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Implementation Gaps and Challenges of the Universal Healthcare Act in the Provision of Hemodialysis Services

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Abstract

Expanded hemodialysis coverage under the Universal Health Care Act requires effective implementation at the facility level to address patients' treatment needs and financial concerns. This study examined the perceived implementation of the Act and the challenges encountered in providing and accessing hemodialysis services in Batangas, Philippines. A quantitative descriptive observational design was employed, using structured survey responses from 45 healthcare providers and 64 patients and family members. Data were summarized using frequencies, percentages, and weighted means. Healthcare providers rated implementation as moderately implemented, with a composite mean of 3.19, whereas patients and family members rated it as slightly implemented, with a composite mean of 2.45. Providers reported moderately challenging implementation conditions (2.64), while patients and family members reported slightly challenging conditions overall (2.48). Facility overcrowding was the highest-rated challenge among providers (2.96), whereas delays associated with limited availability of specialized healthcare workers ranked highest among patients and family members (2.77). Out-of-pocket expenses were also among the leading concerns of both groups. These findings indicate differing stakeholder perceptions of implementation, particularly regarding financial protection and operational constraints. The study supports clearer communication of benefit entitlements, transparent billing, improved staffing and scheduling, and more responsive administrative and referral processes. The findings describe perceived implementation gaps and do not establish causal effects of the policy.

Keywords: *universal health care; hemodialysis services; policy implementation; financial protection; healthcare delivery; Philippines*

1. Introduction

Hemodialysis requires continuing access to treatment, specialized personnel, medical supplies, and diagnostic services. For patients who depend on this therapy, financial protection concerns extend beyond the availability of a dialysis session to the services and resources needed to sustain treatment. A systematic review of chronic kidney disease costs in Asian countries identified hemodialysis as a major component of treatment expenditure, illustrating the substantial resources required for long-term renal care (Nisar et al., 2024). Community-based laboratory screening of older adults in Manila has likewise included renal markers such as blood urea nitrogen and creatinine, reflecting attention to kidney-related health monitoring in Philippine populations (Patron, Bermido, et al., 2026). These demands make hemodialysis service delivery an important setting for examining how healthcare coverage is implemented and experienced.

In the Philippines, the Universal Health Care Act established a framework for improving access to health services and protecting Filipinos against financial hardship associated with healthcare needs (Universal Health Care Act, 2019). Across ASEAN economies, universal health coverage has also been examined as an indicator of health-system strength and has been positively associated with life expectancy and labor productivity (Patron, Quinto, & Atento, 2026). Within this policy context, PhilHealth expanded its hemodialysis benefits. Circular No. 2024-0023 provided for coverage of up to 156 hemodialysis sessions annually and a benefit rate of PHP 6,350 per covered session, together with specified services and supplies (Philippine Health Insurance Corporation, 2024). These provisions established a basis for examining whether covered benefits are consistently made available to eligible patients.

The translation of policy provisions into routine service delivery depends on institutional capacity, administrative coordination, and the availability of healthcare resources. This view is consistent with broader scholarship emphasizing that health outcomes are shaped by institutional capacity as well as clinical factors (Quinto, 2026). In their examination of the Philippine UHC reform, Co et al. (2024) discussed the continuing challenges of implementing national policy within a complex health system. Implementation gaps in community-level service delivery under the Act have also been documented in CALABARZON, where cost was the dominant barrier among respondents reporting difficulties in accessing care (Morcilla & Quinto, 2026). Workforce concerns further shape the capacity of healthcare institutions to provide services consistently (Pepito et al., 2025). In hemodialysis settings, these considerations direct attention to how facilities organize treatment, communicate benefit entitlements, manage supplies, and respond to patients' needs.

Healthcare providers and service users occupy different positions within these processes. Providers encounter the operational requirements of delivering treatment and administering benefits, while patients and family members experience the accessibility of services, treatment-related expenses, and the procedures required to obtain care. Examining these perspectives together can identify areas in which institutional assessments and service-user experiences differ. Such differences warrant investigation without assuming that either perspective alone establishes the quality of implementation or the causes of reported difficulties.

The present study examined these issues in hemodialysis settings in Batangas Province. Its empirical focus was the perceived implementation of UHC-related hemodialysis provisions and the challenges reported by healthcare providers, patients, and family members. This local assessment contributes evidence on how policy provisions are experienced at the point of service delivery. It also provides a basis for identifying practical priorities for improving implementation, while recognizing that descriptive survey findings do not establish changes attributable to the policy.

