



WISN

WORKLOAD INDICATORS
OF STAFFING NEED

APPLYING THE WISN METHOD IN PRACTICE

Case studies from Indonesia,
Mozambique and Uganda



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The original Workload Indicators of Staffing Need method was applied at many sites throughout the world after its publication by the World Health Organization in 1998; in several instances, experience with applying the method was documented. In 2008, the WHO Department of Human Resources for Health convened a working group consisting of Peter Hornby, Riitta-Liisa Kolehmainen-Aitken, Marjolein Dieleman, Grace Namaganda, Serpil Ozcan and Ferruccio Vio to rewrite the manual. The group decided that it would also be useful to offer access to a selection of the documented experience. In this way, the potential user could get a feel for the strength of the method in helping to reorganize the workforce at various levels of the health system to achieve a more responsive and balanced distribution of staff.

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Foreword

In 1998, the World Health Organization published guidance on how to analyse staff utilization at the various levels of the health care system. Many countries have since applied the method to study and improve the performance of their local health systems by identifying the workloads of specific staff categories and establishing a more balanced distribution of their human resources as a result of analyses performed.

The updated Workload Indicators of Staffing Need method has benefited from having been applied in many contexts. New knowledge was generated on the application of the method, the way it can be most efficiently taught, and how the results can be prepared for presentation and mutual learning.

The case studies presented here give an overview of the results obtained from applying the method in diverse health care settings. They also indicate that the method can be used dynamically and tailored to individual circumstances.

Introduction

This document, which complements the revised *Workload indicators of staffing need (WISN): user's manual*, provides examples of how the WISN method has been applied in practice. The case studies described here come from Indonesia, Mozambique and Uganda. The WISN applications in these diverse settings had different origins, purposes and scopes, thus demonstrating the broad relevance and versatility of the WISN method.

The initiative to use WISN at the local level in Indonesia came from a donor-funded project. In Mozambique, the Human Resource Directorate of the Ministry of Health made the decision to experiment with WISN without any involvement of external agencies. A local university spearheaded the use of WISN in Uganda. The initiative for the first Ugandan WISN study came from the country's Ministry of Health, with an external donor providing technical and financial support. The second WISN study was implemented in response to a request by the management team of a private, not-for-profit hospital.

The Indonesian WISN effort started small, in two provinces. The initial focus was to develop WISN for a single staff category in one type of health facility. In NTT Province of the case study, the target was health centre midwives. This bottom-up approach was in contrast to a prior national, top-down WISN exercise, which was not successful.

The Mozambique WISN experiment was also carried out in two provinces, but it targeted a much larger number of staff categories. They covered maternal and child health workers, clinicians and nurses. These staff members worked in hospitals or rural and urban health centres.

In Uganda, the first WISN application focused on two districts as a first step to introducing the WISN method. Activity standards were developed for multiple categories of health staff working in several different types of health facilities. The second Ugandan WISN study focused on nurses, midwives and nursing assistants in a single tertiary-level hospital.

Donor funding helped start the WISN process in Indonesia, but local budgets provided funding for subsequent WISN efforts. In Mozambique, workload and human resource data for WISN were collected during routine supervision visits and no special budget allocation was made. Before the WISN experiment, workloads were defined in terms of Delivery Units (DU), a standard unit of 10 minutes of working time. In developing WISN, Ministry of Health staff applied these DUs to the principal health activities. In Uganda, university faculty members were responsible for applying WISN. In developing WISN for the private hospital, they supervised a team of 15 Masters of Health Services Management students.

The authors of all four case studies emphasize the crucial importance of involving stakeholders from the start. In Indonesia, engagement of local senior decision-makers and policy-makers was essential for success. These individuals accepted the WISN results and acted on them because they understood and supported the WISN method. The Mozambique experience showed the WISN method to be easily usable and the existing information system sufficiently reliable for routine application of WISN. Political changes and the reorganization of the Ministry of Health prevented a wider acceptance of the WISN method at the time, however. In Uganda, national activity standards were developed and work is in progress to implement WISN fully at the national level. In the work with the private hospital, the hospital's senior management commissioned the WISN study and was involved in all stages. It was thus not surprising that they accepted the WISN results and based important staffing decisions on them.

