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Piecing the Puzzle: Addressing the Multi-Payer and Fragmented Health Financing System in the Philippines

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Valerie Gilbert T. Ulep

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Abstract

In this report, we characterize the government health expenditures, examine the fragmented and overlapping nature of different financing streams, and propose a framework to address these challenges. In the past decade, the Philippines has experienced unprecedented growth in government health expenditures, driven by growing fiscal space, policy prioritization towards health, and rising national income. While this trend is commendable, we observed growing fragmentation in the system despite consolidation attempts under the Universal Health Care (UHC) Act. Multiple financing streams, including PhilHealth, the country's national health insurance program, national and local government budgets, and medical assistance programs and subsidies in the form of patronages, often overlap and sometimes compete. This undermines efficiency and equity by risk pooling, limiting economies of scale, and leading to instances of "double funding."

Keywords: Health Financing, Health Expenditure, Universal Health Care, National Health Insurance Program

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Piecing the Puzzle: Addressing the Multi-Payer and Fragmented Health Financing System in the Philippines

Ida Marie Pantig and Valerie Gilbert Ulep

Introduction

In this report, we characterize the fragmented health financing system in the Philippines and propose a framework to address it. Over the past decade, the share of out-of-pocket (OOP) expenditures, although still high, has declined, primarily driven by the crowding-out effects of increasing public or government spending. Between 2013 and 2023, the average annual public spending on health, even adjusting for population and inflation, increased by 9.5%. By 2023, public sources accounted for approximately 60% of total health expenditures. Public financing for the health sector is drawn from multiple sources, inter alia, national government allocations, local government budgets, and PhilHealth. While the growth in public spending on health is commendable, we argue that the different public financing streams are fragmented and overlapping, sometimes competing, exacerbating inefficiencies and inequities.

Reducing fragmentation in health financing sources is crucial to achieving Universal Health Coverage (UHC). Multiple and overlapping sources hinder the pooling of resources, undermining efficiency and equity due to missed opportunities for strategic purchasing, which leads to higher healthcare costs (Siqueira et al. 2021). Because these streams are uncoordinated, “double funding” commonly results in inefficiencies because of waste, potentially leaving other programs unfunded. Also, it perpetuates inequity because of uneven health spending across the country. Richer Local Government Units (LGUs) will rely on their resources to augment PhilHealth reimbursements and national subsidies. In contrast, poorer LGUs will rely on their limited budgets to top up the limited national government sources. From a patient’s perspective, this fragmentation translates to a more costly and unpredictable healthcare journey, as patients must often navigate the political and bureaucratic complexities of multiple financing schemes.

The UHC Act 2019 addressed this fragmentation by clarifying the institutional roles of PhilHealth and DOH and integrating these different public financing streams. It delineated the function of the national government (i.e., DOH) and PhilHealth. The Act consolidated all the possible sources of public spending on health of other national government agencies (e.g., PCSO, PAGCOR)¹ to PhilHealth. It increased the financial leverage of the Corporation, making it the country’s national purchaser of health services. It clarified the financing role of DOH moving forward, which is financing population-based health services. However, available data suggest that meaningful consolidation has yet to be achieved, and the system continues to exhibit signs of increasing fragmentation with the escalating national government spending from different sources to finance patient subsidies outside PhilHealth (e.g., medical assistance programs or MAIFIP), the country’s supposed national purchaser of health services.

This report is divided into three sections. The first section examines the health financing system by decomposing public spending on health. The second section examines the fragmentation of public spending on health. The final section outlines a framework to address this fragmentation.

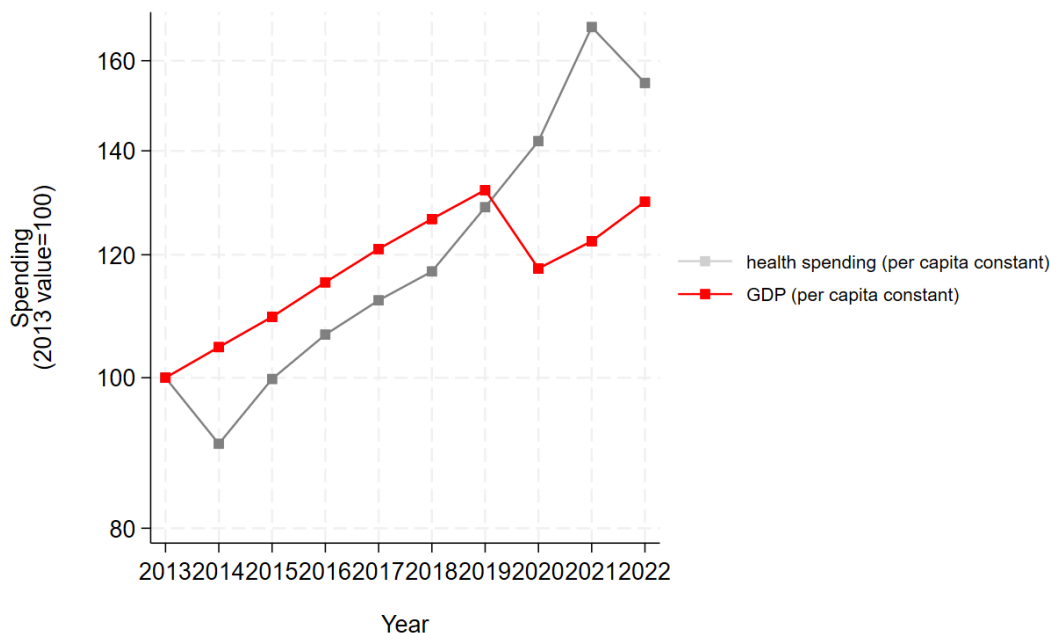
¹ Philippine Amusement and Gaming Corporation (PAGCOR) and Philippine Charity Sweepstakes Office (PCSO)

Health Financing in the Philippines

Unprecedented growth in health spending

According to the 2023 Philippine National Health Accounts, the Philippines spends approximately PHP 11,083 per person on health (PHP 1.44 trillion). Even after adjusting for population growth and inflation, health spending has increased 54% since 2013.² The share of health spending relative to its GDP is around 3-4%, comparable to the average for lower-middle-income countries. The average annual growth in health spending (5.3%) during the same period is much higher than the economic growth (3.0%). Figure 1 shows the indexed trends in per capita health spending and per capita GDP (in constant terms), with 2013 as the base year (index = 100). After adjusting for population growth and inflation, the figure shows that while both indicators exhibit an upward trajectory over 2013–2022, health spending per capita grew faster than GDP per capita, especially from 2018 to 2021. Between 2013 and 2019, GDP per capita rose steadily, while health spending increased modestly until 2017. However, from 2018 onward, health spending accelerated, peaking sharply in 2021. By 2022, health spending per capita remained well above its 2013 baseline, reflecting sustained health spending even as GDP growth moderated.

Figure 1. Health Spending and Gross Domestic Product



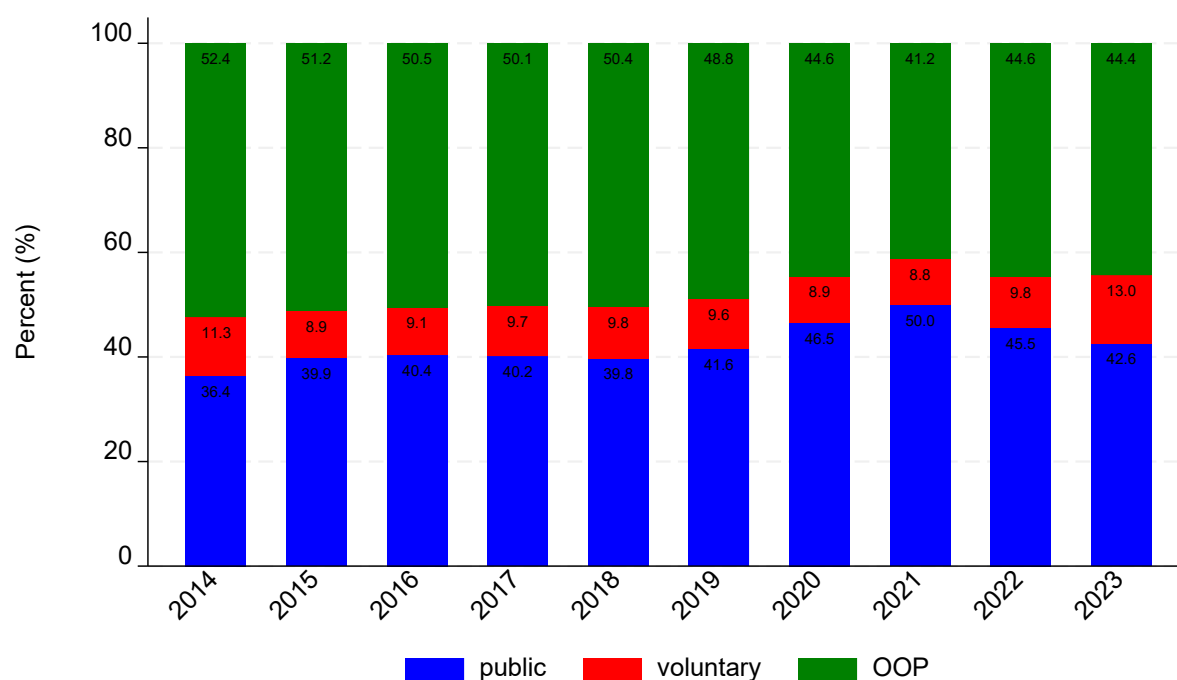
Source: Authors' analysis of Global Health Expenditure database

² According to GHED, the current health expenditure (per capita constant in 2021 prices) in 2013 is 120 USD compared to 187 USD in 2022.

The transition towards public or government spending on health

The growing health spending in the Philippines results from the increasing share of public or government spending on health in recent years. From 2013 to 2023, health spending increased from 36% in 2014 to 42% in 2023, reaching 50% during the COVID-19 pandemic. However, the current level is comparable to the average for lower-middle-income countries but remains way below the average share for upper-middle-income countries, which is 60% (see Figure 2). Most middle-income countries, such as the Philippines, are amid a health financing transition, with declining “unpooled” private sources (i.e., out-of-pocket) of health expenditure payments and increasing pooled public spending (Fan and Savedoff 2014). In the Philippines, the share of OOP has declined from 52% in 2014 to 44% in 2023 (Philippine Statistics Authority, 2023).

