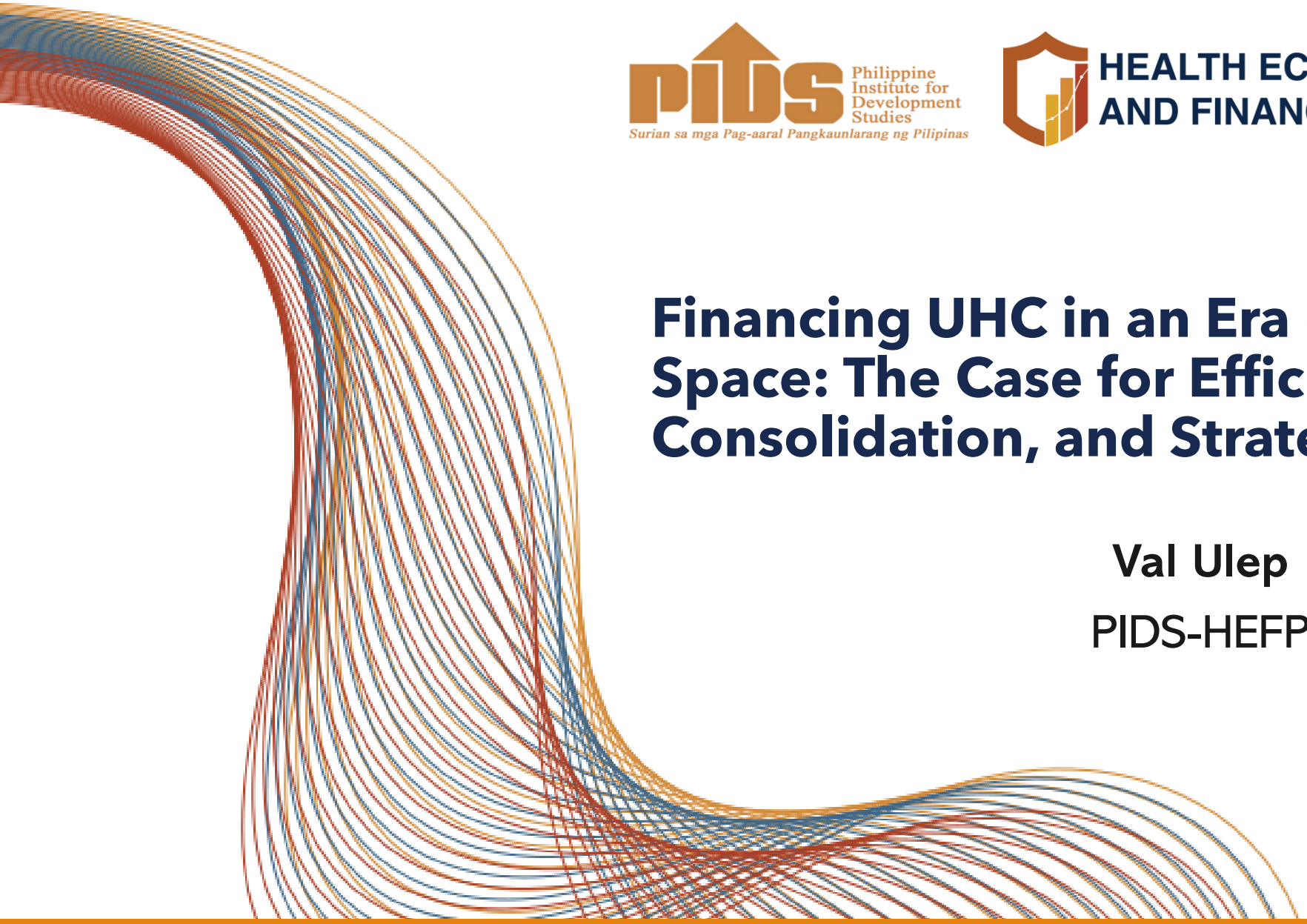


Financing UHC in an Era of Tight Fiscal Space: The Case for Efficiency and Consolidation, and Strategic Purchasing

Val Ulep

PIDS-HEFP

THE FLOW OF MY PRESENTATION

A new fiscal reality makes spending better on health.

1

A new fiscal reality.

The Philippines is entering an era of slower growth and tighter fiscal space.

Less room for rapid expansion of health spending.

2

But health needs will not slow down.

Demand, expectations, and the cost of delivering UHC will continue to rise.

More people, higher needs, and more costly care.

3

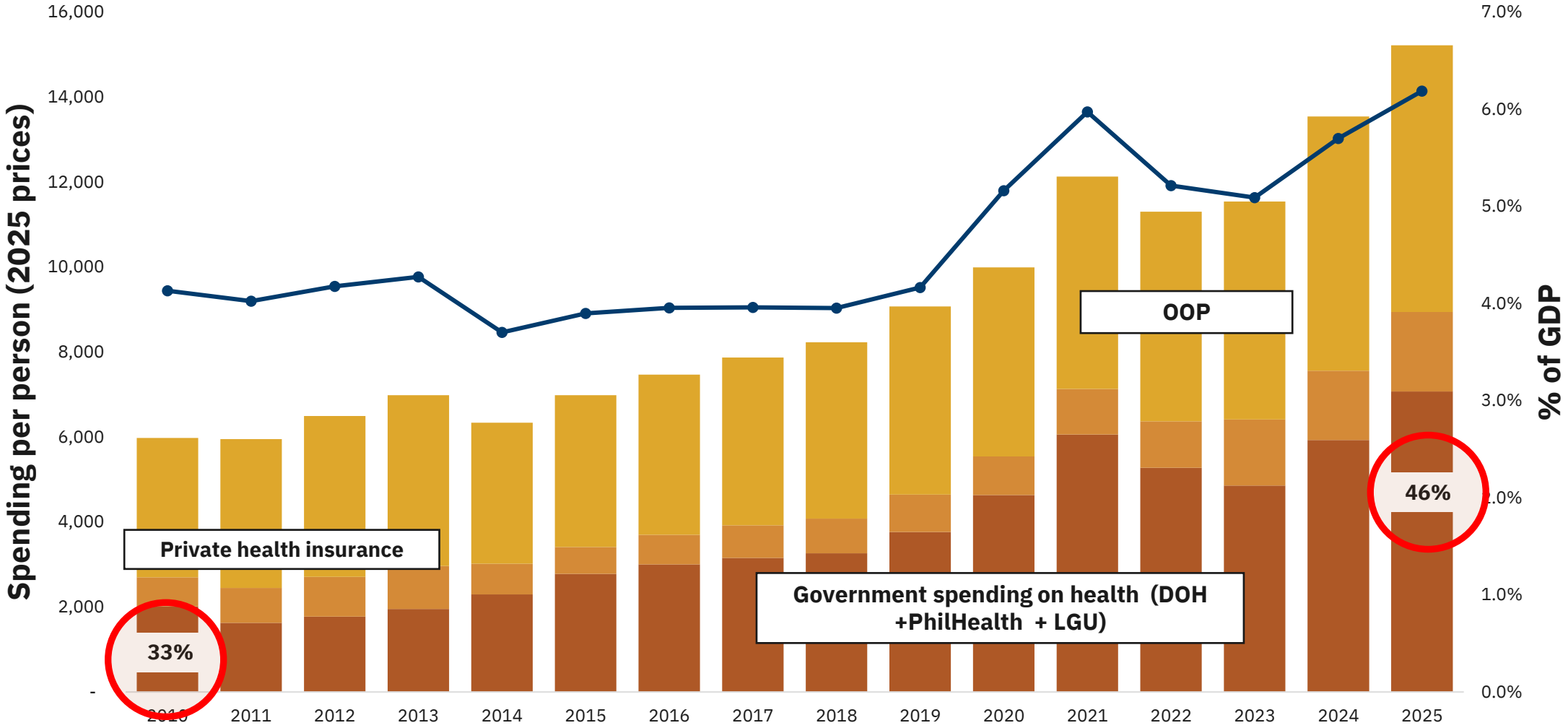
So, spending better becomes more important that ever.

With limited room for additional resources, efficiency must become a source of fiscal space.

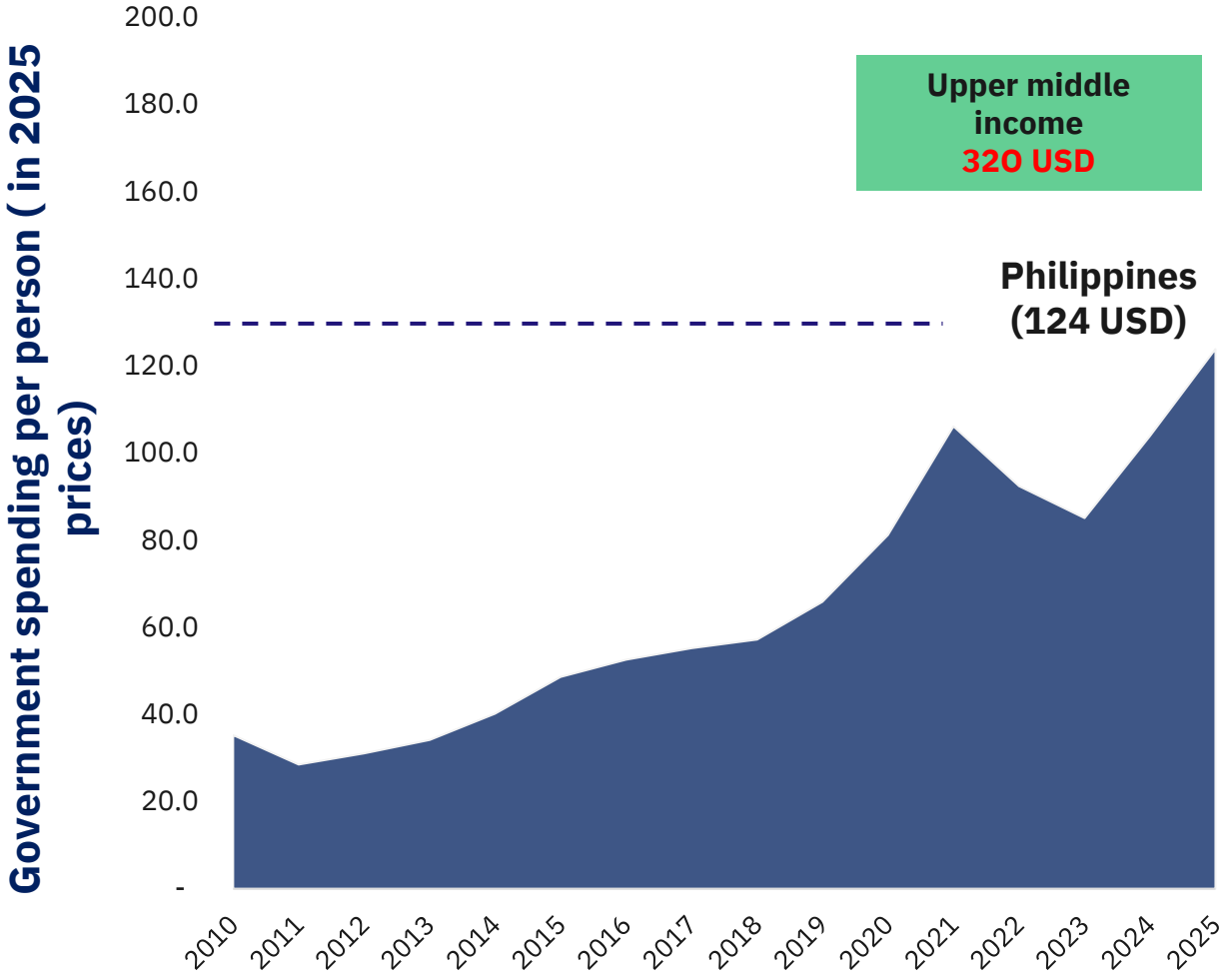
Get more health and financial protection from every peso we spend.

