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Report No: PAD5312

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$ 200 MILLION

TO THE

REPUBLIC OF CHILE

FOR A

PROGRAM FOR UNIVERSAL PRIMARY HEALTHCARE COVERAGE AND RESILIENCE

November 10, 2023

Health, Nutrition & Population Global Practice

Latin America And Caribbean Region

CURRENCY EQUIVALENTS

Exchange Rate Effective October 31, 2023

Currency Unit =	Chilean Pesos
US$1 =	904.38 CLP
US$0.0011 =	1 CLP

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Carlos Felipe Jaramillo
Regional Director:	Jaime Saavedra
Country Director:	Issam A. Abousleiman
Practice Manager:	Tania Dmytraczenko
Task Team Leader(s):	Cristian Alberto Herrera Riquelme, Marvin Ploetz

ABBREVIATIONS AND ACRONYMS

ACGs	Anti-Corruption Guidelines
CPF	Country Partnership Framework
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
DPFP	Department of Financial Programming and Budget *(Departamento de Programación Financiera y Presupuesto)*
ECICEP	Comprehensive People-Centered Care Strategy (*Estrategia de Cuidado Integral Centrado en las Personas*)
EHS	Environmental Health and Safety
E&S	Environmental and Social
ESSA	Environmental and Social Systems Assessment
FONASA	Public National Health Fund (*Fondo Nacional de Salud*)
GBV	Gender-based Violence
GDP	Gross Domestic Product
GRID	Green, Resilient and Inclusive Development approach
HBP	Health Benefit Package
IFRs	Interim Financial Reports
IPSAS	International Public Sector Accounting Standards
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 Healthcare Facilities
PRAPS	Reinforcement Program for Primary Healthcare *(Programa de Reforzamiento de la Atención Primaria de Salud)*
RA	Results Area
REMs	Monthly Statistical Record Series (*Serie de Registros Estadísticos Mensuales)*
SEREMIs	Regional Ministerial Health Secretariats *(Secretarías Regionales Ministeriales de*

	Salud)
SIGFE	Integrated Financial Management Information System *(Sistema de Información de Gestión Financiera del Estado)*
SISREC	Accountability System (*Sistema de Rendición de Cuentas)*
SNSS	National Health Services System *(Sistema Nacional de Servicios de Salud)*
UPHCP	Universal Primary Healthcare program
WB	World Bank

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Chile	Chile: Program for Universal Primary Healthcare Coverage and Resilience	
Project ID	Financing Instrument	Does this operation have an IPF component?
P179785	Program-for-Results Financing	No

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternate Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Enhanced Implementation Support (HEIS)	

Expected Project Approval Date	Expected Closing Date
13-Dec-2023	30-Jun-2028

Bank/IFC Collaboration

No

Proposed Program Development Objective(s)

The objective of the Program is to improve coverage, quality, and efficiency of primary healthcare and the health system's resilience.

Organizations

Borrower :	Republic of Chile
Implementing Agency :	Ministry of Health
Contact:	Bernardo Martorell Guerra

Title:	Coordinador de la Reforma de Salud, Gabinete Ministerial
Telephone No:	56-9-8921-3944
Email:	bernardo.martorell@minsal.cl

COST & FINANCING

SUMMARY

Government program Cost	2,575.05
Total Operation Cost	1,511.09
Total Program Cost	1,510.59
Other Costs	0.50
Total Financing	1,511.09
Financing Gap	0.00

Financing (USD Millions)

Counterpart Funding	**1,311.09**
Borrower/Recipient	1,311.09
International Bank for Reconstruction and Development (IBRD)	**200.00**

Expected Disbursements (USD Millions)

Fiscal Year	2024	2025	2026	2027	2028
Absolute	0.00	61.02	31.79	50.55	56.64
Cumulative	0.00	61.02	92.82	143.36	200.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Moderate
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Moderate

COMPLIANCE

Policy

Does the program depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the program require any waivers of Bank policies?

[ ] Yes [✓] No

Legal Operational Policies

	Triggered
Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

Legal Covenants

Sections and Description

Schedule 2, Section I. Implementation Arrangements, A. Program Institutions: 1. The Borrower, through MoH, shall be responsible for the overall implementation and oversight of the Program. To this end, the Borrower, through MoH, shall operate and maintain within MoH, throughout Program implementation, a Program Coordination Team (PCT) with a structure, functions, and responsibilities acceptable to the World Bank (WB), as set forth in the Operation Manual, including, inter alia: (a) a technical sub-division, and (b) a financial/administrative sub-division.

Sections and Description

Schedule 2, Section I. Implementation Arrangements, B. Participation Agreements: 1. Prior to carrying out activities with a Participating Municipality under the Program, the Borrower, through MoH, shall cause the pertinent National Health Services Entities to enter into an agreement ("Participation Agreement") with each of the Participating Municipalities (or, if applicable, amend the existing Participation Agreement), which shall include, inter alia, the Participating Municipality's obligations to carry out the Universal Primary Healthcare program (UPHCP) in accordance with its guidelines and instructions, which shall include the obligations related to the Program, including, inter alia, the ones set forth in the Operation Manual and the Anti-corruption Guidelines (ACGs).

Sections and Description

Schedule 2, Section I. Implementation Arrangements, D. Verification Arrangements: 1. The Borrower, through MoH, shall appoint, not later than three (3) months after the Effective Date, and thereafter maintain, throughout Program implementation, one or more verification agents with experience and qualifications and under terms of reference acceptable to the WB (the "Verification Agents") to verify the data and other evidence supporting the achievement(s) of one or more DLIs/DLRs.
2. The Borrower, through MoH, shall ensure that the Verification Agent referred to in the preceding paragraph shall: (a) carries out the DLIs/DLRs' verification process(es) in accordance with the Verification Protocol; and (b) submit to MoH the corresponding verification reports in a timely manner and in form and substance satisfactory to the WB.

Sections and Description

Schedule 2, Section III. The Borrower, through MoH, shall furnish to the WB each Program Report not later than seventy-five (75) days after the end of each calendar semester, covering the calendar semester.

Sections and Description

Schedule 2, Section I. Implementation Arrangements, E. Program Action Plan (PAP): The Borrower, through MoH, shall: (a) undertake the actions set forth in the PAP in a manner satisfactory to the WB; (b) except as the WB and the Borrower, through MoH, shall otherwise agree in writing not to assign, amend, abrogate, or waive, or permit to be assigned, amended, abrogated, or waived, the PAP, or any provision thereof; and (c) maintain policies and

procedures adequate to enable it to monitor and evaluate, in accordance with guidelines acceptable to the WB, the implementation of the PAP.

Conditions

Type	Financing source	Description
Effectiveness	IBRD/IDA	ARTICLE IV - 4.01. The Additional Condition of Effectiveness consists of the following, namely that the Borrower, through MoH, has developed and approved the Operation Manual set forth in Section I.C.1 of the Schedule 2 to the Loan Agreement in form and substanceacceptable to the WB.
Disbursement	IBRD/IDA	Schedule 2. Section IV. Withdrawal of Loan Proceeds, B. Withdrawal Conditions; Withdrawal Period: 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (a) on the basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed USD 50,000,000 may be made on the basis of DLRs achieved prior to this date but on or after January 1, 2024.
Disbursement	IBRD/IDA	Schedule 2. Section IV. Withdrawal of Loan Proceeds, B. Withdrawal Conditions; Withdrawal Period: 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (b) for any DLR under Categories (1), (2), (3), (4), (5), (6), (7), (8), until and unless the Borrower has furnished evidence satisfactory to the WB that said DLR has been achieved.

