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The Republic of Chile

PROGRAM FOR UNIVERSAL PRIMARY HEALTHCARE COVERAGE AND RESILIENCE (P179785)

Program for Results (PforR)

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

DRAFT

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Prepared by the World Bank

Table of Contents

TABLE INDEX

INDEX OF FIGURES

1. INTRODUCTION

In compliance with the Operational Policy (OPS5.04-POL.107 of 2017) and the Directive (OPS5.04-DIR.107 of 2022)[1] for the financing of Programs for Results (PforR) of the World Bank, this Environmental and Social Systems Assessment (ESSA), aims to present the findings and recommendations of the risk assessment carried out by the World Bank of the environmental and social management systems that govern the implementation of the Program for Results*: Program for Universal Primary healthcare Coverage and Resilience* (P179785). An analysis of the legal and institutional aspects applicable to the PforR in preparation is being carried out in order to determine if:

- They promote environmental and social sustainability in the design of the Program; avoid, minimize and/or mitigate adverse impacts, and promote informed decision-making in relation to the social and environmental impacts of the Program.
- They avoid, minimize and/or mitigate impacts on natural habitats or on physical and cultural resources that could be affected by the Program.
- They duly protect communities and workers against potential risks derived from activities such as: i) construction and/or operation of facilities and other practices under the Program; ii) exposure to toxic products and hazardous waste resulting from Program activities; and iii) reconstruction or rehabilitation of infrastructure located in areas vulnerable to the impact of natural disasters.
- Appropriately manage land acquisition and restriction of access to natural resources in such a way as to avoid or minimize displacement and social and economic impacts by assisting affected groups to improve or at least restore the living conditions in which they live. are found before the implementation of the Program.
- They guarantee that the rights and interests of indigenous groups and vulnerable groups are taken into account through their informed participation in Program decisions that may affect them, and at the same time guarantee equitable and culturally appropriate access to the Program's benefits.
- They avoid exacerbating social conflicts, especially in fragile territories and areas with social conflicts or territorial disputes.

[1] PfR Policy and Directive, available at: https://www.worldbank.org/en/programs/program-for-results-financing#3

1.1 Purpose of the ESSA

The purpose of this ESSA is: i) to identify potential environmental and social (E&S) risks that may affect the achievement of the Program's results; ii) assess the borrower's ability to manage those risks (its legal framework, regulatory authority, organizational capacity, and performance), with emphasis on environmental and social policies, legislation, procedures, and institutional systems to assess their consistency with the Policy and World Bank Directive for PforR ; and recommend specific actions to strengthen the capacity of executing agencies with respect to the effective management of environmental, health and safety, and social issues during execution. Some of these measures will be incorporated into the Program Action Plan (PAP) and others will be incorporated into the Program Operating Manual (POM), as detailed in Section 5.

1.2 ESSA methodology

PforR investment operations and is prepared by World Bank staff. The findings, conclusions and opinions expressed in the ESSA document are those of the World Bank. The draft ESSA report was shared with counterparts in the Chilean Ministry of Health (MINSAL) prior to the ESSA consultation meetings and comments and input received were incorporated into this report. Comments received from the public consultations will be incorporated into the final ESSA report as appropriate.

The methodology for the development of this ESSA is aligned with the provisions of the WB Guide prepared to conduct ESSA for PforR financing operations. The methodology involves:

i. Identification of potential environmental, safety and health risks for workers and the population (ASS) and social risks that may result from the activities to be supported by the PforR;

ii. Documentary review of the laws, regulations, requirements and guidelines of the national systems regarding ASS and social management to prevent or mitigate the identified risks, provided by the client and/or consulted on the official websites of the relevant agencies of the Government of Chile;

iii. Meetings with representatives of the government agencies involved, including virtual missions to prepare the operation and a field visit to two types of Primary Care establishments in the Coltauco commune (a Family Health Center -CESFAM- and a health post). These missions provided a better understanding of the potential environmental and social risks associated with these types of activities and the capacity and procedure of government departments to address such risks, including the relevant measures currently taken in accordance with relevant laws and regulations;

iv. Review of documents generated by the WB during the preparation of the PforR, such as the Program Evaluation Document (PAD) and Memory Aid of the last preparation mission carried out.

v. Review of ESSA reports for other WB PforR operations.

vi. A public consultation of the draft ESSA, to be held after the Decision Meeting, with government representatives and relevant civil society actors. The draft of the ESSA report will be attached to the call for consultations; and

vii. The preparation of the final version of the ESSA report taking into account the comments and observations collected in the consultation. This final version will be published on the MINSAL website, as well as on the World Bank website.

2. PROGRAM DESCRIPTION

Below is a summary of the Program for Results for the Coverage and Resilience of Universal Primary Health Care (PHC) in Chile, based on the version provided in the Program Evaluation Document (PAD) from the World Bank in August 2023.

2.1 The government program

The Health Reform that guarantees universal access to health is one of the four structural reforms proposed in the Government Program I Approve Dignity of President Gabriel Boric[2] for the period 2022-2025. This emphasizes the development of an intersectoral health strategy at the local level, based on the primary care system, capable of guaranteeing universal access and zero discrimination in the public health network, centered on people and their diversity, as well as on the role of communities. To this end, it proposes measures aimed at modernizing health management, improving accessibility to the public health system and the efficiency of public spending on the matter.

One of the pillars of the Health Reform is the **Universalization of Primary Care[3]**, which is recognized as the heart of the public health system and as a strategy in the prevention and promotion of health, in line with the Alma Ata Declaration (1978)[4] and the Astana Declaration (2018)[5].

The Government of Chile (GdCl) program for the Universalization of Primary Care is one of the fundamental steps for the beginning of the transformation of the Chilean health system into a Universal Health System and is the main strategy of the GdCl to improve access effective and timely high-quality health services for the entire population. This program is led by the National Commission for the Universalization of PHC, chaired by the Minister of Health, Undersecretaries of Public Health and Assistance Networks, and made up of a technical team made up of the corresponding Divisions and Departments of MINSAL, the National Fund for Health of Chile (FONASA) and the Superintendence of Health.

The Universal PHC program is designed with four objectives: (a) expand effective coverage through PHC optimization, (b) make PHC more resilient, (c) improve the social care model and health, with dignity and quality and (d) optimize resources and implement a performance monitoring and evaluation (M&E) framework that supports the PHC strategy.

This program began to be implemented this year 2023 with a pilot experience in seven communes (Alhué, Canela, La Cruz, Coltauco, Linares, Perquenco and Renca). These pioneer municipalities were chosen following a "scalability strategy" that sets out the way forward so that the lessons from the pilot can offer the greatest amount of information on future feasibility and implementation (for example, on regulatory issues, resource needs, the functioning of the health network), which allows its coverage to be increased annually until reaching half of the communes by the end of President Boric 's mandate . In addition, the seven municipalities reflect the diversity and heterogeneity of the different territories of Chile, including,

[2] The four structural reforms proposed in the Government Program I Approve Dignity (2022-2025) are: (i) Universal Access to Health; (ii) Decent pensions without AFP; (iii) Free and quality public education system; and (iv) Formation of the first environmentalist government in the history of Chile. Source: https://observatorioplanificacion.cepal.org/sites/default/files/plan/files/Plan%2Bde%2Bgobierno%2BAD%2B2022-2026%2B%282%29.pdf

[3] A general summary of what constitutes the Universalization of PHC can be seen at: https://www.minsal.cl/universalizacion-de-la-atencion-primaria-de-salud/

[4] High Soul Declaration. 1978. WHO – PAHO – UNICEF. Source：https://www.paho.org/hq/dmdocuments/2012/Alma-Ata-1978Declaracion.pdf

[5] Astana Declaration. 2018. United Nations. Source：https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration-sp.pdf

among others, the location (urban vs. rural), the composition of its population (already covered/reached by PHC or not) or the availability of the infrastructure to deliver PHC.

As explained below in section 2.2, the scope of the World Bank credit will only cover the financing of a part of this Government program for the Universalization of PHC.

2.2 Results Program

2.2.1 Scope of the Program for Results

The proposed Program for Results (PforR) would support[6] the PHC Universalization Government program during the four-year period 2024-2028, with a geographical coverage of 187 communes (52% of the total communes in Chile) and some actions throughout the country, with an investment of US$200 million. The PforR will support improvements in the coverage and quality of PHC; strengthening of resilience in PHC; and the efficiency in PHC financing, through investments and activities linked to the **Result Areas (ARs)** described below:

- **AR1: Coverage and Quality of PHC:**

  Under this AR, a new care model will be established where all people, regardless of the type of health insurance to which they are subscribed, will have access and will be effectively covered by PHC, with a strong equity component. This AR would also close the gaps regarding the quality of care, with a special focus on the prevention and control of Noncommunicable Diseases (NCDs) and with a gender perspective (women and LGBTIQA+ people). Activities under this AR will strengthen and install a new People-Centered Comprehensive Care Strategy (ECICEP), a revamped Health Benefits Package, and a patient navigation system. Finally, it will support the redesign of strategies for the participation of individuals, families, and communities in decision-making, to provide care and services acceptable to citizens, and to strengthen the social role of PHC.

- **AR2: Resilient APS:** This area aims to strengthen PHC in its contributing role in building a resilient health system to face future challenges derived from public health emergencies such as epidemics and pandemics; consequences of climate change; natural disasters; fragility, conflict and violence, among others, incorporating the lessons learned from the COVID-19 pandemic. The activities mainly include : the development of a Guide for the 'Surveillance of Public Health Emergency Risks and Climate Change in the Universal PHC', the training of personnel, the creation of designated "Comprehensive Response Teams" (georeferenced to the municipalities participants) and trained for Emergency Risk Surveillance, and the development and subsequent construction of a New Infrastructure Model (adjusted for exposure to climate-related hazards, geographic distribution, and energy efficiency standards).

- **AR3: Efficiency of the APS:** This area is focused on improving the processes associated with the management of PHC that favor the optimization of the use of resources and, consequently, of health care. Among other activities, it would include actions to: (i) modernize the allocation of PHC financial resources based on social and health risks, (ii) train municipal PHC administrators to install capacities related to effective leadership and efficiency in the execution of the budget in PHC, (iii) guarantee connectivity in PHC, and data governance and interoperability, and (iv) generate a dual virtual platform for health management. This platform (that is, web portal and mobile application) on the one hand will allow citizens to verify health information and health services, schedule appointments, receive reminders and information on healthy lifestyle, evaluate the services received in APS, among others. It is also expected to build an evaluation

[6]This version of the ESSA is based on this outlined scope (based on the August 2023 PAD version). Any change in this scope could imply changes in what is described/proposed in the final version of the ESSA.

framework that has sentinel indicators of health and epidemiological management for decision makers at the local level and the central authority, as well as to change the PHC accreditation model, creating a single comprehensive performance evaluation instrument.

2.2.2 Program Development Objectives (PDO) and Results Indicators at the PDO level

The **Program Development Objectives (PDOs**) are to support improvements in: (i) the equitable coverage and quality of primary health care; (ii) the contribution of primary care to a resilience of the health system; and (iii) the efficiency and transparency of the use of resources for PHC.

Indicators of the Program Development Objectives (PDI). The Program will have 3 result indicators to achieve its PDO, these are:

- ***AR1 Coverage and Quality of PHC – PDI1*:** Decrease in the rate of avoidable hospitalizations of PHC patients with multimorbidity in Participating municipalities [7].
- ***AR2 Resilient APS – PDI2*:** The Participating Municipalities have a Health Sector Plan that includes a plan for Emergency Risk Surveillance in Public Health and Climate Change.
- ***AR3 Efficiency of the APS – PDI3*:** Participating municipalities with positive user experience.

2.2.3 Indicators Linked to Disbursements (DLIs)

DLIs have been defined that are considered critical for the achievement of the PDOs. Based on these and its results (DLR), the World Bank will disburse the funds to PforR. The following table presents a summary of these DLIs:

[7] "Participating Municipality" means any Municipality that has signed a Participation Agreement and participates in the Universal APS Program in accordance with the eligibility criteria established in the Operating Manual.

Table 1Indicators Linked to PforR Disbursements

Results Area	DLIs
AR1: Coverage and Quality of PHC	**DLI1.** Gradual Implementation of the Universal APS Program and increase in its coverage. The expansion of the Universal APS program is expected to reach 187 municipalities (out of 346) by the end of the PforR period, covering 54% of the total number of municipalities in the country. - **DLR 1.1** It will be considered successful when 187 Municipalities join the APS Universal program[8], - **DLR 1.2** will track the increase in the number of people enrolling in an APS facility for the first time to ensure program reach.
	DLI2. Incorporation of the gender perspective and the control of gender violence, considering women and LGBTIQA+ people within the framework of the universal PHC model. - **DLR2.1** Community health agents trained in gender violence in the participating municipalities. - **DLR2.2** Improvement of positive quality treatment to the user in relation to the LGBTIQA+ community.
	DLI3. Decrease in the rate of avoidable hospitalizations of people living with multimorbidity.
	DLI4. Use of new services of high health value of the new Family Health Plan II - **DLR4.1** materialization of the new Family Health Plan II. - **DLR4.2** Increase in the use of new services of high value for health, which will be determined during implementation in accordance with the WB.
AR2: Resilient APS	**DLI5.** Establishment and deployment of the package "Surveillance of public health emergency risks and climate change in universal PHC". - **DLR5.1** Design and implementation of the Ministerial Guide for Emergency Risk Surveillance in Public Health and Climate Change in Universal PHC. - **DLR5.2** Development of capacities and human resources assigned to manage public health risks and emergencies. This will contribute to the evaluation of training and the formation of community 'Comprehensive Response Teams' with PHC personnel to monitor public health and climate change emergency risks.
	DLI6. New infrastructure model adjusted to the geographic distribution of the population and energy efficiency standards and the necessary conditions to reduce climatic vulnerabilities. - **DLR6.1** will support the design of the new PHC infrastructure**.** - **DLR6.2** Further training of health infrastructure specialists from health services and municipalities will take place on this new model, with subsequent construction of new health care facilities.
AR3: PHC efficiency	**DLI7.** Modernization of PHC financial resource allocation mechanisms.
	DLI8. Design and implementation of a virtual health management platform for citizens and those responsible for health services. - **DLR8.1** Development of the ecosystem for the virtual health operational center. - **DLR8.2** Consultations managed through the web portal and mobile application and user experience.

[8]A Municipality will be considered included in the program when a Participation Agreement is signed between the Municipality and the corresponding National Health Services Entity.

2.2.4 Institutional arrangements for the implementation of the PforR

MINSAL will execute the Program, since it has the function of general stewardship of the health system. Within the Minister's Cabinet Reform Team, the Program Implementation Unit (UIP) will be created. The IPU will be made up of a Program Coordinator, and 2 subdivisions: a technical coordination subdivision and a financial/administrative coordination subdivision.

The **functions of the technical coordination subdivision** of the UIP will be: (i) coordinate the execution of the Program activities between the different MINSAL Areas and Units and other actors inside and outside the health sector, (ii) coordinate the collection of data when appropriate, (iii) monitor the performance of indicators and reporting of DLIs , (iv) coordinate the external verification process with the verification agency, and (v) supervise and follow up on environmental and social (E&S) and fiduciary issues. Within the MINSAL departments relevant to the Program, as well as in each of the other participating entities, a team of one or two key staff members will be designated as focal points to oversee the implementation of the Program, according to their areas of expertise. competence and ensure timely coordination to achieve the objectives of the DLIs. The focal points will work closely with the IPU.

The **functions of the financial/administrative coordination subdivision** of the UIP will be (i) coordinate the execution of the Program's budget, (ii) supervise that the execution of the budget (including acquisitions, bidding processes, etc.) is within the framework of the conditions established by the Program, (iii) prepare financial statement reports and (iv) develop and facilitate the external verification process with the verification agency and attend the financial audit. The UIP will coordinate with the GoCl Budget Office (DIPRES) to allow it to submit disbursement requests to the World Bank.

Regarding the physical interventions of the Program, based on information provided by MINSAL, the design of the prototype of the new PHC infrastructure to be built with the Program, including W&S sustainability standards, will be done at the central level of MINSAL and the Responsibilities for the construction of this infrastructure will fall on the Health Services (SS) of MINSAL, while the municipalities will be in charge of its operation.

2.2.5 Physical interventions of the Program for Results

As of the date of this draft of the ESSA, MINSAL, based on a preliminary analysis of the gaps in PHC infrastructure in the country, anticipates that the infrastructure to be included in the Results-Based Program (AR2, DLI6) to be financed by the Bank, would be less complex [9]and would have the following characteristics:

- Construction of new PHC devices (called “neighborhood units”) that would include 2 boxes (or care units) per device. Each device of 100 m^2, occupying a plot of 200-300 m^2, which is more feasible to find in urban and rural areas, and would serve around 3,000 inhabitants.
- The construction of a device per commune that is universalized is estimated. It is expected that there will be 187 communes (52% of the total communes), with which the construction of 187 devices is estimated in four years (duration of the PforR).
- New technologies and principles of energy efficiency are planned to be incorporated into these new devices.

[9]In accordance with Article 2 [of] the **Organic Regulation of less complex health establishments and network self-management establishments** , the Less Complexity Establishment is one that carries out open, closed and emergency care activities of low complexity. , which mainly develops activities at the primary level and some of the specialty, according to its role within the Care Network that it integrates and in the area of competence determined by the Director of Service in consultation with the Integration Council of the Care Network.

- The investments would include construction, provision of basic services (electricity, water, sewerage), equipment with minor clinical furniture, and until obtaining the health authorization for the device to operate, granted by the regional health authority, the Regional Health Ministerial Secretariats (SEREMIS).
- Devices will not be equipped with major medical equipment.
- The implementation of mobile clinics or tents will not be included.
- Remodeling or conditioning works of existing infrastructures will not be financed.
- Works to establish internet connectivity will not be financed, nor will investments to remodel, condition or expand existing PHC infrastructure.

Both the technical standards, sustainability, service offering, among others, as well as the design of this new infrastructure will have to be developed and regulated prior to its construction.

This ESSA has been developed based on this information on the scope and type of infrastructure planned to include the Program. Any change in this information could imply changes in what is described/proposed in a subsequent version of this evaluation.

Once MINSAL completes the gap analysis on PHC infrastructure, the details of the new [10]PHC infrastructure to be built with financing from the Program will be confirmed, in terms of number of establishments, materials, design, exact location, sustainability standards[11] that will include, among others.

2.2.6 Social interventions of the Program

Based on the reviewed documentation, it is possible to point out that the three result areas of this Results-Based Program address aspects related to improvements in the provision of PHC that have been identified by the Ministry itself and key health agents as fundamental elements for overcome the gaps in accessibility, equity, quality, opportunity, relevance and coverage of the PHC network, recognizing the diversity of both current and potential beneficiaries with a focus on human rights and a gender perspective and social inclusion.

In the social sphere, AR1 activities include: (i) the design and implementation of a new People-Centered Comprehensive Care Strategy (ECICEP); (ii) a renewed Health Benefits Package; (iii) a navigation system for patients; and (iv) the redesign of strategies for the participation of individuals, families, and communities in decision-making, to provide care and services acceptable to citizens and strengthen the social role of PHC.LGBTIQA+

In the social sphere, AR2 activities include: (i) the design of a ministerial Guide for Surveillance of Emergency Risks in Public Health and Climate Change in the PHC Network; (ii) training in the Guide for health teams; (iii) the formation of Community Comprehensive Response Teams with PHC personnel capable of monitoring the risks of public health emergencies and climate change.

In the social sphere, the activities of the AR3 include: (i); the design and implementation of a telematics system that allows PHC consultations to be managed through a web portal and a mobile application; and (ii) the measurement of the user experience.

2.2.7 Alignment with the Alma Ata Declaration. and the Astana Declaration

In general, the activities proposed in this PforR are considered in line with the principles of both declarations in relation to strengthening Primary Health Care by eliminating biases in care through its

[10]The final gap analysis is expected to be completed before the effectiveness of the Program.
[11]The main environmental risk of this P4R derives from these physical interventions.

universalization with a human rights approach and a gender perspective and social inclusion, through improvements in the Family Health Plan, the training of primary health personnel and the incorporation of user experience as a modeling element of public policy in primary health care.

2.2.8 Exclusion list

Based on the findings of this draft ESSA, no significant adverse environmental and social impacts are expected as a result of the Program. The following exclusion list defines the type of activities that cannot be included in the Program due to the risks and significant adverse impacts that they would cause on the environment and/or the people affected. This exclusion list will include, among others:

- any construction in protected areas or priority areas for the conservation of biodiversity, as defined in national legislation [12];
- construction in high-risk areas due to natural hazards (floods, landslides, earthquakes, tsunamis);
- activities that have the potential to cause significant loss or degradation of critical natural habitats, either directly or indirectly, or that may generate adverse impacts on these habitats, including urban or rural wetlands;
- purchase or use of chemicals prohibited/restricted for medical use;
- any activity that affects physical cultural heritage, such as tombs, temples, churches, historical relics, archaeological sites, or other cultural structures;
- activities that due to their magnitude and scale require an Environmental Impact Study (EIA)[13], according to the Environmental Impact Assessment System (SEIA) of Chile;
- Activities that cause significant air, water, or land pollution that may have significant adverse impacts on the health or safety of individuals, communities, or ecosystems;
- working conditions that expose workers to significant risks to personal health and safety;
- activities that may cause or lead to forced labor or child abuse, child labor exploitation, or human trafficking, or that employ or involve children, age 14 or older and age 18 or older, in connection with the Program;
- any activity on land that has disputed ownership or tenure rights;
- any activity that causes significant physical and/or economic displacement;
- any activity that requires Free, Prior and Informed Consent (FPIC) as defined in the World Bank Environmental and Social Framework.

[12]National System of Protected Wilderness Areas of the State (Law No. 18,362); Law No. 21,202 on the protection of urban wetlands; other priority sites, https://areasprotegidas.mma.gob.cl/otras-designaciones/

[13]The projects and activities that must present an EIA are regulated in article 11 of Law 19,300 of General Environmental Bases and, in general, refer to those that have significant negative impacts.

3. POTENTIAL ENVIRONMENTAL AND SOCIAL EFFECTS OF THE PROGRAM

3.1 Potential Benefits and Environmental Risks

3.1.1 Potential environmental benefits

Based on the findings of this draft, the main positive environmental effects are related to the use of sustainability standards[14] and resilience to climate change for the implementation of a new model of energy-efficient PHC establishments (AR2, DL6). It is expected that the Program will also strengthen the environmental supervision and management capacity of the Health Services in charge of the construction of the new PHC facilities (AR2-DLI6), through specific training activities of the Program, as detailed in section 5 of this document, and the development of capacities in response to emergencies and in the implementation of community policing plans.

