NATIONAL HEALTH INSURANCE

FOR SOUTH AFRICA

TOWARDS UNIVERSAL HEALTH COVERAGE

<u>DENOSA INPUTS AND ANALYSIS</u>

DEMOCRATIC NURSING ORGANISATION OF SOUTH AFRICA

1. THE FOREWORD

The DENOSA leadership wish to congratulate the Minister of Health and his team for the enormous progress done regarding Universal Health Coverage, a long outstanding health agenda for all South African citizen. We welcome the white paper on NHI as it reflects the Democratic Development state's willingness to live up to its constitutional obligations of progressive realization of the rights contained in section 27 of the constitution. According to the constitution the primary health services provider for the entire population (everyone) is government. This means the government must not only provide what it can afford, but has a mandatory responsibility to provide for all and continuously improve these services based on the population needs and health challenges.

DENOSA national congress has resolved to support NHI based on its stated objectives which are to:

- Meet population health needs;
- Remove financial barriers to health care;
- Reduce incidence of catastrophic health expenditures;
- Facilitate the attainment of national and internationally agreed health goals; and
- Contribute to better quality of life, poverty alleviation and human development.

The white paper does indeed in a detailed manner, cover the necessary steps and or processes to be undertaken in order to realize these objectives and addresses the key principles that under pin a construction of an affordable funding system to support the health care system.

The White paper reflects a great foundation towards meeting the seventeen sustainable developmental goals (SDG) embedded within the Primary Health Care, the heartbeat of the Health system. The analysis and opportunity has brought great awareness and understanding of the value of the National Health Insurance (NHI) and the current imbalances of the health services enjoyed by less than twenty percent of the South African population. DENOSA provides the input in this document with the commitment to support, defend and be one of the ambassadors of implementation of the National Health Insurance (NHI).

The submissions made herein are based on a collaborated effort of DENOSA as a united voice, which includes provincial and national leadership and other stake - holders such as Nursing academic institutions; Nurse practitioners; Managers of health provider facilities and Primary health care facilities. Furthermore the various scientific studies, international and National documents were consulted to support some suggestions and recommendations in this document.

DENOSA leadership appreciates greatly the wealth of input received from all participants towards developing this document, united indeed we shall stand.

The NHI White paper analysis and input herein is from the DENOSA national and provincial leadership structures including representatives from the following organizations:

INSTITUTION	CATEGORY
Ann Lastky Nursing College	Nurse educators
Brits Hospital	Nurse Practitioners
Charlotte Maxeke	Nursing Service managers
Gauteng Province DENOSA office	Provincial Secretary and Netcare FTSS
George Mukhari Hospital	Nursing Service Managers and Quality Assurance
Louis Pasteur Hospital	Nurse Manager
Northwest Province DENOSA office	Chairperson
University of Pretoria	Senior Lecturers
UNISA	Senior Lecturers

2. THE ANALYSIS AND INPUT

CHAPTER	DISCUSSIONS	SUGGESTIONS/ RECOMMENDATIONS
GENERAL OUTLOOK	Provision of the Legislative framework, list of abbreviations and Definitions as part of the first parts of the document a concern. 1. Legislative framework: necessary to set the tone for inter-sectorial collaboration and health in all policies WHO policy. 2. No Definitions of words/terms and Abbreviations of acronyms. 3. The inter-sectorial collaboration is too scattered and not well coordinated in the document, note the phrase supporting the necessity of the link below: • "Chapter 6:222): Patient satisfaction will be measured systematically through collaboration with the OHSC, other statutory bodies and stakeholders". • The WHO declaration on Health Inclusion in all policies (HIAP) and Community Health	**Input**: Indicate/ outline all the related and linked pieces of legislation that intends to promote collaboration aspired by NHI, e.g., National Health Act, Nursing Act, Occupational health and Safety etc. point(146,7). **Input**: Definition of health care workers, as in the National Health Act excludes CHW- NHI embrace Community health care workers (CHW) – Critical to provide definitions related to this piece of legislation. **List of abbreviations**: helpful to ensure a user friendly document UHC, NHI, hard to reach areas(227), health care workers, rural communities(17), urban areas, rural areas, semi-rural communities. The definition of terms will assist with planning, monitoring and bargaining for proper remuneration and allowances (227: Hard to reach areas, rural areas). This will assist in ensuring that proper implementation and services occur, avoiding the repeat of wrong implementation like it occurred with the OSD). **Input**: To reflect the key departments linked to efficient and effective implementation of the INH- e.g., Department of Home Affairs, Social Services and Justice etc. Inclusion of the relevant pieces of legislation affirming this contact. **Input**: Team to urgently explore the recommendation and progress of the HiAP document and link it to the NHI document-

