be given to academic health professionals who will train, transfer skills and develop innovative care interventions, and to clinicians who are willing to work in rural areas. [681] During 2013, a further 95 medical specialists will be recruited from Cuba to serve public sector needs.[682]

The recent HRH Strategy for the Health Sector 2012/13-2016/17 recommends that the DoH should review foreign recruitment policies to draw more health professionals, and also attract locally trained persons back from abroad. Other potential policy interventions include staff exchanges between health facilities (i.e. structured temporary development opportunities); twinning (i.e. establishing links with foreign hospitals to support resources locally) and educational support (foreign educators or educational resources move temporarily to hospitals and training facilities in South Africa); as well as bi-lateral agreements between a local and foreign health facility to train and develop staff.[683]

The SAPC also requested the DoH to recruit foreign qualified pharmacists for the public sector, especially from SADC countries.[684]

678 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
679 Bateman, C. 2010. "Ham-fisted policies, overworked officials put foreign doctors 'on ice' ". South African Medical Journal. March 2010. 100 (3).Published at http://www.scielo.org.za/pdf/samj/V100n3.(Accessed August 2010).
680 DoH.2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.
681 Department of Health. 2010. "Health Sector Strategic Framework: The 10 Point Plan" in the *Strategic Plan 2010/11-2012/13.*; National Treasury. 2010. "Vote 15: Health". *Estimates of National Expenditure 2010.*
682 Matsotso M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.*Published at http://www.hst.org.za/publications/south-african-health-review-2013.(Accessed 11 July 2013).
683 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
684 SAPC.2011. Pharamcy Human Resources in South Africa 2011.

5.8.7 Management of the public sector health facilities and health workforce

The DBSA Road Map process found that many of the human resource problems in the public sector arise from institutional problems in the public sector itself.[685] Health sector analysts believe that the most effective short-term response to the crisis of human resources is to use existing resources better. This means improving the management of health systems.[686] Better outcomes achieved by poorly resourced districts compared with those of well-resourced districts are attributed to effective management.[687]

Institutional factors such as poor planning, sub-standard clinical care, poor governance, inadequate management systems, lack of effective controls, low levels of organisational responsibility for actions and failures, and inadequate devolution of authority to make effective operational decisions about patient care all have an impact on how effective skills are deployed.[688] The effectiveness of skills development and training programmes for middle- and senior managers is compromised, as working environments are not conducive to change and innovation.[689] National-level attempts to develop effective management-training programmes for managers have not achieved the desired success and it is suggested that HEIs should deliver appropriate courses at local level.[690]Government established the Leadership and Health Management Academy in October 2012 to develop leadership and management capacity in the public health sector.[691] Draft regulations published in 2012 require that every hospital CEO must be a graduate in a health-related field and preferably also hold a management qualification.[692]

Other research has found that poor treatment of doctors and other health professionals in the public sector was the major reason for them leaving the public sector and

685 Development Bank of South Africa. 2008. *A Roadmap for the Reform of the South African Health System*.
686 Quotation from Rajat Gupta, Board Chair of the Global Fund to fight AIDS, Tuberculosis and Malaria in Rispel, L. 2011. "Understanding demand and supply of health services: managing the health workforce". ERSA Symposium on health reform, Stellenbosch, 1 July. Published at http://econrsa.org/home/...=54&Itemid=61.(Accessed 20 August 2011).
687 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" in *South African Health Review 2010*.
688 Harrison, D. 2009. An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. Development Bank of South Africa. 2008. *A Roadmap for the Reform of the South African Health System.*
689 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care".*South African Health Review.*
690 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system" inSouth African Health Review 2010.Published at http://www.hst.org.za/publications/south-african-health-review-2010.(Accessed 19 August 2011).
691 Matsotso M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months" in *South African Health Review 2012/13.*Published at http://www.hst.org.za/publications/south-african-health-review-2013.(Accessed 11 July 2013).
692 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation" in South African Health Review 2012/13.Published at http://www.hst.org.za/publications/south-african-health-review-2012/13. (Accessed 13 July 2013).

the country.[693] If this situation does not improve quite significantly other interventions to retain staff and to increase the supply of skills may prove to be ineffective.

In recognition of these challenges, Government will adopt measures to improve the working environment of the health workforce. Management and leadership in the health sector are viewed as primary priorities to improve the motivation and abilities of healthcare professionals. The DoHand provincial health departments will address a series of interdependent matters, such as job design, performance management, remuneration, employment relationships, the physical work environment and equipment, workplace cultures and practices, facility workforce planning and career pathways.[694]

In addition, measures will be introduced to actively manage the health workforce. Specific strategies are under development to secure supply, meet the demand for services, enable access, and to attract and retain graduates in the public and private sectors. In the shortterm enhanced support will be given to community service professionals while their retention in the public sector will be encouraged. Minimum staffing norms and workload analysis will be used to guide planning and the freezing of critical posts will be re-visited. Over the medium term the DoH will link the growth in posts to service, staff planning and budgets. Efforts will be made to align education strategies (supply of health workers) and employment (demand) in both public and private sectors. A rural health strategy to attract and retain health professionals in rural areas will also be developed.[695]It is also envisaged to contract private sector health professionals to work in the public sector and to develop incentives to retain health professionals in PHC services.

5.8.8 Socio-economic realities of potential learners

Lastly, prevailing socio-economic realities and the lack of equal educational opportunities for differing population groups continue to impact on the number of black African learners who enter the health professions. Long training periods mean that aspiring health professionals forego earning an income for many years and this deters people, especially persons from lower socio-economic positions, from entering the professions. The relatively high costs of education in the health sciences, compared with other tertiary programmes, may also affect the supply of skills.

693 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care" South African Health Review 2008.Published at www.hst.org.za/publications/841.(Accessed August 2010).
694 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
695 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

5.9 FACTORS INFLUENCING THE SUPPLY OF SKILLS IN THE SOCIAL DEVELOPMENT SECTOR

Several factors influence the supply of skills to the social development sector, including gaps in policy development, the absence of an occupational framework for social services, the capacity of HEIs, government policies and the availability of workplace training. These factors are considered below.

5.9.1 Policy gaps

The new statutory framework for social services demands services from occupational groups that are not yet formally recognised or organised.[696]According to the Children's Act, 2005 a "social service professional" includes a probation officer, development worker, child and youth care worker, youth worker, and a registered social auxiliary- andsocial security worker who are registered as such in terms of the Social Service Professions Act, 110 of 1978.[697] Social workers are excluded from the definition but are defined separately. This may be an oversight, especially since social workers are regarded as the key delivery agents of social development services.[698]Although new categories of workers have been identified in legislation and policy documents, Government and key role-players have not identified which cadres of workers should be developed and deployed.[699]

At present the statutory framework for social service occupations only recognises social workers and SAWs.The Professional Board for Child and Youth Care at the SACSSP was established but, as a result of challenges in the sector, it was not operational for several years.Renewed efforts were underway in 2012 to revive this Boardand in March 2013 the new Board members were inaugurated.[700]

5.9.2 Absence of a broader occupational framework

Although the SACSSP has taken steps to categorise more social service professions and occupational groups, progress has been slow and proposals are still under

696 Loffel, J., Allsopp, M., Atmore, E. and Monson, J. 2008. "Human resources needed to give effect to children's right to social services" in *South African Child Gauge 2007/08*.
697 The Children's Act appears to include more occupational categories than those currently controlled by the SACSSP in terms of the Social Service Professions Act, 110 of 1978 as the latter Act only permits the registration of social workers and social auxiliary workers, as well as students/learners in the respective categories.
698 Loffel, J., Allsopp, M., Atmore, E. and Monson, J. 2008. "Human resources needed to give effect to children's right to social services" in *South African Child Gauge 2007/08*.
699 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).
700 South African Council for Social Service Professions. 2013. SACSSP E-News. April 2013. Vol 2(2).Published at: http://www.sacssp.co.za/website/wp-content/uploads/2013/01/SACSSP-E-News-April-2013v2.pdf(Accessed 7 August 2013).

development.[701]Government has indicated the need to diversify the social services occupational groups and to recognise them formally. During 2012, a DSD task team was working on a draft policy for social services practitioners to guide the development of new legislation and aninstitutional framework for human resources in the sector. The intention is to develop anHR model that provides for different social services occupations, as well as their roles and responsibilities, scopes of practice, competencies, qualifications and registration requirements.[702]The future model will also define delivery units for social welfare services, including teams of practitioners, administrative support, supervision and management. A need also exists to develop an occupation-specific dispensation for care workers and to recognise their status in order to improve the skills base in the sector.[703]

During interviews held to prepare this SSP, several stakeholders expressed their concerns about role conflicts between social workers and SAWs, and that this affects services delivery. It is hoped that an occupational framework will bring more clarity about the respective roles and responsibilities.According to the SACSSP, a new NQF level 5 qualification for SAWs will replace the FET-level qualification and will be registered by the QCTO. During 2013 the Professional Board for Social Work of the SACSSP was developing standards to meet QCTO requirementsfor the qualification.[704]

By early 2012 only two areas of specialisation in social work had been developed, namely adoptions and probation social work. Other areas of specialisation under development include forensic social work and occupational social work. The SACSSP is also working to possibly develop further areas of specialisation – social work in education, school social work, and social policy and planning, as well as management and supervision.[705]It has been mooted that a postgraduate qualification will be required in future before social workers will be permitted to specialise in a field of social work.

701 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa. Published at http://www.uj.ac.za/.... (Accessed 20 August 2011); South African Council for Social Service Professions. 2012. SACSSP Newsletter. May 2012. Vol.1 (1).Published at: http://www.sacssp.co.za/website/?page_id=192.(Accessed 24 August 2012).

702 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

703 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/... (Accessed 20 August 2011).

704 South African Council for Social Service Professions. 2013. SACSSP E-News.December 2012-January 2013.Published at: http://www.sacssp.co.za/.../Newsletter-v2.pdf.(Accessed 7 August 2013); South African Council for Social Service Professions. 2013. Newsletter Feb-Mch 2013. Published at:http://www.sacssp.co.za/...Newsletter-Feb-2013... (Accessed 7 August 2013).

705 South African Council for Social Service Professions. 2012. SACSSP Newsletter. May 2012. Vol.1 (1).Published at: http://www.sacssp.co.za/website/?page_id=192.(Accessed 24 August 2012); SACSSP. 2012. Mapping of Specialities.