3.1.2 Potential Environmental and Health and Safety Impacts and Risks

No significant adverse ASS impacts are expected as a result of the Program. However, some of the activities supported under the PforR , specifically some related to AR2, will have potential risks and negative impacts associated with the construction of the new model of PHC establishments and their operation. It is expected that this new infrastructure will include, in broad terms, the construction of the new APS establishment model, its connection to the electrical service, private drinking water supply and sewerage, among others, and an operation stage that contemplates the use of the infrastructure and management of domestic and clinical solid waste. The following Table 2 presents the expected potential environmental and health and safety risks and impacts associated with the construction and operation activities of the new PHC infrastructure that the Program would finance.

[14]In order to establish the standards of environmental sustainability and resilience to climate change of the new APS establishments that are built with the Program, it is recommended that MINSAL review the following document: WHO guidance for weather resilient and environmentally sustainable health care facilities (2020). Available at: https://www.who.int/publications/i/item/9789240012226

Table 2Potential risks and Environmental Impacts and Safety and Health (ASS)

PRE-CONSTRUCTION STAGE OR CONSTRUCTION SITE PREPARATION		
Activity	**Environmental risks**	**SS risks**
Removal of vegetation cover (during the opening of access roads and/or during the clearing of the land at the construction site)	• Damage to the vegetation in the area due to the removal of trees and smaller species. • Damage to the fauna associated with the affected vegetation, due to the disappearance of nesting, refuge and feeding areas, as well as direct damage to burrows and individuals that inhabit the removed vegetation. • Soil erosion due to removal of vegetation on steeply sloping terrain and near slopes. • Affectation of air quality due to the generation of smoke in the event of using fire to remove the vegetation cover	• Injuries to workers during vegetation removal activities to prepare the work site due to lack of use of personal protective equipment. Injuries from reaching machinery and accidents with tools and equipment. • Injuries to workers due to snake bites or bites from other threatened animals during works to remove vegetation and when opening roads. • Damage to the health of workers and people in transit through the work area, due to smoke inhalation.
clearing of the land	• Direct affectation to the soil due to its removal at the construction site and due to erosion in the limits of the depalmed area, where dragging by wind and rainwater occurs. • Affectation of the stormwater runoff pattern of the site. • Affectation of air quality due to the generation of polluting emissions from the operation of machinery, which emits fumes and gases from its engines and which raises particles due to the movement of earth. • Affectation of the work environment within the construction site due to the generation of noise from the operation of the machinery.	• Injuries to workers due to the reach of machinery and by accident with tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using the appropriate personal protective equipment.
Excavations and land leveling	• Affectation of the natural topography of the site and the pattern of stormwater runoff, with the possible effect of flooding the property or surrounding land, or reducing the infiltration rate into the subsoil. • Affectation of air quality due to the generation of emissions of particulate matter and pollutants from the operation of machinery, which emits fumes and gases from their engines and raises particles from the movement of earth. • Affectation of the work environment within the construction site due to the generation of noise from the operation of the machinery. • Affectation of cultural heritage by destruction or looting of historical or archaeological artifacts discovered during excavations.	• Damage to the health or physical integrity of workers by falling into excavations or by collapses in excavations with workers inside. • Injuries to workers due to the reach of machinery and by accident with tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using the appropriate personal protective equipment.

	• Affectation of air quality due to smoke and particle emissions during the transport of excavation waste to authorized dump sites. • Damage to the vegetation and its associated fauna, to the landscape, and contamination of soils and surface and groundwater, due to improper disposal of excavation waste in unauthorized places.	
Camp and storage of materials	• Contamination of the soil, surface water and groundwater, due to leaks or spills of fuels or other stored chemical products, which can be washed away by rain. • Contamination of bodies of water and affectation of drainage and sewage systems near the construction site, due to construction materials carried by the action of the wind or by rain. • Contamination of soil, surface water and groundwater due to incorrect management and disposal of sewage generated by the personnel participating in the work.	• Damage to the health of workers by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated food or water. • Damage to the physical integrity of workers due to fire in the camp or materials warehouse. • Damage to the health of workers by consuming water or food contaminated by wastewater or feces of workers participating in the work.
Preparation of the site and construction of the work	• Increase in the population at the project site due to the arrival of workers for the project, with the consequent increase in waste, affectation of the quality and quantity of water, emissions associated with the increase in traffic.	• Increase in road insecurity, insecurity of people in the community, sexually transmitted diseases, insecurity.
CONSTRUCTION STAGE		
Activity	**Environmental risks**	**SS risks**
Foundation construction	• Affectation of air quality due to the generation of polluting emissions from the operation of machinery, which emits fumes and gases from its engines and which raises particles due to the movement of earth. • Affectation of the work environment within the construction site due to the generation of noise from the operation of the machinery. • Affectation of cultural heritage by destruction or looting of historical or archaeological artifacts discovered during excavations.	• Injuries to workers due to being hit by machinery, due to falls into excavations or collapses in excavations with workers inside, and due to accidents involving tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using the appropriate personal protective equipment.
Transportation of construction materials, operation of machinery and vehicles	• Transfer of pollutants to the atmosphere (dust, combustion gases and noise). • Transfer of pollutants to soil and water, by falling or dispersing construction materials during transport	• Damage to the health or physical integrity of the construction workers, residents in the area and people in transit through the site and its surroundings, due to exposure to dust and noise; by scope of the machinery; or due to a vehicular accident when working in urban areas.

Construction equipment and machinery maintenance	• Contamination of soil, surface water, and groundwater due to incorrect handling and disposal of hazardous waste (used lubricating oils, solvents used to clean parts, impregnated with oils and solvents, empty containers, etc.) resulting from the maintenance of machinery participating in the work.	• Damage to the health of workers by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated food or water.
Exploitation of material banks	• Damage to the vegetation and associated fauna, soil and bodies of water, due to use of construction materials from unauthorized material banks. • Contamination of soil and roads, and impact on air quality, due to particle and material emissions during transportation from the materials bank to the construction site.	• Damage to the physical integrity of workers due to road accidents that occurred during the transport of materials to the construction site.
Rupture of pavements, demolition of sidewalks, major demolitions.	• Transfer of pollutants to the atmosphere (dust and noise). • Damage to the existing infrastructure in the work area, such as communication lines, drinking water, drainage, natural gas, electricity, railways and the like. • Deterioration of the visual environment in the work areas and their surroundings. • Damage to the vegetation and its associated fauna, to the landscape, and contamination of soils and surface and underground waters, due to inadequate disposal of demolition waste, in unauthorized places.	• Damage to the health or physical integrity of workers, residents in the area and people in transit through the work, due to exposure to dust and noise; or by accident with tools and equipment, or by contact with materials leaked from damaged pipelines (gas, fuel).
Waste management	• Transfer of contaminants to soil and water and affectation of the associated flora and fauna, due to the dispersion of waste in the temporary storage site; or by dispersion during transport and by disposal of waste on unauthorized sites.	• Damage to the health or safety of construction workers, residents in the area, and people in transit through the site and its surroundings, due to exposure to hazardous waste such as solvents or other toxic substances; or by consumption of water or food contaminated by waste from the work.
Management of fuels, lubricating oils, additives and other chemical products	• Contamination of soil, subsoil, and surface and underground water and affectation of the associated flora and fauna, due to spills of fuels, oils, additives, and other chemical products, stored without spill control devices or leaks from the vehicles and machinery involved in the work.	• Damage to the health of workers by inhalation or direct contact with spilled chemical products.
Closing streets and blocking access to public places or businesses and residential areas	• Restriction of the use of highways or paths and accesses, with inconveniences for people in transit and for inhabitants of the area. • Increase in traffic and vehicular emissions in the areas surrounding the work.	• Damage to the health or physical integrity of the workers and people in transit through the work, in the event of a fall into open pits, due to the reach of machinery, due to an accident with tools and equipment, due to a vehicular accident when working on urban roads, etc.
Fire and accidents on the construction site	• Transfer of pollutants to the atmosphere (fumes)	• Damage to the health or physical integrity of the workers, residents of the area and people in transit through the work, due to smoke inhalation or direct contact with the fire.

wastewater management	• Contamination of soil, subsoil and bodies of water and affectation of the associated flora and fauna, due to inadequate management and disposal of wastewater generated in the sanitary services authorized for the personnel participating in the work.	• Damage to health due to contamination of drinking water or food with wastewater.
Dismantling of support infrastructure at the end of the work	• Transfer of pollutants to soil and water, damage to vegetation and its associated fauna due to incorrect handling and disposal of waste in unauthorized sites. • Affectation to the landscape due to the permanence of waste or remains of camps, warehouses and other support services for the work.	• Damage to the physical integrity of workers due to accidents or incidents that occurred during the dismantling of the support infrastructure on the construction site, or with tools and equipment.
OPERATION STAGE		
Activity	**Environmental risks**	**SS risks**
Use of services and road infrastructure in the area	• Affectation of the availability of water, electricity, drainage, etc., due to an increase in their demand derived from the operation of the PHC establishment. • Affectation of the roads near the project due to increased vehicular traffic, which implies higher emissions into the atmosphere and noise pollution. In addition to promoting an increase in buildings and parking facilities.	• Accidents or road incidents due to the increase in traffic and pedestrians at the PHC establishment site and its surroundings. • Inconvenience to residents near the new PHC establishment due to increased noise due to increased traffic, vehicle emissions
Storage of fuels and chemicals	• Contamination of soil and water and damage to the physical integrity of the population and workers, due to leaks or spills of chemical products and generation of toxic vapors, or due to fire, derived from the storage of chemical products (disinfectants and liquids for cleaning and maintenance of facilities) and fuels (LP Gas and diesel) without existing spill control systems and without fire control devices	• Damage to the health and physical integrity of workers due to direct contact and handling with chemical products and spilled fuels without the corresponding protective equipment. • Damage to the health and physical integrity of workers and the population due to fires caused by the inappropriate storage of fuel residues and chemical products.
Generation of emissions into the atmosphere	• Affectation of air quality due to the emission of smoke from the steam generation and water heating systems (boilers).	• Impact on the health of site workers and nearby population
wastewater generation	• Contamination of drainage systems and bodies of water due to the dumping of chemical products from inappropriate management of cleaning products, clinical analysis, or dumping of water from the bathrooms of the PHC establishment.	• Impact on the health of the population in the area of the new PHC establishment due to the alteration of the quality of drinking water.
Solid waste generation	• Contamination of the work environment due to inadequate storage of solid waste, which can generate the proliferation of disease vectors such as insects and rodents. • Soil and water contamination due to improper handling and disposal of solid waste in unauthorized sites.	• Damage to the health of workers and the population due to contact with disease vectors such as insects and rodents.

Generation of hazardous waste	• Soil and water contamination due to improper handling (mainly storage and transport in unsafe conditions) and incorrect disposal of hazardous waste (maintenance waste and residues of chemical products, disinfectants, needles, as well as mercury thermometers, pressurized containers and pesticide containers) on unauthorized sites.	• Damage to the health of workers due to handling hazardous waste without adequate personal protective equipment and without the required training
Generation of off-specification, expired or obsolete drugs	• Incorrect management and disposal of drug residues, which can contaminate the soil and bodies of water.	• Damage to the health of the population due to the consumption of off-specification, expired or obsolete drugs, which are incorporated into informal commerce as a consequence of incorrect handling and disposal of drug residues.
Generation of waste with biological risk	• Incorrect management and disposal of waste with biological risk, which can contaminate the soil and bodies of water.	• Damage to the health of the population and workers due to the incorrect separation of waste with biological risk, which is taken without treatment to common waste management sites. • Damage to the health of workers who directly handle biohazardous waste, due to contagion of infectious diseases, derived from the lack of personal protective equipment and the performance of unsafe practices due to lack of training and supervision.
street trade attraction	• Contamination of soil and water sources due to increased waste generation and the presence of disease vectors such as insects and rodents.	• Impact on the health of the population, due to the presence of disease vectors such as insects and rodents that develop in the uncontrolled waste generated by the installation of street stalls attracted by the influx of people in the vicinity of the project.
In all stages of the construction project, emergencies may occur due to disaster risks, such as seismic risk, floods, fires, etc.		

3.2 Potential Benefits and Social Risks

3.2.1 Potential social benefits

Based on the findings of this draft evaluation, the main social benefits of the Results-Based Program are related to: (i) the incorporation of telematic platforms for remote care and request for medical appointments in PHC that will provide new beneficiaries access roads, thus allowing not only to reduce crowds in the APS facilities, but also to provide care to groups of the population who, due to geographic and time factors, movement problems or care responsibilities, among others, find it very difficult access face-to-face services; (ii) improvement of the quality, timeliness, and relevance of benefits at the primary health level through actions that will allow updating and evaluating the Comprehensive Family and Community Health Care Model through a human rights approach and perspective of gender and social inclusion, incorporating social determinants, and establishing minimum training standards for health teams and civil servant training systems in key subjects to guarantee dignified, relevant care without discrimination; (iii) strengthening community participation through the training of community agents; and (iv) permanent and systematic measurement of user satisfaction, providing a key opportunity to observe the effectiveness of activities at the local, regional, and national levels; (v) the construction of new PHC centers and the rehabilitation of existing PHC centers as an important advance in territorial coverage, especially beneficial for inhabitants of rural, semi-rural, or highly populated areas.

The main positive social effects are related to the institutional commitment to the cultural and territorial adequacy of the provision of PHC services aimed at special care groups, such as women who suffer gender violence, the LGBTIQA+ population, the elderly, immigrants, rural residents, as well as well as people belonging to indigenous and tribal peoples, among others. Also noteworthy are the activities aimed at raising awareness and training health personnel in care for special care groups, as well as the training of community agents to support cutting-edge approaches to address gender violence.

3.2.2 Potential impacts and social risks

No significant adverse social impacts are expected as a result of the Program, mainly because Chile has a solid legal and regulatory framework regarding: (i) protection of indigenous lands or lands with patrimonial moratorium; (ii) protection of workers; (iii) social inclusion and non-discrimination; (iv) citizen participation; (v) resolution of complaints in public services; and (vi) guarantee and access to health, where health care is guaranteed to the entire population, including people who are not registered with any type of health insurance company, the extremely poor, immigrants in an irregular migratory situation, and people belonging to the sexogeneric diversities.

In relation to the construction of new PHC centers, MINSAL has a guideline for the selection of land in rural areas [15]that contemplates a review of the feasibility of construction in terms of availability of basic services, ownership and moratoriums on the land, and proximity and accessibility for the target population, among other criteria that guarantee compliance with national and institutional regulations and that include social criteria in the selection of land. The poor perception of citizens about the functioning of the public health system, including the primary level (APS), associated with long waiting lists, poor quality of care and discriminatory practices[16] are seen as a challenge for the Universalization Program Primary Health Care, especially in relation to: the incorporation of new PHC users; the results of the measurement of the user

[15] According to the BS21 Indicator: Average time in minutes to the closest primary health center to the rural entity, of the Rural Life Quality Indicator System, in the 2019 version. in the rural communes of the country (54%) the time The average commute to the nearest APS facility is 29 minutes, reaching more than an hour in 21 rural communes of the country Source National Institute of Statistics: https://www.ine.gob.cl/herramientas/portal- de-maps/sicvir

[16] Study of Health Users regarding the Law of Rights and Duties. 2015. Superintendence of Health. Source : https://www.supersalud.gob.cl/difusion/665/articles-12611_recurso_1.pdf

experience and the adjustments that are agreed thereon; as well as the strengthening of a citizen participation system focused on collaboration rather than complaints.

On the other hand, the diversity and heterogeneity of the municipalities that administer approximately 92.6% of the PHC facilities, in relation to the equity of resources, both financial and human, as well as the capacity that the Ministry of Health may have to carry out the standardization of their capacities in management and performance, have been seen by specialists as one of the main reasons for the persistence of care inequity [17]. From the point of view of social risks, this continues to be the main challenge for the Program: establishing and normalizing PHC mechanisms, standards, criteria, and procedures that allow the population to perceive equity and quality in the care received without historical deficiencies interfering. availability of financial resources that the poorest municipalities have experienced up to now due to the financing model.

In relation to the construction or rehabilitation of PHC centers, it is expected that within the criteria used by MINSAL to define the location of the new PHC infrastructure, it is considered that in the country's rural communes (54%) the average travel time to the nearest APS facility is 29 minutes, reaching more than an hour in 21 rural communes of the country [18].

The following table describes the social risks associated with the construction or rehabilitation of PHC centers.

[17] Primary Health Care in Chile and in the International Context: validity, experience and challenges. 2019. Gattini Collao, Cesar. Chilean Public Health Observatory. Fountain: https://www.ochisap.cl/wp-content/uploads/2022/04/APS_en_Chile_e_Internacional_Gattini_OCHISAP_2019.pdf

[18] Indicator BS21: Average time in minutes to the closest primary health center to the rural entity. System of Rural Life Quality Indicators. 2019. National Institute of Statistics. Source: https://www.ine.gob.cl/herramientas/portal-de-mapas/sicvir

Table 3Potential risks and Social Impacts

PRE-CONSTRUCTION OR REHABILITATION STAGE OF APS CENTERS	
Activity	**social risks**
Selection of communes where new PHC centers will be built	• Omission of demographic, social, cultural and health characteristics of the population that prevents the design of adequate facilities. • Omission of characteristics related to geographic connectivity and the type of commune in which a PHC center will be built that prevents improving accessibility to PHC centers in towns that currently do not have a nearby PHC center.
Selection of land on which new APS centers will be built	• Selection of land that omits the demographic, social, cultural and health characteristics of the population that prevents the design of adequate facilities for dignified, timely care and with social and cultural relevance. • Involuntary physical and/or economic displacement as a result of the acquisition of selected lands. • Construction of new PHC centers on indigenous lands or that have a patrimonial moratorium that affect the cultural, tangible and intangible heritage of the population and the country. • Omission of citizen and/or indigenous consultation that prevents the population from actively participating in the construction process of new PHC centers.
Design of new PHC centers or redesign of existing PHC centers	• Omission of demographic, social, cultural and health characteristics of the population that prevents the design of adequate facilities, with cultural relevance and attention capacity. • Omission of citizen and/or indigenous consultation that prevents the population from actively participating in the process of designing new PHC centers or their rehabilitation.
Selection of entities in charge of the construction or rehabilitation of PHC centers	• Irregular hiring of workers by the winning bidders in charge of the construction or rehabilitation of the PHC centers that prevents compliance with national regulations on labor and social security matters for the workers of the works. • Recruitment processes for personnel involved in the construction or rehabilitation of APS centers that discriminate based on sex, gender identity, ethnicity, nationality, age or other conditions protected by national and international regulations. • Child exploitation by the awarded entities in charge of the construction or rehabilitation of PHC centers.
Site preparation and construction or rehabilitation of APS centers	• Omission of multi-channel information processes addressed to the community explaining the scope of the works and the mechanisms to request more information or make claims and suggestions.
CONSTRUCTION OR REHABILITATION STAGE OF APS CENTERS	
Activity	**social risks**

Construction of new PHC centers or rehabilitation	• Increase in the floating population at the project site due to the arrival of workers for the project that could affect the coexistence of the inhabitants, such as: use of public spaces for food, rest or others; increase in vehicular traffic; increased insecurity due to robberies, fights or other conflicts; increase in the incidence of gender-based violence; restrictions on the use of public roads and access to services. • Adverse impacts on merchants (eg., reduction in income) affected by access blockades to their stores, even if temporary. • Lack of clear and expeditious mechanisms to receive and respond to claims from the inhabitants in relation to the affectations that the works could cause.
PHC CENTER OPERATION STAGE	
Activity	**social risks**
Commissioning of the APS center	• Occurrence of illegal activities in the vicinity of the APS center, such as: street commerce, robberies, sexual harassment and others that could affect the coexistence and safety of the people who pass through there. • Informal business in the immediate vicinity of the center that could be used by children and adolescents. • Lack of clear and expeditious mechanisms to receive and respond to claims from the inhabitants in relation to the affectations that the works could cause.

4. ASSESSMENT OF ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

4.1 Environmental Management Systems relevant to the PforR

This section mainly contains a summary of the laws, regulations and institutional framework that govern the management of risks to the environment, occupational health and safety (particularly the risks highlighted in the previous section) in health care facilities in Chile. , with a focus on low-complexity PHC establishments, as is expected to be the new infrastructure model to be built with World Bank funds. It should be noted that some aspects related to social management are strongly linked to environmental management and, therefore, are fully addressed in the following sections, other specific aspects of social management are addressed in section 4.2.

4.1.1 Legal framework in environmental matters relevant to the Program

Regarding the management of risks and environmental impacts of civil works, Chile has a robust environmental impact assessment system (SEIA), administered by the Environmental Assessment Service-SEA. Based on the information available to date on the scope of the construction of the new infrastructure that will include the Program, as detailed in section 2.2.5, it is expected that it will not require submitting to the Environmental Assessment System under the SEIA of Chile, in accordance with Law No. 19,300 on General Environmental Standards (LBGMA) and its regulations, (article 10 of Law No. 19,300 establishes the types of projects that must be submitted to the SEIA and these are specified in the Article 3 of the SEIA Regulation), which will not exempt them from complying with the pertinent national, regional and local environmental and health and safety standards required by the competent authorities for this type of works.

On the other hand, once there is confirmation from MINSAL on the scope of the physical interventions to be included in the Program, in the event that any require submission to the SEIA, it would have to be of a scope whose required impact assessment instrument is a Environmental Impact Statement (DIA), in accordance with the LBGMA and SEIA Regulations (as explained in section 4.1.3), since activities that require the development of an Environmental Impact Study will be excluded from the Program.

The following Tables then identify the general and specific environmental regulations applicable to the Program. The latter are analyzed in relation to environmental components, such as air, water, soil, flora and fauna and cultural heritage, safety and health at work, among others.

