



Evidence Based Planning and Management: Workload Indicators of Staffing Needs

Determining Staffing for Primary Care Services Using WISN in the Philippines
Advocacy Brief

Introduction

The health workforce is the key component of the health system and health services cannot be delivered without an adequate number and type of trained health workers. Global evidence points to a direct correlation between the size of a country's health workforce and its health outcomes. The Philippines, like other countries is faced with human resources for health (HRH) challenges including shortages, inadequate skill mix and inequitable distribution of health workforce across levels of care. To produce, develop and deploy the right numbers and cadres of health workers, proper evidence-based planning is needed. In attempts to address these issues using evidence in the Philippines, the Health Human Resource Development Bureau (HHRDB) of the Department of Health (DOH), with the technical assistance from the United States Agency for International Development (USAID) through Human Resources for Health in 2030 (HRH2030) Philippines Project, introduced the World Health Organization's Workload Indicators of Staffing Need (WISN) method to understand the current workload pressure of health workers, determine the staffing needs and set staffing standards to optimize management of the health workforce to achieve universal health care (UHC) in the country.

Methodology

WISN is a planning and management tool which offers an objective and scientific method to estimate health workforce requirements based on actual workload.¹ The WISN tool helps determine the number and type of health workers that are needed to appropriately manage the workload of a given health facility, looking at both the health service and non-health service activities that are conducted by health workers, using actual data from the facility. Based on this analysis, managers and decisions makers will have the evidence they need to understand how to tackle inefficiencies, address trends in actual health worker activities, and identify true gaps in workforce availability. Overall, WISN takes account of the different health service packages and complexity of care in health facility settings.

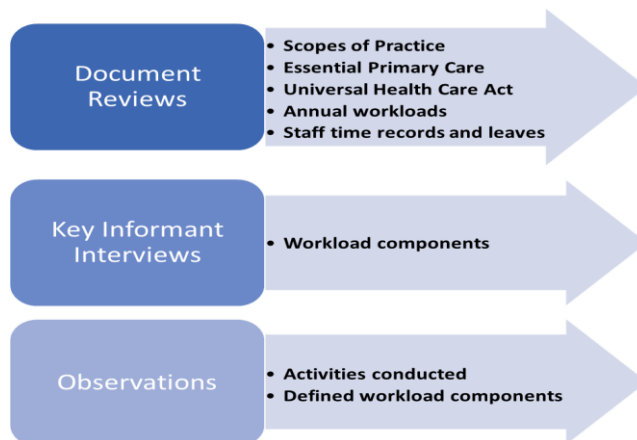
- 1 Determining priority cadres and health facility types
- 2 Estimating available working time
- 3 Defining workload components
- 4 Setting activity standards
- 5 Establishing standard workloads
- 6 Calculating allowance factors
- 7 Determining staffing requirements based on WISN
- 8 Analyzing and interpreting WISN results

¹ World Health Organization. (2016). HRH Observer Series No. 15. WISN: Selected Country Implementation Experiences.

Implemented between October 2018 to March 2019, the following activities were conducted in close coordination between USAID's HRH2030 and the DOH HHRDB under the guidance of the Steering Committee and collaboration with the Technical Taskforce and Expert Working Groups.

The study included four interdependent cadres, namely: physicians, nurses, midwives and medical technologists engaged in essential primary care services. The primary care services included in the study were offered in selected service areas of the facilities, namely the out-patient department, family planning (FP) clinics, tuberculosis (TB) Directly Observed Treatment Short-course (DOTS) centers, emergency wards, labor/birthing rooms and laboratories.

Purposive stratified sampling design was deployed to capture the nine regions based on HRH TB burden in urban and rural areas and geographically isolated and disadvantaged areas (GIDA). Further criteria for selection of the regions included priority provinces and cities with poor health outcomes², proportional representation from the three major island groups (Luzon, Visayas, and Mindanao), equal representation from high and low access areas and representation from a conflict-affected area in the country. Thus, the following regions were selected for the study: 3, 4A, 4B, 7, 8, 11, 12, National Capital Region and Autonomous Region of Muslim Mindanao.



Findings

The WISN results suggests that services provided are generally of good quality, however some inefficiencies in the systems can still be addressed to improve the services. While detailed results can be found in the complete WISN report, the below highlights some of the key findings that should be taken into consideration for planning and management of the workforce.

	<p>The immediate results show where there was a mix of staff shortages, surpluses and sufficient numbers of health workers within the local context of the Philippines. The workload pressure varied according to the facilities' levels and cadres. Generally, physicians, nurses and midwives in the RHUs/CHOs had higher workloads. Extremely low workload pressures were experienced by the midwives at the BHSs, medical technologists at the RHUs/CHOs and at level 1, 2 and 3 Hospitals indicating staff underutilization in almost all the services offered. Shortages in the BHSs were recorded as 16% and 15% at the RHUs/CHOs with surpluses at 34% for BHSs and 84% in the RHUs.</p>
	<p>The study noted that some roles overlapped between nurses and midwives such as immunizations and FP services. Other overlaps were seen for normal spontaneous deliveries conducted by physicians, nurses and midwives. This signifies ongoing informal task shifting and sharing without clear policies and guidelines to guard against any compromised quality of services.</p>
	<p>Staff absences varied across cadres for different reasons like compulsory leave, public holidays, sick leaves and trainings. The physicians exhibited the highest absences due to prolonged training programs out of the health facilities and training absences was lowest among the midwives. Staff on contracts recorded fewer absences due to the terms and conditions of services.</p>

² Health outcome indicators for inclusion included maternal and infant deaths from the Philippine Statistics Authority, 2016 and unmet need for modern FP, and HRH indicators from the 2017 NDHS.



