ORIGINAL ARTICLE

Factors Influencing the Implementation of a Disability Package for Children with Developmental Disabilities: A Policy Analysis

Pauline Gail V. Martinez, MIH, OTRP[1] and Michael P. Sy, PhD, OTRP[1,2]

[1]University of the Philippines Open University, Philippines
[2]ZHAW Zurich University of Applied Sciences, Switzerland

ABSTRACT

Objective. This study analyzed the factors influencing the implementation of the disability benefit package for children with developmental disabilities (CDDs) in the Philippines.

Methods. Data collection was done through document review of policy documents and focused group discussions (FGDs). Guided by Walt and Gilson's policy triangle framework, data were analyzed through content analysis.

Results. Twenty-two (22) policy documents were reviewed and a total of 16 participants joined the FGDs. Facilitators and barriers were identified and categorized through the policy elements: 1) context is anchored by presence of laws and policies but is hindered by issues on politics, governance, and labor force; 2) policy actors are hopeful in the continuous implementation of the policy but there is a lack of participation from all potential policy actors and limitations with human resources; 3) content is sound and comprehensive but there are costing issues and compliance concerns with requirements; and 4) processes emphasize quality assurance and promising initial dissemination efforts but the lack of stakeholder engagement activities and the tediousness of requirements discourage potential service providers.

Conclusion. While the launch of the disability benefit package for CDDs in the Philippines seemed promising, the policy remains underutilized as the identified barriers outweigh the facilitators. Specific recommendations for the improvement and implementation of the benefit package were outlined and framed based on the policy triangle framework.

Keywords: policy analysis, disability policy, benefit package, developmental disability, policy implementation

INTRODUCTION

The World Health Organization (WHO) defined *policy* as "health goals at the international, national, or local level and specifies the decisions, plans, and actions to be undertaken to achieve these goals."[1] The Centers for Disease Control and Prevention further classifies *policy* as "a law, regulation, procedure, administrative action, incentive or voluntary practice of governments and other institutions."[2]

For a developing country like the Philippines, the passing of the Republic Act (RA) 11223, also known as the Universal Health Care (UHC) Act of 2019, was crucial in landmarking the country's commitment to attain the third Sustainable Development Goals, which seeks to ensure healthy lives and promote well-being for all at all ages.[3] The UHC Act also mandates the expansion of the national health insurance, through the Philippine Health Insurance (PhilHealth), to ensure that all Filipinos can get affordable and free health care

eISSN 2094-9278 (Online)
Published: December 18, 2025
https://doi.org/10.47895/amp.vi0.11818

Corresponding author: Michael P. Sy, PhD, OTRP
ZHAW Zurich University of Applied Sciences
Katharina-Sulzer-Platz 9, 8400 Winterthur, Switzerland
Email: Michael.Sy@zhaw.ch
ORCiD: https://orcid.org/0000-0003-0849-2874

services.[4] In spite of this legislative progress, the Philippine healthcare system remains inaccessible for all since 60% of hospitals are privatized and 54% are categorized as out-of-the-pocket expenses of the overall health expenditure.[5]

All Filipino citizens can benefit from PhilHealth, especially the poor and the marginalized specifically the children with disabilities (CWDs). In a 2018 report by the UNICEF, there are more than 5 million Filipino CWDs.[6] Reports showed that poverty rates were 50% higher in families with CWDs compared to families with typically-developing children and that only one of five (20%) of these families with CWDs availed of a disability identification card to be used to receive a 20% discount on daily expenses.[7]

To increase access to rehabilitation services, the PhilHealth launched a policy in 2018 called the *Z Benefit Package* for children with developmental disabilities (CDDs). This policy is a promising scheme that ensures financial risk protection and prevents catastrophic pocket expenditure when accessing basic and quality healthcare services.[8] Specifically, the benefit package constitutes assessment, planning, rehabilitation therapy sessions, and discharge plans by a team of medical and rehabilitation professionals (i.e., physician with specialty in developmental pediatrics, occupational therapist, physical therapist, and/or speech therapist).

To receive the benefit package, CDDs must enlist and avail of the needed healthcare services from a contracted Healthcare Institution (HCI). Based on PhilHealth Circular 2017-0029, PhilHealth is partnered with selected tertiary government hospitals that will provide specialized services covered by the benefit package.[9] After pilot testing with some public hospitals, it has been expected that other public and private HCIs can be contracted to expand the utilization and implementation of the *Z Benefit Package*. Contracted HCIs are privileged to provide care to PhilHealth members and can exercise the right to reimburse payment for rehabilitation services. Four years after its launch, as of January 2023, there are only four HCIs accredited for the Z benefit package for CDDs: two in National Capital Region, one in Leyte (Region 8), and one in Davao (Region 11).[10]

METHODS

This is a qualitative study that utilized a case study design.[11] The study focused on investigating the *Z Benefit Package* for CDDs through Walt and Gilson's policy triangle that aims to systematically analyze a policy from three different factors or elements, namely: content, actors, context, and process.[12] The flexibility of a case study design enabled the researchers to examine the policy under study by drawing from multiple data sources, underpinning a constructivist approach. Walt and colleagues also asserted how case studies of health policies allow for a multifaceted understanding of policy implementation gaps, enabling the generation of sound and evidence-informed policy propositions and recommendations.[13] This study was granted an exemption by the University of the Philippines Manila Research Ethics Board last August 1, 2022, with code UPMREB 2022-0361-EX.

The study employed a combination of data collection procedures: 1) document review and 2) focus group discussion (FGD) of the identified policy actors (Figure 1). The first procedure supplied the available information on published documents concerning mainly the policy's context, content, and process, and less on policy actors except for their specified roles and responsibilities stipulated in the documents. The document review emphasizes the value of objectivity, in which the collected information can be triangulated with the collected subjective information from the policy actors themselves.[14] The second procedure involved the policy actors who shared their perspectives on their roles in the policy implementation and their viewpoints on the policy context, content, and process. Kahan argues that an FGD, along with one-one interviews with key informants, is part of the standard toolkit in policy analysis.[15] The diversity of policy actors and their pluralized perspectives on a policy enables a researcher to investigate how these nuances affect policy implementation. The combination of these data collection procedures has been conducted in numerous health policy analyses in developing countries like Bangladesh, Lebanon, Sri Lanka, Zambia, Nigeria, and Pakistan.[16–20]

Data Collection

Document Review

The document review adopted the READ approach by Dalglish and associates.[14] It offers a systematic step-by-step process of collecting documents and gathering information for health policy studies. READ is the abbreviation for the steps following this approach: 1) Ready your materials, 2) Extract data, 3) Analyze data, and 4) Distill your findings. The four-step approach led to the consolidation of relevant policy documents, followed by the analysis and distillation of a total of 22 documents. Documents were included if they meet the following criteria: 1) address the policy documents; and 2) relate to the policy elements. Common reasons for exclusions were: 1) document is unrelated (i.e., financial reports of other policies, annexes included in the main policy documents); and 2) the document is about Z benefits but not for CDDs. A spreadsheet using Microsoft Excel was used to categorize key elements found in the reviewed documents according to the policy elements: content, actors, context, and process. This key information was then uploaded to ATLAS.ti version 22 for the coding process (Table 1).

Focus Group Discussions

The FGD involved the participation of identified policy actors through a non-probability and purposive sampling:

- rehabilitation professionals (OT practitioner, PT practitioner, SLP practitioner, rehabilitation medicine specialist/ developmental pediatrician);
- administrators from public and private HCIs;

Table 1. Summary of Codes from the Document Review

Policy Actors	Context	Content	Process
• Information dissemination and FAQs are mostly for CDDs • Formal policy documents are mainly for interested HCI	• Mentioned statistics of potential beneficiaries (CDDs)	• Updated and aligned to existing laws • Presence of list of FAQs in the Filipino language • Presence of visual information • Organized step by step processes	• Numerous information dissemination posts during launch • Consideration given during the pandemic • Lack of information dissemination targeted to interested HCI

FAQ – frequently asked questions, HCI – healthcare institution, CDD – children with developmental disabilities

- professional organizations of the service providers involved; and
- parents of CDDs

Additionally, FGD participants must (be): 1) aware of PhilHealth as an institution, 2) willing to be interviewed, and 3) assume the roles of the identified policy actors who may be associated with contracted HCI or potential HCIs. Informed consent was obtained prior to the FGDs.

Invitations were sent via email to professionals, administrators, and professional organizations. A digital poster with the Google Form link was uploaded on Facebook on the first week of August 2022 for parents and family members of CDDs. Follow-up emails and reposting of posters were done the following week. Participants who confirmed for the FGD were invited for a Zoom call that lasted for 100-120 minutes each during the last two weeks of August 2022. A total of four FGDs were scheduled; one for each cohort: rehabilitation professionals, administrators, professional organization representatives, and parents of CDDs.

The guide questions for the FGD are summarized in Table 2, while specific probing questions for each cohort are outlined in Appendix A. Three experts, including a public health professional, a rehabilitation worker who work with children and families, and a doctoral student on disability studies validated the FGD guide. The questions were pilot tested via an FGD for the first cohort, which rendered no revisions to the FGD guide. All FGDs were recorded and transcribed for analysis. Access to all data sets was only enabled for the primary author.

Table 2. Questions Used to Facilitate Focus Group Discussions

1. How did you know about this Z benefit package for CDDs?
2. In the country's health system and status, how impactful is the Z benefit package?
3. In your current role, what do you think are your roles and responsibilities in the implementation of the Z benefit package for CDDs?
4. What are your thoughts on the package in terms of content?
5. What are your thoughts on the package in terms of process?
6. What do you think are the factors that hinder effective implementation of this policy?
7. What do you think are the factors that facilitate effective implementation of this policy?
8. What are your recommendations/suggestions to improve implementation of the Z Benefit package for CDDs?