Table 4General regulations applicable to the Program for Results in environmental matters

Law/Regulation	Description
Political Constitution of the Republic. Supreme Decree No. 100/2005. Ministry General Secretariat of the Presidency	Fundamental standard of the national legal system that regulates the organization of the State, the rights and duties of individuals, the structure and functions of institutions, among other matters. The Political Constitution takes charge of the environmental issue in its Chapter III "On constitutional rights and duties", specifically in its article 19 number 8, where it recognizes as a fundamental right "The right to live in an environment free of contamination. It is the duty of the State to ensure that this right is not affected and to protect the preservation of nature. The law may establish specific restrictions on the exercise of certain rights or freedoms to protect the environment. Additionally, it guarantees the terms that must be made compatible with the protection of the environment, the right to property, the freedom to acquire all kinds of goods, the right to carry out any legal economic activity, equality before the law and the right not to be discriminated against. by the State or its agencies in economic matters, all of them equally protected by jurisdiction, and under which the holders assume their corresponding investment projects or activities in terms that must be compatible with the protection of the environment.
Resolution No. [7] of March 26, 2019, of the Comptroller General of the Republic, which Sets Rules on Exemption from the Proceedings of the Comptroller General of the Republic	The taking of reason is a mandatory control of the legality of the acts, which ensures the protection of the principle of probity, the right to a good Administration and the care and proper use of public resources.
Law No. [19.886] /2003 (last reform 2022), Bases Law on Administrative Contracts for the Supply and Provision of Services (Public Procurement Law)	The fundamental objective of this Law is to standardize the administrative procedures for contracting the supply of personal property and services necessary for the operation of the Public Administration and to improve transparency in the management of the Public Treasury at the State and municipal levels. With this law, the necessary institutionality was created to ensure transparency and efficiency in purchases, preserve equal competition and consider due process. For these purposes, a web platform was also created, which is the Electronic System for Public Purchases www.chilecompra.cl, with the aim of being able to carry out all the necessary transactions in a purchase, both for public services and municipalities.
Law No. 18.575/1986 Constitutional Organic General Bases of the State Administration	This norm establishes the general principles and the structure that will govern the State Administration.
Law No. 19.880/2003 that establishes the bases of the administrative procedures that govern the acts of the bodies of the State Administration.	This standard regulates the administrative procedures through which the State Administration acts and makes decisions.
Law No. [19,300] /1994 of General Bases of the Environment (LBGMA) and its modifications	This norm regulates in a general way the right guaranteed in the Constitution to live in an environment free of contamination. It establishes the applicable principles, environmental management instruments, liability for environmental damage, inspection standards, among other matters. Article 8 of this LBGMA establishes that "The projects or activities indicated in article 10 may only be carried out or modified after evaluating their environmental impact, in accordance with the provisions of this law." Said article 10

Law/Regulation	Description
	indicates a list of "projects or activities likely to cause an environmental impact, in any of its phases, which must be submitted to the environmental impact assessment system", which are specified in turn, in article 3 of the Regulation of the Environmental Impact Assessment System (RSEIA). Health infrastructure projects and therefore PHC, in accordance with the provisions of Law 19,300 (Art. 10) belong to the typology of urban or real estate development projects.
Law No. 20.417/2010. Creates the Ministry, the Environmental Assessment Service and the Superintendence of the Environment.	Creates the Ministry, the Environmental Assessment Service and the Superintendence of the Environment.
Supreme Decree No. 40/2012, Approves Regulation of the Environmental Impact Assessment System (RSEIA) Ministry of the Environment	This regulation establishes the provisions by which the SEIA and Community Participation in the Environmental Impact Assessment process are governed, in accordance with the provisions of the LBGMA. The art. 3 of the RSEIA (literal g.1.2 and literal h.1) specifies the criteria for urban or real estate development projects that, because they are likely to cause an environmental impact, must be submitted to the SEIA. Those that do not meet these criteria should not be submitted to the SEIA. Article 26 of the RSEIA regulates the pertinence consultations for admission to the SEIA, stating that "[...] proponents may contact the Regional Director or the Executive Director of the Service, as appropriate, in order to request a ruling on whether, based on Based on the information provided for this purpose, a project or activity, or its modification, must be submitted to the SEIA. The response issued by the Service must be communicated to the Superintendency".
Decree 458/2023 approves the new General Urban Planning and Construction Law. Ministry of housing and urbanism	Establishes the provisions relating to urban planning, urbanization and construction. Article 5 provides that.- The Municipalities shall apply this law, the General Ordinance, the Technical Standards and other Regulations, in their administrative actions related to urban planning, urbanization and construction, and through the actions of the services of respective public utility, and must ensure, in any case, compliance with its provisions.
Decree 14/2019 that modifies DS 47/92 of housing and urban planning of 1992, General Ordinance of Urban Planning and Construction (OGUC) Ministry of Housing and Urban Planning	Establishes the provisions and measures that must be taken in all construction, repair, modification, alteration, reconstruction or demolition projects to mitigate the impact of dust and material emissions, deposit materials in authorized public spaces, maintain cleanliness of the public space where they are find the work Establishes the provisions for Communal Urban Planning that will regulate the physical development of urban areas, through a Communal Regulatory Plan (PRC)[19]
Law No. [20,703] /2013, Creates and regulates the national registers of Technical Construction Inspectors (ITO) and reviewers of structural calculation projects, modifies legal norms to guarantee the quality of constructions and expedite the requests before the municipal works directorates.	This Law dictates regulations on Technical Work Inspectors (ITO) and creates and regulates the National Registry of Technical Work Inspectors (ITO) and the National Registry of Structural Calculation Project Reviewers.

[19]Regulatory Framework Communal Regulatory Plan , available at: https://www.catalogoarquitectura.cl/cl/oguc/marco-normativo-plan-regulador-comunal

Law/Regulation	Description
	It establishes, among others, who may register in the National Registry of ITO and remain registered in it, requirements to register, as well as categories of technical work inspectors, according to their technical suitability and professional experience according to the type of work in question, in the terms indicated by this law and its regulations.
Law No. _ 21.455/2022 Climate Change Framework Law	Establishes climate governance, powers and obligations of Chilean State agencies for climate action, and establishes the goal of carbon neutrality and resilience for 2050.
DFL No. 725/1968, modified by Law No. 21.030/2017 Sanitary Code. MINSAL	It governs all issues related to the promotion, protection and recovery of the health of the inhabitants of Chile, except those subject to other laws. Within its regulation it includes norms related to the hygiene and safety of the environment and workplaces.
Law No. 20.285/2008 on Access to public information	This law regulates the principle of transparency of the public function, the right of access to information of the bodies of the State Administration, the procedures for the exercise of the right and for its protection, and the exceptions to the publicity of the information.
Law No. 20,500/2011 on Associations and citizen participation in public management	This law establishes definitions and mechanisms to form associations of citizens of public interest, and defines the ways in which said entities will participate in the management of the authorities.
Decree No. 680/1990 Approves instructions for the establishment of Information Offices for the user public in the State Administration of the Ministry of the Interior	This Decree establishes the obligation of ministries and other public services to have Offices of Information, Claims and Suggestions (OIRS) and regulates their operation.
Law No. 21.305/2021 on Energy Efficiency	The purpose of this law is to establish the obligation of the Ministry of Energy to prepare a National Energy Efficiency Plan every 5 years. The "Plan" must include, among other things, a goal to reduce energy intensity of at least 10% by 2030, compared to 2019; It also stipulates that homes, buildings for public use, commercial buildings and office buildings must have an energy rating to obtain final or definitive acceptance by the respective Municipal Works Directorate, among others.
Law No. 21.364/2021 Establishes the National Disaster Prevention and Response System	This standard establishes the National Disaster Prevention and Response System and regulates a series of disaster risk management instruments.
Decree No. 1.434/2021 Exempt. Approves National Emergency Plan 2020 - 2030 of the Ministry of the Interior and Public Security	This Plan is an instrument for disaster risk management whose purpose is to establish response actions in the different operational phases, in situations of emergency, disaster or catastrophe, with the aim of providing protection to people, their property and the environment, in the national territory, through the coordination of the National Civil Protection System.

Table 5Specific environmental regulations

Law/regulation	Description
Air quality and atmospheric emissions	
Decree No. 138 of the Ministry of Health establishes the obligation of the holders of fixed sources of air pollutant emissions to deliver to the respective Health SEREMI the necessary information to estimate the emissions from each of their sources.	It regulates the declarations of emissions of all economic activities. Emission declarations must be made by those who work in agricultural sectors, trade, tourism, industry, transportation and telecommunications, real estate, health, education, social and community service companies, among others who own hot water or steam boilers or use equipment generators Regulated parties must annually submit information to the Health Authority so that the State estimates the emissions of atmospheric pollutants on an annual basis. This regulation does not establish emission limits, only the obligation to provide information to calculate emissions
Emission standards established by the Atmospheric Decontamination Plans (PDA) and which must be met by all sources located where there is a PDA.	They are environmental management instruments that, through the definition and implementation of specific measures and actions, aim to reduce air pollution levels in a saturated area, in order to protect the health of the population.
Supreme Decree No. 144/1961. Establishes Norms to Avoid Emanations or Atmospheric Pollutants of Any Nature. Ministry of Health.	Establishes that gases, vapors, fumes, dust, fumes or pollutants of any nature, produced in any manufacturing establishment or place work, must be captured or eliminated in such a way that they do not cause danger, damage or nuisance to the neighborhood.
Supreme Decree No. 279/1983. Approves Regulations for the Control of the Emission of Pollutants from Internal Combustion Motorized Vehicles. Ministry of Health.	Establishes the regulatory and technical aspects for the control of the emission of pollutants evacuated by the exhaust pipe of motorized internal combustion vehicles
Supreme Decree No. 75/1987, modified by Supreme Decree No. 78/1997. Establishes Conditions for Cargo Transportation that indicates. Ministry of Transport and Telecommunications.	Establishes the conditions for cargo transportation
Supreme Decree No. 38/2011. Establishes Noise Emission Standards Generated by Sources indicated. Ministry of Environment.	The levels generated by noise emitting sources must comply with the maximum permissible sound pressure levels.
works on the road	
Decree No. 90/2003 Approves the New Text and Annexes of the Fifth Chapter of the "Traffic Signaling Manual" that establishes Temporary Signaling and Safety Measures for Road Work	Chapter 5 of the Traffic Signage Manual addresses the signs, devices, security measures and signaling schemes that must be used when work is carried out on the road, understanding as such any work or temporary restriction that causes the partial or total obstruction of this.
Solid waste	

DS 6/2009 Regulation on Waste Management from Health Care Establishments (REAS). MINSAL	Establishes standards for the management of "solid" waste generated in health facilities
Law No. 20.920/2016. Establishes the Framework for Waste Management, the extended responsibility of the Producer and Promotion of Recycling. Ministry of the Environment (MMA)	The purpose of this law is to incorporate the recovery of waste as a fundamental element in the management of solid waste and to introduce into the existing regulation on the matter, an economic instrument that seeks to generate mechanisms that allow increasing the levels of recycling of the waste that currently they are disposed of in sanitary landfills or deposited in illegal dumps.
Dangerous residues	
Supreme Decree No. 148/2003. Approves Sanitary Regulations on Hazardous Waste Management. MINSAL	Establishes the minimum sanitary and safety conditions related to the generation, possession, storage, transportation, treatment, reuse, recycling, final disposal, and other forms of elimination of hazardous waste.
The DS 43/15, Regulation of storage of dangerous substances. MINSAL	Establishes the storage conditions of classified hazardous substances in accordance with the provisions of NCh382:2013. The substances to which this regulation applies are compressed gases, flammable liquids, flammable solids, oxidizers and organic peroxides, acutely toxic, corrosive and various dangerous substances.
Basic Sanitary Services	
Decree with Force of Law (DFL) No. 382 of 1988, General Sanitation Services Law, and its regulation DS No. 1199 of 1998 of the Ministry of Public Works (MOP**),** if the service is provided by a concessionaire of sanitary services.	They govern the provision of basic drinking water and sewerage services in a health care facility located within the urban area.
MINSAL Sanitary Code, in its articles 71 and 72, as well as DFL No. 1 of 1989, also from MINSAL.	In the case of health establishments that are located outside the operational areas of the sanitation companies, the provision of basic services is through particular drinking water supply and wastewater evacuation systems. The responsibility for building, operating and maintaining these particular systems rests with the property owners. Any private drinking water supply and sewage evacuation system must have project approval and operating authorization from the respective Regional Health Ministerial Secretariat.
DS 735 of 1969 of MINSAL Regulation of water supplies intended for human consumption.	Regulates the quality of drinking water, both in urban and rural areas.
DS 236 of 1926 of MINSAL, General regulation of private sewers	Regulates the basic sanitary conditions of particular wastewater evacuation systems.
Water Code Law No. 21,435 Reform of the Water Code, of the Ministry of Public Works. Posted on April 6, 2022	This set of codified norms regulates the use of the country's water resources, establishing, among other figures, the right to use water. This Law reforms the Water Code, recognizes access to water and sanitation as an essential and inalienable human right, which must be protected by the State; and that it is a national good for public use, whose domain and use belong to all the inhabitants of the nation.
Health and Safety at Work	

DS 594, Regulation on Basic Sanitary and Environmental Conditions in Workplaces	It establishes the basic sanitary and environmental conditions that all workplaces must comply with, without prejudice to the specific regulations that have been or will be issued for those tasks that require special conditions. It also establishes the permissible limits of environmental exposure to chemical agents and physical agents, and those limits of biological tolerance for workers exposed to occupational risk.
Work code DFL Nº1/2003 of the Ministry of Labor and Social Welfare	Codified body of norms that regulates labor relations between workers and employers. The Labor Code includes norms related to the employment contract (workers' rights, their obligations, regulation of remuneration, rest, term); worker protection (social insurance against risks and accidents, against sexual harassment); union organizations and collective bargaining; and, the labor jurisdiction.
Law No. 16.744/1968 that Establishes Rules on Work Accidents and Occupational Diseases. Ministry of Labor and Social Welfare	Standard that regulates the compulsory nature of insurance against risks of work accidents and occupational diseases for both dependent and independent workers who are listed in the social security system. The insurance protects in case of accidents at work, commuting accidents, accidents suffered by union leaders and occupational diseases.
Decree No. 40/69 of the Ministry of Labor and Social Welfare approving the Regulation on Occupational Risk Prevention	Establishes the regulations on the prevention of professional risks, which are understood as accidents at work or occupational diseases. Among other measures, it establishes the obligation of employers to prepare or keep updated a safety and hygiene regulation, inform workers of the risks they run and train them to adequately face them. It also points out that statistics on occupational accidents and illnesses should be kept.
Decree 157/2007 Regulation of pesticides for sanitary and domestic use. MINSAL	Regulates the import, storage, possession, transportation, distribution, application, and disposal conditions of pesticides for sanitary and domestic use, including a wide range of disinfectants and antiseptics.
Biodiversity, protected natural areas	
Convention on Biological Diversity. Decree No. 1963/1995 of the Ministry of Foreign Affairs	The purpose of this treaty is the conservation of biological diversity, the sustainable use of its components and the fair and equitable sharing of the benefits derived from the use of genetic resources.
Decree No. 14/2008 National Biodiversity Strategy 2017-2030 of the Ministry of the Environment	The Strategy is a guiding document for the sustainable management of biodiversity in Chile, which has five strategic objectives (1) Promote the sustainable use of biodiversity for human well-being, reducing threats to ecosystems and species; (2) Develop awareness, participation, information and knowledge about biodiversity, as a basis for the well-being of the population; (3) Develop a robust institutional framework, good governance and a fair and equitable distribution of the benefits of biodiversity; (4)

	Insert biodiversity objectives into policies, plans and programs of the public and private sectors; and (5) Protect and restore biodiversity and its ecosystem services.
Convention Relative to Wetlands of International Importance, especially as Waterfowl Habitat. Decree No. 771/1981 of the Ministry of Foreign Affairs	The purpose of this Convention is the conservation and rational use of wetlands, carrying out actions at the local, regional, national and international cooperation levels. Among its provisions, it establishes that States must prepare a list with wetlands or execute plans for the conservation of these and waterfowl.
Law No. 18.362 /1984. Creates a National System of Protected Wilderness Areas of the State	This Law creates a National System of Wilderness Protected Areas of the State, including regulations for its management, creation, administration and disaffection, as well as the prohibitions and sanctions in case of non-compliance with this regulation.
Law No. 20.283/2008. On the Recovery of the Native Forest and Forest Promotion and its Regulation (DS 93/2009 of the Ministry of Agriculture)	The purpose of this Law is to protect, recover and improve the country's native species, ensuring their forest sustainability, through management and preservation plans.
Law No. _ 21.202/2020 of the MMA Modifies various legal bodies with the aim of protecting wetlands	Its objective is to protect urban wetlands declared as such by the Ministry of the Environment, either on its own initiative or at the request of the respective municipality, in view of their great importance for the environment.
Cultural heritage	
Law No. 17,288 and DS 484/1990, of the Ministry of Education, Regulations on Excavations and/or Archaeological, Anthropological and Paleontological Surveys.	Legislation on National Monuments.

4.1. 2 Institutional framework for environmental management of the Program

The main potential environmental and health and safety risks of this PforR are associated with the construction and operation of a new type of PHC establishments with the WB credit.

Based on information provided by MINSAL, those responsible for managing the construction of the new PHC establishments will be the **Health Services** and they will be in charge of:

i) the contracting of works by bidding, through the Public Procurement system[20], which will be carried out in accordance with bankruptcy-type bases established by the Comptroller[21] for this type of works (it is expected that the same bases will be used as for the construction of rural posts -smaller PHC establishments, about 400-500 m ^{2}). The standard bidding rules consider the legal framework that must be applied when building the infrastructure, including the socio-environmental one. The bidding documents also include specifications with specific technical specifications regarding the scope and risks of the work, including the environmental and social mitigation plans that the work in question must implement;

ii) the supervision of these works, including the application of the specific E&S regulations and mitigation for the work in question, for which the corresponding **Health Service Directorate** must hire a **Technical Works Inspector** (ITO), registered in the National Registry of ITO of the Ministry of Housing and Urbanism.

The Technical Inspector of the work will depend on the Direction of the SS and has administrative, civil and criminal responsibility. You must verify that the work complies with the conditions of the contract and all the applicable legal framework, including environmental, health and safety, and social.

In addition, the **Contractor**, the company hired by the corresponding SS to carry out the work, must include among its staff a **risk prevention** professional, a professional with the required skills and must be registered with a Health SEREMI. This is responsible for ensuring compliance of the work with specific regulations and prevention and mitigation measures on safety, health, labor conditions and rights, and the environment.

The work budget dedicated to the implementation of the environmental and social prevention, mitigation and control measures is not included as a specific item, but is included in the item of general expenses of the work that considers the administration of the work, and includes all company personnel who are going to work on the site, which must include the risk prevention specialist and specific specialists who also have to verify or carry out actions in accordance with the requirements of the regulations for the work in question.

As part of the contracting process to carry out a work, there are guarantees that are requested from the contractor and are applied when the company presents a breach (technical, environmental, safety and health, others) to cover the cost of what is meant. These guarantees are established based on the total cost of the work.

building permit must be requested from the corresponding municipality, through its **Municipal Works Directorate (DOM)**, the governing body responsible for verifying that the contractor company complies with all the necessary regulations to start the execution of a work, including urban, environmental, and social regulations, among others. Before requesting this permit, the contracting company must have all the feasibilities resolved, for example, the connection of the new APS center to the drinking water supply and sewerage, the connection to the electrical system, when necessary, a preliminary topography, a mechanical of preliminary soils, the land where it is going to be built, among others. The bidding file for the work is put together by the corresponding Health Service, with all these background information resolved and the feasibility of executing the work.

The DOM also supervises the works under construction, it can visit the work and verify that it is complying with all the applicable regulatory framework, including environmental and social. In addition, these works are also supervised by the ITO, the Labor Directorate and the corresponding Health SEREMI.

Complaints and claims that may be filed for the work are handled by the DOM, in conjunction with the SS Directorate and the ITO. The claim of someone affected by the work can reach the DOM and from there the company is required to resolve the complaint or claim.

[20]Public Market is a platform for public purchases of products, works and services in Chile, available at https://www.mercadopublico.cl/Home

[21]The Comptroller General of the Republic is a higher control body of the State Administration, contemplated in the Political Constitution, which enjoys autonomy from the Executive Power and other public bodies. Verifies that the bodies of the State Administration act within the scope of their powers and subject to the procedures provided by law.

The Regional Ministerial Health Secretariats (SEREMIS) are the authorities that grant the new PHC facilities the **Sanitary Authorization**[22] required for their operation and operation.

Once the work is finished, the **municipal reception must be requested from the municipality**, this is the last verification that the work was carried out in accordance with what was requested and with the applicable legal framework, including A&S aspects.

During the operation of the new PHC facilities, supervision of compliance with environmental and social requirements would be carried out by SEREMIS and by the local authorities where the facility is located. The relevant legal framework (Table 6) establishes the roles and responsibilities of these agencies in the E&S management of PHC facilities.

According to information provided by MINSAL, the new PHC establishments built with the WB credit will be operated and managed by the municipalities, through their Municipal Health or Primary Health Directorates, or PHC Corporations. Therefore, the environmental and social management of these centers will be supervised by the municipality where the new PHC establishment is established and the corresponding SEREMIS. For example, for the management of hazardous waste, the municipalities hold contracts with companies that are supervised by the SEREMIS for the disposal of hazardous waste in accordance with the Regulations on Waste Management in Primary Care Establishments (REAS). In addition, each Municipal Health Directorate and each establishment must register, through the SEREMIS, where they must declare how they manage their waste.

Table 6 below shows the main agencies of the State Administration that make up the institutional framework for environmental regulations, control and enforcement in which the physical interventions of the Program will be carried out.

