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The Republic of Chile

PROGRAM FOR UNIVERSAL PRIMARY HEALTHCARE COVERAGE AND RESILIENCE (P179785)

Program for Results (PforR)

TECHNICAL ASSESSMENT

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Prepared by the World Bank

ABBREVIATIONS AND ACRONYMS

DALYs	Disability-Adjusted Life Years
DIFAI	Division of Finance and Internal Administration (*División de Finanzas y Administración Interna)*
DIVAP	Division of Primary Care (*División de Atención Primaria*)
DIPRES	Chilean Budget Directorate *(Dirección de Presupuestos de Chile)*
DLIs	Disbursement Linked Indicators
DLR	Disbursement Linked Result
ECICEP	Comprehensive People-Centered Care Strategy (*Estrategia de Cuidado Integral Centrado en las Personas*)
EHS	Environmental Health and Safety
E&S	Environmental and Social
FONASA	Public National Health Fund (*Fondo Nacional de Salud*)
GBV	Gender-based Violence
GDP	Gross Domestic Product
HBP	Health Benefit Package
ISAPRES	Private Health Insurance Institutions (*Instituciones de Salud Previsional)*
LGBTIQA+	Lesbian, Gay, Bisexual, Trans, Intersex, Queer and Asexual (+ other identities)
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NDC	National Determined Contribution
NCDs	Non-Communicable Diseases
NPV	Net Present Value
OECD	Organization for Economic Cooperation and Development
PAP	Program Action Plan
PCT	Program Coordination Team
PDO	Program Development Objective
PforR	Program-for-Results
PHC	Primary Healthcare
PHE	Public Health Emergency
PHFs	Primary Health Facilities
POM	Program Operations Manual
PRAPS	Reinforcement Program for Primary Healthcare *(Programa de Reforzamiento de la Atención Primaria de Salud)*
RA	Results Area
SEREMI	Regional Ministerial Health Secretariats *(Secretarías Regionales Ministeriales de Salud)*
WB	World Bank

1. PROGRAM'S STRATEGIC RELEVANCE AND TECHNICAL SOUNDNESS OF THE APPROACH

1. **From a technical point of view, the Program scope as well as the RAs of the PforR are aligned with the WB's longstanding knowledge work in the area of PHC-driven health sector reform and in particular on the recent flagship publication on how PHC can and needs to incorporate lessons from the COVID-19 pandemic.**[1] Investing in PHC generates positive externalities, as a healthy and productive work force faciliates economic growth that benefits society in ways that are not captured by individiual transactions in the health sector. Investing in PHC is a cost-effective means of boosting stocks of human capital, through evidence-based management of non-communicable diseases (NCDs) and the resulting improvements in labor productivity. In addition, the PforR will support results (i.e. DLI7) that will review and enhance the payment mechanisms used for PHC and thereby ensure that the financial incentives structures are aligned with the objectives of the Universal PHC program (UPHCP).

2. **The Program's Development Objective (PDO) is aligned with the UPHCP** and will support improvements in the coverage, quality, and efficiency of PHC and the health system's resilience. By doing so, the PforR takes into consideration the challenges that have prevented Chile from achieving desired results in the health sector in the past years: (a) the epidemiological transition shifting the disease burden towards NCDs and mental health illnesses; (b) the fragmented nature of service delivery and regional inequities; (c) the insufficient quality of services; (d) the lack of clarity about the role of PHC for health system resilience to cope with PHEs and risks from climate change, and (e) the additional need to improve the efficiency of health financing arrangements. From a strategic perspective, the Government program and the PforR are well-balanced with respect to the focus on supporting improvements in the municipalities that will join the UPHCP in a gradual manner over the course of the PforR-supported period of 2024-2027 and more transformational reforms that change the way the current PHC system operates, and which will apply to the entire country at the time of implementation. The remainder of this section explains the observed challenges for the health system and analyzes how the UPHCP addresses these challenges adequately.

3. **To respond to Chile's demographic and epidemiological transition and the increase in the prevalence of chronic conditions, investing in preventive care and a strengthening of the PHC system is crucially needed.** The demographic transition is well advanced in Chile (the life expectancy at birth is 78 years for men and 82.5 for women), while the ensuing population aging is generally associated with an increased prevalence of NCDs such as cardiovascular diseases, diabetes, cancer, and neurodegenerative disorders, while the financial sustainability of a healthcare system is in turn challenged by the growing burden of NCDs among the elderly. NCDs are the main cause of death and disability in Chile, accounting for 82.12 percent of all DALYs as of 2019 and continuing to grow in their importance for the disease burden (see Figure 1). Approximately 85 percent of all deaths that occurred in Chile in 2019 were caused by NCDs, compared to 87 percent in all OECD member countries in 2019.[2] Among the OECD member states in Latin America, Chile has the highest percentage of deaths caused by NCDs in 2019 (Costa Rica 82 percent; Mexico 80 percent; Colombia 76 percent). Amongst OECD countries, Chile is amongst those with the highest risk in mortality from stroke and has a below average cancer survival rate, highlighting quality of care issues. The age-standardized cancer mortality rate in Chile was 95.7 deaths per 100,000 people in 2018, which was the second highest among selected Latin American countries, namely Mexico, Colombia, Brazil, and Argentina.[3] Within Chile, low-income households, which are more

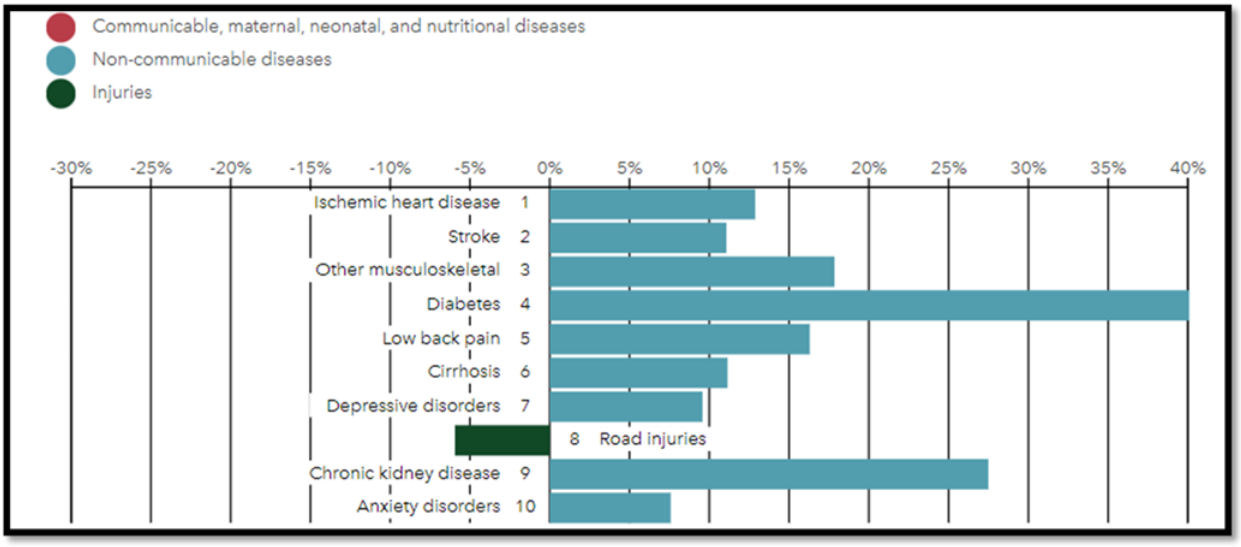
[1] Barış, Enis; Silverman, Rachel; Wang, Huihui; Zhao, Feng; Pate, Muhammad Ali. 2021. Walking the Talk: Reimagining Primary Health Care After COVID-19. © World Bank, Washington, DC.

