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Medical Assistance to Indigent and Financially Incapacitated Patients (MAIFIP): A Health System's Program Review

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Abstract

Aim: This study aimed to evaluate the effectiveness, implementation challenges, and sustainability of the Medical Assistance to Indigent and Financially Incapacitated Patients (MAIFIP) Program in the Philippines, which serves as a financial safety net complementing PhilHealth and advancing the goals of Universal Health Care (UHC).

Methodology: A qualitative research design was employed, drawing on 50 interviews with indigent patients, 8 interviews with policymakers and program implementers, and a review of relevant policy documents. Data were thematically analyzed to examine program responsiveness, financial relief mechanisms, and integration with broader health systems.

Findings: The program was perceived as valuable in reducing hospitalization costs and minimizing financial hardship among indigent patients. However, its implementation faced constraints including slow fund disbursement, inconsistent leadership, fragmented coordination with other health programs, and limited outpatient coverage. Concerns over politicized allocation of funds and weak monitoring systems further limited long-term sustainability.

Conclusion: Beyond its practical role in bridging the gaps left by PhilHealth, the MAIFIP Program offers broader policy insights into how social protection mechanisms can enhance equity in healthcare access. The study contributes to health policy discourse by highlighting the importance of adaptive capacity, digital integration, and citizen-centered governance in ensuring program sustainability. These insights extend the theoretical understanding of public value creation in health systems and provide actionable guidance for reform aligned with UHC objectives.

Keywords: *Medical Assistance Program, Universal Health Care, Health Policy, Public Value*

INTRODUCTION

Public health is not only concerned with preventing and treating disease but is also a collective endeavor grounded in equity, resilience, and the universal right to well-being. In the Philippines, the health system has long been shaped by socioeconomic disparities, geographic inequities, and persistent underfunding. Decentralization under the Local Government Code of 1991 was intended to improve responsiveness but instead created fragmented capacities across local governments, resulting in uneven health outcomes. Despite reforms, millions of indigent and financially incapacitated households continue to face catastrophic out-of-pocket (OOP) healthcare expenses (World Health Organization [WHO], 2018; Department of Health [DOH], 2023).

To address these inequities, the Department of Health (DOH) established the MAIFIP Program in 2023, the culmination of more than two decades of reforms to expand financial protection. From early funding allocations under Republic Act 8174, through the institutionalization of the Medical Health Care Assistance Program (MHCAP) in 2010, and its later integration with Malasakit Centers, MAIFIP Program represented the government's most comprehensive attempt to institutionalize health equity through direct financial support.

The program provides a vital safety net for patients excluded from full Philippine Health Insurance Corporation (PhilHealth) coverage, easing the costs of hospitalization, diagnostics, and medicines. However, challenges such as slow fund disbursement, politicized allocation, complex eligibility rules, and weak monitoring undermine its effectiveness. This highlights a research gap: while MAIFIP Program represents a major step in health financing reform, little empirical evidence exists on how it actually operates in practice, how beneficiaries and implementers experience it, and how sustainable it is within the broader Universal Health Care (UHC) system.

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Accordingly, the objectives of this study are stated early for clarity: (1) to assess the program's role in reducing OOP expenditures, improving access, and influencing health outcomes; (2) to identify obstacles to effective implementation; (3) to evaluate its long-term sustainability; and (4) to recommend strategic directions to enhance its contribution to equitable healthcare.

This study makes three contributions. First, it is among the few comprehensive reviews of MAIFIP Program that triangulates beneficiary experiences, implementer perspectives, and documentary evidence. Second, it introduces the Contextual Adaptive Systems Implementation Theory (CASIT)—a framework merging Systems and Policy Implementation theories within the Philippine governance context—to highlight the creation of public value. Third, and most importantly, this study is different from previous works because it not only documents implementation challenges but also develops a phased policy reform framework and an outcome-based monitoring tool. These contributions extend beyond program evaluation and provide transferrable lessons for strengthening other social health protection schemes in low- and middle-income countries.

By combining the Input–Process–Output–Outcome (IPOO) model with CASIT, the framework captures both the logical sequence of program implementation and the adaptive, contextualized mechanisms through which MAIFIP Program contributes to equitable health service delivery. The findings hold implications for the DOH, PhilHealth, Congress, local governments, and other stakeholders working toward a more equitable and resilient health system.

Review of Related Literature and Studies

Health Systems and Models

Health systems encompass institutions, organizations, and actions aimed at maintaining and improving population health, with effectiveness shaped by governance, financing, and service delivery arrangements (WHO, 2018). The WHO's six building blocks highlight that weaknesses in any one component undermine the entire system. In low- and middle-income countries (LMICs), hybrid structures typically combine features of the Beveridge, Bismarck, and National Health Insurance models, characterized by fragmented pooling, heavy reliance on OOP payments, and targeted subsidies (WHO, 2018). The Philippines exemplifies this hybridity, integrating decentralization, Philippine Health Insurance Corporation (PhilHealth) coverage, and targeted medical assistance programs such as the MAIFIP Program (DOH, 2023).