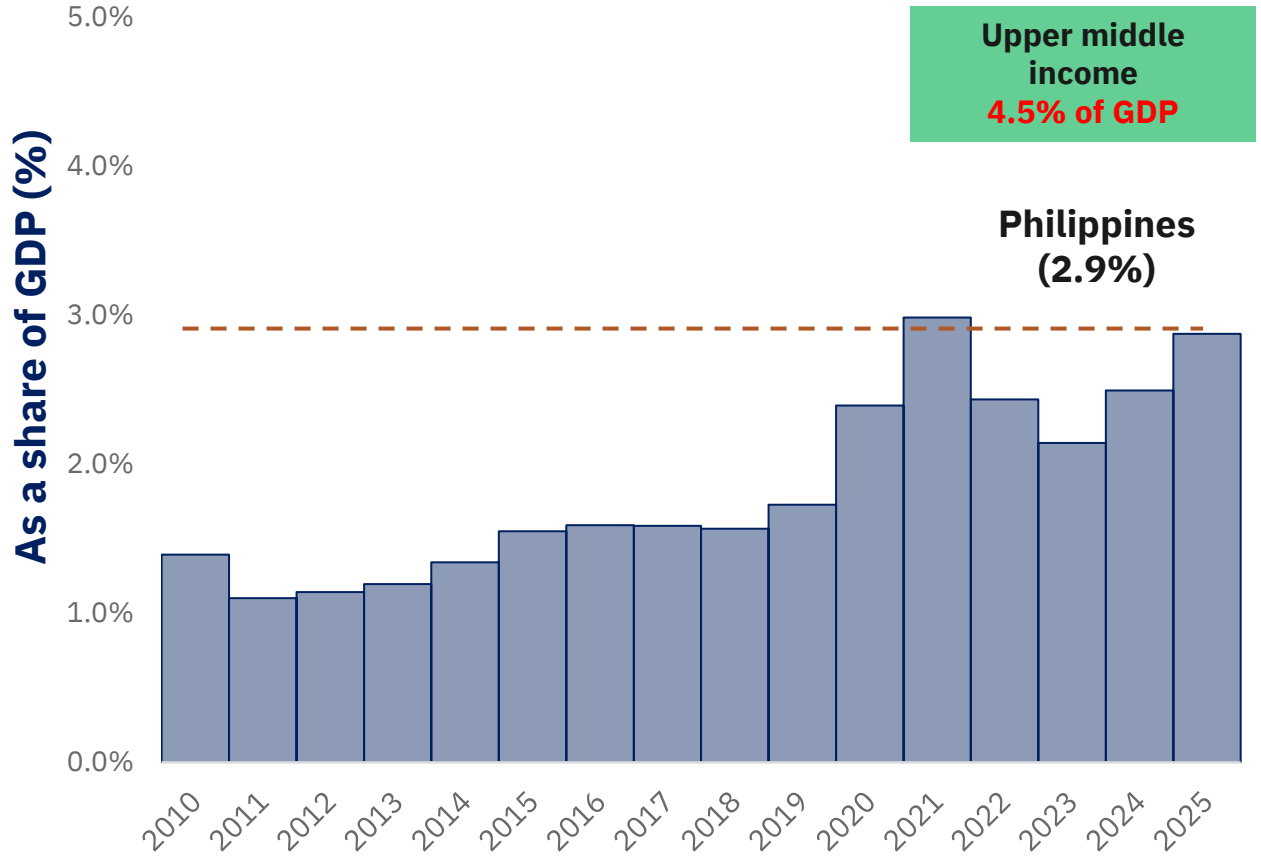
The challenge ahead: achieve more health and financial protection from every peso we spend.

Health spending has increased significantly even adjusting for population growth and inflation.

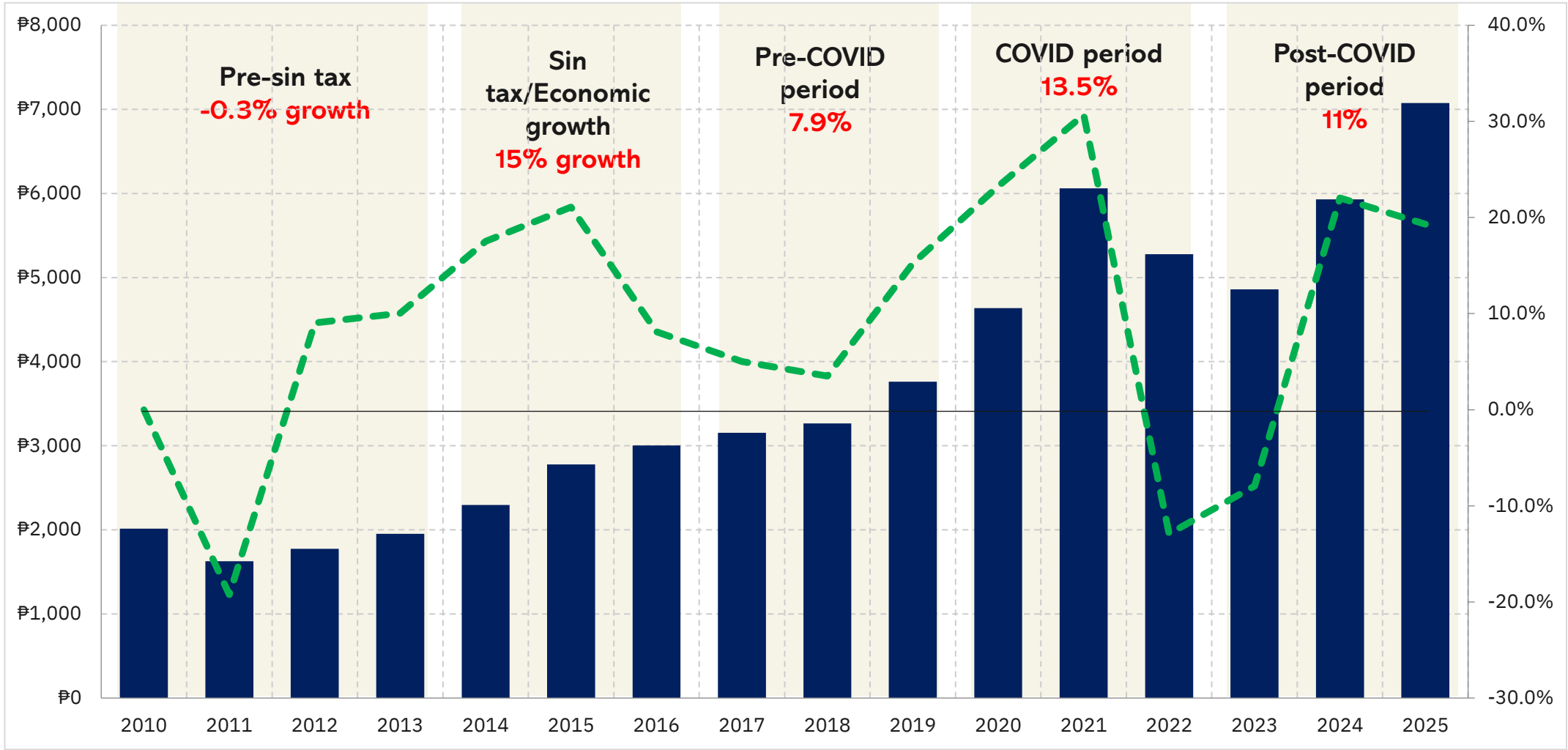


Government health spending (DOH, PhilHealth, and LGUs) has tripled, but the Philippines still trails upper-middle-income countries.

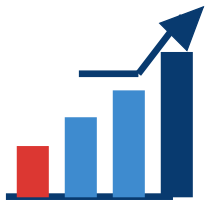




Government spending (DOH, PhilHealth, and LGUs) has been the main driver of the exceptional growth in health spending over the past decade, growing by more than 10% annually per capita.



What are the drivers of government spending on health?



1. Size of the economy

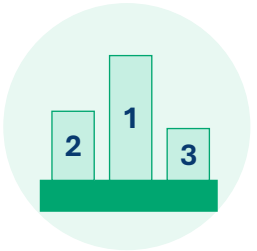
GDP per person

×

2. Government's share of the economy

Government spending as % of GDP

×



3. Priority given to health

Health spending as % of government spending

The bigger the economy, the more resources are available.

Higher government spending means more fiscal space.

Higher priority for health means a larger health share.

Government health spending per person
DOH + PhilHealth + LGUs

Philippines (2025)

1. Size of the economy
GDP per person
US$4,038

×

2. Government's share of the economy
Government spending as % of GDP
24%

×

3. Priority given to health
Health spending as % of government spending
12%

=

Government health spending per person (DOH + PhilHealth + LGUs)
≈ US$124
per person

Economy grows
More resources
→
Government spends more
More fiscal capacity
→
Health gets higher priority
More for health

Model based on: Tandon, A., Cain, J., Kurowski, C., Dozol, A., & Postolovska, I. (2020)

What determines government spending on health?

1 Size of the economy

GDP per person

Determined by

- Productivity & investment
- Employment & income growth
- Population dynamics

LOW-GROWTH REGIME
Slower expansion of the resource base

×

2 Gov't spending share of the economy

Government spending as % of GDP

Determined by

- Tax revenue mobilization
- Fiscal deficit & borrowing
- Public debt & debt service