[2] https://data.worldbank.org/indicator/SH.DTH.NCOM.ZS?locations=CO-CL

[3] https://www.hsph.harvard.edu/health-systems-innovation-lab/wp-content/uploads/sites/2633/2023/03/UICC-ICCILA-Chile-Report-ENGLISH-FINAL.pdf

likely to be insured by FONASA, have higher odds of co-occurrence of three or more risk factors for NCDs compared to high income households that are more likely to be covered by one of the ISAPRES.[4]

Figure 1. Top 10 Causes for Death and Disability (DALY) in Chile in 2019 and percent change 2009–2019[5]



4. **Because most elderly patients are covered by FONASA, this in turn reduces the incentive for ISAPRES to invest in prevention and public health programs and foster a hospital-centric healthcare model.** The population with access to hospital care (i.e., above all privately insured persons) 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. As a result, ISAPRES beneficiaries make greater use of specialist visits and hospitalizations. In contrast, FONASA beneficiaries (who do not have to incur any co-payment when medically assisted at PHC facilities) make greater use of emergency room visits and routine checkups. This situation is exemplified when comparing coverage for depression care for those in need (82 percent for individuals with ISAPRES vs. 56 percent for FONASA members) and effective coverage of diabetes (ISAPRES 42 percent, FONASA 34 percent) but not for PHC hypertension checkups (18 percent FONASA vs 13 percent ISAPRES). [6]

5. **Expanding PHC coverage in Chile implies reaching quite different population subgroups with different impacts on the key health system dimensions of efficiency and equity.** On the one hand, reaching the ISAPRES population, which tends to access specialist care, can improve the efficiency of healthcare spending, as comprehensive PHC addresses healthcare problems and provides prevention in a less resource-intensive context. This approach may reduce the use of avoidable hospital admissions (see DLI 3) and specialist visits which in turn would improve health spending efficiency. However, a considerable part of the population – particularly poor and vulnerable population segments in various parts of the national territory – lack access to high–quality healthcare services. Reaching these otherwise left-out FONASA population segments would also improve the equity of health outcomes and healthcare access, an important steppingstone in the implementation of the broader reform to establish Universal PHC. Increasing

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8569195/
[5] https://www.healthdata.org/chile
[6] Chile National Socioeconomic Characterization Survey 2013-2014

the quality of PHC for these population segments will lead to a better user experience and a potential increase in patient satisfaction with the health system (see DLI 8)

6. **Table 1 shows the scope of the UPHCP and its correspondence with PforR Result Areas. The PforR will support the UPHCP (2023-2029) with its four strategic lines over the four-year period of 2024-2027, defining the PforR boundary timewise:** (a) Expand effective coverage through PHC optimization; (b) Increase PHC resilience; (c) Improve the health and social care model, with dignity and quality for the population; and (d) Optimize resources and implement a performance M&E framework. The four strategic lines have a total of up to 38 subcomponents with corresponding activities. However, 7 of these subcomponents are currently only tentatively included under the Government program, depending on the eventual availability of resources to implement these subcomponents. The proposed PforR will support all four strategic lines of the UPHCP and in particular all subcomponents under the Government program with an assigned estimated budget. The PforR will be structured around three results areas: RA1 (Coverage and Quality of PHC); RA2 (Resilient PHC; and RA3 (Efficient and transparent PHC).

Table 1. Scope of the Government program – The UPHCP and the PforR[7]

UPHCP		**PforR**
Area & Strategic Line	**Activities**	**Results Areas (RA)**
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 across the world that are related to prioritized care.	Coverage and Quality of PHC (RA 1)
	B. Analysis of the effective capacity and institutional arrangements for online appointment management.	
	C. Elaboration of technical guidelines for Health Services Entities and PHC at the municipality level.	
	D. Establishment of registry, monitoring, and evaluation of compliance with this guarantee in PHC facilities.	
	E. Design and development of a platform that establishes prioritization of attention based on the characteristics of the patients.	
	F. Elaboration and dissemination of protocols to use the platform.	
2: Expansion of service provision by extending operating hours	A. Generating new technical guidelines and control tools to define services provided in extended hours.	Coverage and Quality of PHC (RA 1)
3: Development of a platform for agenda management (optimization of demand and supply)	A. Developing a technical base to build a platform for agenda management integrating information of demand and supply of PHC.	Coverage and Quality of PHC (RA 1)
	B. Call for proposals to develop a platform for agenda management.	
	C. Development of the platform, including testing of pilots.	
	D. Drafting guidelines to use the visualization and monitoring platform.	
	E. Evaluation of the implementation of the platform.	
4: Development of a communication plan	A. Preparation of technical bases for the design of a communication campaign for PHC and the UPHCP..	Coverage and Quality of PHC (RA 1)
	B. Design of a communication campaign to inform the general population about enrollment options at the PHC facilities in municipalities participating in the UPHCP.	
	C. Implementation of a multi-platform communication campaign (TV, social networks, internet platforms, etc.).	Not included*
5: Expansion of service provision through telemedicine	A. Generation of technical guidelines to implement telemedicine in PHC.	Coverage and Quality of PHC (RA 1)
	A. Design of a technical bases for bidding for purchasing mobile clinics.	

[7] Based on MoH Resolution No. 112 published on February 9, 2023.

6: Purchasing of mobile clinics	B. Management of Health Services Entities and MoH to purchase mobile clinics.	Not included
	C. Bidding and subsequent acquisition of mobile clinics.	
	D. Delivery of mobile clinics and/or tents on loan.	
	E. Generation of technical guidelines for the implementation of extramural activities.	
	F. Review and provision of records of extramural primary health care activities.	
7: Reviewing and defining standards of assistance and non-assistance hours of PHC teams to develop technical orientations for other PHC teams	A. Conducting an analytical study on the distribution of hours of professional and non-care hours in PHC facilities.	Coverage and Quality of PHC (RA 1)
	B. Development of recommendations based on the findings of the study.	
	C. Dissemination of the findings among key stakeholders.	
	D. Generating recommendations for municipalities on the balance between assistance and non-assistance hours.	
8: Integration of social and health care services into a "One-Stop-Service" modality*	A. Survey on the requirements to integrate health information into a "One-Stop-Service" modality.	Not included
	B. Establishing a working group with the Ministry of Social Development to develop the integration of the health module to the "One-Stop-Service" modality.	
	C. Implementing a pilot of the "One-Stop-Service" modality.	
	D. Evaluating the piloting process and planning the implementation.	
	E. Nationwide implementation of the "One-Stop-Service" modality.	
	F. Evaluation of the implementation of the "One-Stop-Service" modality.	
9: Development of instances for reflection, participation, and the design of strategies to improve user experience of PHC (Citizen Dialogue)	A. Design and validation of an instrument to measure user experience.	Coverage and Quality of PHC (RA 1)
	B. Design and testing of the application to measure user experience.	
	C. Elaboration and dissemination of protocols to use the application.	
	D. Generating a user guide for PHC teams.	
10: Development of a plan to improve user experiences in PHC contact channels	A. Generation of technical guidelines to support local teams in the development of multichannel user experience improvement plans.	Coverage and Quality of PHC (RA 1)
	B. Approval of the plan by the Health Services Entities.	
	C. Elaboration on annual evaluation reports of the plan.	
2: Improve PHC resilience		
11: Teams trained for health emergencies	A. Elaboration of the training program for PHEs and climate change risks in PHC, considering the lessons learned from COVID-19.	Resilient PHC (RA 2)
	B. Training sessions for PHC teams aimed at strengthening public health emergency management.	
12: Development and implementation of surveillance processes (pandemic, E&S surveillance)	A. Design of an epidemiological and environmental surveillance model.	Resilient PHC (RA 2)
	B. Education and training in the surveillance model	
	C. Elaboration of community surveillance plans based on the national model.	
	D. Supervising the implementation of community surveillance plans.	
13: Local strategies for environmental health	A. Generating technical guidelines for local teams to facilitate the development of plans.	Resilient PHC (RA 2)
	B. Elaboration of adaptation plans with measures to strengthen the resilience of primary care in municipalities.	
	C. Approval of the adaptation plans by the Health Services Entities.	
	D. Implementation of the approved adaptation plans.	
	E. Evaluating the implementation of the adaptation plans.	
14: Development PHC infrastructure standards (easy to build, maintain, energy efficient etc.)	A. Creating an intersectoral round table with different government bodies to develop a PHC infrastructure across neighborhoods.	Resilient PHC (RA 2)
	B. Study on PHC infrastructure gaps for the national territory.	
	C. Training of teams in Health Services Entities and Municipalities regarding the new infrastructure model.	