This study aimed to examine implementation gaps and challenges of the Universal Healthcare Act in the provision of hemodialysis services in Batangas. Specifically, it sought to describe the respondents' demographic and relevant service-setting characteristics; assess the perceived level of implementation among healthcare providers and patients or family members; identify the implementation challenges reported by these groups; and provide an empirical basis for a program to enhance implementation.

2. Review of Related Literature

2.1 Financial Burden and Financial Protection in Hemodialysis

The financial demands of chronic kidney disease become particularly substantial when patients require continuing renal replacement therapy. In a systematic review of costs reported across Asian countries, Nisar et al. (2024) identified hemodialysis as a major source of expenditure. Their findings establish the importance of examining treatment affordability alongside service availability. However, cost estimates drawn from different countries require contextual interpretation because financing arrangements, service prices, and the components included in treatment costs may differ. Such estimates provide background on the economic demands of dialysis but do not directly establish the expenses incurred by patients in Batangas.

In the Philippine setting, PhilHealth's expanded hemodialysis package provides an institutional mechanism for financing recurring treatment. Circular No. 2024-0023 specifies coverage of up to 156 sessions annually at PHP 6,350 per covered session, together with defined benefit components (Philippine Health Insurance Corporation, 2024). These provisions supply concrete reference points for evaluating perceived implementation, including access to covered sessions, medicines, supplies, laboratory services, and protection against additional charges for covered care.

Read together, the cost literature and the benefit provisions support examining both the scope of financial protection and its reported implementation (Nisar et al., 2024; Philippine Health Insurance Corporation, 2024). For the present study, the relevant concern is whether providers and patients or family members perceive these benefits as consistently available. Survey ratings can identify concerns about coverage and expenses, although they cannot independently establish the amount, frequency, or appropriateness of particular charges.

2.2 Policy Implementation and Coordination of Healthcare Services

The Universal Health Care Act provides the legislative basis for reforms intended to improve access, coordinate healthcare delivery, and strengthen financial protection in the Philippines (Universal Health Care Act, 2019). These objectives require implementation across institutions with different responsibilities and resources. Co et al. (2024) discussed the progress and challenges of the reform, including the relationship between national policy directions and the organization of local health services. Their analysis places institutional coordination at the center of understanding how policy commitments become accessible services. Private-sector providers also adapt to these reforms; a case

study of the country's dominant pharmacy chain highlighted the need to align affordability policies with private-sector viability under universal healthcare (A. G. Atento & Atento, 2025).

Within this framework, primary care and referral arrangements are intended to support continuity across levels of care (Universal Health Care Act, 2019). For hemodialysis, the relevant policy provisions also include arrangements for covered services that may not be available within the treating facility, such as specified laboratory services (Philippine Health Insurance Corporation, 2024). Implementation therefore involves both the provision of treatment within a dialysis center and coordination with other service providers.

This literature supports examining administrative and referral processes alongside the availability of treatment benefits (Co et al., 2024). In a related hospital-based study, middle managers involved in PhilHealth Benchbook II accreditation identified resource constraints and documentation and process burden as conditions moderating implementation reliability (Garcia & Atento, 2026). In the present study, these processes are reflected in respondents' assessments of documentary requirements, claims processing, transfers, and feedback mechanisms. Their inclusion recognizes that access involves navigating institutional procedures as well as obtaining a treatment appointment. Qualitative evidence from Batangas City has similarly identified documentation requirements, long waiting times, and system complexity among the barriers restricting access to care for homeless individuals (Macatangay & Magnaye, 2026). Differences between provider and service-user ratings may identify processes requiring closer investigation, although the ratings alone cannot determine where responsibility for a reported difficulty lies.

2.3 Health Workforce and Facility Capacity

Workforce availability and employment conditions are relevant to the implementation of healthcare coverage. Pepito et al. (2025) examined health workforce issues and recommended practices in implementing universal health coverage in the Philippines. Broader analyses have similarly described domestic fragilities in the Philippine health workforce pipeline, including migration-driven attrition and institutional undercapacity (R. G. Atento, Quinto, & Espelita, 2025). Their work provides a basis for considering staffing as an implementation concern rather than treating expanded coverage solely as a financing measure. It also supports attention to the organizational conditions under which healthcare personnel provide services.