[22]The Sanitary Authorization is the act by means of which the Regional Sanitary Authority (SEREMIS) allows the operation of Institutional Health Providers, verifying that they comply with the structure and organization requirements, expressed in regulations. Decree with Force of Law No. 1 of 1989, Determines matters that require express sanitary authorization. Available at: https://www.bcn.cl/leychile/navegar?idNorma=3439

Table 6Institutional framework for regulations, control and environmental inspection of the Program

National Environmental Authorities	
Ministry of the Environment (MMA)	The MMA is responsible for coordinating environmental matters and for the design and proposals of environmental policies that strengthen the sectoral regulatory frameworks in environmental matters, including the health sector, as well as the protection and conservation of biological diversity and renewable natural and water resources, promoting sustainable development, the integrity of environmental policy and its regulatory regulation. The Ministry has a National Advisory Council and Regional Advisory Councils in each region of the country, created from Law No. 19,300 on General Bases of the Environment, as mechanisms for citizen participation for environmental issues. In addition, the Minister of the Environment chairs the Council of Ministers for Sustainability and Climate Change.
Environmental Assessment Service (SEA)	The SEA's main function is to manage the Environmental Impact Assessment System (SEIA), which regulates the evaluation process of projects that may generate significant impacts on the environment. The SEA's decision on the environmental evaluation materializes in the Environmental Qualification Resolution (RCA), which establishes the mitigation, compensation and environmental monitoring measures that must be implemented during the execution of the project. Against this resolution, in certain cases, a claim can be filed with the Committee of Ministers. In addition, the Service has the task of standardizing the criteria, requirements, conditions, background, certificates, procedures, technical requirements and procedures of an environmental nature established by the ministries and other competent State agencies, through the establishment, among others, of procedure guides. In the event that any of the infrastructure works of the Program must be submitted to the SEIA, it must follow the process provided in the LBGMA and RSEIA for the evaluation of its environmental risks and impacts and obtain the respective RCA. In accordance with the Program's exclusion list, interventions that require an EIA will be excluded from financing.
Superintendency of the Environment (SMA)	The SMA is the body with exclusive power to execute, organize and coordinate the monitoring and control of the Environmental Qualification Resolutions (RCA), of the measures of the Prevention and/or Environmental Decontamination Plans, of the content of the Quality Standards Environmental and Emission Standards, and Management Plans, when applicable, and all other instruments of an environmental nature established by Law. The SMA fulfills its function through three inspection modalities: direct, by its officials; by other sectoral bodies, entrusting it with inspection tasks on the basis of specific programs and subprograms; and, through third parties accredited by the Superintendency. Infrastructure works included in the Program that require submitting a DIA to the SEA and obtaining the respective RCA will be subject to environmental control by the SMA.
Bodies of the State Administration with Environmental Competence (OAECA)	The OAECAs are the State bodies that participate in the Environmental Impact Assessment of the project or activity. Article 24 of the RSEIA defines them as those that have attributions in terms of permits or sectoral environmental pronouncements regarding

	the project or activity in particular. In the event that any infrastructure work included in the Program requires submission to the SEIA through a DIA, these bodies will rule on the DIA of the work.
Department of Labour, Safety and Health	The Labor Directorate is a decentralized public service, supervised by the President of the Republic through the Ministry of Labor and Social Welfare. Their roles include monitoring compliance with labor, social security and hygiene and safety regulations at work, and carrying out actions aimed at preventing and resolving labor conflicts.
Regional Governments	Law No. [19,300] establishes the obligation of regional governments to pronounce on the territorial compatibility of the projects presented in the region of their competence (article 8). In the event that any of the infrastructure works included in the Program must be submitted to the SEIA through a DIA, the work must obtain the report from the Regional Government, the respective Municipality and the competent maritime authority, when applicable, on the compatibility territory of the submitted project.
Municipalities	The operation of Municipalities in Chile is governed by Law No. 18,695 Constitutional Organic Law of Municipalities. The management of PHC establishments at the community level depends on the municipality in 321 of the 345 communes in the country. In these cases, each one manages the human and financial resources, makes purchases of goods and services, and is responsible for the maintenance of infrastructure and equipment. The Municipalities have among their functions and responsibilities the management [23]of the environment and public health and safety in their municipality and develop mechanisms to comply with the responsibilities granted by the Constitution of the Republic on these issues, the LBGMA in terms of environmental management (control of environmental quality, represent community complaints on environmental matters, implement decontamination plans, among others) and the Sanitary Code (ensure compliance with the hygiene and safety provisions established in the General Ordinance for construction and urbanization. The municipalities are responsible for issuing the building permit to start a civil work in their territory and for granting the acceptance of the work once it is finished, they also supervise the compliance of the work with the applicable legal framework, during construction, as well as well as during its operation The construction and operation of the new APS infrastructure will be subject to compliance with the pertinent environmental and social regulations, acts and municipal ordinances. The municipalities that are in charge of PHC establishments have well-standardized cleaning and ornamentation departments that are in charge of environmental management, or there are municipalities that call them environmental management departments.
Sectoral environmental authority (Health Authority)	
MINSAL	MINSAL is responsible for formulating and setting the health policies that are developed within the national territory. Having, among others, the following functions and objectives: - Exercise stewardship of the health sector - Ensure due compliance with health standards, through the Regional Health Ministerial Secretariats, without prejudice to the jurisdiction that the law assigns to other agencies. - Carry out public health surveillance and assess the health situation of the population.

[23]Municipal Environmental Management. 1995, available at: https://proactiva.subdere.gov.cl/bitstream/handle/123456789/52/GESTION_AMBIENTAL_MUNICIPAL.PDF?sequence=1&isAllowed=y

	- At the national regulatory level, it has the power to formulate policies and regulations to control environmental factors that may put the population's health at risk. MINSAL manages PHC at the central level, represented by the Primary Care Division (DIVAP), dependent on the Undersecretary of Assistance Networks.
Department of Risk Management in Emergencies and Disasters (DGREYD)	Inserted in the MINSAL Chief of Staff, DGREYD's mission is to promote comprehensive risk management in emergencies and disasters in the health sector, considering the guidelines of the National System for Disaster Prevention and Response (SINAPRED) and sectoral agreements in the international framework for disaster risk reduction. Among its objectives are: • Prepare the necessary technical guidelines for the implementation of the Sectoral Policy for Risk Management in Emergencies and Disasters, as well as the necessary protocols for the formulation of plans, to monitor the implementation of said policy in the MINSAL, in the SEREMIS, in Health Services and network establishments. • Coordinate and monitor the implementation of the Climate Change Adaptation Plan of the Health Sector at the national level, through the executive coordination unit for climate change belonging to this department. DEGREYD will contribute to monitoring and reporting on AR2 activities related to PHC emergency preparedness and surveillance and climate change resilience.
Department of Environmental Health (Undersecretary of Public Health)	It is inserted in the Division of Healthy Policies and Promotion, which in turn depends on the Undersecretary of Public Health. Responsible for ensuring that all factors, elements or agents of the environment that affect the health, safety and well-being of the country's inhabitants are eliminated or controlled in accordance with the provisions of the Sanitary Code and its regulations. Its policies, standards, and mandates on environmental health issues must also be implemented in new APS establishments that are built with credit from the Program.
Occupational Health Department (Undersecretary of Public Health)	Also dependent on the Division of Healthy Public Policies and Promotion. Its main objective is to promote the development of healthy work environments that improve the quality of life of workers, therefore, it complies with regulatory, supervisory and advisory functions to contribute to the formulation of environmental and work health policies, preparing plans and national programs to protect the health of the population and workers from the risks associated with the environment. Its policies, norms and mandates in matters of occupational health must also be implemented in the new APS establishments that are built with the credit of the Program.
Regional environmental management	

Regional Health Ministerial Secretariats (SEREMIS)	The regional health authority must supervise and sanction provisions of the Sanitary Code and other regulations. Likewise, the Health SEREMI oversees matters such as hygiene and safety of the environment and workplaces; food; laboratories; pharmacy; burials; exhumations and transfer of corpses. In terms of Occupational Health, supervision falls on the Units or Sub-departments of Occupational Health of the SEREMIS in each region. In terms of Environmental Health, at the regional level, control falls on the Department of Sanitary Action of the SEREMIS, and may have a different conformation in each region. The SEREMIS will be responsible for supervising and sanctioning provisions of the Sanitary Code and other regulations in the new APS establishments that are built with the WB credit, during their construction and operation, related to factors of environmental quality, emissions, waste, drinking water, sewerage, safety and hygiene in PHC establishments, among others. It is the regional authority that issues the health authorization for the start of operation of a health facility.
local environmental management	
Health Services (SS)	The SS depend on the Undersecretary of Assistance Networks of MINSAL. Regulated by Law No. [19,937] on the Health Authority and the Health Services Regulations (Decree 140/2004). There are 29 SS in the country. In Article 22 (of Decree 140) on the functions of the Sub-directorate of Physical and Financial Resources of the SS, it is established, among others, that the SS must ensure compliance with policies and regulations regarding infrastructure, physical resources and supply. Based on information provided by the MINSAL to date, the Health Services (SS) with jurisdiction in the communes where the new PHC establishments included in the PforR are implemented, will be responsible for the construction, and corresponding A&S supervision of the construction of new PHC establishments. The W&S management requirements will be aligned with the relevant national regulations and the basic principles established in the PforR Financing Policy and Directive, and will be supervised by the Health Service Directorate responsible for the work, through a Technical Works Inspector. who will be hired by the SS for the tasks of monitoring compliance of the execution of the work with the conditions of the contract and the legal framework applicable to the specific work.
Municipalities	The municipal governments have among their responsibilities, ensuring the protection of the environment and guaranteeing the safety and public health of their territory, supervising compliance with environmental and safety and public health legislation of civil works in their municipality, granting permits for works, facilitate proper waste management, provide sanitary services to your commune, control air pollution, among others. This is done in collaboration with the regional ministerial secretaries for the environment and health in the region where they are located, among other relevant public institutions. The municipal government will apply its pertinent norms and ordinances in the construction and operation of the new APS establishments included in the Program, as has already been explained, in general, in this section.

4.1.3 Implementation of Environmental Management Systems

In Chile, the management and supervision of environmental aspects of civil works in health establishments are regulated by various regulations and entities in charge of ensuring compliance with environmental provisions, as stated in the previous sections.

In the first place, the main regulation that regulates environmental aspects in Chile is Law No. 19,300 LBGMA. This law establishes the basic principles and standards for the protection, conservation and recovery of the environment, and establishes the Environmental Impact Assessment System (SEIA) and its regulations (RSEIA). The SEIA is an environmental management instrument that allows evaluating and forecasting the environmental impacts that projects and activities carried out in the country may generate and that, according to the law, must be evaluated. Article 10 of Law No. 19,300 establishes which are the projects or activities that must be submitted to the SEIA and art. 3 of the RSEIA, specifies these projects.

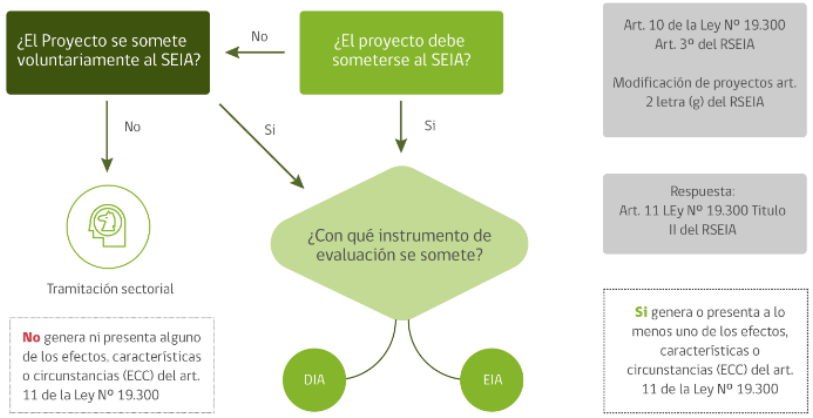
Law No. 19,300 also distinguishes between projects that must submit an Environmental Impact Statement (DIA) and those that must submit an Environmental Impact Study (EIA). The projects and activities that must present an EIA are regulated in article 11 of the same law and, in general, refer to those that have significant impacts. The minimum contents of the EIA and DIA are established in articles 18 and 19 of the SEIA Regulation, respectively.

Therefore, to manage and supervise the environmental aspects of the civil works carried out by the Health Services in Chile, the procedures established in Law No. 19,300 must be followed and the projects submitted to the SEIA, obtaining the corresponding RCA and complying with the established mitigation and environmental monitoring measures. The SMA is in charge of monitoring compliance with these provisions and applying sanctions in case of non-compliance.

It is highlighted that, although the Program will exclude works that may cause significant risks and impacts, described in the exclusion list (section 2.2.8), including those that require, in accordance with the LBGMA and its regulations, an Environmental Impact Study. Interventions that could require a DIA are not excluded, for example in the case of the construction of the new PHC establishment model that includes the Program, which would be small-scale works, could require a DIA if the work had any regulatory impossibility, for example, that for its construction it is required to change the use of the land.

In general terms, the environmental evaluation process can be graphed as follows:

Figure 1Environmental assessment process



Source: SEA, available at: https://www.sea.gob.cl/evaluacion-de-impacto-ambiental/cual-es-el-proceso-de-evaluacion-de-impacto-ambiental .

Health infrastructure projects and therefore PHC, in accordance with the provisions of Law 19,300 and its regulations (RSEIA), belong to the typology of an urban or real estate development project and should be submitted to the SEIA if it is likely to cause an environmental impact. For this, one of the following specific criteria must be met (RSEIA, Article 3, literal g.1.2 and literal h.1):

- This is located in an area that has not been declared saturated or latent and has a constructed area equal to or greater than 5,000 m ^{2};
- with property surface equal to or greater than twenty thousand square meters (20,000 m ^{2});
- a capacity of attention, influx or simultaneous permanence equal to or greater than 800 people;
- or has 200 or more vehicle parking spaces.
- This is located in an area declared saturated or latent and requires its own production and distribution systems for potable water or collection, treatment and disposal of wastewater;
- or has capacity for 5,000 or more people;
- or has 1,000 or more parking spaces

In view of these criteria (previous paragraph), in the case of the new infrastructure that is planned to be built with a World Bank credit, due to its type and scope, described in section 2.2.5 of this document, these will not require submitting to the SEIA, in accordance with Law No. 19,300 and its regulations, unless the work has some regulatory impossibility, such as the requirement to change land use for its construction, as previously mentioned. If a project does not meet the criteria established to submit to the SEIA and obtain an RCA, it is considered a smaller project or one with lesser environmental impacts. However, even if the RCA is not required, it is important that the works under the responsibility of the Health Services comply with the environmental provisions established in the LBGMA and other applicable regulations as described in section 4.1.1. Therefore, the companies contracted to carry out the works must comply with the legal framework applicable to the work and implement preventive measures, mitigation and environmental, safety and health and social control that must be specified in the bidding documents for the work and contract for construction, as explained in section 4.1.2 of this document.

Some of the actions that are carried out to manage the environmental aspects of these projects that do not require submitting to the SEIA are at least:

- **Identification of environmental aspects:** Carry out an initial evaluation to identify the possible environmental and social aspects associated with the work. This implies analyzing the possible risks and impacts on the natural and social environment, such as the generation of waste, emissions, noise, use of natural resources, risks of natural disasters, among others.
- **Planning and design:** Consider from the initial stages of the works measures for the prevention, mitigation and control of environmental risks. This implies designing and planning the work in such a way that negative effects on the environment are minimized and sustainability is promoted.
- **Regulatory Compliance:** Ensure compliance with all applicable local, regional and national environmental regulations. This includes regulations on air quality, waste management, land use, protection of natural resources, road safety, among others.
- **Monitoring and follow-up:** Establish a monitoring and follow-up program to evaluate the environmental performance of the works during their execution. This implies carrying out periodic measurements of relevant environmental variables and evaluating compliance with the established limits and standards.

- **Training and awareness:** Promote the training and awareness of the personnel involved in the works (contractors, subcontractors, supervisory firms, among others) regarding relevant environmental aspects and the mitigation and control measures to be implemented. This ensures that all those responsible are familiar with good environmental practices.

4.2 If relevant social management systems for PforR

4.2.1 Legal and regulatory framework for the social management of the Program

The right to health is considered a universal and inalienable human right [24]. According to the World Health Organization, "A human rights-based approach to health offers strategies and solutions that make it possible to face and correct inequalities, discriminatory practices and unfair power relations that are often central aspects of inequity in health outcomes" [25].

In the area of human rights, Chile has signed all the substantial international treaties in force within the framework of the United Nations and the Inter-American System for the Protection of Human Rights, with three ratifications still pending.[26] [27] [28]as described in the Social Assessment Annex to this document. In addition, in terms of Primary Health Care, Chile has signed the Declaration of Alma Ata. (1978) and the Astana Declaration (2018).

At the national level, the current Political Constitution of the Republic of Chile [29]guarantees all people the right to health protection, and states that "The State protects free and equal access to actions for the promotion, protection and recovery of health and rehabilitation of the individual. It will also be responsible for the coordination and control of actions related to health. It is a preferential duty of the State to guarantee the execution of health actions, whether they are provided through public or private institutions, in the manner and conditions determined by law, which may establish mandatory contributions.

Since 1990, the Chilean State has made progressive progress in recognizing, promoting and guaranteeing human rights, non-discrimination, citizen participation and the resolution of claims addressed to the State Administration, through a set of laws, regulations, institutions and mechanisms. that contemplate guarantees in state actions and benefits for all citizens, but also for some Special Attention Groups (GEA) [30].

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[24] Article Nº 25. Universal Declaration of Human Rights. 1948. United Nations. Source: https://www.un.org/es/about-us/universal-declaration-of-human-rights

[25] Health and Human Rights. 2022. World Health Organization. Source : https://www.who.int/es/news-room/fact-sheets/detail/human-rights-and-health

[26] As of the date of this report, the ratifications of: the International Covenant on Economic, Social and Cultural Rights are pending; the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance; and the Inter-American Convention against All Forms of Discrimination and Intolerance.

[27] International Treaties Signed and Ratified by Chile on Human Rights. International recommendations with constitutional incidence. 2020. Parliamentary Technical Advisory. Department of Government, Defense and International Relations. SUP No .: 123705. Source: https://obtienearchivo.bcn.cl/obtienearchivo?id=repositorio/10221/28223/1/Acuerdos_internacionales_e_incidencia_constitucional_rev_BH.pdf

[28]See Annex Social Assessment: international legislative framework on human rights and health.

[29] Decree No. 100 that Sets the Consolidated, Coordinated and Systematized Text of the Political Constitution of the Republic of Chile. 2005. Ministry General Secretariat of the Presidency. Source : https://bcn.cl/2f6sk

[30] Groups of Special Attention (GEA) are considered to be those groups made up of people who, due to various physical, social, economic or cultural conditions, are at a disadvantage in the enjoyment and exercise of their rights with respect to other groups in society, and who they may require affirmative actions on the part of the State to replace this disadvantage, such as: Boys, girls and adolescents (NNA); victims of human rights violations by the State; women; population of sex-generic diversities ; people in

The Ministry of Health, like the rest of the State departments, must consider this legal framework in its procedure, which establishes acceptable degrees in terms of guarantee and protection of rights, non-discrimination, citizen participation and consultation, access to information and mechanisms to file complaints.

This regulatory framework can be seen in the following table:

Table 7General regulatory framework on the guarantee and protection of rights, non-discrimination and citizen participation and consultation

Guy	No.	Year	Rule	Ministry	GEA
Constitutiona l reform	Article Nº5	1989	It elevates recognition and respect for human rights and the duty of the State to protect them to constitutional status.	All	All
Law	20,285	2008	About Access to Public Information	Ministry General Secretariat of the Republic	All
Law	20,405	2009	Creates the National Institute of Human Rights (INDH)	autonomous entity	All
Law	20,500	2011	On associations and citizen participation in public management	Ministry General Secretariat of Government	All
Law	20,609	2012	Establishes measures against discrimination	Ministry General Secretariat of Government	All
Law	20,885	2016	Creates the Undersecretary of Human Rights	Ministry of Justice and Human Rights	All
Law	21,067	2018	Create the Ombudsman for Children	autonomous entity	Childhood
decree	680	1990	Approves Instructions for the Establishment of Information Offices for the User Public in the State Administration	Ministry of the Interior and Public Security	All
decree	236	2008	Promulgates Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries of the International Labor Organization	Ministry of Foreign Affairs	Indigenous and Tribal Peoples
decree	66	2013	Approves Regulations Governing the Indigenous Consultation Procedure by virtue of Article 6 No. 1 Letter a) and No. of Convention No. 169 of the International Labor Organization and Repeals Regulations Indicating	Ministry of Social Development and Family. Undersecretary of Social Services	Indigenous and Tribal Peoples

poverty; migrants and refugees; old people; people with disabilities; persons deprived of liberty; indigenous and tribal peoples; and victims of the crime of Human Trafficking and Sexual and Labor Exploitation. International Instruments, Observations and General Recommendations of Human Rights on Equality, Non-Discrimination and Special Protection Groups. 2014. National Institute of Human Rights. Fountain: https://bibliotecadigital.indh.cl/bitstream/handle/123456789/654/instrumentos.pdf?sequence=1&isAllowed=y

Res. Ex.	1,757	2018	Creates Observatory for Citizen Participation and Non-Discrimination	Ministry General Secretariat of Government	All

In addition, Chile has a solid track record in public health, its origins dating back to the 19th century and the Primary Health Care Network has played a fundamental role in prevention and health promotion over the years.

Among the main milestones of the Public Health System in Chile related to the development of PHC, the formation of the National Health Service (1952-1979), the reform that gave rise to the National Health Services System in 1979, the modality of municipal administration of APS since 1981; and the Health Reform in 2004 that created the Undersecretariat of Assistance Networks, in charge of managing the Health Network at its three levels of care.

The following describes the legal and regulatory framework that governs the Ministry of Health in relation to the administrative aspects that govern the Primary Care Network, its coordination, the rights and duties explicitly guaranteed, and the mechanisms for citizen participation.