5.9.3 Extended Public Works Programme

The Sector Skills Plan (SSP) for the EPWP 2011 to 2014 outlines a major scaling up of the programme, with a target of 4.5 million job opportunities by 2014. A range of training opportunities will be offered to 125 000 workers in community care- and personal care occupational categories. These include learnerships, skills programmes, non-accredited courses, and bursaries. Training will be provided to 125 000 unemployed people in areas relevant to the health and social development sector:

a) Learnerships up to levels 4 and 5: ABET and ECD practitioner training, nursing, pharmacy, child and youth care, ancillary healthcare, psychosocial support, community healthcare, assistant probation service, social auxiliary work, assistant pharmacy work, youth development work, and community development work;
b) Skills programmes: child and youth care, emergency care technician, reflexology, human physical development and sexuality, project management, care for people with disabilities, child care, counselling, and bookkeeping; and
c) Non-accredited courses: toy making, needlework, knitting, cooking, first aid, candle making, bead making, basic health promotion, principles of hygiene, frail care, life skills, HIV counselling, personal finance management, and team work.

Recent research has found that the skills developed as part of the EPWP are often not retained in the social development sector. This is attributed to structural issues, as unskilled, unemployed workers are given new competencies and leave once the sector cannot retain them as salaried workers.[706]

5.9.4 Capacity of higher education institutions

Although the number of social work graduates increased over the last five years or so, the supply to the sector is still insufficient. The increased enrolment of social work students has put pressure on student-lecturer ratios at training institutions. Currently, universities and institutions of higher learning have the capacity to accommodate 3 040 social work graduates per annum.[707]The DHET also caps student intake based on the available infrastructure, training facilities and teaching posts.

According to the DSD a number of factors continue to impact on the capacity of academic institutions and so too on the output of social services professionals.Government subsidies to tertiary institutions for social work are lower than for certain other fields of study (which require

706 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa. Published at http://www.uj.ac.za/EN/Faculties/humanities/researchcentres/csda/research/.(Accessed 10 September 2012).

707 HWSETA. 2011. *Sector Skills Plan for the Social Development Sector in South Africa.*

similar academic inputs). To produce quality graduates capable of dealing with the challenge of social work practice in South Africa, there is a need to train students in small groups and to provide individual supervision for them in fieldwork placements. Academic departments struggle to cope with training demands and the growing student numbers against the present subsidy formulae. Lecturers who leave academia are often not replaced. Many difficulties arise to place and maintain students in fieldwork placements that provide them with practical training.

Another concern relates to inadequate selection processes at HEIs. According to the DSD, candidates apply for admission to social work programmes for the wrong reasons. Many candidates access bursaries for social work,although they are not committed to study and work in the field. One respondent feared that some candidates viewed the bursaries as "their tickets out of poverty". Academic criteria for admission to social work programmes are generally in the lower ranges – typically a 50% pass in Grade 12, and so candidates expect to enter a "lighter" academic programme.[708]The dropout rate of undergraduates in social work remains high, especially among distance learners.

5.9.5 Limited access to workplace training

Academic institutions are increasingly challenged in placing final-year social work students in the field. Workplace training providers often lack the resources to take in students and to provide adequate supervision. High staff turnover in organisations depletes skills and the remaining social workers are often too inexperienced to supervise social work students. Some social workers in the field have not kept abreast with developments in the profession and are not sensitive to students' learning needs and are thus unable to provide students with the required support.

Community carers deployed in EPWPs require training in home- and community-based care as well as ECD. Although a learnership is available, there has been limited access. Workplace training is provided by NPOs, which often fund their own training (or receive limited help from government) and are hampered by resource constraints and administrative problems.[709]Many NPOs also lack the funds, capacity and infrastructure to accommodate learners in formal learnerships such as the Level 4 learnership in social auxiliary work.[710] While a number of NGOs provide training to health and social development workers, most lack the capacity to seek accreditation. There are also significant capacity weaknesses in training provision in the sector when compared with projected demand.[711]

5.9.6 Government initiatives to improve supply

Government has several initiatives to improve the supply of skills in the social development sector.[712] As part of an active recruitment and retention strategy, the DSD is working to improve the remuneration and working conditions of social workers. Full scholarships to social work students are provided and in 2012/13 a total of 6 339 students were sponsored at various universities.[713] By 2011 the programme had produced 2 086 graduates who were employed across all nine provinces.[714]However, the absorption by Government of the newlytrained social workers has been slow because of budget constraints and the non-availability of public sector posts. Government approached NGOs to deploy unemployed social work graduates, but given the vast differences in remuneration structures, many candidates have been reluctant to work for NGOs.[715]By 2015/16 the number of students who will receive financial assistance from the DSD will drop to 4 248.[716]

The DSD is driving the training of community development workers to facilitate effective community development processes. A skills audit in 2009/10 identified the need to for training in research and analysis, project management, conflict management, human resources management, budgeting, effective writing skills, and computer literacy. Plans are underway to establish community development as a profession and to introduce an occupational framework for community development. The DSD is working with HEIs to support the implementation of community development qualifications at NQF levels 5 and 8 by 2014/15.[717]To facilitate formal recognition of skills, the DSD will support the development and implementation of a RPL model for community development. Targeted training programmes in community development practice will also be offered to 1 400 CBOs over the period 2013/14 to 2015/16.

The DSD has also introduced measures to improve the delivery- and governance skills of CSOs, and by 2014 a

708 Interview with Prof. Antoinette Lombard, Head of Department of Social Work, University of Pretoria in October 2012.
709 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.Published at http://www.uj.ac.za/EN/.../researchcentres/csda/publications.(Accessed 20 August 2011).
710 Earle-Malleson, N. 2008. "Social workers", in Kraak, A. and Press, K. (eds). Human Resources Development Review 2008: Education, Employment and Skills in South Africa.
711 Macheke, C. 2010. HWSETA Health Sector Baseline Study. Johannesburg: The Growth Laboratory and HWSETA.
712 Loffel, J., Allsopp, M., Atmore, E. and Monson, J. 2008. "Human resources needed to give effect to children's right to social services" in *South African Child Gauge 2007/08*.
713 National Treasury. 2013 "Vote 19: Social Development". *2013 Estimates of National Expenditure.*
714 National Treasury. 2011. "Vote 19: Social Development". *2011Estimates of National Expenditure*.
715 Perspective conveyed during personal interviews held in October 2012 by the HWSETA with the DSD, Child Welfare SA and Family Life (branch of FAMSA) and academics involved in the training of social workers.
716 National Treasury. 2013 "Vote 19: Social Development". *2013Estimates of National Expenditure.*
717 Department of Social Development. 2013. *Annual Performance Plan 2013/2014*.Published at http://www.dsd.gov.za.(Accessed 15 July 2013).

total of 25 000 persons will be trained in the provisions of the Non-Profit Organisations Act, 71 of 1997 and governance practices.[718]

Under the *Isibindi* programme of the DSD some 10 000 unemployed people will be trained as child and youth care workers (CYCWs) to assist orphans and vulnerable children in their homes and schools, and to access health- and government services.[719]The public sector has embarked on a huge drive to bring back retired social workers to mentor young social services professionals. This is proving challenging, as the older cadres were trained under different curricula for different roles while the young professionals are required to provide developmental social services in a rights-based context.[720]

Financial constraints and the limited number of accredited training providers hamper efforts to train CHWs and caregivers.Recently the DSD developed three accredited skills programmes in psychosocial support, child protection and supportive supervision to train caregivers in the core areas of their work and to provide them with coping skills in a very stressful environment. The DSD will request the HWSETA to allocate funding and to increase the number of accredited training providers for these programmes.[721]

5.9.7 Measures to enhance professionalism

The recently published norms and standards for social services practitioners promote professionalism and set benchmarks for practice. These include requirements for basic qualifications, professional registration, compliance with codes of conduct, adherence to work scope, and participation in CPD.[722]The SACSSP, the statutory body responsible for regulating social work, introduced a CPD policy to ensure that professionals keep pace with developments and advances in their disciplines and fields of practice. All registered persons (excluding learners) are required to obtain a minimum of 20 CPD points annually and to keep portfolios of evidence of their learning activities and the credits attached to each. The SACSSP is empowered to monitor and assess these portfolios.

The DSD has also devised norms and standards for the structured supervision of social welfare practitioners and students, including norms for the qualifications, practical experience, skills levels and duties of supervisors.[723]These generic norms and standards for social welfare services were finalised late in 2012 and implementation is expected during 2013/14.[724]The DSD has also commenced a process to improve HR management in the welfare sector. Providers of social welfare services will be required to set policies for recruitment and retention of staff, training and development, conduct,maintaining staff levels,performance, and working conditions.[725]In addition, providers will also be obliged to offer professional support and development to social welfare practitioners in the form of structured training, personal development plans and debriefing sessions to advance their health and mental well-being.[726]Interim standards and norms have been set for the span of control over social service practitioners to enable adequate supervision and facilitate consultation.

5.10 CONCLUSIONS

A combination of complex factors influences the supply of skills to the health sector. At the heart of the problem are the number 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. 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.

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 SACP 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 due to constraints in clinical training platforms; the numbers of health educators and health academics; infrastructure and equipment; and budgets. However, the strengthening of academic medicine and health training platforms is a key strategic area for the DoH. Measures will be introduced to improve the management of academic resources. Opportunities to train healthcare professionals in the private sector are also limited, as private HEIs appear to be challenged in

718 Department of Social Development. 2011. Strategic Plan 2011/12 – 2013/14.
719 National Treasury. 2012. "Social security and national health insurance". 2012 Budget Review; Department of Social Development. 2012. Strategic Plan 2012-2015.Published at http://www.dsd.gov.za.(Accessed 10 August 2012).
720 Interviews with DSD, October 2012.
721 Interviews with DSD, October 2012.
722 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
723 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
724 South African Council for Social Service Professions. 2013. Newsletter February-March 2013. Vol 2(2).Published at:http://www.sacssp.co.za/...Newsletter-Feb-2013-PDF.pdf.(Accessed 7 August 2013).
725 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
726 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

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.