For the present study, this workforce perspective informs the examination of reported delays associated with the availability of specialized personnel. Provider profiles, including professional role, experience, and employment status, offer context for interpreting these assessments. However, these characteristics should not be treated as direct evidence of inadequate staffing, burnout, or turnover. Establishing those conditions would require corresponding measures beyond the descriptive profiles used in the study.

The broader implementation issues discussed by Co et al. (2024), considered alongside the workforce concerns examined by Pepito et al. (2025), also support assessing the relationship between service requirements and institutional capacity. Accordingly, the study includes perceptions of overcrowding, supply availability, and the capacity to accommodate patients. In selected private hospitals in Batangas, nurses likewise identified time pressure and interruptions as constraints on consistent clinical practice (Torres & Magnaye, 2026). These indicators allow operational concerns to be described from different stakeholder positions. They do not, by themselves, establish objective capacity deficits or demonstrate that expanded insurance coverage caused the reported difficulties.

2.4 Synthesis and Gaps

The reviewed literature identifies three connected considerations in hemodialysis service delivery: the financial demands of continuing treatment, the institutional coordination required to implement healthcare policy, and the workforce conditions supporting service provision (Co et al., 2024; Nisar et al., 2024; Pepito et al., 2025). PhilHealth's hemodialysis provisions translate aspects of financial protection into defined benefits that can serve as reference points for an implementation assessment (Philippine Health Insurance Corporation, 2024).

However, the sources reviewed here do not establish how healthcare providers and patients or family members in the participating Batangas settings assess these provisions and related operational challenges. This is the context-specific gap addressed by the study. Examining both groups provides an opportunity to identify areas of agreement and divergence concerning implementation, financial concerns, staffing, and administrative processes.

The study contributes a descriptive account of these stakeholder perspectives. Its contribution lies in identifying locally reported priorities for service improvement, while recognizing that perception-based findings require further investigation before conclusions can be drawn about policy effectiveness, verified compliance, or the causes of implementation gaps.

3. Methodology

3.1 Research Design

The study employed a quantitative descriptive observational design to examine the perceived implementation of the Universal Healthcare Act in hemodialysis services and the challenges encountered by healthcare providers, patients, and family members. It described existing service conditions without manipulating variables or introducing an intervention. Survey-based assessment of perceived implementation levels has also been used in comparable Philippine organizational studies (Gamasan & Atento, 2026). The analysis focused on respondent characteristics and implementation and challenge ratings across the two stakeholder groups.

3.2 Setting and Respondents

The study examined hemodialysis services in Batangas Province, Philippines. Respondents reported receiving or providing services in government, private, and stand-alone dialysis settings.

The sample comprised 109 respondents: 45 healthcare providers and 64 patients or family members. Healthcare providers included 18 nurses, 11 dialysis technicians, three physicians, and 13 respondents classified under other professional roles. The patient/family group comprised 30 patients and 34 family members, including 26 children of patients, four spouses, and four parents. Findings for this group therefore represent a combination of direct patient reports and family members' assessments. Family caregivers occupy a distinct position in care, as caregiving is often characterized by emotional demands and role overload (Quinto et al., 2026).

3.3 Sampling Technique

The sampling plan specified cluster random sampling, with hemodialysis facilities designated as clusters and random selection of respondents within participating facilities.

3.4 Research Instrument

The structured survey covered respondent profiles, characteristics of the dialysis settings, perceived implementation of hemodialysis benefit provisions, and implementation challenges. Profile information included demographic characteristics, professional role and experience for healthcare providers, and relationship to the patient for patient/family respondents. Facility-related information included facility type, number of dialysis stations, and years of operation.

Implementation was assessed through 20 indicators addressing covered sessions, application of the benefit rate, access to medicines and supplies, laboratory services, treatment resources, and communication and application of coverage provisions. A separate set of 20 indicators assessed challenges involving financial expenses, staffing, overcrowding, supplies, administrative procedures, referral processes, and related operational concerns.

The reported interpretation intervals for implementation scores were 3.50–4.00, highly implemented; 2.50–3.49, moderately implemented; 1.50–2.49, slightly implemented; and 1.00–1.49, never implemented. Challenge scores were interpreted as 3.50–4.00, highly challenging; 2.50–3.49, moderately challenging; 1.50–2.49, slightly challenging; and 1.00–1.49, not challenging.