CDD – children with developmental disabilities

Data Analysis

The study adopted the content analysis procedure proposed by Elo and Kyngas.[21] This procedure utilized a deductive approach from which the analysis structure was operationalized through the policy triangle: content, context, process, and actors. The steps for analysis constituted: 1) preparation, 2) organizing, and 3) reporting. (Figure 1)

Preparation

Before transcription, the researcher assigned pseudonyms to all the participants. Aside from gender and role, there was no other personal information included. Pseudonyms were assigned by retaining the participants' initials and assigning another Filipino gender-specific name. To reflect the ethnicity of the participants, a Filipino name was used.[22] Then, the first author transcribed verbatim all the recordings from the FGDs. All the transcriptions were reviewed (by the primary author) before transferring them to the spreadsheet for analysis.

Organizing

The study adopted the categorization matrix outlined by Elo and Kyngas and Bengtsson.[21,23] The primary author organized the transcripts via the spreadsheet for deductive coding following these steps: 1) identified meaning units per line for open coding; 2) created a condensed meaning unit; 3) identified codes for all meaning units; and 4) grouped and assigned codes with similar ideas to sub-categories. The four policy elements were determined to be the "main categories." Categories, such as facilitator and barrier, were then classified into themes. To integrate the analyses from the document review and FGD, the primary author combined the initial codes from the document review (Table 3) with the codes created from the FGDs.

Reporting

All codes and categories were transferred to ATLAS.ti (version 22) to finalize the categories and themes, and to generate themes. To ensure rigor and trustworthiness, during the analysis, the four-dimension criteria (i.e., credibility, conformability, dependability, and transferability) were applied.[24,25] For *credibility*, the researcher rechecked codes, categories, and transcript themes. After this, initial codes from the document review were combined and followed by a re-organization of categories and themes. For member checking,

Table 3. A Sample Categorization Matrix from One of the FGDs (with parents of CDDs)

Line #	Meaning unit	Condensed meaning unit	Code	Sub-category	Category (Actor, Content, Context, Process)	Themes (Facilitator, Barrier)
22	For me, the pricing of the services is too low. It's very hard to invite professionals to volunteer themselves to be accredited in the Z package.	Pricing of services too low.	Inadequate costing of services	Inadequate costing of services	Content	Barrier
		Professionals will be hesitant to subcontract.	Preference in private sector employment	Issues in employment	Context	Barrier

FGD – focus group discussions, CDD – children with developmental disabilities

participants of FGD reviewed the tabulated summary of identified facilitators and barriers. Since minor revisions were done on the summary, no significant changes occurred to affect the findings. The authors also acknowledged their positionality as occupational therapists who have had 5 to 6 years of experience in working with children with disabilities within the Philippine healthcare system. Both authors have heightened awareness of their biases and were mindful in also including their experiences in the interpretation of findings. For *conformability*, the researcher facilitated another round of revisions for data triangulation with research memos and policy documents, while the participants' voices were reflected through direct quotations to represent the information accurately. Then, the researcher conducted a peer debriefing with the second author (who was also the thesis supervisor of the first author) to gain critical views and minimize biases. The researchers also performed an audit trail by noting each step done in data collection and analysis for *dependability*. For *transferability*, the variety of participants using purposeful sampling mirrors the reality of a multi-disciplinary approach in policy analysis.

RESULTS

A total of 22 documents composed of seven policy documents, three policy frequently asked questions (FAQs), six reports, and six social media posts underwent review and analysis, and are summarized in Appendix B. Four group discussions were conducted and one individual interview with a private hospital administrator was scheduled.

The following policy actors participated in the FGD: three rehabilitation professionals, five HCI administrators, five representatives of professional organizations, and three parents of CDDs. More than half (nine out of 16; 56.25%) of participants were female. Only three (18.75%) participants were involved during policy formulation, while five (31.25%) were directly involved in the policy implementation. Despite repeated invitations, no developmental pediatrician participated in any of the FGDs.

Appendix C shows the demographic profile of the participants. It is also important to note that all the parents who participated have at least one child diagnosed with autism.

Discussed in this section are the factors influencing the disability benefit package for CDDs following each of the elements from Walt and Gilson's policy triangle framework. In each element, we present the identified facilitators and barriers towards policy development and implementation. A summary is illustrated in Figure 2.

Context

In terms of context, the results revealed the macro-contextual factors that necessitated the development of the Z benefit package, the socio-economic context of beneficiaries, governance, and laws and issues encompassing the nation.

Facilitators

The PhilHealth Circular 2017-0029 highlighted the campaign for early intervention and access to therapy sessions, which may potentially benefit the estimated two million CDDs.[9] All participants in the FGD support this advocacy and are hopeful of its realization once the policy is implemented. Parents of CDD added that aside from relief from financial burden and impact on child's development, access to these services may provide relief and help them have better family dynamics. Josephine, a parent of three CDDs, expressed:

> *"It's not only for the children, it's also for the family. It's a relief for the parents. It is because when you are aware of what you are dealing with, it's not as difficult. Broken marriages leading to broken families can happen when the situation of the child is too difficult to handle. I think that's also one of the benefits – to have a more peaceful and a more understanding home."*

The PhilHealth Circular 2021-0022 stipulated that the policy is updated to align provisions on RA 11032: Ease of Doing Business Act and RA 11223: Universal Healthcare Act.[30] RA 11032, regarded as the Anti-Red Tape Act, aims to "*promote integrity, accountability, proper management of public affairs and public property as well as to establish effective practices aimed at efficient turnaround of the delivery of government services and the prevention of graft and corruption in government.*"[3] Thus, the PhilHealth Circular 2022-0012 streamlined the step-by-step processes of filing for claims reimbursement for all Z benefits packages for easier preparation and transaction.[31] On the other hand, RA 11223 was emphasized to strengthen the commitment to promoting health and widening access to services to those in need while

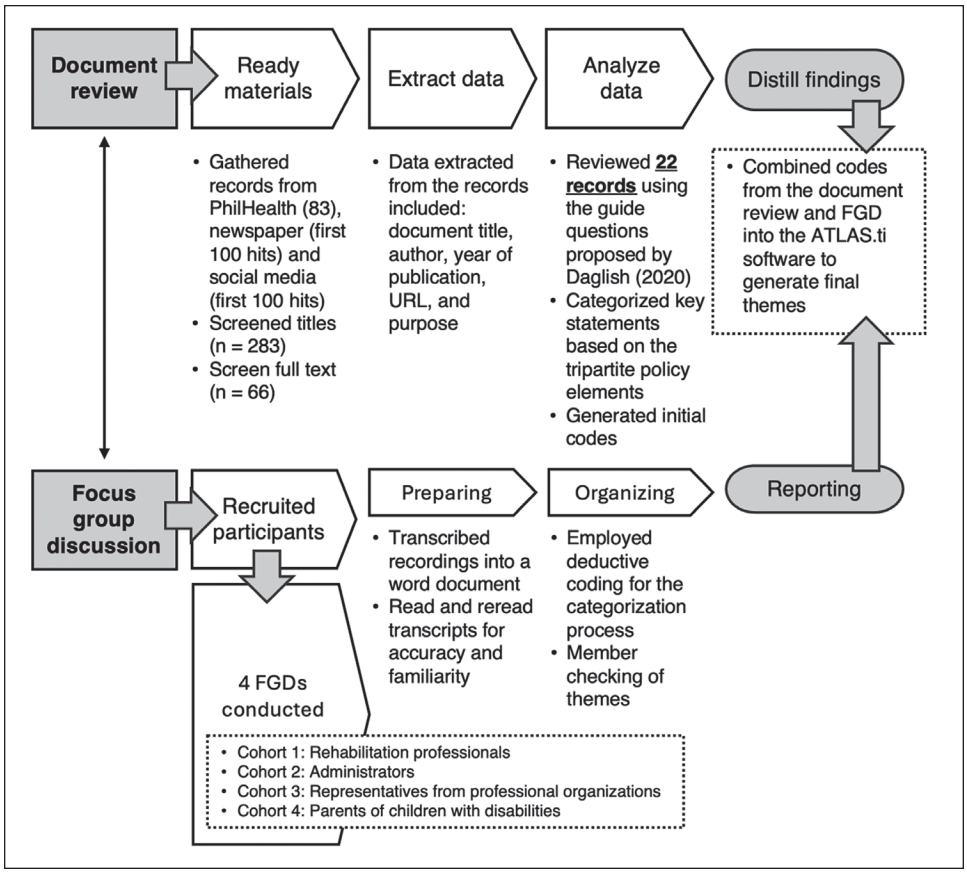

Figure 1. Illustration of the data collection and analysis procedures utilized in the study.

Policy elements	Facilitators	Barriers
Context	• Campaign for early intervention and to therapy • Increased accessibility helps families with CDDs • Alignment with existing laws • Passing of relevant laws • Presence of legislative representation in Congress	• Package has low impact and reach after 4 years of launch • Financial burden felt by families across SES • Issues on politics and governance in the country • Issues related to employment of professionals • Implementation is disrupted by the COVID-19 pandemic
Actors	• Involvement during policy formulation and implementation of organizations and public sector • Administrative advantage of the public sector • Alignment with values and advocacy	• Lack of involvement of other potential service providers • Human resource issues • Help received in disability sector is focused on allowance instead of services
Content	• Generally comprehensive and with complete list of services and rates • Presence of a separate document with Frequently Asked Questions in the Filipino language • Organized and easy to follow policy documents	• Inadequate cost of services • Concerns on required resources • Absence of certain protocols
Process	• Numerous information dissemination during launch • Subcontracting private professionals • Assuring quality of policy implementation • Extension of validity of approved pre-authorization applications in consideration of the COVID-19 pandemic	• Issues in information dissemination • Lack of stakeholder engagement activities from the PhilHealth • Bureaucratic processes (i.e., "red tape") • Limited number of sessions to merit re-evaluation (of therapy)

Figure 2. Summary of facilitators and barriers in the Z benefit package for CDDs.

decreasing the financial burden of all Filipino citizens. This is further supported by *RA 11228: An Act Providing For The Mandatory PhilHealth Coverage for All Persons with Disability (PWDs)*, which indicates that all PWDs, including the CDDs, are automatically enrolled in PhilHealth and that the government pays for their premium contributions.[44] Moreover, the "No Balance Billing Policy" of the RA 10606 National Health Insurance Act is applied to the disability benefits package for CDDs as well. No balance billing means qualified members of PhilHealth, such as CDDs, shall not be forced to pay out-of-pocket expenses for services needed for the interventions entailed in the packages.