3: Improve the health and social care model, with dignity and quality for the territory		
15: Strengthening and implementation of the integrated health and social care model (ECICEP)	A. Evaluating the implementation of the ECICEP strategy in pilot centers.	Coverage and Quality of PHC (RA 1)
	B. Publication of a report with recommendations to strengthen the strategy and its implementation.	
	C. Updating the operational framework of the ECICEP strategy (2021).	
	D. Elaborating on the scalability of the ECICEP strategy at the national level.	
	E. Monitoring and implementing actions at the Ministerial level for scaling the ECICEP strategy.	
	F. Execution of the scalability plan: distribution of resources and strengthening of the strategy at the community and health facility levels.	
16: Creation and implementation of a health-risk stratification strategy for the Chilean population	A. Study with national health and clinical data to test variables to be considered in new risk stratification.	Coverage and Quality of PHC (RA 1)
	B. Generation of a mechanism to process the data as stratification.	
	C. Testing of the new stratification with electronic medical record providers developments.	
	D. Start of a scalable implementation of the new stratification in primary care electronic clinical records.	
17: Development of strategies to promote family and social health (focus on gender)	A. Adaptation and validation of a test to detect GBV.	Coverage and Quality of PHC (RA 1)
	B. Development of a test for GBV screening.	
	C. Elaboration and dissemination of protocols for an application that allows detecting GBV.	
	D. Generating a guide for use by primary health teams, available at all levels of governance (MoH, Health Services Entities, municipalities, facilities).	
	E. Piloting of the GBV detection test.	
18: PHC Health Benefit Package	A. Design of technical bases and study of high-value healthcare services under the PHC health benefit package.	Coverage and Quality of PHC (RA 1)
	B. Costing of the PHC Health Benefit Package Preventive Services.	Efficient and transparent PHC (RA 3)
	C. Elaboration of a methodological proposal to update the healthcare services periodically under the PHC Health Benefit Package.	
	D. Updating of the PHC Health Benefit Package and publication of the modified version.	
19: Integration of social care with other sectors (such as SENAME)	A. Identification of possibilities for integration and characterization of the social and health care provided.	Coverage and Quality of PHC (RA 1)
	B. Planning intersectoral work at the central and local level to implement programs for social and health care.	
	C. Planning and modifying programs implemented in centers that are part of the social network.	
	D. Update or development of technical guidelines for the integration of health and social care with other sectors.	
	E. Implementing new programs or changing existing ones.	
	F. Planning the integration of information and healthcare services into the local social management platform.	
	G. Implementing the integration of information and healthcare services into the local social management platform.	
20: Design and implementation of patient network navigation offices	A. Planning the model for patient network navigation offices based on national and international experiences.	Coverage and Quality of PHC (RA 1)
	B. Education and training of healthcare professionals and technicians.	
	C. Modification of platforms and/or information systems to achieve interoperability (must be scalable at the national level).	
	D. Implementation of the patient navigation office strategy in pilot centers.	
	E. Design and implementation of nationwide scalability of navigation offices.	
21: Creation of a network of specialists that are integrated in the PHC network	A. Development of a plan to integrate PHC specialists that includes the technologies necessary for their performance.	Coverage and Quality of PHC (RA 1)
	B. Designing a model for the integration of PHC specialists into the health care network.	

4: Optimize resources and implement a performance M&E framework that supports the PHC strategy		
22: Securing the connectivity of PHC	A. Definition of standard requirements (human resources, physical resources, training, equipment) to ensure connectivity in primary care.	Efficient and transparent PHC (RA 3)
	B. Transfer of key resources for the fulfillment of connectivity standards in PHC and closing of gaps.	
	C. Development and implementation of a connectivity plan in pilot municipalities.	
	D. Evaluation of the implementation process and effectiveness of the connectivity plan in pilot municipalities.	
23: Creation of a technical guideline for data governance to ensure quality, timeliness and relevance of the data obtained	A. Formation of a working group with key actors involved in the electronic clinical registry processes to discuss the objectives, scope, and implementation of data governance policy to ensure data reliability.	Efficient and transparent PHC (RA 3)
	B. Analysis of existing gaps in data quality 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.	
24: Development of interoperability between levels of care in the network	A. Developing an interoperability pilot plan.	Efficient and transparent PHC (RA 3)
	B. Definition of conditions (human resources, physical resources etc.) necessary for the development of interoperability in pilot municipalities.	
	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.	
25: Implementation of a system for M&E of social determinants of health	A. Study of available and relevant information for the evaluation of social determinants.	Not included*
	B. Generating a technical base for the construction of a platform for visualization and monitoring of social determinants.	
	C. Development of the visualization and database integration platform for the social determinants surveillance system.	
	D. Drafting 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.	
26: Development of a PHC results monitoring framework	A. Analysis of available indicators in PHC and selection of those that allow a comprehensive evaluation and monitoring of PHC performance.	Efficient and transparent PHC (RA 3)
	B. Generating the technical basis to construct a visualization and database integration platform for the PHC monitoring framework.	
	C. Development of the visualization and database integration platform for the PHC performance results monitoring framework.	
	D. Writing guidelines for the visualization platform of the primary care performance results framework.	
	E. Training of teams to use the visualization platform of the primary care performance monitoring framework.	
27: Creation and implementation of an entity that safeguards the quality of PHC performance	A. Establishing the foundation and structure of an institution guaranteeing quality in primary care.	Not included*
	B. Determining the financing for this action and defining what costs are covered by which institutions.	
	C. Elaborating the draft law for the formation of an institution that safeguards quality in primary care.	
28: Development and definition of clinical and general management HR standards for PHC facilities	A. Proposal to adjust PHC financing based on human resource requirements and gap closure.	Not included*
	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.	
	E. Analysis of the status of current human resource standards.	
29: Development and definition of equipment standards for PHC facilities	A. Analysis of the status of current equipment standards.	Not included*
	B. Elaboration of equipment recommendations based on the findings of the analysis.	
	C. Generation of guidelines for equipment layout and maintenance, based on the findings of the analysis.	
	D. Dissemination of equipment disposal and maintenance guidelines in the different lines of governance.	
	E. Facility standardization plan for compliance with equipment maintenance standards.	
	F. Execution of equipment maintenance standardization plan.	
	G. Evaluation of equipment maintenance standardization plan.	
30: Development and definition of infrastructure maintenance standards for PHC facilities.	A. Generation of infrastructure maintenance guide.	Not included*
	B. Dissemination of infrastructure maintenance guidelines in the different lines of governance.	
	C. Plan for the normalization of facilities for compliance with infrastructure maintenance standards.	
	D. Evaluation of the infrastructure maintenance standardization plan.	
31: Per capita payment redesign and health risk-based payment mechanism	A. Analysis of the per capita payment mechanism.	Efficient and transparent PHC (RA 3)
	B. Proposal for a per capita payment scheme and associated institutional framework.	
	C. Preparation of a new per capita decree incorporating the findings of the analysis.	
32: Analysis and reconfiguration of health care resource allocation and accountability	A. Analytical study on the processes for resource accountability in PHC.	Efficient and transparent PHC (RA 3)
	B. Redesign of the process of resource allocation in PHC.	
	C. Implementation of the redesign of the PHC accountability process.	
	D. Evaluation of the implementation of the redesign of the resource accountability process in PHC.	
33: 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.	Efficient and transparent PHC (RA 3)
	B. Preparation of suggestions and recommendations based on the findings of the analytical study.	
	C. Dissemination of the study findings and suggestions generated on the municipal contribution to primary care among stakeholders.	
	D. Generation of recommendations for the municipalities.	
34: 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.	Efficient and transparent PHC (RA 3)
	B. Preparation of suggestions and recommendations based on the findings.	
	C. Dissemination of the study findings and suggestions generated on the municipal contribution to primary care among stakeholders.	
	D. Analysis of possible legislative and regulatory modifications related to payment associated with human resources.	
	E. Implementation of the necessary legislative and regulatory modifications to adjust the payments associated with human resources.	
35: Establishment of a leadership school for managerial and budget execution skills	A. Identification of specific content for training municipal managers.	Efficient and transparent PHC (RA 3)
	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.	
36: Development of standards for the infrastructure of PHC facilities that should be in place to achieve progressive health care for the	A. Status analysis of current Infrastructure and sustainability standards.	Resilient PHC (RA 2)
	B. Creation of an intersectoral technical working group.	
	C. Preparation of recommendations based on the findings of the analysis and the working group.	
	D. Generation of a proposal for a new Medical Architectural Program.	