I. STRATEGIC CONTEXT

A. Country Context

1. **Chile is in a social and political transition to build a more equitable society**. Massive bursts of social demonstrations throughout the country started in October 2019, with protestors demanding better access to quality social services such as health, education, and pensions. An agreement signed in November 2019 by a wide political spectrum establishment 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; however, 62 percent of voters rejected its constitutional proposal. A second election process was held in May 2023 that elected a new Constitutional Convention that will draft a new proposal based on a text prepared by an Expert's Committee that was appointed by Congress. In December 2023, a second Constitutional referendum will be held.

2. **The economic contraction caused by the COVID-19 pandemic significantly affected Chile's household incomes 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 purchasing power parity) increased to 10.8 percent in 2020 from 8.6 percent in 2017, meaning that more than 1.5 million people were considered poor in 2020. The pandemic also reversed national gains in shared prosperity. 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 data collected in 2020 by the World Bank (WB) 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. The data also revealed that income losses and food insecurity were more prominent among rural and poor households.

3. **Fueled by a strong fiscal response to COVID-19, Chile experienced one of the fastest recoveries worldwide in 2021, but a sharp adjustment started in 2022 and continues in 2023.** After growing 11.7 percent year-on-year in 2021, real gross domestic product (GDP) growth decelerated to 2.4 percent in 2022, as both fiscal and monetary policies were tightened significantly. Economic slowdown continued in 2023 and GDP is expected to contract by 0.4 percent, led by a further drop in domestic demand amid contractionary policies, tight financing conditions and subdued investment sentiment. A gradual recovery is expected in 2024. After reaching a peak of 14.1 percent year to year in August 2022 amid an overheated economy, inflation declined to 5.1 percent in September 2023 as demand pressures weakened after a determined monetary tightening. The Central Bank hiked interest rates from 0.5 in July 2021 to 11.25 percent in October 2022, and as inflation fell, a rate cut cycle started in July 2023.

4. **Progress has been made in shared prosperity, but Chile's Multidimensional Poverty Index[1] shows that deprivation is still 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

[1] https://www.un.org/d1evelopment/desa/dspd/wp-content/uploads/sites/22/2021/05/Rios_Presentation_PDF_UNCT_Chile_Poverty1.pdf

comparison with Organization for Economic Cooperation and Development (OECD) countries. The Multidimensional Poverty Index accounts for deprivations in five dimensions: education, health, work and social security, housing and environment, and social networks and cohesion. 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.

5. **Climate change threatens Chile's population, as the country's unique and wide ranging geography and topographical features are highly vulnerable to multiple hazards.**[2] According to the Global Climate Risk Index (2021), Chile is in the top 25 countries most vulnerable[3] to extreme weather changes.[4] According to Chile's Climate Risk Maps (used to present projected climate impacts and risks), 84 percent of the 345 municipalities are at high risk of one or more climate shock.[5,6] From 1965 to 2019, Chile incurred more than US$5 billion in losses from 37 flooding events, the most significant of which represented a loss of approximately US$2 billion, equivalent to 0.62 percent of GDP for the year. Projected decreases in precipitation levels, heightened during *La Niña* years, in the northern and central areas of the country, exposed Chile to increased periods of drought. Evidence indicates an increase in temperatures throughout the country, with greater intensity in the northern zone and in the mountain areas of the Andes range.[7]

B. Sectoral (or Multi-Sectoral) and Institutional Context[8]

6. **While Chile has some of the best health outcomes in Latin America and the Caribbean and a long history of successful health sector reforms, health outcomes in the country are characterized by major inequalities, and the significant shift in the disease burden towards non-communicable diseases (NCDs) creates challenges with respect to the achievement of universal health coverage.** Despite considerable improvements in recent decades, the health status of the population remains consistently below the OECD average. In addition, individuals of lower socioeconomic status are more likely to have worse health outcomes. For instance, the 2017 National Health Survey indicates that those with less than eight years of schooling have a higher prevalence of health conditions, and that NCDs are more prevalent among the population with public health insurance compared to the one with private insurance.

7. **Chile's bipartite health insurance model results in a concentration of patients with worse health in the public sector, further contributing to Chile's large health inequities.** Chile's health insurance system consists in principle of the Public National Health Fund (*Fondo Nacional de Salud,* FONASA) and Private Health Insurance Institutions (*Instituciones de Salud Previsional*, ISAPRES). While FONASA covers 80 percent of the population and serves as the public and solidarity-based insurer, about 15 percent of the population are insured by one of the seven ISAPRES. In addition, the Armed Forces administer their own insurance pool. ISAPRES charge individual risk-based insurance premiums, thereby performing a risk selection of their insurees. Most elderly patients are covered by FONASA, and ISAPRES can manage their insurees' health risks by adjusting insurance premiums.

[2] *https://climateknowledgeportal.worldbank.org/sites/default/files/2021-07/15916-WB_Chile%20Country%20Profile-WEB%20%281%29.pdf*
[3] It has seven of the nine characteristics defined by this agency: low-lying coastal areas; arid and semi-arid lands, forest cover areas, and areas prone to forest deterioration; areas prone to socio-natural disasters; areas prone to drought and desertification; areas of high urban air pollution and areas of fragile ecosystems, including mountain ecosystems.
[4] 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
[5] https://cambioclimatico.mma.gob.cl/wp-content/uploads/2021/11/ECLP-LIVIANO.pdf
[6] *Ministerio Medio Ambiente*, 2021, "*Cuarta Comunicación Nacional de Chile ante la Convención Marco de las Naciones Unidas sobre Cambio Climático*", in English: "Fourth National Communication of Chile to the United Nations Framework Convention on Climate Change", executive summary, numeral 3.2, page 28-29, available on the website: cambioclimatico.mma.gob.cl/*publicaciones-destacadas*/
[7] https://cambioclimatico.mma.gob.cl/wp-content/uploads/2020/08/NDC_2020_Espanol_PDF_web.pdf
[8] For more information see the Technical Assessment.

8. **ISAPRES have limited incentives to invest in prevention and public health programs, resulting in low private provider capacity for preventive care and primary healthcare (PHC).** As in many countries, a hospital-centric care model has been sustained in the health sector, particularly in the private sector where hospitals are perceived as providing high-quality care, resulting in a perceived need for more specialists. As a result, ISAPRES beneficiaries make greater use of services such as specialist visits, dental care, imaging, and hospitalization. Furthermore, although FONASA beneficiaries have free PHC access (i.e., without any copayments), about 1.5 million beneficiaries are not enrolled with a PHC facility and, amongst those registered, many frequently skip PHC, relying instead on emergency care.