3.5 Data Gathering Procedure

Structured survey responses provided the data for the descriptive results. The documented procedure included explaining the study's purpose and participation requirements and obtaining written informed consent before participation. Responses were organized for separate analysis of healthcare providers and patients or family members.

3.6 Data Analysis

Frequencies and percentages summarized respondent profiles and reported characteristics of the dialysis settings. Weighted means described individual implementation and challenge indicators, while composite means summarized each set of indicators. Item rankings identified the highest- and lowest-rated aspects within each respondent group.

Provider and patient/family ratings were examined descriptively to identify similarities and differences in reported perceptions. No inferential tests of group differences or statistical before-and-after comparisons were presented. Consequently, differences in mean ratings were interpreted as descriptive findings rather than statistically established differences or evidence of policy effects.

3.7 Ethical Considerations

Written informed consent was reported as obtained before participation. The stated ethical provisions included voluntary participation, the right to decline or withdraw, and protection of respondents' identities and information through anonymity and confidentiality.

4. Results and Discussion

4.1 Respondent and Service-Setting Characteristics

The study included 45 healthcare providers and 64 patients or family members. Among healthcare providers, 37.8% were aged 20–29 years and 33.3% were aged 30–39 years. Female respondents constituted 64.4%, while 68.9% were married. Nurses comprised the largest professional group (40.0%), followed by other professional roles (28.9%), dialysis technicians (24.4%), and physicians (6.7%). Regarding dialysis experience, 44.4% reported more than six years, 15.6% reported four to six years, 22.2% reported one to three years, and 17.8% reported less than one year. Most held permanent positions (64.4%), while 35.6% were contractual employees.

Within the patient/family group, 30 respondents were patients (46.9%) and 34 were family members. Children of patients accounted for 40.6% of the group, while spouses and parents each accounted for 6.3%. The largest age category was 20–29 years (39.1%), followed by 40–49 years (25.0%), 30–39 years (18.8%), and 50 years or older (17.2%). Female respondents represented 53.1%. These demographic characteristics describe the combined respondent group and should not be interpreted as the characteristics of patients alone.

Most patient/family respondents reported a treatment frequency of three sessions weekly (78.1%), followed by two sessions weekly (14.1%) and a variable frequency of two to three sessions weekly (7.8%). Reported monthly income was below PHP 12,030 for 17.2%, PHP 12,031–24,060 for 28.1%, PHP 24,061–48,120 for 29.7%, and PHP 48,121 or more for 25.0%.

Stand-alone dialysis centers were the most frequently reported service setting among both providers (75.6%) and patients or family members (76.6%). Most respondents also reported settings that had operated for less than one year or one to three years: 82.2% of providers and 84.4% of patient/family respondents fell within these combined categories. These percentages describe respondents' reported settings rather than the distribution of distinct facilities in Batangas. The findings therefore primarily reflect experiences associated with stand-alone centers, with more limited representation of other facility types.

4.2 Perceived Implementation of Hemodialysis Benefit Provisions

Table 1 presents implementation ratings from healthcare providers and patients or family members. Providers reported a composite mean of 3.19, interpreted as moderately implemented, while the patient/family group reported 2.45, interpreted as slightly implemented. Provider ratings were higher across all 20 indicators.

All provider-rated indicators fell within the moderately implemented category. The highest-rated indicator concerned the absence of charges for covered laboratory tests and arrangements for externally provided laboratory services (3.40). Application of the PHP 6,350 benefit followed at 3.31, while provision of AV fistula kits received 3.29. The lowest provider ratings concerned covered heparin preparations and coverage of machine use, both at 3.07. Thus, providers generally reported implementation across the assessed provisions, although none of the item means reached the highly implemented category.

Patient/family ratings presented a less favorable assessment. Their highest-rated indicators were the provision of central venous catheter kits (2.66), compliance with dialyzer reuse limits and safety protocols (2.63), and coverage of up to 156 sessions annually (2.61). These indicators were moderately implemented under the study's interpretation intervals.

The lowest patient/family ratings concerned application of the PHP 6,350 benefit (2.19) and the absence of additional fees for covered medicines, supplies, and laboratory services (2.22). Monthly CBC and serum creatinine testing and the use of covered heparin preparations both received 2.34. The pattern identifies financial and ancillary-service provisions as areas requiring closer examination.