Healthcare Financing and Equity

Financing shapes equity through mechanisms of resource collection, pooling, and purchasing (International Labour Organization [ILO], 2021). OOP payments remain regressive, discouraging service utilization and exacerbating financial hardship among disadvantaged populations. Although PhilHealth expanded coverage, gaps persist, especially for the poor and informal workers (Philippine Health Insurance Corporation [PHIC], 2025). MAIFIP Program emerged to fill these financing gaps, yet its effectiveness has been constrained by fragmented funding streams and dependence on annual appropriations.

Healthcare Inequities

Globally, inequities persist due to geographic, financial, and sociocultural barriers, disproportionately affecting rural and marginalized populations (WHO, 2018). In the Philippines, high OOP spending continues to deepen poverty among vulnerable households (Philippine Institute for Development Studies [PIDS], 2025). Programs such as MAIFIP Program aim to reduce these inequities by providing direct financial support, though challenges in coverage scope and fund allocation remain (DOH, 2023).

Social Health Protection and Universal Health Coverage

Social Health Protection (SHP) initiatives reduce financial barriers through risk pooling and subsidies for vulnerable groups (ILO, 2021). Integrated within Universal Health Coverage (UHC), SHP enhances equity and resilience, as shown in Thailand's Universal Coverage Scheme and Indonesia's Jaminan Kesehatan Nasional (Tangcharoensathien et al., 2011). In the Philippines, MAIFIP Program complements UHC objectives but remains administratively fragmented and fiscally uncertain (DOH, 2023).

Comparative Insights from Southeast Asia

Thailand's Universal Coverage Scheme significantly reduced catastrophic expenditures through tax financing and rural health system investments (Tangcharoensathien et al., 2011). Indonesia's Jaminan Kesehatan Nasional

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expanded coverage to over 230 million citizens but struggled with fiscal deficits and inequitable service access. Vietnam's Social Health Insurance surpassed 88% population coverage through national pooling and targeted subsidies (Le et al., 2020). Compared to these programs, MAIFIP Program remains reactive, fragmented, and heavily dependent on annual budget allocations, underscoring its fiscal vulnerability (DOH, 2023; WHO, 2018).

Operational and Sustainability Challenges

Implementation of SHP programs often encounters inefficiencies such as weak beneficiary identification, delays in fund disbursement, and poor monitoring systems. In the Philippines, despite ongoing health information system reforms, persistent issues with data quality, interoperability, and cybersecurity have undermined effective monitoring (Chung et al., 2025). These operational weaknesses intersect with fiscal constraints, as identified in the 2023–2028 Health Care Financing Strategy, which highlighted overlapping financing roles, weak incentives for integration, and fragmented pooling across local governments (P4H Philippines, 2023). The growing burden of non-communicable diseases, population aging, and budgetary caps on primary health care further threaten the sustainability of programs like MAIFIP Program (Pepito et al., 2025).

Synthesis

The reviewed literature provides three insights. First, financing remains central to achieving equity, yet reliance on OOP spending continues to burden LMICs. Second, Southeast Asian experiences demonstrate that sustained financing, national pooling, and strong governance are critical to reducing catastrophic health expenditures. Third, while the Philippines has expanded coverage through PhilHealth and MAIFIP Program, persistent fragmentation, weak monitoring, and fiscal uncertainty continue to constrain their impact. Crucially, although MAIFIP Program is embedded within UHC reforms, there is limited empirical evidence on its actual effectiveness, long-term sustainability, and adaptive capacity. This study addresses that gap by triangulating perspectives of beneficiaries, implementers, and policy documents, applying the CASIT, and offering evidence-based policy recommendations. This study is different from previous works because it not only evaluates financial and equity impacts but also integrates a contextual governance framework to highlight adaptive capacity and public value creation.

Theoretical Framework

This study was guided by Systems Theory and Policy Implementation Theory, providing a multi-level lens to analyze the MAIFIP Program.

Systems Theory, originally advanced by von Bertalanffy and Sutherland (1974), posits that organizations or programs function as dynamic, interconnected systems composed of inputs, processes, and outputs, where changes in one component influence the whole. Feedback loops, adaptability, and interdependence are central to this perspective, emphasizing holistic coordination and resilience (Gadsby and Wilding, 2024; Silburn, 2025). In the context of MAIFIP Program, the program is viewed as a system linking the DOH, local government units (LGUs), healthcare providers, and patients. Disruptions such as delayed fund releases, inadequate infrastructure, or weak communication channels can therefore affect the entire service delivery chain. Systems Theory underscores multiple potential pathways to achieve program goals—such as direct subsidies, PhilHealth integration, or telemedicine innovations—while situating the program within broader political, demographic, and social determinants.