	Inclusion Index (CHII). NB***HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity* (WHO,2014). Refer to WHO Health in All Policies (HiAP) Framework for Country Action of 2014. • Departments or sectors such as the RAF, Workman Compensation, Social, basic education, Palliative care associations, HWSETA are referred to in the document but not linked accordingly. Noting this phrase there is urgent clear articulation of inter-sectorial collation as informed by the HiAP and CHII.	Multi - disciplinary health services - Palliative care; rehabilitation and social services form part of the health services referral system which the PHC nurses will refer to as the patient's health needs require based on the health assessment done. **Input**: Propose inclusion of this information in capacitating nurses. What about social service grants, rehabilitation. Note Chapter5, 131: Please add: alternative healthcare providers such as traditional healers and others, also geriatric care**. *What role will traditional healers have in the PHC re – engineering i.e. where does the traditional healers fit into the four streams of PHC re –engineering?***
	4. **The Monitoring and Evaluation(M&E) component is not a clearly stipulated process that is embedded in all phases of the health services in order** to support and guard the implementation of NHI processes- Noting the HiAP and standard significance of M&E .	**Input**: 1. Propose Include Monitoring and Evaluation as the 5th point which is wrong in the Public Sector (1. Human Resources, 2. Financial Management3. Procurement / Supply Chain and 4. Infrastructure). 2. Inclusion of a full M&E stream as part of the key interventions to resolve system challenges and monitor mushrooming unintended challenges. DENOSA **propose inclusion of the M&E processes/stream in all phases, types and levels of the NHI services. –** It is important to include Monitoring and Evaluation in all phases of 15 yrs of the implementation plan thereby ensuring that the current structural problems identified in the health system and the burden of disease is managed timeously and competently. ..

Chapter 1: INTRODUCTION	**Chapter 1,12**: The Office of Health Standards Compliance (OHSC) has been established to assure quality of health services and the SANC Act No 33 of 2005, Chapter 2(g):functions of Council-: **conduct inspections and investigations of nursing education institutions, nursing education programs and health establishments, in order to ensure compliance with** this Act and the rules and standards determined by the Council in terms of this Act; (h) **investigate complaints against any health establishment in respect of its nursing service**;- **(17)** Vulnerable groups such as children, orphans, the aged, adolescents, and people with disabilities, women **and rural communities** will be prioritized.	Document is silent about synergizing the two stakeholders and discouraging duplication- The NHI is silent about the link of the roles of the office of Health Standards compliance on inspections and investigations against health establishments stated in the Nursing Act 33 of 2005. **The NHI document must include the roll and line of authority that SANC has in relation to the Office of Health standards Compliance (OHSC) to ensure compliance and that the two entities work hand in hand.** **Input**– provide linking phrases of the SANC function in health services and OHSC. The phrase that link SANC and OHSC to section 17 (it is an example of how the issued NHI Card is linked to the Department of Home Affairs system). **Input**: **The informal settlements communities** in urban areas are a reality- propose be <u>indicated and included as part of the vulnerable group- the informal settlement communities</u> in rural and urban areas.
Nurses training	Chapter 1: 38: The process of strengthening the nursing colleges as the primary training platform is underway…. The statement….” has undermined nursing colleges through a policy which favored universities as primary Training platforms, resulting in disinvestment in nursing colleges”. This statement does not reflect the realities….. Nursing colleges – With nursing curriculum now packed within the higher education band; the process to phase out the old legacy qualifications(EN and ENA and Bridging course 2018); There is certainly a large number of nurses not qualified and competent to manage the PHC services.	The Strategic Nursing 2011-2017 and Dr. Mkhize the SANC executive education manager confirmed that Nursing Colleges are the primary trainers NOT UNIVERSITIES. The SANC, 2015 study on unemployed enrolled nurses confirms that the Registered nurses and the specialized registered nursing categories are not sufficient to respond to the health objectives. **<u>Input:</u>** The increase resources for Nursing colleges **should include the Ministry of Health, chief Nursing Officer, the Nursing department in Universities, the Ministry of Health(Clinical facilities) the Regulatory board, South African Nursing Council (SANC) and CHE s**o that they can focus on aligning the updating the current undergraduate and post graduate nurses to the relevant content regarding the PHC, SDGs as well as other related