population and reduce the health care gap		

*Sub-components not included in the PforR are those sub-components which have no estimated budget assigned yet. The PforR will support all subcomponents from the Government program with an allocated estimated budget.

RA1–- Coverage and Quality of PHC

7. **The fragmented nature of service delivery is a barrier that has prevented Chile from achieving desired results in the health sector.** Fragmentation of health service delivery mainly stems from the fact that healthcare providers in Chile are divided between public and private institutions. This division results in differences in the quality and availability of services. Public providers may experience overcrowding and resource shortages, while private facilities can provide more specialized and timely care. The UPHCP contributes to i) establishing PHC as the initial point of contact between a patient (independent of its insurance status) and the public health care system that provides outpatient care to individuals, families, and communities and ii) enabling PHC to fulfill its objective to provide comprehensive high-quality care centered on individuals, their families, and the community while having a strong focus on preventive care.

8. **While some of the population has access to healthcare facilities, people living in remote areas of the country lack access.** Furthermore, even some people in urban areas lack access to PHC due to a limited number of heath care facilities for people living in highly populated areas. The extent of this situation is reflected in the fact that 1.5 million FONASA beneficiaries are not enrolled in a PHC facility, meaning that there is a considerable population segment that is effectively not being reached by the healthcare system.

9. **Beyond access, quality of care and in particular the lack of continuity of care across different care levels, which is crucial for patients with multimorbidities, is a concern.** Chronic diseases are often multifaceted in nature, and affected patients frequently have complex care needs, many of which cannot be met by overly fragmented primary and secondary care.

10. In response to the described challenges, RA 1 focuses on improvements in both the coverage and quality of PHC. First of all, **DLI 1** will track the progressive implementation of the UPHCP. The scaling up of the UPHCP is estimated to reach 187 of 346 municipalities (i.e., 54 percent of all municipalities in the country) during the PforR implementation period. Disbursement Linked Result **(DLR) 1.1** will disburse for each municipality integrated into the UPHCP. A municipality will be considered included in the UPHCP when a Participating Agreement has been signed between the municipality and the corresponding National Health Services Entity. **DLR 1.2** will track the number of Participating municipalities with at least 50 percent of the registered population receiving at least one PHC service, measured over one year.

11. **DLI 2** will support advancing the gender perspective and violence control within the Universal PHC model framework, with a focus on women and persons identifying as LGBTIQA+. This will involve various activities such as training, creating new protocols, and incorporating sexual identity variables into M&E programs. Progress in this area will be tracked through **DLR 2.1** which measures the availability of Community Health Agents in participating municipalities that are trained in gender-based violence (GBV). **DLR 2.2** measures user experience improvement amongst the LGBTIQA+ community.

12. **DLI 3** will monitor the decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity. The ECICEP Strategy allows classifying patients according to their multimorbidity profile (see Box 1) and has had a successful implementation experience in Chile, proving that a complex intervention for complex patients in the public health system are possible and can be cost-effective. Since 2019, the ECICEP model has progressively been implemented by the MoH without however reaching most parts of the country. This scale-up will be supported by the PforR. The indicator measures the decrease in avoidable hospitalization of people with multimorbidity as per ECICEP characterization for 3 different cohorts. Cohort 1 will be composed of the population of the municipalities that will adhere to the UPHCP before the end of 2024 (estimated to be 20 municipalities) **(DLR 3.1**). The subsequent Cohort 2 will be composed of the population of the municipalities adhering to the UPHCP during the course of 2025 (estimated to be 47 municipalities) **(DLR 3.2)** and Cohort 3 will be composed of the population of the municipalities adhering to the UPHCP during the course of 2026 (estimated to be 60 municipalities) **(DLR 3.3)**. For each cohort, a baseline of the indicator will be determined, once the municipalities making up the cohort have been confirmed. A 2 percent reduction in the rate of avoidable hospitalization is the expected target.

13. **DLI 4** will monitor participating municipalities with an increase in the number of people using high-value healthcare services to be determined during implementation in accordance with the WB using criteria from health technology assessments (including, inter alia, clinical effectiveness, cost-effectiveness, quality of life and patient-reported outcomes, equity and accessibility, acceptability and feasibility and comparative effectiveness criteria). High-value services will be identified among services that are already part of the universal HBP or in a reinforcement program of PHC and also might be added, based on the national and international evidence on PHC services.

Box 1. Comprehensive People-Centered Care Strategy (ECICEP) as a Successful Tool to Improve the Health in a Complex Context

In Chile, 13.4 percent of the population live with multimorbidity. Patients with multimorbidity, in addition to generating a significant burden on health systems, tend to die prematurely, have higher rates of hospitalization, poorer quality of life and a higher prevalence of depression, among others. International evidence has demonstrated the efficiency of person-centered care as an effective strategy for addressing multimorbidity.[8] [9]

The ECICEP strategy seeks to reconfigure the way care is delivered to the population, adapting it to the needs of individuals according to their risk profile and transforming the care process towards collaborative and person-centered care, ensuring continuity of services. In this sense, it stratifies the population empaneled to different PHC facilities (based on a weighted sum of chronic pathologies) to establish the intensity of care each person will require (G1 to G3). Accordingly, a person who is at high risk will receive a greater number of health interventions to reduce the probability of aggravating his or her multimorbidity condition, including self-management interventions, a consensual care plan, a follow-up team, telephone follow-up, a liaison professional in hospitals and complete visualization of his or her health status in his or her electronic medical record.

The ECICEP strategy is currently under implementation in 19 Health Services Entities, 47 municipalities and 73 health facilities. The incorporation of patients into ECICEP has been progressive and increasing over time. At the end of September 2022, 70,163 patients had joined the strategy, predominantly from

[8] U.S. Department of Health & Human Services. Multiple Chronic Conditions: A Strategic Framework. Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. 2010.

[9] Kuipers SJ, Cramm JM, Nieboer AP. The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. BMC Health Serv Res. 2019 Jan 8;19(1):13.

high-risk patients (G3), which is in line with the strategy's operational framework and recommendations. The evidence of the cost effectiveness of the ECICEP model and the feasibility of implementing it across different local contexts is growing and has sustained the expansion of the ECICEP model's implementation.[10]

RA2 - Resilient PHC

14. **As the COVID-19 pandemic has demonstrated, Chile needs to strengthen its health system resilience.** During the COVID-19 pandemic, a lack of preparedness and resilience of the health system, including PHC, led to service delivery disruptions with long-term health effects for children and youth, adults, and older people. For example, the reduction in the number of cancer diagnoses between March and May 2019 was 64.8 percent for the publicly insured population in Chile.[11] 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. Cancer cases were projected to increase by ten percent in 2022 because of delayed diagnosis and treatment[11]. Missed diagnoses and late-stage cancer diagnoses will translate into higher mortality and higher costs can be anticipated with the more intensive treatments required for advanced cancers.