Policy Implementation Theory, building on the foundational work of Pressman and Wildavsky (1973), focuses on how policies are translated into practice, emphasizing the role of implementing agencies, frontline workers, and institutional capacity. It acknowledges the discretion of "street-level bureaucrats" and the potential fragmentation that arises during implementation, while recognizing the importance of political and fiscal support (Mériade et al., 2023). For MAIFIP Program, this theory illuminates how program implementation depends on the capacity of local hospitals and LGUs, the discretion of frontline staff in assessing eligibility, and the continuity of funding and political backing. Feedback mechanisms such as grievance systems and community consultations allow for program refinement, though their application remains uneven (Han, 2021).

These two theories were selected because they provide complementary insights: Systems Theory frames MAIFIP Program's macro-level interdependencies across institutions and resources, while Policy Implementation Theory sheds light on micro-level operational dynamics and frontline discretion. Alternative frameworks such as Governance Theory or the Policy Analysis Triangle (Walt & Gilson, 1994) were considered but deemed less suited for capturing the program's combined systemic and implementation-specific challenges. Thus, the chosen theories align most directly with the study's objectives of evaluating effectiveness, challenges, and sustainability.

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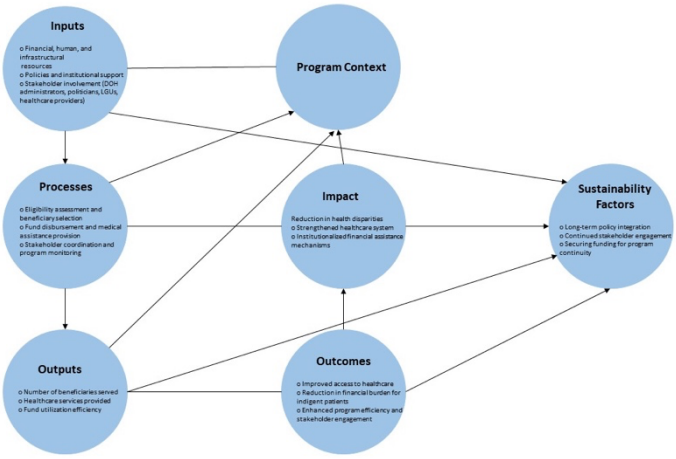
By integrating Systems Theory and Policy Implementation Theory, this study captures both the macro-level structures and micro-level processes of MAIFIP Program, enabling a holistic understanding of its performance, challenges, and areas for improvement.

Conceptual Framework

This study employed the Input–Process–Output–Outcome (IPOO) framework as a structured lens to analyze the implementation of MAIFIP Program. The IPOO model traces the flow from inputs (resources, policies, and institutional arrangements) to processes (service delivery and coordination), outputs (patients served, funds disbursed), and outcomes (financial risk protection, equitable access, and trust in public health systems).

Figure 1. Conceptual Framework of the Study



To address the limitations of the linear IPOO model, this study integrated the CASIT, developed as an original theoretical contribution of this research. CASIT emphasizes adaptiveness, public value orientation, and feedback-driven governance. Its components—Implementation-as-Adaptation, Public Value Orientation, Feedback-Driven Governance, and Cross-Scale Negotiation—offer an expanded view of how programs adapt and sustain effectiveness in complex environments. While informed by systems thinking and implementation literature, CASIT is explicitly advanced here as a novel conceptual tool tailored to the MAIFIP Program context, thereby extending existing theoretical approaches and contributing to the academic discourse on health program implementation.

Within inputs, CASIT highlights that resources and mandates are shaped by multi-level negotiations among national, regional, and local actors. Processes involve adaptive service delivery, where frontline staff exercise discretion to overcome bureaucratic delays and resource gaps. Outputs are evaluated not only quantitatively but also through CASIT's public value lens, which emphasizes fairness, legitimacy, and equity. Outcomes reflect long-term effects on financial protection and health equity, strengthened by participatory monitoring and grievance redress mechanisms.

By combining IPOO with CASIT, the framework captures both the logical sequence of program implementation and the adaptive, feedback-oriented, and cross-scale dynamics of MAIFIP Program. This dual framework directly maps onto the study's objectives: (a) assessing effectiveness through IPOO outcomes and CASIT's public value lens, (b) identifying implementation challenges through IPOO processes and CASIT's adaptation lens, and (c) evaluating sustainability through cross-scale negotiation and feedback mechanisms.

Figure 1 presents the integrated framework, with IPOO as the backbone and CASIT overlaying each stage, framed within Systems Theory (macro-level interdependencies) and Policy Implementation Theory (micro-level processes). This diagram illustrates how theories and frameworks converge to support the study's objectives and methods.