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 HEIs in health-related fields over the medium- to longer term. Between 2010 and 2011 the total output from the HET sector in the health-related fields of study grew on average by 0.7% at first three-year B Degree level and at 5.7% at first four-year B Degree level. However, comparative analysis reported in the previous HWSETA SSP for the period 2012-2017 showed that, with the exception of basic healthcare sciences, the growth in supply of new graduates from the higher education system has been moderate, and even low, over the last decade. Total output from nursing colleges reached 17 963 in 2011, and has increased on average by 8.3% per year since 2002, while the number of pupil nurses has risen sharply since 2008.

Growth in the registration of health professionals with their respective professional councils has been slow since 2000 and in some instances lower than the growth rates in graduates produced for the particular professional category. For example, from 2002 to 2011 the annual average growth rates of nursing graduates in the four-year- and bridging programme were 7.4% and 6.5% respectively, while from 2000 to 2011 the annual growth in SANC registrations in the category of registered nurses was only 2.2%.

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 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.

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 MLWs, their roles in healthcare teams and 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.

In order to provide the sector with better skilled practitioners, 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 FET- 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.

Skills formation for the social development sector takes place via direct entry from school, after school via learnerships, and after completion of higher education. Volunteer workers may also enter the sector via EPWPs and via NPOs through informal training and work experience. Although “academic-stream” subjects such as mathematics and science at Grade 12 level do not present barriers to entry into the social development sector, the personal characteristics of learners in respect of well-developed communication skills, personal trustworthiness, and a desire to serve others are important.

The number of social work graduates has grown substantially over the last ten years, as did the number of registered social workers. However, the educational infrastructure is under great pressure and it is unlikely that the growth that is needed to supply social workers for the country’s needs can be sustained. The main constraining factors are practical placements for final-year social work students and supervision capacity of practice supervisors. Placing undergraduate students in suitable workplace training is becoming increasingly challenging, mainly because of limited resources in social services organisations and CSOs. Access to learnerships in the social development sector is also hampered because NPOs, the main delivery channel for social services, lack the infrastructure, funds, and human resources to accommodate learners. While the availability of bursaries has boosted the numbers of social work graduates, screening or selection processes to identify candidates with the desired attributes for social services appear inadequate. As a result, the retention rate of new professionals in the sector is too low. More recently, the absorption of new social work professionals in the public sector has been impeded by budget restrictions and the absence of positions.

It is anticipated that the introduction of new generic norms and standards for social welfare services and a higher education qualification for SAWs will impact directly on training and skills development needs of thousands of workers in the social development sector.

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 2011/12 more than 9 400 learners had completed learnerships, and were recorded on the HWSETA’s electronic system. Many more completed learnerships that are quality-assured by professional councils and their achievements are recorded by the councils and not by the HWSETA. The SETA also supports skills development through internships and workplace training programmes, skills programmes,

scholarships, ABET, partnerships with other role-players, and small-enterprise development.

Measures to increase the number of health and social work professionals are only part of the challenge to increase the supply of skills. Other challenges relate to up-skilling and re-skilling the existing workforce to adopt new roles and scopes of practice, and to implement practices such as taskshifting and tasksharing to improve the basis for service delivery.

Health workers and community caregivers risk exposure to HIV/AIDS in the workplace and face increased risks of contracting the disease compared with workers in other sectors. By 2002 the prevalence rate of HIV/AIDS among health workers was 15.7%, much higher than the national prevalence rate at the height of the pandemic in 2010. As a result of AIDS, skilled health workers and community caregivers leave the sector prematurely – either because they fear infection, become ill themselves, or need to care for others who fall ill.

Delays in establishing effective regulatory frameworks for several professions and evolving occupational categories have also impacted on skills formation for the sector, especially in nursing and social services fields such as ECD, and child and youth care. Skills development of CHWs and CCWs is required on an extensive scale to incorporate them into PHC teams. However the supply of skilled CHWs and CCWs 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.

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 information presented in this chapter shows that unless major improvements in leadership and management of the health system at all levels are made, migration of health professionals out of the public sector and emigration to other countries are 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 regulatory frameworks for such professions and occupations. For as long as those arrangements are not in place, efforts to supply critical skills for healthcare and social development will be hamstrung.

6

Skills Development Priorities of the HWSETA

6.1 INTRODUCTION

Throughout this SSP the health and social development sector has been portrayed as a sector faced with enormous challenges. Evidently skills problems are at the heart of many of these challenges. The nature and magnitude of the challenges are such that they can only be addressed through a very concerted and, as far as possible, integrated effort of a host of role-players. These role-players include the provincial and national departments of health and social development, the public higher education and training sector, private education and training providers, public and private health facilities, NPOs, and the HWSETA.

As the HWSETA is only one of a number of institutions tasked with the funding and provision of skills development for the sector, it is important to outline the specific role that the SETA will play in terms of skills development. At the same time the SETA forms part of the institutions that are required to deliver on the NSDS III and to support various government initiatives, including the National Development Plan, to stimulate employment growth and to expand the skills base of the country.

This chapter starts with a discussion of the main priority areas that the HWSETA will focus on in the coming five years. The programmes according to which the SETA's activities are structured are then outlined.

The rest of the chapter discusses the various policy imperatives that are driving skills development initiatives and indicates how the HWSETA will contribute to and support the various national policies, plans and other government initiatives. Attention is given to the President's outcomes approach to planning government's work and how the HWSETA will assist in attaining the high-level performance targets set for the Minister of Higher Education and Training. The SETA's contribution to Government's objectives for development and economic growthas stated in the National Development Plan are discussed, and in particular: the contribution to government's MTSF objectives; the contribution to the strategic areas of focus for the NSDS III; the contribution to the Human Resource Development Strategy for South Africa; the contribution to the green economy and the contribution to the Presidential Infrastructure Coordinating Commission. The chapter also looks at government's New Growth Path (NGP) and the National Skills Accord, which is a broad-based agreement to adopt the NGP.

6.2 THE HWSETA'S SKILLS DEVELOPMENT PRIORITIES

This section outlines the broad skills development priorities that the HWSETA will address in the five-year period covered by this SSP. The skills development priorities were informed by the analysis of the skills situation in the sector, needs identified by stakeholders and NSDS III.

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. Outcomes of the skills development interventions will be evaluated at three levels. Firstly, qualifications conferred and work experience gained will be assessed as low-level outcomes. Secondly, intermediate-level outcomes are linked to whether learners secure employment on a permanent basis. Thirdly, high-level outcomes of the interventions will be assessed in terms of sustainable livelihoods, healthy communities, and alleviation of poverty. In addition, the HWSETA is piloting RPL centres across the country focusing on Primary Health Care, Community Health Work and Ancillary Health Care. These RPL centres work with FET Colleges and Nursing Colleges in their respective areas. This is another initiative that complements the HWSETA's skills development interventions.

The HWSETA's skills development programmes and projects will be implemented across four sub-programmes described below.

6.2.1 Occupationally directed programmes

The HWSETA will facilitate and increase access to occupationally directed programmes so that learners may achieve credits in such programmes. Specific interventions will focus on the six areas discussed in a) to f) below:

a) The development of mid-level skills

In view of the acute shortages of key higher-level skills in health sciences and the social services professions, there is a pressing need to equip MLWs to share and take over tasks usually performed by higher-level professionals. Research by the HWSETA reported in this SSP clearly identified the need for mid-level skills in the health and welfare sector.

The introduction and expansion of MLWs is one of the seven foundations of the HRH SA model for the period 2012/12 to 2016/17.[727]As discussed in Chapter 3, mid-level skills are also needed to support healthcare services in the NHI scheme.While the HWSETA recognises that policy makers and the organised health professions still need to develop the categories of MLWs required, it is already evident that the ranks of clinical associates,

727 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

pharmacy technicians and pharmacy technical assistants must be increased, and the ranks of mid-level nurses be boosted.[728]

Over the planning period the HWSETA will work with stakeholders and national- and provincial government departments to support the development of mid-level skills for the health and social development sector. HWSETA recognises that policy makers and the organised professions also need to cooperate to develop the categories of MLWs required.

b) Development of artisans

During interviews with stakeholders in preparation of this SSP, it was confirmed that the national shortage of artisans is affecting service delivery and quality of care, especially in the health sector. To address the need for mid-level technical skills outlined in Chapter 4, the HWSETA will design projects and implement partnerships to assistlearners to enter training programmes for artisans which will enable them to qualify, and to become work ready.

c) Development of high-level national scarce skills

Discussions in chapters 3, 4 and 5 underscore the necessity to expand development of high-level skills in many priority areas in health sciences as well as the social development field. Technical skills and professional competences are required to improve the health profile of South Africans and to steer many critical programmes and policies aimed at enhancing human- and social development. Stakeholders with whom the HWSETA engaged to prepare this SSP emphasised the need for work-ready professionals, especially in the social development sector.

The HWSETA will address the shortage of high-level national scarce skills through projects aimed at producing work-ready graduates from HEIs. The SETA will support appropriate interventions to enable students to enter work experience and experiential learning programmes. Postgraduate students will also be supported to access work opportunities.

d) Research, development and innovation capacity

It is also necessary to develop the research and development and innovation capacity of the health and social development sector and to establish innovative research projects. The HWSETA will put programmes in place that focus on the skills needed to produce research that is relevant to the sector, and that will have an impact on the achievement of economic- and skills development goals of the sector.Flagship research projects will be established in cooperation with university faculties and other stakeholders and support will be provided to researchers.

To ensure that support is provided to researchers, the HWSETA at the time of writing this update, had developed innovative research themes to attract masters'and doctoral students to participate in the HWSETA Research Postgraduate Bursary Programme. The programme was announced to the general public and to the HE institutions. A total of 41 applicants have been approved for this programme in 2013.

The following themes are covered in the Research Bursary Programmes:

- Labour market related research for the health and welfare sectors.
- Traditional healing related research in SA.
- Education and training in the health and welfare sectors.
- Medical research: Burden of diseases.
- Health and welfare sectoral skills development policy research.