9. **The health system in Chile does not meet the expectations and needs of FONASA and ISAPRES affiliates in terms of delivering accessible, high quality and timely care, nor dignified treatment or financial protection.** Citizen satisfaction with the health system is low, with a slightly downward trend registered between 2007 and 2018 (from 43 percent to 40 percent respectively), a level that is considerably below the 70 percent OECD and 55 percent Latin America and the Caribbean regional average.[9] Waiting times for healthcare is the primary source of dissatisfaction. Since 2000, prompted by civil society organizations, Chile initiated health policies for the lesbian, gay, bisexual, trans, intersex, queer and asexual (+ other identities) (LGBTIQA+) community, initially focused on sexual health and later expanded to transgender care. Despite policy progress, LGBTIQA+ people still face discrimination (e.g., 33 percent of lesbian women feel discriminated, and 95 percent of transgender people report high rates of identity questioning in health centers).[10,11]

10. **The current governance and financing models for PHC also lead to an inefficient allocation and opaque use of resources, which hampers the public service delivery system from becoming more PHC-centric and focused on prevention.** PHC funding and delivery in Chile is largely public. Some inefficiencies relate to the absence of an updated costing and prioritization of the PHC health benefit package (HBP) and to the payment mechanisms used to pay for PHC services. Capitation-based financing of PHC – despite many advantages – creates the financial incentive for healthcare providers to minimize costs and care provision, potentially leading to patients with higher healthcare needs being referred out of PHC and into higher care levels. The current capitation financing scheme in Chile also faces the following challenges: (a) an outdated per capita calculation methodology; (b) limited capacity to adjust capitations to the epidemiological reality in various parts of the country, and (c) missing accountability mechanisms. This situation has led to an ad-hoc funding process that has become part of a political negotiation, lacking transparency and evidence-based funding decisions.

11. **Climate change is posing additional threats for the population's health and its effects are already noticeable**. In Chile, average annual temperatures are expected to increase by 1.4°C–1.7°C by mid-century and by as much as 3°C–3.5°C by the end of the century. The annual probability of heat waves in Chile could also increase by 8 percent by the 2040s. Anticipated increasing temperatures in Chile are projected to increase heatwave-related excess mortality, reaching a 462 percent increase in excess deaths between 2031 and 2080. Cumulative rainfall in central Chile will decrease by an average of 15 percent in the medium term compared to historical values. The frequency of droughts is also projected to increase by 10-23 percent between the Coquimbo and Los Lagos regions in the medium-term

[9] OECD. Satisfacción ciudadana con los servicios públicos. *Panorama de las Administraciones Públicas América Latina y el Caribe 2020*, https://www.oecd-ilibrary.org/sites/7dd508f2-es/index.html?itemId=/content/component/7dd508f2-es (2020).
[10] According to the study *'Being a lesbian in Chile'*, more than 33% of respondents said they had felt discriminated by medical personnel and 68% said they had not had a PAP smear for fear of discrimination in health centers. Likewise, in the *First Survey for trans people in Chile*, conducted in 2017, 95% of trans people reported having suffered from discrimination in health centers (i.e., a questioning of their identity, denied attention, sexual harassment).
[11] OTD, First survey for trans and gender non-conforming people in Chile (2017), p.24.

future.[12] Vector-borne diseases will also be affected by changes in precipitation and temperature patterns. Models estimate that the habitats for mosquitos that are vectors for malaria will expand in the country.[13]

12. **Climate-related and natural hazards such as floods and earthquakes also pose a major risk to the functioning of health system infrastructure in Chile.** During the earthquake in 2010, six hospitals in southern Chile collapsed and two others were unable to function due to sustained damage. That earthquake is estimated to have caused around US$30 billion in damages, which is close to 14 percent of the 2010 GDP.[14] Overall, floods comprise around 25 percent of total climate-related and natural hazards, followed by earthquakes with 19 percent.[15] To face and manage the challenges that climate change imposes on health infrastructure, an unprecedented transformation of the sector is necessary. This transformation will need to ensure that the location of primary healthcare facilities (PHF) – and their respective building codes – account for current and projected future climate risks and improve resilience to extreme climate events. PHC infrastructure with lower environmental footprint can also contribute to the objective of carbon neutrality.

13. **The Government of Chile proposed a major reform of the national health system in 2022, with the Universal Primary Healthcare program (UPHCP - the program) as the first reform component being implemented.** The health system reform is structured in five fundamental axes that path the way towards a universal health system: institutional strengthening of the health authority; establishment of a Universal Health Fund (under a single-payer model); regulation of a voluntary health insurance market for complementary/supplementary private insurance; reform of the sick leave benefits scheme; and implementation of the universal PHC system. The universal PHC component of the reform enjoys broad technical and political support, and its implementation has already started. The National Commission for universal PHC was created in July 2022 and has been providing stewardship for the reform. Since then, new PHC guidelines have been established, together with an implementation strategy that promotes the availability of comprehensive and timely high-quality PHC services. In 2023, the UPHCP was piloted in seven municipalities.

C. Relationship to the CPS/CPF and Rationale for Use of Instrument

14. **The proposed Program-for-Results (PforR) contributes to the WB Mission of ending extreme poverty and boosting prosperity on a livable planet by increasing access to quality public healthcare services and improving health system efficiency and resilience.** By supporting the UPHCP across the territory of Chile, the proposed PforR (the Program) will also contribute to equity in health outcomes, thereby benefiting the population more likely to be poor.

15. **The proposed PforR is aligned with the WB's FY23-27 Country Partnership Framework (CPF)[16] for the Republic of Chile (discussed by the WB Board of Executive Directors on June 28, 2023) as well as the Green, Resilient and Inclusive Development (GRID) approach**. 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 to move towards universal

[12] https://climateknowledgeportal.worldbank.org/sites/default/files/2021-07/15916-WB_Chile%20Country%20Profile-WEB%20%281%29.pdf
[13] Guo, Y., Gasparrini, A., Li, S., Sera, F., Vicedo-Cabrera, A. M., Coelho, M. de S. Z. S., Saldiva, P. H. N., Lavigne, E., Tawatsupa, B., Punnasiri, K., Overcenco, A., Correa, P. M., Ortega, N. V., Kan, H., Osorio, S., Jaakkola, J. J. K., Ryti, N. R. I., Goodman, P. G., Zeka, A., … Tong, S. (2018). Quantifying excess deaths related to heatwaves under climate change scenarios: A multicountry time series modelling study. PLOS Medicine, 15(7), e1002629. *https://doi.org/10.1371/journal.pmed.1002629*
[14] *https://www.paho.org/en/news/1-3-2010-access-health-services-challenge-after-chile-earthquake#:~:text=Six%20hospitals%20collapsed%20and%20two,left%20by%20the%20damaged%20facilities*.
[15] *https://sinia.mma.gob.cl/wp-content/uploads/2021/04/17-eventos-extremos-y-desastres.pdf*
[16] World Bank. Chile - Country Partnership Framework for the Period FY24-FY27 (English). Washington, D.C.: World Bank. *http://documents.worldbank.org/curated/en/099060523092533067/BOSIB08bf6ca1d02d0b4410610a16810e43*

health coverage, but structural issues prevail that continue to generate significant inequalities. By strengthening the health system's resilience, including to climate change-induced health emergencies, the proposed Program would directly support the CPF's high-level outcome 1 "Increased access of vulnerable groups to quality social services" and indirectly support high-level outcome 2 "Increased mitigation and adaptation to climate change and critical environmental challenges." More 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 PforR is also aligned with the GRID approach by accelerating climate change mitigation and adaption efforts in the health sector, promoting the adoption of new technologies (i.e. a virtual health management platform), strengthening health sector resilience and risk management.