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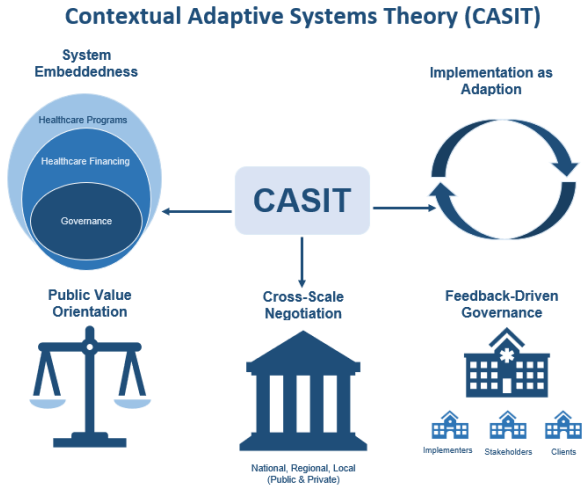
Figure 2. Contextual Adaptive Systems Theory



Statement of the Problem

The MAIFIP Program was designed to provide financial risk protection, reduce OOP expenditures, and expand healthcare access for vulnerable populations. However, despite these intentions, its actual effectiveness in achieving these goals—particularly in improving beneficiary experiences and health outcomes—remains insufficiently studied. Persistent challenges such as financial constraints, evolving healthcare needs, limited institutional capacity, and vulnerability to leadership or policy shifts further threaten both proper implementation and long-term sustainability. This evidence gap underscores the need for a systematic evaluation that examines not only the program's direct impacts but also the contextual barriers shaping its performance and viability.

Research Objectives

To comprehensively evaluate the effectiveness, implementation challenges, and long-term sustainability of the MAIFIP Program in reducing financial burden and improving equitable healthcare access. Specifically, the study aimed to:

1. To assess the program's effectiveness in reducing OOP healthcare expenditures, improving healthcare access, and addressing the service needs of indigent patients.
2. To identify key challenges affecting program implementation, including financial, institutional, and governance-related barriers.
3. To evaluate the sustainability of the program in the context of leadership transitions, fiscal constraints, policy shifts, and evolving healthcare needs.
4. To develop strategic policy recommendations that enhance service delivery and strengthen MAIFIP Program's long-term viability.

Research Questions

1. What is the effectiveness of the MAIFIP Program in terms of:
    - Reducing OOP healthcare expenses?
    - Improving healthcare access and utilization among indigent patients?
    - Addressing the service needs of beneficiaries?
    - (Optional, if feasible) Contributing to improved health outcomes?
2. What are the primary challenges that hinder the effective implementation of the MAIFIP Program?
3. What factors influence the program's long-term sustainability, particularly with respect to leadership, financing, policy continuity, and responsiveness to evolving healthcare needs?
4. What strategic policy directions can be recommended to strengthen the MAIFIP Program's performance and long-term impact on equitable healthcare?

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METHODS

Research Design

This study employed a qualitative exploratory design within a constructivist paradigm to examine the implementation and impact of the MAIFIP Program. This design was most appropriate because little was previously known about how MAIFIP is experienced across institutional and community levels, and it allowed the researcher to capture the lived realities of policymakers, implementers, and beneficiaries within a complex and evolving health system. The constructivist paradigm was further suited to the study because it emphasized understanding multiple stakeholder perspectives and interpretations of program value and implementation.

Population and Sampling and Other Sources of Data

This study engaged a diverse set of participants and data sources to capture multiple perspectives on the implementation and impact of the MAIFIP Program.

Sampling Technique. Purposive sampling was employed to include individuals with substantial knowledge and direct experience of MAIFIP Program. This allowed the deliberate selection of participants capable of providing rich and contextually grounded insights. Diversity in roles, institutional levels, and geographic contexts was emphasized to capture variations in implementation. Data collection proceeded until saturation was reached, with no new significant themes emerging.

Participants. A total of 50 indigent or financially incapacitated patients who had received MAIFIP Program support for medical procedures, medicines, or professional fees were interviewed. To capture institutional perspectives, officials from the Department of Health–Malasakit Program Office (DOH-MPO) were engaged, including the Director or a designated representative and Division Chiefs. One official from the DOH Health Policy Development and Planning Bureau (HPDPB) participated to provide a policy perspective. Program managers from the Center for Health Development (CHD) in Metro Manila, CHD MIMAROPA, CHD Central Visayas, and the Vicente Sotto Memorial Medical Center were also interviewed to reflect regional and hospital-level implementation.

Other Sources of Data. Complementary sources included policy documents, administrative orders, implementation reports, and program guidelines issued by the Department of Health and partner institutions. Participant observation was also conducted at a Malasakit Program Office for non-consecutive days, focusing on workflows, staff-client interactions, and administrative processes.

