Program Information Document (PID)

Concept Stage | Date Prepared/Updated: 22-Nov-2022 | Report No: PIDC272255

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Parent Project ID (if any)	Program Name
Chile	P179785		Chile: Program for Universal Primary Healthcare Coverage and Resilience
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Does this operation have an IPF component?**
LATIN AMERICA AND CARIBBEAN	16-Mar-2023	25-May-2023	No
Financing Instrument	**Borrower(s)**	**Implementing Agency**	**Practice Area (Lead)**
Program-for-Results Financing	Republic of Chile	Ministry of Health	Health, Nutrition & Population

Proposed Program Development Objective(s)

To support improvements in the health system through: (i) the efficiency of primary healthcare spending; (ii) the accessibility of quality primary healthcare, and (iii) the contribution of primary healthcare to health system resilience.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	2,500.00
Total Operation Cost	200.00
Total Program Cost	199.50
Other Cost	0.50
Total Financing	200.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	200.00
World Bank Lending	200.00

Concept Review Decision

The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **Chile is in a social and political transition to build a more equitable society**. This was marked by massive protests and bursts of social demonstrations throughout the country starting in October 2019. Protesters' demands included better access to quality social services such as health, education and pensions. An agreement signed by a wide spectrum of the political establishment in November 2019 charted a path towards a new constitution as the existing constitutional framework, originated under the 1970-80s dictatorship, was seen as an obstacle to enabling the required social and political consensus. In December 2021, Chile elected its youngest and most left leaning candidate since the return to democracy with a mandate to deliver greater equity. On September 4, 2022, Chile held a referendum on the draft constitution prepared by a democratically elected, gender balanced and indigenous inclusive convention. Reflecting a sense that the document overstepped the public demands, 62 percent of voters rejected the Convention's constitutional proposal. This was a setback for the Boric administration that relied on some of the changes in the proposed draft constitution for implementing part of its reform agenda. Discussions are underway to define the features of a new constitutional process and the paths to continue with the social reform's agenda.

2. **After six months in office, the Boric administration faces significant obstacles in building a legislative majority to advance its reform agenda.** The plebiscite results and approval ratings in the low to mid-thirties led President Boric to introduce his first major cabinet reshuffle, shoring up the moderate wing within the current government coalition. This adjustment and an expected moderation of the administration's stance should provide a better chance for attaining the legislative majorities needed for passage of the proposed tax, and upcoming pension and health reforms.

3. **Fueled by a strong fiscal response to COVID-19, Chile experienced one of the fastest recoveries worldwide in 2021, but a sharp deceleration is expected in 2022 and 2023. High inflation has triggered fast monetary tightening.** Real Gross Domestic Product (GDP) growth peaked in the third quarter of 2021. After growing 11.7 percent year-on-year (y/y) in 2021, GDP is expected to grow 1.8 percent in 2022 and contract 0.5 percent in 2023, while a gradual acceleration is expected afterwards. Inflation accelerated to 13.1 percent y/y in July 2022, the highest reading since 1994. Inflation started to increase mid-2021, driven by strong demand pressures amid an overheated economy. High energy prices and global supply shocks added new price pressures. Since the start of the Ukraine war, inflation drivers switched to a larger contribution from food prices. In response, the Central Bank hiked interest rates from 0.5 to 9.75 percent in one year. Inflation is projected to remain high in the second half of 2022, further fueled by the recent currency depreciation. Pressures would wane in 2023, as macroeconomic imbalances are addressed, and the external shock subsides. Chile and its economy are highly vulnerable to climate change (e.g., through wildfires during hot spells) and according to the Global Climate Risk Index 2021, the country is in the top 25 of countries most vulnerable from extreme weather changes[1].