The Indonesian experience shows that the WISN method, when clearly taught, can be applied by health workers, even those working at the peripheral level. These health workers found it highly motivating that the WISN results they had calculated were used by decision-makers to improve the staffing situation.

The WISN method is only one in a set of tools that improve how human resources are planned and managed. Applying WISN with other relevant human resource tools builds more robust human resource systems than using WISN in isolation. These case studies are intended to encourage readers to apply the WISN method in their own settings, while at the same time considering what other tools might be needed to complement WISN.

Decentralized application of the WISN method in Nusa Tenggara Timur Province, Indonesia, 2008

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Background and rationale

The Indonesian Ministry of Health (MoH) has used various methodologies over the years to plan human resources for health. Difficulties were encountered, however, in attempting to develop a method to plan the health workforce of different facilities. In 1979, the MoH issued Decree No. 262, stating that bed ratios would be the basis for calculating staff requirements of hospital wards. Fixed standard staffing patterns were also used for district hospitals and health centres.

The original Indonesian decentralization and autonomy laws were passed in 1999. They came into effect on 1 January 2001, but with insufficient transition. Powers were decentralized directly to the district levels, with only a minimum level of authority given to the provinces. The laws were amended in 2004 to provide the provinces with slightly more authority.

Responsibility for health human resources was also decentralized to the district level. Payment of salaries, development of career paths, recruitment and placement into civil service positions is now the responsibility of the respective district governments.

The central government retains the authority for new personnel allocations and the setting of civil service regulations. The provincial government has almost no function in human resources. The only exceptions are coordination, monitoring and evaluation functions and the transfer of personnel among districts or provinces. Provincial health workforce planning functions are negligible. Districts decide on human resource matters on their own, except for new staff allocations. As mentioned, these require central authorization by the National Personnel Board under the State Ministry for Administrative Reforms (MENPAN).

The Board for Health Human Resources Development and Utilization (BPPSDMK) was established in 2001 as part of the Ministry of Health (DEPKES). Its four centres cover all the health human resources aspects from planning and utilization, pre-service education and in-service training to professional empowerment and foreign work affairs. The Board has accreditation powers for educational and training institutions, but oversees only DEPKES-owned health polytechnics. There is almost no direct connection between the BPPSDMK and district health offices and governments.

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DEPKES Decree No.1202/2003 issued *Healthy Indonesia 2010 indicators* in 2003. Population ratios were applied to calculating staff requirements (e.g. 100 midwives for a population of 100 000). Following decentralization, a further DEPKES decree (No. 81/2004) on staffing was issued. It was called *Guideline of planning health workforce for district health office, district hospital, and health centre*. This decree promoted the use of three methodologies for determining required staffing: population per staff ratios, facility-based staffing standards and WISN.

The central BPPSDMK organized a series of training courses in Jakarta on the three methodologies. The trainees were representatives of the 33 provinces in Indonesia. The impact of the training was limited, due to a number of factors:

- The BPPSDMK specified who the trainees should be. It had no control, however, over whom the provinces actually sent to the course.
- Many provincial trainees were administrative staff. They were neither sufficiently senior in status nor appropriately placed to be able to influence provincial and district leaders regarding adoption of the methodologies.
- The training was short and WISN was covered in only one day. This was inadequate to achieve any level of competence in the method. Furthermore, the training focused narrowly on doing the calculations, not on interpreting results.
- The training response varied greatly, depending upon the interest, ability and seniority of individual trainees. On return to their province, some merely reported back on the training. Others commenced implementation of WISN but quickly encountered problems.
- Senior managers at the central level changed frequently. There was neither strong backing for using WISN nor adequate funding to follow up with the trainees.
- Provinces (and districts) were already using the ratio method. It was thus easier for them to revert to using ratios, which were also included in Decree 81.
- Decentralized decision-makers and politicians were unwilling to accept the recommendations on staffing levels. They did not know or understand the WISN method on which these were based. Hence they continued to influence employment and deployment of health personnel on political grounds.

The top-down approach to introducing WISN thus proved to be too centralized for effective implementation at the local level.

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