15. **The extent to which a shock such as a pandemic or climate change event affects a health system and the population's lives depends largely on the chronic vulnerabilities of the health system.** The COVID-19 pandemic has sparked a debate around health system resilience, stressing that efforts should focus not only on responding to shocks precipitated by emerging health needs, but also on: (a) preventing and preparing for emergencies, and (b) ensuring continuity of essential health care during a shock episode. Strengthening health system resilience will ensure that access to quality healthcare during times of crisis (e.g., from infectious disease outbreaks and catastrophic climatic events) is available.

16. **The PforR will support activities and results to strengthen the resilience of Chile's health system anchored in a strengthened PHC**. For instance, activities such as the development of surveillance processes, adaptation plans with measures to strengthen the resilience of PHC in municipalities as well as the training of teams for health emergencies under RA 2 will strengthen the role of PHC for health system resilience. In addition, establishing a new PHC infrastructure model that responds to the health needs of remote and rural parts of the country while improving energy efficiency standards will also improve the PHC system's resilience to locally specific climate vulnerabilities, as climate-resilient infrastructure can significantly boost health system resilience by providing a foundation for maintaining essential healthcare services during and after climate-related disasters and extreme weather events.

17. **DLI 5 will support the establishment and deployment of the "Surveillance and Preparedness for PHEs and Climate Change Risks in Universal PHC" package,** which includes designing and implementing a new guide **(DLR 5.1),** to manage public health and climate change risks and emergencies. The guide will identify the main risks for climate change impacts and PHEs at the municipality level, outlining the best tools available for surveillance and prevention (e.g., climate-sensitive diseases such as dengue and malaria, heat related illness, etc.) and for preparedness and planning to emergencies response (e.g., physical injury and mental health support during extreme weather events,

[10] Zamorano, P., Espinoza, M.A., Varela, T. et al. Economic evaluation of a multimorbidity patient centered care model implemented in the Chilean public health system. BMC Health Serv Res 23, 1041 (2023). https://doi.org/10.1186/s12913-023-09970-y

[11] Cristóbal Cuadrado, Francisca Vidal, Jorge Pacheco, Sandra Flores-Alvarado, "Cancer Care Access in Chile's Vulnerable Populations During the COVID-19 Pandemic", *American Journal of Public Health* 112, no. S6 (August 1, 2022): pp. S591-S601.

natural disasters such as earthquakes, epidemic diseases isolation and treatment, etc.). **DLR 5.2 (PDO Indicator 2)** will monitor that participating municipalities take part in at least one locally relevant and adapted drill. See Climate Change Section.

18. **DLI 6 will support the design and implementation of a new PHC infrastructure model that will contribute to improved climate resilience**. **DLR 6.1** will be triggered by the publication of a Ministerial Resolution establishing the new PHC infrastructure model that responds to the health needs of territories, improves energy efficiency standards, and standards for climate resilience to locally specific climate vulnerabilities. Further training of health infrastructure specialists from Health Services Entities and municipalities on this new model will take place. **DLR 6.2** will track the increase in new PHC facilities built that operate according to the basic requirements of the new PHC infrastructure model.

RA3 - Efficient and Transparent PHC

19. **There are currently two main payment mechanisms for PHC services delivered by PHC centers administered by municipalities: Per capita and prospective payment per service through different PRAPSs, creating a blended payment mechanism for PHC.**[12] The capitation base rate (per enrolled person) is calculated by the MoH annually in reference to the cost of delivering the PHC health benefit package. The capitation mechanism includes risk adjusters across municipalities, such as the socioeconomic level of the population (measures of poverty), the proportion of elderly population living in the municipality as well as their community's rurality and the difficulty in providing and accessing health care. However, the variables used for the risk adjustment process have been criticized for not capturing the local context well enough. An illustrative example is the rurality index, which is based on a 30 percent threshold. As a result, some municipalities with an index value of 31 percent receive 20 percent additional financing compared to those municipalities with an index value of 29 percent. In addition, it has been argued that the adjustment variables do not properly consider population health risks and its disease burden. Finally, the process to calculate the per capita payment has been criticized as untransparent.[13] In addition, the independent National Commission for Evaluation and Productivity identified a gap in the per capita funding for PHC. Even though the per capita payments increased from $2.894 in 2010 to $9.048 in 2022 (In real 2018 Chilean pesos), the commission estimated that a gap of 33 percent existed with respect to the actual resource need for the provision of the basic PHC benefit package.

20. **The planned revision of capitation payments as well as other PHC payment mechanisms (under DLI 7) can significantly improve health system efficiency by promoting allocation fairness, incentivizing cost-effective care, and ensuring that healthcare resources are allocated appropriately.** Properly risk-adjusted capitation payments take into account the health status and needs of individual patients. By updating the way in which resources are allocated across different parts of the country based on patient needs, the UPHCP will ensure that healthcare providers are better equipped to deliver appropriate care to each patient. Likewise, the update of the risk-adjusted capitation payments can encourage healthcare providers to focus on preventive and early intervention services. Providers have a financial incentive to keep their patients healthy and prevent the development of expensive chronic conditions. This shift toward prevention can lead to better health outcomes and reduced long-term healthcare costs.

[12] Cuadrado C, Fuentes-García A, Barros X, Martinez MS, Pacheco J. (2022). Financing Primary Healthcare in Chile: An Assessment of the Capitation Mechanism for Primary Health. Lancet Global Health Commission on Financing Primary Healthcare. Working Paper No. 2.
[13] *Comisión Nacional de Evaluación y Productividad (2022). Eficiencia en la Gestión de Atención Primaria de Salud (APS), Santiago de Chile: Ministro de Economía, Fomento y Turismo.*

21. **Several countries – among them many OECD members - combine payment methods to create a blended payment system, or mixed model, to maximize the beneficial incentives and minimize the unintended consequences of each payment method.**[14] Capitated payment systems for PHC often incorporate a small number of fee-for-service payments for priority preventive services, such as prenatal care and immunization, to counteract the potential perverse incentive in capitation to underprovide services. Payment methods are also often combined with specific performance-based rewards or penalties (i.e., results-based financing or pay-for-performance). Improving financing and payment for PHC needs to consider the country's context and the system's objectives to define the right payment mechanism or most likely a mix of several approaches. The Chilean PHC payment mechanisms are in principle aligned with this international best practice, but they require a revision to achieve a more accurate PHC payment method which creates incentives for preventive care provision to complex and vulnerable patients under RA 3.

22. **DLI 7 will support a revision of the costing of PHC services and health purchasing arrangements. DLR 7.1** will review the process of costing the preventive services under the PHC HBP, which is outdated and will be optimized, providing transparency and the latest information that will inform financial allocations to PHC. The cost of providing PHC services is largely determined by the cost of the human resources involved in the provision of these services. As a result, the costing of PHC services will rely on an analysis of the different work profiles in PHC as a crucial input. **DLR 7.2** will support improvements of the current PHC payment mechanisms by revising and enhancing the capitation mechanism**.** The new PHC funding decree will establish refined risk adjustment factors that will be used by the MoH to fund PHC. In particular, the revised methodology will: (a) improve the adjustment of capitation payments based on epidemiological factors; and (b) increase the accountability of providers in the use of received resources through the incorporation of new performance and results-based funding components. The capitation scheme and its adjusting factors ("indexers"), along with the PRAPSs which are a fee-for-service funding mechanism for PHC subject to a volume cap, would be updated accordingly, thereby leading to a more precise resource allocation to benefit vulnerable populations with higher health needs.