Instruments

Data were gathered using semi-structured interview guides for both beneficiaries and key informants, developed through a review of literature, expert validation, and pilot testing. The interview guides covered domains such as access to services, out-of-pocket expenditures, perceived benefits and challenges, and sustainability concerns**.** A document analysis guide was also used to systematically review program-related policies and reports.

Validation. The instruments were validated by two professionals: (1) a Division Chief from the DOH-MPO, and (2) the dissertation adviser, a Doctor in Public Administration. Their expertise ensured contextual appropriateness and academic rigor**.** Pilot testing further enhanced clarity and cultural sensitivity. Triangulation across data sources (beneficiaries, officials, and documents) strengthened trustworthiness.

Data Collection

Data collection occurred from May 2024 to June 2025 in Metro Manila, MIMAROPA, and Central Visayas, capturing urban, rural, and remote contexts. Key Informant Interviews lasted between 45–60 minutes and were conducted either face-to-face or online, with participant consent for audio recording. Selection of MAIFIP Program beneficiaries was coordinated appropriate offices, who assisted in reaching patients that had availed of program services., while officials were formally invited through letters of request. Field observation and document review were conducted alongside interviews. Data collection across regions was done sequentially.

Treatment of Data

Interview data were transcribed verbatim and analyzed using thematic analysis. Codes were generated inductively from transcripts and then compared against program documents to identify convergence and divergence. Data coding was conducted manually without the use of specialized software**,** while constant comparison techniques allowed refinement of themes. Selected responses were quantified where necessary to illustrate emerging trends. Triangulation across interviews, observations, and documents further ensured credibility and consistency.

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Ethical Considerations

Ethical approval was obtained from the Polytechnic University of the Philippines Ethics Review Board. Informed consent was obtained in English or Filipino, with provisions for illiterate participants (verbal consent done). Participation was strictly voluntary, and confidentiality was upheld through anonymization of identifiers. All data were securely stored in accordance with the Data Privacy Act of 2012.

RESULTS and DISCUSSION

1. Perceived Value and Benefits of the MAIFIP Program (RQ1)

The MAIFIP Program served as a vital safety net that eased financial hardship, improved access to services, and supported treatment completion among indigent patients.

1.1. Reduced Out-of-Pocket Expenses

The program significantly lowered costs by covering hospital charges not paid by PhilHealth. Still, professional fees and non-formulary drugs required out-of-pocket spending.

> ***Recipient 9: "Lahat po ng bayarin sa laboratory at operasyon ay sagot ng MAIFIP Program, kaya halos wala po akong inilabas na pera."***
> (All laboratory and operation expenses were covered by the MAIFIP Program, so I almost did not spend any money.)
> ***Recipient 14: "Nakatanggap po ako ng full assistance sa bayad sa operasyon at laboratoryo. Dahil dito, hindi na po kami nangutang sa ibang tao."***
> (I received full assistance for the operation and laboratory expenses. Because of this, we did not borrow money from others.)
> ***Recipient 15: "Hindi po lahat ng gamot ay naibigay, kaya may out-of-pocket pa rin kami."***
> (Not all medicines were provided, so we still had out-of-pocket expenses.)

These accounts illustrate both the protective value of the program and its limitations, consistent with evidence that social health protection schemes in low- and middle-income countries (LMICs) often leave gaps, particularly for medicines and provider fees (Kodali, 2023; Moezzi et al., 2024).

1.2. Improved Access and Utilization

By removing financial barriers, MAIFIP Program expanded utilization. Coverage rose from 1.4 million in 2018 to 4.5 million in 2023. Malasakit Centers simplified requirements:

> ***Recipient 4: "Mas mabilis na po ang proseso at tinulungan po ako ng staff na maglakad ng requirements."***
> (The process became faster, and the staff assisted me with the requirements.)

Despite ₱15.22 billion reimbursed in 2023, bottlenecks persisted. Patients cited long queues and strict requirements, and regional inequities limited reach, especially in BARMM and MIMAROPA.

> ***KII Respondent 2: "We were overwhelmed—demand kept growing, but staffing and supply chains could not always keep up."***
> ***Recipient 23: "Sana po ay tunay na maparating ang tulong sa lahat, hindi lang sa may kakilala."***
> (Hopefully, the support truly reaches everyone, not only those with connections.)

These concerns parallel recent findings on administrative bottlenecks and inequitable access in Philippine indigent health financing programs (Serafica et al., 2024; Moezzi et al., 2024).

1.3. Perceived Health Outcomes

Beneficiaries reported improved recovery and uninterrupted treatment. However, outcomes were not systematically tracked.