Further calls for participation will be made in 2014. The programme is aimed at supporting 250 research postgraduates that will contribute to the research and development and innovation capacity in the health and social development sector. At this juncture, the HWSETA is preparing MoUs with the relevant universities for the implementation of this bursary programme. Furthermore, the HWSETA has signed an MoU with the University of KwaZulu-Natal (UKZN) to partner with the university for future planned research projects.

e) N-courses and pre-apprenticeships

The Minister of Higher Education and Training initiated a process to bring back the National Technical Education (NATED) programmes- or 'N' courses, which had historically formed an integral part of the apprenticeship system.[729]Government and HWSETA stakeholders recognise the need for learners in trades to undergo solid theoretical training and have relevant work experience so that they may enter the labour market with marketable skills and obtain employment. The National Certificate (Vocational) and N-courses are recognised by employers as important base qualifications through which young people are obtaining additional vocational skills and work experience that prepare them to successfully enter the labour market. The HWSETA will allocate funding to support learners on pre-apprenticeship training and N-courses for technical trades required in the sector.

728 Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).

729 Department of Higher Education and Training. 2010. Media Briefing on Performance Monitoring and Evaluation for Minister of Higher Education and Training, B Nzimande.

f) Partnerships

The HWSETA will enter into partnerships with universities and universities of technology, public FET colleges, employers and private providers to increase the skills base to meet the needs of the health and social development sector. Work experience grants will be made available to learners attending public FET colleges and work experience for graduates of middle-level qualifications will be supported.

6.2.2 Workplace based skills development

The HWSETA will encourage the better use of workplace-based skills development and engage with stakeholders in the health and social development sector to provide substantial quality programmes for employed workers.

6.2.3 Training initiatives for cooperatives, small enterprises, workers, NGOs and the community

Research by the HWSETA clearly identifies the need to develop the capacity of NGOs, CBOs, cooperatives and small enterprises to be more self-sustaining. The HWSETA will encourage and support training initiatives to help achieve this goal..

a) Cooperatives

Projects will be established based on research conducted on the skills needs of emerging cooperatives. The measures will aim to contribute to employment and economic growth in the health and social development sector. Another goal is to support the establishment of cooperatives.

b) Small businesses

The HWSETA will provide funding for training and development support to small businesses in both the health and social development sectors.

c) Workers

Education programmes for workers, NGOs and communities will be supported. Training projects for skills development facilitators or labour representatives of trade unions will continue, their impact measured and reported on by the HWSETA.

d) Levy-exempt organisations

Skills-development programmes will be established for levy-exempt organisations and the HWSETA will encourage stakeholders to expand successful projects with support from the NSF.

6.2.4 Capacity building for the public sector

The HWSETA will contribute to capacity building in the public sector to improve service delivery. Interventions will support the building of a developmental state and increased efficiency.Education and training plans for the public sector will be revised and programmes will be implemented to strengthen the capacityof the DoH and the DSD.

6.3 THE HWSETA STRATEGIC BUSINESS PLAN

The Strategic Business Plan is structured according three programmes, each with sub-programmes. The programmes and sub-programmes are:

Programme 1 – Administration

Sub-programmes:

- Research, Innovation, Monitoring and Evaluation
- Corporate Services

Programme 2 – Skills development programme implementation and projects

Sub-programmes:

- Projects
- Learning programmes

Programme 3 – Quality assurance and qualification development

The three programmes coincide with the structural and operational arrangement of the HWSETA and cut across all four skills development priority areas outlined in paragraph 6.2 above. Each of the programmes has a programme objective and a set of strategic objectives. Targets, performance indicators and budgets are set for each of the strategic objectives.

The programmes, sub-programmes, indicators, targets and the budgets allocated for the 2014/2015 financial year are indicated in Table 6-1..

The way in which the HWSETA will contribute to various government imperatives are outlined in the sections that follow.

Table 6-1 HWSETA performance indicators and budget: 2014/2015

	Sub-programme	No	Performance indicator	Five-year target	2014/2015 target	2014/2015 budget
ADMINISTRATION	Research, Information, Monitoring and Evaluation	5	Percentage artisans and unemployed learners funded by HWSETA find employment within 6 months of completion	80%	80%	Admin budget
		12	Number of applied research reports completed and signed off that inform planning	25	5	R 534 000
		13	Number of post graduate research students funded in the health and welfare field	380	90	R 2.369 mil
	Corporate Services	15	Number of learners reached through HWSETA career development awareness programmes	43 500	11 000	R 500 000
		18	Percentage of filled positions in the HWSETA	94%	90%	R 894 000
		20	Percentage of HWSETA processes automated and integrated	95%	50%	R 4 mil
SKILLS DEVELOPMENT PROGRAMMES AND PROJECTS	Projects	2	Number of employers participating in work-based training	480	50	Included in learnerships and skills projects budgets
		4	Number of apprentices funded and enrolled to become artisans through HWSETA funding	800	300	R 28.875 mil
		6	Number of HWSETA funded students in higher education institutions funded for high-level scarce skills	1340	225	R 11.65 mil
		7	Number of students enrolled for work-experience and experiential learning programmes funded by the HWSETA	4644	325	R 11.250 mil
		9	Number of cooperatives in the health and social development sector whose skills needs are funded by the HWSETA	90	15	R 750 000
		10	Number of small and emerging businesses funded	450	75	R 4.950 mil
		11	Number of skills development projects funded to support NGOs, CBOs and trade unions	755	150	R 6 mil
		22	Number of levy-exempt organisations funded by the HWSETA	510	110	R 10 mil
		17	Number of learners in FET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses funded by the HWSETA	6 650	1 000	R 5.6 mil
		14	Number of projects funded through discretionary grant aimed at the public sector education and training	14	4	R3.3 mil
	Learning programmes	1	Number of programmes funded through grants to develop and address middle level skills	18	6	R 6.6 mil
		3	Number of learners registered in learnership training programmes	18 350	2 800	R 81.55 mil
		8	Number of employed and unemployed learners in skills programmes funded by the HWSETA	12 680	5800	R 11.600 mil
		21	Number of learners registered for AET programmes funded by the HWSETA	3 000	700	R 1.75 mil
QUALITY ASSURANCE AND QUALIFICATION DEVELOPMENT		23	Number of partnership agreements signed through MoUs outlining areas of collaboration	50	7	R 2.984 mil
		19	The number of skills development training providers accredited to offer full qualifications	240	40	R3.3 mil

6.4 THE NATIONAL DEVELOPMENT PLAN AND HWSETA STRATEGIES

Two of the central priorities of the National Development Plan are to improve the quality of education, skills development and innovation, and to build the capability of the state to play a developmental role. These themes also underpin the strategic outcomes for the NSDS III. The HWSETA's strategic objectives and operational interventions are aligned to the core priorities of the NDP.

6.5 SECTORAL CONTRIBUTION TO STRATEGIC AREAS OF FOCUS FOR NSDS III

6.5.1 Overview of NSDS III

The focus of training and skills development in the NSDS III is to enable learners to enter the formal workforce or create a livelihood for themselves. More particularly, the emphasis is on those who lack the relevant technical, reading, writing and numeracy skills to access employment. The key developmental and transformation priorities for the NSDS III are:

a) Racial and economic inequality: Preference in skills provision should be for previously and currently disadvantaged South Africans and specifically African blacks;

b) Class: Skills provision should reduce social and economic inequalities in society;

c) Gender: Women and black women in particular should benefit from skills development programmes to advance their employment and career development;

d) Geography: Skills provision should train rural people to deliver services in rural areas and to contribute to the economic development of rural areas;

e) Age: Skills provision must focus on training the unemployed youth;

f) Disability: Skills programmes must overcome labour market barriers for persons hampered by physical and intellectual disabilities by opening employment opportunities for them; and

g) HIV and AIDS pandemic: All skills development programmes must incorporate measures to fight and manage HIV/AIDS in the workplace.

The analysis of the health and social development sector presented in the previous chapters clearly shows that the current shortages of skills in the public sector lead to massive inequalities in terms of access to proper healthcare and social services. This leads to the perpetuation, and even the intensification, of inequalities in South African society. Therefore, the HWSETA's skills development interventions will be strongly focused on the alleviation of skills shortages and the development of new skills that can be applied in the poorest and most under serviced areas of the country and segments of the population. Skills development support and interventions will also give preference to historically disadvantaged individuals, and specifically African blacks and women, and people with disabilities.

The HWSTA makes every effort to ensure participation from the following groups in all of its projects and programmes:

- 85% Black,
- 60% women,
- 5% people with disabilities,
- 70% youth (35yrs and less), and
- 20% people from the rural areas

This is how the HWSETA contributes to transformation and equity imperatives. This is evident in the HWSETA's skills development projects and programmes (refer to Table 6-1).

6.5.2 HWSETA contributions to the NSDS III goals

This section outlines the HWSETA's contribution to the goals of the NSDS III.Particular skills development strategies for the health and social development sector are described with reference to the NSDS III goals. The requirements of the NGP and National Skills Accord are incorporated within reasonable, feasible skills development strategies and constrained resources. The section refers specifically to the HWSETA Annual Performance Plan for 2014/2015(as adjusted), which forms part of the 2013-2017Strategic Business Plan (as adjusted).

The following discussion is structured according to eight NSDS III goals. The main purpose of this discussion is to link the HWSETA's Strategic Business Plan and its Annual Performance Plan to NSDS III goals. The specific indicators in the Strategic Business Plan are referenced. It must be noted that the Strategic Business Plan covers all of the HWSETAs activities and although the total functioning of the SETA is in general supportive of the NSDS III, not every indicatorin the Strategic Business Plan can be directly linked to the NSDS III. These indicators are also linked to other Government strategies such as the following:

a) National Skills Accord;

b) National Development Plan;

c) Green Paper on the NHIandHuman Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17;

d) DHET-- Delivery agreement 5: A skilled and capable workforce to support an inclusive growth path (Development priority entrusted to the Minister of HET);

e) New Growth Path; and

1) Establishing a credible institutional mechanism for skills planning

Several strategies will be implemented to ensure that national needs in relation to skills development are researched, documented and communicated to enable effective planning across the health and social development sector. Resources will be allocated to ensure that the HWSETA conducts sound analysis of the health and welfare skills development needs that respond to Governmental and sectoral strategies.The HWSETA will conduct research and sectoral analysis in accordance with acceptable academic standards to produce SSPs which are supported by empirical evidence, provide sound analysis of the sector, and are confirmed by key stakeholders. Monitoring and evaluation of programmes and projects and impact assessments of skills development interventions will be undertaken by the HWSETA throughout the planning period – with a specific focus on the employability of learners and their absorption in the labour market after completion of HWSETA-funded training. Furthermore, the SETA will build research capacity in the sector through its support of post-graduate students – also in the field of labour market and skills development research. (*Programme 1, Indicators 5, 12 and 13*)

2) Increasing access to occupationally directed programmes

The second NSDS III goal is to increase access to occupationally directed programmes, referring specifically to intermediate skills, higher-level professional qualifications and PIVOTAL grants.[730]The sub-goals under this broader goal also include the development of research and innovation capacity in the sector.