TIGHT FISCAL SPACE
Smaller government spending envelope

×

3 Priority given to health

Health spending as % of government spending

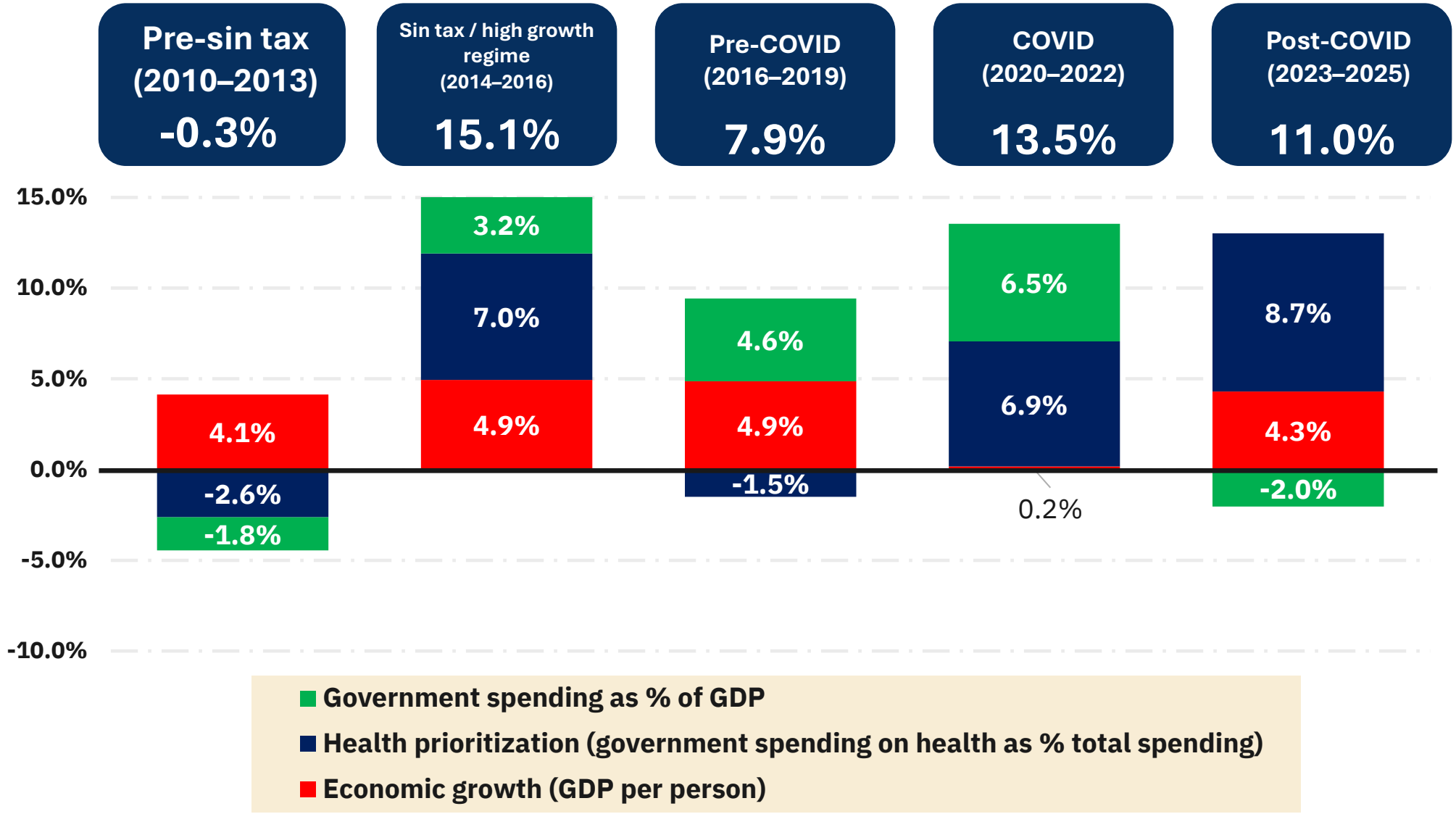
Determined by

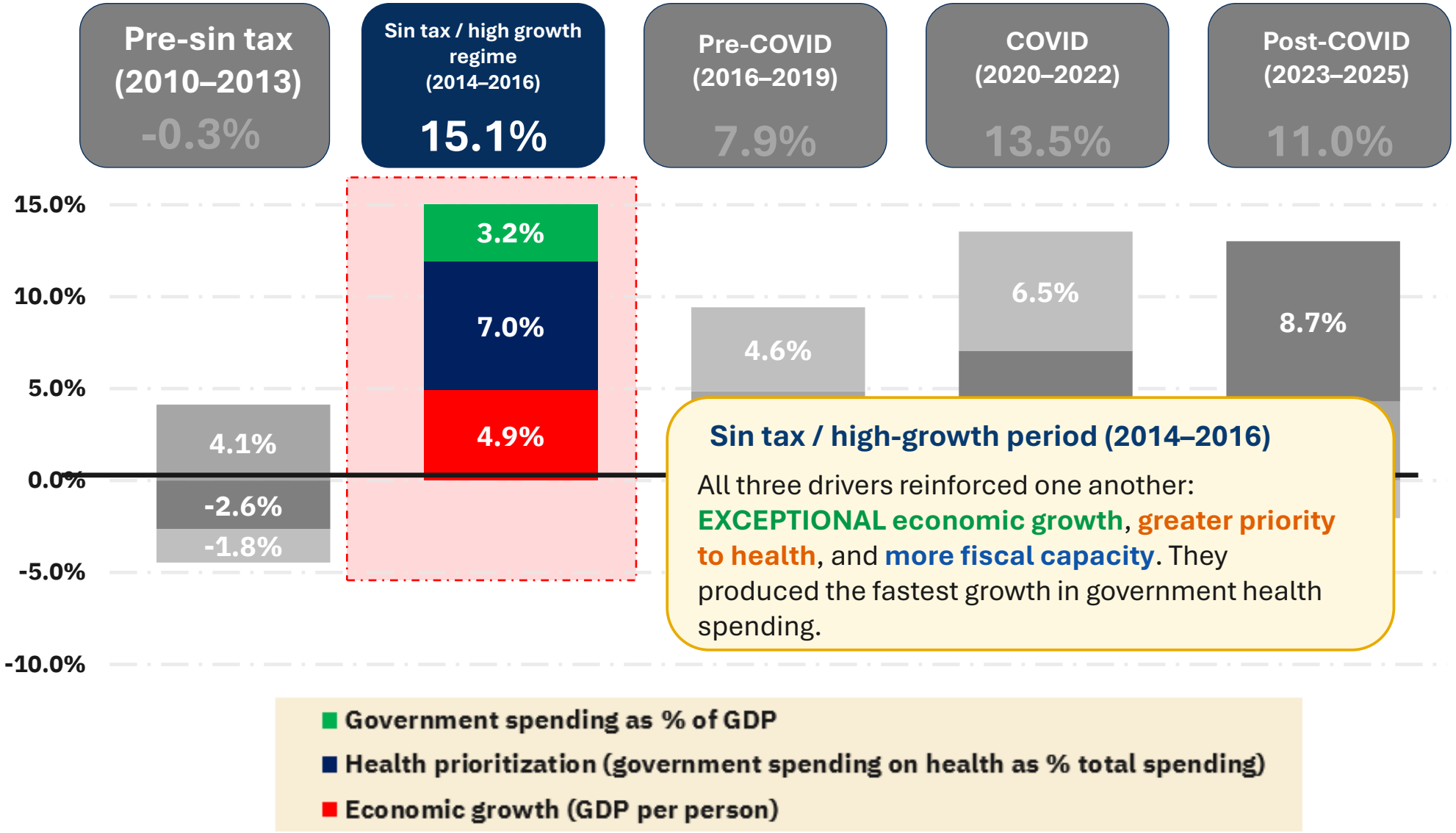
- Political & policy priorities
- Sector-specific revenues (e.g., sin tax earmarked to health)

HEALTH PRIORITIZATION
Determines health's share of the envelope

Government health spending per person = GDP per person × GGE/GDP × PHE/GGE

Model based on: Tandon, A., Cain, J., Kurowski, C., Dozol, A., & Postolovska, I. (2020)


Pre-sin tax (2010–2013)
-0.3%
Sin tax / high growth regime (2014–2016)
15.1%
Pre-COVID (2016–2019)
7.9%
COVID (2020–2022)
13.5%
Post-COVID (2023–2025)
11.0%
15.0%
10.0%
5.0%
0.0%
-5.0%
-10.0%
4.1%
-2.6%
-1.8%
3.2%
7.0%
4.9%
4.6%
4.9%
-1.5%
6.5%
6.9%
0.2%
8.7%
4.3%
-2.0%
Government spending as % of GDP
Health prioritization (government spending on health as % total spending)
Economic growth (GDP per person)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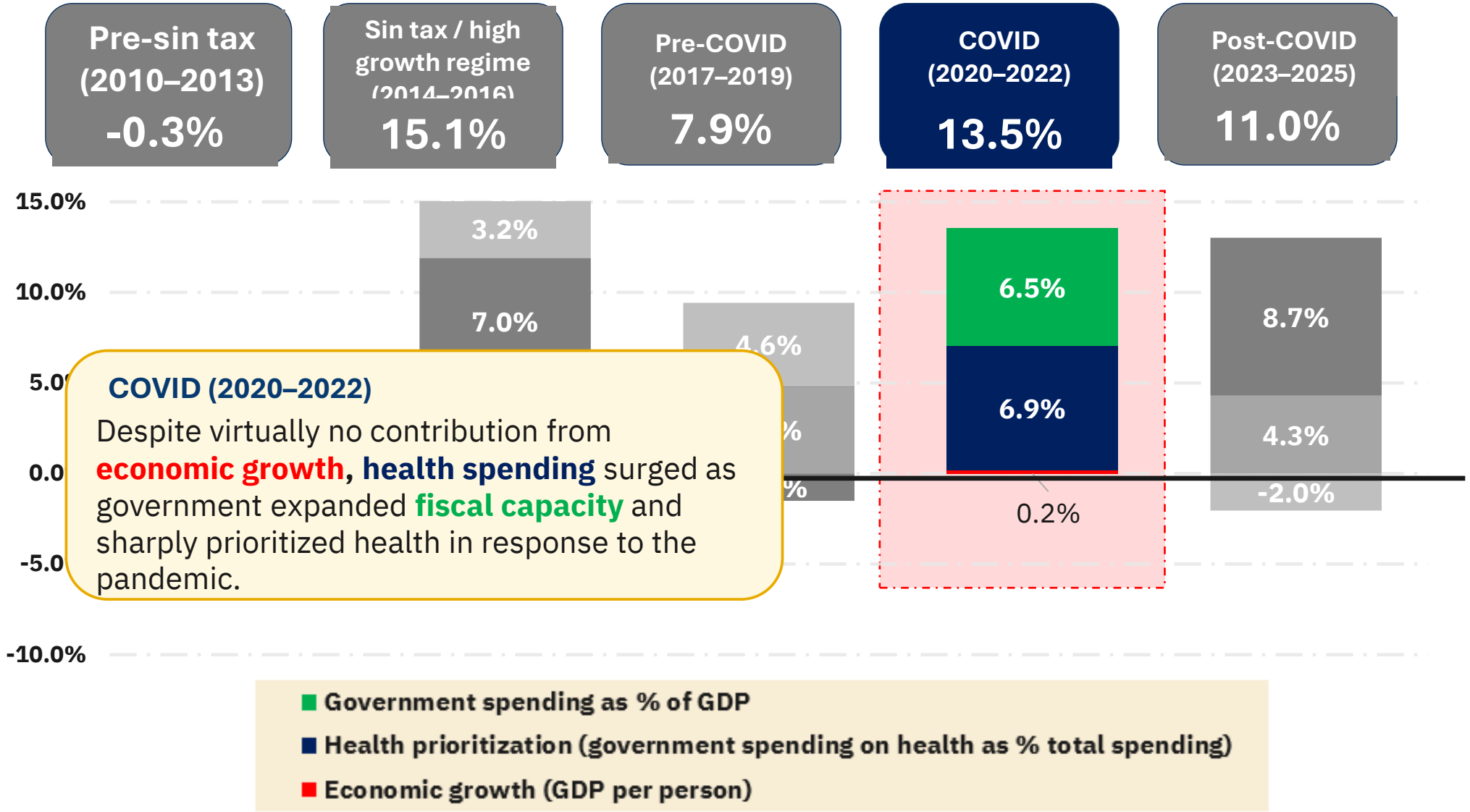
-10.0%
4.1%
-2.6%
-1.8%
3.2%
7.0%
4.9%
4.6%
6.5%
8.7%
Sin tax / high-growth period (2014–2016)
All three drivers reinforced one another: EXCEPTIONAL economic growth, greater priority to health, and more fiscal capacity. They produced the fastest growth in government health spending.
Government spending as % of GDP
Health prioritization (government spending on health as % total spending)
Economic growth (GDP per person)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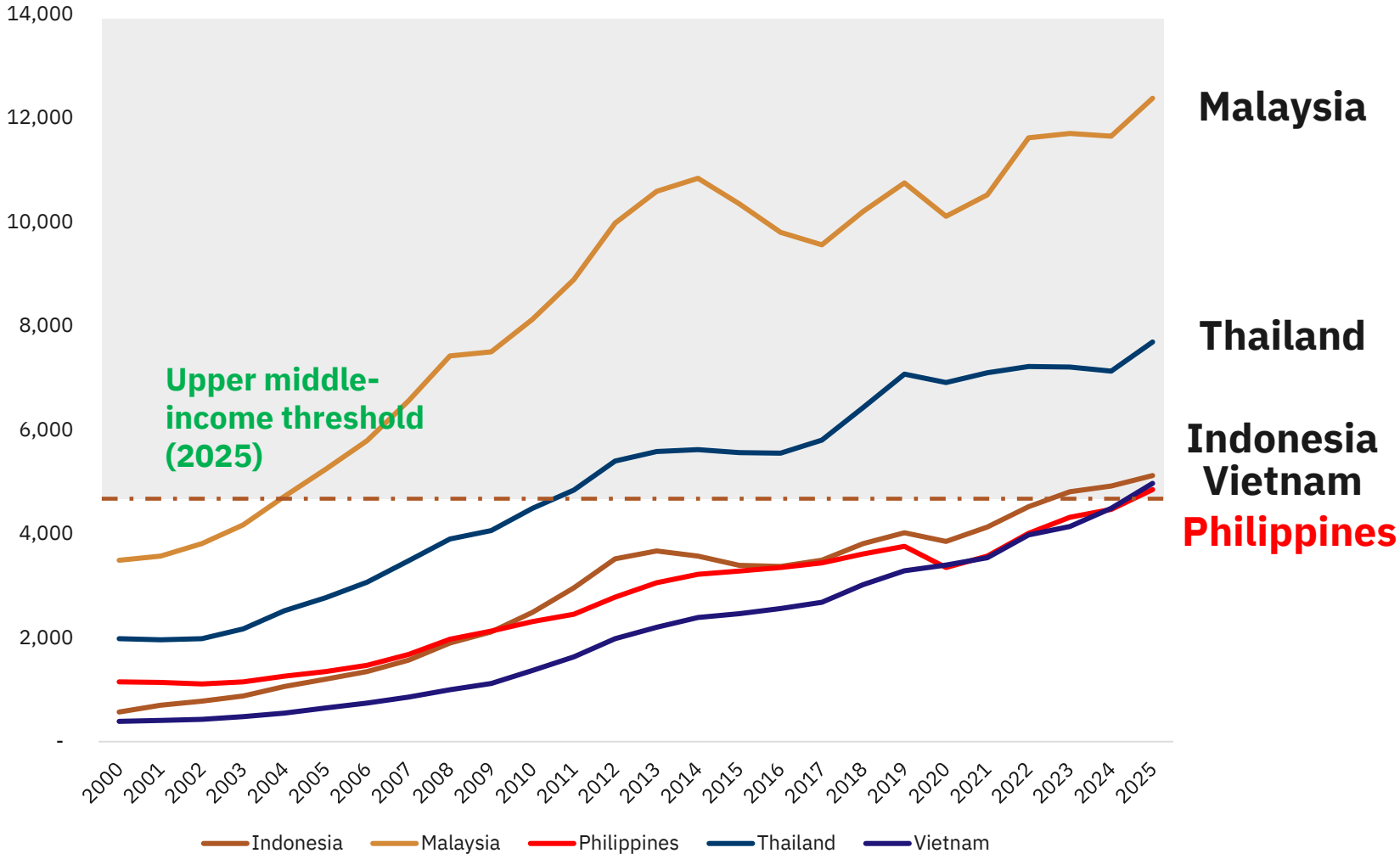
-5.0
-10.0%
3.2%
7.0%
4.6%
6.5%
6.9%
0.2%
8.7%
4.3%
-2.0%
COVID (2020–2022)
Despite virtually no contribution from economic growth, health spending surged as government expanded fiscal capacity and sharply prioritized health in response to the pandemic.
Government spending as % of GDP
Health prioritization (government spending on health as % total spending)
Economic growth (GDP per person)

1. Size of the economy

Despite reaching upper-middle-income status, slower growth means less additional fiscal space for health.