[1] Kreft, S./ Eckstein, D./ Melchior, I. (2021): Global Climate Risk Index 2021. Available at: https://reliefweb.int/attachments/b6a6928e-214a-3398-bc01-1460f32bb3ad/Global%20Climate%20Risk%20Index%202021_1.pdf

4. **Chile experienced a substantial decline in income poverty and an expansion of the middle-class before the COVID-19 pandemic, achieving one of the lowest poverty rates in Latin America.** The population living on less than $US 6.85 a day (2017 purchasing power parity -PPP-) -a standard poverty metric used in international comparisons- dropped from 29.9 percent in 2006 to 7.5 percent in 2017.[2] Poverty measured against Chile's national poverty line[3] declined from 29.1 to 8.6 percent. During the same period, the population at risk of falling into poverty also declined, while Chile's middle class expanded quickly, rising from 31.0 percent to 57.5 percent of the population.[4]

5. **Progress was also made in shared prosperity, but Chile's Multidimensional Poverty Index (MPI) still shows that deprivations are common among the population.** Between 2013 and 2017, income growth was pro-poor. The average per-capita income of the bottom 40 percent of the income distribution grew at an annualized rate of 4.9 percent, faster than that of the overall population (3.8 percent). In line with the faster-than-average income growth at the bottom 40 percent, the Gini index fell from 45.8 to 44.4 percent. Nonetheless, inequality remained high in comparison with OECD countries. The MPI accounts for deprivations in five dimensions: education, health, work and social security, housing and environment, and social networks and cohesion.[5] One in five Chileans experienced deprivation in at least one of these areas in 2017. Importantly, there was no progress in reducing multidimensional poverty between 2015 and 2017. Deprivation in work and social security was most common and experienced by 31 percent of those considered multidimensionally poor.

6. **The economic contraction caused by the pandemic significantly affected household welfare and deepened pre-existing inequalities**. Emergency social protection programs implemented in 2020 partially helped cushion income losses of poor and vulnerable families. Poverty (US$6.85 a day in 2017 PPP) slightly increased to 8 percent in 2020, meaning that over 1.5 million people were considered poor in 2020. However, using the national definition of poverty, 10.8 percent of the population (more than 2.1 million people) were living in poverty in 2020. The pandemic also reversed gains in shared prosperity in the country. The average per-capita income of the bottom 40 percent of the income distribution grew by 1.9 percent annually between 2015 and 2020, while the average per-capita income nationwide grew by 2.5 percent. Accordingly, the Gini index increased to 44.9 percent in 2020. High-Frequency Phone Surveys (HFPS) data collected in 2020 by the World Bank to monitor households' socio-economic situation during the pandemic showed that women, youth, the elderly (65+), and low-skilled workers accounted for most of the job losses resulting from lockdown measures. Also, the data revealed that income losses and food insecurity were more prominent among rural and poor households.

Sectoral (or multi-sectoral) and Institutional Context of the Program

7. **Chile has some of the best health outcomes across the Latin America and Caribbean (LAC) region and a long history of successful reforms to move towards Universal Health Coverage (UHC).** The establishment of the National Health System (NHS) in 1952, subsequent infrastructure expansions and reforms have enabled Chile to move closer to universal coverage. Important improvements have been achieved in the last 50 years, such as decreases in infant and maternal mortality, the incidence of infectious diseases (IDs) and important increases in life expectancy. The 2005 health reform significantly improved funding of the public sector and made a priority package of services available with

[2] International poverty is measured against income in 2017 purchasing power parity (PPP) US dollars.
[3] National poverty is defined as the percentage of the population with an equivalized income below the minimum income necessary to satisfy a set of basic needs. It allows for comparisons over time but not across countries.
[4] The population at risk of falling into poverty is defined as those with daily per capita income between $6.85 and $14 in 2017 PPP. This group declined from 37.6 to 31.1 percent. The middle-class is defined as the population with daily per capita income between $14 and $81 in 2017 PPP.
[5] The Multidimensional Poverty Index (MPI) in Chile is calculated by the Ministry of Social Development and Family (MDSF) using the national survey of income and living conditions "*Encuesta Nacional de Caracterización Socioeconómica*" (CASEN).

guaranteed access, timeliness, quality and financial protection - the *Acceso Universal a Garantías Explícitas* (AUGE) conditions — based on clinical protocols, defined maximum waiting times for diagnosis, treatment and rehabilitation, and limited out-of-pocket payments[6]. However, several important issues for further reform remain pending.

