POLICY BRIEF

Improving Health Workforce Planning and Management

STATEMENT OF THE ISSUE

The workload of health care professionals affects the quality of health care services they provide to communities. Workload pressures, especially at primary care facilities, are influenced by various factors such as health workforce supply, utilization rates of health care services, and other health care activities undertaken by the facility. In the advent of universal health coverage (UHC), the demand for health care services is expected to increase. The Department of Health (DOH) will need to consider how to strengthen local planning and management of human resources for health (HRH) to ensure that primary care facilities are adequately staffed with trained health care workers who can provide quality health care services and meet the population's health needs. This policy brief explores approaches that the DOH can adopt to support local planning and management of HRH; and ensure that an appropriate mix of health care professionals are available at the primary health care level to deliver essential health care services to the communities.

BACKGROUND

In the Philippines, basic public health services are delivered through primary care facilities, such as the Rural Health Units (RHUs)/Main Center (MC) and Barangay Health Stations (BHS). In 2016, there were 2,590 RHUs/MCs and 20,065 BHS, but, according to DOH estimates, the country still lacked 696 BHSs and 2,600 RHUs.[1] Most regions had adequate numbers of BHSs except for the National Capital Region (NCR), Regions 3, 4A, 5, 8 and Bangsamoro Autonomous Region of Muslim Mindanao (BARMM).[2] For RHUs, only the Cordillera Administrative Region (CAR) met the recommended number based on the 1:20,000 ratio for RHUs. Wide variations in the number of BHSs and RHUs existed in Regions 2 and Region 4A. Although NCR lacked BHSs, private clinics proliferated in the region.

Primary care facilities are managed by a team of health care professionals composed of a doctor, public health nurse, midwife, dentist, medical technologist, and sanitary engineer or inspector. Determining the number of health staff needed per facility is based on a standard HRH to population ratio of: 1 RHU/MC physician to 20,000 population, 1 public health nurse (PHN) to 10,000 population, 1 Rural Health Midwife (RHM) to 5,000 population, and 1 dentist to 50,000 population.[3] Current HRH densities are low, with RHU/MC Physicians, PHNs, Rural Health Midwifes, and dentists falling below the recommended ratios.

Overall, the Philippines has a current summary ratio of 19.7 HRH to 10,000 population. Compared with the ratio of 44.5 health workers per 10,000 population recommended by the WHO, the Philippines is below the suggested benchmark. Translated into shortages, these HRH density ratios indicate a shortage of 2,031 RHU/MC Physicians, 4,467 public health nurses (PHN), 3,966 rural health midwives (RHM), and 148 public health dentists.[4]

Among the 17 regions in the country, only NCR and CAR have met the appropriate number of doctors based on the recommended standards.[5] Seven regions (CAR, Ilocos, Cagayan Valley, MIMAROPA, Western Visayas, Northern Mindanao and Caraga) had adequate number of RHMs and three regions (NCR, Ilocos and Caraga) had adequate number of public health dentists. None of the regions had the adequate number of nurses.

Limitations in the use of HRH to population ratios as a basis for determining HRH staffing needs exist. Although the approach is a quick and simple method of benchmarking HRH sufficiency, it does not take into account other variables aside from population size that are known to have an impact on health worker performance in improving health outcomes, such as: epidemiology and burden of disease, patterns of service and provider utilization, organizational efficiency, health policies, regulations and standards, and distribution of the health workforce by occupation, among others.[6,7] It also does not consider the workload pressures of RHU staff in providing health care services. With the increasing number of public health programs required to be implemented by the RHU staff and the support activities necessary to operate these services, workload pressures are critical in HRH planning and determining staffing requirements.

Health seeking behavior of the population differs and is influenced by various socio-economic factors such as sex, age, social status, type of illness, access to services and perceived quality of service[8] such as proximity, affordability, prompt attention, and ready available drugs.[9] The health seeking behaviors of the people in the community served, would need to be considered in HRH planning, training, deployment and distribution to ensure that the appropriate health care professional is available and accessible to respond to community health needs.

Health care utilization is an important indicator in the use of health services by the community to prevent or cure health problems, promote the maintenance of health and well-being, or obtain health information.[10] Several factors predisposes a population to increase or decrease its use of the health care services such as socio-economic status, physician supply, risk behaviors of a population and health status,[11] provider factors and perception of quality (which push patients to seek health care from lower level to higher level facilities[12]), and health service related factors.[13] Evidence, therefore, from health service utilization are important inputs to planning human resources, physical capital and consumables for the provision of quality health care services.