Figure 2. Source of health spending, 2014 to 2023



Source: Authors' analysis of National Health Accounts from PSA

Public spending on health has grown by 9.7% annually since 2013. What factors have contributed to this sustained increase? From a macro-fiscal perspective, following Tandon et al. (2020), the growth in public spending on health (that is, national government, local government, and PhilHealth) in the Philippines could be explained through a decomposition framework and written in a simple equation:

$$\Delta PH = \Delta GG + \Delta I + \Delta P, \text{ where: } GG = \frac{Gov}{GDP} \text{ and } P = \frac{H}{Gov}$$

ΔPH = Average growth rate in public spending on health per capita (in constant terms)

Gov = General government expenditure

GDP = Gross Domestic Product

H = Public spending on health (national, local government, and PhilHealth)

ΔI = average growth of GDP per capita (in constant terms)

ΔP = average growth of prioritization

ΔGG = average growth of macro-fiscal envelope

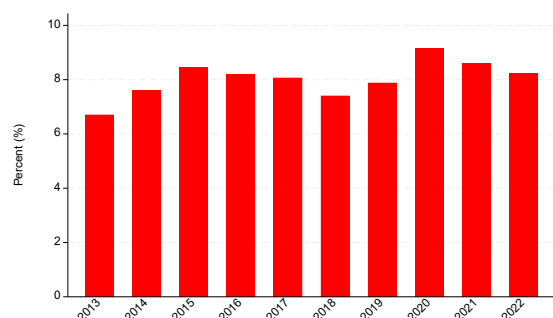
Under this framework, the growth in public spending on health is decomposed into three drivers: national income (GDP per capita), I , improving the macro-fiscal environment of the government, GG , and prioritization of the government towards health, P . First, increases in GDP per capita, I , drives higher public spending on health. As national income increases, demand for healthcare also increases. This is consistent with empirical evidence that public health spending is income-elastic, with elasticity often close to one (Musgrove, Zeramini, and Carrin 2002). Health becomes a priority as GDP per capita increases, and governments allocate more resources to meet the demand. Second, a larger macro-fiscal envelope, GG , drives higher public spending on health. An increase in the macro-fiscal envelope, the share of government expenditure to the national economy (i.e., GDP), means the government is spending a larger share of national income, which can translate into greater absolute resources available for health. Changes in budgetary prioritization, P , suggests how much health is favoured within the government. Even without changes in economic size or government spending, an increase in the share of the budget allocated to health results in higher public spending on health.

Figure 3 shows the three key drivers of public health spending growth in the Philippines using the decomposition framework above. The bottom panel shows that GDP per capita (in constant terms) steadily increased from 2013 to 2019, before dipping in 2020 due to the pandemic and recovering thereafter. The average annual growth rate of GDP per capita from 2013 to 2022 was 3%. The top right panel depicts the share of government expenditure to GDP. The average share of government expenditure to GDP was 21%, with the share annually growing around 4%. While the share has been consistently growing in the past decade, the growth, especially from 2019 to 2021, is notable, suggesting an expansion in government spending to finance COVID-19 response measures, both health and non-health. The top left panel shows the share of public spending on health of total government expenditure. The average share of government expenditure to GDP was 8%, with the share annually growing around 2%. While this share fluctuated slightly across years, it generally increased from 2013 to 2021, indicating that the health sector has received a growing share of the public budget. From 2013 to 2015, the increase in the share of public spending could be attributed to sectoral priorities of the Aquino administration, in which sin tax revenues were allocated towards health (Kimwell et al. 2023). Again, in 2020, the health sector's share increased to augment the COVID-19 response.

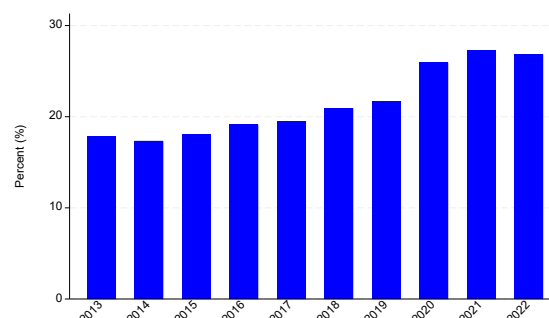
Public spending on health per capita increased by 9.8% annually from 2013 to 2022, driven by three key factors: growth in national income (2.9%), expansion of government fiscal space (4.5%), and increased prioritization of health in the budget (2.3%). While fiscal space was the primary driver of the increase, national income and the shift toward allocating a greater budget share to health also positively contributed to the growth.

Figure 3. Drivers of Public Spending in the Philippines

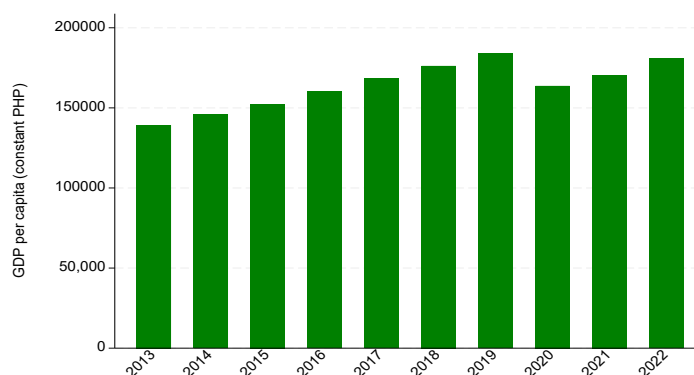
Share of public spending on health to total government expenditure (Prioritization)



Share of government expenditure to GDP (fiscal space)



GDP per capita (constant)



Source: Kimwell et al. (2023)

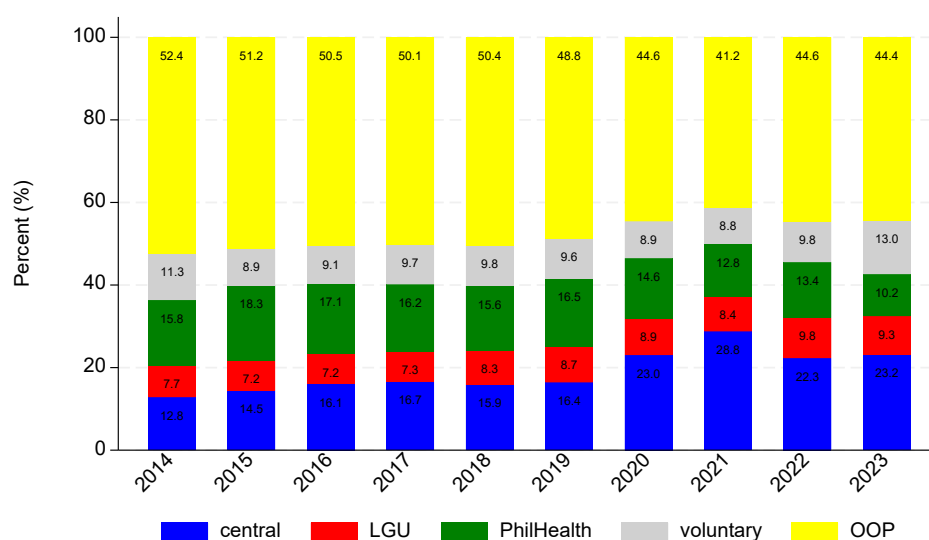
Table 1. Decomposition of Public Spending on Health

Public spending per capita A+B+C	Growth in prioritization (A)	Growth in national income (B)	Growth in government in fiscal space (C)
9.8%	2.3%	2.9%	4.5%

Policy paradoxes in public spending on health

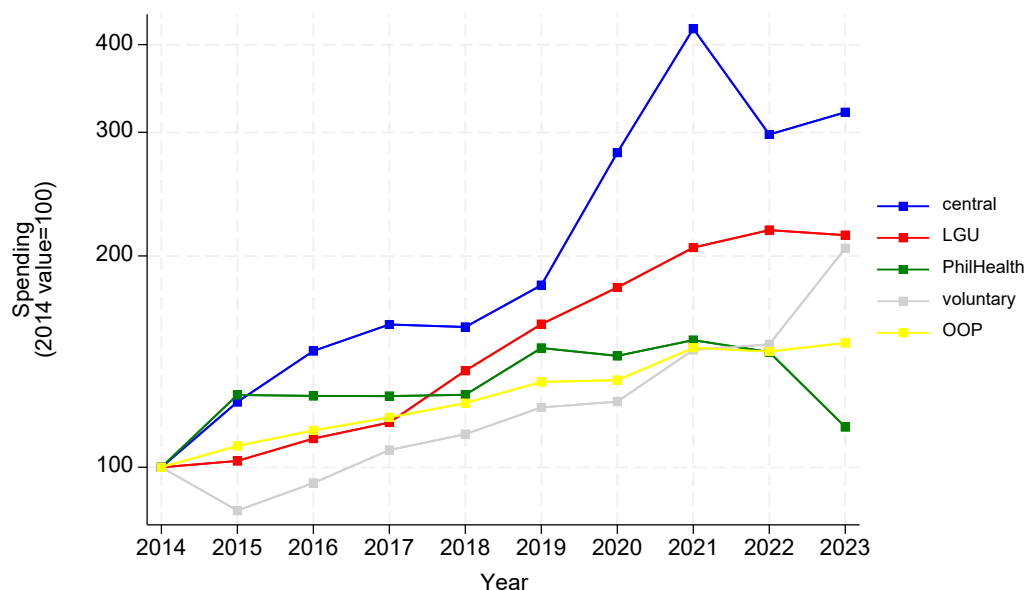
Public health spending in the Philippines can be disaggregated into three sources: (1) the central government, (2) local government units (LGUs), and (3) PhilHealth. In 2023, the national government financed most of the public spending on health, while the shares of PhilHealth and LGUs were equal. Central government spending on health remains large and increasing despite the expected bigger role of local government and PhilHealth. The health system is decentralized, but local government spending has remained consistently lower than that of the national government. PhilHealth, which is supposed to be the main purchaser of health services under the UHC Act, has seen a decline in its share of total health spending. PhilHealth's contribution dropped from 17% in 2014 to just 10% in recent years. **Figure 4** presents indexed trends in health spending by financing source from 2014 to 2023, with 2014 set as the base year (index = 100). The most substantial growth is observed in central government spending, which tripled in 2023, while LGU spending steadily increased, but modestly. PhilHealth spending, in contrast, showed slow growth until 2021 and declined sharply in 2022 and 2023. OOP expenditures remained relatively stable, indicating that households' direct payments grew more slowly than other sources. In general, this shows a shift toward greater public financing, particularly from national governments. This trajectory of different public spending lies in the fact that despite decentralization and the legal mandate for PhilHealth to act as the main purchaser of health services under the UHC Act, the central government remains the major source of public spending on health. This contradicts the envisioned roles in current reforms. Even with the implementation of the Mandanas Garcia ruling of the Supreme Court, which was meant to reinforce decentralization of service delivery, local government spending on health remains modest. Some LGUs would instead prioritize other projects such as roads or infrastructure as part of their general or economic services (Nuevo, Sigua, Samson, Co, & Yap, 2022), or that the unclear roles between the national government and LGU may actually lead to confusion and weak accountability for health spending (Cuenca, 2018). At the same time, PhilHealth's share of public spending on health has declined, undermining its strategic purchasing role. This paradox between policy intent and actual financing patterns reflects a fragmented and misaligned system where central control persists despite policy reforms.