Table 8Regulatory Framework for the Primary Care Network in terms of coordination, guaranteed rights and duties and citizen participation mechanisms

Guy	No.	Name	Ministry	Promulgation Date	Subject	Detail	Fountain
decree	602	Create Local Health Councils	Health	09-01-71	Stake	Article 3. - It will correspond to the Local Councils to examine the health problems that affect the community; tend to its solution through quick and effective actions; promote the interest of the inhabitants to participate actively in solving them; collaborate in the dissemination of health action plans, and represent the anomalies that appear in the execution of these actions. Article 5. - The Local Councils of Health Establishments will be made up of: 1.- The head of the establishment of the National Health Service, which serves as the local base for the Council. 2.- A representative of each one of the population organizations (territorial and functional) of the Neighborhood Units of the sector corresponding to the jurisdiction of the Health Establishment. 3.- A representative of each one of the organizations of urban workers and/or Rural Councils constituted in the sector. 4.- A number of representatives, distributed in equal proportion, among the following organizations of health workers of the Establishment: National Federation of Health Workers, Federation of Professionals and Technicians of the National Health Service and officials subject to Law No. 15,076. This number must be determined jointly by the organizations named above and may not be greater than the sum of the representatives of the population organizations of urban workers and/or Campesino Councils. 5.- A representative of the Internal Government Service. 6.- A municipal representative. 7.- A local education representative. ANNEX: However, and in relation to the functions provided for said Councils in the document under review and, especially, with what is established in articles 6 and 9 in order that the Joint Councils referred to in those precepts are directly responsible for the compliance with the "functions and powers" assigned to the Local Health Councils and must "contribute to the development of health programs", it is opportune, in the opinion of this Office of the Comptroller General, to point out that this cannot be understood except in the sense that the aforementioned Councils have to act as mere advisory or consultative bodies, without, therefore, it being possible to consider that those norms would allow the development of functions of	https://bcn.cl/2xybo

						a decision-making or executive nature, which are exclusive to the public departments that must be created by law.	
DFL	36	Norms that will be applied in the Agreements that the Health Services celebrate	Health	07-10-80	Execution	Describes the provisions that govern the agreements entered into between the Health Services and the natural or legal persons entrusted with the exercise of health actions through said agreements.	https://bcn.cl/2n1dj
Law	18834	Approves the Administrative Statute	Inside	09-15-89	Public administration	Regulates the relations between the State and the personnel of the State Civil Administration for the fulfillment of its administrative function.	https://bcn.cl/2fxvv
DFL	4	Adapts Plants and Ranks of the National Health Fund to Article No. 5 of Law 18,834 on Administrative Statute	Health	02-28-90	Public administration	Describes the plant and ranks of health personnel	https://bcn.cl/3dzan
Law	19378	Establishes Municipal Health Primary Care Statute	Health	03-24-95	PHC staff	Rules the administration, financing regime and coordination of primary health care, whose management will be transferred to the municipalities.	https://bcn.cl/2f8iv
Law	19490	Establishes Assignments and Bonuses for Health Sector personnel	Health	03-01-97	Public administration	Establishes the annual creation of Improvement Programs associated with goals of efficiency and quality of services that will accrue monetary incentives for health officials.	https://bcn.cl/2ga62
Law	19602	Modifies Law No. 19695, Constitutional Organic of Municipalities, in Municipal Management Matters	Inside	03-12-99	Municipalities	Authorizes municipalities to develop, directly or with other bodies of the State Administration, functions related to public health and environmental protection. In addition, it establishes the duty of each municipality to have an ordinance for the modalities of citizen participation at the local level.	https://bcn.cl/2qhhz
Law	19813	Grants Primary Health Benefits	Health	06-18-02	PHC staff	Article 1.- Establishes for personnel governed by the Primary Care Statute of Law No. 19,378, an assignment for development and encouragement of collective performance...	https://bcn.cl/2m8lz
Law	19937	Modifies DL Nº 2763, of 1979, with the purpose of	Health	01-30-04	Reform	It transforms the former Health Undersecretary into two Undersecretaries: a Public Health Undersecretary and a Healthcare Networks Undersecretary. In addition, it transforms the previous ISAPRES Superintendence into the Health Superintendency,	https://bcn.cl/2f7j5

		establishing a new conception of the health authority, different management modalities and strengthening Citizen Participation				with powers to supervise not only the ISAPRES but also the National Health Fund (FONASA) and public and private health providers.	
Law	19966	Establishes the Health Guarantees Regime	Health	08-25-04	Rights and Duties in Health	It establishes Explicit Health guarantees related to access, quality, financial protection and opportunity with which the benefits associated with a prioritized set of programs, diseases or health conditions indicated by the corresponding decree must be granted. The National Health Fund and the Social Security Institutions must compulsorily ensure said guarantees to their respective beneficiaries.	https://bcn.cl/2fckl
decree	136	Organic Regulation of the Ministry of Health	Health	08-09-04	Public administration	Describes the functions of the Ministry of Health. Article 15.- The Ministry of Health must ensure the effective coordination of healthcare networks, at all levels of complexity, articulating the entities of the system that provide services for promotion, prevention, protection, recovery, rehabilitation, palliative care, way to obtain maximum efficiency and effectiveness in the development of these actions and the best use of available resources. In order to fulfill this function, it will dictate the resolutions and adopt the necessary measures leading to obtaining an adequate and expeditious collaboration between said entities.	https://bcn.cl/3dzap
DFL	1	Fixed Consolidated, Coordinated and Systematized Text of Decree Law No. 2,763 of 1979 and Laws No. 18,933 and No. 18,469	Health	09-23-05	equal access Free access Stake	Art 1º: The Ministry of Health and the other organizations contemplated in this Book are responsible for exercising the function that corresponds to the State to guarantee free and equal access to actions for the promotion, protection and recovery of health and rehabilitation of the person. sick… Article 18: ...The beneficiaries referred to in Book II of this Law must enroll in a primary care facility that is part of the Health Service Assistance Network where their home or workplace is located. Article 34.- There will be an Advisory Council for Users, which will be made up of 5 representatives of the neighborhood community and 2 representatives of the Establishment's workers.	https://bcn.cl/2qjwe

						Article 40.- By resolution of the Undersecretary of Assistance Networks, the way in which the user population of the Establishment may express their requests, criticisms and suggestions will be regulated. Article 131.- The exercise of the constitutional right to health protection includes free and equal access to health promotion, protection and recovery actions and those aimed at the rehabilitation of the individual, as well as the freedom to choose the state or private health system to which each person wishes to benefit.	
Law	20548	Regulates the Rights and Duties of People in Relation to Actions Related to their Health Care	Health	04-13-12	Rights and Duties in Health	Article 2.- Every person has the right, regardless of the provider that carries out actions for the promotion, protection and recovery of their health and their rehabilitation, to have them given in a timely manner and without arbitrary discrimination, in the forms and conditions determined the Constitution and laws.	https://bcn.cl/2f7cj
Law	20645	Creates an Assignment Associated with the Improvement of the Quality of User Treatment, for Officials Governed by the Municipal Primary Health Care Statute	Health	12-14-12	PHC staff	Assignment to Municipal APS officials associated with user treatment	https://bcn.cl/2k2lt
Law	20646	Creates Assignment Associated with the Improvement of the Quality of User Treatment, for Officials Belonging to the Technician, Administrative and Auxiliary Plants of Health Services Establishments	Health	12-14-12	PHC staff	Assignment to Health Services officials associated with user treatment	https://bcn.cl/2m3ei
Rule		Methodology for the Preparation, Evaluation and Prioritization of	Ministry of Social Developmen	2013	Social variables to consider	Page 70 Considers the variables of: Gender approach (does not detail) Environment (does detail) Intercultural and Heritage Relevance (does detail)	https://sni.gob.cl/storage/docs/Atencio%CC%81n-

		Primary Care Projects in the Health Sector	t and Family (MIDESO)				Primaria-Salud-2013.pdf
Law	20850	Create a Financial Protection System for Diagnoses and High Cost Treatments	Health	06-01-15	Rights and Duties in Health	Creates a Financial Protection System for Diagnosis and Treatment of High-Cost Diseases, insured by the National Health Fund for the beneficiaries of the Chilean health insurance systems;	https://bcn.cl/2fpjz

4.2.2 Institutional framework for the social management of the Program

Currently, the system of pension health insurers in the country is mixed: public and private. According to the public account of the National Health Fund (FONASA) 2022, 77% of the population living in national territory is affiliated with FONASA; On the other hand, private health insurance (ISAPRE) covers 17% of the population.

Health System Governance: The Ministry of Health (MINSAL) is responsible for: (i) formulating, creating, and coordinating health plans at the sectoral and intersectoral level (public and private) and with national and international coverage; (ii) issue and ensure compliance with general and specific regulations on health issues; (iii) carry out sanitary surveillance and evaluate the health of the population; (i) formulate and execute the annual sectoral budget; and (v) coordinate care networks at all levels.

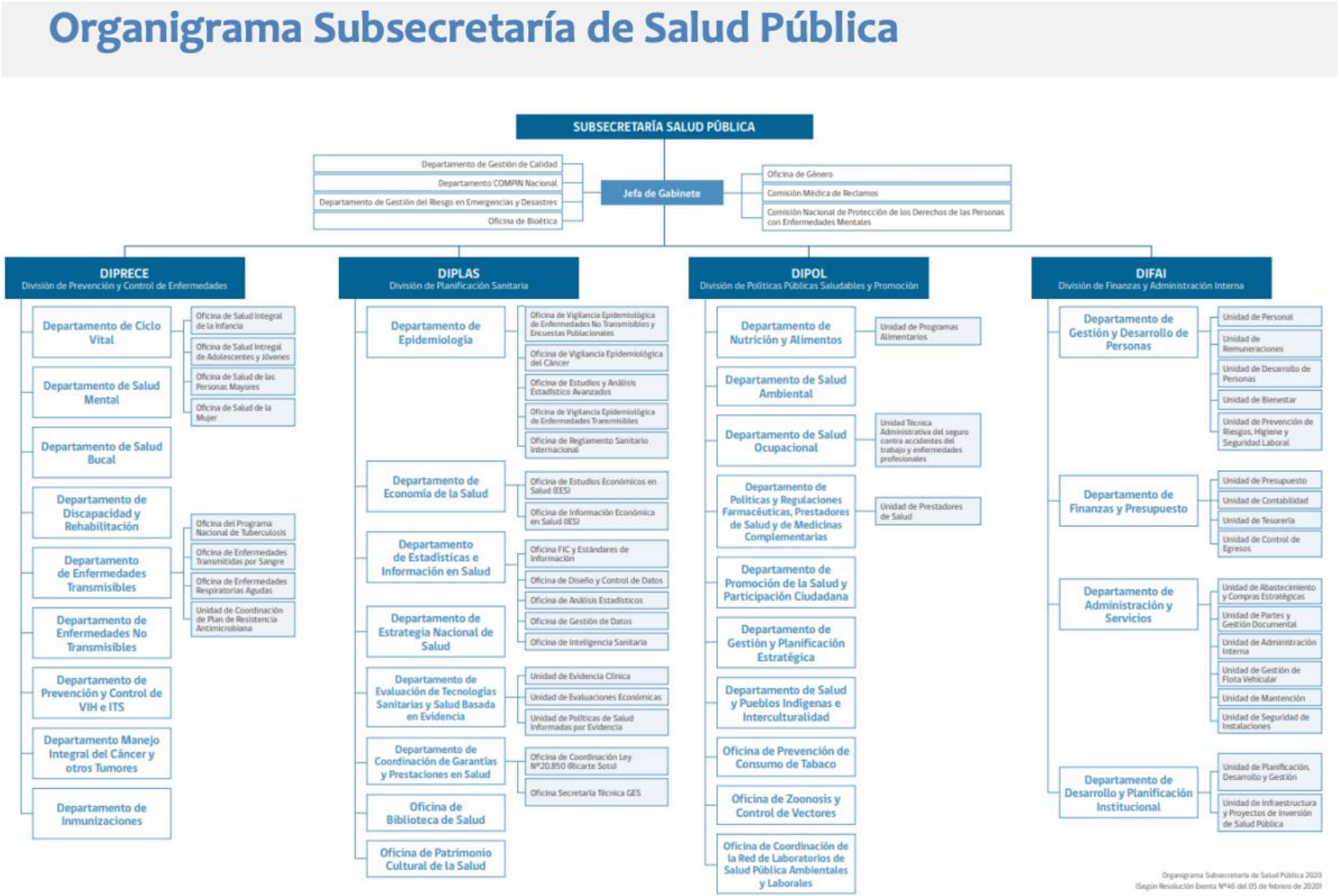
The Ministry is made up of two sub-secretariats:

1. The Undersecretariat of Public Health, in charge of leading the health strategies that allow improving the health of the population, exercising the regulatory, normative, surveillance and supervisory functions that the State of Chile is responsible for in matters of public health.
2. The Undersecretary of Assistance Networks, in charge of regulating and supervising the operation of health networks through the design of policies, regulations, plans and programs for their coordination and articulation.

Figure 2Compact Organization Chart of the Ministry of Public Health

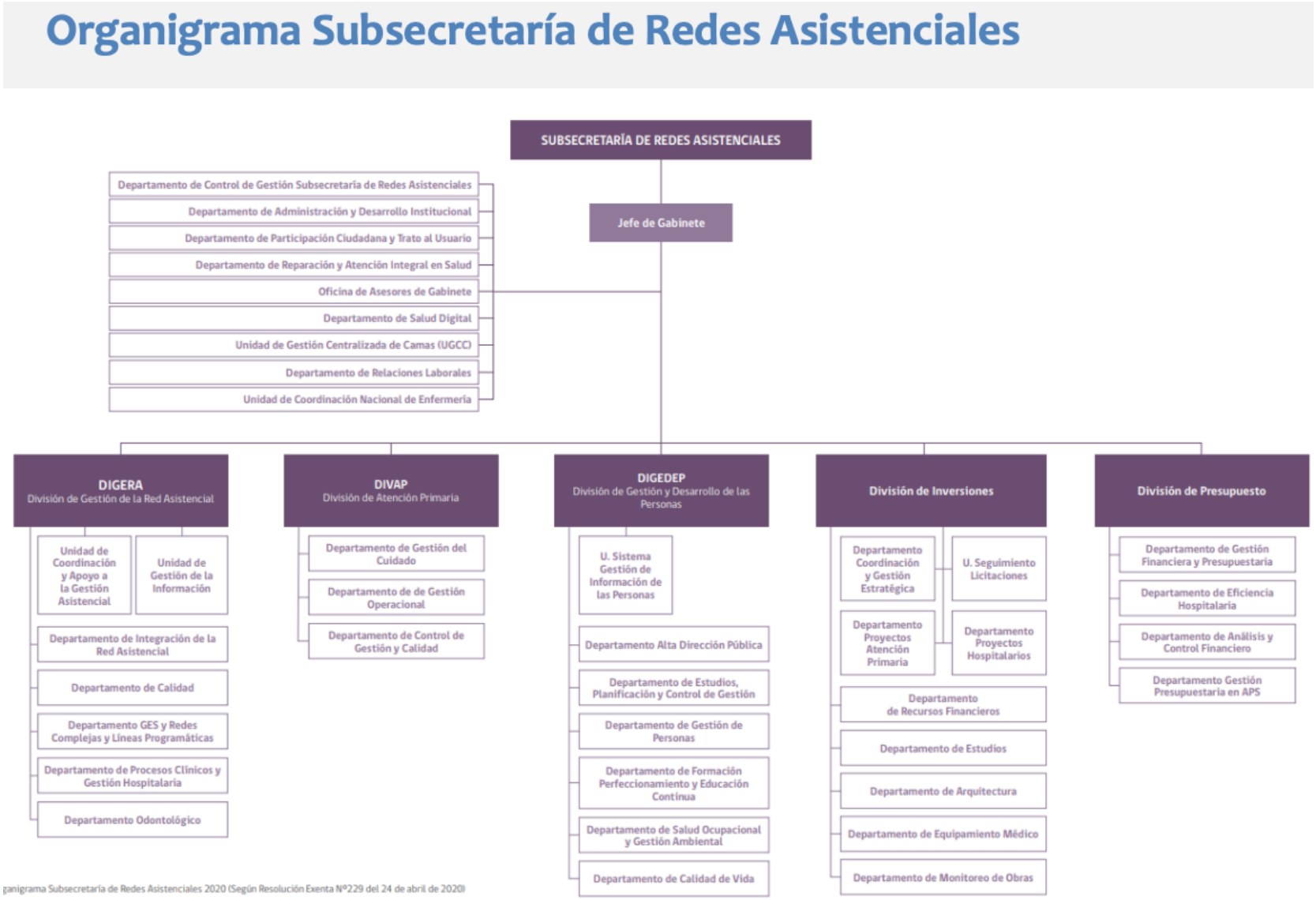
Source: MINSAL Presentation. 2020. Link: https://saludresponde.minsal.cl/wp-content/uploads/2020/11/Presentacion-estructura-minsal.pdf

Figure 3Organizational chart Undersecretary of Public Health



Source: MINSAL Presentation. 2020. Link: https://saludresponde.minsal.cl/wp-content/uploads/2020/11/Presentacion-estructura-minsal.pdf

Figure 4Organizational chart Undersecretary of Assistance Networks



Source: MINSAL Presentation. 2020. Link: https://saludresponde.minsal.cl/wp-content/uploads/2020/11/Presentacion-estructura-minsal.pdf

Governance , regulation and other functions of the health system in Chile are exercised by the sector as a whole through the following entities:

Ministry of Health (MINSAL) whose mission is to build a health model based on strengthened and integrated primary care, which puts the patient at the center, with an emphasis on caring for populations throughout the life cycle, and which also stimulate health promotion and prevention, as well as monitoring, traceability and financial coverage.

Bodies dependent on MINSAL:

1. Regional Ministerial Secretariats of Health (16 SEREMI of Health, one per region) that exercise the function of health authority in the regions.

Autonomous, decentralized bodies, with management autonomy, own assets and dependent on MINSAL:

1. The 29 Health Services, in charge of managing the health care networks of their constituencies (region, province or other, depending on the extension of the territory).
2. The National Health Fund (FONASA), in charge of collecting, managing and distributing the financial resources of the health sector, financing the health benefits granted to its users, characterizing the people benefited by this Fund and managing public health insurance.
3. Institute of Public Health (ISP), which has the function of regulating medicines and medical supplies, in addition to acting as a national reference laboratory and producing vaccines and reagents.
4. Health Superintendence, in charge of protecting the ISAPREs and FONASA, among other functions.
5. The National Supply Center (CENABAST) in charge of acting as an intermediary for the purchase of products for the public health sector.

Management of the Assistance Network: In order to adequately manage the public health assistance network, MINSAL has 29 Health Services throughout the country that are related to MINSAL through the Assistant Secretariat for Assistance Networks, which exercises, among other functions, the role of coordination between the Health Services and the Ministry. In addition, PHC service providers are related to MINSAL through Health Services.

The Health Services are functionally decentralized state agencies, endowed with legal personality and their own assets. They are administratively related to the health authority through the Undersecretariat of Assistance Networks.

The healthcare network of each Health Service is made up of three levels of care: primary, secondary and tertiary, differing from each other by the level of complexity in the care they provide and the coverage they have. The primary level is considered the first point of contact for the community with the Network and is intended to provide less complex services aimed at health promotion and prevention; the secondary level is oriented to grant specialized services to those who have been referred from the primary level or an emergency unit. The tertiary level is mainly oriented towards highly complex services.

Primary Care Network : Chilean Primary Health Care has wide geographical coverage and has different administrative units:

a. Primary Municipal Health Care, whose administration is found in the municipal health administrating entities and their network of establishments. According to the Department of Health Statistics and Information, MINSAL (DEIS), 92% of the PHC Network establishments are managed by municipalities.
b. Primary Care, dependent on the Health Services themselves, whose administration is the corresponding Health Service, with its establishments, rural and urban general offices, attached or not. According to the DEIS, about 7% of PHC establishments are managed under this modality.
c. Non-Governmental Organizations (NGOs), which through DFL 36/80 agreements signed with the respective Health Services, execute actions at the primary level of care. It corresponds to 1% of the total.

PHC establishments are classified as follows:

Community Mental Health Center (CECOSAM);

Family Health Center (CESFAM);

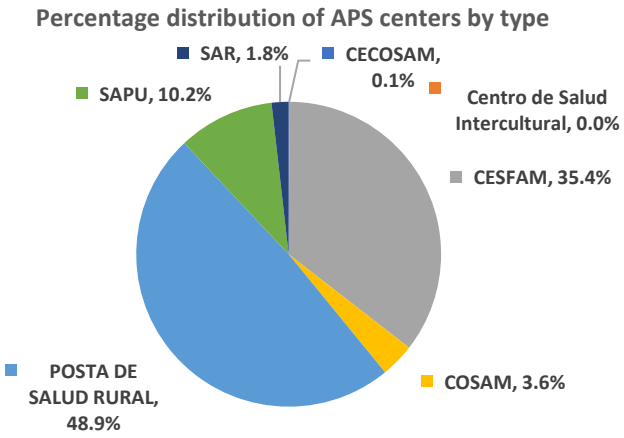
Intercultural Health Center;

Mental Health Center (COSAM);

Rural Health Post;

Primary Emergency Care Service (SAPU);

Resolution Emergency Primary Care Services (SAR).



Source: Own elaboration based on information published by the Department of Health Studies and Information [29]

According to data published by [31]MINSAL's Department of Health Statistics and Information (DEIS), it is estimated that there are currently around 2,366 PHC establishments present in 336 of the country's 346 communes. Rural Posts are the type of PHC establishment with the greatest presence in the country, followed by Family Health Centers (CESFAM).

Health information systems: The most solid element of the information system is represented by certificates of vital events (births and deaths), whose coverage reaches almost 100% and allows calculation of mortality rates and disease burdens. The communicable disease surveillance system is also functional and universal. The scarcest data are those that refer to other diseases that are not included in the surveillance system, as well as to financing and provision of services, particularly in the private sphere. During the COVID-19 Pandemic, MINSAL's information systems were reinforced.

Organization of health regulation actions : Health care is regulated by regulations framed in the health programs established by the Ministry of Health. These programs define coverage, frequency or periodicity of contacts between users and care providers, as well as responsibilities by level of care in the system.

[31] List of establishments. Department of Health Studies and Information (DEIS) of the Ministry of Public Health. Consulted in June 2023. Source : https://reportesdeis.minsal.cl/ListaEstablecimientoWebSite/default.aspx

Sanitary regulation of public sector health establishments is the responsibility of the Health SEREMI of each Region.

Certification and the exercise of the health professions : Professional titles can only be delivered by universities, which in turn are regulated by the Ministry of Education. The legal framework does not establish the mandatory certification of a medical specialty after obtaining the professional title of Surgeon. By virtue of the changes derived from the health reform of 2004 (Law 19,937), the Ministry of Health, together with the Ministry of Education, is assigned the responsibility of establishing a system of certification of specialties and subspecialties of professional individual providers. with the character of natural persons. The Superintendence of Health is responsible for the supervision of all public and private health providers, as natural persons with respect to their certification.

Organization of public health services , in the context of a National Health Plan, general objectives are established aimed at promoting healthy lifestyles and environments, increasing individual and community knowledge and capacity for self-care, and reinforcing the regulatory function of the State on the determinants of health.

4.2.3 Implementation of social management systems

In addition to the general regulatory framework described in this document, which establishes mechanisms to manage citizen participation processes, access to information, resolution of claims and conflicts, as well as consultations with indigenous and tribal peoples in matters that concern them. , the Ministry of Health has in its two sub-secretariats divisions, departments and units aimed at designing, disseminating and supervising public policies aimed at safeguarding the universal right to health and access to decent and quality benefits.

On the other hand, the Ministry of Social Development and Family (MIDESO), through its Sub-Secretary for Social Evaluation, has developed a solid evaluation framework for social policies aimed at the permanent evaluation of the social programs implemented by the State, through the Ex-Ante and Ex-Post evaluations, whose objective is to evaluate the consistency of the program design, in order to resolve situations of fragmentation and possible duplication of programs, that is, interventions aimed at solving similar problems for very similar populations.