16. **The PforR builds on 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.**[17] The PforR helps address issues that are critical for the country to advance toward a level of sustainable development, as it supports important institutional strengthening in the health sector, helping to bring the public sector closer to Chile's aspirational comparator countries. In addition, Chile's experience in implementing its UPHCP will be highly relevant to other countries from the region and beyond, as Chile has been a model for countries in the region (and beyond) for health sector reform.[18] Other countries may look to design similar reforms, and learning from Chile's experience will provide important knowledge spillovers for the WB and lessons and approaches to potentially replicate with clients globally. By implementing the PforR in support of the UPHCP, the WB will contribute to the generation of regionally and globally relevant knowledge about high-priority health sector reforms supported by the PforR (i.e., innovative PHC strengthening; and the addressing of climate change, gender issues, and pandemic risks).

17. **The PforR is the most appropriate financing instrument to support the Ministry of Health (MoH) in implementing the UPHCP**, as the PforR promotes the use of country systems, which are considered strong. The UPHCP focuses on results and the PforR embraces the results-based focus while addressing the main constraints to their achievement. The use of country systems is warranted by the history of Chile's PHC system having incorporated results-based financing mechanisms and developed a solid monitoring system that will enhance the UPHCP's development impact and sustainability. The PforR will also support efficiency gains in the UPHCP over time, while still paying attention to system strengthening and institutional capacity building.

18. **The proposed operation is aligned with the goals of the Paris Agreement, consistent with Chile's National Determined Contribution (NDC), Long-Term Strategy, and National Adaptation Plan.** In the latest NDC submitted to the United Nations Framework Convention on Climate Change, Chile commits to reaching greenhouse gas neutrality by 2050 and outlines health as a priority sector for climate change adaptation. In its contribution, Chile commits to implementing all the 2030 Agenda Goals for the health sector, as well as disaster risk management plans by all health sector companies. The Long-Term Strategy states that one long-term sectoral goal for the health sector is to monitor extreme weather events and its effects on people's health. In addition, the Chilean National Adaptation Plan aims to increase Chile's capacity to adapt to the adverse effects of climate change and to strengthen its resilience. The proposed UPHCP will contribute to increase Chile's capacity to adapt to adverse effects of climate change by strengthening the capacity of health personal to respond to public and climate-related emergencies. Under the UPHCP, Chile's resilience against climate-related hazards will also be improved by increasing its risk surveillance

[17] Barış, Enis; Silverman, Rachel; Wang, Huihui; Zhao, Feng; Pate, Muhammad Ali. 2021. Walking the Talk: Reimagining Primary Healthcare After COVID-19. © World Bank, Washington, DC.
[18] Bitran, Ricardo. Explicit health guarantees for Chileans: the AUGE benefits package (English). Universal Health Coverage (UNICO) studies series; no. 21 Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/308611468014981092/Explicit-health-guarantees-for-Chileans-the-AUGE-benefits-package

capacity and mitigating the effect on people's health by implementing a virtual health management platform. This is consistent with Chile's commitment to monitor extreme weather events and its effects on its population. Furthermore, PHF constructed under the UPHCP will be adapted to climate change and constructed with low greenhouse gas emissions to support Chile's NDC mitigation target.

II. PROGRAM DESCRIPTION

A. Government's program

19. **The UPHCP came into effect in early 2023 and will be implemented until 2029 to improve effective and timely access to high-quality healthcare services for the entire population, consolidating PHC as the foundation of the healthcare service delivery system.** The UPHCP targets both the population currently not covered by FONASA (i.e., mainly ISAPRES insurees and Armed and Security Forces affiliates), as well as the population covered by FONASA that does not use PHC services or is not enrolled with any PHC center. In the future, it is expected that the FONASA population will continue to use PHC services at a significantly higher rate than the current ISAPRES members. Thereby the UPHCP will mainly benefit the former.

20. **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 so-called Reinforcement Program of Primary Healthcare (*Programa de Reforzamiento de la Atención Primaria de Salud*, PRAPS) to finance specific PHC activites and laws. The objectives of PRAPSs are to solve the most urgent problems of access, resolution capacity and healthcare coverage by introducing a fee-for-service component into PHC financing, but in practice they are very diverse. Some PRAPSs are aimed at financing PHC-based emergency care, while others incentivize the provision of high-priority services from the PHC HBP. Other PRAPSs may even finance infrastructure investments or improvements.

21. **The MoH has formalized the UPHCP and assigned an initial budget for each of its four strategic lines.** The government's program was originally established through the MoH Resolution No. 112 published on February 9, 2023, which approved the UPHCP through a PRAPS included in the 2023 national budget. The UPHCP is designed with the following objectives: (a) expand effective coverage through PHC optimization; (b) enhance the contribution of PHC to health system resilience, and (c) improve the health and social care model, with dignity and quality. Over the period of 2023-2029, the UPHCP has a projected budget of US$2.58 billion.

22. **The UPHCP is being implemented progressively over several years, based on analytical work that lays the basis for its rollout.** The UPHCP has begun implementation with a pilot in seven municipalities as of 2023. These pilot municipalities were chosen following a "scalability strategy", so that the lessons learned from the pilot can offer the most insights about future feasibility and inform implementation (e.g., regulatory aspects, resource needs, the functioning of the healthcare network). All seven municipalities reflect the diversity and heterogeneity of different territories across Chile, including but not limited to location (urban vs. rural), the composition of their population (already being covered/reached by PHC or not) and the availability of service delivery infrastructure in PHC. At present, there is no other external financing for the health sector.

B. Theory of Change

23. **Over the four-year period of 2024 to 2027,[19] the proposed PforR will support investments and activities aimed at improving equitable coverage and quality of PHC, increasing the contribution of PHC to health system resilience,[20] and obtaining efficiency and transparency gains in the use of resources for PHC.** These three areas address the main challenges identified for the health system: (a) the epidemiological transition to NCDs; (b) the fragmented nature of service delivery and inequities; (c) the insufficient quality of services; (d) the lack of clarity about the role of PHC for health system resilience and in coping with public health emergencies (PHEs), including those related to climate change, and (e) the need to improve the efficiency of health financing. For each Results Area (RA), the PforR supports activities to improve institutional processes and health service delivery, and defines outputs and intermediate results needed to achieve the Program Development Objectives (PDOs) (See Figure 1)**.** A mapping of the UPHCP's strategic lines and activities vis-à-vis the PforR RAs can be found in Table 2 of the Technical Assessment.

[19] The PforR will reward results achieved during the period January 1, 2024- December 31, 2027 but the closing date of the PforR will be June 30, 2028 such that results achieved in 2027 still can be verified and disbursed against before PforR closing.

[20] Resilient health systems are defined as integrated systems that are: (i) aware of threats and risk drivers; (ii) agile in responding to evolving population health needs; (iii) absorptive to contain health shocks; and (iv) adaptive to minimize disruptions. To this end, PHC plays a fundamental role as it acts as a gateway for both, case management and engagement on broader social determinants, as well as prevention and surveillance systems and multisectoral coordination at community level.