Malaysia

Thailand

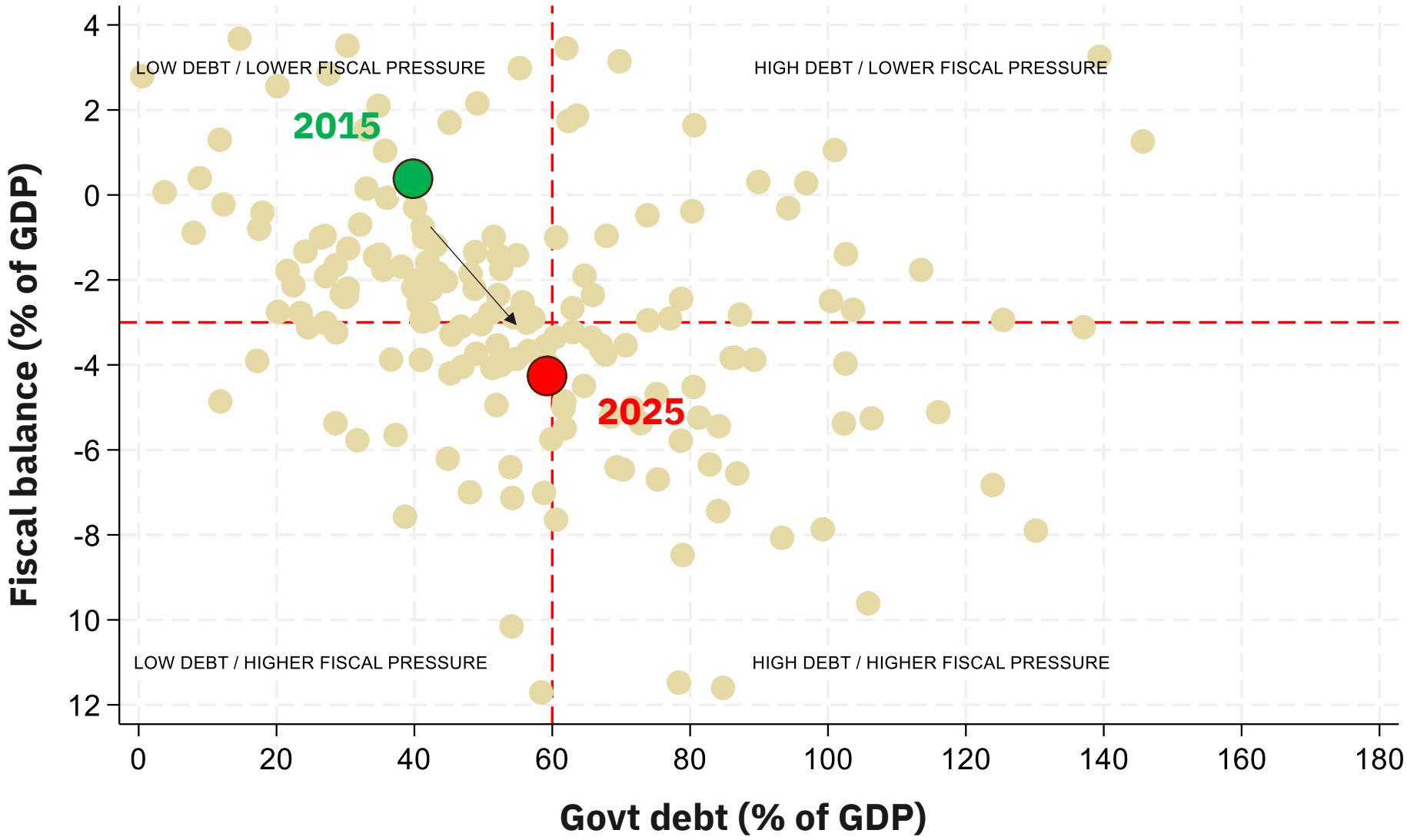
Indonesia
Vietnam
Philippines

GDP Growth Rates

Country	2026 Q1	2026 Q2
Malaysia	5.4%	6.0%
Thailand	2.8%	1.9%
Indonesia	5.6%	5.3%
Vietnam	7.8%	8.4%
Philippines	2.8%	2.3%

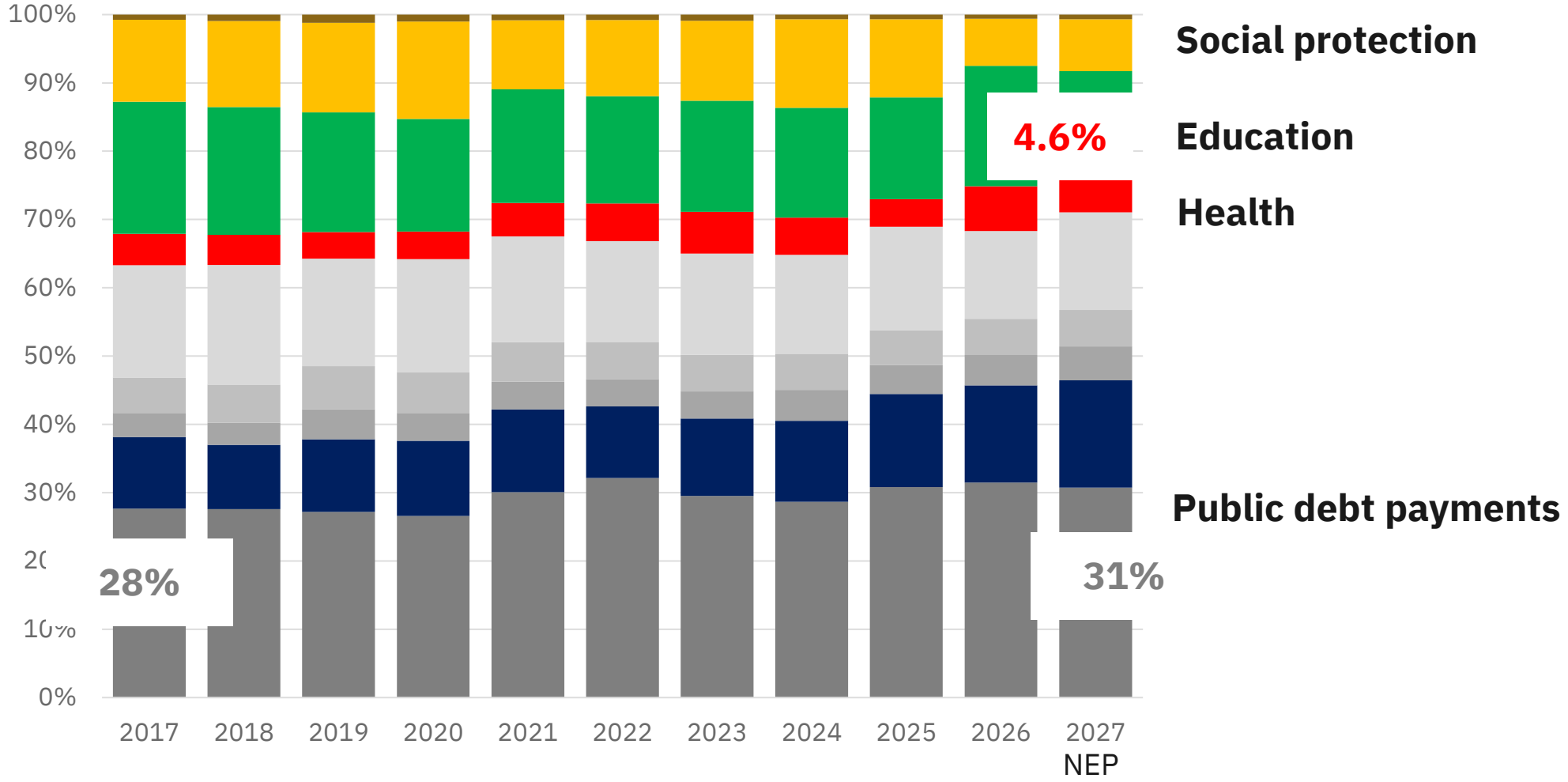
2. Government's share of the economy

Fiscal capacity is becoming more constrained. Deficits, debt and debt service limit room for expenditure expansion.



3. Priority given to health

The national budget shows intensifying competition for limited fiscal resources, constraining the share available for health.



In summary:

The Philippines benefited from more than a decade of robust fiscal space for health and/or sustained economic growth.

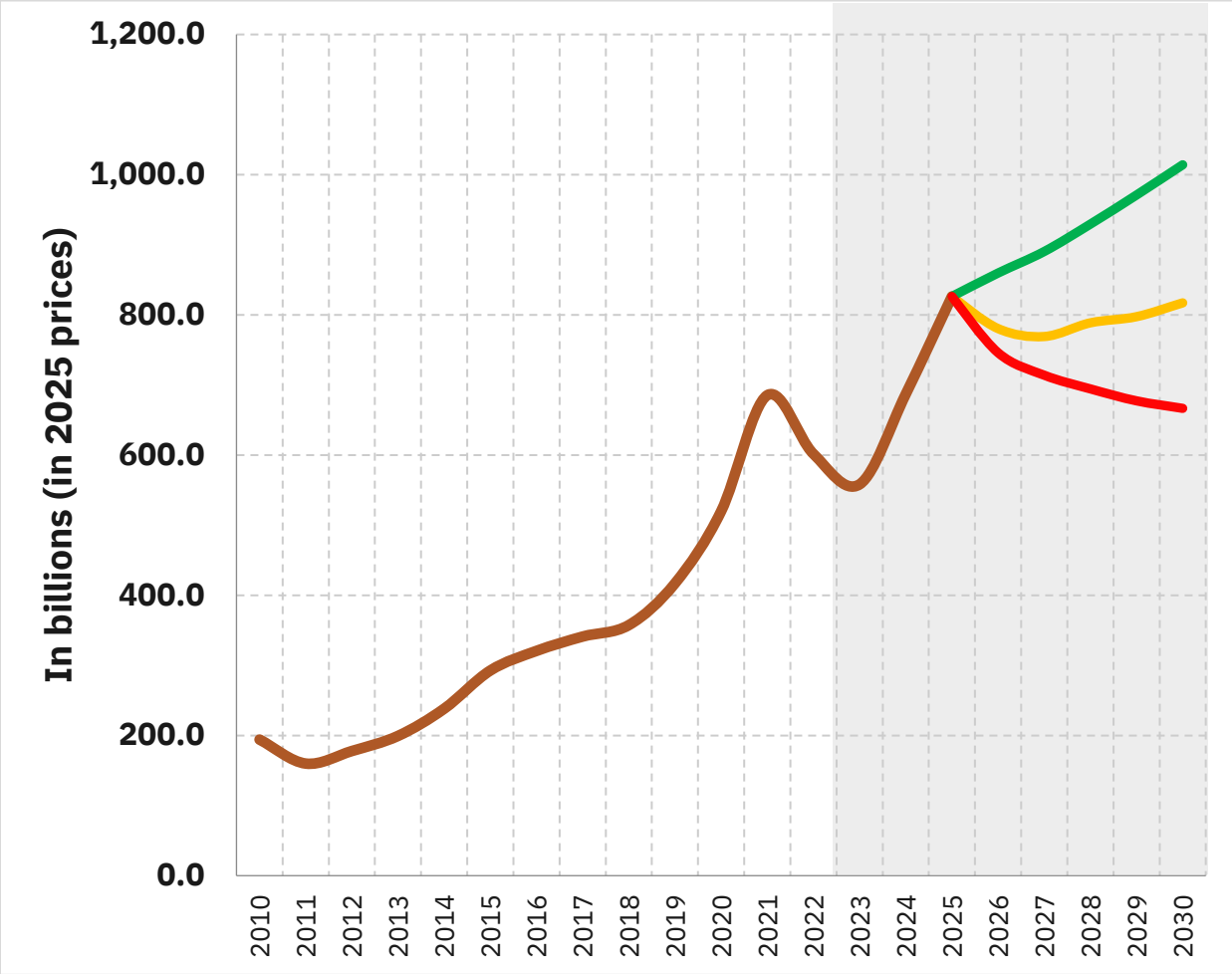
But the fiscal environment is changing.

Slower growth + tighter fiscal space + rising fiscal pressures + competing priorities

Implication for UHC

The era of relying primarily on additional funding to solve health-system problems is becoming more difficult. Spending better will matter as much as spending more.

The era of rapidly expanding health budgets may be ending, which makes efficiency increasingly critical to sustaining UHC.