The divergence is particularly apparent in covered laboratory services, rated 3.40 by providers and 2.38 by patients or family members. Similarly, application of the benefit rate received 3.31 from providers and 2.19 from the

patient/family group. These findings indicate differing assessments of how benefits are implemented. They do not establish whether the differences arise from service availability, billing practices, understanding of entitlements, or variation among the facilities represented.

Table 1 *Perceived Implementation of Hemodialysis Benefit Provisions by Respondent Group*

Implementation indicator	Healthcare providers (n = 45)	Patients/family members (n = 64)
Coverage of up to 156 hemodialysis sessions annually	3.16	2.61
Application of the PHP 6,350 benefit per covered session	3.31	2.19
Access to covered sessions without unnecessary restrictions	3.24	2.59
Separate claiming of eligible sessions during admission for another illness or procedure	3.18	2.38
Monitoring of annual session utilization	3.22	2.55
Provision of prescribed erythropoietin-stimulating agents	3.09	2.45
Administration of prescribed iron sucrose	3.16	2.48
Use of covered heparin preparations when required	3.07	2.34
Provision of monthly CBC and serum creatinine tests when indicated	3.24	2.34
Provision of six-monthly hepatitis testing when indicated	3.09	2.47
No charges for covered laboratory tests, including external arrangements	3.40	2.38
Dialyzer reuse within allowable limits and safety protocols	3.09	2.63
Provision of a dialysis kit for each treatment	3.13	2.38
Provision of AV fistula kits when required	3.29	2.55
Provision of central venous catheter kits when required	3.22	2.66
Coverage of hemodialysis machine use	3.07	2.58
Coverage of facility use and treatment area	3.22	2.39
Implementation of no co-payment for covered services	3.16	2.52
Information about services excluded from the benefit package	3.16	2.38
No additional fees for covered medicines, supplies, and laboratory services	3.27	2.22
Composite mean	3.19	2.45
Overall interpretation	Moderately implemented	Slightly implemented

Note. Values are the weighted means reported in the source manuscript. Indicator wording is condensed for presentation. Interpretation intervals: 3.50–4.00 = highly implemented; 2.50–3.49 = moderately implemented; 1.50–2.49 = slightly implemented; 1.00–1.49 = never implemented. CBC = complete blood count; AV = arteriovenous.

4.3 Challenges in Implementing and Accessing Hemodialysis Services

Table 2 summarizes the reported implementation challenges. Healthcare providers reported an overall mean of 2.64, interpreted as moderately challenging. Patients and family members reported 2.48, interpreted as slightly challenging. Despite the lower overall patient/family rating, several individual concerns reached the moderately challenging category.

Table 2. *Perceived Challenges in Hemodialysis Service Implementation by Respondent Group*

Challenge indicator	Healthcare providers (n = 45)	Patients/family members (n = 64)
Treatment approvals or consultation processing	2.53	2.45
Out-of-pocket medical expenses despite UHC coverage	2.84	2.70
Medication availability and the need for purchases using personal funds	2.51	2.48
Overcrowding of hospital facilities	2.96	2.33
Speed of access regardless of social status	2.56	2.20
PhilHealth or UHC claims processing and reimbursements	2.51	2.44
Out-of-pocket costs for uncovered diagnostic tests or supplies	2.84	2.61
Insufficient financial resources for essential supplies	2.73	2.50
Affordable transportation for recurring treatment	2.51	2.30
Transfers through the referral system	2.53	2.55
Documentary requirements	2.51	2.39
Emotional tension or misunderstandings concerning coverage	2.67	2.42
Timely completion of admission or discharge procedures	2.64	2.50
Operation of digital platforms and verification systems	2.53	2.41
Building confidence in public healthcare institutions	2.62	2.50
Service delays associated with limited specialized personnel	2.47	2.77
Shortages of dialysis supplies, equipment, or essential materials	2.69	2.47
Resolving problems without prompt feedback mechanisms	2.84	2.52
Accommodating patient volume within existing physical capacity	2.53	2.63
Overall implementation of UHC in hemodialysis services	2.84	2.41
Composite mean	2.64	2.48
Overall interpretation	Moderately challenging	Slightly challenging

Note. Values are the weighted means reported in the source manuscript. Indicator wording is condensed for presentation. Interpretation intervals: 3.50–4.00 = highly challenging; 2.50–3.49 = moderately challenging; 1.50–2.49 = slightly challenging; 1.00–1.49 = not challenging.