The Ex-Ante evaluation is the first step in the life cycle of public, social and non-social programs. The Budget Office (DIPRES) and the Undersecretariat for Social Evaluation verify that there is coherence between the public problem to be addressed, the affected population, the defined objectives and the measurement of results. This allows for subsequent ex-post monitoring and evaluation of the initiative, which contributes to greater efficiency and transparency in the use of public resources. The results of the evaluations, ex-ante and ex-post, can be reviewed in the Integrated Bank of Social Programs [32].

These evaluations -coordinated by DIPRES and the MIDESO Social Evaluation Undersecretariat- also generate inputs for the budget formulation process, which contributes to greater transparency of public spending and facilitates the monitoring and subsequent evaluation of the performance of the public offer.
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In general, the evaluations carried out by the Undersecretariat for Social Evaluation generate recommendations that the departments must adopt in the shortest possible time.

[32] Integrated Bank of Social Programs. Source: https://programassociales.ministeriodesarrollosocial.gob.cl/que_es#marcador-3

4.3 Evaluation of the Program's environmental and social management systems in relation to the basic principles of the PforR policy

Based on the evaluation of the ASSL systems applicable to the Program, it is concluded that in general, the legal and regulatory framework in Chile is aligned with the basic principles of the PforR policy and the planning elements of the PforR directive. The legal framework of laws, regulations, guidelines, policies and norms provide complete coverage of environmental, health and safety aspects. The country's legal framework, in general, provides a reasonable basis for addressing the environmental, health and safety issues that are likely to arise in the proposed PforR, as described in the previous section.

The result of the evaluation carried out for each principle is presented below:

Table 9Result of the Environmental and Social Evaluation by Basic Principles of the PforR

Basic Principle 1. The environmental and social management systems of the Program are designed to (a) promote environmental and social sustainability in the design of the Program; (b) avoid, minimize or mitigate adverse impacts; and (c) promote informed decision-making in relation to the environmental and social effects of the Program.
In general terms, there is a well-developed general and sectoral legal and regulatory framework on E&S, as well as an institutional framework at the national and regional level with clear and defined functions, as detailed in section 4.1 and 4.2 of this document. Based on the information provided to date, the Health Services (SS) will be responsible for bidding and supervising the execution of the PHC infrastructure works included in the Program. These apply bidding processes, in accordance with the standard bases for this type of works established by the National Comptroller's Office, which include the requirement that the works comply with the applicable legal framework, including that referring to the environment and social issues. The bidding documents must also include technical specifications including the requirements for planning prevention, mitigation, and environmental, health, safety, and social control, based on the complexity of the work in question that the contractor must implement. The SS supervise the implementation of the E&S management requirements during the execution of the work with the support of an ITO who is a professional with the competencies and accreditations validated by the State to carry out this task. The contractor of the works must also have among its staff a risk prevention specialist responsible for supervising and enforcing the requirements of the work in environmental, safety, health and social matters. The works are permanently supervised by different competent authorities. There is a complaints and claims mechanism that works in this type of works, where the DOM and the ITO receive the complaint or claim and must seek that the contractor resolve it. Therefore, based on the information available to date, as indicated in the previous paragraph and analyzed in more detail in sections 4.1 and 4.2, no relevant differences have been identified regarding this principle and the processes for management and supervision. environmental and social aspects of the Program.
Basic Principle 2: The Program's environmental and social management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR funding
It is specified that the Program includes an exclusion list of activities as detailed in section 2.2.8, among which are, among others, those associated with construction in protected areas or priority areas for the conservation of biodiversity, such as defined in national legislation; activities that have the potential to

cause significant loss or degradation of critical natural habitats, either directly or indirectly, or that may generate adverse impacts on these habitats, including urban or rural wetlands; and any activity that affects physical cultural heritage, such as tombs, temples, churches, historical relics, archaeological sites, or other cultural structures; activities that due to their magnitude and scale require an Environmental Impact Study, according to the SEIA. Therefore, the interventions proposed in the Program are not expected to cause significant adverse impacts on critical natural habitats or on critical cultural heritage.

In addition, as explained in section 4.1, based on the information provided to date on the scope and typology of the works to be built under the Program, these will not have to submit to the SEIA, however, they will also have to comply with applicable environmental and social legislation, regarding the identification and management of E&S risks, related, for example, to environmental quality, natural resource management, hazardous and non-hazardous waste management, land use, among others. This will be addressed by the corresponding SS when preparing the bidding file for the work with all the technical and regulatory issues resolved and the feasibility of executing the work, including aspects of prevention, mitigation and environmental control, requirement to obtain the building permit issued by the corresponding municipality.

Therefore, based on the information available to date, no relevant differences have been identified regarding this principle and the processes for the environmental and social management and supervision of the Program.

Basic Principle 3: The Program's environmental and social management systems are designed to protect the safety of the public and workers against potential risks associated with (a) the construction and/or operation of facilities or other operating practices under the Program; (b) exposure to toxic chemicals, hazardous waste, and other hazardous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

The exclusion list of the Program excludes, among others, activities that imply: i) contamination of air, water or land that causes significant adverse impacts on the health or safety of people, communities or ecosystems; ii) working conditions that expose workers to significant risks to personal health and safety; iii) activities that may cause or lead to forced labor or child abuse, child labor exploitation, or human trafficking, or that employ or involve children, age 14 or older and age 18 or older, in connection with the Program; iv) construction in high-risk areas due to natural hazards (floods, landslides, earthquakes, tsunamis); v) purchase or use of chemical products prohibited/restricted for medical use.

The national and sector institutional, legal, and regulatory framework has policies, laws, and regulations that establish measures, guidelines, and rules for the protection of the safety and health of workers and the community against risks associated with the construction and operation of food establishments . APS (as detailed in Tables 5 and 6). The corresponding SS Directorate, through the ITO, will supervise the implementation in the work of the prevention and control of potential risks related to the safety and health conditions at work and in the community where the work is being built, in addition to the contractor companies. Those who carry out the works are required by law to have a risk prevention professional on site to guarantee the application of the relevant regulations and manage the environmental, health and safety and social risks that may arise. Likewise, during the operation of the new PHC establishments, they must apply the pertinent regulations and will be supervised by the corresponding municipality and SEREMIS.

Therefore, based on the information available to date, no relevant differences have been identified regarding this principle and the processes for the environmental and social management and supervision of the Program.

Core Principle 4**: **Program environmental and social systems manage land acquisition and loss of access to natural resources in a way that prevents or minimizes displacement and helps affected people improve, or at least restore, their livelihoods subsistence and living standards .

It is not clear whether or not the Program contemplates the acquisition of land and whether this may cause people or communities to lose access to natural resources. Even so, the national legal framework is clear in establishing that the expropriation of land by the State must be duly justified and that these must be corrected in such a way that people do not see their livelihoods and living standards affected. In addition, MINSAL has an internal protocol for the preliminary selection of land through which its feasibility is evaluated in conjunction with the municipalities, in terms of ownership, availability of basic services, accessibility and connectivity, among others.

Basic Principle 5**: **The Program's environmental and social systems give due consideration to the cultural appropriateness of and equitable access to program benefits, paying special attention to the rights and interests of indigenous peoples/historically underserved traditional local communities sub-Saharan Africa, and to the needs or concerns of vulnerable groups.

One of the main axes of the Program is to strengthen the cultural adequacy of benefits at the primary health level, through a human rights approach, with a gender perspective and social inclusion, with an emphasis on the LGBTIQA+ population and violence against women. gender, as noted in AR1. In addition, MINSAL has the legal obligation to apply an intercultural health model in those territories with a high concentration of indigenous population, thereby guaranteeing cultural adaptation for these communities.

***Basic Principle 6**: **The Program's environmental and social systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes*.**

According to the information available, it is not observed that the Program's actions could cause social conflicts.

5. RECOMMENDATIONS AND ACTIONS FOR THE E&S SYSTEMS OF THE PROGRAM

Based on the evaluation of the Environmental and Social Management Systems applicable to the proposed PforR, it is concluded that Chile has environmental and social management systems to address the environment, health and safety, as well as the acquisition of land and the concerns of indigenous peoples and other vulnerable groups related to the activities proposed under the PforR framework . These systems are consistent with the basic principles and key planning elements defined in the Bank's Policy for PforR . Potential overall environmental and social risks from this PforR are rated moderate and can be effectively mitigated within existing environmental and social management systems.

However, specific actions and recommendations have been identified to strengthen the effective management of environmental and social risks during the implementation of the Program.

5.1 Actions to include in the Program Action Plan (PAP)

Actions that are proposed to be included in the PAP:

1. **Appoint within the PIU an environmental specialist**, with experience in occupational health and safety, as a focal point for Results Area 2 to facilitate inter-institutional coordination. This specialist would have among its responsibilities:
    - Coordinate and implement the programs for capacity building in W&S management of the executing agencies of the Program;
    - Supervise the performance of the E&S management of the Program, including compliance with the E&S strengthening measures agreed upon in the PAP;
    - Support the preparation of the Program Operating Manual (MOP) and supervise its compliance;
    - Implement an adaptive E&S management approach for the Program (identify changes in the E&S risks and impacts assessed in the ESSA, as well as changes in the E&S systems applicable to the Program that may require new measures to be adopted);
    - Supervise the application of the criteria for exclusion of activities defined in section 2.2.8.
    - Prepare reports and report to the UIP coordinator on accidents that occurred during the construction of the works.
    - Coordinate and support the preparation of periodic monitoring reports that demonstrate compliance with the E&S systems applicable to the Program and the measures agreed upon in the PAP and MOP, as well as other agreed reports, to be submitted to the World Bank; others to be determined.
2. **Appoint a social specialist within the PIU**, with experience in public policies with a human rights approach and a gender and inclusion perspective, as a focal point for Results Areas 1 and 3 to facilitate inter-institutional coordination. This specialist would have among its responsibilities:
    - Coordinate and implement the programs to strengthen the capacities in social management of the executing agencies of the Program;
    - Supervise the performance of the E&S management of the Program, including compliance with the E&S strengthening measures agreed upon in the PAP;
    - Support the preparation of the Program Operating Manual (MOP) and supervise its compliance;

- Supervise the performance of the Complaints and Claims Attention Mechanisms and the response capacity of the Program to the complaints received.
- Implement an adaptive E&S management approach for the Program (identify changes in the E&S risks and impacts assessed in the ESSA, as well as changes in the E&S systems applicable to the Program that may require new measures to be adopted);
- Supervise the application of the exclusion criteria defined by the Bank.
- Coordinate and support the preparation of periodic monitoring reports that demonstrate compliance with the E&S systems applicable to the Program and the measures agreed upon in the PAP and MOP, as well as other agreed reports, to be submitted to the World Bank; others to be determined.

5.2 Processes to include in the Program Operations Manual (MOP)

Processes that are proposed to be included in the MOP include:

1. **Definition of the human resources that will be in charge of environmental and social management in the agencies in charge of executing the new PHC infrastructure to be financed with the World Bank credit.** Define their roles, responsibilities and professional profile. At a minimum, these professionals must have experience in the application of the national legal framework and relevant environmental and social management systems for the works to be built with the World Bank credit.
2. **Checklist to identify activities that meet the exclusion criteria** defined in the ESSA and, therefore, cannot be financed by the Program. This checklist will correspond to the one included in section 2.2.8.
3. **Minimum technical specifications that must be included in the bidding documents for the environmental and social management of the civil works** that will be implemented by the contractors, as well as the ASSL management guidelines that will be applied during the construction and operation of the new APS facilities, consistent with national regulations, relevant international good practices and basic principles and key planning elements set out in the PforR Funding Policy and Directive ;
4. **Template for the preparation of semi-annual environmental and social monitoring reports** that will be submitted to the WB, and will include, at least, the minimum contents of the E&S reports, including the report on the resolution of complaints and claims, as well as the responsibilities and procedure for its preparation.
5. **Procedure for reporting incidents and accidents to the BM**. It will include, at least, the deadlines, procedure, relevant information to include in the report, such as: details of the incident (date, time, person responsible for the report), type and description of the incident, actions taken to address the incident, support provided to the affected person.
6. **Procedure/mechanism for handling complaints and claims.** It will include, at least: the process for registering complaints or claims, the process and deadlines for addressing and following up on them, measures implemented to prevent the causes of the claims from reoccurring, those responsible for implementing the complaints response mechanism, and claims.
7. Others to be determined.

5.3 recommendations

The following recommendations are proposed based on the information available to date. The proposed recommendations will be specified in the final version of the Report for ESSA.

- Design and implement training and certification programs to strengthen the capacities in environmental and social management of the Health Services and/or other agencies that participate, both in the execution of the infrastructure works included in the Program, and in the operation of the new APS centers that are built with financing from the Program.
- Rescue the experience and capacity building in E&S management for the execution of infrastructure acquired by the SS involved in the PforR to replicate it in the operation of other SS in the country.
- Advance in the energy diagnosis and the inventory of greenhouse gases for the determination of the baseline at the APS level to support the implementation of the Framework Law on Climate Change of the country, in terms of adaptation and mitigation of climate change.
- Design and implement an information system for interoperability between the new PHC establishments supported by PforR in the country to facilitate the exchange of information, experience, and implementation of good practices in W&S management, challenges, and lessons learned in the operation of the establishments.
- Incorporate sociodemographic, accessibility and connectivity criteria in the selection of the territories where new APS facilities will be built, in which a survey of the population is considered, especially migrants, both nationally and internationally.
- Detach the evaluation of the user experience from the performance goals of PHC officials.
- Strengthen the mechanisms for citizen and indigenous consultation through mechanisms for returning the results of the consultations, in which the reasons that led the institutions to make decisions are explained to the communities.

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7. SOCIAL EVALUATION ANNEX

Table of Contents

Brief History of the Public Health System in Chile

Chile has a long history in public health.

In 1833 the first School of Medicine was founded and in 1840 some groups of workers organized groups called Mutual Aid Societies (SSM) aimed at providing protection against accidents, illness, disability or death of their members. On the other hand, in 1891 the Superior Council of Public Hygiene and the Institute of Hygiene were created by law, in addition to making municipalities responsible for public hygiene and the sanitary state of their communes.

and Compulsory Worker's Insurance [33]were created by law. [34]Both legal frameworks established the mandatory monthly contribution by workers and employers in order to contribute to a solidarity fund for sickness and disability, in addition to involving the State in the provision of health care and social security for workers.

In 1938 the Preventive Medicine Law was issued. In 1942, the National Employee Medical Service (SERMENA) and the General Directorate for the Protection of Children and Adolescents (PROTFINA) were created.

In 1952, Law No. 10,383 [35]created the National Health Service (SNS) whose responsibility was to carry out all sanitary actions for the promotion of health, disease prevention, healing and rehabilitation. The Workers' Insurance Fund, PROTFINA and the Municipal Medical Services were merged into the SNS.

In 1959 the Ministry of Hygiene, Assistance and Social Welfare was divided into two ministries through Decree with Force of Law No. 25 [36]that created the Ministry of Labor and Social Welfare and the Ministry of Public Health with its corresponding sub-secretary. The new Ministry of Health was left in charge of programming, coordinating, and controlling public health, and the following entities remained under its authority: (i) The National Health Service; (ii) The National Employee Medical Service; (iii) The Hospital Establishment Construction Society; and (iv) La Polla Chilena de Beneficencia.

During the 1960s, important social reforms were carried out aimed at investing in care centers, increasing the public health staff, and extending the geographic coverage of the National Health Service.

Between 1970 and 1973, state health services were improved and a single social security system was created. However, the sustained progress of public health policy was abruptly interrupted by the civil-military dictatorship (1973 and 1988), causing an institutional breakdown that weakened public health policies. In counterweight, non-governmental organizations arose that responded to the health needs of the population not covered by the State, in addition to promoting the adoption of the Alma Ata Declaration. which in 1978 [37]ordered all governments, health workers and the international community to promote

[33] Law No. 4,054 that creates the Workers' Insurance. Fountain: https://bcn.cl/2ngaz

[34] Law Decree No. 131 that creates the Ministry of Hygiene, Assistance and Social Welfare. Fountain: https://bcn.cl/3dwzb

[35] Law No. 10,383 that modifies Law No. 4,054 related to compulsory insurance and that creates the National Health Service. Source: https://bcn.cl/2lpr3

[36] Decree with Force of Law (DFL) No. 25 that creates the Ministry of Labor and Social Welfare with two sub-secretariats and the Ministry of Public Health. Fountain: https://bcn.cl/2map9

[37] In 1978 the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the United Nations Children's Fund (UNICEF) organized the International Conference on Primary Health Care, in which 134 countries participated. and 67 international organizations. It established the Declaration of Alma Ata. which points out the importance of primary health care as a strategy to achieve a better level of health for the people and urges all governments, health workers and the

actions tending to protect and promote the primary health care model as a primary strategy to achieve a better level of health for the people.

In 1979, the National Health Services System (SNSS), the National Health Fund (FONASA), the Public Health Institute (ISP) and the National Supply Center (CENABAST) were created. In addition, the administration of health facilities was decentralized and care was organized according to levels of complexity and coverage, through the municipalization of primary care.

A. A year later, in 1980, the administration and management of the PHC Clinics were transferred to the municipalities and the reform of the pension and health insurance system was carried out, which allowed the entry of private insurers into both systems: Health Insurance [38]Institutions (Isapres) and the Pension Fund Administrators (AFP), which still exist to this day.

In 1985, Law No. 18,469 was passed [39], regulating the exercise of the constitutional right to health protection and creating a health benefits regime that obliges healthcare establishments of the National Health Services System to provide care to those who need it. require, without condition of payment, with some exceptions.

At the same time, during the 1980s, state universities began the professional training of family doctors to teach PHC and there was a growing academic development in family medicine. The universities also supported the creation of Urban General Clinics based on a family health model strategy. In 1989, the National Coordinator of Municipal Health Primary Care Workers was established.

During the 1990s, with the recovery of democracy, the Health Superintendence [40], the Chilean Association of Municipalities (AChM) and the National Confederation of Municipal Health Officials (CONFUSAM) were created. Within this framework, the Primary Care Statute was issued through Law 19,378 [41]and the permanent work table "Tripartite Commission" made up of municipalities, workers and the MINSAL was established by Exempt Resolution.

Henceforth, the State adopted the principles of Alma Ata. and made progress in establishing specific objectives for the Health System, such as: improving access to the primary level of care; free for the beneficiary population of APS (Fonasa); and the strengthening of actions for the prevention and protection of health. A new model of care based on the principles of family medicine was conceptualized and state universities incorporated curricular innovations to strengthen training in family medicine with a focus on PHC, both in undergraduate and postgraduate training.

international community to promote actions aimed at protecting and promoting the care model health primary. Its motto was "Health for all in the year 2000". Twenty-five years later, PAHO adopted a Renewed Strategy for Primary Care in which it recognizes that PHC is a strategy that makes it possible to significantly reduce health inequities. Then, in 2008, the WHO published the report on Health in the World "Primary Health Care, more necessary than ever" where it proposes four normative orientations for PHC: (i) Universal coverage; (ii) People-centered services; (iii) Healthy public policies; and (iv) leadership. September 1978. Source: https://www.paho.org/hq/dmdocuments/2012/Alma-Ata-1978Declaracion.pdf

[38] Decree Law No. 3,626. 1981. From the Ministry of Labor and Social Welfare. Source : https://bcn.cl/3dxqw

[39] Law No. 18,469 that regulates the exercise of the constitutional right to health protection and that creates a regime of health benefits. November 14, 1985. Ministry of Public Health. Source : https://bcn.cl/2f7ib

[40] Law No. 18,933 that creates the Superintendency of Social Security Institutions, Dictates Rules for the granting of Benefits by Isapre and Repeals Decree with Force of Law No. 3 on Health, of 1981. 1990. Ministry of Health. Fountain: https://bcn.cl/2gwpn

[41] Law No. 19,378 that establishes the Municipal Primary Health Care Statute. 1995. Ministry of Health. Source: https://bcn.cl/2f8iv

Regarding the resolution of complaints and citizen participation, in 1990 through Decree No. 680 [42]the Ministry of the Interior approved the establishment of information offices for the public user in the State Administration, including the MINSAL. In 1995, the Ministry of Public Health instructed the creation of Local Development Councils (CDL) made up of both users and health officials, in order to formalize the participation of communities in the local management of the services at all levels of health care.

In 1999, Law No. 19,650 [43]was promulgated, perfecting regulations in the area of health and guaranteeing that people who suffer serious or vital health emergencies can be cared for in any health establishment, public or private, without being denied access. attention or demand any payment. This law also establishes a legal loan that allows beneficiaries to finance vital emergency care received at the health center from admission to stabilization.

In the 2000s, a reform to the health system was carried out that established the responsibility of the State to guarantee equitable access to health, of high quality and resolution, financial protection in events of illness and greater citizen participation for the population, incorporating the concept of quality as the axis associated with results.

Within the legal framework, said reform considered:

1. A law that allows the financing of social policies through the increase in the Sales and Services Tax (VAT) and other specific taxes, and that in the case of Health guarantees the financing of the Health Plan with Explicit Guarantees (AUGE) for beneficiaries FONASA [44];
2. A law that establishes various solvency and protection rules for people incorporated into health insurance institutions, pension fund administrators and insurance companies [45];
3. A law that creates the Superintendency of Health and the Undersecretariat of Assistance Networks, and that creates new management instruments for the Assistance Network, with greater powers for managers of health establishments, as well as financial incentives for staff [46];
4. A law that establishes a mandatory health plan for Fonasa and the Isapres (the Guarantee Regime or Plan Auge), consisting of diagnostic confirmation and standardized treatments for a set of diseases prioritized due to their high health and social impact, and that defines explicit guarantees and demandable access, opportunity, quality and financial coverage (GES) [47]; and a law that, among other matters related to the operation of the Isapre System, regulates the process of annual adaptation of contracts, price increases, factor tables and establishes the Solidarity Compensation Fund for the GES among the Isapres [48].

[42] Decree No. 680 Approves Instructions for the Establishment of Information Offices for the User Public in the State Administration. 1990. Ministry of the Interior. Fountain: https://bcn.cl/38siw

[43] Law No. 19,650 that improves regulations in the area of health. November 19, 1999. Ministry of Public Health. Source: https://bcn.cl/2gwzz

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[47] Law No. 19,966 that Establishes a Regime of Health Guarantees. 2004. Ministry of Health. Source: https://bcn.cl/2fckl

[48] Law No. 20,015 that Modifies Law No. 18,933 on Social Security Institutions. 2005. Ministry of Health. Fountain: https://bcn.cl/2hmko

In 2012, Law No. 20,584 [49]was enacted, which regulates the rights and duties that people have in relation to actions related to their health care, and which establishes the obligation of all health providers, public or private, to timely inform their patients about their rights and duties; as well as the right of patients to safeguard their medical information, to decent treatment, respect for their privacy, to receive quality and safe health care, and to accept or reject any treatment, among others.