Intermediate skills

As indicated in Chapters 3 and 4, the need for mid-level skills in the sector emanates from the shortage of professionals as well as the vast range of needs faced by a large portion of South African society.The HWSETA Strategic Plan provides for several strategies and projects to address the need for intermediate-level skills in the sector.Cooperation will be established with employers nationally to support the development of mid-level skills through work-based training opportunities (Programme 2, Indicator 2). Students will be supported to qualify on learning programmes (Programme 2, Indicator 1) and to obtain the workplace training required through a workplace experience grant (Programme 2, Indicator 7).

Vocational skills

Learners on pre-apprenticeships and N-courses will be supported to develop vocational skillsand qualify for entry into vocational programmes at FET colleges. New career paths will be developed for learners to access the sector. In this regard the HWSETA will continue with measures to support the reviewand development of the NCVPrimary Healthcare. (Programme 3, Indicator 16).

So far the HWSETA has developed several partnerships with FET Colleges for training towards the NCV: Primary Health Care (see Table 6-2).

730 Department of Higher Education and Training. 2011. National Skills Development Strategy III. Published at http://www.dhet.gov.za.(Accessed 9 August 2011).

Table 6-2 FET colleges in partnership with HWSET

FET college	Province
Ekurhuleni East	Gauteng
South West Gauteng	Gauteng
Maluti	Free State
Taletso	North West
Waterberg	Limpopo
Umfolozi	KwaZulu-Natal
West Coast	Western Cape
Northern Cape Urban	Northern Cape
Eastern Cape Midlands	Eastern Cape
Northlink.	Western Cape

In the 2014/2015 lecturers at FET colleges will be trained (Programme 3, Indicator 16).

The development of vocational skills will also focus on the trades relevant to the sector. Apprentices will be funded in order to increase the number of qualified artisans (Programme 2, Indicator 4).

High-level professional skills

The HWSETA will ensure that appropriate interventions are in place to advance entry into priority programmes for high-level national scarce skills. The main vehicle for this is the provision of bursaries at tertiary institutions (Programme 2, Indicator 6).

PIVOTAL programmes

PIVOTAL programmes are "professional, vocational, technical and academic learning" programmes that meet the critical needs for economic growth and social development. PIVOTAL programmes generally combine course work at educational institutions with structured learning at work and culminate in an occupationally directed qualification. In the health sector most of the entry-level learning paths can be classified as PIVOTAL programmes. Learning paths for a number of occupations in the social development sector may also be categorised as such.

During this planning period the HWSETA will support increased access of learners and students to occupationally directed programmes. Formal partnerships will be established with FET colleges, universities of technology, universities, and other stakeholders to enable workplace-based training in mid-level skills and scarce high-level skills needed in the sector. The SETA will also support learners in learnerships and in skills programmes (Programme 2, Indicators 1, 3, 6, 7 and 8).

Research and innovation capacity

Several measures will be taken to cultivate and strengthen relevant research and development and innovation capacity required for the sector. In the planning period the focus will specifically be on partnerships with universities and universities of technology and on the cultivation of research and innovation capacity through post-graduate studies (Programme 1, Indicator 13).

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

According to the NSDS III and the NGP, the public FET college system is central to the government's programme of skilling and re-skilling youth and adults. The National Development Plan proposes that FET colleges be strengthened and expanded and that the graduation rate be increased to 75%. This will require pro-active measures to improve the quality and relevance of FET courses. A number of HWSETA interventions will support these goals. Partnerships will be established between the HWSETA, DHET, employers and public FET colleges to offer the NCV Primary Health Care and other relevant courses (Programme 3, Indicator 16). The training of FET college lecturers and their exposure to work experience is a direct contribution to the capacity of the FET colleges (Programme 3, Indicator 8). Direct financial support will be offered to learners on vocational programmes at FET colleges (Programme 2, Indicator 17). The FET college system will also benefit from the opportunities that will be created for learners to complete the workplace components of their qualifications (Programme 2, Indicator 7). These interventions will increase the throughput rates of the FET colleges.

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

Through its discretionary budget the HWSETA will support unemployed adults to undergo literacy training and AET (Programme 2, Indicator 21).

5) Encouraging better use of workplace-based skills development

During the planning period the HWSETA will support the training of employed workers to address critical skills and enhance productivity. Programmes that stimulate economic growth and the ability of the workforce to adapt to change in the labour market will receive financial backing. In view of these objectives, the HWSETA will allocate funds for particular projects that address sector-specific health and social development skills gaps. Funding will be made available for learnerships and skills programmes for unemployed and employed learners (Programme 2, Indicators 3 and 8).

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

Chapters 3 and 4 of this SSP highlight the skills development challenges faced by NPOs that deploy workers and volunteers for community-based healthcare and social services. One of the "jobdrivers" in the NGP is to leverage the social economy and support NPOs and civil society organisations. During the planning period the HWSETA will engage with trade unions, NGOs and community-based organisations in the sector and identify skills needs, community-based education programmes and strategies to address them. Specific projects will be established to support and develop cooperative organisations and to establish further cooperatives (Programme 2, Indicator 9).

Education programmes to support levy exempt organisations and trade unions will be funded (Programme 2, Indi-

cator 11) as well as small and emerging businesses (Programme 2, Indicator 10).

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

In Chapters 3 and 4 of this SSP reference was made to the significant challenges faced by the public sector to deliver quality services in healthcare and social development. Many of these challenges can be attributed to serious skills gaps and capacity constraints associated with sub-optimal skills levels of public service managers, officials and workers. Among the critical actions identified in the NDP involve steps by the state to professionalise the public service.The HWSETA will also contribute to this end.

The HWSETA will engage with national and provincial departments of health and social development to determine their capacity needs, especially in terms of critical skills.Education and development plans and funding arrangements will be agreed between the various departments, the HWSETA, the PSETA and other relevant SETAs. Specific projects aimed at education and training for the public sector will be funded (Programme 2, Indicator 14).

8) Building career and vocational guidance

According to the NSDS III, the need exists to provide career- and vocational guidance to young people in order to direct them to training areas needed in the economy and to identify programmes for which they have an aptitude. The HWSETA will adopt strategies to create awareness of the occupations in the health and social development sector at all levels. Special attention will be given to occupations in which skills shortages are experienced and new mid-level occupations that are being created to alleviate the shortages of professionals. More specifically, the HWSETA will update its career guides with relevant labour-market information for all the health and social development sub-sectors. Career paths will be mapped to qualifications.The SETA will participate in career awareness programmes and events and aims to reach at least 11 000 learners in the 2014/2015 financial year (Programme 1, Indicator 15).

6.6 SECTORAL CONTRIBUTION TO GOVERNMENT'S MTSF OBJECTIVES

In government's MTSF ten priorities are set for attaining higher- and sustainable economic growth for the country and for improving the conditions of life of all South Africans.[731] Five of the strategic priorities are central to the work of the HWSETA:

a) Priority 2, which involves programmes to build economic and social infrastructure;

b) Priority 4, which is tostrengthen the skills and human resource base of the country;

c) Priority 5, which is to improve the health profile of all South Africans;

d) Priority 7, which is to build cohesive, caring and sustainable communities; and

e) Priority 10, which is to build a developmental state and improve the delivery and quality of public services.

In previous chapters of this SSP various strategies and plans of government to improve the health and social development systems have been discussed. The HWSETA will continue to work closely with the DoHand the DSD, and will support these departments'public service strategies through skills development.It must, however, be noted that these initiatives may be hampered by a disjuncture between the different ministries involved in the planning of health and social development services. Within its own mandate and budgetary allocations the SETA will contribute to the supply of larger numbers of health and social services workers equipped with the skills necessary to improve healthcareand the quality of life of vulnerable persons in South Africa.

Learnerships in social auxiliary work, child and youth care work, community development, and ECDconstitute significant investments in social capital and will contribute to social infrastructure development in communities. The HWSETA will encourage learning programmes that are accessible to people living in rural areas and will support innovation in the provision of these programmes.In addition, the development of skills in community-based interventions and multi-disciplinary team work will be promoted and supported.

A developmental social welfare response requires a range of social service occupational groups who are able to work cooperatively in multi-disciplinary teams.The HWSETA will promote skills development for all occupational groups in the social development sector, and will support development of the "emerging" professions – including child and youth care work and community development.

731 The Presidency. 2009. *Together doing more and better: Medium Term Strategic Framework*.

6.7 THE NEW GROWTH PATH AND NATIONAL SKILLS ACCORD

South Africa's New Growth Path (NGP) is essentially a policy package that strives to create employment on a large scale to reduce poverty and inequality.[732]The main objectives are to reduce unemployment from 25% to 15% over a ten-year period and to prioritise employment creation in all policies.All economic role players are required to create decent work (i.e. more and better jobs), enhance skills, and develop small enterprises. Among government's key priorities are investment in health and education to improve service delivery, access to employment, and competitiveness. Five "job-drivers" are identified to create employment on a large scale, four of which are relevant for the HWSETA. These are: targeting labour-absorbing activities in the services field; utilising opportunities in the knowledge- and green economies; leveraging social capital in the social economy and public services by supporting CBOs and cooperatives; and fostering rural development.

Key strategies in the NGP focus on measures to step up education and skills development. Higher education must meet the needs of broad-based development and shortfalls in technical and artisanal skills must be addressed. Extensive workplace-based skills interventions are envisaged, with SETAs encouraged to improve the skills in every job and to co-finance training of 10% of the workforce annually. FET colleges must be strengthened, as they are major providers of mid-level skills for young people.