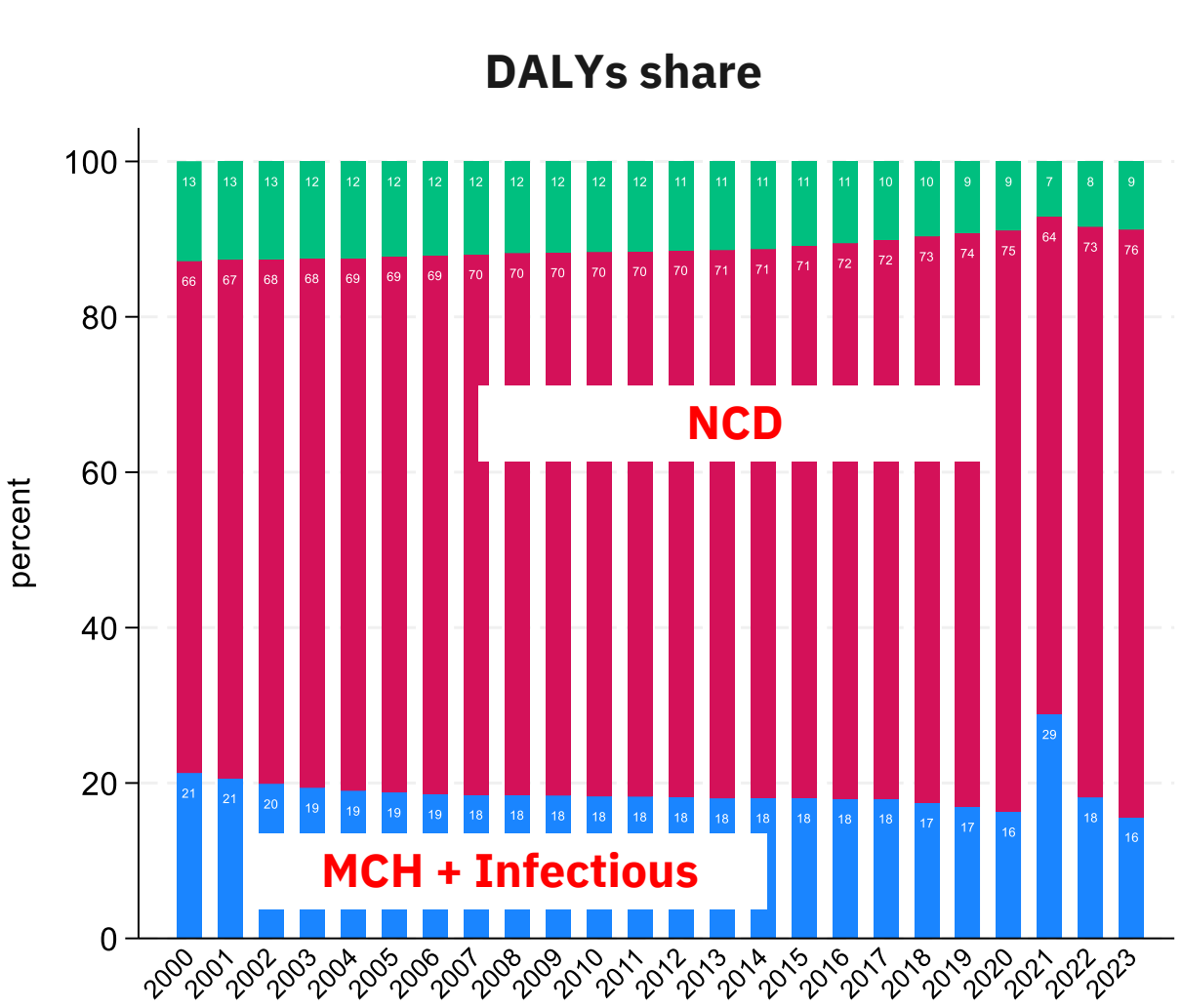
	Upside	Low-growth baseline	Downside
Economic growth	Recovers toward DBCC medium-term growth outlook	Recovery remains below DBCC outlook	Prolonged weak growth
Fiscal space (GGE/GDP)	Gradual consolidation	Moderate consolidation, anchored on IMF general-government outlook	Stronger fiscal consolidation
Health priority (PHE/GGE)	Protected / stable	Modest decline, then stabilizes	Progressive decline

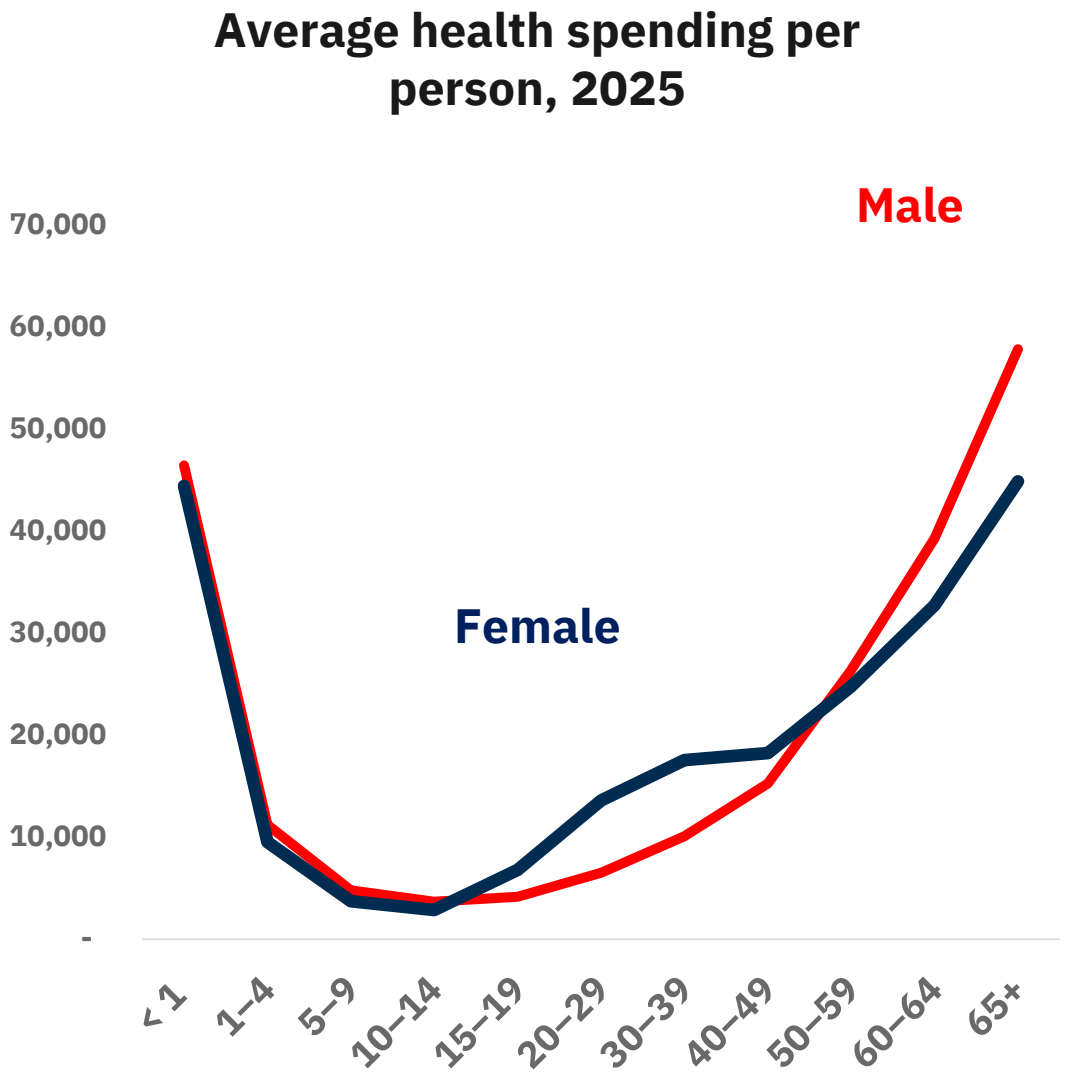
Fiscal space is tightening.

Health needs are not.

The question is no longer only how to spend more, but how to spend better.

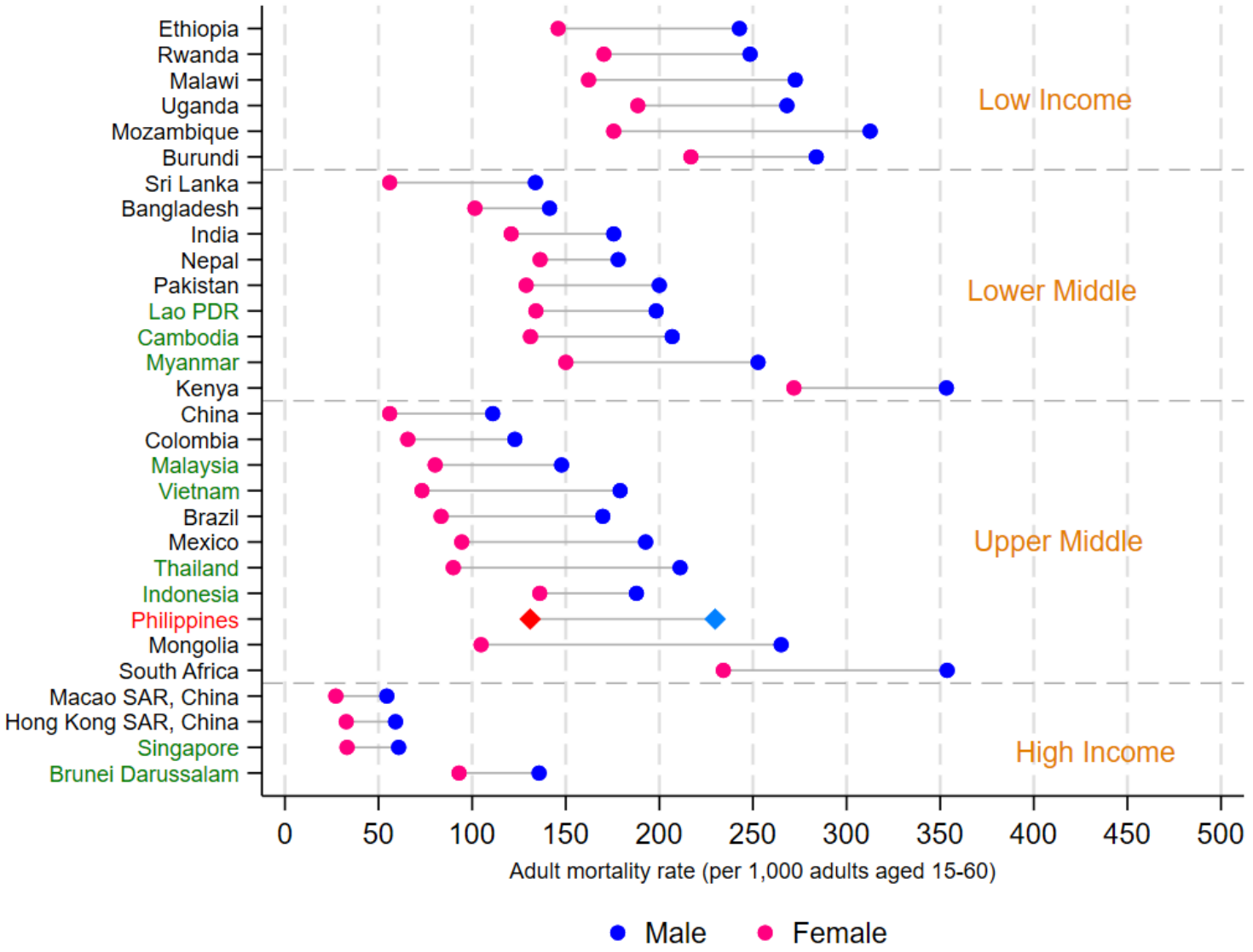
An aging population and rising NCD burden will continue to increase health spending needs.



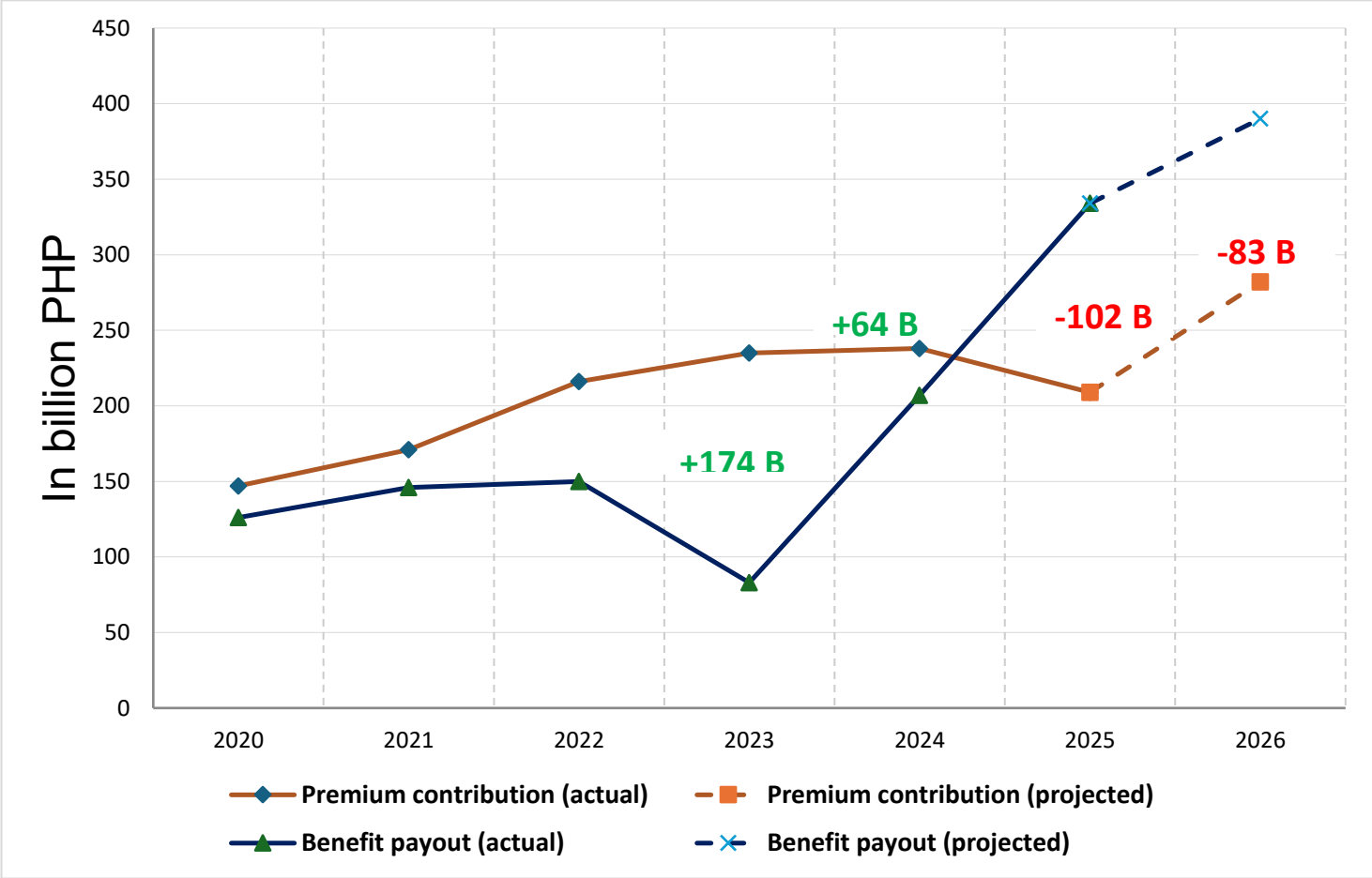


Adult mortality remains high relative to our regional and income peers.