8. **Fueled by the demographic transition, the country's disease burden has changed significantly over the last decades and is now dominated by non-communicable diseases (NCDs).** The demographic transition (i.e., a phase of declining birth and mortality rates) is well advanced in Chile, where the life expectancy at birth is 78 years for men and 82.5 for women. Progressive aging in turn brings about changes to a predominance of NCDs and mental health problems. While Chile has seen considerable improvements in recent decades, the health status of the population nonetheless is consistently below the OECD average. The probability of dying from any cardiovascular diseases (CVD), cancer, diabetes, between age 30 and exact age 70 was 10 percent in 2019 and contributed to 58 percent of the premature deaths in the country. Chile is among the countries with the highest risk in mortality from stroke when compared with the OECD countries and below the OECD average in survival rates for cancer, highlighting quality of care issues.

9. **Inequality in health outcomes and effective access remain the main challenges in Chile, mainly due to the unequal distribution of resources among subsectors and insufficient coverage for low-income quintiles and residents from rural areas.** Chile's health system provides care primarily financed by the public National Health Fund (*Fondo Nacional de Salud* - FONASA), and through private insurers, the *Instituciones de Salud Previsional* (ISAPREs). While FONASA covers 78 percent of the population, almost 20 percent of the population are insured by one of the ISAPRE. ISAPREs can unilaterally charge a risk-rated premium and thereby perform a risk selection of their insurees. This practice has produced a segmentation of the population. As per the Association of ISAPREs, 10 percent of people change their insurance plans every year, leaving the population with fewer health risks in the private sector. Most elderly patients are covered by FONASA because they cannot pay premiums. This in turn reduces the incentive for ISAPREs to invest in prevention and public health programs. For example, the population covered by ISAPREs does not have access to Primary Healthcare (PHC) which is key for prevention and early diagnosing, as there is no noteworthy PHC among private care providers.

10. **The health system is hospital-centric and has a fragmented service delivery network.** While PHC provision is decentralized and is overseen mostly by local governments (municipalities), the overall health system remains "hospital-centric" in Chile, unaligned with the recommendation to develop PHC-based health systems currently promoted by World Bank (WB), World Health Organization (WHO), and other international agencies. This model allocates most resources to the hospital sector and increases inefficiencies and inequalities (e.g., higher costs due to unnecessary medical care and even harmful interventions). As in many countries, this hospital-centric model has been sustained, as the population perceives hospitals as the facilities where experts are, and the institutions that can solve health problems. When hospital care is not available (e.g., due to insufficient supply), this leads to frustration and a perceived need for more specialists. Finally, this model is further fostered by the medical education system, which continues to cater to the dominant role of hospitals, as the perception among doctors is that prestige and success are concentrated there.

11. **Limited supply of healthcare services in the public sector and in particular in PHC remains one of the main challenges for the Chilean health system and has resulted in considerable waiting times.** For example, waiting times for non-emergency services without guaranteed access and established maximum waiting times etc. (i.e., services that are not included in the list of regulated AUGE conditions) have been constantly growing. According to the WHO, only 36.4 percent of health facilities had availability of an affordable set of essential medicines for the treatment, prevention, and management of acute and chronic diseases (World Health Statistics 2022). The lack of sufficient supply for the management and treatment of chronic conditions in the public health sector is however not the only issue. In addition, only 13.5 of the 15 million beneficiaries of FONASA are enrolled with a PHC facility, meaning that there is a considerable

[6] https://www.tandfonline.com/doi/pdf/10.1080/23288604.2020.1789031?needAccess=true

population segment which is very hard to reach through PHC.