Figure 4. Sources of health expenditures, Philippines, 2014-2023



Source: Authors' analysis of National Health Accounts

Figure 5. Trends in different sources of financing (indexed=100)



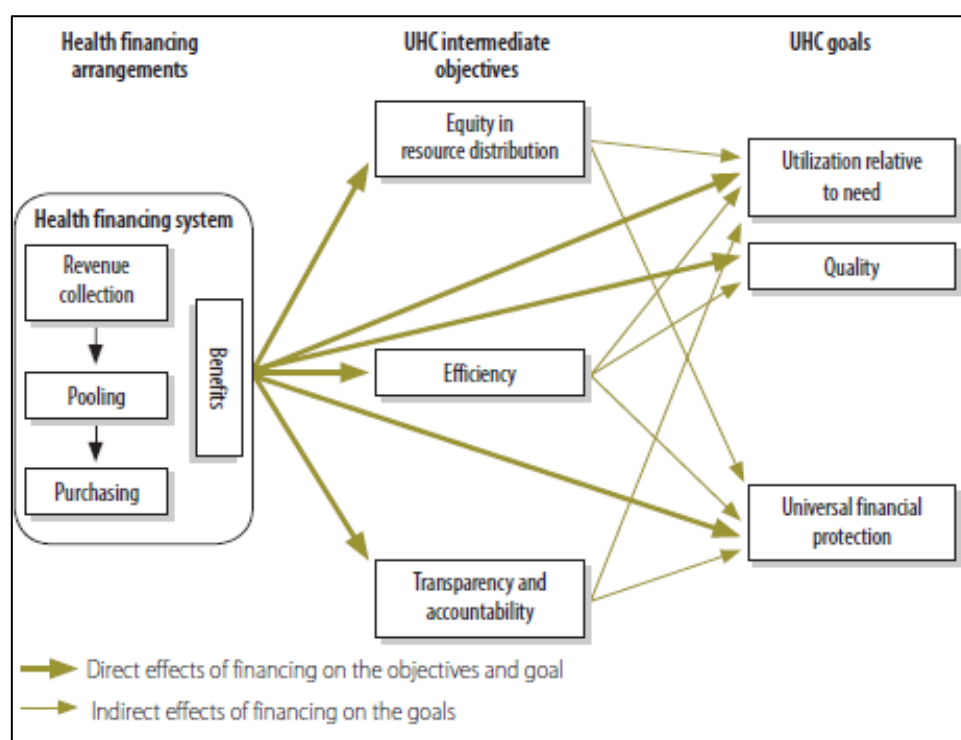
Source: Authors' analysis of National Health Accounts

Fragmentation of public financing for health

Pooling: an important element of UHC

Fragmentation in health financing violates the concept of pooling, a critical function of health financing. Health financing rests on three critical functions: revenue collection, pooling, and purchasing (Kutzin 2013). Revenue collection is raising health funds through budgets, social insurance contributions, and external aid. Pooling is “the accumulation and management of ‘prepaid’ financial resources” on behalf of some or all the population to ensure financial protection and equitable access to health services (Mathauer et al. 2020, p.132). Health budgets and social health insurance are considered prepaid. Purchasing involves allocating pooled funds to health providers, such as health workers or health facilities. The health financing system contributes to attaining the health system’s intermediate and UHC goals, including equity in resource distribution, efficiency, transparency, accountability, utilization relative to need, quality, and universal financial protection (Figure 6).

Figure 6. Immediate objectives and final goals of universal health coverage (UHC)



Source: Kutzin (2013)

The purpose of pooling is to share financial risk among individuals. Pooling is achieved by consolidating health funds into larger, unified pools to pay for healthcare services for a broad population. To achieve pooling, health financing must be pre-payment (i.e., payment occurs before the illness), and this must be mandatorily collected (in the form of taxes for health budgets or as premiums for SHI or government subsidies for the poor), along with standardized benefits (Mathauer, Saksena, and Kutzin 2019; Tandon and Reddy 2021). All these elements ensure equitable access and effective risk sharing. Countries envision including pooling as a goal because this will reduce financial risk by spreading the risk of illness across a large population. It promotes equity and efficiency by enabling cross-subsidization from healthy to sick individuals and from rich to poor, thereby improving the health system's ability to purchase services strategically and negotiate better prices.

Fragmentation in health financing occurs when financing sources, population coverage, and benefit entitlements vary across multiple and uncoordinated systems. This prevents risk pooling and weakens equity and efficiency within the health system (Siqueira et al. 2021). Fragmentation occurs when multiple payment systems exist, such as health insurance schemes covering different population groups. It occurs when national sub-units or local governments manage health budgets independently, as seen in highly decentralized systems, or when a central government health budget covers only segments of the population, leading to unequal access to services, duplicative administrative costs, and weak bargaining power with providers. Fragmentation creates disparities in the availability of health services and the level of financial protection, hindering the health redistributive goals and limiting the strategic use of pooled funds to achieve health system goals (Matovu, Gatome-Munyua, and Sebaggala 2022).

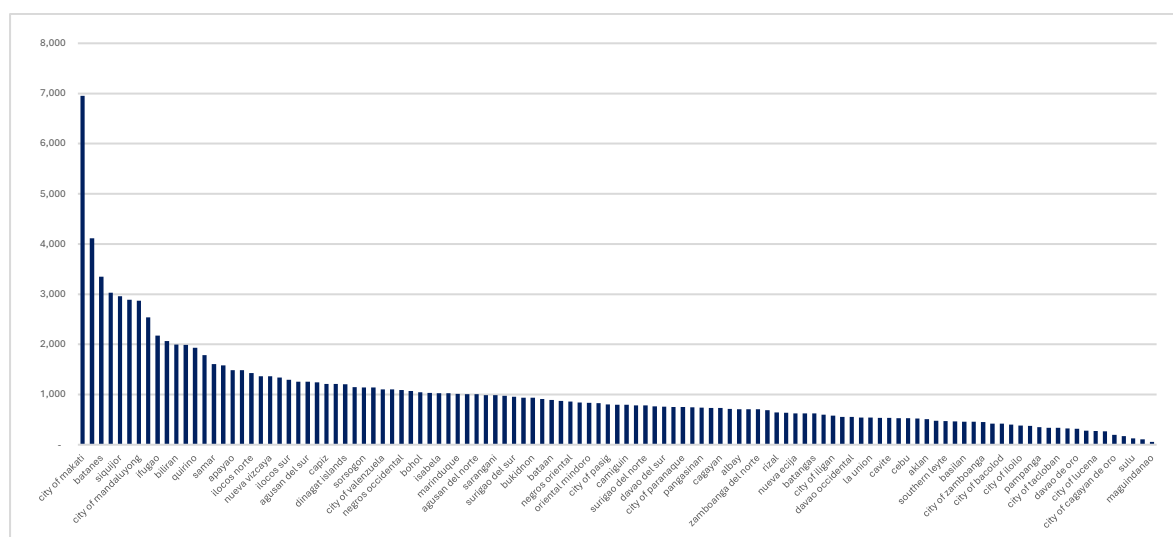
Fragmentation in the Philippine health financing system

Variable spending across local governments

The Philippines has a highly decentralized health system, with over 1,600 municipalities and cities having autonomy over their health budgets and priorities. LGUs are mandated to provide primary healthcare services in RHUs (i.e., municipalities) and curative care services in hospitals (i.e., provinces). In theory, each sub-national unit serves as a pool. While a single unified pool is ideal, multiple non-competing pools can still be pursued, especially in a decentralized regime as argued by Mathauer, Saksena, and Kutzin (2019), if each has a sufficiently large population and adequate financial capacity. However, more than 1,600 pools are often small and vary widely in terms of financial capacity to deliver PHC services. When territorially distinct pools are too small in population, their risk profiles become financially precarious, raising concerns about efficiency and capacity. Also, when the sizes of these pools differ significantly across the country, they tend to have unequal redistributive capacities (Mathauer et al. 2019).

Figure 7 shows the significant variation in public spending on health of LGUs. This variation suggests differences in LGUs' capacities to finance and deliver health services. Because LGUs operate independently in delivering health services, including procurement of drugs, commodities, and other health products, inefficiencies and inequities arise (Abrigo et al. 2021). For example, one major inefficiency stems from the fact that each LGU procures in small volumes, which drives up prices due to the absence of pooled procurement and economies of scale. These multiple pools increase costs but weaken bargaining power, contributing to wastage or inefficiencies at the sub-national units.

Figure 7. Per capita spending on health, by province/ HUC, 2022



Source: Authors' analysis of DOF-BLGF

Vertical overlaps in the health system

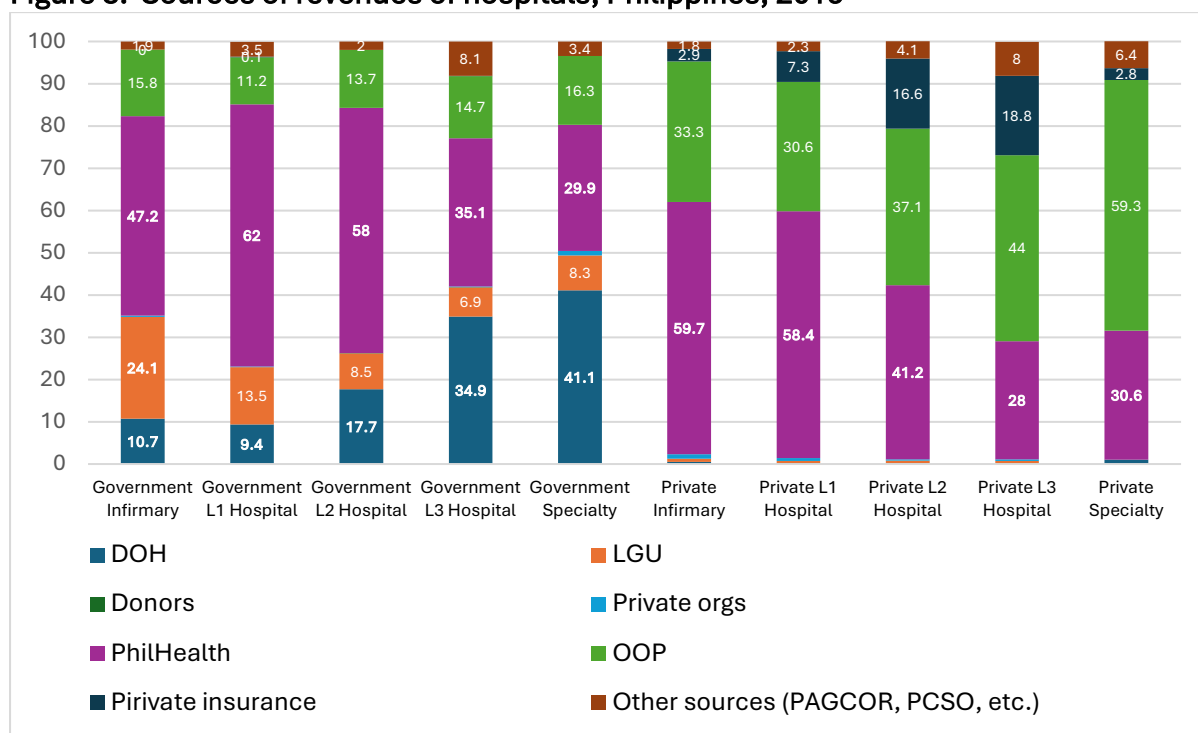
Territorially distinct pooling refers to organizing health financing pools along geographic lines (e.g., LGUs), where each pool funds the delivery of health services to the population within its boundaries. In theory, multiple pools could be acceptable, especially in decentralized systems, provided each territory has a sufficient population size, financial capacity, and clear mandates for the services it covers.