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Recipient 49: "Gumaan po ang pakiramdam ko at unti-unting bumalik ang dating lakas."
(I felt better, and my strength gradually returned.)
Recipient 30: "Hindi na po nila kailangang ipagpaliban ang gamutan dahil sa gastos."
(They no longer needed to postpone treatment due to expenses.)
***KII Respondent 5*: "We were spending more on healthcare, but it was not yet clear if people were getting healthier."**

The disjuncture between financial protection and measurable health gains is echoed in UHC literature, which highlights weak outcome monitoring as a major challenge in LMICs (Yanful et al., 2023). Overall, MAIFIP Program substantially reduced costs, expanded service use, and supported treatment completion, making it the most comprehensive safety net for indigent patients. Yet, exclusions, regional disparities, and weak outcome monitoring limited its long-term impact.

2. Implementation Challenges (RQ2)

The MAIFIP Program acted as an important financial safety net, but beneficiaries and implementers reported operational, regulatory, political, and sociocultural barriers. Seven major challenges emerged.

2.1. Lack of Awareness.

Information gaps limited program reach, particularly for new patients and those in remote areas. Beneficiaries often learned about MAIFIP Program only after being hospitalized, delaying assistance and increasing stress. Similar knowledge gaps are documented in Philippine studies on healthcare access, where awareness influences timely utilization (Kawi et al., 2024).

Recipient 25: "Yung una po, hindi ko alam na may ganitong programa kaya nahuli ako sa pag-apply."
(At first, I did not know about this program, so I was delayed in applying.)

2.2. Administrative Barriers.

Long queues, repeated documentary requirements, and delays discouraged access, especially during emergencies. Although Malasakit Centers centralized services, understaffing and rigid processes slowed delivery. This reflects evidence of administrative burden as a universal barrier to healthcare access in LMICs (Lilford et al., 2025).

Recipient 26: "Napakahaba ng proseso, paulit-ulit ang requirements kahit emergency na."
(The process was too long, and requirements were repetitive even during emergencies.)

2.3. Financial Constraints.

While MAIFIP Program received large allocations, funds were unevenly distributed and sometimes depleted before month-end. This created inequities, with patients in high-volume hospitals more likely to experience funding shortages.

Recipient 17: "...ubos na raw ang pondo para sa buwan na 'yon."
(The fund for that month was already depleted.)

2.4. Policy and Regulatory Issues.

Benefit limitations prevented full protection. Professional fees and non-formulary medicines were often excluded, forcing patients to pay out of pocket despite MAIFIP Program support.

Recipient 22: "...hindi po nasaklaw ang mga gamot na kailangan ko."
(The medicines I needed were not covered.)

2.5. Political Influence.

Several respondents noted that personal connections and endorsements sometimes influenced prioritization, raising concerns about fairness and transparency in assistance distribution.

Recipient 10: "Priority ang may endorsement ng politiko."
(Those with political endorsements were prioritized.)

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2.6. Monitoring and Evaluation.

Current reporting focused on budget utilization and the number of patients served, with little attention to outcomes such as recovery or long-term health improvements. This limited evidence for policy refinement.

Recipient 18: "...parang wala namang record na pinanghahawakan pagbalik namin."

(It seemed there was no record to rely on when we returned.)

2.7. Sociocultural Barriers.

Deep-seated mistrust, hesitancy to ask for help, and cultural practices shaped patient behavior. Some delayed seeking care due to pride or fear of indebtedness, reducing the program's reach. These sociocultural constraints are consistent with Southeast Asian studies showing that shame and mistrust inhibit service use (Luu et al., 2022).

Recipient 27: "Inuna ko po ang gamutan ng anak ko... Nahihiya rin po akong humingi ng tulong."

(I prioritized my child's treatment… I also felt shy to ask for help.)

Overall, while MAIFIP Program significantly reduced out-of-pocket spending, these operational gaps constrained its ability to deliver equitable protection. From a CASIT perspective, the program adapted to systemic weaknesses but required reforms in benefit integration, policy adjustments, governance, and culturally responsive implementation to strengthen its impact.

3. MAIFIP Program Sustainability (RQ3)

The long-term sustainability of the MAIFIP Program depended on leadership stability, financial resilience, coherent policies, and responsiveness to shifting health needs. Respondents acknowledged its vital role in financial protection but stressed that reforms were necessary to ensure its continuity.

3.1. Leadership.

Leadership strongly influenced program direction and efficiency. Effective leaders mobilized resources and advocated for policy support.

Recipient 17: "Mas maganda ang takbo ng serbisyo noong panahon na alam ng lider kung ano talaga ang pangangailangan ng mga pasyente."

(Services were better when leaders understood the real needs of patients.)

Recipient 9: "Iba-iba ang sistema bawat taon, depende kung sino ang bago. Minsan okay, minsan malabo."

(The system changed yearly depending on new leadership—sometimes effective, sometimes unclear.)

Recipient 31: "Kung maayos ang palitan ng pamunuan, tuloy-tuloy sana ang serbisyo."

(If leadership transitions were smooth, services would have continued without interruption.)