12. **Issues with quality of care and the patient-centeredness dimension[7] in the provision of chronic care are paired with more fundamental issues such as Gender-based Violence (GBV), a poor treatment of women in healthcare as well as the overall consideration of gender and diversity aspects in public healthcare provision.** On the one hand, the health system and PHC have not achieved the implementation of an integrated care model that allows for better addressing the needs of chronic care patients, which is reflected in NCD-related healthcare outcomes that lag those of other OECD countries. However, there are more fundamental issues that impair the experience of patients in the public health sector. For instance, women report that the public health system is where they are most likely subject to bad treatment and even episodes of physical violence, such as obstetric violence[8]. In addition, biological difference, gender roles, and social marginalization expose people to different NCDs risks. Women and men manifest certain NCD symptoms and risks differently. Most studies to diagnose NCDs are undertaken on men, implying that women may be less likely to be diagnosed with an NCD at an early stage. Women also experience less apparent symptoms of cardiovascular disease than men and, consequently, are less likely to be diagnosed and treated.

13. **During the COVID-19 pandemic, the limited health system capacity was further demonstrated by Chile's considerably impaired ability to maintain the provision of essential healthcare services, highlighting the relevance of investing in health system resilience.** For example, in 2020, fewer crucial cancer screening examinations took place: 127,000 fewer mammography, 100,000 fewer endoscopies, 98,000 fewer cervical smears, and 33,000 fewer colonoscopies. A study in Chile illustrated a projected 10.0 percent increase in cancer cases in 2022 because of delayed diagnosis and treatment. These disruptions to the provision of essential healthcare services have put an additional burden on the public healthcare system and make the strengthening of preventive and screening activities even more imperative.

14. **In 2022, the new Government of Chile began to design of a major reform of the national health system that is intended to address the main challenges of the health system.** In particular, these issues include the challenges for the service delivery model stemming from the demographic transition, the change in the epidemiological profile of the population, the lack of equity in access to healthcare, the population's dissatisfaction with care and the increasing costs of the system. The Health System Reform is structured in five fundamental axes that make up the design of the Universal Health System (SUS). These thematic axes include *the institutional strengthening of the health authority (axis 1), the* establishment *of a Universal Health Fund (FUS) (axis 2), the regulation of the Voluntary Health Insurance (VHS) market (axis 3), a reform of the Preventive Medicine and Disability Commission (COMPIN) (axis 4), and the implementation of Universal PHC (axis 5).*

15. **The Universalization of Primary Healthcare is one of the fundamental steps for the beginning of the transformation of the Chilean health system into a SUS.** The reform presented by the Government seeks to elevate primary healthcare to become the main strategy to improve access to high-quality healthcare services for the entire population, consolidating PHC as the first point of contact for care, and making it the foundation of the healthcare service delivery network and further development of the health system. In addition, the universalization of PHC also implies that PHC services should be made available to the population currently not covered by FONASA as well as to intensify the active outreach towards the population covered by FONASA but which does not use any PHC services and is not even registered with any PHC center. To this end, on July 12, 2022, the National Commission for the Universalization of Primary Healthcare was formed, and the main guidelines were established, together with an implementation strategy for comprehensive PHC

[7] Following the WHO's definition, quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. Quality of care is a multidimensional concept, with patient-centeredness being one of the key dimensions, in particular for chronic care patients.
[8] Available at: https://iris.paho.org/handle/10665.2/55886

services (including promotion, prevention, cure, rehabilitation, palliative care, and good death) that are available to the entire population in a timely fashion, and that are relevant and of high quality.

Relationship to CAS/CPF

16. **The Program contributes to the WB's Twin Goals of reducing poverty and promoting shared prosperity** by improving the quality of public health services as well as the health system's efficiency and resilience, which in turn benefits the population more likely to be poor, which relies on public health services. By supporting the universalization of PHC services across the territory of Chile, the program also contributes to equity in health outcomes.