Figure 1. Theory of Change

Challenges: (a) the epidemiological transition to NCDs; (b) fragmented nature of service delivery and inequities; (c) the insufficient quality of services; (d) the lack of clarity about the role of PHC for health system resilience to cope with public health emergencies and climate change, risks and (e) the need to improve the efficiency of payment mechanisms for PHC.

Interventions	Output	Intermediate Outcome	Outcomes	Impact
Participation agreement signed / Design and implement a communication plan	Municipalities participating in the Universal PHC program increased (DLR 1.1)	**Outreach:** Newly Registered Population at the national level, increased **(IRI)**	**Access for new & current population** Participating municipalities with increased population receiving PHC services (DLI1.2)	**RA1: Coverage and quality of PHC** PDO1=DLI 3 Decrease in the rate of avoidable hospitalizations for patients with multimorbidity in participating municipalities
Telemedicine / extension of minimum services beyond regular business hours/ Digital appointment platform	Population receiving PHC services through telemedicine and during extended out-of-office hrs. / Digital appointments	**Optimization:** Reduction in the % of users who do not get a response in <72 hrs. when using the TeleSalud portal **(IRI)**		
Patient navigation program Training in GBV/Incorporate Sexual identity variables into surveys / Develop protocols for the inclusive care of LGBTIQA+ community Design a 'user experience' improvement plan	Available community health agents trained in GBV(DLR 2.1) Available health care workers trained in GBV **(IRI)** Sexual identity variables incorporated into survey	**Health networks are strengthened:** Community protocols for the inclusive care of LGBTIQA+ community developed **(IRI)**	**Improved quality and integration of care** Participating municipalities with positive user experience amongst LGBTIQA+ community (DLR 2.2)	
Comprehensive People-Centered Care strategy (ECICEP)	Population characterized per their risk Definition and inclusion of high-value health services	**Risk-based care:** increase in the number of people using high-value health services (DLI 4)		
Design guide for surveillance and preparedness for PHE and climate change risks in Universal PHC/ Train personnel / Develop locally adapted plan	New ministerial guide for surveillance and preparedness for PHEs and climate change risks in Universal PHC (DLR 5.1)	Comprehensive surveillance, preparedness & response teams trained and appointed to monitor risks	Plans developed and available with risk mapping for PHEs and climate change as established in Law 21364 **(IRI)**	**RA2: Resilient PHC** PDO= DLI 5.2 Participating municipalities have partaken in at least one drill for PHEs and climate change risks response
Design new PHC infrastructure / Construct new PHC facilities	New PHC infrastructure model adjusted to the geographic distribution of the population, energy efficiency and climate resilience standards (DLI 6.1)	New PHC facilities available and operating according to the new PHC infrastructure model (DLI 6.2)	**Adaptation and mitigation to climate change**	
Revision of the costing of PHC services and health purchasing/ Design training program	Costing the PHC health benefit package preventive services (DLR 7.1) Updated PHC financial resource allocation mechanisms (DLI 7.2)	Municipal managers knowledgeable in crucial areas for PHC management **(IRI)**	**Efficient spending and income in PHC adjusted according to epidemiological and health reality**	**RA3: Efficient and transparent PHC** PDO3 = DLR 8.2 Participating municipalities with positive user experience
Internet for PHC in rural areas / Develop quality standards and data governance / Interoperability	Participating municipalities refer at least 70 percent of their patients through digital referral **(IRI)**	**Clinical and decision making and timely management**	**Monitoring of process performance results, impact and user experience**	
Design virtual health management platform / Train personnel	Virtual health management platform operational (DLR 8.1)	**Citizens and decision-makers are trained and can engage**		

C. PforR Program Scope

24. **RA1 - Coverage and Quality of PHC:** This RA focuses on establishing universal coverage for and access to effective and accessible quality PHC services for all people in the Borrower's territory, regardless of their health insurance status. This RA would: (a) increase the number of municipalities included in the UPHCP; (b) increase the registered population receiving PHC services; (c) close gaps in the quality of care, with a special focus on the prevention and control of NCDs and the needs of women and persons identifying as LGBTIQA+; and (d) strengthen the implementation of a new Comprehensive People-Centered Care Strategy (*Estrategia de Cuidado Integral Centrado en las Personas, ECICEP*), and a patient navigation system.

25. **RA2 - Resilient PHC:** This area focuses on strengthening PHC to build a resilient health system that can effectively prevent, prepare for, respond to, and withstand future PHEs (i.e.; due to epidemics) and the impact of climate change. The RA will also address preparedness for natural disasters, fragility, conflict and violence. Activities mainly include: (a) developing a guide for "Surveillance and Preparedness for PHEs and Climate Change Risks in universal PHC"; (b) training staff for emergency risk surveillance, and creating "Comprehensive Surveillance and Response Teams" appointed and georeferenced to participating municipalities; (c) organizing and conducting PHEs and climate change drills (e.g., infectious respiratory diseases, climate change related heat strokes, emerging vector borne diseases, etc.), and (d) designing and constructing a new PHC infrastructure model that is adjusted to climate-related hazard exposure, geographic distribution, and energy efficiency standards.

26. **RA3 - Efficient and transparent PHC:** This area focuses on improving the use of resources in healthcare, leading to more efficient and effective care. Activities will include: (a) modernizing the allocation of PHC funding based on health and social risks; (b) costing the current preventive component of the PHC HBP; (c) training municipal PHC managers to develop effective leadership and PHC budget execution skills; (d) developing and implementing an interoperable referral digital system between PHF and specialist doctors in their correspondent hospital network, and (e) creating a virtual health management platform for PHC users that allows them to access their health and healthcare information, schedule appointments, receive reminders and information about healthy lifestyles and/or threats, and evaluate the PHC services received.

Table 1. Boundaries of the PforR vs. the UPHCP

	UPHCP	PforR	Reasons for non-alignment
Objective	(a) expand effective coverage through PHC optimization; (b) make PHC more resilient; (c) improve the health and social care model, with dignity and quality, and (d) optimize the use of resources for PHC and implement a performance monitoring and evaluation (M&E) framework.	Support investments and activities aimed at improving the equitable coverage and quality of PHC, improving the contribution of PHC to a resilient health system, and obtaining efficiency gains in the use of resources for PHC.	The Government and PforR objectives are fully aligned. The PforR will support the activities of the UPHCP but has slightly differently organized RAs (see the Technical Assessment).
Duration	2023-2029	2024 to 2027	The PforR supports the UPHCP to achieve a critical mass of municipalities under implementation.
Geographic coverage	Incremental per year, with the aim of reaching almost the entire country by 2029. Some actions will have a national impact starting in 2025.	Mainly 187 municipalities, while some supported activities are transversal and will immediately benefit the whole country.	The PforR supports the entire geographic coverage that the UPHCP will have during the implementation period of the PforR.
Results Areas	N/A	Areas 1 to 3	N/A
Overall Financing	US$2.58 billion.	US$1.51 billion, with US$200 million being IBRD financing.	The PforR supports the government's program during the period 2024-2027.

D. Program Development Objective(s) (PDO) and PDO Level Results Indicators

27. **The Program's PDOs are to improve coverage, quality, and efficiency of PHC, and the health system's resilience[21].** The PforR would primarily benefit those people living in the areas where the UPHCP is subsequently being implemented, but certain transversal activities that will be implemented starting in the first year of the PforR will benefit the entire population of almost 20 million people.[22]

28. **The proposed PDO Indicators are directly associated with the Program's development objectives:**

(a) For coverage and quality of PHC: Decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities.