The National Skills Accord is an agreement between business, organised labour, constituent communities at the National Economic Development and Labour Council (NEDLAC)[733] and government to establish partnerships to achieve the broad goals of the NGP. In July 2011 the parties made commitments to training and skills development in eight areas and a commitment specifically to:[734]

a) Expand the level of training by using existing facilities more fully by training more artisans, technicians and technical skills than are needed by employers;

b) Make internship and placement opportunities available in workplaces;

c) Set guidelines of ratios of artisans and trainees in technical vocations;

d) Improve the funding of training and the use of funds available for training and incentives for companies to train – including the effective use of the NSF and allocating part of the mandatory grant to fund workplace training for FET college students, university of technology students, and middle-level skills;

e) Set annual targets for training in state-owned enterprises;

f) Improve SETA governance and financial management and stakeholder involvement;

g) Improve the role and performance of FET colleges by positioning them as preferred providers of skills training and steering the SDL towards programmes provided by FET colleges.

The HWSETA's skills development strategies for the health and social development sector as discussed in the previous sectionsclearly address the key objectives of the NGP and National Skills Accord. In particular, the HWSETA will contribute to the national commitment to increase the number of artisans that enter training, qualify and enter the labour market with the required skills. The HWSETA will also support workplace experience for learners from public FET colleges and internships for third-year students of universities of technology. The HWSETA is also making a new commitment to provide training exposure in a work environment for lecturers at FET colleges.

6.8 HWSETA CONTRIBUTION TO THE HUMAN RESOURCES DEVELOPMENT STRATEGY

The Human Resources Development Strategy South Africa 2010-2030 sets out strategic objectives to develop priority skills, such as artisansneeded to accelerate economic growth.A further objective is to improve the employment outcomes of post-school education.The need for unemployed adults, especially women, to have access to skills development programmes that will enable employment and income-generation is also stated. In order to improve the foundation of human development in the country, access to literacy training, adult basic education and ECD must be expanded.[735] These strategic priorities are covered in the HWSETA's Strategic Business Plan. The HWSETA will enable unemployed adults to have access to training opportunities in literacy and ABET.

732 Department Government Communications and Information Systems. 2010. The New Growth Path: The Framework.Published at http://www.info.gov.za/aboutgovt/programmes/new-growth-path/index.html.(Accessed 12 September 2011).

733 The community constituents at NEDLAC include organisations of civic structures, women, youth, people with disabilities and co-operatives.

734 Department of Economic Development. 2011. New Growth Path: Accord 1 – National Skills Accord.Published at http://www.info.gov.za/view/DownloadFileAction?id=149083.(Accessed 12 September 2011).

735 Department of Education. 2010. Human Resources Development Strategy South Africa – draft strategy for discussion 2010-2030. Published at http://www.info.gov.za/view/DownloadFileAction?id=117580.(Accessed August 2010).

6.9 PERFORMANCE TARGETS FOR MINISTER OF HIGHER EDUCATION AND TRAINING

As the Executive Authority of SETAs, the Minister of Higher Education and Training expects of the HWSETA to align its skills planning and skills development to performance outputs set by Government for the period 2010 to 2014. Responsibility to coordinate the following performance outputs are assigned to the Minister:[736]

f) Output 1: Establish a creditable institutional mechanism for skills planning;

g) Output 2: Increase access to programmes leading to intermediate- and high-level learning:

- Provide youth and adults with foundational learning qualifications.
- Create "second-chance" bridging programmes leading to a matric equivalent.
- Provide learning options to learners with matric but no university exemption.

h) Output 3: Increase access to occupationally directed programmes in needed areas and thereby expand the availability of intermediate-level skills (with a special focus on artisan skills):

- Strengthen theoretical aspects of learnerships.
- Strengthen and support FET colleges.
- Increase enrolment at FET colleges for mid-level occupations.

i) Output 4: Increase access to high-level occupationally directed programmes in needed areas:

- Increase the graduate output in animal and human health.
- Increase the graduate output in natural and physical sciences.

j) Output 5: Research, development and innovation in human capital for a growing knowledge economy:

- Increase output of honours graduates, research masters graduates, and doctoral graduates.

The skills development priorities and programmes set by the HWSETA will address these high-level performance outputs entrusted to the Minister. In particular, the HWSETA contributes to the achievement of Output 1 through extensive research in the sector, stakeholder engagement to identify skills needs, and the allocation of resources to support skills planning. The SETA has set specific objectives to increase access to programmes directed at developing mid-level and high-level skills (Output 2) and several interventions will support increased access to occupationally directed programmes (outputs 3 and 4). The HWSETA will put programmes in place that focus on expanding the research, development and innovation capacity in the health and social development sector.

6.10 CONTRIBUTION TO THE GREEN ECONOMY

The HWSETA will work to refine facilities and systems to accommodate paperless processes in its internal operations and services to stakeholders so that information may be exchanged and stored electronically.

Aspirations to advance the green economy are closely linked to someof the environmental focus areas that deal with the management of waste, pollution, hazardous substances and abattoirs, as well assurveillance measures needed for food safety. Environmental health interventions aim to prevent the outbreak of diseases, as humans interact with their surroundings and with animals. As discussed in Chapter 3, environmental health officers will be key members of PHC teams to monitor the environmental conditions in which people live and work. The HWSETA will work with the DoH and provincial health departments to design programmes to train environmental health practitioners.

6.11 PRESIDENTIAL INFRASTRUCTURE COORDINATING COMMISSION

In 2012 Government adopted the infrastructure plan proposed by the Presidential Infrastructure Coordinating Committee to support economic development and improve service delivery, especially in the poorest provinces. Seventeen strategic integrated projects (SIPs) have been developed,which aim to transform the economic landscape, create jobs and strengthen public services. The SIPs cover a range of economic and social infrastructure.[737] The work in these SIPs is being aligned with human settlement planning and with skills development, which areseen as key cross-cutting areas. The following SIPs are relevant for the health and social development sector:

- SIP 12 – Revitalisation of public hospitals and other health facilities: Work has commenced to build and refurbish hospitals and to revamp 122 nursing colleges, while extensive capital expenditure is needed to prepare the public health system for the NHI system.

736 Department of Higher Education and Training. 2010.Delivery Agreement 5: A skilled and capable workforce to support an inclusive growth path; Department of Higher Education and Training. 2010. Media Briefing on Performance Monitoring and Evaluation for Minister of Higher Education and Training, B Nzimande.

737 Presidential Infrastructure Coordinating Commission. 2012. Provincial and Local Government Conference A summary of the Infrastructure Plan.

- SIP 14 – Higher education infrastructure will be developed to expand lecture rooms, laboratories, libraries, student accommodation and ICT connectivity.

Specific opportunities are identified as "enablers" for further economic development. In the health sector, Government will work to support the establishmentof a pharmaceutical manufacturing plant to complement the expansion of clinic and hospital infrastructure. Industrial pharmacists, i.e. highly skilled specialist pharmacy professionals with postgraduate qualifications, will be needed for all phases of the manufacturing process. In Chapter 3 the HWSETA reported on the need to train pharmacists in specialist areas, including public health management and industrial pharmacy.

The intention is to support the implementation of the SIPs with skills development programmes, and role-players such as SETAs are required to align their skills planning accordingly. Chapters 3 and 4 of this SSP describe the demand for additional healthcare workers in public hospitals and skilled practitioners to deliver services under the NHI. The HWSETA recognises the pressing skills development needs across all the occupational categories in the public health sector and will continue to support learnerships, training courses and occupationally-directed programmes to alleviate scarce skills. Expansion of the higher education platform will grow the training capacity of institutions but more lecturers and educators will be needed and more students will require bursaries. The HWSETA has taken note of these further opportunities to contribute to skills development for the health and social development sector.

6.12 CONCLUSIONS

The skills development priorities and interventions set out in this chapter will be further developed and implemented within the available funding of the SETA. The success and impact of these strategies and interventions will be assessed on a continuous basis and the overall strategy and Strategic Business Plan will be revised annually.Concerted efforts will be made to improve service delivery and governance of the HWSETA. During this planning period the HWSETA will engage with stakeholders in the sector on an on-going basis regarding the skills development strategies and outcomes of the skills development interventions.

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ANNEXURE A HWSETA BUDGET 2011/12 TO 2016/17

HEALTH AND WELFARE SECTOR EDUCATION AND TRAINING AUTHORITY 5 YEAR BUDGETS

STATEMENT OF FINANCIAL PERFORMANCE

	Actual audited	Actual audited	Adjusted Budget	MTEF projections			
	2011/12 R'000	Act. 2012/13 R'000	2013/2014 R'000	2014/15 R'000	2015/16 R'000	2016/17 R'000	
REVENUE							
Non - Exchange Revenue	**282,240**	**337,306**	**365,659**	**385,350**	**406,105**	**427,575**	
Skills Development Levy: income	280,585	333,431	364,659	384,350	405,105	426,575	
Skills Development Levy: penalties and interest	1,655	3,875	1,000	1,000	1,000	1,000	
Exchange Revenue	**21,272**	**23,952**	**23,726**	**25,007**	**26,358**	**27,755**	
Interest income	20,716	**22,468**	23,726	25,007	26,358	27,755	
Other income	556	1,484					
Total revenue	**303,512**	**361,258**	**389,385**	**410,357**	**432,462**	**455,330**	
EXPENSES							
Total expenses	**204,327**	**255,372**	**385,385**	**286,378**	**300,643**	**451,619**	
Employer grant and project expenses	145,626	190,431	263,932	193,493	202,250	347,553	
Administration expenses	58,701	64,941	87,771	92,406	97,894	103,466	
QCTO funding			457	480	500	600	
FET Infrastructure Grant			33,225	0	0	0	New Infrastructure Grant
Finance costs	0	0	0	0	0	0	
Net surplus for the Period before capex	**99,185**	**105,886**	**4,000**	**123,979**	**131,819**	**3,711**	
Capital expenditure		**3,500**	**4,000**	**4,321**	**4,009**	**3,711**	
Net surplus for the Period after capex		-	-	**119,658**	**127,810**	-	
				290,699	304,652	455,330	
				290,699	304,652	nil	**Ceiling Expenditure**

STATEMENT OF FINANCIAL PERFORMANCE (Cont...)