23. **DLI 8 will support the design and rollout of a New Virtual Health Management Platform.** This platform will be published and disseminated **(DLR 8.1),** providing citizens with: (a) access to their own health information; (b) general healthcare information and guidance; (c) access to the TeleSalud portal to be able to get appointments; (d) the possibility of interacting with a health worker (operator) for health counseling and risk triage, or refer patients to a teleconsultation with a doctor of basic specialties; and (e) the possibility to provide feedback on their experience with the PHC services received **(DLR 8.2/PDO Indicator 3**)[15]. The Virtual Health Management Platform will generate greater transparency by providing in-time, relevant and reliable information and guidance to the population and will collect information from patients through surveys on user experience and other topics. In addition, the patient navigation system under the Virtual Health Management Platform that will help patients navigate the PHC system for their health needs, make appointments and even telemedicine consultations will make quality PHC more accessible for the population. In particular, the TeleSalud platform will also incorporate a system using artificial intelligence to schedule TeleSalud appointments more efficiently and manage demand for these TeleSalud services.

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[14] https://www.jointlearningnetwork.org/wp-content/uploads/2019/11/phc-financing-payment-models-six-lessons.pdf

[15] User experience within the healthcare sector refers to experiences people have with any healthcare products and services. Research findings consistently reveal that this is high when PHC addresses the majority of their patients' needs, thereby embodying a people-centered approach (OECD, 2020). In this context and within the framework of this PforR, the number of participating municipalities with positive user experiences (DLI 8.2/PDO indicator 3 as well as DLI 2.2) serves as an indicator of a healthcare system that operates with efficiency and effectiveness.

24. Results under the PforR help Chile and the health system to better adapt to climate shocks and mitigate greenhouse gas emissions (see Table 2 for an overview of different adaptation and mitigation measures).

Table 2. Climate Adaptation and Mitigation Measures in the Program

DLI	Description
DLI 4 (US$15 million): Use of high-value healthcare services	**DLI 4 will support the use of high-value healthcare services** to be determined during implementation in accordance with the WB. The delivery of these services will be via telemedicine and face to face. Given the impact of climate change during health service delivery, this platform will enable the provision of healthcare services amid extreme weather events (flooding) and PHEs (such as lockdowns during pandemics) that limit access to health facilities. This will allow continuation of healthcare services for climate vulnerable populations, supporting the health system's adaptation to the health impacts of climate change which are expected to comprise 20 percent of the activity, translating into US$ 3 million **(Adaptation).**
DLI 5 (US$ 15 million): Emergency Risk Surveillance Public Health and Climate Change Universal PHC	**DLI 5 will support the establishment and deployment of the "Surveillance and Response to PHEs and Climate Change Risks in Universal PHC" package,** which includes designing and implementing a new guide **(DLR 5.1),** and capacity building activities and human resources assigned to manage public health risks and emergencies**.** The guide will identify the main risks for climate change impacts and PHEs in Chile, outlining the best tools available for surveillance and prevention (e.g., climate-sensitive diseases such as vector-borne conditions, heat related illness, etc.) and for preparedness and planning to emergencies response (e.g., extreme weather events, natural disasters, epidemics, etc.). As per this guide, training will take place and support the formation of 'Comprehensive Surveillance and Response Teams' that will be georeferenced to municipalities to lead and coordinate on-the-ground climate and public health risk and emergency management activities, such as the design and implementation of plans that address the specific climate-related hazards (mentioned in the sector context) climate-sensitive diseases (NCDs and vector-borne diseases), and public health hazards at the local level. 50 percent of the activities related to this guide will relate entirely to climate change, translating into US$ 2.5 million **(Adaptation).** **DLR 5.2 (PDO Indicator 2)** will monitor that Participating Municipalities that are part of the UPHCP, take part in drills for PHE and climate change responses. These drills will be locally relevant and locally adapted. For example, against floods, heatwaves, response to earthquakes, etc. This will help the health system more effectively adapt and respond to the health and health service delivery impacts of climate change. 75 percent of the activities related to these drills will relate entirely to climate change, translating into US$ 7,5 million **(Adaptation).**
DLR 6 (US$57.77 million): New PHC infrastructure model.	**DLI 6 will support the development of a New PHC infrastructure model, adjusted to the geographical distribution of the population, complying with energy efficiency standards, and outlining locally specific criterial for resilience to climate vulnerabilities.** It is expected that this new health facility infrastructure achieves better performance to respond to the health needs in the different territories. To define the necessary standards that facilities must have in terms of infrastructure, a Mapping/GAP-Study at national level will be conducted taking into consideration climate vulnerability: (a) autonomy conditions during climate shocks (electrogenic group for 72hrs, flood risk, water and hygiene autonomy), (b) geographic location and its relation to vulnerable population[16] to bring close care during an emergency, and (c) adaptation and mitigation standards to the geographic characteristic. This study will then support the design of the New PHC infrastructure model **(DLR 6.1)**. These measures will ensure health facilities are resilient to climate shocks and will outline locally specific measures which go beyond

[16] Vulnerability is considered in this sense to those who are most vulnerable to floods, landslides, extreme weather, droughts, hurricanes, forest fires, as well as those who lack nearby healthcare facilities.

	standard practice for health facilities. This will help health facilities adapt to the impacts of climate shocks and climate change. These might include but not be limited to: (i) location of the facilities: facilities will not be located in areas susceptible to floods or landslides, or any other hazard that can affect the stability and functions of the facility; (ii) general requirements for the construction of healthcare facilities, including measures for potable water, water tanks, water treatment, waste management, and atmospheric pollutants; (iii) general requirements for the design of facilities, including measures for environmental sustainability and energy efficiency: (a) the use of equipment and materials that are energy efficient (at least 20 percent more efficient than standard practice), (b) natural ventilation and lighting, to reduce cooling and illumination needs for buildings, and air conditioning use and costs, (c) lighting standards (i.e. sensor-controlled lighting) and equipment specifications to reduce consumption and GHG emissions, (d) efficient heating equipment to reduce consumption and GHG emissions, and improve production and distribution of hot water, and (e) collection and use of rainwater for irrigation of green areas. This design will go beyond current national standards of construction to ensure that specific adaptation measures are integrated in the design. Around 80 percent of this DLR will finance development of climate adaptive and energy efficient health infrastructure guidelines, translating into US$ 28 million **(Adaptation & Mitigation).** Later, the construction of new healthcare facilities will take place (**DLR 6.2**). The entirety of this DLR will finance development of climate adaptive and energy efficient health construction and training of infrastructure specialists, translating into US$ 24 million **(Adaptation & Mitigation).**
DLI8 (US$18 million): Virtual Health Management Platform	This Platform will help transform the current health system's efficiency whilst reducing its emissions. Amongst its many functions, the Platform will help patients navigate their personal data, make appointments and even telemedicine consultations. The Virtual Health Management Platform, on its mobile app form, will: (a) send accurate and timely alert systems (e.g., heat–health warning systems trigger warnings) (b) survey people or monitor for symptoms specially during extreme weather events (e.g., heat waves) and (c) help prevent worst health outcomes by giving behavioral as well as medical advice to the public. This is crucial given the epidemiological transition to NCDs and its vulnerability to Climate Change. Furthermore, the impact of climate change and extreme natural events on population can only be monitored if associated population health data are adequately reported. Therefore, the Virtual Health Management Platform will strengthen information systems, by: (a) recording of climate-related diseases, alongside and (b) infrastructure and maintenance indicators of the facilities delivering essential healthcare services (such as continuous utility supply and access in emergency situations) reported by patients in their user experience surveys. The platform will include specific measures and components on climate and emergency surveillance, warning, and notification, which are expected to comprise 40 percent of the activity, translating into US$ 7.2 million. This will help strengthen the health system's ability to respond to climate shocks **(Adaptation).**

2. INSTITUTIONAL ARRANGEMENTS AND MONITORING & EVALUATION

25. **The UPHCP will be implemented under the leadership of the MoH and involving Health Services Entities and municipalities. The implementation will be gradually extended over time to cover an estimated 187 municipalities by the end of the PforR implementation period.** The MoH is responsible for the overall direction of the health system; as such, it develops norms, standards and guidelines that service providers apply. In particular, the MoH is responsible for identifying health priorities and financing for PHC services while the management of facilities has been transferred to the municipalities. To date, 92.6 percent of all public PHC centers are managed by municipalities. The central government transfers payments to local governments according to the size of their population. This is legally regulated by Ley 19.378, article 49 and 56.