(b) For the contribution of PHC to health system resilience: Participating municipalities have participated in at least one drill for PHEs and climate change preparedness conducted by Comprehensive Surveillance and Response Teams.

[21] Resilient health systems are integrated systems that are aware of threats and risk drivers, agile in response to evolving needs, absorptive to contain shocks, and adaptive to minimize disruptions. - World Bank. 2022. Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19. © Washington, DC. http://hdl.handle.net/10986/38233 License: CC BY 3.0 IGO.

[22] https://www.ine.gob.cl/estadisticas/sociales/demografia-y-vitales/proyecciones-de-poblacion.

(c) For the efficiency and transparency of PHC financing: Participating municipalities with positive user experience.

E. Disbursement Linked Indicators (DLIs) and Verification Protocols

RA1: Coverage and Quality of PHC

29. **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, which shall include the obligations related to the PforR, including, inter alia, the ones set forth in the Operation Manual and the Anti-Corruption Guidelines (ACGs) has been signed between the municipality and the corresponding National Health Services Entity and when the municipality participates in the UPHCP in accordance with eligibility criteria set forth in the Operation Manual. **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.

30. **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. (See gender section.)

31. **DLI 3 will monitor the decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities.** It is the only DLI that is time-bound. The ECICEP Strategy allows patients to be classified according to their multimorbidity profile (see the Technical Assessment). The indicator measures the decrease in avoidable hospitalization of people with multimorbidity as per ECICEP characterization for three different cohorts. Cohort 1 will be composed of the population of the municipalities that will adhere to the UPHCP as of December 31, 2024 (estimated to be 20 municipalities) **(DLR 3.1**). Cohort 2 will be composed of the population of the municipalities adhering to the UPHCP as of December 31, 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 as of December 31, 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 (see Annex 1). This DLI will also serve as PDO Indicator 1.

32. **DLI 4 will monitor participating municipalities with an increase in the number of people using high-value health services** to be determined during implementation in accordance with the WB. High-value health service means a service of high health value included in the PHC HBP or in a PRAPS, selected in accordance with common criteria used in health technology assessments (e.g., clinical effectiveness, cost-effectiveness, quality of life and patient-reported outcomes, equity and accessibility, acceptability and feasibility, comparative effectiveness) and which will be set forth in the Operation Manual to be approved by the WB.

RA2: Resilient PHC

33. **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 for emergencies responses (e.g., physical injury and mental health support during extreme weather events, natural disasters such as earthquakes, epidemic diseases isolation and treatment, etc.). The guide will officially be published through a ministerial resolution (*resolución exenta)*. **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.)

34. **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 (*resolución exenta)* 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 PHF built that operate according to the basic requirements of the new PHC infrastructure model. (See Climate Change Section.)

RA3: Efficient and Transparent PHC

35. **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 to 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 and reviewing the prioritization criteria for the creating and funding of PRAPSs**.** 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 methodology to define funding for PRAPSs would be updated based on the review, thereby leading to a more precise and transparent resource allocation to benefit vulnerable populations with higher health needs.

36. **DLI 8 will support the design and rollout of a 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 a referral to a teleconsultation with select specialists; and (e) the possibility to provide feedback on their experience with the PHC services received **(DLR 8.2/PDO Indicator 3**).[23] The Virtual Health Management Platform will generate greater

[23] 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.

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 TeleSalud platform will promote efficiency in the PHC system by incorporating a system using artificial intelligence to schedule TeleSalud appointments more efficiently and manage demand for these TeleSalud services.

37. **By the end of 2027, it's expected that 187 municipalities will have joined the UPHCP.** However, the end target for all DLRs related to the number of municipalities in the Results Framework, except for DLR 1.1, reflects the estimated number of municipalities that will have joined the UPHCP by the end of 2026, which is approximately 127 municipalities. This distinction is made because the corresponding DLIs will measure results that require about a year to implement. As such, the 60 municipalities that are expected to join the UPHCP and starts implementing activities in 2027, will only have their results for the related DLRs, excluding DLR 1.1, available by the end of 2028 (after the PforR closing date).

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

38. **The PforR will be implemented by the MoH and dependent Health Services Entities under the National Health Services System (*Sistema Nacional de Servicios de Salud* - SNSS).** In addition, in most of the country, municipalities oversee the provision of PHC services in most of the country and thereby participate in the SNSS, as formalized through agreements that they enter with the Health Services Entities. Specifically, the SNSS has 29 Health Services Entities with a defined geographical assignment that cover the entire territory of the country. These 29 Health Services Entities are decentralized, endowed with legal personality and their own assets to take care of the provision of healthcare services - other than PHC services delegated to municipalities - throughout the country. The Health Services Entities are directly in charge of hospitals and, if this role is not being carried out by the municipality, PHC centers., as it has the overall stewardship role for the health system. The MoH develops norms, standards, and guidelines, and provides technical assistance for their implementation.

39. **The MoH Reform Team is part of the Minister's Cabinet Office and is in charge of the implementation of the UPHCP.** Within the MoH Reform Team, a Program Coordination Team (PCT) has been created to support the UPHCP and PforR implementation. The PCT has a director who oversees two areas: a technical sub-division and a financial/administrative sub-division. Initial staff for the PCT has been hired and this team will continue to grow in size and build capacity prior to PforR implementation. The technical sub-division is responsible for general supervision of the PfoR implementation and for high-level coordination with the other actors involved in implementation of the UPHCP. The specific functions of the technical sub-division are inter alia: (i) the general supervision of the Program execution; (ii) coordinating: (a) the implementation of the Program's activities across MoH's secretariats and other actors within and outside the health sector; (b) data collection, as applicable; and (c) the external verification process with the Verification Agents; (iii) monitoring performance and reporting of the DLIs/DLRs; and (iv) overseeing and following up on environmental and social (E&S) and fiduciary issues. Within the MoH departments relevant for the UPHCP and the PforR, as well as in each of the other participating entities, a team of one or two key staff members will be designated as focal points. These focal points will closely collaborate with the PCT and oversee PforR implementation according to their areas of competence to ensure the achievement of the DLRs.

40. **The financial/administrative sub-division is responsible for financial management (FM) and procurement-related activities, as well as preparation of financial statements.** Precisely, the financial/administrative coordination unit shall be responsible for budget management, procurement and financial management, including, inter alia: (i)

coordinating and overseeing the Program's budget execution; (ii) overseeing the procurement and bidding processes executed by the National Health Services Entities and Division of Finance and Internal Administration (*División de Finanzas y Administración Interna,* DIFAI), and the activities under the Program carried out by participating municipalities; (iii) preparing financial statement reports; (iv) developing and facilitating the external verification process with the Verification Agents; and (v) facilitating access to information required for the carrying out of financial audits. The PCT will also coordinate with the Chilean Budget Directorate *(Dirección de Presupuestos de Chile*, DIPRES) to enable it to submit disbursement requests to the WB.