Health services data and records were available in the facilities though not captured in a standardized manner across the facilities and LGUs. There were slight differences in the way data

on health services was reported, thus making it challenging to ensure that health services data was consistent across all facilities.



If standard packages were revised for the levels of care to match the categories of staff, then the surpluses would reduce. Most physicians at the RHUs in the rural areas offered limited services. They mainly provided consulting and

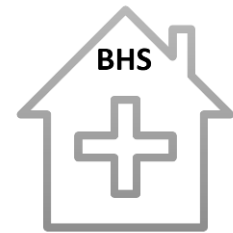
referrals services to the patients/clients.

Recommendations

Following analysis of the WISN study results, the following recommendations were developed for strengthening primary care services. To begin, facility level recommendations were considered, followed by cross cutting recommendations for the immediate, short and long term. Subsequently, short and long-term recommendations were developed based on the WISN results. Short-term recommendations are focused on administrative and operational actions that should be taken. The long-term recommendations may require significant policy, financial and wider stakeholder consultations and involvement before implementation.

Barangay Health Stations

To address the differences in service provision found among BHSs, services should be standardized and options for optimizing services between midwives and BHWs should be discussed. The health service package for a BHS therefore needs revision to define health interventions and specific health provider(s) to address the issue of staff underutilization. A midwife and nurse assigned full time in a BHS will improve access and coverage for more clients and patients.



Globally, countries are increasingly turning to community health workers, or BHWs as they are known in the Philippines, to extend health services to underserved areas. During the study interviews, the researchers found that BHWs contributed most of the workloads captured in BHSs and some RHUs. Supporting and recognizing the importance of BHWs, as part of a diverse and sustainable health workforce skills mix through relevant short training, supervision and provision of equipment, will go a long way to strengthen the health system. This is an opportunity for the Philippines to reconsider the engagement and remuneration terms of these workers.



Rural Health Units and City Health Offices

The study results show that high priority should be given to revising the standard services offered by nurses in RHUs/CHOs. Generally, the facilities at this level were not offering the full range or package of services as expected. The nurses were underutilized, and the annual workloads were too low for this level of care. They should ideally provide gatekeeping services at the primary care levels. Based on the WISN results and the planned UHC services for RHUs/CHOs, more midwives and nurses are needed in urban areas, since BHSs that act as an entry point to primary services do not exist, and also due

to the fact that midwives have a role in supporting the existing BHWs.

Given the above points recommend a rationalization of workload, it is recommended that RHUs/CHOs should have functioning laboratories with at least two medical technologists to manage cases referred from the BHSs after initial consultations and interventions have been tried and are beyond the capacity of the BHS. Laboratory services at this level of care will minimize overcrowding at Level 1 and 2 facilities, increase early detection of various conditions and thus provide appropriate care nearer to the patients.

Immediate and Short-term Recommendations

Develop new HRH norms and standards based on workloads for primary care facilities.	Strengthen the capacity of health facility managers to improve resource management, supportive supervision and service efficiency at all levels of care. This will create a conducive environment for health workers to implement health programs.
Expand the nursing scope to offer clinical services at BHSs and GIDAs where there are few physicians.	Expand and strengthen the HRH coordination network to involve more relevant stakeholders as HRH issues are complex and require a multisectoral approach to solve them. Cascade this to the regional levels as they also play a key role in HRH recruitment, development and management.
LGUs and HHRDB should conduct annual needs assessments and then plan for training and any other development programs. Equal opportunities for skill development based on identified needs should be prioritized.	Negotiate with development partners on feasible deployment mechanisms for extra staff that are sustainable within the capacities and structures of the government. Additional staff recruited and deployed by development partners should be aligned to government guidelines and structures for the specific cadres, considering remuneration and job descriptions within regulatory frameworks
Advocate among LGUs to redistribute staff from facilities with high numbers of staff compared to the needed workloads to understaffed facilities within the SDN/ ILHZ.	

Long-term Recommendations

Develop referral guidelines to strengthen services at all levels involving both the public and private sector befitting the urban, rural and GIDA contexts.	Revision of job descriptions to align with scopes of practice to accommodate new cadres, upgrade others and even create new ones to meet the health needs and respond to trends in the labor market. This can also involve the revision of curricula.
Consider accelerating production of nurses and midwives as most of them involved in the different steps of WISN indicated an aging staff.	DOH to develop standardized tools for adoption by the LGUs for collection of health service statistics at the service points.
LGUs to consider merging and/or reclassifying some staff to align them with the needs of the populations.	Standardize the package of services offered to reduce variation among BHSs and RHUs.