The effective and efficient management of daily activities of the health workforce and time applied to the provision of health care service also contribute to building the quality of health care services given by the primary care facilities. Thus, it is important to consider how daily activities are done by health workers and the amount of time they use in the provision of services to input into HRH planning. Regional differences in the health situations also inputs to the menu of services offered by primary care facilities. In order to ensure a responsive health care team to provide services appropriate to the needs of the community, health situations need to be considered as a basis to determining staffing levels.

Workload Indicators for Staffing Needs
Workload Indicators for Staffing Needs (WISN) is a planning tool developed by the World Health Organization (WHO), which offers an objective and systematic method to estimate health workforce requirements.[14] The WISN tool helps determine the number of health workers of a specific type that is needed to appropriately manage the workload of a given health facility. WISN assesses workload pressure of health workers using actual data from the health information system. Taking account of the different health service packages and complexity of care in health facility settings, it provides critical information to enable health managers to address gaps in workforce availability.

WISN has been implemented in various countries to establish evidence-based staffing norms for their countries. Based on an assessment of workload pressures, WISN enables health managers to use results to establish staffing models in line with desired health reforms in their countries and improve planning and

distribution of their health workforce. Implementing WISN involves the establishment of a technical task force, responsible for developing a WISN strategic and implementation plan and coordinating activities. Users of WISN set activity standards based on actual tasks conducted by the primary level facility, conduct trainings for the application of WISN, collect data, validate quality of the data collected, and develop staffing norms based on the results.

In 2018, the DOH, through the USAID HRH2030 Philippines project, implemented the WISN methodology in nine regions, focusing on tuberculosis, maternal and child health, and family planning services.[15] Through WISN, the workload pressures of four cadres in the delivery of primary health care services were analyzed in rural and urban areas. WISN point persons were oriented in the methodology and trained in the use of the tool. Five variables - available working time, workload components per workload group, activity standards, annual workload data and current staffing, were used in the calculations. Staffing needs and standard workloads based on the specific tasks undertaken by the RHU staff, were used to estimate the standard workload for each staff category per facility and the total time required to carry out these activities.

WISN results indicated that none of the RHUs were operating at optimal levels, with 85% indicating staff underutilization. Only 15% of RHUs/CHOs had significant shortages. Differences in the provision of services were noted, indicating a lack of standards in service delivery. WISN measures workload pressure in terms of extremely low, very low, low, normal, high and very high, indicating the volume of tasks a health worker has in their available working time. Majority of the physicians had very high workloads but performed only minimal tasks such as consultations and referrals. Nurses had both very high workload pressure and performed a large volume of tasks, but this was due to work outside of their scopes of practice, such as performing services that must be provided by midwives like deliveries and family planning services, and services not directly related to the provision of health care services like reporting and attending training. Medical technologists had low workload pressures because most of the facilities only offered minimal laboratory services. Analysis of workload and activity standards at the RHUs indicated inefficient distribution of tasks among RHU staff. Health interventions were not well defined and specific health staff responsible for providing these services were not identified.

The WISN results enabled health managers to identify strategies to improve HRH staffing that will result in service delivery enhancements. For example, a full-time midwife and nurse could be assigned to the BHSs to improve access and coverage of services to the community. An administrative position could be created to be responsible for record keeping, to enable RHU staff to focus more on service activities. A policy to guide on task shifting and sharing without adequate training and supervision could be put in place to ensure coordination and efficiency of services. The WISN study also identified the need to strengthen capacities of facility managers in resource management, supportive supervision, and service efficiency at all levels of care.

The use of the WISN methodology effectively captures the critical elements of health service provision and management, such as workload pressures and activity standards to determine staffing needs. The methodology may be applied to any primary care facility and can be undertaken by trained local health staff at the primary health care facilities. The health workforce will be able to assess their own workloads and determine activity standards based on the actual tasks undertaken. After analysis of data collected, results can advise the need for additional staff or re-assign tasks to better manage workload. Staffing norms may be determined based on WISN results, which can model the number and type of health staff needed to manage a specific menu of health services. WISN can be used to calculate the required human resources for future models based on assumptions, such as the results of staff training, demographic changes, and disease

profiles and staff turnover.[16] Applied across primary care facilities, the methodology has potential to systematically address inequity issues on staffing.