However, in practice, while LGUs are responsible for the delivery of health within their locality, the national government and PhilHealth continue to fund many of the same services, including PHC and curative or hospital care for capital investments, operating expenses, and salaries. As a result, the pooling structure leads to overlapping mandates and responsibilities. With these potentially overlapping streams of public financing, inequities are exacerbated, as richer LGUs can better leverage PhilHealth reimbursements, access national grants (e.g., HFEP and other national grants), and mobilize their local revenues (Tomas et al. 2025). From a pooling perspective, this fragmentation of the health financing system weakens risk-sharing, as funds are disbursed from multiple, unlinked sources for the same services or populations, rather than being combined into a single pool or at least complementing each other. The UHC Act of 2019 envisioned consolidating the different sources of public financing (i.e., LGUs, PhilHealth, and national government subsidy) at the provincial level by creating the Special Health Fund (SHF). Still, this provision of the Act has not yet been realized (Official Gazette of the Republic of the Philippines 2019b).

Multiple sources of revenue in hospitals

The multiple and overlapping sources of health financing mirror the multiple revenue streams that hospitals rely on to cover their expenses. **Figure 8** shows the distribution of revenues across public and private hospitals. The share of PhilHealth reimbursements accounts for approximately 60%. PhilHealth's share tends to decline as the hospital level increases. In contrast, subsidies from the DOH are more prominent in Level 3 hospitals, which is expected, given that most facilities are directly owned and operated by the DOH. For lower-level hospitals, particularly Level 1 and 2 facilities, the share of LGU is higher but only accounts for about 10-20%. OOP payments remain a significant source of hospital revenue, even in public facilities, accounting for approximately 20% of total revenue. The share of OOP appears to be higher in higher-level facilities. In private hospitals, PhilHealth and OOP are the predominant sources of revenue. Lower-level hospitals are more reliant on PhilHealth than higher-level hospitals.

Figure 8. Sources of revenues of hospitals, Philippines, 2019



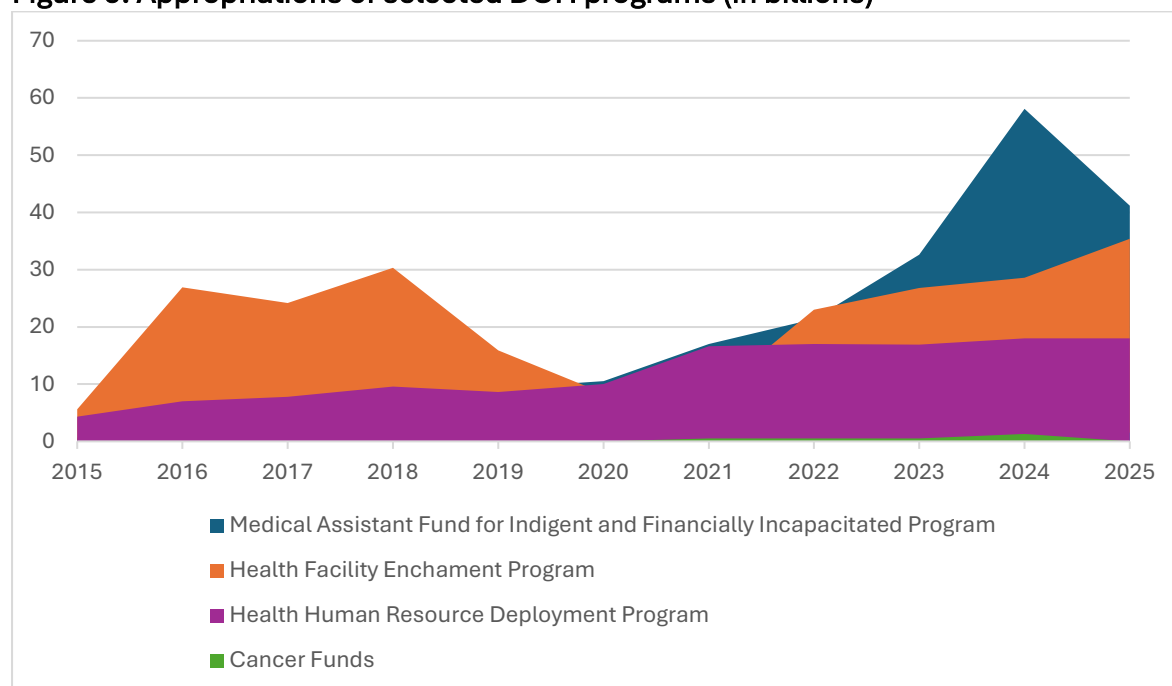
Source: Authors' analysis of Hospital Statistical Report

The distribution of hospital revenues provides insights into the level of fragmentation of health financing. Suppose the goal is for PhilHealth to be the main purchaser of inpatient care services as envisioned in the UHC Act (Official Gazette of the Republic of the Philippines 2019b); it must cover the full cost of care, or at the very least, the operating expenses of service delivery. However, hospitals rely on OOP payments and government subsidies to cover hospital revenues. National government subsidies (i.e., from DOH and other national government agencies and politicians), many of which are intended to support operating expenditures, end up duplicating PhilHealth. In public hospitals, the DOH provides budgetary grants to cover personnel services and allocates direct subsidies to hospitals for capital investments. These multiple and uncoordinated funding streams reflect both the limitations of PhilHealth in fully covering the cost of care because of the slow expansion of benefits and the path dependency of supply-side financing, where longstanding budgetary practices and political incentives perpetuate direct public funding of health services, even as PhilHealth was meant to take on a larger role. PhilHealth's rates, intended to cover operating costs, are uniform for public and private hospitals. However, public hospitals continue to receive additional support through subsidies for supplies, human resources, and other inputs. This double funding, while it increases the revenues for public facilities, contributes to fragmentation in the system and undermines effective pooling, hence inefficiency.

Figure 9 illustrates the budget appropriations of the national government under the DOH; it shows the growing allocation of another source of public financing, such as medical assistance funds and cancer assistance programs. We argue that these budget items are designed to fill gaps in PhilHealth. While these expenditures are well-intentioned and aim to increase public health investment and reduce financial risk to patients, they could contribute to further fragmentation, as they are implemented outside a unified pool or clear delineation of what to fund. This fragmentation helps explain the rising share of national government spending brought by central government spending on individual-based interventions that in theory could

have been covered by the main purchasing entities (i.e., PhilHealth). These increasing appropriations of individual-based interventions are alongside PhilHealth's stagnant or declining share in total health expenditure.

Figure 9. Appropriations of selected DOH programs (in billions)



Source: Various rounds of the General Appropriations Act (DBM)

Zooming in on public hospitals highlights the fragmentation in financing, particularly for nationally run facilities, where the government plans to increase funding significantly. National hospitals receive annual allocations through the General Appropriations Act, with budgets lodged under the DOH. These funds are distributed across 12 Metro Manila hospitals and 67 regional hospitals nationwide. In 2025, PHP 97.6 billion is earmarked for these facilities, a 42.5% increase from the 2024 allocation. This sharp rise is primarily driven by increased funding for operating expenses. However, this allocation trend underscores growing overlaps in financing sources, particularly for operating costs, which PhilHealth reimbursements could otherwise cover. Such overlaps point to persistent fragmentation in the health financing system.

Table 2. Allocation for the operation of DOH hospitals for 2023-2025

	PS	MOOE	CO	Total
	(in PhP and % to total)			
2023				
Metro Manila Hospitals	10,879,587,000 (64%)	5,863,560,000 (34%)	317,700,000 (2%)	17,060,847,000
Regional Hospitals and Other Health Facilities	31,115,352,000 (64%)	13,593,933,000 (28%)	3,739,648,000 (8%)	48,448,933,000
	41,994,939,000	19,457,493,000	4,057,348,000	65,509,780,000
2024				
Metro Manila Hospitals	11,037,081,000 (62%)	6,403,994,000 (36%)	230,000,000 (1%)	17,671,075,000
Regional Hospitals and Other Health Facilities	34,146,976,000 (67%)	15,387,611,000 (30%)	1,333,917,000 (3%)	50,868,504,000
	45,184,057,000	21,791,605,000	1,563,917,000	68,539,579,000
2025				
Metro Manila Hospitals	11,287,244,000 (51%)	10,778,232,000 (49%)		22,065,476,000
Regional Hospitals and Other Health Facilities	37,156,208,000 (49%)	35,540,622,000 (47%)	2,910,000,000 (4%)	75,606,830,000
	48,443,452,000	46,318,854,000	2,910,000,000	97,672,306,000

Source: Various rounds of the General Appropriations Act (DBM)

One of the major sources of inpatient financing for hospitals is PhilHealth reimbursements, which play a role in inpatient financing for both public and private hospitals. **Table 3** shows the amount reimbursed by PhilHealth to hospitals. As the primary purchaser of health services, PhilHealth is a key source of revenue for hospitals to cover their operating expenses, alongside other sources. PhilHealth reimburses its accredited hospitals through its All Case Rates inpatient benefit, where case rates are “fixed rate or amount that PhilHealth will reimburse for a specific illness/case, which shall cover for the fees of health care professionals, and all facility charges, including, but not limited to, room and board, diagnostics and laboratories, drugs, medicines, and supplies, operating room fees, and other fees” (Philippine Health Insurance Corporation 2013, p.3). In 2024, these case rates have significantly increased as part of PhilHealth’s benefit enhancement.

Table 3. PhilHealth reimbursement to hospitals (in billions)

	2021	2022	2023	2024
Public	46.79	40.15	43.87	64.74
Local Government Unit (LGU)	5.92	4.86	5.40	8.11
Department of Health (DOH)	23.31	17.68	19.08	26.63
Department of National Defense (DND)	0.57	0.31	0.25	0.34
Government-owned	3.34	2.16	2.27	3.17
National	0.35	0.31	0.17	0.27
Provincial	13.20	14.70	16.30	24.91
No indicated ownership type	0.11	0.12	0.39	1.31
Private	63.33	45.09	48.25	71.41

Source: Analysis of PhilHealth insurance claims; Data as of 15 April 2025

Emerging sources of public financing on health

With PhilHealth reimbursements and government subsidies falling short of fully covering hospital operating expenses, and other pooled funding sources proving inadequate, a financing gap remains. As a result, many indigent patients and those unable to pay their hospital bills increasingly rely on medical assistance programs provided by national government agencies. In recent years, there has been a growing trend toward adopting stopgap measures to compensate for the limitations of traditional pooled financing mechanisms like PhilHealth, alongside mounting criticism of PhilHealth's inability to cover the total cost of care. These programs have become a critical fallback in addressing balance billing and OOP expenses. Agencies such as the Philippine Charity Sweepstakes Office (PCSO) and Philippine Amusement and Gaming Corporation (PAGCOR) are mandated to generate revenues for the country's socio-civic and national development programs, including health and medical services. Aside from these, the DOH has established its Medical Assistance for Indigent Patients (MAIP) Program, later transformed to the Medical Assistance for Indigents and Financially Incapacitated Patients (MAIFIPP) Program, which now includes those who are financially incapacitated, or those who are "not classified as indigents but who demonstrate a clear inability to pay or spend for necessary expenditures for their respective medical treatment such as, but not limited to, patients with catastrophic illnesses which are life- or limb-threatening and require prolonged hospitalization, illnesses that require extremely expensive treatments, or other special but essential care that would deplete one's financial resources, as assessed and certified by the Medical Social Worker" (Department of Health 2023, p.3). The Department of Social Welfare and Development (DSWD) also implements its Assistance to Individuals in Crisis Situations (AICS), where aid for medical, funeral, food, transportation, education, and other support services is provided to individuals and families requiring such assistance (Department of Social Welfare and Development n.d.).