41. **One or more agents will be selected through public tendering to be responsible for the verification of DLIs.** The terms of reference for the public tendering processes will be prepared in a manner acceptable to the WB. The agent(s) to be hired will provide an independent verification of the achievement of DLRs. Distinct types of DLRs will require different verification methodologies. First, DLRs reflecting processes, such as the development and approval of norms and guides, will require desk-based verification. Second, DLRs reflecting PHC coverage (DLI 1, DLI 4) and PHC quality (DLI 3) will be reported through existing government information systems, particularly records available at FONASA, Health Services Entities reports, monthly statistical records and/or electronic clinical records, amongst others. Reporting and verification arrangements, processes, protocols, and methodologies acceptable to the WB will be documented in the Operation Manual.

B. Results Monitoring and Evaluation

42. **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 healthcare 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 Healthcare Services.

43. **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.

C. Disbursement Arrangements

44. **Disbursement of WB loan proceeds will be made at the request of the Borrower upon achievement of the DLRs.** Some DLRs (see DLR matrix – Annex 2) are scalable, thus allowing for disbursements to be proportional to the progress towards achieving the targeted DLR value. Other DLRs are binary (achieved or not achieved). With the exception of DLRs related to DLI3, DLRs are not time-bound and do not have a firm achievement date attached to them. Nevertheless, verifications for scalable DLRs are scheduled to take place on a semi-annual basis for a continuous flow of funds. Funds not disbursed in one year will be available for disbursement in subsequent years. Depending on the eventual signature date (expected in March 2024 or later), some DLIs may be achieved prior to the signing of the Loan Agreement. However, no results to be achieved prior to January 1, 2024, are considered for any DLI. The operational arrangement for the transfer of resources will be described in detail in the Operation Manual.

D. Capacity Building

45. **As part of technical assessment, the following areas have been identified for technical assistance, capacity building, and institutional strengthening:** (i) identifying implementation options for a resilient PHC to prevent, prepare for, respond and adapt to future PHEs and climate change risks; (ii) supporting alternative implementation strategies for ECICEP at the municipality and PHC facility levels; and (iii) revising the national PHC payment scheme to finance the updated PHC HBP. Depending on the nature of the task, capacity-building activities can take the form of just-in-time technical assistance, knowledge and experience exchange with other countries (e.g., seminars with international stakeholders and governments) or long-term advisory support.

46. **As part of the fiduciary systems assessment, the main areas identified for capacity building and institutional strengthening is the Borrower's familiarization with the PforR Instrument.** The implementation of the Program Action Plan (PAP) will correspondingly contribute to the development of systems and capacities in fiduciary management.

IV. ASSESSMENT SUMMARY

A. Paris Alignment

47. **The proposed operation is fully aligned with the Paris Agreement on climate change adaptation and mitigation goals** and actively invests in measures to strengthen climate adaptation and mitigation.

48. **Adaptation**. Extreme weather events, including heatwaves, floods, and droughts are expected to increase in frequency and severity and pose climate-related risks to UPHCP activities**.** For example, the urban flood hazard in Chile is classified as high, meaning that damaging and life-threatening urban floods are expected to occur at least once in the next ten years.[24] Such a climate-related hazard can hinder the scaling up of the UPHCP. **DLI 1** could be impacted by such events through, e.g., budget cuts and reallocation. However, the public budgeting process in Chile is quite stable and funds for emergencies are normally set aside, which protects funding for priority reforms such as the universal PHC. **DLI 3,** namely a decrease in the rate of avoidable hospitalizations, will most likely not be impacted by climate hazards. **For DLI 2 and 4**, climate-related hazards have the potential to limit the use of services, similarly to what happened during the COVID-19 pandemic. Yet, activities under **DLI 5** (emergency risk surveillance of public health and climate change) aim to increase PHC resilience and reduce such risks under DLI 2 and 4. DLI 5 will most likely not be

[24] https://thinkhazard.org/en/report/51-chile/UF

impacted by climate hazards. **DLI 6** can be at risk due to extreme weather events. For instance, tides and floods are expected to increase along the coast which will most likely damage infrastructure. However, these risks are mitigated by developing a new PHC infrastructure model that considers climate-related risks. The update of PHC financial resource allocation mechanisms (**DLI 7**) will also not be impacted by climate related hazards. The design and rollout of a Virtual Health Management Platform (**DLI 8**) will increase Chile's ability to adapt to climate-related hazards and increases the resilience of patients.

49. **Mitigation.** Activities under **DLI 1-5** and **DLI 7** are not at risk of having a negative impact on the country's low greenhouse gas emissions development pathway. The new infrastructure model under **DLI 6** includes energy efficiency measures that will ensure that buildings are at least 20 percent more energy efficient than standard practice. Furthermore, the rollout of a Virtual Health Management Platform **(DLI 8)** will also not lead to higher emissions. On the contrary, a transformation towards virtual healthcare can be more efficient and reduce emissions. Data from Stanford Healthcare shows that virtual visits emit less than one percent of the greenhouse gas emitted by in-person visits.[25]

B. Technical (including program economic evaluation)

Strategic Relevance and Technical Soundness

50. **The strategic lines and activities of the UPHCP to be supported under the PforR have been purposefully chosen, reflecting the latest international consensus on how to strengthen PHC to achieve overall health system objectives, such as the equity of health outcomes as well the resilience of PHC and the efficiency of PHC financing arrangements.** The MoH has four defined strategic lines for the development of an equitable PHC model that guarantees access to comprehensive and high-quality healthcare for the population. The Government's program is aligned with recent evidence about the characteristics of high-performing PHC systems and needed shifts to prepare PHC for new challenges: (a) offering comprehensive care for all; (b) offering people-centered integration; (c) tackling inequities in access to care and health outcomes, and (d) integrating public health surveillance and outreach capacity, as well as financial and human resource surge capacities into PHC to improve the entire health system's resilience. The proposed PforR will support all four strategic lines of the UPHCP and in particular all subcomponents under the UPHCP with an assigned estimated budget. The PforR will be structured around three RAs: RA1 (Coverage and quality of PHC); RA2 (Resilient PHC; and RA3 (Efficient and Transparent PHC).

51. **From a strategic perspective, the UPHCP and the PforR are well-balanced with respect to the focus on supporting improvements in the municipalities that will gradually join the UPHCP 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 Chilean National Commission for Evaluation and Productivity (*Comisión Nacional de Evaluación y Productividad*), an independent and autonomous advisory institution, evaluated the functioning and efficiency of Chile's PHC system in 2022.[26] The report found that some of the services and benefits under the PHC HBP are, in practice, not always accessible to the Chilean population in certain parts of the national territory, and for some specific populations. Making these essential services more accessible would significantly decrease the incidence of emergency room visits and avoidable hospitalizations.

[25] https://www.nature.com/articles/s41746-023-00818-7#:~:text=SHC%20saw%2013%25%20increase%20in,tons%20of%20GHGs%20in%202021.
[26] To be found at: https://cnep.cl/estudios/estudios-finalizados-mandatados-por-el-gobierno-de-chile/estudio-eficiencia-en-gestion-de-atencion-primaria-de-la-salud/

Program Expenditure Framework

52. **The financial sustainability of the UPHCP is ensured by the existing fiscal and budgetary provisions.** The key role of the MoH in financing the UPHCP contributes to a high predictability of funding, consistent with the country's medium-term fiscal framework. In addition, recurrent revenues from the state budget follow a stable growth trajectory, which ensures the predictability of the part of the UPHCP financed by the state budget. The UPHCP to be supported by the PforR represents an adequate budget in view of the desired results. Furthermore, the budget programs and activities included correspond to core functions of the MoH and have been historically well executed by the MoH. 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 percent, 96.5 percent and 97.3 percent, respectively.