		programs like Computer Literacy, New TB HIV guidelines, PHC reengineering model content. The role players stated earlier(Nursing Colleges, Ministry of Health, chief Nursing Officer, the Ministry of Health(Clinical facilities),the Nursing department in Universities, the Regulatory board, South African Nursing Council(SANC) and CHE) must as a collective ensure that the new curriculum efficiently embraces the set standards of practice as stipulated in the NHI white paper • The DoH to fast track and prioritize the renovation and expansion of **ALL nursing Education Institutions**, not only Colleges including **proper decent accommodation for students(health promoters, CHW,** nurses, etc.,) across the country. • The NHI plan as it commits to expansion of nursing colleges must further **consider strengthening of the Continuous Professional Development (CPD)** to empower the old nursing cadre with research, primary health care knowledge technology driven quality service delivery in Nursing Colleges (Colleges produced majority of registered nurses and the research component was not part of their curriculum). • The urgency to **develop bridging and up skilling programs** that closes the competency gaps between the old legacy Scope of practice and the New Scope of Practice. The New Nursing Scope of practice promotes an independent, analytic critical thinking competent nurse practitioner and a researcher, who is geared to delivering quality service. The old basic need focused and an implementer of Dr's prescription nurse **does not fit to continue** to live in the NHI chapter of health service delivery. • Strengthening of training should promote collaboration agenda thus to include training of all Health care workers on PHC re-engineered model centered competencies (palliative carers, nurses, general practitioners, allied workers, administrators as well as officials in forensic, finances,

		leadership, technology, research and quality assurance*). The Ministry of Health, SANC to increase the number of learners for Bridging course intakes and facilitate increase intake of registered nurses for Community nursing science and Primary health care nursing as well as Midwifery .* • Establishment of **Nursing** and **other related health care workers (HCW) education institutions in all 9 provinces** (promote access and affordability) in order to capacitate all HCW (not discriminate and focus on the other, that is general practitioners and nurses). Explicitly indicate how these varied categories in health must collaborate towards quality health outcomes: consider a summarized algorithm or mapped pathway. NHI ombudsman to be linked with the SANC activities outlined in chapter 3 and 4 on professional conduct proceedings.
Quadruple burden	Quadruple burden (4 Highways): Injuries are not explicitly catered for- collaboration with other Departments: **Transport (No 147 -safe driving) basic education (-first aid training, best eating practices).** **Dispensing license** a Pharmacist competence which nurses and Doctors may apply for: few institutions available and at a cost.	The role of **health care workers in safe driving, participation in promotion and prevention programs and awareness campaigns is not** explicit as related to prevention and promotion to prevention of the quadruple burden of diseases(injuries, STI, Obesity) at all levels from household, schools and in workplaces. **Input:** Include collaboration with basic education, department of transport and preventative campaigns and strengthening of emergency responses with health care workers included. The Nurses to be involved in safe driving, first aid programs, injuries statistics, wellness programs, nutrition etc., at all levels from household, early development centers, schools, universities and in workplaces. **Input:** The need to increase access to institution offering a dispensing license and simplify the cumbersome process to be awarded a dispensing license and provide support of pharmacy assistance and mobile pharmacy/dispensary services on 24hour

		over weekends basis without exploiting the nurses especially in rural and hard to reach areas.
	Chapter 5: 117: Yes its population coverage…..what is the population number versus nurse ratio? Increased population what measures are in place to curb nurse work overload and role overload? Chapter 5:118 How do you contextualized the term “vulnerability” within the context of NHI.	Input: Propose the use of WSIN to strengthen the nurse ratio against the population needs and demographics of each region and districts. The current team of WBPHCOT made of one Registered nurse and twelve Community Health care Workers should be reconsidered to have two registered nurses, 2 General practitioners 2 health promoters, etc., to allow other benefits of employment and continuity of care, leave and ***NB**It is important that although we employ WISN; we should consider to have nurse: patient ratios regulated for the sake of the WBPHCOT's and ISHP thereby ensuring that the PHC registered nurse is not overburdened with HCW who is not competent and a community where the numbers of the population makes it impossible to render care and visit the number of homes as specified in a given time.*** (118): Consider including “ vulnerability” to the definitions

	The statement: NHI will be funding systems to all South Africans. Concern: What system will be implemented to ensure that the NHI cover all peoples those living in **informal settlements**, people with no formal identity that is linked to home affairs, homeless people living on the street those with no proof of postal addresses, some places are unknown to the town councilors. 5:119: Term "Legal beneficiary", how does legally excludes others…..it should be broken down. For example, Everybody will get a " NHI card" but what happen if the Dimakatso cross the border tonight, get sick and go to Messina hospital the next day………not clear how ?	Propose : Alternatives and surety that NO CITIZEN and Foreign nationals will be EXCLUDED to access health; **Input:** Caution not to exclude some refugees and foreign nationals especially the illegal immigrants. Consider inclusion of "Legal beneficiary" in the glossary for definition of concepts and Explore accommodating the scenario outlined….
	Chapter5:120: Document as you read seems to exclude certain issues / people, hence there is a need for provider guides / pathways for better reading and understanding.	**Input**: a need to include provider guides / pathways/ algorithms for better reading and understanding in the document.