These accounts illustrated how leadership instability disrupted operations, weakened institutional memory, and hindered policy coherence. Leadership turnover weakened institutional memory and disrupted service flow—an issue widely noted in governance research (Kruk et al., 2018; Lilford et al., 2025).

3.2. **Financial Constraints.**

Allocations under the General Appropriations Act sustained the program, but rising costs and a growing indigent population strained funds. Respondents emphasized that delays in disbursement posed greater challenges than the size of the budget.

Recipient 25: "Matagal po ang proseso minsan kasi walang nakakaalam agad ng dating ginagawa."

(The process often took too long because no one immediately knew what the previous system had implemented.)

Reliance on congressional approval also exposed the program to political shifts. Respondents suggested diversified financing through partnerships with PhilHealth, private hospitals, and pharmaceutical firms to improve resilience.

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3.3. **Policy Changes.**

Frequent revisions in guidelines complicated implementation and reduced predictability. Respondents cited unclear allocation frameworks, shifting eligibility rules, and rigid audit requirements as barriers to timely service delivery. These changes created confusion among both hospitals and beneficiaries, particularly at the local level. From a system view, rigid controls undermined service responsiveness. Digitalization, streamlined compliance, and a medium-term strategic plan were proposed to improve efficiency and stakeholder trust. Frequent guideline revisions reduced predictability and efficiency. Calls for digitalization and streamlined compliance echoed broader LMIC reform trends (Kodali, 2023).

3.4. **Evolving Healthcare Needs.** Rising cases of non-communicable diseases (NCDs) shifted demand toward long-term management rather than acute care.

Recipient 13: "Kapag palit nang palit ang namumuno, pati serbisyo nagkakagulo. Parang paulit-ulit ang proseso."

(When leadership constantly changed, services became disorganized, and processes kept repeating.)

Respondents stressed the need for expanded partnerships with private hospitals, integration with PhilHealth, and preventive care initiatives such as early screening and long-term medication. International models, such as Thailand's Universal Coverage Scheme, demonstrated the importance of embedding treatment and prevention in program design.

In sum, MAIFIP Program's sustainability required stable leadership, adaptive financing, predictable yet flexible policies, and alignment with evolving health needs. Without these reforms, the program risked perpetuating inequities rather than delivering resilient and inclusive protection.

4. Policy Redirection for Improved Performance (RQ4)

Respondents emphasized that the sustainability and long-term impact of the MAIFIP Program could be strengthened not by-passing new legislation but through enabling policies that promote institutional stability, accountability, and responsiveness to local contexts. Leadership instability, weak monitoring, poor communication, systemic fragmentation, geographic inequities, and political favoritism were consistently cited as barriers. From a systems lens, these reflected fragmentation and inefficiency rather than lack of funding or intent, constraining the program's ability to deliver equitable protection.

4.1. Leadership Stability.

Leadership continuity was regarded as a prerequisite for program efficiency and institutional trust.

Recipient 13: "Kapag palit nang palit ang namumuno, pati serbisyo nagkakagulo. Parang paulit-ulit ang proseso."

(When leaders constantly change, services become disorganized and processes keep repeating.)

Recipient 31: "Kung maayos ang palitan ng pamunuan, tuloy-tuloy sana ang serbisyo."

(If leadership transitions were smooth, services would have continued without interruption.)

These testimonies highlighted the disruptive effects of turnover in the Malasakit Program Office and hospital administration. Policies on succession planning, leadership pipelines, and standardized onboarding were seen as essential to maintain coherence. Rwanda's Mutuelles de Santé shows how governance continuity sustains trust even during political shifts.

4.2. Monitoring and Feedback.

Weak monitoring and evaluation (M&E) limited institutional learning and responsiveness.

Recipient 9: "Minsan po, hindi na nakukuhanan ng feedback ang mga pasyente gaya namin kahit tapos na ang gamutan."

(Sometimes, patients like us are not even asked for feedback after treatment is done.)

Recipient 23: "Wala po kaming idea kung napapansin ba yung mga reklamo o suhestiyon naming pasyente."

(We have no idea if our complaints or suggestions are ever noticed.)

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Such gaps reinforced the perception that patients were passive recipients rather than partners in improving care. Respondents called for digital, patient-centered M&E systems, incorporating real-time feedback loops. Thailand's Universal Coverage Scheme provides an example where annual recalibration of services is anchored on continuous user feedback.

4.3. Communication and Public Outreach.
Communication failures, particularly in rural and indigenous areas, undermined program inclusivity.
Recipient 5: "Sa lugar namin, halos walang nakakaalam ng MAIFIP Program."
(In our area, hardly anyone knows about the MAIFIP Program.)

Recipient 8: "Hindi po namin maintindihan yung mga announcement na Tagalog o Ingles."
(We cannot understand the announcements in Tagalog or English.)