EXISTING POLICIES

The government of the Philippines has enacted several policies that govern HRH staffing of health facilities. These policies indicate staffing standards and guidelines for HRH, as follows:

At the national level, the **Republic Act 11223 or the Universal Health Care law[17]** includes provisions on managing and developing HRH. Chapter 6 of the law provides for the formulation of a National Health Human Resource Masterplan that outlines *appropriate generation, recruitment, retraining, regulation, retention and reassessment of the health workforce based on population health needs.* It provides for the creation of a national health workforce support system that aids local public health systems in addressing their human resource needs. Scholarships and training programs will be expanded for existing and new allied and health-related degrees to produce appropriate type and number of health care professionals for the country. Return Service Agreements are required to ensure availability of health workers to serve priority areas in the public sector for at least three years.

The Department of Budget and Management (DBM) also issues policies through the **General Appropriations Act (GAA)** and corresponding **DBM Circulars** related to the creation of permanent *plantilla* positions in government institutions, including health facilities. It outlines the approved structures of government offices, its functions, positions and salary grades of employees which will be funded by government and corresponding budget allocations. Recent re-organization of the DOH has re-configured the number and roles of different units under the agency.

The DOH has several policies that mandate the development of staffing standards to address HRH inequities at health care facilities. Under **Executive Order No. 102**, "**Redirecting the Functions and Operations of the Department of Health,**" the DOH is given the role as *lead agency in ensuring equity, access and quality of health care services through policy formulation, standards development and regulation* and function to formulate policies and standards for health that will govern the health sector. As a regulatory agency, the DOH requires staffing standards for licensing of health care facilities. **Administrative Order 2012-0012 Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines** outlines the licensing requirements for health care facilities based on the classification of hospitals (general or specialty) or services offered (e.g. primary care, custodial care, diagnostic/therapeutic and specialized out-patient). Each category includes standards for personnel, physical facilities, equipment and instruments, service delivery, quality improvement activities, information management, and environmental management. In addition, the DOH sets HRH requirements for the certification of primary health facilities to provide Basic Emergency Maternal, Neonatal and Obstetrics and Comprehensive Emergency Maternal, Neonatal and Obstetrics. HRH qualifications are also required by the Philippines Health Insurance Corporation (PHIC) for health care professionals wanting to reimburse payment for their services.

At the LGU level, DOH also uses **standard ratios** for physicians, nurses, midwives, and dentists working in a primary health care facility that are used as a norm by both the DOH and the LGUs in identifying staffing needs at the primary care facilities. Although these standards are not contained in any DOH national issuance, the norms are indicated in several planning documents such as the National Objectives for Health 2017 – 2022.

RA 11223 and EO 102 provide DOH with the policy mandate to create appropriate staffing standards at the primary care level to achieve UHC. Increasing the health workforce for UHC implies a large investment that may need to be funded by the DBM from the GAA. With the proposed menu of services to be provided under the UHC, staffing requirements in various health facilities would need to be well planned and managed. The method of determining staffing needs in HRH planning and management would need to consider new workloads and activities that the primary care facilities will undertake under the UHC Law.

POLICY GOALS
To achieve UHC, the DOH must ensure that quality health care services are equitably delivered by capable health workers in all primary care facilities. Given the essential health packages to be provided under the UHC, it will be essential to improve the efficiency of health services delivered by the health workforce through appropriate HRH planning and management that result in high-quality health service delivery that is responsive to community health needs.

POLICY ALTERNATIVES
There are three proposed policy alternatives that the DOH may consider implementing in the next five years in the country.

I.   **LGUs to determine staffing needs at primary care facilities based on local health needs**
This policy option represents the current method by which DOH and LGUs address staffing inequities at the primary care level. Under this option, the responsibility for determining staffing needs at primary care facilities rests upon the LGU. The LGUs are mandated by law to be responsible for human resources and development in their respective units as stated in the Local Government Code of 1991, Title III human resource development, Section 77.[18] Under the law, the chief executive of every local government unit, in keeping with his or her responsibilities for human resources and development, takes all personnel action in accordance with the constitutional provisions on civil service and policies of the Civil Service Commission.