	How will people in rural areas be included on the data base, considering access and availability of effective and efficient information on technology in these areas and the individuals? **Management of Foreign nationals-** (121-123): Asylum seekers and refugees in particular Chapter 5:121: What is the responsibility of the nurse when an asylum seeker is not registered but in need of health care? The NHI document clearly differentiate between care of an Asylum seeker and a refugee, how than do we specify the care to be rendered to an illegal immigrant?	Input: Outline the support or alternative center to "Gogo Pheladi" in that mud house for searching information and accessing services through Technology. Recommend that the NHI team must consider the Constitution of South Africa and consult the human rights experts to ensure fairness and unfair practices in this document. To consider opening centers at the point of care to provide none registered, illegal foreign nationals then link the customer with the relevant officials(home affairs, Police officers, human rights lawyers) **without the Nurse being exposed to threats, conflict**… Consider to link the process with the current "**Foreign policy on health" used in health establishments.**
	Chapter5:125: What is the meaning of the statement: NHI will not cover everything for everyone…..???- NB****Very vague and open to abuse: please re phrase and clarify**. *The statement is contradictory as the document does differentiate between care for the asylum seeker/ the refugee and to some extent but not clarified the "moral health hazardous individual"* 128:….referrals done by PHC, pt. not allowed to go to hospitals without be seen by a professional nurse or Dr. ….as a result Professional nurses might be overloaded with work. More human resources needed; Training have to take place soon.	**Input: NB**Very vague and open to abuse, discriminatory…. please re-phrase and clarify**. **Input:** Recommend to consider the **Constitution of South Africa and consult human rights experts** to ensure fairness and unfair practices. The placement of nurses using WISN in PHC and aligning each category **to their Scope of Practice** is important. Old practices of overloading NURSES with additional task should be avoided. The current litigation cases on the Department of Health and in the Nursing Council is of great concern. **DENOSA believes all citizens and employees, the HCW included must be protected by the labor relations Act**, fair and just working conditions: this seems not to be the case for ALL: Consider a clear support and provision of fair labor practices. ***The HCW in some provinces is contract workers if this cadre is expected to form part of the WBPHCOT they must be in the employment of the Dept. of Health/ permanent employees***

		thereby reducing the risk of exploitation as well as creating a sense of accountability.
	137: Note the phrase Moral hazard may occur when beneficiaries of NHI get involved in undue risky behavior….:”	**Input: Include the definition of MORAL HAZARD in definitions.** To address the issue of risky behavior, a collaborative approach with multiple sectors, services and all HCW should be made available- See HiAP input and motivation above. These should include training measures to curb the expansion of these behavior beyond PHC to the curative level …… Collaboration with all relevant sectors involved in health promotion and disease prevention.

Chapter 6	Point 128/158 – 164 – PHC is indeed the heart-beat of the health system; thus no compromise. Noting the current status quo the burden on the PHC will be enormous. •Resources – currently many PHC does not have the necessary equipment e.g. Baumanometers/ functional ECG machines/ well equipped Emergency trolleys, the list is endless. Unless the resources issue is sorted it will be impossible for PHC's to function at the level expected. Site inspections are done and employees are instructed that they must have stethoscopes/ baumanometers/ opthalmoscopes etc. in each cubicle, albeit they are not told where to source the equipment from.	**Input:** It is critical to ensure that these PHC centers are well equipped and that the personnel is skilled in the competencies related to the (16) "Comprehensive package of health services" with proper comprehensive training, research, monitoring and evaluation. **Input: Strengthening Health care workers training**- nurses, medical practitioners etc… critical to Include other critical drivers: (176 Chapter 6) Professionals at Early centers of development, Laboratory service, oral care, Health Inspectors, Health Promoters, ENT professionals, Radiography, Speech therapist. NB**The Minister verbally referred to the inclusion of the Essential Equipment list like the EDL; but it is not documented in the White paper.
	Identification, tracing and supporting of citizens in informal settlements with no physical address- a problem for ward based outreach teams- **the hard to reach areas? How will such areas be serviced, supported, monitored and identified?**	**Input**: Define the hard to reach areas, provide specific details to ensure how such areas will be serviced, supported, monitored and identified.