In 2014, the Sanitary Code regarding the regulation of pharmacies and medicines was modified through Law No. 20,724 [50], which establishes that the medical prescription must include the prescribed medicine and its bioequivalent . In addition, medicines may be sold per unit and their value must be clearly indicated in the places of sale, among other provisions.

In 2015, Law No. 20,850 was enacted [51]that creates a financial protection system for high-cost diagnoses and treatments and that covers all people who contribute to a pension health system.

Some of the public policies in terms of guaranteeing equitable access to health in recent decades include:

1. The guarantee of access in the primary care network to the preventive and curative benefits considered in the Health Code for all people living in the national territory, regardless of their health insurance system.
2. The Chile Crece Contigo program that accompanies children who are cared for in the public health system, from the first prenatal check-up, until they enter the school system in different areas, such as: health, education, family conditions, neighborhood and your community.
3. The Explicit Health Guarantees regime (AUGE/GES) that grants financial protection and guarantees access, opportunity and quality for more than 80 pathologies to patients regardless of their health insurance system.
4. The Law on Financial Protection for High-Cost Diseases and Treatments that guarantees financial protection for high-cost diagnoses and treatments to patients regardless of their health insurance system.
5. The Special Program for Health and Indigenous Peoples, created in 2000 in order to fulfill the mandate of Law No. 20,584 that regulates the rights and duties of the patient and that explicitly states that "public institutional providers must ensure the right of persons belonging to indigenous peoples to receive health care with cultural relevance". For this, MINSAL created intercultural centers with linguistic facilitators and trained intercultural facilitators in the regions of Arica and Parinacota, Iquique and Antofagasta (for Aymaras), in the Santiago Metropolitan Region (for migrants), Biobío, Araucanía and Los Lagos (for Mapuche). .

In 2018, Chile signed the Astana Declaration [52], which establishes commitments in four key areas in terms of primary care: (i) make bold political decisions for health in all sectors; (ii) build sustainable primary health

[49] Law No. 20,584 that regulates the rights and duties that people have in relation to actions related to their health care. April 23, 2012. Ministry of Public Health. Source : https://bcn.cl/2f7cj

[50] Law No. 20,724 that Modifies the Sanitary Code in Matters of Regulation of Pharmacies and Medications. January 30, 2014. Ministry of Public Health. Source : https://bcn.cl/2om64

[51] Law No. 20,850 that creates a financial protection system for high-cost diagnoses and treatments and that pays posthumous tribute to Don Luis Ricarte Soto Gallegos. June 1, 2015. Ministry of Public Health. Source : https://bcn.cl/2fpjz

[52] Astana Declaration. 2018. World Health Organization (WHO), United Nations Children's Fund (UNICEF) Source : https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration- sp.pdf?ua=1

care; (iii) empower individuals and communities; and (iv) align stakeholder support with national policies, strategies and plans.

Currently, the health sector faces the challenge of guaranteeing dignified, safe, timely and quality access to the entire population regardless of their health insurance system.

Social and Economic Context in Chile: Pre and Post Pandemic by COVID-19

In the last three decades Chile has enjoyed strong economic dynamism, where poverty measured by income fell precipitously and the country today has one of the lowest poverty rates in Latin America. Similarly, per capita income has more than doubled and is among the highest in the region. In 2013 Chile was the first country in Latin America to reach high income status.

At a global level, the 2022 United Nations Special Report on New Threats to Human Security [53]indicates that even though in 2019 the world had reached unprecedented levels in the Human Development Index, six out of seven people feel insecure in what they do. relative to being able to satisfy their basic needs, protect their physical integrity and their human dignity. This is explained because in recent decades the focus for development has been oriented towards economic growth and territorial security, instead of focusing on human security [54]that seeks to guarantee a life without fear, without misery and with dignity for all. .

Paradoxically, despite the fact that economic and well-being indicators point to positive growth rates for the region and for Chile in particular, according to the World Bank report Poverty and Shared Prosperity 2022 [55]the income gap between the richest and the poorest in the region was 27 times, while in Chile it was 29 times. In addition, the 2022 World Inequity Report from the World Bank[56] points out that economic inequality in Chile has been extreme for the last 120 years. One of his conclusions is that half of the population in Chile earns only 10% of the country's total income, while a tenth of the population receives almost 60%.

According to the 2021 [57]Latinobarómetro Report, social demonstrations in Chile in 2019 were triggered, among other factors, by socioeconomic inequality, political discontent with the Government and citizen demand for greater guarantees in various aspects of social security. In the measurement, Chile was the country in the region with the lowest regional average for the perception of social security guarantees, also presenting the highest perception of social inequality.

During the 2010s, health demands were related to unreasonable waiting times in the public system, untimely attention, unworthy treatment, high health and medication costs, as well as the inequities caused by the coexistence of two systems. of health affiliation: one public and one private, whose standards of care and infrastructure are diametrically opposed.

[53]Special Report 2022 The New Threats to Human Security. UNDP. 2022 Source: https://reliefweb.int/sites/reliefweb.int/files/resources/Special%20Report%202022%20-%20The%20new%20threats%20to%20%20human%20security%20in%20the%20Anthropocene%20demand%20a%20greater%20solidarity%20%28Panorama%20General%29.pdf

[54]Human Security. Paragraph 143 of the Final Document of the 2005 Summit, resolution 6'/1. United Nations General Assembly. Source: https://www2.ohchr.org/spanish/bodies/chr/docs/wsoutcome2005_sp.pdf

[55] Poverty and Shared Prosperity. 2022. World Bank. Fountain: https://www.worldbank.org/en/publication/poverty-and-shared-prosperity

[56]Word Inequality Report 2022. Source: https://wir2022.wid.world/

[57] Report 2021 Latinobarómetro Corporation . Source: https://www.latinobarometro.org/lat.jsp?Idioma=0&Idioma=0#:~:text=Informe%20Latinobar%C3%B3metro%202021

Already in 2015, the Study of Health Users regarding the Law of Rights and Duties [58]of the Superintendency of Health, indicated that the rights of the patient were perceived by the users as an enforceable standard, but that is usually not fulfilled. 65% of the people interviewed estimated that PHC establishments do not contribute positively to respecting the rights of patients, and 64% estimated the same in the case of public hospitals. The most important thing for the users was to be treated with dignity, in a timely manner, with understandable language and through safe and quality care. The research also indicates that the poor, immigrants, indigenous people, residents of rural areas and the elderly are those who receive the worst treatment in health care.

The social crisis of October 2019 was followed by the COVID-19 Pandemic, which forced countries to decree severe measures to control contagion. The social and economic effects of the Pandemic are overwhelming from every point of view: economic, educational, labor, cultural and health, and are palpable to this day.

In Chile, as in the rest of the countries, the economic contraction was reflected in the decrease in the Gross Domestic Product, which according to the Monetary Policy Report of March 2021 decreased by 5.8% [59]during 2020. The levels employment also fell to levels seen only in the economic crisis of the 1980s. According to the first round of the Social Survey COVID-19 of July 2020 [60]of the Ministry of Social Development and Family, if in 2019 the percentage of employed people it was 57.9% in June 2021 it was 48.6%. The most affected households were those belonging to the two lowest quintiles and those headed by women. According to World Bank estimates, the incorporation of women into the workforce fell back by 10 years as a result of the Pandemic. On the other hand, the prolonged closure of schools caused a setback equivalent to 1.3 years of schooling.

In addition to the number of people who died from COVID-19, during the first two years of the Pandemic, thousands of people experienced mental health problems for the first time or worsened. According to the sixth round of the Mental Health Thermometer in Chile 2022 [61], carried out by the Catholic University and the Chilean Security Association, 51% of people thought that their life was quite or completely different from what they had before COVID-19. 19. 13.9% had moderate or severe symptoms of depression, and between 20.6% and 21.6% of people with one or more chronic health conditions suspected they had mental health problems.

In 2020, the expectation of a substantial improvement in the public health system that would address structural inequities was reflected as one of the main citizen priorities in the public consultation carried out between September and October of the same year by the campaign team of the then candidate for the presidency of Chile, Gabriel Boric Font, who embodied in his Government Program I Approve Dignity the intention to carry out four fundamental reforms during his government, among them: A health reform that guarantees universal access to public health through the development of an intersectoral health strategy at the local level, based on the primary care system, capable of guaranteeing universal access and zero discrimination in the public health network, and whose design will be centered on people and

[58] Study of Health Users regarding the Law of Rights and Duties. 2015. Superintendence of Health. Source : https://www.supersalud.gob.cl/difusion/665/articles-12611_recurso_1.pdf

[59] Monetary Policy Report (IPOM) March 2021. Central Bank. Source : https://www.bcentral.cl/contenido/-/detalle/informe-de-politica-monetaria-marzo-2021-1

[60] First round Social Survey Covid-19. July 2020. Ministry of Social Development and Family. Source: https://observatorio.ministeriodesarrollosocial.gob.cl/encuesta-social-covid19-primera-ronda

[61] Sixth round Mental Health Thermometer in Chile. 2022. UC-ACHS. Source: https://www.achs.cl/docs/librariesprovider2/noticias-2022/achs-149852/tms-rond-6-conferencia.pdf

communities. To this end, he proposed measures to modernize health management, improve accessibility to the public health system and the efficiency of public spending on the matter.

By 2023, the effects of the Pandemic in terms of public health persist and have deepened the gaps detected previously. The 2020 health crisis caused the suspension of thousands of elective surgeries in order to prioritize the use of beds in COVID-19 patients. According to statements by the Minister of Health, Ximena Aguilera, [62]made almost a year after the administration of President Gabriel Boric , during 2020 and 2021 the average wait, both for surgeries and for consultations with specialists, was 700 days. At the beginning of 2023, that average had decreased to 400 days of waiting. Currently, the waiting lists in the public health system continue to be long and difficult to overcome despite the injection of $35 billion pesos made by the Government between 2022 and 2023 to improve hospital care.

In addition, so far in 2023 the public debate on health has revolved around the mechanism that the Executive must design to comply with the ruling of the Third Chamber of the Supreme Court on the obligation for private health insurers [63]: Isapres , use the table of risk factors prepared by the Superintendence of Health (SS) in 2019 for the collection of their benefits and compliance with which should cause the return of the surpluses collected from their contributors from 2020 onwards.

In this scenario and in response to the short bill presented by the Executive to Congress in May 2023 [64], the Association of Isapres of Chile (AICH) has declared that the short bill is not feasible and that its compliance will force the transfer of more than three million people to FONASA [65].

In summary, if before the COVID-19 Pandemic Chile already showed high rates of socioeconomic inequality that were complex to overcome, such as access to social security and basic quality health, education and pension benefits, during the three years after During the Pandemic, the social and economic gaps deepened even more, particularly affecting women, children, adolescents, the elderly and, in general, the groups called for special attention (GEA) in addition to people living in poverty.

[62] Minister Ximena Aguilera on waiting lists: "We hope to recover the production of a pre-pandemic year this year." February 9, 2023. The Counter. Source : https://www.elmostrador.cl/dia/2023/02/09/ministra-ximena-aguilera-sobre-listas-de-espera-esperamos-recuperar-la-produccion-de-un-ano-prepandemico- this year/

[63] Ruling of the Third Chamber of the Supreme Court on improper charges by the Isapres to their affiliates. November 2022. Source : https://www.pjud.cl/prensa-y-comunicaciones/noticias-del-poder-judicial/83477

[64] Schedule of the short bill in the Senate. Source : https://www.senado.cl/definen-cronograma-tentativo-para-tramitar-ley-corta-de-isapres

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Government Program 2022 to 2025: Reform of the National Public Health System

The health reform that guarantees universal access to public health is one of the four structural reforms proposed in the Government Program I Approve Dignity of President Gabriel Boric [66]for the period 2022-2025. Its inclusion in the Government Program is based on the results of a citizen consultation, carried out between September and October 2021 by the citizen participation team of the then candidate, in which 33,728 people participated, in person and remotely, through 603 citizen tables: in 80 communes of the country (21 % of the total communes) and 14 tables abroad. The main categories proposed by the citizens to incorporate into the Program were: Public education (15.5%); public health (11.4%); economic recovery (10.4%); human rights (10%) and climate crisis (8.8%), with Public Health being the programmatic axis that obtained third place in the programmatic prioritization at the national level, with the exception of the regions: Tarapacá, Antofagasta, Maule, Los Ríos and Los Lakes that did not prioritize this category among the first three places.

The Program emphasizes the development of an intersectoral health strategy at the local level, based on the primary care system, capable of guaranteeing universal access and zero discrimination in the public health network, and whose design will be centered on people and the communities. To this end, it proposes measures aimed at modernizing health management, improving accessibility to the public health system and the efficiency of public spending on the matter.

Universalization of Primary Care: In general, the Program recognizes the structural gaps in the public health system: such as waiting lists and number of waiting days, as well as the gaps left by the first two years of the COVID Pandemic -19, and one of its goals in terms of public health is proposed to strengthen the Primary Care system, which it recognizes as the heart of the public health system, guaranteeing access to PHC for 100% of the population and reactivating the Primary Health Care system through: (i) the implementation of a digital health strategy that integrates all care levels and that at the primary care level allows virtual scheduling and remote access to PHC benefits through of digital tools such as teletriage; (ii) the implementation of a comprehensive care model centered on people in a context of multimorbidity; (iii) updating and strengthening the Family Health Plan as a key element in the prevention, control and early detection of diseases.

Said reactivation will be accompanied by a comprehensive strategy in the management of the public health network in order to improve the time spent on waiting lists and to provide people and their families with active support in transit from Primary Care to Health up to the secondary and tertiary levels of care, in addition to establishing public criteria for clinical prioritization and maximum waiting times according to the level of risk of the pathologies, among other measures.

Priority in strategies for mental health: The Program contemplates the strengthening of the mental health component in the APS, through the strengthening of the coverage of the Psychosocial Accompaniment Program in the APS. In addition, the Program makes special mention of the inter-institutional reinforcement of mental health programs for children and adolescents through: The strengthening and expansion of the Chile Crece Contigo Program of the Ministry of Social Development and Family; A new program in the Ministry of Education called the Socio-Emotional Well-being Program aimed at educational communities; and a Mental Health Training Plan, with a focus on human rights and a gender perspective,

[66] The four structural reforms proposed in the Government Program I Approve Dignity (2022-2025) are: (i) Universal Access to Health; (ii) Decent pensions without AFP; (iii) Free and quality public education system; and (iv) Formation of the first environmentalist government in the history of Chile. Source: https://observatorioplanificacion.cepal.org/sites/default/files/plan/files/Plan%2Bde%2Bgobierno%2BAD%2B2022-2026%2B%282%29.pdf

for health teams with an emphasis on improving the accessibility and acceptability of mental health services for the population belonging to gender and gender diversity, with a focus on adolescents and youths.

The Program also mentions the design of a communication strategy that tends to reduce the stigma and discrimination that is usually associated with mental health treatment, in addition to promoting work with the National Care System and designing comprehensive programs that address mental health. in women, children and gender diversity who suffer gender violence.

Territorial and cultural relevance: rurality and intercultural health:

Based on the National Rural Development Policy 2014 - 2024 [67]in charge of the Interministerial Commission of City, Housing and Territory, the Program proposes to address the historical inequalities that those who live in rural territories have faced in relation to guaranteeing access to social services basic, such as: education and health, through the prioritization of the investment in equipment and infrastructure to improve the accessibility to health services in rural areas.

In terms of intercultural health, the Program proposes: (i) The creation of a national system for monitoring health inequities for indigenous and tribal peoples; (ii) The design of a National Intercultural Education Plan for all workers in the public health system; (iii) The redesign of the Special Program for Health and Indigenous Peoples (PESPI) respecting the provisions of Convention No. 169 of the International Labor Organization (ILO) through the APS; (iv) The incorporation of autonomous intercultural health initiatives, surpassing the current financing based on DFL Nº36 of 1980; (v) Guarantee of health care for migrants in an irregular migratory situation, in accordance with Decree No. 67 of the National Health Fund (FONASA) and the Health Policy for International Migrants of MINSAL; and (v) the availability of Creole/Spanish interpreters in those centers with a higher percentage of Haitian population.

Progress status of the 2023 public health reform project

According to statements by President Boric in December 2022 [68], it is estimated that the health reform project will be presented to Congress at the end of 2023 or in 2024. All in all, the project addresses the challenge of rethinking the public health care model , strengthening the binding role and participation of the community, placing people and their diversity at the center of the care model, in order to achieve equity in health and universal access, through four axes:

1) Dignification and modernization of the public health system through the use of different digital technologies.
2) Universalization of Primary Care aiming at improving the efficiency, equity and health results of the population, establishing PHC as a strategy that accompanies people throughout their lives, expanding access to the population that is not currently a beneficiary of FONASA .
3) Address the social determinants that affect the health condition of people.
4) Creation of a Single Health Fund (FUS) in order to generate a universal floor through a fund of all social security resources and from that floor, distribution to providers based on risk.

[67] National Rural Development Policy 2014 – 2024. Source: https://www.odepa.gob.cl/wp-content/uploads/2018/10/Poli%CC%81tica-Nacional-de-Desarrollo-Rural.pdf

[68] Interview with President Gabriel Boric on Sonar radio, minute 19:30. December 19, 2022. Source: https://www.t13.cl/noticia/politica/presidente-boric-reforma-salud-fines-proximo-ano-19-12-2022

Advances in health during the Government of President Gabriel Boric 2023

According to what was reported in the 2023 public account of President Gabriel Boric , some of the advances in public health are:

1) Zero copayment for FONASA users of sections C and D, which represents around five million people.
2) Development of 76 conservation projects in rural posts in 37 communes of the country.
3) Creation and implementation of the National Registry of Caregivers that grants preferential access to different public services, including health.

Likewise, some of the commitments and announcements regarding health announced in the 2023 public account are:

1) Isapres bill : that allows solutions to be found to responsibly comply with the ruling of the Supreme Court, which obliges private health insurers (Isapres) to adjust their plans to the table of factors and return the surpluses collected to the and the contributors, without jeopardizing benefits to families or promoting a pardon to the Isapres.
2) Investment of seven billion pesos in rural posts, to be carried out between 2023 and 2024, which will be extended in the following years.
3) Investment in mental health to build 30 Community Mental Health Centers in the country during the period of the administration of President Gabriel Boric (from 38 to 68)

Table of activities defined by the Ministry of Health for the Universalization of Primary Health Care. 2023

The following table describes the activities contemplated by the Ministry of Health for the Universalization of Primary Health Care. These are organized through strategic areas and lines defined by MINSAL and linked to the three result areas proposed by the World Bank in the Results-Based Program called Chile: Program for Universal Coverage of Primary Health Care and Resilience, which is intended to support improvements in three outcome areas: (i) the coverage and quality of primary health care, (ii) the contribution of primary health care to the resilience of the health system, and (iii) the efficiency of financing primary health care.

Table 10of Activities for the Universalization of PHC defined by MINSAL by PforR Result Area

Area and Strategic Line Defined in the Government Program	Activities Defined in the Government Program	Results Areas (RA) World Bank Results Program
Strategic Area 1: Expand effective coverage through PHC optimization		
1: Introduction of digital tools for online appointment management	A. Analysis of technical, clinical and regulatory guidelines in Chile and in the world related to prioritized care. B. Analysis of the effective capacity and institutional arrangements for the management of online appointments C. Development of technical guidelines for health services and primary health care at the municipal level. D. Establishment of registration, monitoring and evaluation of compliance with this guarantee in APS establishments. E. Design and development of a platform that establishes the prioritization of care based on the characteristics of the patients. F. Preparation and dissemination of protocols for the use of the platform.	**Expand coverage and quality of care at the primary health care level (AR 1)**
2: Expansion of service provision by extending hours of operation	A. Generate new technical guidelines and control tools to define the services provided during extended hours.	Expand coverage and quality of care at the primary health care level (AR 1)
3: Development of a platform for the management of the agenda (optimization of supply and demand)	A. Develop a technical base to build a platform for the management of the agenda integrating information on demand and supply of PHC. B. Call for proposals to develop a platform for agenda management.C. Development of the platform, including pilot tests. D. Preparation of guidelines for the use of the visualization and monitoring platform. E. Evaluation of the implementation of the platform.	Expand coverage and quality of care at the primary health care level (AR 1)
4: Developing a communication plan	A. Communication campaign to inform the population about the possibility of enrolling in PHC establishments. B. Implementation of a multiplatform communication campaign (TV, social networks, internet platforms, etc.)	Expand coverage and quality of care at the primary health care level (AR 1)

5: Expansion of service delivery through telemedicine	A. Generation of technical guidelines to implement telemedicine in PHC.	Expand coverage and quality of care at the primary health care level (AR 1)
6: Purchase mobile clinics	A. Design of technical bases for the bidding for the purchase of mobile clinics. B. Management of health services and the Ministry of Health for the purchase of mobile clinics.C. Generate technical guidelines for the use of mobile clinics. D. Review and record of PHC activities in mobile clinics.	Expand coverage and quality of care at the primary health care level (AR 1)
7: Review and define attendance and non-attendance hour standards for primary health care teams to develop technical guidelines for other PHC teams	A. Carrying out an analytical study on the distribution of hours of professional care and non-care in PHC establishments. B. Development of recommendations based on the study findings. C. Dissemination of findings to key stakeholders. D. Generate recommendations for municipalities on the balance between attendance and non-attendance hours.	Expand coverage and quality of care at the primary health care level (AR 1)
8: Integration of social and health services in a "single window" modality	A. Survey on the requirements to integrate health information in a "single window" modality. B. Establish a working group with the MDSF to develop the integration of the health module into the "single window" modality. Implementation of a pilot project of the "single window" modality. D. Evaluate the pilot process and plan implementation. National implementation of the "single window" modality. F. Evaluation of the implementation of the "single window" modality.	Expand coverage and quality of care at the primary health care level (AR 1)
9: Development of instances of reflection, participation and design of strategies to improve the PHC user experience (Citizen Dialogue)	A. Design and validation of an instrument to measure user experience. B. Design and testing of the application to measure the user experience. C. Preparation and dissemination of protocols for the use of the application. D. Generation of a user guide for PHC teams.	Expand coverage and quality of care at the primary health care level (AR 1)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**
10: Development of a plan to improve the user experience in APS contact channels	A. Generation of technical guidelines to support local teams in the development of plans to improve the multichannel user experience. B. Approval of the plan by the Health Services. C. Preparation of annual evaluation reports of the plan.	Expand coverage and quality of care at the primary health care level (AR 1)