Malasakit Centers

Republic Act No. 11463, or the Malasakit Centers Act, was passed in 2019 and establishes Malasakit Centers in all DOH Hospitals in the country and the Philippine General Hospital (PGH). Based on its Implementing Rules and Regulations, Malasakit Centers provide medical and financial assistance through a one-stop shop and have the following roles and function: provide patient navigation and referral to the appropriate health facilities, provide information regarding membership, coverage, and benefit packages in PhilHealth, and provide responsive and people-centered processes, including culturally appropriate services to the patients, among others. The Malasakit Centers shall provide access to the medical and financial assistance programs of its partner implementers: the DOH MAIP/MAIFIPP, DSWD AICS, PCSO Medical Assistance Program, and other medical and financial assistance programs provided by other government agencies, local government units, non-government organizations, and private institutions and individuals (Official Gazette of the Republic of the Philippines 2019a).

As part of its implementation, the DOH, DSWD, PCSO, and PhilHealth put together a Joint Administrative Order (JAO) No. 2020-0001 in December 2020 entitled "Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially Incapacitated Patients under Republic Act No. 11463 also known as "Malasakit Centers Act of 2019" Under this JAO, medical and financial assistance to be provided by Malasakit Centers shall come from PhilHealth, PCSO, DSWD, DPH, PGH, host hospitals, and LGUs as they may provide, and no balance billing or no co-payment policy shall apply. The

JAO specifies the order of charging based on the medical and financial assistance provided to the patient:

- 1 - Host Hospital: mandatory discounts applicable (Senior Citizens, PWD, etc.)
- 2 - PhilHealth: medical packages/case rate
- 3 - Health Maintenance Organization (HMOs): existing insurance policy
- 4 - PCSO: Medical Assistance Program funds and Endowment Fund
- 5 - DSWD: AICS program fund
- 6 - DOH: MAIP/MAIFIPP
- 7 - Host Hospital: through quantified free service (QFS), hospital initiative, MOOE, and other funding sources.

Based on this order of charging, all sources provide medical assistance except for the DSWD AICS, which provides financial assistance. The transfer of medical assistance from the Malasakit Center to the host hospital is made through agreements between the two institutions, and no monetary assistance is provided directly to the patient. The number of limitations and restrictions varies depending on the existing guidelines specific to each program. It is also assumed that the host hospital absorbs whatever portion of the hospital bill is not covered by any form of assistance, being the last in the order of charging, and if the patient is no longer able to shoulder the remaining balance after all forms of medical and financial assistance have been exhausted.

Both indigent patients and financially incapacitated patients are eligible for the assistance. Indigents refer to those who have no visible means of income, or whose income is insufficient for their family's subsistence, as assessed by the DSWD or the medical social worker of the health facility. On the other hand, financially incapacitated patient refers to those “who are not classified as indigent but who demonstrates clear inability to pay or spend for necessary expenditures for one’s medical treatment, such as patients with catastrophic illness or any illness, which is life- or limb-threatening and requires prolonged hospitalization, extremely expensive therapies, or other special but essential care that would deplete one’s financial resources” (Department of Health et al. 2020, p.2).

Under the Malasakit Program, the existing PhilHealth, PCSO, DSWD, and DOH-MAIFIPP programs are implemented and offered through a one-stop shop. As of March 2022, there are 151 Malasakit Centers located in DOH hospitals, LGU hospitals, and SUC hospitals nationwide (Malasakit Center Tracking, 2022). Based on the latest available data for these programs, their accomplishments are summarized in **Table 4**.

The DOH MAIFIPP disbursed around PHP 20 billion from January to September 2024, the largest disbursement among all financial assistance programs. This disbursement benefited more than 500,000 patients, averaging PHP40,174 of medical assistance per patient. On the other hand, PCSO MAP, distributed through the Malasakit Center, disbursed around PHP 700 million in CY2024, benefiting 60,000 patients. This is equivalent to an average of PHP 11,933 medical assistance per patient. Lastly, based on available data, AICS provided financial assistance for medical purposes to 5,425 beneficiaries in 2022, with over PHP 30 million disbursed. This translates to average financial assistance worth PHP 5,591 per beneficiary. It should be noted that AICS provides other forms of assistance through Malasakit Centers, such as food subsidy, transportation assistance, burial assistance, cash assistance, and psychosocial assistance.

Table 4. Medical and Financial Assistance Provided through the Malasakit Center

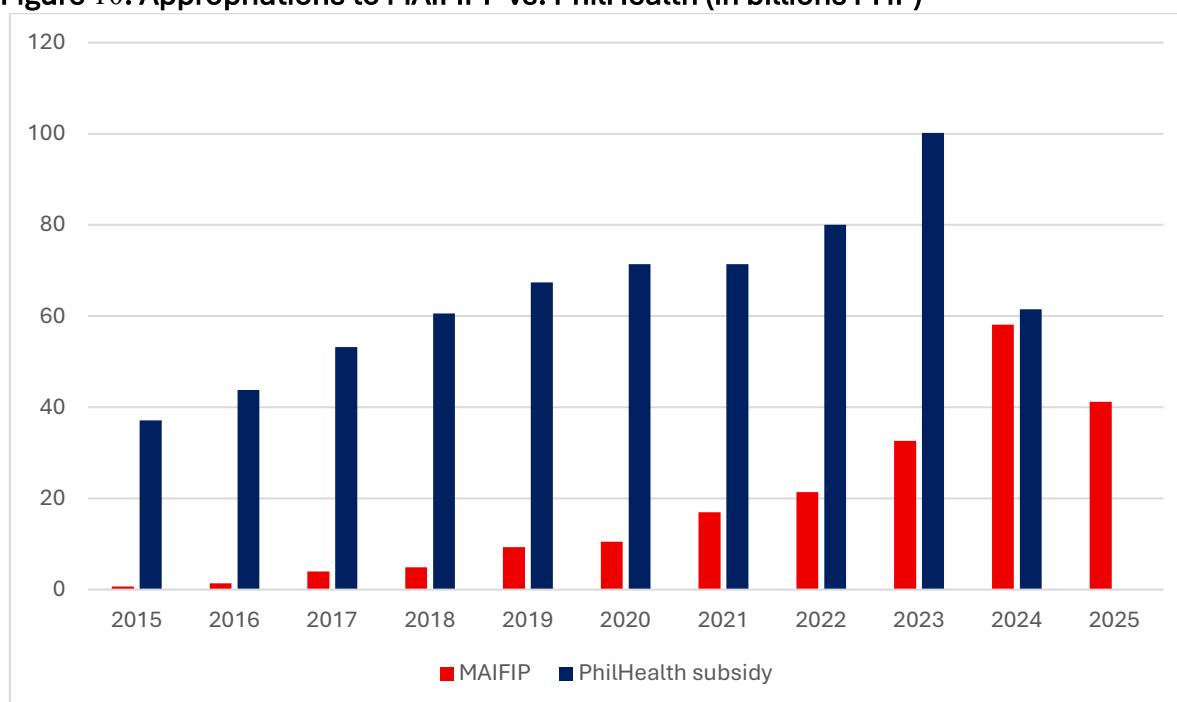
Program	Accomplishment
DOH MAIFIPP (January to September 2024)	Total beneficiaries: 505,585 MAIFIPP Disbursements: PHP 20,311,594,900 Average support per beneficiary: PHP 40,174
PCSO MAP (CY 2024)	Total beneficiaries: 60,252 Amount of assistance: PHP718,972,468 Average support per beneficiary: PHP11,932
DSWD AICS Medical Assistance (2022)	Total beneficiaries for medical assistance: 5,425 Total amount disbursed: 30,335,686 Average financial assistance per beneficiary: PHP5,591

Sources: DOH Statement of Appropriations, Allotments, Obligations, Disbursements and Balances (as of Quarter Ending September 30, 2024); MAIP Monthly Report of Recipients from January to September 2024 from <https://doh.gov.ph/mpo/maipp-recipients/>; PCSO Accomplishment Report 2024; 2022 Annual AICS Accomplishment Report for Malasakit Centers from <https://aics.dswd.gov.ph/2023/06/malasakit-center-2022-annual-accomplishment/>.

As mentioned, in addition to the PCSO and DSWD assisting patients through the Malasakit Centers, the MAP and AICS assistance can be requested directly from the corresponding national agencies. Therefore, the numbers provided in this section for the medical subsidy only constitute a portion of the financial assistance subsidized by national agencies, in addition to the DOH and PhilHealth. A detailed exploration of these programs are in **Annex 1**.

The Medical Assistance for Indigents Program budget, or MAIP, and now the MAIFIPP, has seen unprecedented increases in the past six years. The budget for MAIP was PHP 10 billion in 2020 and jumped to PHP 58 billion in 2024. It decreased to PHP 41 billion in 2025. This upward trajectory in direct medical assistance contrasts sharply with the relatively stagnant or modest increases in government subsidies to PhilHealth. As illustrated in Figure 9, while PhilHealth is mandated to provide comprehensive coverage under the National Health Insurance Program, public funds are funneled toward individually targeted assistance programs.