	What progress has been made since implementation in 2012(lessons learned) regarding the PHC reengineering model programs that should be incorporated into the successful NHI? Outreach Teams Challenges known from key hands on participants: • Inadequate • Verbal reports • Transport • CHW role is blurred • Lack of supervision • No Monitoring & Evaluation • Discretionary • Risk factor is high • Resource deficits • Task shifting	• The four streams of PHC - It must be clearly defined how the WBPHCOT's will augment service delivery with SHP;DCT and non - specialist professionals is assumed that the WBPHCOT teams will have knowledge of the comprehensive health services available to ensure proper home based treatment regimens and referrals. **Input**: Suggest clear specific processes that strengthens PHC services for all including early development centers in rural and informal settlements and protection systems for officials. **Inpu**t: DENOSA **propose infusion** of the 2014 PHC findings and recommendations of the three structures as with the DENOSA professional Institute (DPI) Health workers for change (HWFC) workshops there were challenges and proposals cited by the nurses and Community Health care workers**.** **Recommendations** • Safety • Quality theoretical and clinical trainingl • Accompaniment and Support of CHW • CPD programs and career path to avoid burnout • Acceptable Ratios of nurse to CHW/environmental officer and Health promoters – catchment group and population density. • Provision of resources / transport/protection, security gadgets- whistle etc., **ISHP- Propose full standardization and integration as per Figure 1 under Annexures. The integration to further include** SH Capacitation (CPD), development of School Health Nurse Specialization curriculum, expansion of PHC Training, provide mobile pharmacy, standardize the service and ensure consistency in all Provinces.
Chapter 6:	6.3.1(198) Refers to: D**istrict hospital is the smallest type of hospital**	**Input:** Use of the word "small "is relative and might be open to abuse. Propose to quantify small link it to number of beds or

	6.7; 6.8; and 6.9 reflects affirms collaborated services significant in all health services but are not explicitly linked to mobile and 24hour services **The 6.1 PHC reengineering excludes community based indigenous ad traditional services DENOSA wish to cite that the t**raditional medicine, traditional circumcision projects where nurses have already been involved are not linked in this Paper? Palliative care is now part of the SDGs and the Universal Health Coverage as declared by WHO. Therefore It is critical that the community and the institutions like hospices, old age homes, rehabilitation centers and the occupational health and safety in areas of employment be indicated as part of preventative, promotion of health. Incentives on preventative programs, encouraging healthy life style and medical check- up, participation in wellness campaigns- low salt diet and exercise necessary to cement positive behavior on healthy living focusing on prevention than curative—	wards per institution. The dynamics of each region and province vary… **Input:** Expand the pharmaceutical services, national health laboratory emergency to reach all rural areas and hard to reach areas; thus provide mobile services and 24hours services. **Input**: Explore and position these two categories within the PHC and palliative care- Indicate the link with traditional or indigenous medicine, circumcision processes. Consider HWSETA programs on palliative care, community health care workers. **Input**: expand Wellness centers and programs with an incentive like tax rebate, discount on food items etc. to promote prevention and early diagnosis of diseases such as cancer, HIV, obesity, depression, substance abuse, violence, hypertension etc.
Chapter 6: 161 and 162	The 161 paragraph seems irrelevant as it is covered in 162. 6.1.2. Integrated school programs: It seems the Early Development Centers (EDC) are not included and since they are being strengthened and having different schools (Grade R-Grade 12) and inclusion of FET Colleges and HE universities and Colleges not	**Input**: Delete paragraph 161…. **Input**: Suggest specific phrases **confirming inclusivity of all school** going ages and perhaps define the phrase school to exclude misinterpretation. Concrete statement with key provision for ECD, FETs and HE even the feeding/linking of health information electronically accessible to health care workers as the consumer enters basic education

	clear? We are losing the youth and infants at these levels of learning **What about Early centers of development (ECD), FET colleges, Colleges, Universities**? Point 137/138. **Moral hazard** – based economics of health care, the assumption is that insured people use too much health services thereby increasing costs, therefore the belief is that if people are exposed to the true cost of health services they will act more responsible and become better consumers. The concern with the statement in point 137 is that those who do not lead a healthy lifestyle exposing themselves to risk of Diabetes or Hypertension may be marginalised as indicated in 138. Please clarify what gate keeping steps will be implemented and how "abuse "of services will be managed.	from ECD, them to FET or HE. Elimination of duplication, burdensome repeated history taking to both the consumer and HCW and strengthening continuity of care and adherence (assist with indirect pre-screening of students). **Input**: Please clarify what gate keeping steps will be implemented and how "abuse "of services will be managed.
Chapter 7	Financing NHI- Direct taxation (personal income tax) – there must be consultation with tax paying citizens before a contribution table is finalised. A benefit design must be considered if the contribution is based on income (sliding scale) alternatively a tax incentive based on contributions to the NHI. The contingency fund for refugees must be included in the NHI finance plan.	**Input:** Other tax options not disadvantaging the poor and middle class- Value added tax – consider increasing other forms of Tax- Moral hazards etc., so that all citizens of SA including informal sector contributes towards NHI.
Chapter 8	Purchasing of Health services – DENOSA is concerned about the private public partnership(PPP) with current private hospitals at different levels- what selection criteria will be in place for care at PPP, will it be based on contribution?	**Input: DENOSA does not support the involvement of private sector in the provision, administration, management and monitoring of the Health services under NHI.** Proper structured processes addressing the raised concerns are necessary.