	Actual audited	Actual audited	Adjusted Budget	MTEF projections			
SKILLS DEVELOPMENT INCOME	**2011/12**	**Act. 2012/13**	**2013/2014**	**2014/15**	**2015/16**	**2016/17**	
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	
Levy income: Administration	**77,554**	**84,697**	**92,227**	**97,207**	**102,457**	**107,887**	
Levies received from SARS	29,427	36,317	41,158	43,381	45,723	48,146	
Government levies received	48,122	48,361	51,069	**53,827**	**56,734**	**59,740**	
Interseta transfers in	10	19.00	-	-	-	-	
Interseta transfers out	-5	-	-	-	-	-	
Percentage of admin expense/ admin income	75.69	76.67	95.17	95.06	95.55	95.90	
Levy income: Employer Grants	145,780	178,242	78,397	82,630	87,092	91,708	
Levies received from SARS	145,830	178,145	78,397	82,630	87,092	91,708	
Interseta transfers in	14	97.00	-	-	-	-	
Interseta transfers out	-64	-	-	-	-	-	
Levy income: Discretionary Grants	57,251	70,492	194,034	204,512	215,555	226,980	
Levies received from SARS	57,250	70,453	194,034	204,512	215,555	226,980	
Levies received from GOVERNMENT DEPARTMENTS							
Interseta transfers in	7	39.00	-	-	-	-	
Interseta transfers out	-6	-	-	-	-	-	
	280,585	**333,431**	**364,658**	**384,350**	**405,105**	**426,575**	
				343,772	**375,745**	**412,618**	**Revenue ceiling excluding government levy contributions**

EMPLOYER GRANT AND PROJECT EXPENDITURE	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	
Mandatory grants	87,643	123,194	55,662	58,668	61,836	91,708	
Discretionary grants	57,983	67,237	241,495	134,825	140,414	255,845	
	145,626	**190,431**	297,157	**193,493**	**202,250**	**347,553**	
			71%	71%	71%		**participation rate**

STATEMENT OF FINANCIAL PERFORMANCE (Cont...)

	Actual audited	Actual audited	Adjusted Budget	MTEF projections		
ADMINISTRATIVE EXPENDITURE	**2011/12**	**Act. 2012/13**	**2013/2014**	**2014/15**	**2015/16**	**2016/17**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Depreciation	792	903	1,500	1,581	1,900	2,000
Amortization of Intangible assets	235					
Operating and finance lease	5,629	6,005	7,175	7,562	8,310	9,132
Buildings	5,483	5,905	7,000	7,378	8,116	8,927
Plant, machinery and equipment	146	100	175	184	194	205
Maintenance, repairs and running costs	252	110	305	321	339	357
Property and buildings	229	105	305	321	339	357
Machinery and equipment	23	5				
Advertising, marketing and promotions, communication	1,584	1,465	1,854	1,954	2,071	2,181
Consultancy and service provider fees	252	474	280	295	311	328
Legal fees	168	954	500	527	555	585
Cost of employment	28,788	31,835	47,086	49,629	52,314	55,090
Travel and subsistence and accommodation	5,872	6,240	7,329	7,725	8,142	8,573
Staff training and development	530	665	1,462	1,054	1,111	1,170
Remuneration to members of the accounting authority	1,211	1,773	1,872	1,973	2,080	2,190
Remuneration to members of the audit committee	206	208	220	232	244	257
External auditor's remuneration	1,795	1,345	2,017	2,126	2,241	2,359
Audit fees	1,795	1,345	2,017	2,126	2,241	2,359
Other	11,387	12,964	16,171	17,426	18,276	19,244
Workshops	2,226	2,140	2,600	2,740	2,888	3,041
Internal audit fees - Audit fees	1,405	1,661	1,150	1,212	1,278	1,345
Special assignments	882	386	500	527	555	585
Courier and postage	125	338	400	422	444	468
Telephone	836	781	800	843	889	936
Programme evaluations - ETQA	304	911	1,000	1,054	1,111	1,170
Printing and stationery	1,378	1,754	1,852	1,952	2,057	2,166
Staff welfare	295	473	800	1,000	1,054	1,110
SDF Contractors		0	164	246	259	273
Office cleaning	179	330	400	422	444	468
Insurance	271	280	330	348	367	386

STATEMENT OF FINANCIAL PERFORMANCE (Cont...)

	Actual audited	Actual audited	Adjusted Budget	MTEF projections		
	2011/12	Act. 2012/13	2013/2014	2014/15	2015/16	2016/17
	R'000	R'000	R'000	R'000	R'000	R'000
Motor vehicle expenses	49	83	88	92	97	103
Software support	970	1,107	1,250	1,700	1,700	1,790
Storage	242	32	272	287	302	318
Subscriptions	291	283	299	315	332	350
Staff bursaries	6	29	249	262	277	291
Security	19	10	22	23	25	26
Water and electricity, rates and taxes	931	915	1,100	1,159	1,222	1,287
Recruitment costs	518	571	848	894	942	992
Bank charges	53	41	85	89	94	99
IT systems	154	486	513	541	570	600
Branding	112	21	200	500	527	555
Other consumables	38	34	0	0	0	0
Office move	0	6	0	0	0	0
Catering and refreshments	103	231	250	258	272	286
General expenses	0	0	0	6	6	7
Bad debts written off		40	0	0	0	0
Research costs			999	534	563	593
Loss on scrapping of assets	0	21	0	0	0	0
	58,701	64,941	87,771	92,406	97,894	103,466

ANNEXURE B THE PROCESS OF UPDATING 2013 EMPLOYMENT DATA

For the 2013 update, data from three databases were used. WSPs submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the PSETA. This information was augmented with data extracted from the MEDpages database.

Public service

Data for the public health and social development sectors was obtained from the PSETA. All nine provinces' departments of health and of social development as well as the two national departments submitted employment data to the PSETA in 2013. Information on scarce skills was not submitted by the Northern Cape Department of Health and the Department of Social Development in Mpumalanga.

Private sector

The information that employers submit to the HWSETA in their annual mandatory grant applications is the only information that deals specifically withthe private health sector. However, not all the organisations in the sector submit mandatory grant applications. In order to compensate for organisations belonging to the HWSETA that did not submit WSP-ATR information, the data received in 2013 was weighted to a sectoral total. This was done by using the levy amount paid as a proxy for employment. Weighting was done separately for each Standard Industrial Classification (SIC) code.

In each of the industries the weights applied were calculated as follows:

Weight = Levy amount paid (all organisations)/levy amount paid (organisations – WSPs approved).

Estimated employment = (Weight * WSP employment)

The exact calculations are shown in the tables below.

Weights by SIC code (industry)

SIC code	SIC description (industry)	Total Levy amount	Levy amount WSPs	Weight
0	Unknown	R 318 046.10	R 311 470.69	1.021110847
33531	Traditional healing services	R 662 139.96	R 27 238.97	24.30855352
37410	Manufacture of medical and surgical equipment and orthopaedic appliances	R 1 720 069.01	R 762 497.83	2.25583463
37411	Orthopaedic appliances	R 619 765.97	R 233 291.61	2.656614912
62312	Retail of prescribed medicines and pharmaceutical products by registered/licensed pharmacy	R 12 440 518.95	R 9 180 991.16	1.355030054
82132	Medical aid schemes	R 496 318.81	R 141 713.95	3.502257964
87000	Research and development	R 921 696.95	R 547 035.21	1.684895109
87130	Medical and veterinary research	R 651 878.02	R 111 205.41	5.861927221
87131	SA medical research council	R 16 352.67	R 10 117.67	1.616248603
87200	Research and experimental development on social sciences and humanities	R 954 761.43	R 717 719.85	1.330270342
88221	Biomedical engineering	R 54 059.03		0
88915	Health professionals employment agencies	R 2 467 015.41	R 2 207 468.73	1.117576605
93101	Universities; specialist pharmaceutical and drug information services	R 177 112.17	R 141 569.30	1.251063401
93102	Public and private rehabilitation	R 147 231.17	R 72 956.20	2.018076188
93103	Other services including local government; mines and industry	R 309 524.22	R 164 402.82	1.882718435
93104	Ancillary health care services	R 797 567.92	R 616 046.36	1.294655681
93105	Residential care facilities	R 932 983.75	R 315 537.90	2.95680408
93106	Rehabilitation services	R 304 933.13	R 135 077.01	2.257476161
93107	Environmental and occupational health and safety services	R 386 513.12	R 232 992.78	1.658905997
93108	Health maintenance organisations	R 163 214.74	R 30 588.24	5.335865679
93110	Hospital activities	R 1 536 380.29	R 1 118 623.42	1.373456216

SIC code	SIC description (industry)	Total Levy amount	Levy amount WSPs	Weight
9311B	Private hospitals	R 27 974 109.32	R 27 556 090.21	1.015169754
9311C	Mine hospitals	R 33 757.75		0
9311E	Hospice care facilities	R 25 633.25		0
9312A	Public sector doctors	R 382 328.07	R 7 717.32	49.54155976
9312B	Private sector doctors	R 3 166 643.59	R 489 188.65	6.473256463
9312C	General and specialist practice	R 12 640 574.65	R 5 033 897.96	2.511090759
9312D	Industry based doctors	R 40 218.68	R 9 049.77	4.444165984
9312E	Doctors in charitable organisations	R 19 555.35		0
9312F	Paediatrics	R 149 385.64	R 32 264.21	4.630072765
9312G	Public service dentists	R 116 330.25	R 11 147.99	10.4350874
9312H	Private sector dentists	R 688 346.24	R 10 339.14	66.57674043
9312I	Oral hygienists	R 54 222.09	R 6 702.49	8.08984273
9312J	Dental therapists	R 519 499.99	R 23 815.65	21.813387
9312K	Dental laboratories	R 367 333.81	R 62 402.00	5.886571103
93190	Other human health activities	R 2 140 558.24	R 1 211 071.98	1.767490517
93192	Clinics and related health care services	R 1 672 391.44	R 484 239.50	3.453645231
93193	Nursing services	R 2 101 450.93	R 1 473 681.26	1.425987415
93199	Other health services	R 14 078 220.52	R 11 279 230.64	1.248154326
9319A	Public sector emergency services	R 70 440.87		0
9319C	State services	R 3 272.51		0
9319D	Public hospitals and clinics	R 323 160.65	R 127 300.68	2.538561852
9319E	Community services	R 280 822.26	R 94 350.25	2.976380667
9319F	Private hospitals and clinics	R 10 284 569.68	R 10 007 959.40	1.027639029
9319M	Optical and optometric services	R 2 580 601.57	R 710 513.04	3.632025628
9319N	Dietetics and nutritional services	R 46 665.73		0
9319O	Hearing and audiometric services	R 8 242.85		0
9319P	Complementary health services	R 125 741.88	R 18 570.27	6.77113903
9319Q	Laboratory services	R 15 232 691.89	R 14 790 590.45	1.029890723
9319S	Ambulance services	R 695 208.85	R 613 730.76	1.132758687
9319T	Blood transfusion	R 2 425 565.84	R 324 846.99	7.466794875
9319U	Psychological and psychometric testing	R 78 193.19	R 5 008.93	15.61075719
9319W	NGOs involved in health work	R 104 344.56		0
93200	Veterinary activities	R 1 321 016.72	R 159 999.06	8.256403006
93300	Social work activities	R 43 561.23		0
93301	Public sector	R 54 495.37		0
93302	Hospices	R 2 457.58		0
93303	Development and social services	R 59 519.45	R 3 731.75	15.94947411
94000	Other community; social and personal service activities	R 2 066 359.61	R 560 480.86	3.686762131