Figure 10. Appropriations to MAIFIPP vs. PhilHealth (in billions PHP)



Source: various rounds of GAA

Patient-level perspective on fragmented financing

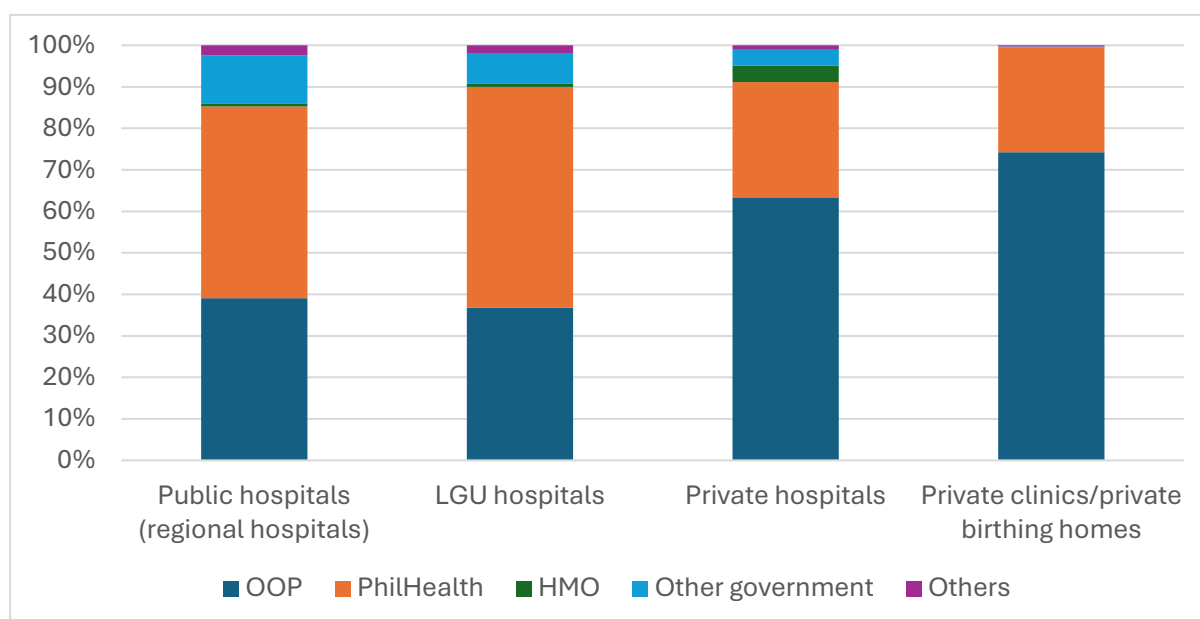
The consequences of fragmentation are even more pronounced at the patient level. In the Philippines, the cost of care is often unpredictable, and the support value from each financing source is typically low, rarely covering the full cost of treatment (**Table 5**). As a result, patients are forced to rely on multiple sources of financing to pay for care. **Figure 11** shows that OOP payments represent the largest share of inpatient bills across all facility types. While PhilHealth covers a larger portion of public hospitals, especially regional ones, it remains inadequate in substantially reducing OOP costs. Other government subsidies contribute less than 10% across all facility types, highlighting their limited role in enhancing financial protection

Table 5. Average amount of inpatient hospital bill, 2022

	Total hosp. bill	OOP	PhilHealth	HMOs	Other government assistance	Other sources
Public hospitals (regional hospitals)	45,720	13,699	20,386	301	9,281	2,053
LGU hospitals	29,445	10,436	15,517	315	2,644	534
Private hospitals	84,693	55,051	21,164	4,108	3,239	1,132
Private clinics/private birthing homes	15,748	12,340	3,338	-	35	34

Source: Analysis of the National Demographic and Health Survey, 2022

Figure 11. Share of different sources of payment for inpatient care, by hospital type



Source: Analysis of the National Demographic and Health Survey, 2022

There are stark differences in sources of payment among patients. As income increases, total hospital bills and related expenses rise significantly, with the richest quintile spending over five times more than the poorest on inpatient care. Despite higher PhilHealth coverage rates among wealthier groups, out-of-pocket (OOP) spending also increases sharply, comprising over 90% of total costs for the richest, compared to 71.5% for the poorest (**Table 6**). Notably, the poorest rely more heavily on “other government sources” (e.g., MAIP or LGU subsidies), which account for 17.2% of their total costs, compared to only 10.1% for the richest. However, these subsidies remain insufficient to offset the financial burden, particularly for low-income households fully. The data suggest that while PhilHealth coverage is broader among higher-income groups, the poorest still face high OOP expenses and must rely on fragmented and often unpredictable public assistance.

Table 6. Share of different sources of payment for inpatients, by SES

	Average cost (PHP)		Sources				
	Total hospital bill	Transportation cost	OOP	PhilHealth	HMOs/ Private Insurance	Other government sources	Others
Poorest	19,450	512	71.5%	63.9%	1.8%	17.2%	4.9%
Poorer	30,970	848	74.8%	65.9%	1.7%	16.5%	3.2%
Middle	40,025	688	80.0%	73.4%	1.4%	17.4%	3.6%
Richer	56,919	1,215	84.3%	74.8%	4.4%	13.9%	4.5%
Richest	103,337	2,883	90.6%	80.8%	8.4%	10.1%	1.7%
Total	53,667	1,340	81.1%	72.5%	3.8%	14.7%	3.5%

Source: Analysis of the National Demographic and Health Survey, 2022

Note: Patients' income was categorized into five groups (quintiles): poorest, poorer, middle, richer, and richest, with each quintile representing a progressively higher income bracket.

The system becomes burdensome for patients because of the unpredictability of payments and the need to navigate multiple financing sources. Accessing these funds often requires patients or their families to undergo complicated and onerous procedures, such as submitting documents to various offices or waiting hours and days for approval from different agencies. In many cases, access to financial assistance depends on political patronage, reinforcing inequality and favoring those with connections or influence. The emotional and psychological toll on patients and their families' dignity is considerable, especially during periods of illness. These inefficiencies also carry multiple hidden costs: direct financial costs due to high OOP spending, opportunity costs from lost time and income, and transaction costs involved in navigating the different bureaucracy (see **Box 1**).

In addition to the hospital bill, patients often incur additional expenses when seeking inpatient care. The hospital bill represents only a portion of total inpatient spending, and the data clearly show that miscellaneous costs can be substantial (Table 7). Out-of-pocket hospital spending remains significant across all income groups: even among inpatients, 60–70% of patients purchase medicines outside the hospital, and around 30% pay separately for diagnostic tests. This reflects supply-side constraints because of limited supplies in both the public and private sectors. Many hospitals remain under-equipped or lack sufficient supplies, despite receiving capital subsidies from the government as part of their revenue streams

Box 1. Medical and Financial Assistance for Hospitalization: Patient Experience

Resorting to medical and financial assistance is a result of the inadequacy of PhilHealth to cover majority of the hospitalization costs. With a low support value ranging from 20%-40% and increasing costs of care, it has become inevitable that patients from low to middle income groups gather additional resources to cover both billed and non-billed hospitalization costs. In some instances, medications and diagnostics are not available in the hospital, and patients need to pay out of pocket. Patients and their families must still pay for expenses such as transportation, living allowances, and salaries of caregivers and/or patient watchers on top of the lost income during periods of hospitalization (Concha, 2023).

The physical and emotional toll on patients and their families when seeking medical and financial assistance have been documented. A study done by Lasco, Yu & David (2022) in 2018-2019 conducted 30 focus group discussions across area types (i.e., highly urbanized cities, and 1st to 5th class cities and municipalities) to explore the financing of catastrophic expenditures in the Philippines. With the anticipated “hidden” costs of health care such as hospital deposits, transportation costs and other ancillary expenses, individuals would rather endure their illnesses than pay high costs of medical and non-medical expenses. Should there be unavoidable costs, individuals opt to borrow from families and coworkers first before soliciting help from both government and non-government actors. The physical labor of going from one place to another to gather and submit the document requisites and emotional labor of having to appeal to emotions to those in positions of power are some of the ordeals the patients and their families must go through on top of having to recover from their illnesses. There are financial costs as well such as transportation costs and administrative costs for securing various hospital and administrative forms that need to be produced in multiple copies to be distributed to various organizations providing medical and financial aid (Lasco, Yu, & David, 2022). The requisites and the physical effort also contribute to inequities in access to medical and financial assistance, particularly to those from geographically isolated and disadvantaged areas (GIDAs). Having to go back to the residence to get the required documents needed to seek assistance costs time and money to the already disadvantaged patients. In some medical and financial assistance programs, barangay certification of voter’s certificate is required, compelling patients and their families in GIDAs to go home to gather and produce copies of the requirements, and to travel back to the city center to submit (Pernadas-Astudillo & Roño, 2023).

These findings are not far from the experiences of patients in 2013 as documented by Caballes (2013). Before the Malasakit Center was introduced, patients seeking additional funding after exhaustion of their own resources had to resort to institutional support, and there was no systematic way of obtaining information on these. Based on his findings, information on institutional support was obtained from acquaintances, other patients, and from hospital social workers. There was also no way of ascertaining the amount of support they will be granted, much less the basis for such grants. Guarantee letters are sent to hospitals after more than a month and patients still need to go back to the institution to line up and follow up if the request is approved (Caballes, 2013).

Table 7. Amount (in PHP) of the hospital bill and out-of-hospital spending

Socio-economic status	Total hospital bill	Inpatient purchased drugs outside		Purchased diagnostics outside	
	PHP (average)	Percent (%)	PHP (average) (incl. zeros)	Percent (%)	PHP (average) (incl. zeros)
Poorest	19,450	60.9%	3,131	26.1%	4,231
Poorer	30,970	67.4%	6,647	32.6%	8,414
Middle	40,025	67.1%	9,337	36.0%	12,597
Richer	56,919	62.4%	11,084	37.0%	16,926
Richest	103,337	59.7%	14,203	33.8%	17,701
All	53,667	63.5%	9,084	33.3%	12,746

Source: Analysis of the National Demographic and Health Survey, 2022

Note: Patients' income was categorized into five groups (quintiles): poorest, poorer, middle, richer, and richest, with each quintile representing a progressively higher income bracket.

Addressing fragmentation in health financing

In this section, we propose key reform areas to address the growing fragmentation of the health system. First, the multiple territorial pools that have emerged because of the decentralized health system need to be consolidated. Second, clarifying and delineating the roles and responsibilities in hospital financing is essential to reduce duplication and ensure more efficient resource allocation.