Chapter 9	"Chapter 9 :(409; 417): Implementation phase - Nurses backbone of health system"- The Nurses position within the NHI agenda NOT heavy and explicit!!! The practice to burden nurses with implementation without them participating in policy development and trials must be a thing of the past. The PPE culture is clearly linked to NHI therefore the nurse's rights and patient rights must be balanced including attractive remuneration packages supporting the expanded scope of practice for nurses, e.g., NIMART, PHC team leaders, school health has been successful. Clear roles and well defined responsibilities with the regulatory bodies is significant. The specific content (curriculum) capacitating nurses, mentoring and coaching programs to support health care workers are to be worked through with the relevant regulatory (statutory) bodies and proper remuneration packages with all the relevant stakeholders. **Example: (222) Patient satisfaction will be measured systematically through collaboration with the OHSC, other statutory bodies and stakeholders**.-- 9.11: Opening of nurses colleges, the Workforce indicators, Security and Safety of HCW in PHC institutions, starting with the community up to hospitals, WISN – Workload Indicators of Staffing	**Input:** Propose the **word "nurse"** be stated to confirm Nurses as drivers of the PHC together with the general practitioners". Programs cited in Chapter 10 are Nurse driven; this affirms the citing of the phrase "nurse" as the health care worker who is backbone of the health system". Suggest inclusion of the word "Nurse(s)" equally as it with the use of a phrase" general medical practitioners"; not a general phrase used- "health care workers". The role of the regulatory bodies, such as SANC, HPCSA, and Pharmacy Council are to be aligned to the NHI implementation policy collaborating with the Office of Standards Compliance ombudsman. The cross referencing and link to various Acts is necessary to decrease duplication and long beauracratic processes which may delay intervention of incompetent health care workers. **Input**: The silo approach should be discouraged and collaboration be encouraged. The Nursing Act outlines the objectives, functions and powers of the Council regarding professional practice, education and training and Unprofessional Conduct, e.g., dispensing of medication. It is significant to link these pieces of legislation within the NHI document to eliminate duplication, manage costs. The PHC model is linked to CHW, health promoters, environmental officials- these are not mentioned in the NHI White Paper. The qualification of CHW is located within the FET band level and are quality assured by the Quality Council of Trade and Occupations (QCTO) and HWSETA. The CHW are part of the PHC WBOTS program and palliative care which is led by the registered nurses. The CHW categories are currently not regulated and their training is but are led by Registered nurses.

	Needs and the inter-sectoral Collaboration are key areas to cover as a basis to roll out NHI.	Strengthening the collaboration and functioning of these categories institutions within the NHI is significant. **Input**: **Propose that the "CHW GROUP" be explored and unpacked clearly to allow smooth working relations with all other health care workers at the PHC level.** Provide security, safety, quality and support within all the specific cross-sectorial centers and officials. The role of Traditional Healers and other alternative medicine is not positioned within the PHC yet most community members embrace it as their PHC system: Please add: alternative healthcare providers such as traditional healers and others, also geriatric care. The phrase: (179) contracting also requires a **strong regulatory framework** for determining the costs for health services and the tariffs that should be charged" What about the CHC and palliative care workers; **they are not regulated yet?** The Nursing Act accommodates Nurses as private practitioners, Introduction (21) the **clause to state the nursing categories – "What is the position of the private nursing practitioners" within NHI?** **Input:** The details on these four issues are to be contextualized and unpacked clearly in line with strengthen service delivery especially training of nurses, workload PHC in service centers, clinic and WBOTS.
Chapter 6.6	6.6. Human resource for health - the other categories within PHC not mentioned- in terms of strengthening	**Input**: The strengthening the quality of training of WBOTS teams(CHW, Health promoters, Environmental, social to **include-**