The policy actors who participated in the FGDs agreed that these laws are helpful as they protect the rights of CDDs to health and access to services. The representatives from the SLP professional organization highlighted the importance of laws in providing opportunities for service providers. For instance, the passing of the RA 11249: Speech-Language Pathology Act paves the way for the creation of the licensure examination for speech pathologists or therapists to ascertain their professional competences and credibility.[45] The law opened more *plantilla items* (or job positions) for SLPs, and also allowing them to be promoted to higher position in government hospitals and institutions. Francia, a representative from SLP professional organization explained, *"Because of the lack of licensure exam, the highest rank is SLP 2. Now that there is already a licensure exam, we can ask for higher ranks."* In the case of parents of CDDs, they were more hopeful for the presence of legislative presentation in congress through a PWD party list.

Barriers

All FGD participants observed the policy's low impact at present due to limited access to therapy services in most provinces. Susan, a representative from the OT professional organization emphasized, *"I believe the impact is low given that many institutions are not yet accredited. For example, in Region 10, there are no contracted hospitals for the Z benefit package for CDDs yet. This is the whole of Northern Mindanao."* Jethro, a parent and advocate of a local disability organization for CDD, raised the same sentiments, *"I'm from NCR and there are two contracted hospitals here. Among the co-parents within our group, no one was able to access this package yet. How much more in the provinces?"* Parents who participated in the FGD shared the struggle of caring for a CDD. Jethro pointed out that regardless of socioeconomic status, all parents are challenged, he shared:

> *"If you are an ordinary family and the parents are minimum wage earners, therapy services will really be hard to avail. Even if the family is quite well off, it is quite costly and it entails a lot of sacrifices."*

Participants also identified political and governance issues in the country hindering policy implementation. With politics, Corazon (PT, private clinic) and Irina (SLP, contracted public hospital) pointed out that corruption-related issues (i.e., irregular benefit claims, ghost patients, diverted premium payments, and the controversial implementation of advance payments to health care institutions) with PhilHealth affect the openness of private institutions to be involved. However, Irina explained that regardless of the corruption issues, she assured that the public hospital will be supported. With governance, Juanita (parent and advocate, national disabled people organization for CDDs) stressed how implementation issues are observed not only with the Z benefit package but among most laws or policies in the country.

Juanita pointed out that despite the long-standing implementation of the BP 344 Accessibility Law, most buildings remain inaccessible to people with disabilities. She continued by raising the issue of the absence of developmental disabilities among the categories of PWD ID as mandated in RA 7277 Magna Carta for PWD. Juanita explained, *"For instance, for children with autism spectrum disorder, since there is no existing category for developmental disability, they are categorized as learning disability, intellectual disability, mental disorder, etc."* With the automatic enrolment of PWDs as PhilHealth members, she cited the issue on the registry: *"We also need to fix the process of getting PWD IDs. Right now, the basis is the PWD DOH registry. However, there are instances that PWDs registered in the LGU could not be found in the PWD DOH registry."* There is an assumption that this barrier could have been exacerbated by the lack of training of personnel who were tasked to encode names to the DOH registry. On the part of the delivery mechanism of the package, Irina raised the issue of the redundancy of having a package in public hospitals that offer free or subsidized therapy services already. She explained how the social welfare services are classified from classes A to C as those who receive partial subsidy while those in class D or those regarded as indigent receive full subsidy. The next issue discussed was the employment of professionals that hinder the full implementation of the package. Irina shared that there are limited plantilla items in public hospitals for rehabilitation professionals. She elaborated:

> *"There is only one SLP [in our institution]. Opening plantilla positions can be tricky. If they were to open a position, it must be filled within three months. If no one applies, hiring will be closed regardless."*

Jocelyn (OT, contracted public hospital) disclosed, *"Our main concern is the number of therapists. We have 11 therapists at the moment, but we need a team of 20 OT staff members to open more slots for the Z package."* The low supply of rehabilitation professionals compared to the demand was pointed out by Gilda (administrator, private non-profit institution)*: "Our onsite waitlist for speech therapy is around 100 even when we already have 10 speech therapists on board. We also have a waitlist of 60 for OT, even if we already have a team of 25 OT clinicians."* Although other groups did not mention it, it was discussed during the FGD with parents the current issue on

"brain drain". Jethro shared that his child's previous therapists moved overseas already. He said that he understood their situation and expressed, *"We have very limited professionals… and most of them are going abroad for greener pastures. They also need to feel valued by the government."*

Ultimately, the barrier mentioned by the service providers was the disruption caused by the COVID-19 pandemic. Jocelyn and Dona (SLP in contracted public hospital and representative from SLP professional organization) shared that the implementation of the benefit package was paused because of the physical restrictions. Dona added:

> *"Right now, the impact is not yet that significant as it is only in its piloting stages. Just when the program had just started, COVID-19 hit us. Hopefully, the program in our hospital will resume soon. As of now, there is only little impact."*

Policy Actors

The policy documents included explicit roles and responsibilities of the following policy actors: 1) interested HCI administrators to prepare for the necessary processes to be a contracted provider for the Z benefit package for CDDs; 2) rehabilitation professionals (OT, SLP, PT, and rehabilitation medicine specialist/developmental pediatrician) as direct service providers; 3) CDDs who are the direct beneficiaries who are aged 0 to 17 years old and 364 days; and 4) PhilHealth Z benefit coordinator who shall act as the liaison officer during implementation stage with PhilHealth. In the FGDs, administrators, rehabilitation professionals, representatives from professional organizations, and parents of CDDs gave their perspectives on how people influence policy implementation.

Facilitators

During policy formulation, representatives from professional organizations and parent advocate recalled their involvement in the consultations organized by PhilHealth. Mariano (a representative from the PT organization), Francia (a representative from the SLP organization), and Juanita (parent and advocate) attended the said consultative meetings. Susan (a representative from the OT organization) did not participate during this period but made sure that an OT representative was present during these meetings. On the one hand, Mariano shared that the focus of their inputs was mainly on the required resources. On the other hand, Josephine raised concerns and struggles of parents of CDDs and emphasized the potential impact of the existence of this package in alleviating the burden among families. During the contracting process, Jocelyn, Irina, Jose (an administrator and PT who contracted a public hospital), and Dona was involved in helping acquire the required resources by PhilHealth.

Participants affiliated with the public sector highlighted their advantage in terms of administrative support. Contracted HCI received strong support from higher management and has an in-house PhilHealth coordinator. Eugene, a physiatrist and administrator in a contracted public hospital reported, *"We were tasked by the medical director to prepare the institution through reviewing the policy documents and acquiring needed resources to be a contracted facility."* He further elaborated that participating in this kind of package can be seen as a form of investment, such that services are free for the CDDs, but the hospital services are reimbursed through PhilHealth. Jocelyn also expressed that by working in the government, she and her team, who were accustomed to the administrative functions (i.e., filling out forms and coordinating with PhilHealth staff), were involved in the package's implementation. She explained that even with the package, her work as an occupational therapist remains the same, except for the fact that there are just more forms to fill out.

All HCI administrators, rehabilitation professionals, and representatives from professional organizations expressed their willingness to participate in the implementation of the package. As HCI administrators in the non-contracted private institutions, Gilda, Roberto (head in a private tertiary hospital), and Cedric (head and OT in a private therapy center) shared that equitability in service provision is valued by their institutions. Corazon also agreed that, as a private practitioner, she is willing to extend her services to potential package beneficiaries. Mariano and Francia also expressed that professional organizations must have a more proactive role in policy negotiations and re-evaluation towards addressing equitability of benefit access. Mariano further suggested that advocating for the Z benefit package for CDDs is an opportunity for professional organizations and other sectors to collaborate and unite in the shared advocacy.

Barriers

There were organizations reportedly involved during policy formulation, but potential service providers, such as administrators and pediatric rehabilitation professionals who participated in FGD, were not part of the formulation process. Eugene shared his sentiments, *"When they were creating this policy, not all of the people who will be involved in this package were invited. The PhilHealth was not able to ask all relevant stakeholders in creating this package."* Despite the intention stated in the policy to affiliate with interested and capable HCIs, Francia said that during the consultation in 2017, contracting tertiary public hospitals was the focus and that there were no guidelines or standards published about the process of how free-standing clinics, such as therapy centers, may participate.

In terms of human resources, Cedric and Roberto, both heads of private institutions, shared that they do not have a PhilHealth Z benefit coordinator. If ever they are contracted, they might assign one of their staff to have this additional role. Roberto explained, *"Our existing staff may act as a coordinator if PhilHealth will allow that. We still need to review if there will be numerous CDDs availing the package before we can request additional manpower."* Rehabilitation professionals and administrators also pointed out the small number of

full-time professionals compared to part-time professionals in the hospital and centers, thus having limited functions in planning and preparing for contracting with the Z benefit package for CDDs. Irina and Melvin, representatives from the SLP organization, who both experienced working in private and public institutions, emphasized that the work preference of SLPs is mainly because they are better remunerated in the private sector. Moreover, Francia offered a perspective that the assigned policy actors responsible for facilitating the process during policy formulation leave during the implementation stage caused by leadership turnover in agencies and organizations.

The FGD for parents raised the issue on receiving financial allowance instead of actual services.