LGU policies on local HRH vary depending on the local health needs and development priorities of the local chief executive. The number of employees hired are determined by the province or municipal local government unit based on the available internal revenue allocation (IRA) received by the LGU and the budget cap on appropriations for employee's salaries.[19] The budget cap on appropriations for employees' salaries for 1st to 3rd class LGUs is set at 45% of the IRA while 4th to 6th class LGUs have a budget cap of 55%.[20] Wages are based on the salary grades determined by the National Salary Standardization law. The Provincial or Municipality Annual Investment Plan (AIP) presents the proposed budget allocations for the year. This plan includes both the proposed budget allocations for personnel services (PS) and maintenance and other operating expenses (MOOE) of the LGU.

Although provided with the autonomy to manage their own HR systems, spending limits for local personnel set by the Local Government Code often prevents LGUs from hiring enough health workers for their locality. On average, each RHU has one physician, two nurses, five midwives and 0.6 medical technologist.[21] In view of the budget limitations, especially for GIDA where IRA is low, LGUs are constrained from providing needed investments in HRH. Support in the form of HRH deployments, financial incentives, and drug supplies are often provided by the National Government to supplement these limited resources.

The wide variation in the IRA and budget caps of LGUs, especially among 4th to 6th class provinces and municipalities may limit the LGU's ability to hire the appropriate number and mix of health care professionals needed to address the health care needs of their communities. Given these variations and limitations, this option may not meet the equity goal of the policy as LGUs may be unable to meet the DOH

staffing standards for primary care facilities and workload pressures among health staff may remain uneven.

This option may likewise be unable to improve the efficiency of health service delivery. Gaps in the number and mix of health staff at the primary care facilities may cause imbalances in the workload of the health staff, leading to inefficiencies in the delivery of health care services. Using health needs as a basis for determining staffing requirements without considering activities of the primary care facility, workload of health staff, service utilization rates and health seeking behavior of the community, may be ineffective in addressing staffing needs for quality health service delivery.

The lack of HRH planning tools to appropriately determine staffing requirements based on health needs may likewise continue to have an impact on the availability, accessibility, and quality of health care services provided by LGUs to their communities. Most often, LGUs do not have easy access to technical tools that will help them analyze their own HRH situations, determine HRH needs, and develop plans to address staffing gaps. Thus, this option may not be technically feasible as a method to determine staffing needs without the use of appropriate HRH planning tools.

This option is financially and politically feasible since its implementation will not require additional investments from the LGU and can work within the set development priorities of the LGU.

   II.   **DOH strengthens the capacity of LGUs to determine HRH staffing needs.**
Under this option, the DOH can initiate a more enabling environment for HRH planning and management by introducing LGUs to approaches and tools that they can adopt in planning for and managing their local health workforce, such as the needs based, utilization-based or demand-based, service target-based or adjusted service target approaches. HRH planning tools are available on-line and may be accessed by the LGUs. Studies have indicated the use of these tools in estimating and projecting HRH requirements. However, information on its application at primary care facilities in the country are limited. Although the DOH had previously assisted LGUs in planning exercises, most of the tools were focused on planning health service deliveries which either did not include HRH requirements, formed only a minor component of the plan, or followed licensing requirements.

Under this option, the DOH can advocate to the LGUs the use of any of the planning methods to estimate staffing requirements for health facilities for optimal use of HRH. Capacity strengthening interventions will be made to support and empower health facility managers and local government officials in adopting any of the methods. The policy option can likewise include incentive schemes to encourage LGUs to adopt planning and management approaches to the design of staffing patterns for their health facilities.

This policy option builds on the role of local governments in designing and implementing its staffing pattern based on service requirements and financial capability, [22] thus it might be more palatable to the local governments. Also, the option offers capacity building and technical assistance to empower LGUs and facility managers from DOH, which will have no cost to LGUs but will strengthen their local governance of HRH.

Under this option, strengthening the HRH planning and management practices of LGUs will lead to better equity in communities' access to health services. It can likewise foster efficient health service delivery as the health workforce will be optimized. However, the DOH cannot direct, and can only influence, local governments in how they staff their health facilities. This policy option anchors to the awards system provided by the Seal of Good Local Governance Act and the Philippine Quality Act. Therefore, LGU compliance is optional, and adoption could be varied. Although technically feasible, strengthening the capacity of all LGUs will require DOH to allot resources (time, finance, human capital) to conduct the

necessary activities, like advocacy strategies to initiate LGU buy-in, actual capacity development interventions, and follow-up activities.