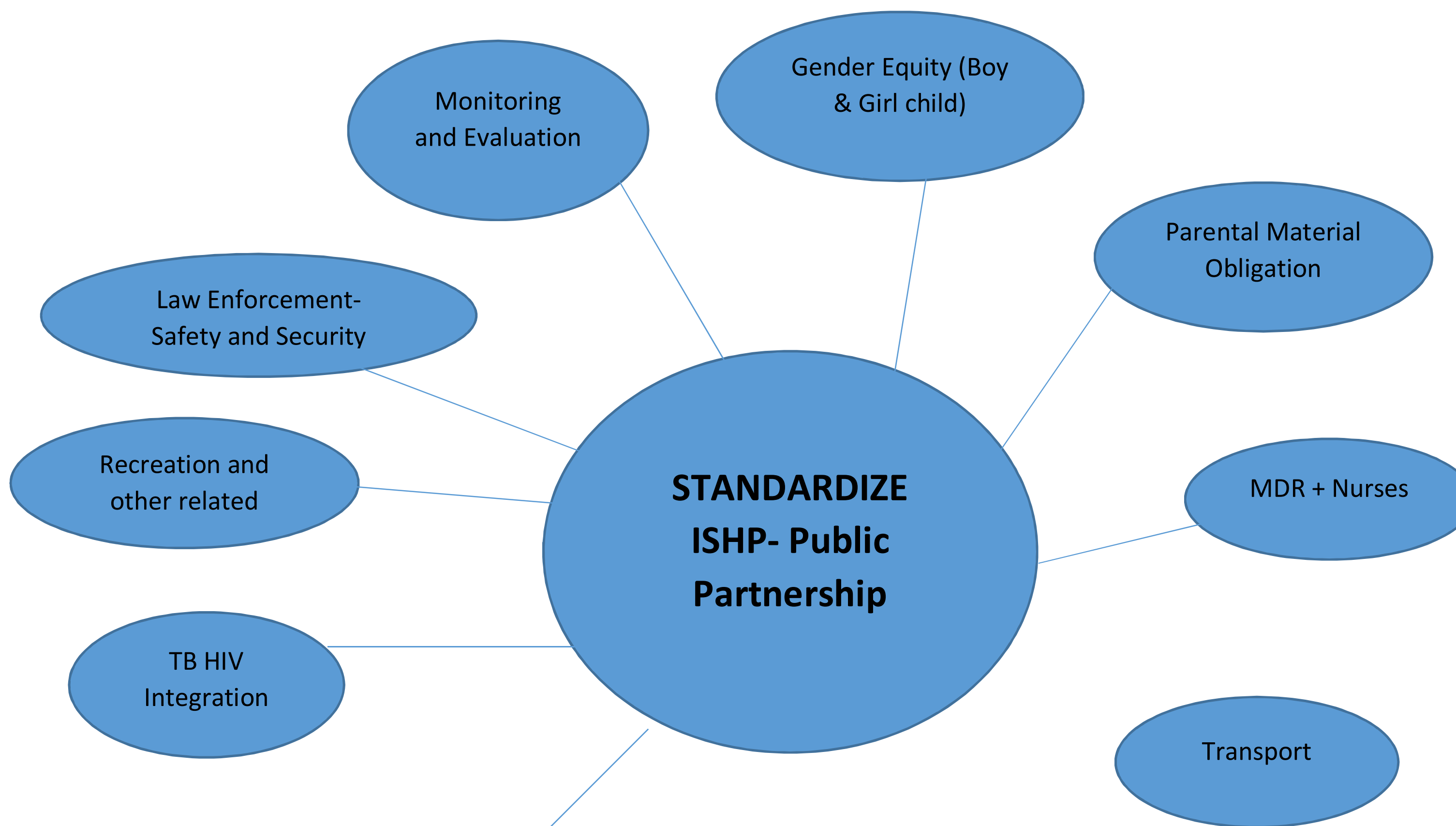
	and increasing their training, incentives for other sectorial professionals and CHW. (227)Incentives for attracting health professionals to work in rural and hard-to-reach areas are necessary as part of broadening access to quality services in these areas.	**their safety, scope of practice and working conditions, indemnity, regulations for CHW and palliative categories.** To sustain this partnership at this level regulating and monitoring this category will be significant. They work directly with nurses in clinics **and their conduct will impact on nurses directly and indirectly.** **Review the processes and policies to appoint HCW, consider** appointment in partnership with stakeholders, community, NGOs etc (governmental and non-governmental organizations) to strengthened compatibility, retention and community support.
Sustainability and M&E	The Nursing Act 33 states functions of the Council: 2(g) quality control inspections in accordance with the prescribed conditions; (h) investigate complaints against any health establishment in respect of its nursing service;- The NHI is silent about the link of the office of Health Standards compliance office processes and with the Regulatory bodies protecting citizens for regulated and not regulated HCWs (SANC, public protector, HPCSA, Pharmacy Council etc.,). NB***The promoters of unethical health related procedures, e.g., Circumcision, illegal abortions, etc., **must be monitored and penalized accordingly.**	Monitoring and evaluation process must be incorporated to ensure consistency in Provinces, regions and institutions(to eliminate fragmentation of implementation, different decision makers this might affect failure or delay in uniform benefit to citizens of SA- avoid overload of one province or region or health facility. Propose considering the model in Figure 2: Sustaining and Monitoring of NHI services. Labor to work with employer to ensure fairness and correct implementation of policy by avoiding biase in working on the (190). Retention strategy of managers and practitioners appreciated ; but c**onsider strengthening solutions on challenges, consider:** • Monitoring and Evaluation with quality Supervision • Palliative care teams, Rehabilitation centers (e.g., substance abuse) • The accreditation and efficient management of SPECIALIST and Private Providers who have a dual role in CURATIVE and PHC. • Introduce Research and research units to ensure scientific monitoring and feedback processes. • Consider the Rural and Danger Allowance(Protect and incentive) – Review and expansion- hard to find areas)