Total employment (weighted) by occupational category

Occupational category	N
Managers	11 652
Professionals	101 190
Technicians and Associate Professionals	64 515
Clerical Support Workers	41 017
Service and Sales Workers	26 914
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 975
Plant and Machine Operators and Assemblers	4 702
Elementary Occupations	10 538
Total	**262 503**

Submission rates for small professional practices in the health sector are very low. However, MEDpages, a private company, collects information on private health professionals and practices on an ongoing basis and at this stage their data is one of the most comprehensive sources of information on private practitioners in the sector. For these reasons the MEDpages data was used to calculate employment of certain professionals. The table below shows the professions for which MEDpages data was used and the employment figures obtained from this source.

Data for professionals obtained from MEDpages

OFO code	Occupation	N
221101	General Medical Practitioner	10 328
221201	Anaesthetist	935
221202	Cardiologist	148
221204	Obstetrician and Gynaecologist	652
221205	Ophthalmologist	283
221206	Paediatrician	428
221208	Psychiatrist	414
221210	Specialist Physician (General Medicine)	325
221211	Surgeon	1 656
223101	Acupuncturist	139
223103	Homoeopath	461
225101	Veterinarian	1 294
226101	Dental Specialist	289
226102	Dentist	3 238
226401	Physiotherapist	3 423
226501	Dietician	1 063
226602	Speech Pathologist	1 333
226701	Optometrist	2 406
226902	Occupational Therapist	1 975
226905	Biokineticist	765
226906	Rheumatologist	30
226907	Dermatologist	151
263401	Clinical Psychologist	1 978
263402	Educational Psychologist	1 112
263403	Organisational Psychologist	266
263405	Research Psychologist	14
263407	Counselling Psychologist	1 751
263409	Psychometrician	218
263507	Social Worker	1 516

ANNEXURE C SCARCE SKILLS IN THE HEALTH AND WELFARE SECTOR

The table includes only occupations in which 10 or more people are needed.

		Scarce skills					
		2013			2012		
OFO Code	OFO description	Public service	Private sector	Total	Public service	Private sector	Total
263507	Social Worker	6 121	82	**6 203**	5 518	95	**5 613**
222112	Registered Nurse (Surgical)	3 687	69	**3 756**	107	7	**114**
222101	Clinical Nurse Practitioner	980	1 146	**2 126**	1 390	183	**1 573**
221101	General Medical Practitioner	1 964	32	**1 996**	2 334	21	**2 355**
222108	Registered Nurse (Medical and Surgical)	847	320	**1 167**	3 637	1 216	**4 853**
226201	Hospital Pharmacist	966	178	**1 144**	923	77	**1 000**
322101	Enrolled Nurse	868	124	**992**	143	51	**194**
134402	Community Development Manager	812		**812**			
222105	Registered Nurse (Critical Care and Emergency)	58	751	**809**	540	238	**778**
222111	Registered Nurse (Preoperative)	41	724	**765**	1 229	304	**1 533**
222109	Registered Nurse (Medical Practice)	277	302	**579**	431	289	**720**
222201	Midwife	132	410	**542**	204	11	**215**
222102	Registered Nurse (Aged Care)	422	95	**517**		113	**113**
311502	Boilers and Pressure Vessels Inspector		500	**500**			
226203	Retail Pharmacist	114	325	**439**	74	672	**746**
811202	Healthcare Cleaner	431		**431**			
341201	Community Worker	410	2	**412**	1 337	13	**1 350**
222104	Registered Nurse (Community Health)	300	77	**377**	71	59	**130**
134201	Medical Superintendent	351	2	**353**	85	5	**90**
325801	Ambulance Officer	275	31	**306**		56	**56**
541902	Emergency Service and Rescue Official	280		**280**			
321301	Pharmaceutical Technician	5	249	**254**		15	**15**
441601	Human Resources Clerk	242		**242**			
341203	Social Auxiliary Worker	210	20	**230**	250	18	**268**
222116	Nurse Manager	30	197	**227**	116	41	**157**
321101	Medical Diagnostic Radiographer	176	39	**215**	322	55	**377**
732101	Delivery Driver	17	185	**202**	1	14	**15**
221207	Pathologist	147	35	**182**	27	20	**47**
226401	Physiotherapist	158	15	**173**	184	1	**185**
325802	Intensive Care Ambulance Para-medic / Ambulance Paramedic	134	30	**164**	130	10	**140**
226501	Dietician	156	1	**157**	126		**126**
226102	Dentist	131	1	**132**	92	2	**94**
263508	Child and Youth Care Worker	100	29	**129**		12	**12**
642601	Plumber	125		**125**	58		**58**
532902	Hospital Orderly	125		**125**			
221210	Specialist Physician (General Medicine)	115	2	**117**	258	3	**261**

		Scarce skills					
		2013			2012		
OFO Code	OFO description	Public service	Private sector	Total	Public service	Private sector	Total
812101	Laundry Worker (General)	105	3	**108**			
226902	Occupational Therapist	96	12	**108**	155	22	**177**
222113	Paediatrics Nurse	47	44	**91**	152		**152**
263506	Parole or Probation Officer	90		**90**	90		**90**
532903	Nursing Support Worker	85	3	**88**		13	**13**
524601	Food Service Counter Attendant	87		**87**			
221204	Obstetrician and Gynaecologist	81		**81**	34		**34**
263401	Clinical Psychologist	66	8	**74**	48	8	**56**
213110	Medical Scientist		70	**70**	3	41	**44**
221211	Surgeon	68	1	**69**	32		**32**
325102	Dental Hygienist	66		**66**			
321201	Medical Laboratory Technician	17	48	**65**		46	**46**
242401	Training and Development Professional	50	11	**61**		11	**11**
321104	Sonographer	17	39	**56**	102	21	**123**
323102	Ancillary Health Care Worker		56	**56**	11	164	**175**
332208	Pharmacy Sales Assistant	21	33	**54**		112	**112**
321102	Medical Radiation Therapist	50	1	**51**	20	10	**30**
411101	General Clerk	47	3	**50**			
441604	Labour Relations Case Administrator	50		**50**			
833401	Shelf Filler		50	**50**			
431101	Accounts Clerk	50		**50**			
226701	Optometrist	38	6	**44**	23	6	**29**
263501	Social Counselling Worker		41	**41**		52	**52**
121101	Finance Manager	30	10	**40**	20	9	**29**
222110	Registered Nurse (Mental Health)	15	25	**40**	87	61	**148**
311901	Forensic Technician (Biology, Toxicology)	33		**33**	47		**47**
226602	Speech Pathologist	26	6	**32**	50	2	**52**
671101	Electrician	28	4	**32**	23	1	**24**
222103	Registered Nurse (Child and Family Health)	18	14	**32**	97	112	**209**
221209	Radiologist	16	13	**29**	9	14	**23**
241107	Financial Accountant	25	4	**29**			
224101	Paramedical Practitioner	25	3	**28**	12	2	**14**
226101	Dental Specialist	25		**25**			
321103	Nuclear Medicine Technologist	25		**25**	15	1	**16**
243302	Sales Representative (Medical and Pharmaceutical Products)		25	**25**		16	**16**
222107	Registered Nurse (Disability and Rehabilitation)	21	2	**23**	58	1	**59**
331503	Insurance Loss Adjuster		23	**23**			
422602	Medical Receptionist		23	**23**			
121206	Health and Safety Manager		23	**23**			
133105	Information Technology Manager	20	2	**22**			

		Scarce skills					
		2013			2012		
OFO Code	OFO description	Public service	Private sector	Total	Public service	Private sector	Total
341204	Auxiliary Child and Youth Care Worker		22	**22**			
321402	Dental Technician	20	1	**21**			
122301	Research and Development Manager	20		**20**			
222114	Nurse Educator		20	**20**		18	**18**
215101	Electrical Engineer	19		**19**			
325501	Massage Therapist	2	16	**18**			
221201	Anaesthetist	15	3	**18**	27	3	**30**
121301	Policy and Planning Manager	16	1	**17**			
321403	Dental Therapist	17		**17**	11		**11**
531105	Child or Youth Residential Care Assistant		16	**16**		16	**16**
263407	Counselling Psychologist	13	2	**15**			
226301	Environmental Health Officer	12	3	**15**	40	1	**41**
226601	Audiologist	15		**15**	19	1	**20**
325301	Health Promotion Officer		15	**15**			
111204	Senior Government Official	15		**15**			
321114	Health Technical Support Officer		15	**15**		36	**36**
213104	Biochemist	14		**14**	14		**14**
242101	Management Consultant		13	**13**			
121901	Corporate General Manager		12	**12**			
221205	Ophthalmologist	9	3	**12**	28		**28**
532202	Aged or Disabled Carer		12	**12**		40	**40**
214402	Mechanical Engineering Technologist	1	10	**11**	39	10	**49**
221208	Psychiatrist	11		**11**	28	2	**30**
321118	Orthotist or Prosthetist	10	1	**11**	50	1	**51**
321116	Electroencephalographic Technician	10		**10**			
325601	Medical Assistant	10		**10**			
226302	Safety, Health, Environment and Quality (SHEQ) Practitioner		10	**10**	20	5	**25**

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