III. DOH adopts WISN as the primary method for determining staffing needs of primary care facilities for UHC

Under this alternative, the DOH adopts a multicomponent approach for scaling up the use of WISN nationally to determine HRH staffing needs at primary care facilities. WISN is a planning tool developed by the World Health Organization (WHO), which offers an objective and systematic method to estimate health workforce requirements.[23] It helps determine the number of health workers of a specific type that is needed to appropriately manage the workload of specific health facility. WISN assesses workload pressure of health workers using actual data from the health information system. It takes account of the different health service packages and complexity of care in health facility settings. The tool also provides critical information to enable health managers to address gaps in workforce availability.

WISN has also been successfully implemented in various countries to establish evidence-based staffing norms for their countries. Based on an assessment of workload pressures, WISN enables health managers to use results to establish staffing models and management strategies in line with desired health reforms in their countries and improve planning and distribution of their health workforce. Implementing WISN involves the establishment of a technical task force, responsible to carry out the methodology, including managing clinical experts, collecting and analyzing data. Clinical experts set activity standards based on actual tasks conducted by the primary level facility. A steering committee is also established to review WISN results and make decisions to better plan and manage the workforce.

The DOH can issue a national policy to adopt WISN as a method to determine staffing needs at primary care facilities and to inform policies on HRH distribution and deployment. This policy would seek to set the norm for HRH planning at the central level and encourage LGUs to do the same. However, the policy cannot mandate LGUs to adopt WISN and so the DOH would need to do more to incentivize LGUs to adopt WISN.

For example, the DOH can issue an AO to require the use of WISN results to determine HRH deployment needs and inform local requests for national health workforce support. This would encourage LGUs to adopt WISN as a tool to determine staffing needs at primary care facilities so that they could continue to receive supplemental HRH support from the DOH. To strengthen the capacity of LGUs to use WISN, DOH can provide technical support to LGUs on its use. As LGUs apply WISN and begin to see the benefits of it in optimizing HRH, they will continue using it to plan and manage HRH, creating a virtuous cycle of improvement. Training budgets from the GAA may be needed to cascade the use of WISN at regional, provincial and municipal levels. Finally, the DOH can incentivize LGUs to adopt WISN by including it as an indicator in the LGU scorecard and Seal of Good Governance.

The health workforce will be able to assess their own workloads and determine activity standards based on the actual tasks they undertake. After analysis of data collected, results can advise the need for additional staff or re-assign tasks to better manage workload. Staffing norms may be determined based on WISN results. It can also model the number and type of health staff needed to manage a specific menu or package of health services under the UHC. WISN can also be used to calculate the required human resources for future models based on some assumptions such as the results of staff training, demographic changes, and disease profiles and staff turnover.[24] WISN results may inform Local Investment Plan for Health (LIPH) of LGUs and the Health Care Provider Networks to be established. Applied across primary care facilities the methodology has the potential to systematically address inequity issues on staffing.

Costs to apply WISN at primary care facilities may be minimal. Initial investments in the training of local health managers may be needed to guide them in its use. However, continued use over the long run, may cost lesser since capacities of local health staff as technical experts in the use of the tool will be available in all primary care facilities.

This option may not be politically feasible with LGUs as they may resist the requirement to conduct WISN to obtain deployed HRH. However, it could be acceptable to LGUs and HRH managers as a useful tool to assist with HRH planning and management.

DISCUSSION
To determine the most feasible policy option that will address staffing inequity especially in GIDA for Universal Health Care, each policy alternative is evaluated based on a set of criteria aimed to meet the policy goals. Five criteria are selected: equity, efficiency, technical feasibility, financial feasibility, and political feasibility.

- Equity is defined in terms of the ability of the policy alternative to address unequal variations in workload and availability of health services in primary care facilities.
- Efficiency is defined as the ability to match workload with the demand for health services and accomplish tasks or activities with the least amount of time and effort.
- Technical feasibility is defined in terms of the health system's technical capability to implement the policy alternative.
- Financial feasibility is defined as the least cost to government and long-term financial sustainability.
- Political feasibility refers to the expected level of acceptance of the policy option by decision-makers.