17. **The proposed Program is aligned with the proposed WB FY23-27 Country Partnership Framework (CPF) for the Republic of Chile, which will be discussed by the Executive Directors in the first half of 2023.** It directly supports the CPF high-level outcome (HLO) 1 "Increased access of vulnerable groups to quality social services" and indirectly also supports HLO 2 "Increased mitigation and adaptation to climate change and critical environmental challenges" by strengthening the health system's resilience, including for climate change-induced health emergencies. Most specifically, it would contribute to Objective 1 "Improve access to and funding of quality social services for vulnerable groups", by expanding access to high-quality PHC services across the national territory. The CPF states that "access to health services is identified by the population as the single most significant contributor to inequality. Chile has implemented policies that move towards universal health coverage; however, significant structural issues prevail that continue to generate significant inequalities."

Rationale for Bank Engagement and Choice of Financing Instrument

18. **The proposed Program directly contributes to Chile's health sector goals and the Government's Plan for Health Sector Reform** (see the section PforR Program Boundary for a description of the objectives of the Plan). Accordingly, the PforR instrument is appropriate for the proposed operation since it will support a broader Government's program. In addition, Chile has sound institutions and procedures (currently PforRs are being prepared in the water and social protection sectors as well) and the PforR would help operationalize the Government's plan for reform in the health sector by (i) linking disbursements to achievement of results that are tangible, transparent, and verifiable, and (ii) allow for improvements in the implementation of the Ministry of Health (MoH's) own technical, fiduciary, and safeguard systems. The use of financial incentives to strengthen the national health system reform as well as other ongoing and upcoming analytical work (RAS and Trust Funds) that will be implemented under Bank-supported programs will strengthen the implementation of the Universalization of PHC. The MoH and Ministry of Finance (MoF) have expressed their strong interest in using the development and implementation of this operation to provide additional implementation support to the sector's reform. The proposed Program is the first lending operation of the WB in the health sector in five years.

19. **The proposed PforR builds on the recent technical reengagement of the WB in the health sector in Chile which has focused on supporting the Government in its plan to universalize PHC.** In addition, the Program will build on the design and lessons learned from other PforRs supporting PHC strengthening. Strong PHC is broadly considered as the foundation for efficient and resilient healthcare systems[9] and an increasing number of PforR operations in the health sector have supported reform focusing on PHC. In addition, the proposed PforR design is also informed by the findings of analytical work and the preparation of a previous health sector project in Chile (i.e., the Public Health Sector Support

[9] Barış, Enis, Rachel Silverman, Huihui Wang, Feng Zhao, and Muhammad Ali Pate. 2022. Walking the Talk: Reimagining Primary Healthcare after COVID-19. doi:10.1596/978-1-4648-1768-7. License: Creative Commons Attribution CC BY 3.0 IGO

Project (P161018) which was approved by the WB Board of Directors in 2017). Currently, the WB is supporting the MoH with the technical preparation work for its strategy to universalize PHC. In particular, with the support of a Trust Fund from the Access Accelerated Initiative, WB-hired consultants are vetting the pilot and implementation design from a technical perspective.

Program Development Objective(s)

20. **The Program Development Objective (PDO)** is to support improvements in the health system through: (i) the efficiency of primary healthcare spending; (ii) the accessibility of quality primary healthcare, and (iii) the contribution of primary healthcare to health system resilience.