26. **A municipality's incorporation to the UPHCP is through an agreement between them and the Health Services Entities.** This process is initiated at the MoH: The division of PHC (DIVAP) issues the resolutions that approve the technical contents of official documents that allow agreements to be made and that approve the distribution of resources. These official documents are sent to the respective Health Services Entities so that they can prepare the agreements to be signed by the mayors of each municipality. Once signed, the agreements are sent, to be signed by the directors of the Health Services Entities. These documents are then sent to DIPRES, where they receive the 'go-ahead'.[17] Finally, the agreements are sent to the Budget Division of the MoH so that the financial remittance (monetary transfer) can be prepared and sent to the Health Services Entities and then to the municipalities.

3. RESULTS MONITORING AND EVALUATION

27. **Chile's routine data collection system is robust, and reporting will rely on well-developed government monitoring systems.** Several entities in the health sector will contribute to data reporting and existing systems will be strengthened as needed to enhance the timeliness and quality of the data. The Department of Statistics and Health Information (*Departamento de Estadísticas e Información en Salud*) of the MoH routinely collects medical and administrative data from public and private providers, including PHC from municipalities and Health Care Services, and then aggregates it at the national level. The Monthly Statistical Record (*Registro Estadístico Mensual*) will be used to measure PHC service utilization and the database of hospital admissions to estimate avoidable hospitalizations. In addition, the Division of Primary Care (*División de Atención Primaria*, DIVAP) of the MoH will collect and report on data related to the new activities developed under the UPHCP such as the introduction of municipalities into the UPHCP, training of PHC personnel, publication of guides and norms, and the development and functioning of digital/virtual tools. The MoH's Department of Disaster and Emergency Risk Management (*Departamento de Gestion de Riesgos en Emergencia y Desastres*) will contribute to monitoring and reporting on activities of RA2 related to PHC resilience. FONASA will provide information about people enrolled in PHC centers, both for municipalities and Health Care Services.

28. **The Coordinator of the PCT, assisted by the technical sub-division, will be responsible for the timely collection of all documentation about PforR implementation progress.** The PCT Coordinator will ensure that the institutions and agencies responsible for each DLI have documented and verified progress on these indicators. The PCT technical sub-division will monitor, collect, and consolidate all Program activity reports as required, review them, and prepare a twice-yearly progress report. The progress report will include information on the achievement of the Program indicators, highlighting bottlenecks and proposed corrective measures. The MoH will submit the monitoring data and progress reports to the WB twice each year.

4. PROGRAM EXPENDITURE FRAMEWORK

29. **Financing of PHC in Chile comes from two sources, namely from the national budget and from contributions made by municipalities.** The financing of the central government for PHC at the municipality level presents almost 90 percent of the annual budget for PHC**.** Of the resources provided from the National Budget, 70 percent are allocated using the per-capita mechanism, while the remainder is assigned using PRAPSs to finance specific PHC activities and laws. Municipalities themselves can also contribute to the financing PHC, but on average this financing source

[17] Depending on the amounts involved in the agreements, they are classified as exempt or affected agreements (resolutions). Affected resolutions are those resolutions that involve the transfer of more than 5,000 UTM (US$ 402,000 dollars, approx.), so they must be approved by the Office of the General Comptroller of the Republic (*Contraloría General de la República*).

represents only ten percent of the total budget for PHC per year. In addition, local governments' own revenues assigned to PHC financing have been decreasing: They represented 25.1 percent of total PHC financing in 2001, having decreased to ten percent in 2019. Yet, there are exceptions. In 2014, ten municipalities were identified that contributed almost twice as much as the MoH to PHC.[18] Importantly, PHC centers do not administer the capitation transfers. Instead, the budget is administered by the municipality responsible for purchasing goods and services, including salaries, required for the operation of the PHC facilities. Therefore, PHC center directors do not have autonomy in using their centers' resources which can limit some of the incentives supposed to be generated by provider payment mechanisms.

30. **The Program Expenditure Framework only considers PHC financing from the national budget, specifically the budget of the MoH.** General revenues financing the Chilean state budget follow a stable trajectory, consistent with the country's medium-term fiscal framework. The MoH has both been predictable and stable over past years, as well as its execution has been consistent. In real terms, the PHC budget grew by 4% from 2020 to 2021, by 2% from 2021 to 2022, but then decreased by 2% from 2022 to 2023 (a result of the extraordinary inflation level in the country). In addition, the budget execution rate for the regular PHC budget program of the MoH (considering both per-capita payments and PRAPSs) for the years 2020-2022 was 98.2%, 96.5% and 97.3%, respectively.[19] Table 3 presents the total estimated budget projections for PHC from 2024 to 2027.[20]

[18] Goldstein, E. (2018). El sistema de salud en Chile y la Atención Primaria de Salud municipal. Marco para un debate sobre desmunicipalización. Biblioteca del Congreso Nacional de Chile, Asesoría Técnica Parlamentaria.

[19] https://www.dipres.gob.cl/597/w3-multipropertyvalues-25910-34905.html#ejec_programa

[20] For the estimated budget, in a conservative manner, an annual adjustment of three percent of the per capita contribution was considered, while the funding amount assigned through PRAPS was projected to remain stable over the same period.

Table 3. The Annual Projected Spending on PHC in the National Budget* (2024 to 2027)

Year	Per-Capita in Billion $USD	PRAPSs in Billion $USD	Total PHC Financing in Billion $USD
2024	2.503	0.946	3.448
2025	2.578	0.946	3.523
2026	2.655	0.946	3.601
2027	2.735	0.946	3.680
Total	**12.90**	**4.73**	**14.25**

*This table excluded expenses for PHC not provided under the responsibility of municipalities. Approximately 10 percent of the population receive PHC services that are under the responsibility of Healthcare Services *(Servicios de Salud).*

31. **The cost of the UPHCP is estimated at US$ 2.58 billion for the period from 2023 to 2029 and at US$ 1.51 billion for the period from 2024 to 2027 during which the PforR will support the Government program.** The WB will support the government's program with a financial contribution equivalent to US$200 million for the period from 2024 to 2027. 89 percent of the total cost of the UPHCP is associated to per-capita payments to municipalities expected to join the UPHCP until the end of the PforR as well as relevant PRAPS (among others, the PRAPS created to finance the UPHCP). Smaller percentages are associated with the construction of new infrastructure, training, and the development of policy instruments. The UPHCP expenditure will represent an estimated 11. percent of the public health expenditure allocated to PHC from 2024 to 2027 (see Table 3 vs. Table 4).

32. **The Program's expenditure framework includes those budget lines necessary to achieve the results that are supported by the PforR and is composed of budget lines that will promote efficiency in the achievement of these results.** Program expenditures will include: (a) Trainings; (b) Internal and external consultancies; (c) Equipment of PHC facilities; (d) expenses for construction of health centers and minor infrastructure investments.; and (e) operational expenses. The magnitude of the expenditure framework is proportional to the expected results, as demonstrated by the economic analysis (see below for the results).