Realize the promise of UHC: Consolidate territorial pools

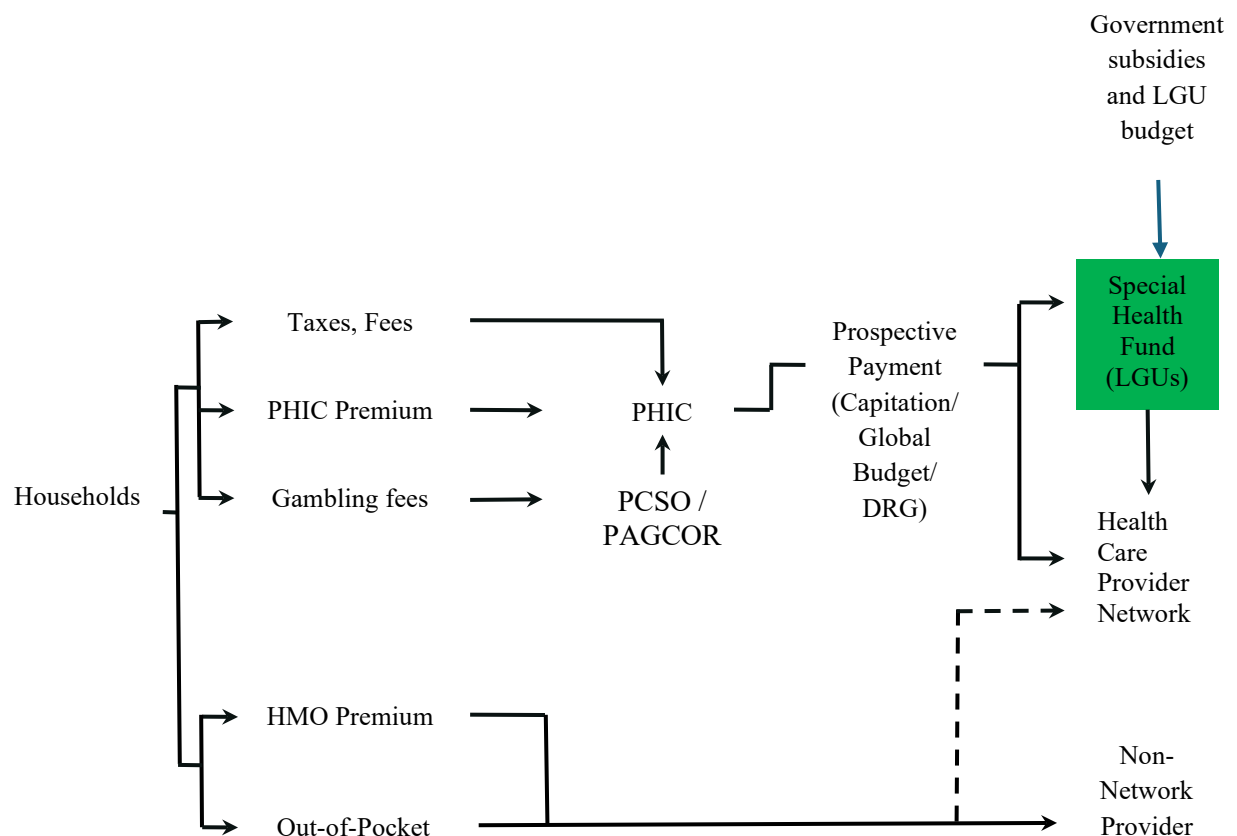
As previously discussed, fragmentation in health financing, driven mainly by multiple territorial pooling arrangements at the LGU level, has contributed to inefficiencies and deepened inequalities in health spending across LGUs. The UHC Act seeks to address this challenge by consolidating local health systems at the municipal level and establishing province- or city-wide health care provider networks (HPCNs). From the perspective of health financing reform, the consolidation of the local health systems could achieve the following:

First, it reduces the fragmented territorial pools from over 1,600 municipalities to less than 200 pooled entities (i.e., provinces and highly urbanized cities). One key aspect in this consolidation of health financing sources is the creation of SHF (Department of Health et al. 2021), which integrates various public health financing streams at the provincial level. **Figure 12** shows the pooling of health financing resources in the Philippines. It shows the role of the Special Health Fund (SHF) in consolidating multiple funding streams at the province-wide level. Under the UHC Act, the SHF is a unified pool that consolidates PhilHealth payments and other government budgets and subsidies (including LGU budgets/subsidies) at the provincial level. This consolidation addresses the fragmentation at the municipal level of health financing by aligning previously separate flows from national agencies and LGUs into a single fund. Through the SHF, provinces can strategically purchase health services from a network of public and private providers using prospective payment mechanisms such as capitation, global budgets, or Diagnosis-Related Groups (DRGs). It allows for greater financial coordination, enhances equity in resource allocation, and enables more coherent planning and service delivery within an integrated Health Care Provider Network (HCPN) network of PHC

providers (i.e., owned by LGUs) and hospitals. By reducing overlapping and uncoordinated funding, the SHF strengthens financial leverage and contributes to more efficient, needs-based financing of health services.

In addition to financial pooling, consolidation at the provincial level facilitates service and clinical integration. Under the current design, LGUs (i.e., municipalities) deliver PHC services, while provincial governments provide curative care through district and provincial hospitals. This jurisdictional and governance structure between the facility levels is incompatible with the design of an integrated care system. Planning for an integrated system becomes more feasible at the provincial level.

Figure 12. Pooling of health financing resources



Source: Authors' illustration

While the UHC Act provided legislative reform to consolidate health financing sources, implementing HPCN remains constrained by the 40-year path dependency of local governance under a highly decentralized system. Integrating services and financing at the provincial level is politically challenging, requiring alignment between municipal and provincial governments. These entities often operate independently and under differing political leadership. This challenge is exacerbated by the need to integrate budgets, plans, and accountability mechanisms across multiple levels of government. Further, LGUs have explained that the lack of clarity in the roles of LGUs in an integrated province-wide health system has led to hesitations in participation from their perspective, and that massive time and resource

requirements to fully integrate will be necessary. Efforts to introduce integration also seem to be done on a piecemeal (vs. systemic) understanding among local leaders, therefore making integration more of a boon than a bane (Pantig, Lorenzo, & Ramos, 2024).

Given these challenges, the following should be explored:

- **PhilHealth covers the full operating costs.** PhilHealth should cover the cost of delivering individual-based PHC (including vaccine administration) and curative services through prospective payment mechanisms (e.g., blended capitation for PHC services and global budget for hospital services) as envisioned in the UHC Act. Covering the full cost of care or at least the operating cost of care is critical to ensure financial leverage of PhilHealth as the primary purchasing entity and to reduce inequities in LGU spending on health. However, this must be accompanied by robust financial management and cost containment policies and regulations (i.e., presence of a fee schedule/pricing policies).
- **Salaries and capital investments can be covered under budget line items.** Municipal governments should retain responsibility for financing capital investments and personnel services (PS) for local health workers providing primary care. Meanwhile, operational costs for service delivery, such as drugs, diagnostics, and utilities, should be financed through the SHF. The national government may provide strategic capital grants through line-item budgets to support local infrastructure development. Additionally, PhilHealth must unbundle PS and capital investment components from its case rates or tariffs in public hospitals, thereby allowing for differential payment structures between public and private providers. This approach ensures that PhilHealth payments more accurately reflect the cost of services delivered, while avoiding duplication of funding.
- Financing population-based public health services should be retained at the municipal level, reinforcing this function stipulated in the local government code. National grants to local communities could be provided, but the DOH should strive for equitable allocation following the national allocation framework (NAF) and performance-based approaches.

Clarify governance and accountability of different financing sources

Fragmentation is evident in the multiple and overlapping sources of health financing in public hospitals. As previously discussed, these overlapping and multiple public financing streams can give rise to several challenges. **Figure 13** provides an illustrative example of the multiple sources of revenue for public hospitals, including government subsidies, PhilHealth reimbursements, and OOP payments by patients. Ideally, the operating costs of public hospitals should be fully covered by government funding and PhilHealth reimbursements. When these revenues fall short, hospitals may be forced to reduce the scope or quality of services (underprovide) or shift the financial burden onto patients through increased OOP.

Figure 13. Revenue and operating costs of a public hospital

Cost: Public Hospital Operating Expenses to Health Facilities					
Government budget			Subsidies/Donation		OOP
PhilHealth	GAA	LGU	DOH subsidy	Other national subsidy (e.g., PCSO)	Fees charged to patient

Source: Authors' illustration

Given this, we proposed the following approaches.

- Use a predictable hospital bill based on a DRG-based global budget. Ideally, the DRG should cover the full cost of care. However, DRG-GB is a function of PhilHealth's budget constraints, and the difference could be funded by other sources.
- Defining and implementing a level/rate of copayment by the patient, to be paid out-of-pocket, or if incapable, can be paid using MAIFIPP funds.
- Any amenities availed outside of the fixed hospital bill will be paid out-of-pocket by the patient
- Unbundled high-cost services from the DRG-GB can be paid using MAIFIPP funds.
- PCSO MAP has a defined list of high-cost expense items that the institution can continue to cover, including specific high-cost medicines and implants. In the same manner, DSWD AICS may also continue providing non-medical financial assistance (i.e., food subsidy, transportation subsidy, etc.) that can complement the patient's medical-related expenses.

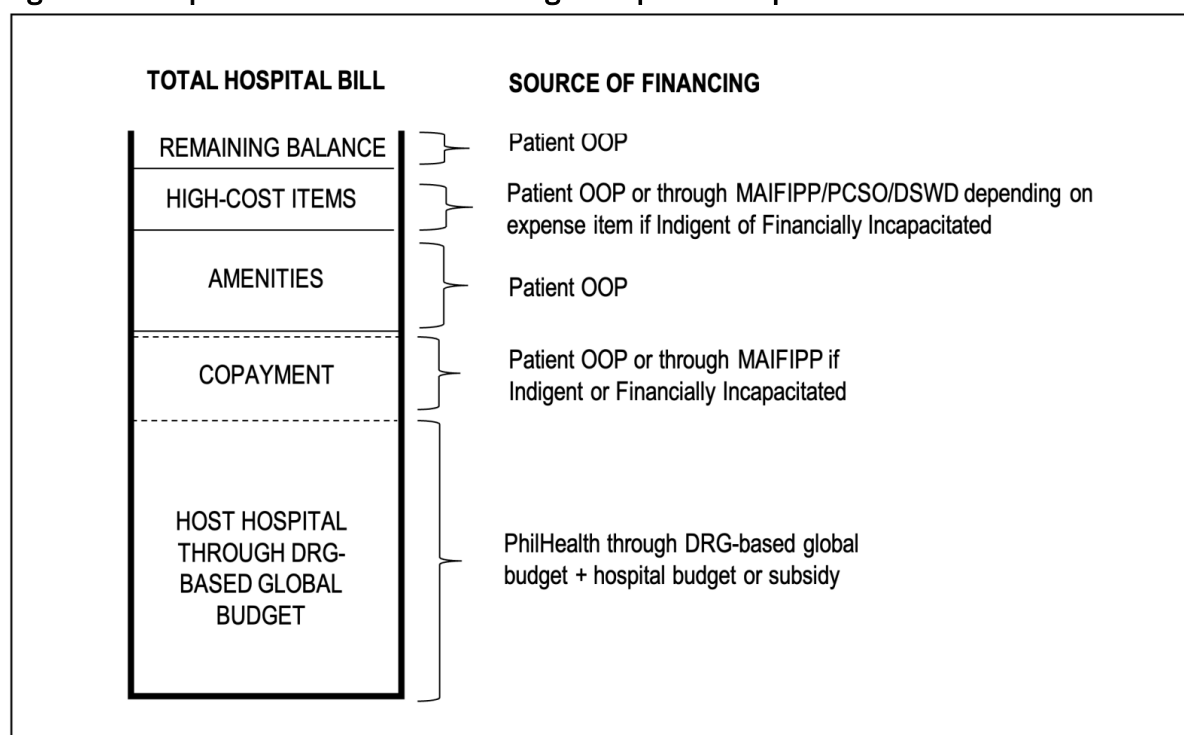
In this proposal, the funds are un-linked to individual patients/target populations and are now linked to specific medical-related cost items. This potentially reduces the risk of allocating funds to populations with high risk of incurring high levels of health expenditures, as in the case of MAIFIPP where grants are being allocated to populations with expected high levels of medical expenditures.