> *"We will continue collaboration with the LGU and federations. Especially now that the focus in the disability sector is allowance. For me, what would I do with the money, say Php 1000? How much does therapy cost? That will only do for one session and the transportation fees." (Jethro)*

Content

Policy content features the policy under study in terms of presentation of information, services, costing, required resources, and overall completeness.

Facilitators

During the FGD, all participants appreciated the existence of the policy. Although there were no specific factors noted, they agreed that the content is generally comprehensive and complete with the list of services and rates in the main policy document PhilHealth Circular 2017-0029.[9] There was also a published compilation of frequently asked questions for policy documents written in the Filipino language, specifically in Tagalog. The information was organized in numbered sections and presented through visual information strategically designed for those who will view it. Summary tables, flowcharts, forms, and sample letters are included in the annexes of the policy documents.

Barriers

The inadequate cost of services was pointed out unanimously across the groups. All were agreeable to the justified rates given to the initial and discharge assessment by medical doctors but deemed that the assigned fees for the services provided by the rehabilitation professionals were insufficient. Cedric explained:

> *"The assessment fees will not compensate the therapists, who may earn 450–550 per hour during therapy sessions, and twice the amount for assessment fees because of the extra work to make the document. The allied health professional is really at a disadvantage."*

He further noted that the allotted fees by PhilHealth for the set of therapy sessions will only cover the therapist's professional fee, but not that of the clinic's cut for the service provided. Thus, it will not be sustainable for the business.

The second concern is about the required resources. The rehabilitation professionals were surprised that the materials, such as the therapy toys needed, were not specified. Corazon argued, *"There are some things which aren't needed while there were which should have been specified such as vestibule, sensory equipment, trampoline, tilt board, benches, chairs, etc. which are necessary for PT sessions."* Corazon also observed that some materials like sphygmomanometer, ultrasound, and paraffin baths are not needed and may be more appropriate for adult practice. Irina and Melvin noticed the lack of feeding tools in the required resources. Melvin reasoned that this might be rooted in the deficiencies in specific descriptors on the service indications. He expressed:

> *"I'm not sure if it would be wise to add more specificities, like if the child has speech and communication problems. For example, the problem is voice or in feeding and swallowing. To what extent can we involve specific conditions based on the definitions in the documents?"*

Furthermore, rehabilitation professionals, administrators, and professional organization representatives brought up the limited scope of assessment tools required in terms of developmental domains, indications, and cultural validity. Corazon pointed out that the required assessment tool for PT, which is the GMFM (Gross Motor Function Measure), is only indicated for children with cerebral palsy and is not appropriate for other developmental disabilities. Cedric also had the same sentiments, "*Assuming, for example, we acquired the Beery VMI which is for school-aged children. What if we have a 2-year-old client, is he not qualified for Beery? I can't use the Z package."* Jocelyn shared a specific experience and narrated:

> *"I remember when procurement for the other assessment tools was still ongoing, we had to use an inappropriate standardized assessment tool. Inappropriate in the sense that the child does not have the skills yet to perform the tasks."*

Aside from the limitations due to indications because of age and conditions, rehabilitation professionals also noted how these required assessment tools are not entirely culturally valid as these are based on Western norms and are in the English language.

Lastly, some participants pointed out the absence of certain protocols, which signals that the policy needs to be revised. There seems to be a lack of protocol for specialized treatment sessions. Melvin was wondering what the implications are on sessions and fees if a certain SLP intervention would need a certain number of sessions and a certain level of training from the provider. On the other hand, Susan pointed out that there was a lack of protocol for the accreditation of rehabilitation professionals aside from the requirement to have a license or certificate from the accredited professional organization. The accreditation for professionals indicated on the website was

only for physicians, nurses, dentists, and midwives. Moreover, Corazon, Mariano, and Francia raised concerns about adding COVID-19 protocols for the policy to be adaptive and responsive to the context.

Process

Policy process refers to the mechanism that involves the stakeholders and the overall implementation of the policy. As stipulated in policy documents, implementation of the Z benefit package for CDDs starts with the accreditation of the facility by PhilHealth (PhilHealth Circular 2012-0054), contracting to be a Z benefit provider (PhilHealth Circulars 2021-0022 and 2022-0012), and providing the services for CDDs (PhilHealth Circular 2017-0029). Across the policy documents, PhilHealth also mentioned the inclusion of marketing and evaluation, and monitoring through policy review. The study participants shared their observations and experiences on the processes such as information dissemination, subcontracting, stakeholder engagement activities, quality assurance, and service delivery.

Facilitators

During the official launch of the package in 2018, numerous information dissemination reports were released in various media. Most participants across the FGDs were familiar with the disability benefits package for CDDs. Several parents of CDDs, disability groups, professional organizations, and rehabilitation professionals reached the information dissemination posts based on the comments and shares in the social media posts.

The next factor appreciated across all groups was the option to subcontract private professionals via the contracted HCI, which could provide multi-disciplinary services despite the lack of a full-time employed set of rehabilitation professionals. Even with the parents of CDDs' lens, Juanita mentioned, *"Maybe if the government will subcontract for this package, it will be feasible. I think the professionals will not be able to give their whole week because the salary is not competitive."*

Equally important, albeit implicitly indicated in the series of policy documents, was quality assurance on the policy implementation. Participants working in the public sector, like Irina and Eugene, stressed the importance of accreditation and contracting standards as these processes stand for accountability and corruption-free implementation. Francia highlighted the clauses for policy review and the importance of evaluation and monitoring to see what is being done. According to the PhilHealth Circular 2021-0022[30], conducting policy reviews should be done regularly between one and three years.

Lastly, the extension of validity of approved pre-authorization applications was one of the collected reports in the document review. For those enrolled in the Z benefit package for CDDs, the approved pre-authorization applications from March 17, 2020, to September 12, 2021, were extended for one fiscal year and 180 calendar days.

Barriers

Participants raised issues regarding their information dissemination process. Through social media postings, people were informed about the package's existence, but there were many unanswered questions on how to avail the benefit package. During the initial launch, there was a failure to mention about the lack of contracted HCI in 2018. A Facebook post by PhilHealth in December 2020 announced that the package is only available in two tertiary public hospitals in NCR and Davao. All 12 information dissemination reports reviewed were targeting parents of CDDs. There was a lack of information dissemination efforts via the official website, newspapers, and social media that target potential service providers for CDDs who intend to partner with PhilHealth.

Another identified barrier was the lack of stakeholder engagement activities from PhilHealth personnel. The lack of visits from capable service providers in the private sector hinders the possibility of having more partners for the Z package. Cedric expressed that other government offices, like the Bureau of Internal Revenue (BIR), hold visits and wondered if PhilHealth could do the same. He explained:

> *"If PhilHealth wants this initiative (to be known), they will go to clinics and spread the "Oh Sir, can you please join this program?" There's a bigger chance for clinics to get involved if PhilHealth is stepping up and asking for partnerships."*

Corazon also provided a similar perspective:

> *"I think that would be easier. PhilHealth will be the one to communicate [with therapy clinics]. Don't they have PhilHealth staff to do this? They can go to the centers and have a census of potential service providers. If there's a requirement, they can readily ask [the clinic administrator] to fill out forms."*

In contrast, since tertiary hospitals were the primary targets, participants from contracted public hospitals disclosed that PhilHealth invited them by sending the needed documents and forms. However, there was a lack of formal orientation sessions on the contracting and implementation process. Corazon, Irina, Jose, and Eugene shared that they navigated themselves through reading the policy documents and intermittently asking questions from the PhilHealth coordinator in their hospitals.

On the other hand, Roberto recalled that PhilHealth staff visited their private hospital and introduced the package with the necessary documents. However, there was a lack of submission status follow-up, and there was no opportunity to clarify questions on contracting after submitting the needed forms for the self-assessment. Gilda also shared the same experience:

> *"There was a time when I was invited to be part of a meeting [with a contracted public hospital and their partner university) and one of the agendas was to subcontract and engage private therapy clinics to be*

providers of the services. However, there was no follow-up after the meeting."

Although stipulated in the PhilHealth Circulars 2017-0029, 2021-022, and 2022-0012 that policy review, as part of monitoring and evaluation, shall be conducted every three years, none of the FGD participants received invitations. There were no uploaded policy documents about revisions to the Z benefit package for CDDs.

Another theme of barriers is the tediousness of the processes for accreditation, contracting, and filing of claims for reimbursement stipulated in PhilHealth Circulars: 2012-0054, 2017-0029, 2021-0022, and 2022-0012. Participants affiliated with the private sector expressed the inconvenience of preparing the budget for procurement, shipping equipment and tools from abroad, and additional staff training for the required standardized assessment tools. Jocelyn who had a first-hand experience in implementing the policy said, *"The process is long and taxing. We needed to prepare and submit claims for reimbursement and ask professionals and parents of CDDs to fill out forms for the services resulting to an extra burden in terms of time for the professionals and parents; and delay in the overall process."* Irina also expressed that forms being written mostly in English impose possible difficulties for the parents of CDDs with limited health literacy. Cedric, a therapy center owner, explained that it would take some time to file claims, because the process may affect the timely disbursement of the consultants' salary. In terms of the experienced implementation during service delivery, there was a limited number of sessions to merit re-evaluation before the client enrolled in another set of therapy sessions, as noted by Jocelyn and Dona. Dona explained:

"For example, the patient is recommended for OT and PT twice a week and then SLP once or twice a week. The ten sessions would be all used up easily. After which, a requirement to submit an assessment so you can move on to the next cycle. You won't see much effect after two or three sessions. "

Through the combination of the document review and FGDs with identified policy actors (i.e., rehabilitation professionals, HCI administrators, representatives of the professional organization, and parents of CDDs), facilitators and barriers in each of the elements (i.e., content, actors, context, and process) of the policy triangle were unpacked. Presented in Figure 2 is the summary of the identified facilitators and barriers.