PDO Level Results Indicators

21. The tentative PDO indicators reflect the three result areas of the PforR and the different dimensions of the Program Development Objective as follows:

Table 1. PDO Elements and Indicators

PDO Elements	PDO Indicators
Efficiency	Use of services in the free-choice modality of FONASA[10]
	Savings in medication expenditures in PHC
Quality	Number of patient journeys through the system improved by patient navigation offices
	Avoidable hospitalizations due to NCDs (disaggregated by sex)
Resilience	PHC staff trained in preparedness and response to health emergencies according to preparedness plans (disaggregated by sex)

D. Program Description

PforR Program Boundary

22. **The proposed PforR would support one of the five axes of the Government's Plan for Health Sector Reform over the three-year period of 2023-2025.** The Health System Reform is structured in five fundamental axes that build the basis for the new design of the SUS. These thematic axes include the institutional strengthening of the health authority (axis 1), the construction of a Universal Health Fund (FUS) (axis 2), the regulation of the Voluntary Complementary Health Insurance (SVS) market (axis 3), a reform of the Preventive Medicine and Disability Commission (COMPIN) (axis 4), and *the implementation of Universal Primary Healthcare (APS)* (axis 5).

23. **The focus of the PforR on PHC is justified by its crucial role for health system effectiveness and efficiency.** In countries that have high coverage of services and good health outcomes, PHC tends to have a central role, with comprehensive care for most conditions provided by the family physician. Strengthening PHC in Chile is a necessary condition for improving access to services and increasing the efficiency of the health system; PHC reaches the largest share of the population and can help shift patients out of hospitals for better efficiency in resource use.

[10] The free choice modality of FONASA (*Modalidad Libre Elección* – MLE) allows insurees of FONASA to receive services from private healthcare providers after paying a higher copayment or even fully paying for the services received (based on a price list established by FONASA).

24. **Axis 5 refers to cross-cutting areas of the Government program which address critical drivers of inefficiency/lack of coordination**.

- Result Area 1: Efficiency in PHC spending. This area will seek to contribute to making better use of financial resources for PHC, in the context of a sustained increase in public expenditure on health.
- Result Area 2: Quality in PHC in terms of processes, model, and people's experience. Activities under this results area will seek to close the main existing gaps to improve access and health outcomes in PHC, in the context of its extension to the entire population of the country.
- Result Area 3: PHC for health system resilience. This area aims to identify and develop the role of PHC in contributing to the resilience of the health system as a whole to respond to various public health shocks and emergencies, addressing prevention, preparedness and response.

E. Initial Environmental and Social Screening

25. **An Environmental and Social System Assessment (ESSA) will be developed for the PforR Program during preparation.** The ESSA will examine the scope, context, and potential impacts (including direct, indirect, induced, and cumulative effects as relevant) of the Program from an environmental and social (E&S) perspective. The ESSA will describe the extent to which the Government has the capacity (legal framework, regulatory authority, organizational capacity, and performance) to manage those effects, with an emphasis on the E&S policies, legislation, procedures, and institutional systems, to assess its consistency with the core principles of the Bank PforR Policy and Directive. The content of the ESSA will include, but not be limited to: (i) a brief description of the Program, including the objectives, relationships between Government's Program and the PforR; (ii) potential E&S risks, impacts and benefits, including any potential issues related to land acquisition; (iii) institutional arrangements and mechanisms in place to deal with the potential E&S risks; (iv) identification of areas in which the implementing entities should improve procedures and performance (which may be expressed through the Program Action Plan (PAP) and the DLIs, as necessary); and (v) inputs to the integrated risk assessment. The ESSA will provide specific recommendations to enhance social inclusion and E&S management capacity and performance, which will be discussed and agreed with the Borrower. Additionally, the ESSA will determine specific barriers to access related to each project activity for women, persons with disabilities, migrants, LGBTI[11] Peoples and indigenous peoples, among other vulnerable groups. If required, based on the ESSA's recommendations, an action plan to ensure appropriate Borrower systems on E&S will be developed and included within the ESSA report. The actions outlined in the ESSA may also be included in the PAP. During the preparation of the ESSA, the Bank team will carry out a consultation and information process with the main Program stakeholders. The consultation and disclosure of the draft ESSA report will be done before the Appraisal phase of the Program.

[11] An acronym for "lesbian, gay, bisexual, transgender and intersex" persons that is also used as shorthand for persons of diverse sexual orientation, gender identity, gender expressions or sex characteristics.

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Borrower/Client/Recipient

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