Facility overcrowding was the highest-rated provider challenge (2.96). Four indicators followed at 2.84: out-of-pocket medical expenses despite coverage, expenses for uncovered diagnostics or supplies, difficulty resolving problems without prompt feedback, and overall implementation. Insufficient financial resources for essential supplies received 2.73, while shortages of supplies, equipment, or essential materials received 2.69. These ratings locate providers' principal concerns in physical capacity, financing, and administrative responsiveness.

The lowest-rated provider challenge was service delay associated with limited specialized personnel (2.47), the only provider indicator classified as slightly challenging. In contrast, this was the highest-rated challenge among patients and family members (2.77). This difference identifies staffing-related service delays as a concern that may be more prominent in the service-user experience than in providers' overall assessments.

Other leading patient/family challenges were out-of-pocket medical expenses despite coverage (2.70), accommodating patient volume within existing capacity (2.63), and expenses for uncovered diagnostic tests or supplies (2.61). Referral transfers (2.55) and the absence of prompt feedback mechanisms (2.52) were also moderately challenging.

Patient/family respondents assigned relatively low challenge ratings to speed of access regardless of social status (2.20), transportation affordability (2.30), and hospital overcrowding (2.33). However, their rating for

accommodating patient volume within existing physical capacity was higher (2.63). These indicators concern related but distinct aspects of service delivery and should not be treated as interchangeable measures of congestion.

4.4 Discussion

The findings identify a consistent divergence between provider and patient/family assessments of implementation, together with different priorities concerning operational challenges. Providers rated all implementation indicators more favorably, while patients and family members gave particularly low ratings to the application of the benefit amount and protection against additional charges. This pattern supports examining implementation through both institutional and service-user perspectives.

Financial protection is a central concern. The economic demands of hemodialysis described by Nisar et al. (2024) provide context for the reported concerns about recurring expenses. PhilHealth's specified benefit provisions establish the policy reference against which covered services can be assessed (Philippine Health Insurance Corporation, 2024). In the present findings, lower patient/family ratings for the implementation of financial provisions occurred alongside moderately challenging ratings for out-of-pocket expenses. Cost has similarly been reported as the dominant access barrier in community-level UHC research in CALABARZON (Morcilla & Quinto, 2026).

Nevertheless, the survey distinguishes between expenses despite coverage and expenses for services identified as uncovered. These categories should remain separate when interpreting financial concerns. The findings do not establish the amounts paid, whether individual charges involved covered services, or whether particular facilities failed to comply with benefit requirements. They identify priorities for examining billing records, benefit explanations, and actual service provision.

The contrasting assessments of staffing-related delays also warrant attention. Pepito et al. (2025) situated workforce concerns within the implementation of universal health coverage. In this study, patients and family members identified delays associated with specialized personnel as their leading challenge, whereas providers rated the same indicator lowest. One possible interpretation is that the groups evaluate staffing through different experiences: patients may focus on delays during treatment encounters, while providers consider staffing alongside broader operational demands. This explanation remains a possibility rather than an established mechanism because waiting times, staffing ratios, and workloads were not directly measured.

Administrative coordination constitutes another area of concern. Providers assigned a relatively high rating to difficulties resolving problems without prompt feedback, while patient/family respondents reported moderate challenges in feedback and referral processes. These findings correspond to the broader implementation and coordination concerns discussed by Co et al. (2024). They are also consistent with hospital-based evidence that documentation and process burden can moderate the reliability of PhilHealth-related implementation (Garcia & Atento, 2026). They support closer examination of how facilities communicate with oversight agencies and coordinate services across institutions, without identifying a particular administrative process as the demonstrated cause of the reported problems.

Several limitations qualify the interpretation. The patient/family results combine direct patient reports with family members' assessments. The predominance of respondents associated with stand-alone centers also limits conclusions about other service settings. Facility characteristics are reported at the respondent level, and the available results do not establish whether provider and patient/family assessments refer to the same facilities. Unresolved sampling and eligibility details further constrain claims of representativeness.

Finally, the results are descriptive. No inferential tests establish statistically significant differences between groups, and no measured before-and-after comparison demonstrates policy effects. Within these limits, the study identifies financial protection, staffing-related delays, physical capacity, and administrative responsiveness as priorities for further assessment and service improvement.