DISCUSSION

Through policy analysis, the study determined the factors that influence the current status of the implementation of the disability benefits package for CDDs in the Philippines. The study showed that the policy is equipped with various mechanisms and supports through passing the Universal Healthcare Act and amendments to the National Health Insurance Act and the Magna Carta for PWDs. Moreover, the invited policy actors understood the significance of the policy and were hopeful that the policy implementation subject to improvement so that equity in health services for CDDs could be achieved. While there seem to be many facilitators noted during the analysis, it was apparent how anchored the facilitators were on the foundations of legislation, promising services, and technical policy processes. On the other hand, the barriers enumerated remained an immense obstacle to the slow implementation and non-participation of potential service providers despite interest in partaking in the equitable service provision. The influence of each policy element based on the study's findings will be discussed on how these elements affect health policies in other developing countries.

Context

In the study, it was found how the passing of laws, such as the UHC Act, National Health Insurance Act, and amendments to the Magna Carta for PWD, serve as the foundation for launching the Z benefit package for CDD. In a narrative review of countries passing the UHC act by Atim and colleagues, they observed that LMICs such as Ethiopia, Ghana, Nigeria, and the Philippines passed the UHC Act to align with their national health priorities.[46] While passing the UHC act enabled developing countries to increase national health insurance coverage, the extent of coverage in benefit packages remains limited as budget resource allocation is still dependent on the country's income level. The push to have a UHC law from a political decision with vague technical analysis and financing mechanisms undermines the sustainability of the package.[46]

The issue of politics and governance challenges the ability of countries to achieve equity and quality in health service delivery. In Southeast Asian and African countries, Naher and colleagues reported that corruption in the health sector is rampant.[47] Corruption within the government is the cause of various financial-related problems, such as poor salaries and benefits of health professionals, and increased out-of-pocket expenses, due to the preference for private HCI for a better quality of health service experience. Furthermore, circumstances like these are also related to the non-preference of health professionals to work for the government and the threat of brain drain, which poses a threat to the Z benefit package implementation for CDDs and other health services in the country. Health professionals from LMICs such as the Philippines, India, Pakistan, Nigeria, Ghana, and South Africa migrate to the United States and United Kingdom due to poor remuneration, poor working environment, unstable political climate, limited career growth, and academic training.[48,49]

Policy Actors

All policy actors in the study expressed willingness to be involved and were hopeful for the successful implementation

of the package. However, it was reflected in the study how policy actors in the form of organizations (i.e., representatives from professional organizations, PWD organizations) were given more agency or sense of control during the formulation of the policy. The participants who do not hold official positions in professional organizations and disability groups felt a lack of input among other potential service providers outside NCR and from the private sector. The explicit statement that PhilHealth focuses on contracting tertiary public hospitals and the lack of protocol accreditation and contracting of free-standing clinics contradict their stated openness to deal with the private sector. This centralized policy-making style, wherein PhilHealth concentrates control on specific policy actors alone, inhibits the Z benefit package for CDDs' potential to achieve equitability in access to therapy services. Centralization of policy-making may help gain momentum during formulation as fewer policy actors are involved. However, other policy actors' possible contributions and innovations are overlooked, affecting participation during the implementation stage.[50,51] Liwanag and Wyss also stressed that centralization fails to consider the diverse context of the indigenous and marginalized policy actors affecting service delivery.[51] In Malawi, Nigeria, and other LMICs, local stakeholders felt they had no influence in policy-making compared to the preferred stakeholders commonly invited who are associated with specific organizations.[52–54]

The limitations on participation in the study's findings and related international literature demonstrate the tokenistic level of participation during policy-making. In Arnstein's ladder of participation, inviting hand-picked policy actors who hold power in organizations is called placation, placed at ladder level 5.[55] To move to the next step of the ladder, which is a partnership, means redistribution of power through negotiations between citizens and people who hold certain official positions shall be implemented.

Content

After considering the various voices of policy actors, the results of the study highlight the concept of sociomateriality - "the entanglement of social and material in everyday life." [56] The dynamic interaction of policy elements embodies a socio-material assemblage, defined by MacLeod and colleagues as "a complex tangle of natural, technological, human, and non-human elements that come together to accomplish both intended and unintended outcomes."[57] Focusing on the policy's content, rehabilitation professionals, administrators, and professional organization representatives all raised concerns about the compliance on required 'material' resources stipulated in the policy's content affecting policy actors and processes. Parents, on the other hand, raised the inconsistencies of disability categorization reflected on the PWD IDs as "developmental disability" is not an official category in the revised RA 7277 affecting claims for the policy benefits for the lack of uniform categorization affecting consistency in administrative processes.

There is an imposed moral conflict on service providers in prioritizing between the code of ethics and equitability in the process of service delivery which is characterized by the following circumstances: 1) using an inappropriate tool to reimburse claims on assessment fees, and 2) maintaining standing on the appropriate use of tool but only accepting clients indicated for available standardized tools in the institution. Moreover, the additional burden of procurement to interested HCIs and waiting time for importing Western-referenced resources affect the timely implementation of rehabilitation services. The preference for using standardized tests is useful for measuring outcomes. However, putting a premium on the use of these quantitative tests when a functional evaluation may be administered is influenced by biomedical standards. This is a manifestation of an ableist approach of rehabilitation professionals to measure the severity of disability which may not always be appropriate to the CDDs' goals.[58]

Additionally, the mentioned lack of protocols in terms of service delivery during the COVID-19 pandemic imposes changes in the demands in terms of required resources, especially when the use of telehealth is prevalent due to the safety risks of a face-to-face delivery is a global practice already.[59] The inclusion of telehealth services in the Z benefit package for CDDs may also be reflected in future amendments so that continuous service delivery may be performed in compliance with physical restrictions and consideration of safety risks.

Process

Based on the policy documents found, the Z benefit package for CDDs included clauses on quality assurance and policy review, yet there were no published reports about these undertakings even though policy reviews are stipulated every three years (PhilHealth Circular No. 2021-0022). Although information dissemination efforts were deemed effective during the launch of the Z benefit package for CDDs – giving hope to several potential beneficiaries. However, interested stakeholders who engaged with posted online publication materials on social media were not responded clearly on how and where to avail of the Z benefit package for CDDs. The lack of timely updates on policy review and issues in information dissemination reflect the low responsiveness of the national health insurance and leave people feeling disappointed by the system of overpromising and underdelivering.[60]

In the dominance of HCIs run by the private sector and with the preference of rehabilitation professionals to work for the private sector, strengthening partnerships with the private sector through sustainable contracting arrangements is crucial for optimal health service delivery. The presence of the partnerships, seen in the listing of Z benefit providers from the private sector, is a positive indicator of the feasibility of further cultivating collaboration. For instance, with the Z benefit for coronary artery bypass graft, 16 out of 24 (66.67%) providers are from the private sector.[10] Factors on successful

contracting with other Z benefits may pave the way for how to invite more service providers for the rehabilitation needs of CDDs.

With the discussion among policy actors from the private sector in the study, the lack of stakeholder engagement from PhilHealth, such as personal visits, and the burden of paperwork for the costing and claims reimbursement were the main hindrances on why they hesitate to apply as a contracted service provider. In a report by Mbogo and colleagues, the social health insurance of Kenya achieved sustainable service delivery through organizing the private sector, digitization, and contracting through an intermediary.[61] First, organizing the private sector can be done by working with professional organizations to identify qualified service providers participating in public-private endeavors. Second, through digitization, a clinic management system is installed, which supports "scheduling and patient communications, medical record documentation, billing and payments, quality assurance, inventory management, and external reporting." Lastly, contracting through an intermediary is similar to the process of subcontracting, wherein an accredited HCI may affiliate with private service providers by sharing a caseload of CDDs, which helps streamline the reimbursement claims process.

In this study, the policy actors from the public sector were agreeable to the standardized service fees, while those from the private sector felt that the assigned rates were a bit low compared to the current pricing in their institutions. Honda and Obse argued that these uniform rates by social health insurance systems among public and private service providers can be counterproductive and serve as a source of dissatisfaction on cost in the view of private HCIs.[62] In Ghana, their social health insurance pays higher payment rates for their private service providers such that public service providers already receive salaries and other subsidies from the Ministry of Health. Furthermore, in Malawi and Tanzania, both the social health insurance and the local government units help fund the salaries of contracted private service providers.

Recommendations and Proposed Options

Based on the significance and findings of the study, recommendations for policy reform, education and training, and research were drawn. For the policy reform, the researcher listed specific recommendations for each policy element in Table 4. The researcher also suggests discussing these recommendations during policy review. Moreover, policy actors are encouraged to identify prioritization and strategies considering the study's results and recommendations to achieve better outcomes in terms of the equitability of the policy.

For education and training, the role of service providers and service users as policy actors in policy development is necessary to discuss in the curricula of health professions programs and through workshops/seminars with PWDs. Also, the collaborative nature of the processes involved in policy development necessitates a professional to have competencies to effectively work with people of varying backgrounds consisting of health and non-health professionals. Thus, the introduction of WHO's suggested Framework of Action on Interprofessional Education and Collaborative Practice can be a good resource.[63] Moreover, policy engagements should include co-designing with service users via non-intimidating approaches such as storytelling. In a literature review by Davidson, storytelling as a communication strategy highlights the importance of the policy narrative, which includes first-hand stories of service users.[64] Storytelling is a justifiable way of informing policy-making through informal sharing, photography, role-playing, charting, and cognitive mapping, among others.[64]

For research, more policies affecting health and disability issues in the Philippines and other countries can be investigated through the case-study design and use of the policy triangle framework for holistic policy analysis.[12] Since this study only included external policy actors, future studies are encouraged to involve internal policy actors, such as the Department of Health, Department of Social Work and Development, National Centre for Disability Affairs, and PhilHealth for a complete representation of all concerned policy actors.