Table 4. Preliminary Expenditures under the UPHCP

		2023	2024	2025	2026	2027	2028	2029	Total PforR
Expenditure Type	**Subtitle* under the MoH Budget**		**PforR Expenditure Framework**						**2024-2027**
Training	22	0.23	1.35	4.28	5.86	5.86	5.86	5.86	17.36
Consultancies	21 and 22	1.58	2.57	2.02	1.55	1.45	1.45	1.45	7.59
Equipment	29	0.20	0.38	1.37	1.74	1.74	1.74	1.74	5.23
Infrastructure construction	29 and 33	1.45	3.02	10.93	13.95	13.95	13.95	13.95	41.86
General Operating Costs (HR, medical supplies, utilities, and equipment maintenance)	21, 22 y 29	55.94	103.89	375.62	479.51	479.51	479.51	479.51	1,438.54
Total	N/A	59.41	111.22	394.22	502.62	502.53	502.53	502.53	1,510.59

The mentioned numbers corresponding to Budget Subtitles have the following meanings[21]:

- Personnel Expenses (Subtitle 21): includes all expenditures for salaries etc.
- Consumer Goods and Services (Subtitle 22): includes expenditures for the acquisition of consumer goods and non-personal services necessary for the performance of the functions and activities of public sector agencies.
- Acquisition of non-financial assets (Subtitle 29): includes expenditures for capital formation and the purchase of existing physical assets.
- Capital Transfers (Subtitle 33): includes all financial disbursements, which do not involve the consideration for goods or services, for investment or capital formation.

33. While 187 municipalities are expected to will have joined the UPHCP by the end of 2027 (see Table 5), in the PforR Results Framework, the end target for all DLRs with the exception of DLR 1.1 corresponds the estimated number of municipalities that will have joined the UPHCP before the end of 2026 (i.e., an estimated 127 municipalities). This is the case because the corresponding DLIs will measure results for which the implementation will require about one year. For instance, if a municipality joins the UPHCP and begins implementing activities in 2024, results for the other DLRs apart from DLR 1.1 will be measurable by the end of 2025. Hence, for the municipalities entering the UPHCP during the year 2027 (i.e., an estimated 60 municipalities), activities needed for other DLRs will not have been completed on time by the end of the PforR implementation period.

Table 5. Estimated Number of Municipalities joining the UPHCP

2023	2024	2025	2026	2027	2028	2029
7	13*	47	60	60	60	60

[21]https://www.bcn.cl/presupuesto/glosario.

Before the PforR	PforR Implementation Period	After the PforR

*For 2024, the number of municipalities considered is according to the Budget Law in its version of September 29, 2023 (at the time it was sent to the National Parliament).

5. ECONOMIC JUSTIFICATION OF THE PROGRAM

34. **The strengthening of Chile's PHC system will yield direct economic benefits through increased efficiency in health spending and improved health status** (due to a reduction in premature deaths and DALYs from better access to and quality of PHC).

35. **The Program supports strategic public health activities with a high impact on the population's diseases burden.** It is expected that these interventions will generate significant positive impacts in terms of the health outcomes of the target population and the quality, efficiency, and equity in healthcare services for the target population.

36. **An economic analysis has been conducted to estimate the costs and benefits of the Program.** The economic analysis focuses on estimating medium and long-term benefits of the Program, including the returns to improved health status and reduced hospital admissions. These two analyses are then combined to give a single NPV of the proposed investment. Costs are calculated in US$ and health benefits are estimated in DALYs. The analysis draws on an extensive review of data from Chile and the international literature. It also relies on several assumptions, in line with the economic analysis conducted for a WB project in the Chilean health sector that supported similar interventions.

37. **The monetary value of the Program's health gains is modelled by estimating the potential impact on the burden of chronic diseases.** The benefits attributable to the Program are measured by comparing the situation with the Program and the continuity of existing activities. In the absence of the Program, the DALYs associated with chronic diseases are being projected using an average annual change in DALYs. The interventions of the Program are estimated to produce additional benefits by helping avert more DALYs than the interpolated trend.

38. **For a conservative estimate of the economic benefits, the analysis will consider two quantifiable economic benefits arising from the strategic lines that are proposed to be supported: (a) productivity gains resulting from improved health outcomes as well as reduced morbidity rates related to the prioritized health interventions, and (b) cost savings from reduced avoidable hospital admissions.** These economic benefits will be compared with the flow of costs to obtain the NPV of the Program and the Internal Rate of Return.

39. The estimation of the costs and benefits of the Program will be carried out considering the following basic assumptions:

(a) **Temporal horizon**. For simplicity, the benefits and costs were modelled for the length of the Program (four years). The Program will only disburse from 2024 through 2027, but both monetary and health impacts of the program are expected to continue after the closing of the operation, for which a period of ten years (2024-2033) was modelled.
(b) **Discount rate**. In this evaluation, at the baseline, a six percent real discount rate is utilized, although different rates of discount are used in the sensitivity analysis.
(c) **Impact**. The health impact of the Program is estimated based on the reduction in the burden of disease of the target population associated with the effective coverage rates foreseen by the

Government. The reduction in the burden of disease is expressed in terms of premature deaths and DALYs averted through improved access to and quality of primary care and improved prevention and management of diseases. The disease burden is calculated from official 2020 mortality data by sex and age for selected causes excluding COVID-19 mortality. A health impact is assumed based on ten causes of disease with an effectiveness of no more than five percent reduction in DALYs with exceptions, such as maternal and perinatal causes which were assumed to be more effective at 10-15 percent.

(d) **Monetary Benefits.** To estimate the productivity gain, a monetary benefit per Years of Life Lost due to premature mortality equivalent to the average annual per capita income of the country (approximately US$ 17,000 per year) is used. Years Lost due to Disability avoided are calculated at 70 percent of that income as an approximate measure of the loss of income of a person with a disability.

(e) **Savings from reduced avoidable hospital admissions**: Gradually increasing savings from reductions in hospital admissions is expected from the second year of the Program onwards.

(f) **Costs:** The costs included in the analysis account for both the resources made available by the World Bank and by the Government to include the total cost of the UPHCP being implemented. The financial contribution of the PforR to the UPHCP is US$200 million.

40. **The cost-benefits of the Program are calculated using three scenarios** (baseline, lower impact, and higher impact). The assumptions used in the cost-benefit analysis are summarized in Table 5.

Table 1. Key Inputs and Assumptions used for the Cost-Benefit Analysis

Key Inputs	**Baseline Scenario Assumptions**	**Sensitivity Analysis**	
		Low scenario	**High Scenario**
Benefits from reductions in DALYs	Increase access to quality PHC: 10 percent overall reduction in DALYs related to disease burden in the target population.	Increase access to quality PHC: 12.5 percent overall reduction in DALYs related to disease burden in the target population	Increase access to quality PHC: 8.5 percent overall reduction in DALYs related to disease burden in the target population
Discount rate of the monetary value of future health benefits	6%	4%	8%
Benefits of interventions in terms of DALYs averted	7.5% overall reduction in DALYs related to selected disease burden.	5% overall reduction in DALYs related to selected disease burden.	10% overall reduction in DALYs related to selected disease burden.

41. The full costs of the PforR are considered to derive the Internal Rate of Return and the NPV, which are also calculated for different discount rates and subject to a sensitivity analysis accounting for changes in other variables. Table 6 presents the results of the economic analysis in terms of the internal rate of return and the NPV, underlining the vastly positive impact of the PforR.

Table 6. Summary of the Cost-Benefit Analysis

	Baseline Scenario	Low-Impact Scenario	High-Impact Scenario
NPV (in US$ million)	166.67	122.20	212.46
Internal rate of return	22.1%	15.1%	28.5%

Source: World Bank estimates.

6. TECHNICAL RISKS AND MITIGATION MEASURES

42. The PforR would be implemented using the existing strong institutions and arrangements of the Chilean health sector. Furthermore, the PforR builds on the WB analytical engagement during the 2023 Fiscal Year in the area of PHC strengthening (financed through a Trust Fund from the Access Accelerated Initiative). To mitigate technical risks, the PforR will support technical assistance through the WB team in different areas such as the review of payment mechanisms for PHC and the enhancement of health system resilience. The implementation of the PAP would also contribute to development of systems and capacities in the areas of E&S management and fiduciary management. Correspondingly, the PAP (Annex 6 in PAD) includes specific measures for E&S management capacity development and for fiduciary management.