		• Differentiate: Strategic VS Operational processes(develop clear Standard Operating Procedure • ADHERENCE and COMPLIANCE enforcement. • **Managerial Processes with a**ccountability and monitoring; e.g., introduce a smart PMDS linked to CPD) • **Monitoring of HCW's presence and absence from work, especially the contracted private HCWs- Consider reliable electronic c**locking system with capacitated and skilled Managers to ensure efficient people management, quality services and management of work load. The partnership of the Ombudsman, Inter-ministerial Collaboration- Department of Justice on Safety and Security, Social services, Health regulators, Communication department (audio, visual and print media- SABC). OHSC to work with the Provincial National Core Standard teams and to consider decentralizing the OHSC offices to the Provincial level in future in order to reach targets in terms of assessment of compliance and sustainability (In Chapter 6.4). **The OHSC offices to work together with and support of Whistle-blowers, civil society, organized** labor and community forum including all community members, leaders, academics, policy makers, practitioners and politicians. The development of strong ethical culture to be inculcated at all levels and types of training institutions and service centers etc., must be linked to corruption watch, Ombudsman, civil society, trade organization and traditional leaders ("Magoshi"). A clear COMMUNICATION strategy to be established with inter -sectorial roles and relevant platforms used. The focus should be on specifically health related programs during prime times and

		related to health calendar on, Print, Electronic audio media including campaigns.
	Establishment of NHI Work-streams. 9.1.3(414). The NHI work-streams not explicitly affirming participation of key professional driving the PHC services.	**Input**: Propose full time positions represented by PHC nurses and Managers be made available as part of the teams establishing the NHI work streams. **Input**: DENOSA recommends that the NHI work-streams to include nurses in reasonable numbers from all relevant levels care.

3. ANNEXURE

Propose to consider ISHP indicators to ensure a comprehensive approach and integration of services example



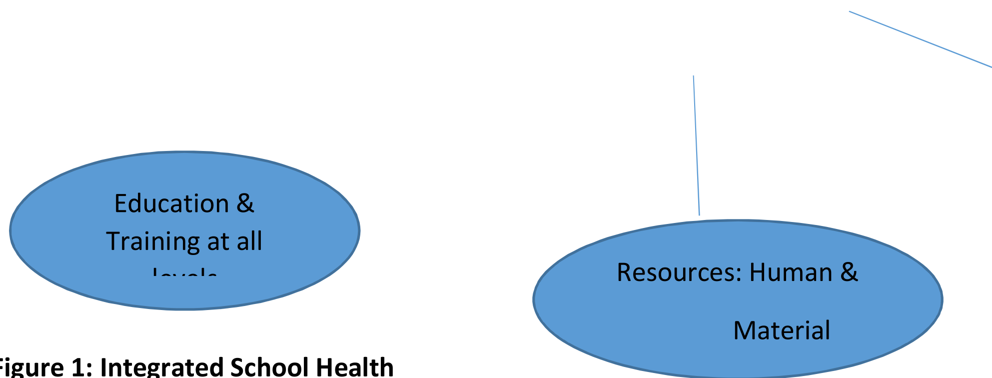


Figure 1: Integrated School Health

2. Development of structure and a model

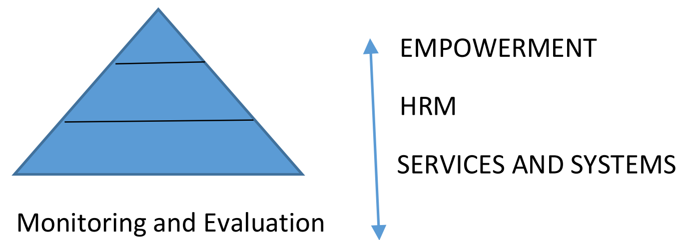


Figure 2: Sustaining and Monitoring of NHI services

REFERENCES