The challenge is not simply that future healthcare needs will cost more. We already have substantial unmet health needs today.



Benefit entitlements are expanding rapidly over the years, which creates spending commitments to citizens that will be difficult to reverse.



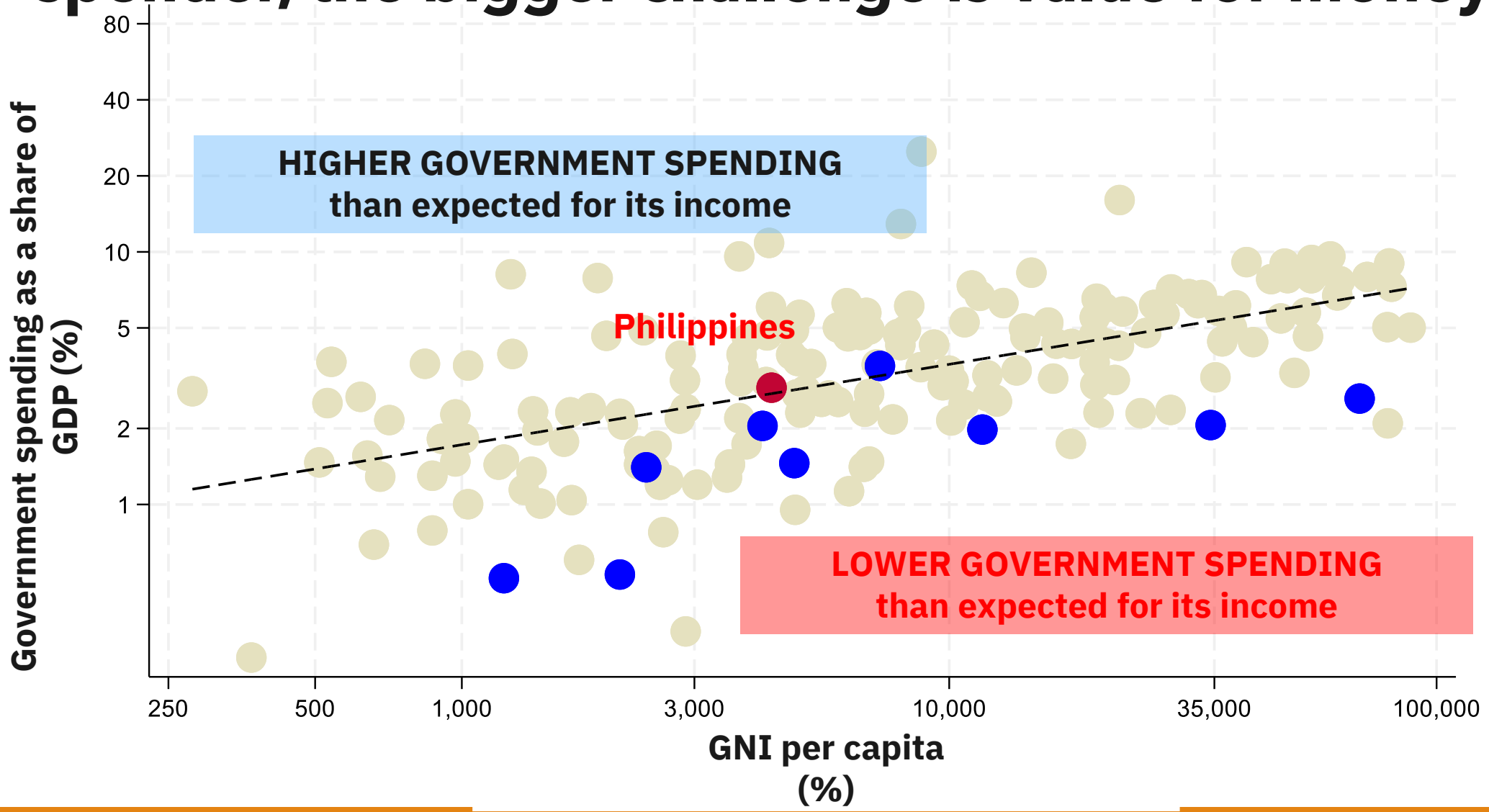
Source: HEFP Analysis of PHIC data

- Aggressive expansion of Primary Healthcare Services and drug benefit (YAKAP and GAMOT) and other benefits.
- Zero Balance Billing
- Doubling of ACR Tariff Rates
- Others

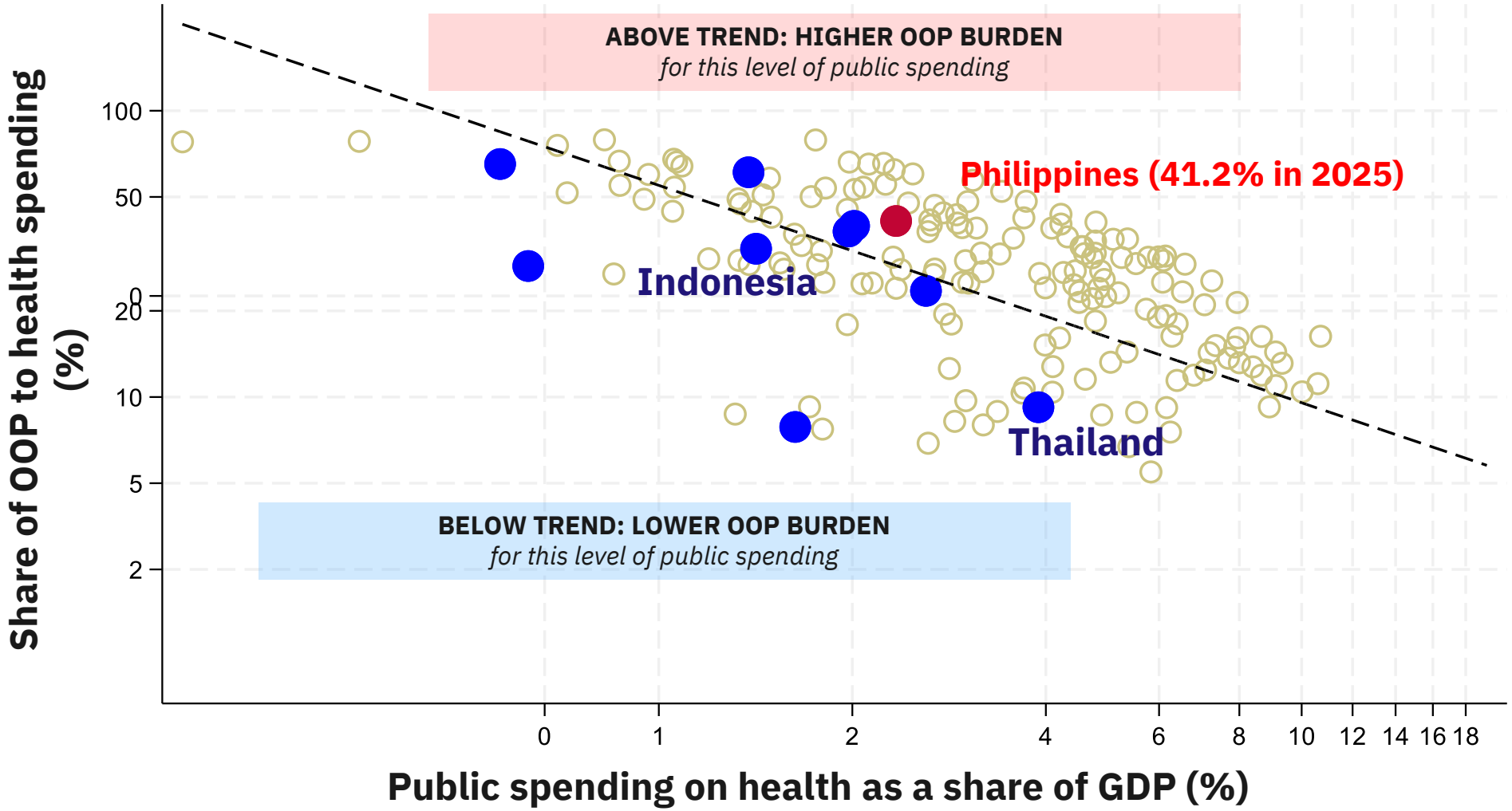
THE NEXT QUESTION IS NOT ONLY HOW MUCH WE SPEND, BUT HOW WELL

More government spending on health has not translated into commensurate improvements in health outcomes and financial risk protection.

For its income level, the Philippines is not a low health spender, the bigger challenge is value for money.



But the Philippines OOP burden remains high for its level of government spending.



Out of pocket as a share of health spending

2020
44.6%

2024
44.5%

2025
41.2%

Two major sources of inefficiency

1 Fragmented financing

Fragmentation blurs incentives and creates duplication and waste.

Multiple funding streams pay for care differently and do not always work toward the same goals.