CONCLUSION

This study offers an overview of the policy elements influencing the current implementation status of the Z benefit package for CDDs using the policy triangle framework of Walt and Gilson.[12] Through document review and FGDs with contracted and potential service providers (i.e., public and private HCI administrators and professional organizations) and beneficiaries (i.e., parents of CDDs and parent advocates) – facilitators and barriers were identified.

In summary, it shows how the current context of the Philippine healthcare system is anchored through the presence of laws and policies supporting the advocacy of early intervention and access to therapy services of CDDs but hindered by issues on politics, governance, and the labor force. The policy actors (service providers and beneficiaries) are hopeful of the continuous implementation of the Z benefit package nationwide and share the advocacy for CDDs. However, the limited involvement of all potential policy actors in policy development and the limited human resources for service provision impede them. Although the policy's content is technically sound and comprehensive, concerns regarding cost and complying with needed resources hold the translation to implementation, and the lack of protocols poses an adaptability and sustainability threat.

Processes and initial dissemination efforts involved in implementation emphasize quality assurance and effectiveness during launch, respectively. However, the lack of activities to continuously engage potential service providers and the tediousness of the overall process limit the participation of

Table 4. Specific recommendations and options for the disability benefit package for CDDs

Policy Element	Recommendations and proposed options for policy
Context	• Increase information dissemination on the Z benefit package for CDDs and implement policy evaluation promptly • Laws such as the Magna Carta of PWDs must be amended to include specific category for developmental disabilities for consistency • Align registry for PWD identification card holders in the DOH registry for easier availing for the Z benefit package for CDDs and other benefits from PhilHealth. • Review standardization of salary of rehabilitation professionals in both the public and private sectors in order to increase employment in public HCIs and decrease brain drain. • Increase plantilla items and review the salary package for rehabilitation professionals in the public HCI • Add protocols in case of pandemic or lockdown
Policy Actors	• Include more potential service providers (i.e., administrators, rehabilitation professionals) both from the public and private sector during policy engagements. Specifically, add more plantilla items for health and social care professionals in government hospitals. • Consider including universities with rehabilitation professions program helping in human resource through internship programs for graduating students and through research endeavors. • Consider teaming up with local government in providing assistance with needs (i.e., transportation allowance) of parents and CDDs in order to access therapy services.
Content	• Review fees of services due to the big gap of fees with the private sector's rates • Review utilization of required assessment tools. Consider using assessment tools that tests wider scope of developmental domains and are more culturally valid. • Consider creating a free standardized form for assessment with the help of experts. • Add a protocol for service delivery during the pandemic such as telehealth services. • Add a protocol on the process of accreditation of rehabilitation professionals, especially from the private sectors. • Include updates on successful service provision and other testimonies of contracted HCIs.
Process	• Review consultation styles used during policy development and review. Adapt rights-based approach and health systems thinking in order to achieve equitability of access to services. • Clarify information dissemination of Z benefit package to CDDs by including contracted HCIs in the publication material. • Upload information dissemination specifically targeted to potential HCIs. • Conduct visits to potential service providers. • Conduct proper orientation to contracted HCIs. • Review allotted number of sessions per type of therapy services in once cycle. Consider increasing the number of sessions needed per cycle as early intervention approach recommends more frequent sessions. Thus, a CDD recommended for all OT, PT and SLP services can easily use up allotted ten sessions in a month then would be automatically subjected for a re-evaluation before he/she can receive the second cycle of therapy sessions. • Consider incentives to contracted HCIs with Z benefit package (i.e., premium contributions, assistance to other required resources, and streamlining benefit packages in the case of assistive device needs). • Utilize subcontracting of private rehabilitation professionals by increasing contracted tertiary public hospitals as these HCIs are automatic accredited by PhilHealth compared to private HCIs which may need to undergo this additional step. • Train personnel in the encoding process for DOH registry.

CDD – children with developmental disabilities, PWD – persons with disability, HCI – healthcare institution, OT – occupational therapy, PT – physical therapy, SLP – speech language pathology

service providers from both the public and private sectors. In conclusion, while the policy seems promising during launch, the disability benefits package for CDDs remains underutilized because the identified barriers outweigh the facilitators on each policy element. Policy reform is needed to improve the implementation of the disability benefits package for CDDs.

In this policy analysis, the policy triangle framework is a helpful tool in mapping out gaps in policy implementation among different aspects: context, policy actors, content, and process. It organizes the analysis structure and enables holistic consideration through a rigorous review of policy documents and exploration of perspectives of policy actors. Identifying factors that support and hinder helps prevent policy failure. Although generalization of results is limited to the case in focus, awareness of facilitators and barriers that affect policy implementation can lead to future policy reform and formulation in other developing countries.

Acknowledgments

The authors acknowledge and thank valuable insights given by Dr. Myra Oruga, Dr. Josephine Agapito, Asst. Prof. Edric Estrella, Dr. Sheila Bonito, and the policy actors interviewed on this study.

Statement of Authorship

Both authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

Both authors declared no conflicts of interest.

Funding Source

None.

REFERENCES

1. Clarke D, Doerr S, Hunter M, Schmets G, Soucat A, Paviza A. The private sector and universal health coverage. Bull World Health Organ. 2019 Jun 1;97(6):434-435. doi: 10.2471/BLT.18.225540. PMID: 31210681. PMCID: PMC6560377.
2. Centers for Disease Control and Prevention, Office of Policy, Performance, and Evaluation. The CDC Policy Process. The CDC Policy Process. 2021. Accessed October 11, 2024. https://www.cdc.gov/policy/polaris/training/policy-process/index.html
3. Senate and House of Representatives (Philippines). An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor.; 2019:18. Accessed October 11, 2024. https://www.officialgazette.gov.ph/downloads/2019/02feb/20190220-RA-11223-RRD.pdf
4. Capuno JJ, Kraft AD, O'Donnell O. Filling potholes on the road to universal health coverage in the Philippines. Health Syst Reform. 2021;7(2):e1911473. doi: 10.1080/23288604.2021.1911473
5. Kutzin J. Anything goes on the path to universal health coverage? No. Bull World Health Organ. 2012;90(11):867-8. doi: 10.2471/BLT.12.113654
6. UNICEF. No Child Left Behind: Study calls for better care of children with disabilities. 2018. Accessed October 11, 2024. https://www.unicef.org/philippines/press-releases/no-child-left-behind-study-calls-better-care-children-disabilities
7. Carraro L, Robinson A, Hakeem B. The Cost of Raising Children with Disabilities in the Philippines. Published online September 1, 2022. Accessed October 11, 2024. https://www.unicef.org/philippines/reports/cost-raising-children-disabilities-philippines
8. Navarro N. PhilHealth Introduces Z Benefit Package for Children with Developmental Disabilities. 2018. Accessed October 11, 2024. https://www.philhealth.gov.ph/news/2018/zben_cdd.html
9. Philippine Health Insurance Corporation. PhilHealth Circular 2017-0029: Z benefits for children with developmental disabilities. Published online 2017. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2017/circ2017-0029.pdf
10. Philippine Health Insurance Corporation. Contracted health care institutions for Z-benefit package as of January 31, 2023. Published online 2023. Accessed October 11, 2024. https://www.philhealth.gov.ph/partners/providers/institutional/accredited/ZBEN_013123.pdf
11. Yin RK. Case Study Research and Applications: Design and Methods. SAGE Publications; 2017.
12. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy Plan. 1994 Dec;9(4):353-70. doi: 10.1093/heapol/9.4.353. PMID: 10139469.
13. Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. Health Policy Plan. 2008 Sep;23(5):308-17. doi: 10.1093/heapol/czn024. PMID: 18701552. PMCID: PMC2515406.
14. Dalglish SL, Khalid H, McMahon SA. Document analysis in health policy research: the READ approach. Health Policy Plan. 2020;35(10):1424-31. doi: 10.1093/heapol/czaa064
15. Kahan JP. Focus groups as a tool for policy analysis. Anal Soc Issues Public Policy. 2001;1(1):129-46. doi: 10.1111/1530-2415.00007
16. El-Jardali F, Hammoud R, Younan L, et al. The making of nursing practice Law in Lebanon: a policy analysis case study. Health Res Policy Syst. 2014;12(1):52. doi: 10.1186/1478-4505-12-52
17. Pearson M, Zwi AB, Buckley NA. Prospective policy analysis: how an epistemic community informed policymaking on intentional self poisoning in Sri Lanka. Health Res Policy Syst. 2010;8(1):19. doi: 10.1186/1478-4505-8-19
18. Mukanu MM, Zulu JM, Mweemba C, Mutale W. Responding to non-communicable diseases in Zambia: a policy analysis. Health Res Policy Syst. 2017;15(1):34. doi: 10.1186/s12961-017-0195-7
19. Mbachu CO, Onwujekwe O, Chikezie I, Ezumah N, Das M, Uzochukwu BSC. Analysing key influences over actors' use of evidence in developing policies and strategies in Nigeria: a retrospective study of the Integrated Maternal Newborn and Child Health strategy. Health Res Policy Syst. 2016;14(1):27. doi: 10.1186/s12961-016-0098-z
20. Ahmed S, Hasan MZ, Ali N, Ahmed MW, Haq E, Shabnam S, et al. Effectiveness of health voucher scheme and micro-health insurance scheme to support the poor and extreme poor in selected urban areas of Bangladesh: An assessment using a mixed-method approach. PLoS One. 2021 Nov 1;16(11):e0256067. doi: 10.1371/journal.pone.0256067. PMID: 34723992. PMCID: PMC8559931.
21. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs. 2008 Apr;62(1):107-15. doi: 10.1111/j.1365-2648.2007.04569.x. PMID: 18352969.
22. Fazio A, Hunt G, Moloney M. "It's one of the better drugs to use": Perceptions of cocaine use among gay and bisexual Asian American men. Qual Health Res. 2011;21(5):625-41. doi: 10.1177/1049732310385825
23. Bengtsson M. How to plan and perform a qualitative study using content analysis. NursingPlus Open. 2016;2:8-14. doi: 10.1016/j.npls.2016.01.001
24. Naturalistic Inquiry.; 2024. Accessed October 11, 2024. https://uk.sagepub.com/en-gb/eur/naturalistic-inquiry/book842
25. Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. Qualitative content analysis: a focus on trustworthiness. Sage Open. 2014;4(1):2158244014522633. doi: 10.1177/2158244014522633
26. Philippine Health Insurance Corporation. PhilHealth Circular 2012-0054: Manual of procedure of the new accreditation process. Published online 2012. Accessed October 11, 2024. https://www.philhealth.gov.ph/downloads/accreditation/MOP_PEACHeS.pdf
27. Philippine Health Insurance Corporation. PhilHealth Circular 2015-035: Guiding principles of the Z benefits. Published online 2015. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2015/circ035-2015.pdf
28. Philippine Health Insurance Corporation. PhilHealth Circular 2015-0014: Guidelines for contracting of HCIs as Z benefit package providers. Published online 2015. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2015/circ014-2015.pdf
29. Philippine Health Insurance Corporation. PhilHealth Circular 2017-0017: Strengthening the implementation of the no balance billing policy. Published online 2017. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2017/circ2017-0017.pdf
30. Philippine Health Insurance Corporation. PhilHealth circular 2021-0022: The guiding principles of the Z benefits (revision 1). Published online 2021. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2021/circ2021-0022.pdf
31. Philippine Health Insurance Corporation. PhilHealth circular No. 2022-0012: Contracting of a health facility as a Z Benefit provider (revision 1). Published online 2022. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2022/circ2022-0012.pdf
32. Philippine Health Insurance Corporation. "Tamang Sagot" PhilHealth circular 2015-0014: Guidelines for contracting of HCIs as Z benefit package providers. Published online 2015. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2015/TS_circ014-2015.pdf
33. Philippine Health Insurance Corporation. "Tamang Sagot" PhilHealth circular no. 2017-0029 Z benefits for children with developmental disabilities. Published online 2017. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2017/TS_circ2017-0029.pdf
34. Philippine Health Insurance Corporation. "Tamang Sagot" PhilHealth circular 2021-0022: The guiding principles of the Z benefits (revision 1). Published online 2021. Accessed October 11, 2024. https://www.philhealth.gov.ph/circulars/2021/TS_circ2021-0022.pdf
35. Castillo J. Guide to PhilHealth's Z Benefit Packages for Kids With Disabilities. smartparenting.com.ph. Accessed October 11, 2024. https://www.smartparenting.com.ph/parenting/kids-with-special-needs/philhealth-benefit-package-children-special-needs-disabilities-a00026-20180305
36. Inso FA. PhilHealth opens benefit package for children with disabilities. Cebu Daily News. 2018. Accessed October 11, 2024.