With a predictable DRG-based hospital bill as base, a fixed rate of copayment can be defined. This rate setting is expected to ensure that PhilHealth's support value is significantly improved, therefore deterring the need for all patients to seek additional medical and financial assistance. Copayment can be a fixed amount or a fixed percentage of the total bill that the patient shares. With a copayment option, individuals are incentivized to use medical services judiciously. MAIFIPP funds may come into play for patients who cannot cover the copayment portion. The MAIFIPP may therefore serve as a top-up to the PhilHealth payment, effectively targeting its intended beneficiaries. Therefore, medical and financial assistance from PCSO MAP and DSWD AICS can be allocated to high-cost medicines and non-medical services, as already practiced, un-linking them from specific patients and population groups.

Unbundled high-cost items can be covered either out-of-pocket or through MAIFIPP/PCSO MAP/DSWD AICS funds, while fine-tuning the eligibility criteria and ensuring that only the

indigent and financially incapacitated are granted assistance. The proposed measures and breakdown of sources of financing are illustrated in Figure 14.

Figure 14. Proposed sources of financing for inpatient expenses



Source: Authors' illustration

Under this proposal, MAIP funds are effectively targeted to its intended beneficiaries, while removing the loose basis for defining the grant amount accorded to the patient. This contributes to a more equitable distribution of MAIFIPP funds. Other forms of institutional medical and financial assistance may continue paying for currently identified expense items or can be expanded to include commonly identified high-cost items that it can complement with the MAIFIPP. If all of the pooled funds are redistributed, any remaining balance will have to be paid out of pocket by the patient but will be based on the predictable estimate of the patient's total hospital bill.

With the DRG-based global budget, the possibilities of harmonizing and ensuring complementarity of the multiple pooled funds may be facilitated. Complementarity, based on the health system perspective, ensures that there will be no duplication of expense items being covered by national government money, and that risks of paying for high levels of expenditures are reduced. Having a harmonized use of multiple pooled funds supports the UHC reform of ensuring appropriate use of funds for the financial risk protection of all Filipinos.

Annex

Annex 1. Details of Medical Assistance Programs under the Malasakit Program

Medical and financial assistance programs from PCSO, DSWD, and DOH

While PCSO and DSWD are part of Malasakit Centers, patients with limited access to the one-stop shop can still request their medical and financial assistance programs. Given the limited accessibility of Malasakit Centers in select government hospitals, patients may request assistance from the different offices of PCSO and DSWD. On the other hand, the MAIFIPP is managed and administered by the Malasakit Program Office (MPO) of the DOH, and funds are directly paid to the hospitals through Memoranda of Understanding (MOUs) between the Center for Health Development and the health facility.

PCSO Medical Assistance Program (MAP)

PCSO's MAP comprises three subprograms: Regular MAP, Medical Assistance in Malasakit Centers (MAM), and Medical Assistance Program for Catastrophic Illnesses. PCSO MAPs cover expenses for confinement, erythropoietin (dialysis injection), hemodialysis, chemotherapy drugs, radiation therapy, specialty medicines³, laboratory, diagnostic, and imaging requests⁴, implant and medical devices⁵, rehabilitation therapy for physical/occupational/speech. Of these three, Regular MAP has the largest number of beneficiaries in CY 2024 at 269,755, while only 60,252 beneficiaries were granted medical assistance through MAM. There were only 16 beneficiaries under the MAP for catastrophic illnesses. This is summarized in **Table 1A**.

Table 1A. Summary of MAP Beneficiaries and Assistance

PCSO Medical Assistance Program	Total Beneficiaries	Amount of Assistance	Average Amount of Assistance
Regular Medical Assistance Program	269,755	₱2,543,791,520	₱9,430
Medical Assistance in Malasakit Centers	60,252	₱718,972,468	₱11,932
Medical Assistance for Catastrophic Illnesses	16	₱8,883,777	₱555,236

Source of basic data: PCSO Accomplishment Report 2024

In terms of reach, the Regular MAP covered a total of almost 270,000 beneficiaries, while MAM only covered around 60,000 beneficiaries. However, patients through MAM received a slightly higher amount of assistance at an average of PHP11,932 compared to recipients of Regular MAP, who received an average of PHP9,430. On the other hand, the Medical Assistance for Catastrophic Illnesses program covers only specific conditions, including organ

³ Medicines for (Hemophilia, Post Kidney/Liver Transplant medicines, Rheumatoid Arthritis, Anti-Lupus, Hematologic and Auto-Immune Disease (IVIg), Psoriasis, Orphan Disease, Idiopathic Thrombocytopenic Purpura (ITP), Thalassemia and Neuro-Psychiatric)

⁴ Except for routine laboratory

⁵ Pacemaker, septal occluder, valves and PCSI devices

transplants for the kidney, liver, lung, pancreas, and heart, as well as coronary artery bypass graft (CABG). According to guidelines, this specific benefit applies to patients who qualify for the PhilHealth Z-benefit (Philippine Charity Sweepstakes Office n.d.).

Patients can access the MAP through the Malasakit Centers or PCSO. Patients or their authorized representatives can submit the MAP application form and required documents to the PCSO branch offices, if available, directly. The social worker evaluates the request and recommends the amount of assistance to be extended by PCSO. The branch manager then approves the assistance. Under this program, no cash is released to the patient; however, PCSO issues a guaranteed letter that the patient can submit to the hospital, dialysis center, diagnostic center, or Partner Health Facility/medicine retailer. The application for MAP may also be done online (Philippine Charity Sweepstakes Office n.d.).

DSWD Assistance to Individuals in Crisis Situations (AICS)

The medical assistance component of the DSWD AICS was first introduced in 2007 when the guidelines for managing DSWD-operated Crisis Intervention Units (CIUs) were amended. At that time, medical assistance was provided in the form of a one-year PhilHealth indigent membership sponsorship by the DSWD (Department of Social Welfare and Development 2007). With updated guidelines in 2011, DSWD medical assistance was provided through medicines paid in cash to the patient, not exceeding PHP5,000, but paid directly to the accredited drugstore through a guarantee letter if the amount exceeded PHP5,000. Hospitalization assistance was paid in cash or through a guarantee letter, based on the same basis as the medicines assistance. For patients with chronic illnesses, DSWD provided PhilHealth insurance coverage sponsorships (Department of Social Welfare and Development 2011).

Based on the latest guidelines in 2022, medical assistance covers hospitalization expenses, cost of medicines, and other medical treatment or procedures such as implants, common laboratory tests, and diagnostic imaging procedures for any illness or ailment, including postpartum complications, and provision of assistive devices. The AICS program, as stated in DSWD Memorandum Circular No. 16, Series of 2022, is intended for individuals and families experiencing crises or extremely difficult situations requiring financial or material support (Department of Social Welfare and Development 2022). The AICS may also be requested directly from the DSWD offices without going through the Malasakit Center. Upon submission of requirements at DSWD Central Office, Crisis Intervention Unit/Crisis Intervention Section/Social Welfare and Development Offices and District Offices, the DSWD Social Worker will screen, interview, and assess the client, which may grant up to PHP150,000 in assistance. The general rule is that assistance for hospital bills is granted once every admission/discharge, except for chronic illnesses, which are on a per-hospitalization/admission basis, and that financial assistance for medicines is granted once every three months. Approving authorities differ based on the amount of assistance, as summarized in **Table 1B**.

Table 1B. Approving Authority based on the range of financial assistance for AICS

Amount	Approving Authority
Up to ₱50,000.00	CIS Head/SWAD Team Leader/CIU Head
Up to ₱75,000.00	Division Chief
Up to ₱100,000.00	Assistant Regional Director for Operations/Assistant Bureau Director
Up to ₱150,000.00	Regional Director/Bureau Director
Over ₱150,000.00	Secretary

*CIS: Crisis Intervention Section; SWAD: Social Welfare and Development; CIU: Crisis Intervention Unit.
Source: DSWD Memorandum Circular No. 16, Series of 2022 entitled, “Revised Guidelines on the Implementation of the Assistance to Individuals in Crisis.”

According to the AICS 2022 Accomplishment Report, 843,704 clients received medical assistance. Of this, 5,425 (less than 1%) of beneficiaries received AICS support through Malasakit Centers. In addition to medical assistance, other forms of assistance are usually granted to clients for medical-related support, including food subsidies and transportation assistance.

DOH Medical Assistance to Indigent and Financially Incapacitated Patients Program (MAIFIPP)

As mentioned, the administration and management of the MAIFIPP is through the Malasakit Program Office, lodged at the DOH. The MAIFIPP provides medical assistance to cover clinically indicated inpatient and outpatient care needs more than the package covered by PhilHealth or other financing sources, e.g., HMO. The MAIFIPP is implemented in hospitals and other health facilities, including private hospitals. The updated guidelines include public and private clinical laboratories and primary care facilities. With the MAIFIPP funds lodged at the DOH, CHDs and health facilities receive the sub-allotment from the Central Office. The CHDs, through the CHD Director, may enter an MOA with Specialty Hospitals, State Universities and Colleges (SUC) Hospitals, and LGU Hospitals for access and utilization of MAIFIPP funds. The MAIFIPP covers the following: drugs and medicines, laboratory, imaging, radiological and other diagnostic procedures, blood and other blood screening/products, high-risk cases, dental cases requiring implants, medical devices and supplies, prescribed post-hospitalization and rehabilitation services, all hospital bills/charges, and professional fees (Department of Health 2024).

To avail of MAIFIPP medical assistance, patients proceed to the hospital's Medical Social Service and present the required documents for screening and evaluation by the Medical Social Worker (MSW). Assessments are based on a standard assessment tool. The MSW will assess, process, and recommend the needed medical assistance. The health facility shall provide the necessary health or medical services based on patient needs and document its provision of these services.⁶ In the case of MAIFIPP, the DOH, through the CHD, will sub-allot the approved financial assistance directly to the facility and not require payment in cash to the patient or authorized representative. The maximum allowable amount can go beyond PHP 2 million if necessary. The approving authority also depends on the amount authorized as medical assistance to the patient, as summarized in **Table 1C**.

⁶ *Ibid.*

Table 1C. Approving Authority for the grant and release of MAIFIPP funds

Amount	Approving Authority
Health Facilities	
Maximum ₱250,000 per approval/ transaction	Chief of Hospital of LGU hospitals Medical Director/representative of select private/public health facilities
Maximum ₱500,000 per approval/ transaction for health facilities under MM-CHD	
Maximum ₱1,000,000 per approval/ transaction	Chief of Hospital/Medical Center Chief/Medical Director of DOH Hospital, Specialty Hospital, SUC Hospital, DBD Hospital, and PNP Hospital
DOH	
Maximum ₱1,500,000 per approval/ transaction	CHD Director
Maximum ₱2,000,000 per approval/ transaction	Cluster Head of MPO
Above ₱2,000,000 per approval/ transaction	Secretary of Health

*MM-CHD: Metro Manila Center for Health Development.

Source: DOH Administrative Order No. 2024-0006 entitled, “Revised Guidelines on the Implementation of the Medical Assistance to Indigent and Financially Incapacitated Patients Program (MAIFIPP)”

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