These accounts reflected the exclusionary effects of centralized, linguistically uniform messaging. Policies must mandate hyperlocal, culturally adapted information campaigns using barangay health workers and indigenous translators. Ghana's National Health Insurance Scheme improved inclusivity after adopting such strategies.

4.4. Institutional Coordination. Fragmentation between MAIFIP Program, PhilHealth, and LGU programs created duplication and inefficiency.

Recipient 10: "Nag-aapply pa kami ulit kahit may PhilHealth na. Doble trabaho, pareho lang ang impormasyon."
(We still apply again even if we already have PhilHealth. It's double work with the same information.)

Respondents recommended integrated claims processing, shared databases, and harmonized referral protocols. Japan's universal insurance model illustrates the efficiency gains of unified billing and coding platforms across providers.

4.5. Geographic Equity. Access challenges were more pronounced in geographically isolated and disadvantaged areas.

Recipient 12: "Malayo po ang ospital, kailangan pa pong mag-jeep at magtricycle, tapos wala rin akong kasama."
(The hospital is far, I still need to ride a jeep and tricycle, and I also have no companion.)

Distance, cost, and lack of support systems limited program reach. Respondents proposed funding for mobile health units, telemedicine, and LGU-level partnerships. Similar innovations, like Indonesia's floating clinics under Jamkesmas, addressed spatial inequities.

4.6. Transparency and Fairness.
Political favoritism undermined the program's credibility and reinforced perceptions of patronage.
Recipient 17: "May ibang inuuna kasi may kakilala sa opisina. Kami, balik-balik sa pila."
(Some people are prioritized because they know someone in the office. We have to keep lining up again and again.)

Such practices eroded trust and diverted resources away from those in greatest need. Respondents emphasized the importance of anti-corruption safeguards, grievance redress systems, and transparent dashboards to ensure fairness.

Taken together, these findings suggest that policy redirection for MAIFIP Program must focus less on new laws and more on strengthening institutional scaffolding, integrating fragmented systems, and addressing inequities. Leadership pipelines, feedback-driven monitoring, localized communication, interoperable financing, geographic targeting, and transparency safeguards are key to transforming MAIFIP Program from a transactional subsidy into a trusted social contract.

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Conclusions

Based on the findings, the study concludes the following, structured in relation to the research questions:

1. RQ1 (Value): The MAIFIP Program expanded access and reduced OOP costs, embodying the UHC principle that no Filipino should be denied healthcare because of poverty.
2. RQ2 (Challenges): Implementation weaknesses—manual processes, leadership turnover, and inequitable practices—undermined efficiency, fairness, and responsiveness.
3. RQ3 (Sustainability): Fiscal stability alone was insufficient; program resilience required feedback systems, institutionalized leadership, and adaptive governance mechanisms, which were lacking.
4. RQ4 (Policy Redirection): Strategic reform—not replacement—was necessary, emphasizing digitalization, frontline empowerment, localized communication, integration of support systems, and institutionalized fairness.

Viewed through CASIT, the challenge lay less in resource limitations and more in rigidity, weak feedback loops, and poor institutional learning. Unlike other countries' SHP models, MAIFIP Program lacked citizen feedback mechanisms and adaptive governance structures. Thus, success depended less on resources than on MAIFIP Program's capacity to evolve into a resilient, integrated, and citizen-centered program that delivers public value, legitimacy, and equitable care.

Recommendations

To strengthen performance, reach, and long-term impact, the study proposes **SMART-based enabling reforms** aligned with Systems Theory, CASIT, and UHC principles.

1. Strategic Reform Matrix

- **Develop a Strategic Reform Matrix (short- and long-term)** with KPIs such as:
  - Coverage rate of indigent beneficiaries
  - Turnaround time for fund release
  - Citizen satisfaction scores

2. Phased Timeframe

- **Year 1:** Adopt e-claims and initiate digital monitoring tools.
- **Years 2–3:** Scale local grievance redress systems and digital dashboards.
- **Years 4–5:** Institutionalize feedback systems and embed reforms into PhilHealth and DOH structures.

3. Monitoring Tool

- **Develop digital dashboards** with open data features to track responsiveness, transparency, and equity.

4. Policy Implication Analysis

- Ensure alignment with UHC Act goals, PhilHealth mandates, and fiscal sustainability.

5. Policy Brief

- Provide a concise summary for DOH, Congress, and LGUs to support uptake of reforms.

6. Stakeholder-Specific Actions

- **DOH:** Create a central MAIFIP Program digital registry.
- **LGUs:** Establish local grievance redress desks and citizen feedback channels.
- **Hospitals:** Designate MAIFIP Program coordinators for improved case management.
- **PhilHealth:** Integrate MAIFIP Program with existing UHC programs for continuity.
- **Civil Society:** Monitor fairness and accountability mechanisms.

This stakeholder-oriented and phased approach ensures reforms are practical, evidence-based, and directly linked to identified gaps in program implementation and sustainability

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