https://cebudailynews.inquirer.net/163805/philhealth-opens-benefit-package-children-disabilities
37. Santos T. PhilHealth launches package for disabled kids. INQUIRER.net. March 5, 2018. Accessed October 11, 2024. https://newsinfo.inquirer.net/972838/philhealth-launches-package-for-disabled-kids
38. Philippine Health Insurance Corporation. Extension of Validity of Approved Pre-Authorization Applications for the Z Benefits and the Outpatient Benefit for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease. Published online 2021. Accessed October 11, 2024. https://www.philhealth.gov.ph/advisories/2021/adv2021-009.pdf
39. Bundoc J. Celebrating awareness, rights and inclusion of children with developmental disabilities. 2017. Accessed October 11, 2024. https://www.facebook.com/josephine.bundoc/posts/pfbid02oaLsx-MpRveeSYgWaSFfucmm6USstyWh9MLELH1RDU8XKaj8K-WSPN5WBKVuuePtKTl
40. Flying Ketchup. PhilHealth offers package for children with disabilities. 2018. Accessed October 11, 2024. https://www.facebook.com/flyingketchup/photos/a.1897719227110226/2057736151108532/
41. Philippine Health Insurance Corporation. MOA signing between PhilHealth and UP-PGH. Accessed October 11, 2024. https://www.facebook.com/PhilHealthOfficial/posts/pfbid02kgvbYuT2aPkEdfx-FHK9Uujeqn5Uj9njcapLWrKjS1xztCPV7nvK1sC9WS9XYJnqcl
42. Brigada [@BrigadaGTV]. Alam n'yo bang mayroong Z Benefits package ang PhilHealth para sa mga batang mayroong developmental disabilities? Ibahagi ito para sa kaalaman ng iba! #Brigada https://t.co/6lt02CcUyB. Twitter. February 3, 2020. Accessed October 11, 2024. https://x.com/BrigadaGTV/status/1224225070765109248
43. Philippine Health Insurance Corporation. PhilHealth Z benefit package for children with developmental disabilities. 2020. Accessed October 11, 2024. https://www.facebook.com/PhilHealthOfficial/posts/pfbid02jpoCqt2UTDoV3it7UULdi5rUpaeQnfBgpEdsJirJ8D-C1vB3rWWPYq7bMetVSMJSYl
44. Senate and House of Representatives (Philippines). An Act Providing for The Mandatory Philhealth Coverage for All Persons With Disability (Pwds), Amending for the Purpose Republic Act No. 7277, As Amended, Otherwise Known as the "Magna Carta For Persons With Disability", RA11228 (2018).\.; 2. Accessed October 11, 2024. https://www.officialgazette.gov.ph/downloads/2019/02feb/20190222-RA-11228-RRD.pdf
45. Senate and House of Representatives (Philippines). An Act Regulating the Practice of Speech Language Pathology in the Philippines, and Providing Funds Therefor. Accessed October 11, 2024. https://lawphil.net/statutes/repacts/ra2019/ra_11249_2019.html
46. Atim C, Koduah A, Kwon S. How and why do countries make Universal Health Care policies? Interplay of country and global factors. J Glob Health. 2021 Nov 20;11:16003. doi: 10.7189/jogh.11.16003. PMID: 34912556. PMCID: PMC8645244.
47. Naher N, Hoque R, Hassan MS, Balabanova D, Adams AM, Ahmed SM. The influence of corruption and governance in the delivery of frontline health care services in the public sector: a scoping review of current and future prospects in low and middle-income countries of south and south-east Asia. BMC Public Health. 2020 Jun 8;20(1):880. doi: 10.1186/s12889-020-08975-0. Erratum in: BMC Public Health. 2020 Jul 9;20(1):1082. doi: 10.1186/s12889-020-09197-0. PMID: 32513131. PMCID: PMC7278189.
48. El Saghir NS, Anderson BO, Gralow J, Lopes G, Shulman LN, Moukadem HA, et al. Impact of Merit-Based Immigration Policies on Brain Drain From Low- and Middle-Income Countries. JCO Glob Oncol. 2020 Feb;6:185-189. doi: 10.1200/JGO.19.00266. PMID: 32023124. PMCID: PMC7051246.
49. Karan A, DeUgarte D, Barry M. Medical "Brain Drain" and health care worker shortages: How should international training programs respond? AMA J Ethics. 2016;18(7):665-75. doi: 10.1001/journalofethics.2016.18.7.ecas1-1607
50. Scarffe AD, Coates A, Evans JM, Grudniewicz A. Centralization and innovation: Competing priorities for health systems? Int J Health Plann Manage. 2022 Sep;37(5):2534-2541. doi: 10.1002/hpm.3531. PMID: 35691008. PMCID: PMC9546220.
51. Liwanag HJ, Wyss K. Optimising decentralisation for the health sector by exploring the synergy of decision space, capacity and accountability: insights from the Philippines. Health Res Policy Syst. 2019;17(1):4. doi: 10.1186/s12961-018-0402-1
52. Masefield SC, Msosa A, Chinguwo FK, Grugel J. Stakeholder engagement in the health policy process in a low income country: a qualitative study of stakeholder perceptions of the challenges to effective inclusion in Malawi. BMC Health Serv Res. 2021 Sep 18;21(1):984. doi: 10.1186/s12913-021-07016-9. PMID: 34537033. PMCID: PMC8449519.
53. Uneke CJ, Ezeoha AE, Ndukwe CD, Oyibo PG, Onwe F, Aulakh BK. Research priority setting for health policy and health systems strengthening in Nigeria: the policymakers and stakeholders perspective and involvement. Pan Afr Med J. 2013 Sep 12;16:10. doi: 10.11604/pamj.2013.16.10.2318. PMID: 24570781. PMCID: PMC3926765.
54. Vanyoro KP, Hawkins K, Greenall M, Parry H, Keeru L. Local ownership of health policy and systems research in low-income and middle-income countries: a missing element in the uptake debate. BMJ Glob Health. 2019;4(4):e001523. doi: 10.1136/bmjgh-2019-001523
55. Arnstein SR. A ladder of citizen participation. J Am Inst Plann. 1969;35(4):216-24. doi: 10.1080/01944366908977225
56. Orlikowski WJ. Sociomaterial practices: Exploring technology at work. Organ Stud. 2007;28(9):1435-48. doi: 10.1177/0170840607081138
57. MacLeod A, Cameron P, Ajjawi R, Kits O, Tummons J. Actor-network theory and ethnography: Sociomaterial approaches to researching medical education. Perspect Med Educ. 2019 Jun;8(3):177-186. doi: 10.1007/s40037-019-0513-6. PMID: 31161478. PMCID: PMC6565649.
58. Yao DPG, Sy MP, Martinez PGV, Laboy EC. Is occupational therapy an ableist health profession? A critical reflection on ableism and occupational therapy. Cad Bras Ter Ocupacional. 2022;30:e3303. doi: 10.1590/2526-8910.ctoRE252733032
59. Doraiswamy S, Abraham A, Mamtani R, Cheema S. Use of Telehealth During the COVID-19 Pandemic: Scoping Review. J Med Internet Res. 2020 Dec 1;22(12):e24087. doi: 10.2196/24087. PMID: 33147166. PMCID: PMC7710390.
60. Zezza M, Nacinovich M. Confounding constituents: complicated healthcare communications and the Affordable Care Act in the United States. J Commun Healthc. 2011;4(3):152-6. doi: 10.1179/1753807611Y.0000000011
61. Mbogo B, Holtz J, Odeyo J. Digitizing and Contracting Private Practices to Sustain Family Planning: Lessons from Kenya. Published online 2021. Accessed October 11, 2024. https://healthmarketlinks.org/sites/default/files/resources/Digitizing%20and%20Contracting%20Private%20Practices%20to%20Sustain%20Family%20Planning%20-%20Lessons%20from%20Kenya%20%28final%29_1.pdf
62. Honda A, Obse A. Payment Arrangements for Private Healthcare Purchasing Under Publicly Funded Systems in Low- and Middle-Income Countries: Issues and Implications. Appl Health Econ Health Policy. 2020 Dec;18(6):811-823. doi: 10.1007/s40258-019-00550-y. Erratum in: Appl Health Econ Health Policy. 2020 Dec;18(6):841-842. doi: 10.1007/s40258-020-00625-1. PMID: 31965556. PMCID: PMC7716847.
63. World Health Organisation. Framework for action on interprofessional education & collaborative practice. 2010. Accessed October 11, 2024. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice
64. Davidson B. Storytelling and evidence-based policy: lessons from the grey literature. Palgrave Commun. 2017;3(1):1-10. doi: 10.1057/palcomms.2017.93r