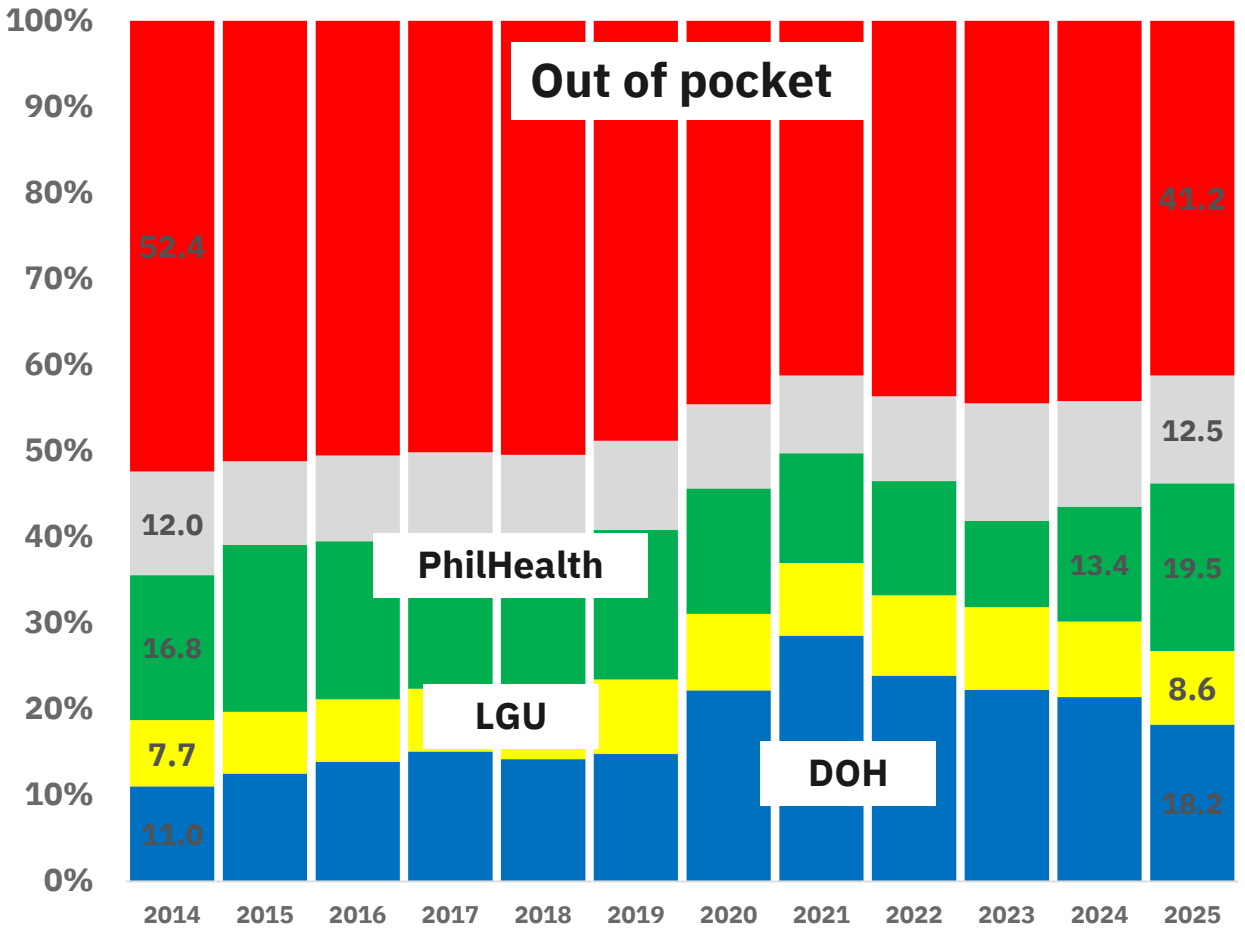
2 Wrong mix of services

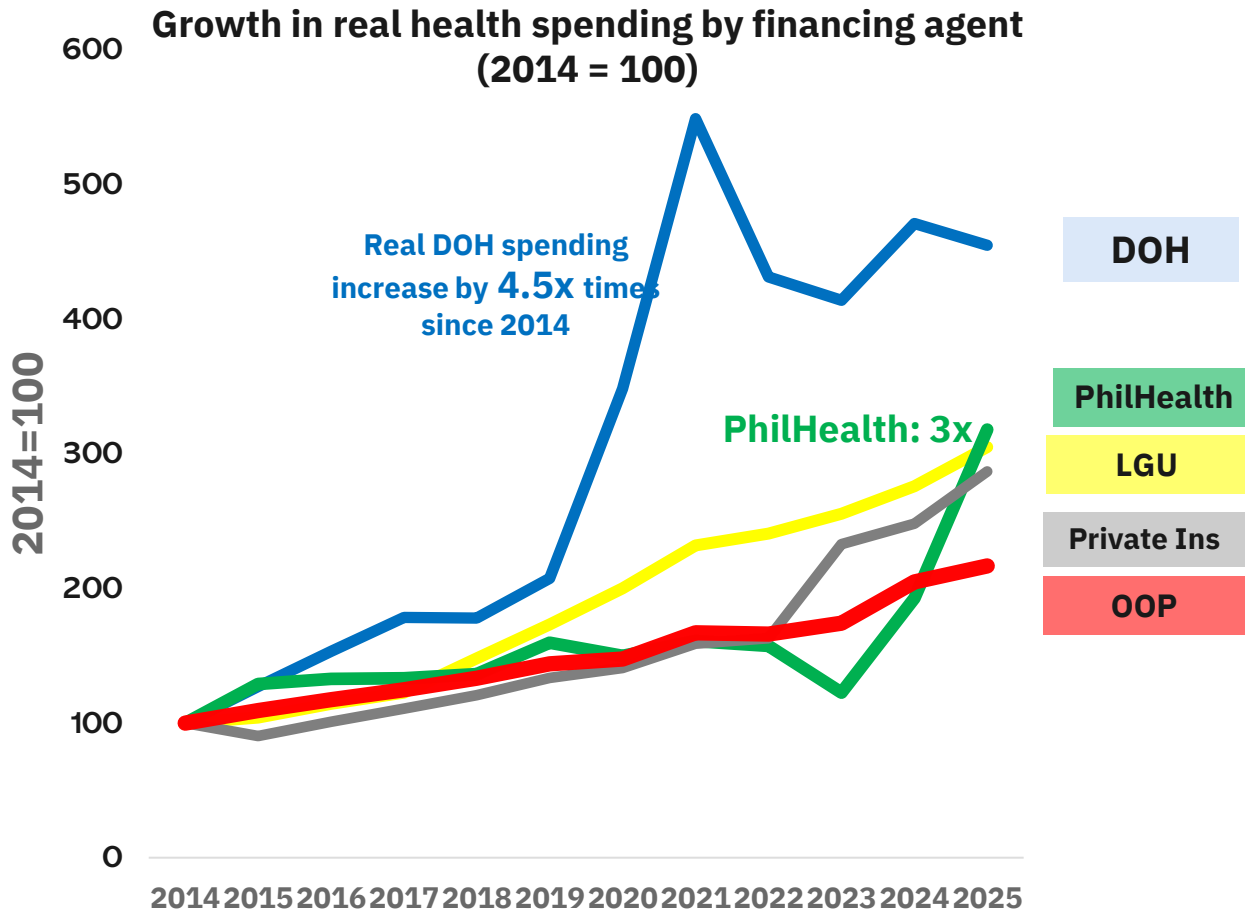
Resources do not always flow to the services that deliver the greatest health gains.

Too much can go to costly downstream care, while prevention, primary care, and other high-value services remain underfunded.

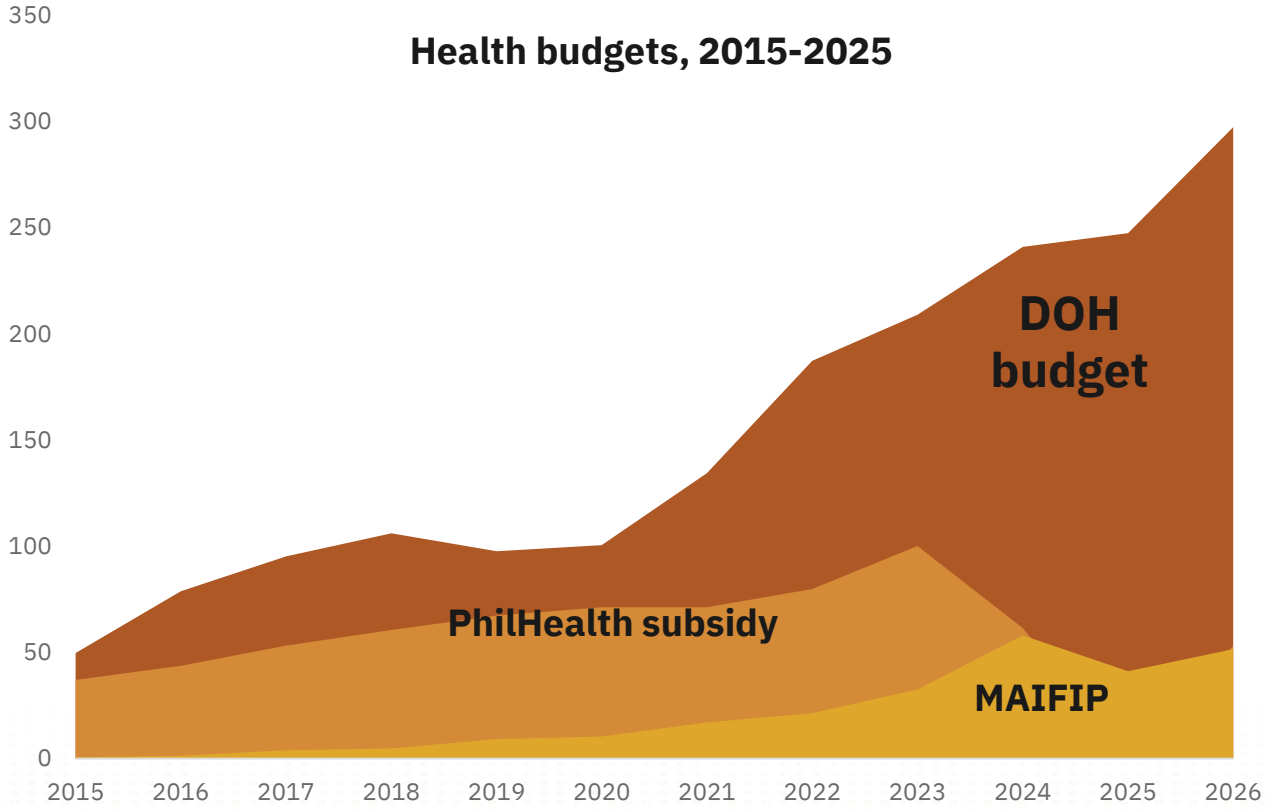
Spend better = organize and purchase resources better + invest in the right services

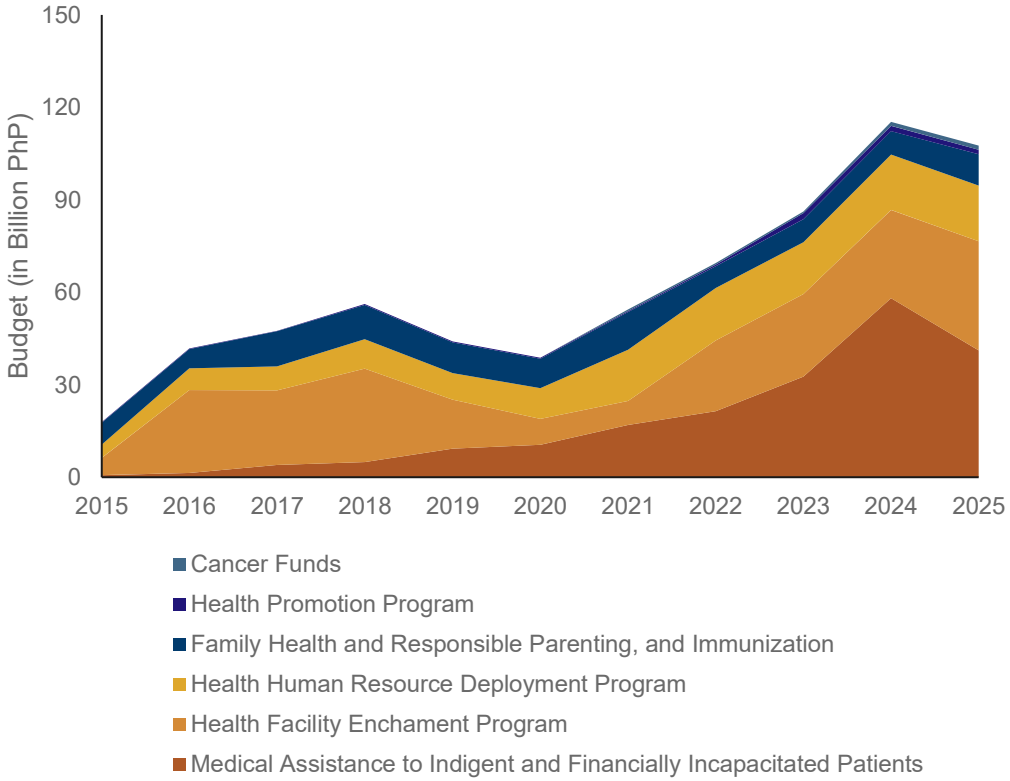
Public financing has expanded unevenly. Driven largely by central government spending, with slower LGU growth and PhilHealth only recently catching up only in 2025.





The paradox: despite decentralization and PhilHealth's intended role as the main purchaser, DOH continues to play a large direct role in financing health services.





Delivery is decentralized and PhilHealth is the intended purchaser, yet national financing still spans facilities, HRH, commodities, operating support and medical assistance.

MAIFIP beneficiaries have higher hospital charges, even after propensity score matching to address possible bias/confounding.

Difference in total hospital charges (in PESO) using 2026 PHIC data

DENGUE

+ ₱6,999

higher charges among MAIFIP patients

ATT after matching

Bill among MAIFIP: 38,929

LAPAROSCOPIC CHOLECYSTECTOMY

+ ₱24,888

higher charges among MAIFIP patients

ATT after matching

Bill among MAIFIP: 194,606

Why this matters for financing design?

- Matching (PSM) narrows the gap in hospital bill between patient with MAIIFP and non-MAIFIP, but it remains positive and statistically significant.
- For laparoscopic cholecystectomy, the estimated gap becomes larger after PSM.
- This raises a policy question: does assistance simply fill a financing gap can it also affect what hospitals charge?

The issue is not only how much MAIFIP pays, but what role it should play alongside PhilHealth and hospital budgets.

Note: ATT = average treatment effect on the treated from propensity-score matching. Results show an adjusted association; interpretation should consider remaining unobserved differences.

Higher reimbursement alone may not be enough to lower hospital bills and strengthen financial protection.

A second signal: hospital service prices continued to rise as PhilHealth substantially increased benefit rates.

What changed?

+50% increase in ACRs January 2025

What did PIDS-HEFP examine?

- Hospital charges for 187 common services / DRGs from 2023–2025.
- Laspeyres price index using a fixed basket of common hospital services.

Estimated hospital service price index

2023 = 100

2023	2024	2025
100	111.5	133.3
Base year	+11.5% YoY	+19.6% YoY

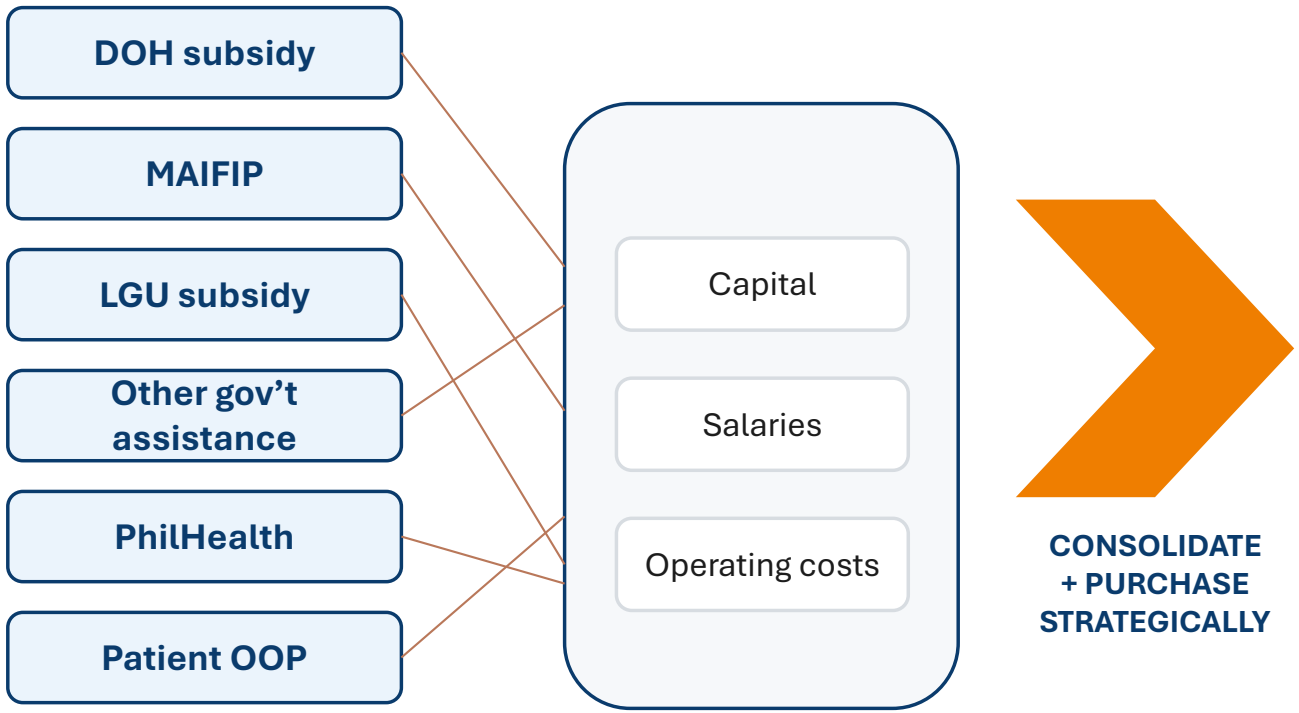
In 2025, higher PhilHealth reimbursement occurred alongside continued growth in hospital service prices.