Policy options are scored on each criterion and assigned a score between 1-3. The score of "1" means that the policy alternative is least likely to achieve the policy goals. The score of "2" means that the policy alternative is likely to achieve the policy goals, but some factors may inhibit its achievement. The score of "3" means that the policy option will most likely achieve the policy goals. Table 1 below presents the evaluation of the policy alternatives based on equity, efficiency and feasibility.

Table 1. Criteria for the Assessment of Policy Alternatives for Equity, Efficiency and Feasibility

Policy Goals	Definition	Policy Alternatives		
		LGUs to determine staffing needs	DOH strengthens LGU capacities to determine HRH staffing needs	WISN results to determine staffing needs
Equity	Ability to address variations in workload and access	1	3	3
Efficiency	Ability to accomplish tasks/activities with the least time and effort	1	2	3
Technical feasibility	Degree of the proposed technical system being easily done	2	2	3

Policy Goals	Definition	Policy Alternatives		
		LGUs to determine staffing needs	DOH strengthens LGU capacities to determine HRH staffing needs	WISN results to determine staffing needs
Financial Feasibility	Possibility that the proposed activity or alternative will be funded	3	2	2
Political Feasibility	Acceptability of the policy alternative to the decision-maker	3	3	2
	TOTAL	10	12	13

Option 1, LGUs to determine staffing needs at primary care facilities based on health needs, may not achieve equity goals of the policy since LGUs have varied IRA allocations and HR systems that influence hiring of health care professionals. Limitations on the budget cap for personnel services may result in reduced numbers and high workloads of the health workforce. The option may not achieve the efficiency goal of the policy because of the possible imbalances in workload brought on by variations in LGU capacities to address staffing shortages at primary care facilities. Technical feasibility may also vary among LGUs because of the different HR systems and methods that LGUs use. This option is financially feasible since no additional costs will be required to determine staffing needs. It may also be a popular option to LGUs since local autonomy is recognized and cost is dependent on availability of LGU funds.

Option 2, DOH strengthens the capacity of LGUs to determine HRH staffing needs, may achieve equity since planning tools chosen by the LGUs will be able to assist them in determining staffing needs at the primary care level. However, since the LGUs have a range of HRH planning approaches to choose from, the basis for determining staffing needs may differ and staffing standards may not be comparable across LGUs. These varying approaches to HRH planning selected by LGUs may not necessarily result in efficient determination of staffing needs expected to provide quality health care services. Some costs would be incurred to train and orient LGUs on the selected planning tool. Since selection of the HRH planning approach is dependent on the decision of the LGU, this option may be politically acceptable to the decision-maker.

Option 3, DOH adopts WISN as the primary method for determining staffing needs of primary care facilities for UHC, may achieve equity and address staffing gaps more precisely, since the approach would be conducted in all primary care facilities to determine the number and mix of health staff. Applied as a standard to all health centers, WISN can enable health managers to determine staffing needs that will deliver quality health care, which is at par with other health facilities. The option can also achieve efficiency since factors that influence demand for health services are considered in determining staffing needs. It can likewise be effective in identifying appropriate HRH since context and service utilization is considered in HRH planning.

The option has high technical feasibility since the WISN tool is an available application which can easily calculate and evaluate staffing needs based on workloads with limited training. It provides an organized and systematic process in determining staffing needs, which may be replicated and sustained by local technical experts and committees. Initial investments for training may be needed at the start of implementation, but after training, the facility would be able to continue applying the method with limited technical assistance from the DOH. While the WISN methodology has been accepted by the DOH executive committee at the central level, this option may not be politically feasible with LGUs, as they may resist the requirement to conduct WISN to obtain deployed HRH.

Conclusion

Of the 3 options, the use of WISN seems to be the most equitable and efficient in determining staffing needs since it considers the context in which health services are delivered. Staffing needs are based on workload, which enable an efficient distribution of tasks among health care workers. The methodology may require training of health managers in the use of WISN, which will require financial investments, but once committees are organized, activity standards are set, and the WISN tool is used, staffing needs at the primary care level can be objectively determined and provide the necessary evidence for HRH planning. The use of WISN in determining staffing needs may not be acceptable to LGUs since the analysis may result in the need for additional personnel. However, findings may also be used to advocate for additional HRH budgetary resources.

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