5. Conclusions, Recommendations, and Implications

5.1 Conclusions

The study identified differing assessments of the implementation of the Universal Healthcare Act in hemodialysis services among healthcare providers and patients or family members in Batangas. The respondents were predominantly associated with stand-alone dialysis centers, and the service-user group included both patients and family members. The findings therefore reflect these stakeholder perspectives and service settings.

Healthcare providers rated implementation as moderately implemented, whereas patients and family members rated it as slightly implemented. Provider ratings were higher across all assessed implementation indicators. The differences were particularly evident in the application of the benefit amount, covered laboratory services, and protection against additional fees. These findings indicate a divergence in perceived implementation but do not independently establish noncompliance, the reasons for particular charges, or the causes of the differing assessments.

Implementation challenges also varied by stakeholder group. Providers identified facility overcrowding as their leading concern, together with financial expenses and limited administrative feedback. Patients and family members identified delays associated with specialized personnel as their principal challenge, followed by out-of-pocket expenses and physical capacity constraints. Financial concerns were therefore shared across groups, while the relative importance of operational difficulties differed.

The findings provide a basis for an enhancement program addressing benefit communication, billing transparency, staffing and scheduling, facility capacity, and administrative coordination. They do not establish causal policy effects or statistically significant differences between respondent groups.

5.2 Recommendations

Dialysis facilities should strengthen communication about benefit entitlements and treatment-related charges. Patients and family members should receive clear explanations of covered services, conditions governing their provision, and any proposed charges. Itemized billing and an accessible process for raising coverage concerns would help address the low patient/family ratings concerning the application of benefits and protection against additional fees. Reviews of billing records and service documentation should distinguish charges for covered care from expenses for services outside the applicable package.

Facility administrators should examine staffing deployment and treatment schedules in response to patient/family concerns about service delays. Recording scheduled and actual treatment start times, reasons for delays, and staffing levels across shifts would help determine whether scheduling adjustments, additional personnel, or changes in workflow are warranted. Employment conditions and retention needs should also be reviewed, although contractual status alone should not be treated as evidence of inadequate staffing or poor service.

Providers' concerns about overcrowding and essential supplies support facility-level assessments of station utilization, available treatment slots, equipment downtime, and inventory interruptions. Decisions about expanding capacity or changing procurement arrangements should be based on these operational records. Where covered services are obtained outside the dialysis center, referral and laboratory arrangements should clearly identify responsibilities for access, documentation, and payment.

Dialysis facilities and relevant administrative offices should establish clear channels for resolving benefit, claims, and service-delivery concerns. A documented query process with designated contacts, response targets, and follow-up procedures could address difficulties associated with delayed feedback. Referral arrangements should similarly clarify the steps and responsibilities involved in transferring patients or obtaining services from another institution.

These priorities may be organized into a facility-level implementation enhancement program with assigned responsibilities and measurable indicators, such as treatment delays, unresolved coverage complaints, supply interruptions, and referral completion times. Such a program would be a proposed application of the findings; its effectiveness would require separate evaluation.

Future research should distinguish patient responses from family members' assessments and, where feasible, compare stakeholder reports within the same facilities. Studies incorporating expenditure records, billing reviews, staffing measures, and treatment waiting times would help examine the mechanisms underlying reported concerns. Longitudinal research could assess changes over time, while clearly documented sampling procedures and instrument validation would strengthen the interpretation of subsequent findings.

5.3 Implications of the Study

The study has practical implications for monitoring hemodialysis service implementation. Provider assessments and patient/family reports offer complementary information, and differences between them can identify aspects of service delivery requiring closer examination. Routine feedback systems should therefore include both groups and provide a means of investigating discrepancies through service and administrative records.

For healthcare administration, the findings support attention to the interaction among financing, personnel, physical capacity, and coordination. Improving one component may leave other reported difficulties unresolved. This is consistent with conceptual work proposing that healthcare organizations pursue health and business outcomes

jointly rather than through siloed priorities (R. G. Atento, Quinto, Espelita, & Castaneda, 2025). An implementation enhancement program should consequently connect financial transparency with operational improvements rather than evaluate coverage solely through the availability of treatment sessions.

Methodologically, the study demonstrates the value and limits of stakeholder perception data. Such data can identify reported implementation concerns and priorities, but establishing compliance, financial protection, or policy effectiveness requires additional evidence. The study's contribution is a local descriptive assessment that can guide more focused institutional review and subsequent evaluation.

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