Strategic Area 2: Make PHC more resilient		
11: Teams trained for health emergencies	A. Preparation of the training program for public health emergencies in primary health care, considering the lessons learned from COVID-19.	Resilient APS (AR 2)
12: Development and implementation of surveillance processes (pandemic, environmental and social surveillance)	A. Design of an epidemiological and environmental surveillance model. B. Development of community surveillance plans based on the national model. C. Oversee the implementation of community policing plans.	Resilient APS (AR 2)
13: Local strategies for environmental health	A. Generate technical guidelines for local teams to facilitate the development of plans. B. Preparation of adaptation plans with measures to strengthen the resilience of primary care in the municipalities. C. Approval of adaptation plans by the Health Services. D. Implementation of the approved adaptation plans. E. Evaluate the implementation of adaptation plans.	Resilient APS (AR 2)
14: Development of APS infrastructure standards (easy to build, maintain, energy efficiency, etc.)	A. Create an intersectoral round table with different government agencies to develop a PHC infrastructure in all neighborhoods. B. Study on the state of infrastructure at the national level. C. Development of a professional technical profile for specialization in health infrastructure (Chile Valora)	Resilient APS (AR 2)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**
Strategic Area 3: Improve the health and social health model, with dignity and quality for the territory		

15: Strengthening and implementation of the integrated model of health and social assistance (ECICEP)	A. Evaluation of the implementation of the ECICEP strategy in pilot centers. B. Publication of a report with recommendations to strengthen the strategy and its implementation. C. Elaborate on the scalability of the ECICEP strategy at the national level. Monitoring and application of measures at the ministerial level to expand the ECICEP strategy. D. Execution of the scalability plan: distribution of resources and strengthening of the strategy at the community and health establishment levels.	Expand coverage and quality of care at the primary health care level (AR 1)
16: Creation and implementation of a risk stratification strategy for the health of the Chilean population.	A. Study with national clinical and health data to test variables to be considered in the new risk stratification. B. Generation of a mechanism to process the data as stratification. C. Evidence of the new stratification with developments of electronic health record providers. D. Start of a scalable implementation of the new stratification in the primary care electronic medical record.	Expand coverage and quality of care at the primary health care level (AR 1)
17: Development of strategies to promote family and social health (gender approach)	A. Adaptation and validation of a test to detect gender violence. B. Development of a test for the detection of gender violence. C. Preparation and dissemination of protocols for an application that allows the detection of gender violence. D. Generate a guide for use by primary health care teams, available at all levels of governance (Ministry of Health, Health Services, municipalities, facilities). E. Piloting the gender violence detection test.	Expand coverage and quality of care at the primary health care level (AR 1)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

18: Development of strategies to promote family and social health	A. Design, adaptation, and validation of mental health screening tests. B. Design and test a mobile application that allows for mental health screening tests. C. Preparation and dissemination of protocols for said application. D. Generate a guide for use by primary health care teams.	Expand coverage and quality of care at the primary health care level (AR 1)
19: Review and optimization of the family health plan II based on PRAPS	A. Study on the benefits of the health value of the family health plan II. B. Preparation of a proposal to update the family health plan II. C. Review and propose a modification of the indicators associated with the updated Family Health Plan II. D. Develop a methodological proposal to periodically update the benefits of the family health plan. E. Update of the basket of benefits of the family health plan and publication of the modification (per capita decree)	Expand coverage and quality of care at the primary health care level (AR 1)
20: Integration of social care with other sectors (such as SENAME)	A. Identification of integration possibilities and characterization of the social and health care provided. B. Plan intersectoral work at the central and local level to implement social and health care programs. C. Plan and modify programs implemented in centers that are part of the social network. D. Updating or development of technical guidelines for the integration of health and social care with other sectors. E. Implement new programs or change existing ones. F. Plan the integration of information and health services in the local social management platform. G. Implement the integration of information and health services in the local social management platform.	Expand coverage and quality of care at the primary health care level (AR 1)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

21: Development of institutional arrangements/standards for the governance of shared networks	A. Review of models in countries with an integrated health network. B. Propose institutional arrangements for shared governance of the network. C. Regulatory and/or legal modifications of the institutional agreements for the governance of the shared network. D. Evaluation of institutional arrangements (proposed changes; results).	Expand coverage and quality of care at the primary health care level (AR 1)
22: Design and implementation of patient network navigation offices	A. Planning of the model for the navigation offices of the patient network based on national and international experiences. B. Modification of platforms and/or information systems to achieve interoperability (must be scalable at the national level).	Expand coverage and quality of care at the primary health care level (AR 1)
23: Creation of a network of specialists integrated into the PHC network	A. Development of an integration plan for PHC specialists that includes the technologies necessary for their performance. B. Design of a model for the integration of PHC specialists in the health care network.	Expand coverage and quality of care at the primary health care level (AR 1)
Strategic Area 4: Optimize resources and implement a performance monitoring and evaluation framework that supports the PHC strategy		
24. Guarantee the connectivity of primary health care	A. Definition of standard requirements (human resources, physical resources, training, equipment) to guarantee connectivity in primary care. B. Evaluation of the implementation process and effectiveness of the connectivity plan in pioneer communes.	Efficiency (AR 3)
25. Creation of a technical guideline for data governance to guarantee the quality, timeliness and relevance of the data obtained	A. Formation of a working group with key stakeholders involved in the electronic clinical record processes to discuss the objectives, scope, and implementation of the data governance policy to ensure data reliability. B. Analysis of existing gaps in the quality of data in primary care. C. Generation of technical guidelines that constitute the starting point of a data governance policy to be disseminated to primary care teams. D. Evaluation and monitoring of compliance with the technical guidelines on data governance in primary care.	Efficiency (AR 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

26. Development of interoperability between the healthcare levels of the network	A. Develop an interoperability pilot plan. B. Definition of the conditions (human resources, physical resources, etc.) necessary for the development of interoperability in the pilot communities. C. Implementation and evaluation of an interoperability pilot plan. D. Development and implementation of an interoperability plan at the national level, incorporating the lessons learned from the pilot phase. E. Evaluation of the implementation process and the effectiveness of the interoperability plan at the national level.	Efficiency (AR 3)
27. Implementation of a social determinants of health M&E system	A. Study of the available and relevant information for the evaluation of social determinants. B. Generate a technical base for the construction of a visualization and monitoring platform for social determinants. C. Development of the database visualization and integration platform for the social determinants surveillance system. D. Development of user guidelines for the social determinants visualization and surveillance platform. E. Training of teams in the use of the social determinants visualization and surveillance platform.	Efficiency (AR 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

28. Development of a PHC results monitoring framework	A. Analysis of the indicators available in PHC and selection of those that allow exhaustive evaluation and monitoring of PHC performance. B. Generate the technical bases to build a database visualization and integration platform for the PHC monitoring framework. C. Development of the database integration and visualization platform for the PHC performance results monitoring framework. D. Writing guidelines for the primary care performance results framework visualization platform. E. Training of teams to use the visualization platform of the primary care performance monitoring framework.	Efficiency (AR 3)
29. Creation and implementation of an entity that safeguards the quality of PHC performance	A. Establish the base and structure of an institution that guarantees quality in primary care. B. Determine the financing of this action and define which costs are covered by which institutions. C. Prepare the bill for the formation of an institution that oversees the quality of primary care.	Efficiency (AR 3)
30. Development and definition of clinical HR standards and general management for PHC establishments.	A. Proposal to adjust the financing of PHC based on the needs of human resources and the reduction of gaps. B. Financial impact study for compliance with PHC human resources standards C. Formation of a working group with intra and extra MoH actors for the review and validation of the standards. D. Development of recommendations for human resources standards in clinical functions. Analysis of the situation of current regulations on human resources.	Efficiency (AR 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

31. Development and definition of equipment standards for PHC facilities.	A. Analysis of the status of current equipment standards. B. Developing equipment recommendations based on the findings of the analysis. C. Generation of guidelines for the design and maintenance of equipment, based on the findings of the analysis. D. Dissemination of the equipment disposal and maintenance guidelines in the different lines of governance. E. Standardization plan for facilities to comply with equipment maintenance standards F. Execution of the equipment maintenance standardization plan. G. Evaluation of the equipment maintenance standardization plan.	Efficiency (AR 3)
32. Development and definition of infrastructure maintenance standards for PHC facilities.	A. Infrastructure maintenance generation guide. B. Dissemination of infrastructure maintenance guidelines in the different lines of governance. C. Facilities standardization plan for compliance with infrastructure maintenance standards. D. Evaluation of the infrastructure maintenance standardization plan.	Efficiency (AR 3)
33. Redesign of per capita payments and payment mechanism based on health risk	A. Analysis of the per capita payment mechanism. B. Proposal for a per capita payment plan and associated institutional framework. C. Preparation of a new per capita decree that incorporates the conclusions of the analysis	Efficiency (AR 3)
34. Analysis and reconfiguration of health care benefits	A. Analytical study on the processes of provision of resources in PHC. B. Redesign of the PHC resource allocation process. C. Application of the redesign of the PHC accountability process. D. Evaluation of the implementation of the redesign of the PHC resource accountability process.	Efficiency (AR 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Results Program**

35. Analysis of the municipal contribution to the financing of primary care in the territories	A. Analytical study on the municipal contribution to the financing of PHC. B. Preparation of suggestions and recommendations based on the results of the analytical study. C. Dissemination of the results of the study and suggestions generated about the municipal contribution to primary care among the interested parties. D. Generation of recommendations for municipalities	Efficiency (AR 3)
36. Review, analysis and redesign of payments associated with human resources in PHC (article 45, law 19,378)	A. Analytical study on payments associated with human resources within the framework of Law 19,378 B. Preparation of suggestions and recommendations based on the findings. C. Dissemination of the results of the study and suggestions generated on the municipal contribution to primary care among the stakeholders D. Analysis of possible legislative and regulatory modifications related to the payment associated with human resources. E. Implementation of the legislative and regulatory modifications necessary to adjust the payments associated with human resources.	Efficiency (AR 3)
37. Establishment of a leadership school for management skills and budget execution	A. Identification of specific contents for the training of municipal managers. B. Creation of a high-level leadership program for primary care. C. Establishment of the training acquisition mechanism. D. Implementation of the high-level leadership school for primary care	Efficiency (AR 3)
38. Development of standards for the infrastructure of PHC facilities that should be in place to achieve progressive health care for the population and reduce the health care gap.	A. Analysis of the state of current infrastructure and sustainability standards B. Creation of an intersectoral technical working group. C. Preparation of recommendations based on the results of the analysis and the working group. D. Generation of a proposal for a new Medical Architecture Program.	Resilient APS (AR 2)
39. Development and definition of infrastructure maintenance standards for PHC facilities.	A. Analysis of the status of current infrastructure maintenance regulations. B. Development of infrastructure maintenance recommendations based on the findings.	Efficiency (AR 3)

International Regulations on Human Rights, Health and Primary Health Care that Chile has signed

Table 11Treaties and other international standards signed by Chile in the field of Human Rights and health

Guy	Instrument	signing year	Year of ratification, accession or succession	Health Mentions
International treaty	International Convention on the Elimination of all Forms of Racial Discrimination	1966	1971	Article 5 In compliance with the fundamental obligations established in Article 2 of this Convention, the States Parties undertake to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of every person, without distinction as to race, color and origin national or ethnic, to equality before the law, particularly in the enjoyment of the following rights:[…] (e) Economic, social and cultural rights, in particular:[…] (iv) The right to public health **, medical assistance, social security and social services** ; […]
International treaty	International Covenant on Civil and Political Rights	1969	1972	
International treaty	International Covenant on Economic, Social and Cultural Rights	1969	1972	Article 12 1. The **States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.** 2. The measures that the States Parties to the present Covenant must adopt to achieve the full effectiveness of this right shall include those necessary for: (a) Provision for the reduction of the rate of stillbirths and infant mortality and for healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions that **ensure to all medical service and medical care in case of illness.**
International treaty	Convention for the Elimination of all forms of Discrimination against women	1980	1989	Article 12 1. States Parties shall take all **appropriate measures to eliminate discrimination against women in the field of health care** in order to ensure, on equal terms for men and women, access to health care services. health, including those related to family planning. 2. Notwithstanding the provisions of paragraph I of this article, States Parties **shall guarantee women appropriate services in relation to pregnancy, childbirth and the postnatal period,** granting free services when necessary, as well as adequate nutrition during the pregnancy and lactation.

Guy	Instrument	signing year	Year of ratification, accession or succession	Health Mentions
International treaty	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1987	1988	
International treaty	Children's rights convention	1990	1990	Article 24 1. The States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to services for the treatment of illnesses and the rehabilitation of health. States Parties shall endeavor to **ensure that no child is deprived of their right to access these health services** . 2. The States Parties shall seek the full application of this right and, in particular, shall adopt the appropriate measures: (a) Reduce infant and juvenile mortality; (b) Guarantee the provision of necessary medical and health care to all children, with emphasis on the development of primary health care; (c) Combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of available technology and the provision of nutritious food and clean drinking water, taking into account the dangers and risks of environmental contamination; (d) Guarantee adequate prenatal and postnatal health care for mothers; (e) Guarantee that all segments of society, in particular fathers and children, are informed, have access to education and receive support in the use of basic knowledge on child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and accident prevention; (f) Develop preventive health care, parental guidance, and family planning education and services.3. The States Parties shall adopt all effective and appropriate measures with a view to abolishing traditional practices harmful to the health of children.4. The States Parties undertake to promote and encourage international cooperation with a view to progressively achieving full realization of the right recognized in this article. In this regard, particular account shall be taken of the needs of developing countries.

Guy	Instrument	signing year	Year of ratification, accession or succession	Health Mentions
International treaty	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	1993	2005	Article 28 **Migrant workers and their families shall have the right to receive all urgently required medical attention to preserve their lives or avoid irreparable damage to their health** , on the basis of equal treatment with the nationals of the State in question. . Said emergency medical assistance may not be denied due to any irregularity in terms of stay or employment. Article 431. Migrant workers will enjoy equal treatment with the nationals of the State of employment in relation to: (e) Access to social and health services, provided that the requirements for participation in the respective regimes are met; Article 451. The Family members of migrant workers will enjoy, in the State of employment, equal treatment with nationals of that State in relation to: (c) Access to social and health services, provided that the requirements for participation in the respective schemes are met ;
International treaty	Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	2000	2003	
International treaty	Second Optional Protocol to the International Covenant on Civil and Political Rights aimed at abolishing the death penalty	2001	2008	
International treaty	Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	2001	2003	
International treaty	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment	2005	2008	
Guy	**Instrument**	**signing year**	**Year of ratification, accession or succession**	**Health Mentions**

International treaty	International Convention for the Protection of All Persons Against Enforced Disappearances	2007	2009	
International treaty	Convention on the rights of persons with disabilities	2007	2008	Article 25 - Health The States Parties **recognize that persons with disabilities have the right to enjoy the highest attainable standard of health without discrimination on the grounds of disability** . The States Parties shall adopt all pertinent measures to ensure the access of persons with disabilities to health services that take gender into account, including health-related rehabilitation. In particular, States Parties: (a) Provide persons with disabilities with the same range, quality and level of free or affordable health care and programs as others, including in the field of sexual and reproductive health and programs population-based public health services; (b) Provide the health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention, as appropriate, and services designed to minimize and prevent further disabilities, including between children and the elderly; (c) Provide these health services as close as possible to the communities themselves, including in rural areas; (d) Require health professionals to provide the same quality care to persons with disabilities than others, including on the basis of free and informed consent, including by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the enactment of standards standards for public and private health care; (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted under national law, to be provided fairly and reasonable; (f) Prevent the discriminatory denial of health care or health services or food and liquids on the grounds of disability.
Guy	**Instrument**	**signing year**	**Year of ratification, accession or succession**	**Health Mentions**

Other universal standards	Declaration of Alma Ata. on primary health care	1978	Yeah	SAW. **Primary health care is** essential health care based on practical, scientifically sound and socially acceptable methods and technology, **made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country they can afford to maintain at every stage of their development, in a spirit of self-sufficiency and self-determination** . It is an integral part of both the country's health system, of which it is the central function and main focus, and of the general social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to the place where people live and work, and it constitutes the first element of a continuous health care process. . VIII. **All governments must formulate national policies, strategies and action plans to implement and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors** . To do so, it will be necessary to exercise political will, mobilize the country's resources and rationally use available external resources.
Other universal standards	Declaration on the right to development	1986	Yeah	1. States **must undertake, at the national level, all necessary measures for the realization of the right to development and shall guarantee, among other things, equal opportunities for all in their access to basic resources, education, health services, food, housing, employment and fair distribution of income.** Effective measures must be taken to ensure that women have an active role in the development process. Appropriate economic and social reforms must be carried out with a view to eradicating all social injustices.
Guy	**Instrument**	**signing year**	**Year of ratification, accession or succession**	**Health Mentions**

Other universal standards	Statement of Commitment on HIV/AIDS	2001	Yeah	The realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response58. By 2003, enact, strengthen or enforce, as appropriate, laws, regulations and other measures to **eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups, and to ensure their full enjoyment of all human rights** and fundamental freedoms, in particular to ensure their access, inter alia, to education, inheritance, employment, healthcare, health and social services, prevention, support and treatment, information and legal protection, while respecting your privacy and confidentiality; and develop strategies to combat stigma and social exclusion related to the epidemic; 59. By 2005, taking into account the context and nature of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and the full enjoyment of all human rights by women; promote the shared responsibility of men and women to ensure safe sexual relations; and empower women to be in control and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;60. By 2005, implement measures to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, mainly through the provision of health care and health services, including sexual and reproductive health, and through preventive education that promotes gender equality within a cultural and gender-sensitive framework;61. By 2005, ensure the development and accelerated implementation of national strategies for the empowerment of women, the promotion and protection of the full enjoyment of all human rights by women and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of gender-based violence, mistreatment and trafficking in women and girls;
Guy	**Instrument**	**signing year**	**Year of ratification, accession or succession**	**Health Mentions**

Other universal standards	Astana Declaration on Primary Health Care	2018	Yeah	I. We firmly affirm our commitment to the fundamental right of every human being to enjoy the highest attainable level of health without distinction of any kind. **Convened on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and underline the importance of health for peace, security and socioeconomic development, and their interdependence.** IV. We reaffirm the primary role and responsibility of governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. SAW. We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. (...) We will protect and promote solidarity, ethics and human rights. (...) VII. (…) In the implementation of this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices and fully respecting national sovereignty and human rights.
Standards for specific groups	Declaration of the rights of the child	1959	Yeah	Principle 4 The child will enjoy the benefits of social security. You will have the right to grow and develop healthily; to this end, special care and protection shall be provided to both him and his mother, including appropriate prenatal and postnatal care. The child shall have the right to food, housing, recreation and medical services.
Standards for specific groups	ILO Convention No. 182: Convention on the worst forms of child labor	1999	Yeah	Article 3 For the purposes of this Convention, the expression "the worst forms of child labour" includes: d) work which, by its nature or the circumstances in which it is performed, may harm the health, safety or morals of children.
Standards for specific groups	Declaration on the elimination of violence against women	1993	Yeah	Article 3 Women have the right to enjoy and protect, under conditions of equality, all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, among others: (f) The right to the highest attainable standard of physical and mental health; […]
Guy	**Instrument**	**signing year**	**Year of ratification, accession or succession**	**Health Mentions**

Standards for specific groups	Beijing Platform for Action – Women and health	nineteen ninety five	Yeah	Women have the right to enjoy the highest attainable standard of physical and mental health. The enjoyment of this right is vital to your life and well-being and to your ability to participate in all areas of public and private life. […]
Standards for specific groups	ILO Convention (No. 169) Concerning Indigenous and Tribal Peoples in Independent Countries	1989	Yeah	Article 7 (2) The improvement of the living and working conditions and the levels of health and education of the peoples concerned, with their participation and cooperation, shall be a priority issue in the overall economic development plans of the zones. that inhabit Special development projects in the areas in question must be designed in such a way as to promote such improvement. Article 20 (2) Governments must do everything possible to prevent any discrimination between workers belonging to the peoples concerned and other workers, in particularly with regard to:[…]c) Medical and social assistance, safety and health at work, all social security benefits and any other work-related benefit, and housing; […]Article 251. Governments must guarantee that adequate health services are made available to the interested peoples, or provide them with resources that allow them to conceive and provide these services under their own responsibility and control, so that they can enjoy the most highest attainable level of physical and mental health.2. Health services should, to the extent possible, be community-based. These services must be planned and managed in cooperation with the peoples concerned and take into account their economic, geographical, social and cultural conditions, as well as their preventive care, curative practices and traditional medicines.3. The health care system will give preference to the training and employment of local community health workers, and will focus on primary health care, while maintaining strong links with other levels of health services.4. The provision of these health services will be coordinated with other social, economic and cultural measures in the country.

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Standards for specific groups	United Nations Declaration on the Rights of Indigenous Peoples	2006	Yeah	Article 21 1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, among others, the spheres of education, employment, vocational training and retraining, housing, sanitation, health and social security. Article 23 Indigenous peoples have the right to determine and develop priorities and strategies for the exercise of their right to development. In particular, indigenous peoples have the right to actively participate in the elaboration and determination of health, housing and other economic and social programs that affect them and, to the extent possible, to administer said programs through their own institutions. Article 241. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous people also have the right to access, without any discrimination, all social and health services. 2. Indigenous people have an equal right to the enjoyment of the highest attainable level of physical and mental health. States shall adopt the necessary measures to progressively achieve the full realization of this right.
Standards for specific groups	Standard rules on equal opportunities for people with disabilities	1993	Yeah	22. The term "prevention" refers to actions aimed at preventing the occurrence of physical, intellectual, psychiatric or sensory impairments (primary prevention) or preventing impairments from causing permanent functional limitation or disability (secondary prevention). Prevention can include many different types of actions, such as primary health care, prenatal and postnatal care, nutrition education, immunization campaigns against communicable diseases, control measures for endemic diseases, regulations safety, accident prevention programs in different settings, including the adaptation of workplaces to prevent occupational disabilities and diseases, and the prevention of disability resulting from environmental contamination or armed conflict.

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Standards for specific groups	The United Nations Principles for Older Persons	1991	Yeah	1. Older people should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help; 11. Older people should have access to health care to help them maintain or regain optimal levels of physical, mental and emotional well-being and to prevent or delay the onset of disease.

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