This raises a broader question: how can multiple financing streams work together so additional public spending translates into lower costs for patients?

Source: PIDS-HEFP estimation; approach informed by Cooper et al. (2020).

Hospital financing is fragmented across multiple funding stream; consolidation can create clearer incentives and accountability.

TODAY: FRAGMENTED FINANCING



Multiple payers • Overlapping purposes
Different rules • Weak accountability for total cost

CONSOLIDATE + PURCHASE STRATEGICALLY

FUTURE: CLEARER FINANCING ROLES

1 CAPITAL
DOH / LGU → infrastructure & major capital investment

2 HEALTH SERVICES
PhilHealth as principal purchaser
DRG / Global Budget → operating costs + provider payment

3 TARGETED SUPPORT
MAIFIP / government → clearly defined gaps, services or populations

Patients → progressively lower OOP

The goal is not to eliminate every funding source, but to clarify roles and align incentives around a coherent purchasing system.

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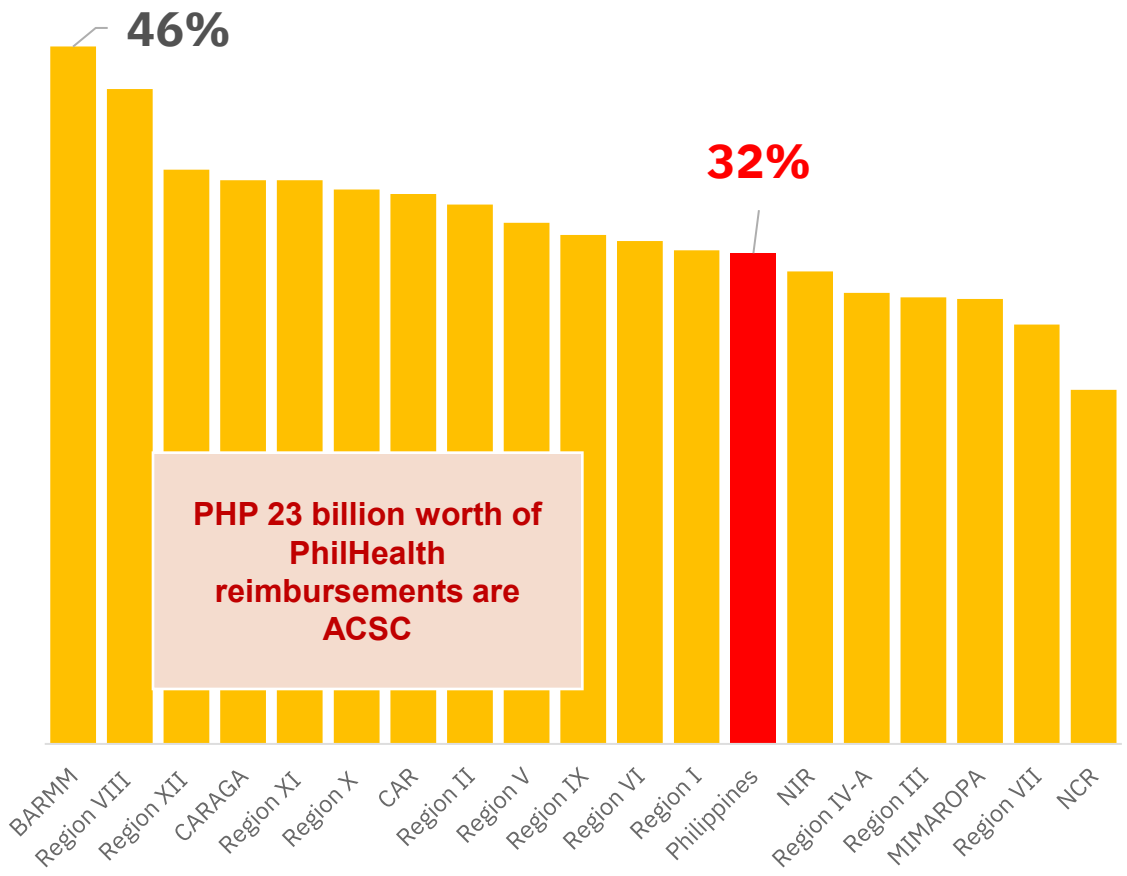
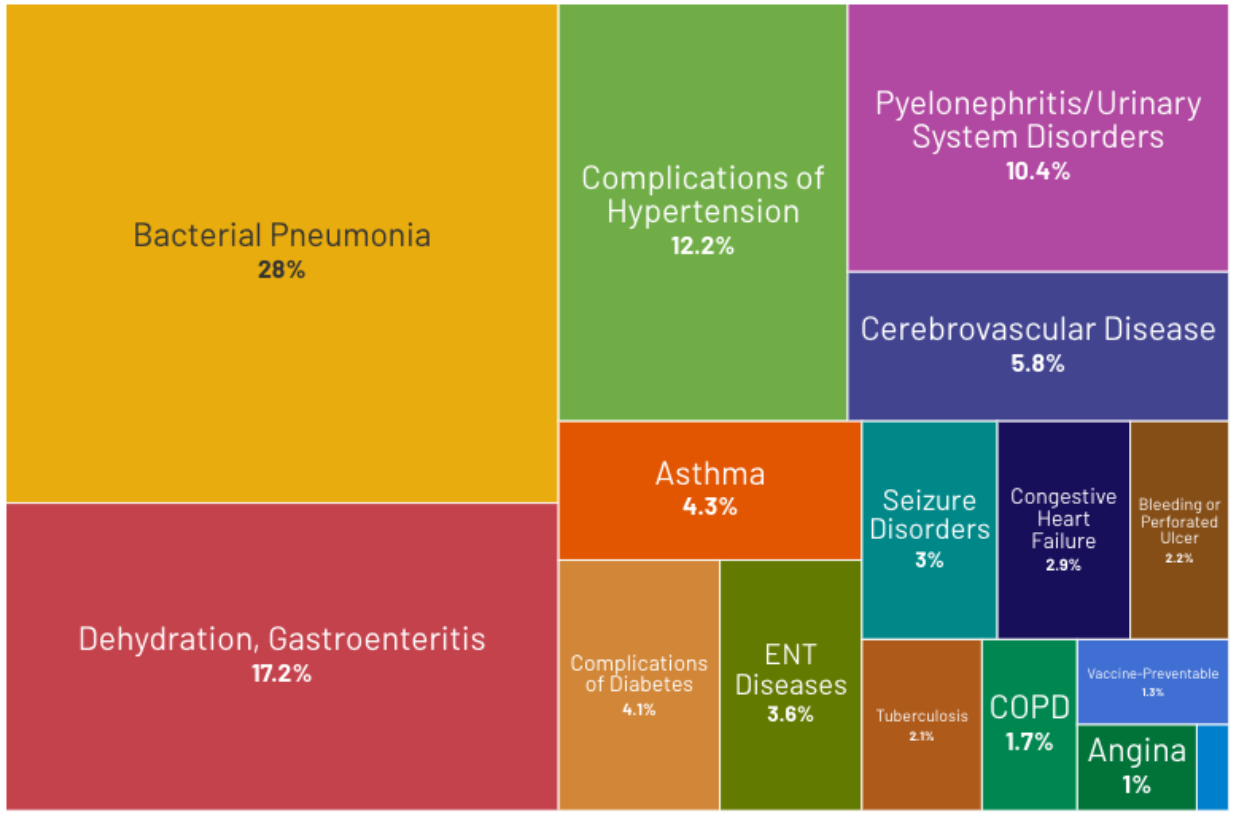
Spend better = organize and purchase resources better + invest in the right services

Nearly one-third of inpatient claims are for conditions potentially avoidable through effective PHC.

Percentage ACSC Claims to Total Inpatient Claims



ACSC Categories



A small share of patients accounts for a large share of healthcare charges

High-cost use is concentrated, and much of it is linked to NCDs, strengthening the case for earlier prevention and better purchasing

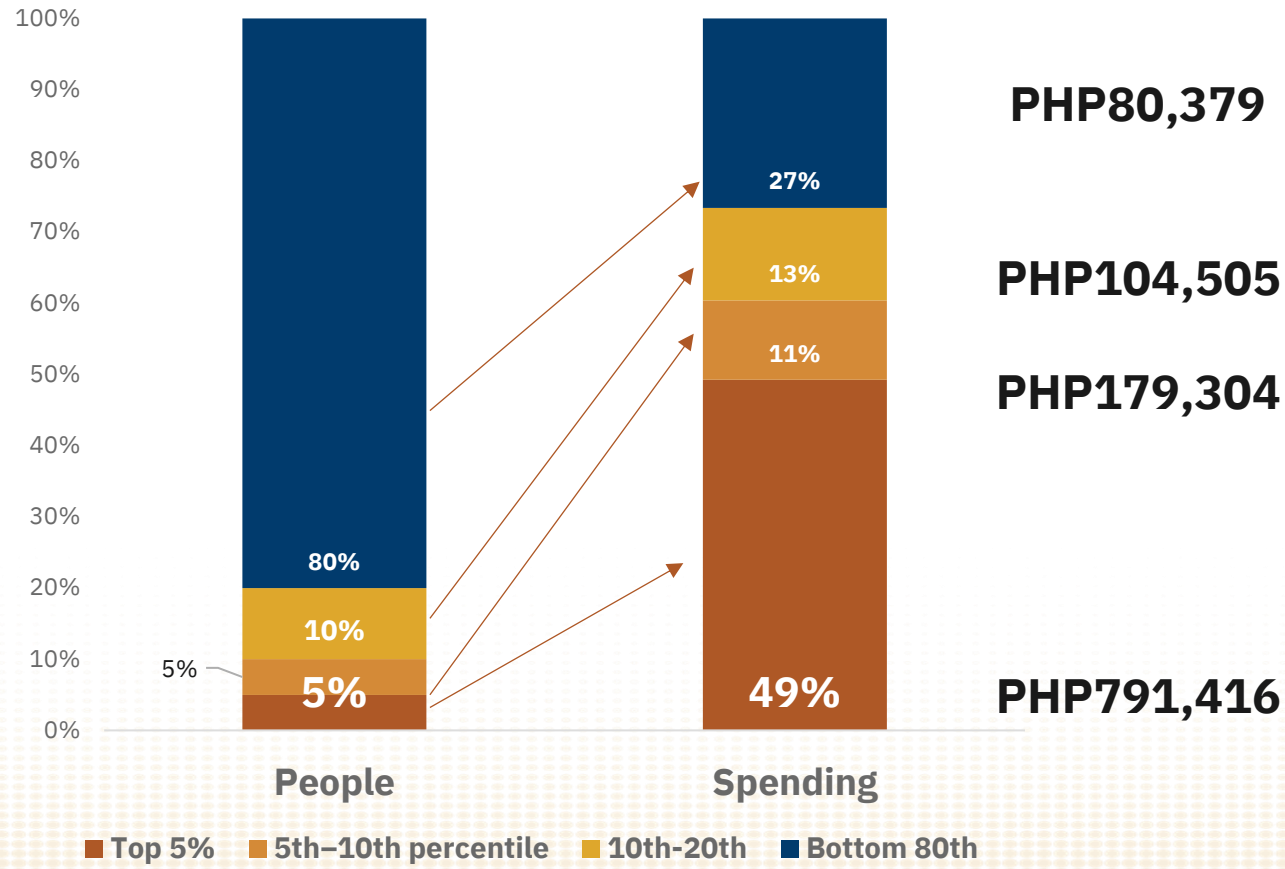
What this means for policy

1. ❑ **Strengthen PHC**

   Identify risk earlier and prevent avoidable progression of NCDs.

2. ❑ **Reform provider payment**

   Reward prevention, continuity and efficient management, not only more treatment.

3. ❑ **Use health information**

   Find high-risk patients early and track utilization across the care pathway.