APPENDICES

Appendix A. Specific questions used to probe participants from the different cohorts to facilitate the FGD

Cohorts	With experience in implementation of the Z benefit package for CDDs	Without experience in implementation of the Z benefit package for CDDs
Managerial and administration heads of HCI offering rehabilitation services for CDDs	What are your preparations in order to participate in the Z benefit package for CDDs? What are the adjustments that you made to participate in this Z benefit package for CDDs? How does this policy scheme align with the mission/vision of your institution?	What do you think about the requirements and the feasibility of your institution to be accredited for this policy scheme? What kind of adjustments are you willing to make in order to participate in this policy? How does this policy scheme align with the mission/vision of your institution? Do you think it is possible for your institution to apply for accreditation with PhilHealth for this Z benefit package? Why or why not?
Health professionals	How did the implementation of this policy scheme affect your work as a health professional? Based on your clinical expertise, what are your thoughts on the required resources stipulated in the eligibility criteria for the accreditation of HCI?	How do you think your work will be affected if your organization participates in this policy? Based on your clinical expertise, what are your thoughts on the required resources stipulated in the eligibility criteria for the accreditation of HCI?
Professional organization representatives	How was your involvement during the formulation of this policy? How do you participate in the implementation of this policy? How does this policy scheme align with the mission/vision of your organization?	How do you think can your organization be involved in this policy scheme? How does this policy scheme align with the mission/vision of your organization?
Parents of CDDs	How was your experience in using the Z benefit package for CDDs? How did the policy scheme affect your child with developmental disability? What can be improved in the Z benefit package in order to reach more CDDs and their families?	What is the feasibility of benefitting from this Z benefit package? If you are not currently benefitting from this, how do you access therapy services for your child?

Appendix B. List of documents reviewed for the policy analysis

Document Type	Title	Author	Date Published	Purpose
Policy document (n=7)	PhilHealth Circular No. 2012-0054: Manual of Procedure of the New Accreditation Process	PhilHealth	2012	To outline procedure needed to be a PhilHealth-accredited facility including the steps, fees, forms, and sample letters in accordance with RA 10606 National Health Insurance Act [26]
	PhilHealth Circular 2015-035: Guiding Principles of the Z benefits	PhilHealth	2015	To establish the guiding principles behind all Z benefits [27]
	PhilHealth Circular 2015-0014: Guidelines for Contracting of HCIs as Z Benefit Package Providers	PhilHealth	2015	To provide guidelines for contracting HCIs for Process for specific Z benefit packages [28]
	PhilHealth Circular 2017-0017: Strengthening the Implementation of the No Balance Billing Policy	PhilHealth	2017	Related policy to be adhered based on the revised guiding principles of the Z benefits (PhilHealth 2021-0022) emphasizing that out-of-pocket payment from PhilHealth members to HCIs are not allowed [29]
	PhilHealth Circular 2017-0029: Z Benefits for Children with Developmental Disabilities	PhilHealth	2018	Main policy document about the Z benefits for CDDs outlining pre-authorization; contracting process, minimum standards of care; availment of the benefits; monitoring and policy review; and marketing, promotion and patient empowerment [9]
	PhilHealth Circular 2021-0022: The Guiding Principles of the Z Benefits (Revision 1)	PhilHealth	2021	To establish the guiding principles of Z benefits and to define the policies and procedure in the delivery of quality health services to all members [30]
	PhilHealth Circular No. 2022-0012: Contracting of a Health Facility as a Z Benefit Provider (Revision 1)	PhilHealth	2022	To update the process of contracting health facility for Z benefit providers emphasizing commitment of PhilHealth to contract with public tertiary hospitals and capable private HCIs [31]

Appendix B. List of documents reviewed for the policy analysis *(continued)*

Document Type	Title	Author	Date Published	Purpose
FAQs (n=3)	'Tamang Sagot' PhilHealth Circular 2015-0014 Guidelines for Contracting of HCIs as Z Benefit Package Providers	PhilHealth	2015	To provide a list of frequently asked questions answered in Filipino language for guidelines on contracting HCIs for specific Z benefit packages [32]
	'Tamang Sagot' PhilHealth Circular No. 2017-0029 Z Benefits for Children with Developmental Disabilities	PhilHealth	2018	To provide a list of frequently asked questions answered in Filipino language about the Z benefits for CDDs [33]
	Tamang Sagot_PhilHealth Circular 2021-0022: The Guiding Principles of the Z Benefits (Revision 1)	PhilHealth	2021	To provide a list of frequently asked questions in Filipino language about the updated guiding principles of the Z benefits [34]
Report (n=6)	PhilHealth Introduces Z Benefit Package for Children with Developmental Disabilities	PhilHealth	2018	To disseminate information on launching of the package [8]
	Guide to PhilHealth's Z Benefit Packages for Kids with Disabilities	Jillian E. Castillo (Smart Parenting)	2018	To disseminate information on launching of the package [35]
	PhilHealth Opens Benefit Package for Children with Disabilities	Futch Anthony Inso (Cebu Daily News)	2018	To disseminate information on launching of the package [36]
	PhilHealth Launches Package for Disabled Kids	Tina G. Santos (Philippine Daily Inquirer)	2018	To disseminate information on launching of the package [37]
	Extension of Validity of Approved Pre-Authorization Applications for the Z Benefits and the Outpatient Benefit for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease	PhilHealth	2021	To disseminate information on extension of approved pre-authorization applications in consideration of COVID-19 pandemic [38]
	Contracted Health Facility for Z-Benefit Package as of June 30, 2022	PhilHealth	2022	To disseminate information on the updated list of contracted HCIs (with the most updated list dated January 2023 [10])
Social media post (n=6)	Celebrating Awareness, Rights and Inclusion of Children with Developmental Disabilities	Josephine Bundoc (Facebook)	2017	To announce successful policy development consultation together with stakeholders, UNICEF, and Physicians for Peace [39]
	PhilHealth Introduces Z Benefit Package for Children with Developmental Disabilities	PhilHealth (Facebook)	2018	To disseminate information on launching of the package [8]
	PhilHealth Offers Package for Children with Disabilities	Flying Ketchup (Facebook)	2018	To disseminate information on launching of the package [40]
	MOA Signing between PhilHealth and UP-PGH	PhilHealth (Facebook)	2019	To disseminate information on successful contracting of the first HCI to offer Z benefit package [41]
	Z Benefits for Children with Developmental Disabilities	BrigadaTV (Twitter)	2020	To disseminate information on launching of the package [42]
	PhilHealth Z Benefit Package for Children with Developmental Disabilities	PhilHealth (Facebook)	2020	To disseminate information on availability of the package in two contracted hospitals in NCR and Region 11 [43]

Appendix C. Demographic profile of FGD participants

Focus Groups (n=4)	Pseudonyms (n=16)	Location	Gender (7M:9F)	Role	Involvement with Policy	
					Formulation (p'=3/16)	Implementation (p'=5/16)
Rehabilitation Professionals	Corazon	Metro Manila	Female	PT practitioner in private clinics	No	No
	Irina	Metro Manila	Female	SLP practitioner in contracted public hospital	No	Yes
	Jocelyn	Metro Manila	Female	OT practitioner in contracted public hospital	No	Yes
Administrators	Cedric	Luzon	Male	Owner and manager of private for-profit therapy center and OT practitioner	No	No
	Eugene	Metro Manila	Male	Department head and Rehabilitation Medicine specialist in contracted public hospital	No	Yes
	Jose	Luzon	Male	Chief Physical Therapist in contracted public hospital	No	Yes
	Roberto	Luzon	Male	Department head and PT practitioner in private hospital	No	No
	Gilda	Metro Manila	Female	Executive director of private non-profit therapy center	No	No
Representatives from Professionals Organizations	Dona	Mindanao	Female	SLP board member and SLP consultant in contracted public hospital	No	Yes
	Melvin	Visayas	Male	SLP board member	No	No
	Francia	Metro Manila	Female	SLP board member	Yes	No
	Mariano	Metro Manila	Male	PT board member	Yes	No
	Susan	Mindanao	Female	OT board member	No	No
Parents of CDDs	Jethro	Metro Manila	Male	Father of a teenager son with autism, Parent advocate in local PWD organization for CDDs	No	No
	Josephine	Luzon	Female	Mother of a young adult son with autism, Parent advocate in national PWD organization for CDDs	Yes	No
	Juanita	Mindanao	Female	Mother of a school-aged boy with autism	No	No