53. **The cost of the UPHCP for the period from 2023 to 2029 is estimated at US$2.58 billion. The WB will support the UPHCP with a loan equivalent to US$200 million for the period from 2024 to 2027, during which time the corresponding budget for the UPHCP is estimated at US$1.51 billion**.

Results Framework and Monitoring & Evaluation Capacity

54. **Chile has a well-institutionalized data collection and reporting system, including routine data reporting by PHFs, specific data collection for health system reform monitoring and regular national household surveys.** Although the country already reports on key indicators of health system performance to the OECD, the PforR lending instrument is new for the Chilean Government and requires good coordination between sectors for data collection. For the PforR implementation, this coordination must be strengthened so that existing data collection systems can be used.

Economic Justification

55. **The UPHCP is designed to improve the health of the Chilean population by increasing access to, and quality of, PHC services, specifically by implementing a user-centered model.** It is expected that these interventions will generate significant positive impacts on the quality, efficiency, and equity of healthcare services and health outcomes for the target population.

56. **The economic analysis estimates the costs and benefits related to the following strategic lines to be supported**: (a) cost-effectiveness considerations of the activities to be implemented according to the international literature; (b) cost-benefit considerations based on the estimation of quantifiable economic benefits and implementation costs; (c) efficiency and equity considerations; and (d) budgetary implications. For the cost-benefit analysis, a baseline scenario with and without the UPHCP and PforR (i.e., counterfactual) was adopted. The estimated benefits are quantified in monetary terms based on the value of lives saved and severe disabilities averted through the strategies that will be supported under the Program. For activities that strengthen the service delivery model in PHC, the analysis projects the epidemiological scenario for the target population and then estimates the number of disability-adjusted life years (DALYs) averted through the Program. The full costs of the PforR are considered to derive the internal rate of return and the net present value (NPV), which are also calculated for different discount rates and subject to a sensitivity analysis accounting for changes in other variables. Table 2 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 2. 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: WB estimates

C. Fiduciary

57. **The Program will be executed by the MoH, and the Fiduciary Systems Assessment (September 2023) has concluded that the FM and procurement systems of the examined Program are adequate to provide reasonable assurance that the financing proceeds will be used for their intended purposes** (see Annex 4 for the description of the fiduciary implementation arrangements and the Fiduciary Systems Assessment).

58. **Risks.** The fiduciary integrated risk is rated **Moderate.**

59. **From a financial management perspective, the Fiduciary risk is rated Moderate.** The assessment identified the following FM risks that could potentially impact the development outcomes of the Program: (a) the MoH has limited experience with the PforR instrument and, as a result, the financial/administrative sub-division will require additional support to ensure effective implementation of the Program; (b) the new procedures for coordinating and informing financial activities between subsecretaries and the new unit could result in a learning curve for the PCT and subsecretaries; (c) MoH has no previous experience reporting on project funds (nor results) under instruments such as the PforR instrument, and (d) some internal control weaknesses have been reported in a sample of external audit reports of the municipalities.

60. **To mitigate these risks, the proposed measures include strengthening system capacity through a joint effort with the internal and external auditors to develop an action plan to improve internal controls. Specific actions to mitigate the above risks include:** (a) appoint a FM Specialist for the Program. Additionally, the WB's fiduciary team will prepare training on fiduciary issues in the short term and provide close implementation support to the Program to ensure that the MoH is equipped with the necessary knowledge and skills to manage the Program's finances effectively; (b) the MoH will detail processes in the Operation Manual that describe how to operate and coordinate internally between the subsecretaries directly involved in the execution of the Program, and (c) the WB team has worked with the MoH to agree on the format and operative procedure to use the Integrated FM Information System *(Sistema de Información de Gestión Financiera del Estado,* SIGFE) database to prepare the semiannual and annual reports on the financial statements required for the Program. Using SIGFE as the primary tool for reporting to the WB and for audit purposes has been deemed appropriate.

61. **From a procurement perspective, the Fiduciary risk rating is considered Low.** The key procurement-related risks to the development outcomes of the Program that underpin the Low-risk rating are the following: (a) non-application of the WB's ACGs fraud and corruption clauses in all procurements under the Program; (b) the risk of awarding a contract to firms and/or individuals debarred or suspended by the WB; and (c) the lack of definition for procurement planning regarding goods and consulting and non-consulting services, specifically of the size of procurement packages, timelines of procurement implementation, and the corresponding resources needed to perform these properly.

62. **The proposed actions to mitigate the above risks include:** (a) inclusion of the WB's ACGs fraud and corruption

provisions, as appropriate, in the bidding documents and contracts ; (b) eligibility verification to ensure that any person or entity debarred or suspended by the WB, or by another multilateral institution with which the WB has signed a cross debarment agreement, is not awarded a contract under the Program during the period of such debarment or suspension; and (c) strengthening of the unit that will implement procurement activities, with experienced staff in accordance with the nature and volume of the planned procurement activities.

63. **The Borrower confirmed that it does not foresee any high-value contract under this Program.** It is not expected that the proposed Program will finance any contract at or above Operations Procurement Review Committee thresholds considering the activities under Low risk, which at the time are at minimum of: (a) US$200 million for works; (b) US$125 million for goods, information technology and non-consulting services; and (c) US$40 million for consulting services.

D. Environmental and Social

64. **The Program's draft Environmental and Social Systems Assessment (ESSA) has been prepared by the WB to meet the requirements of the PforR Financing Policy and Directive,** following WB Guidance for the preparation of ESSAs (OPS5.04-GUID.118). The draft version of the ESSA was disclosed via the WB's website[27] prior to appraisal, as well as in-country.[28] The preparation of the draft ESSA Report has been informed by continual consultations with the WB's counterparts for the Program in the MoH. In accordance with the WB Policy and Guidelines for PforR operations, at the end of September 2023, the draft Report of the ESSA was formally consulted with different key stakeholders. Four virtual focus groups were organized by the WB and conducted with the participation of knowledgeable individuals representing: (a) local health councils; (b) civil society organizations, especially groups of indigenous peoples, LGBTIQA+ communities, and rural residents; (c) trade unions and associations linked to the PHC system; (d) local governmental authorities; and officials from the MoH. The results of the focus groups will feed into the finalization of the ESSA, prior to its public disclosure by the WB and the MoH, after negotiations and before Board approval.

65. **The proposed support to the UPHCP is expected to bring several E&S benefits.** Based on the findings of the draft ESSA, the main positive environmental effects are related to the use of sustainability and climate change resilience standards in the implementation of a new model of PHFs (see Annex 5 and the full ESSA). Likewise, the permanent and systematic measurement of user satisfaction provides a key opportunity to observe the effectiveness of activities at the local, regional, and national level.

66. **Based on the findings of the draft ESSA, no significant adverse E&S impacts are expected because of the Program.** The ESSA includes an exclusion list that screens out activities with a high or substantial E&S risk rating (see Annex 5 and the full ESSA for the list).

67. **Existing national and sectorial E&S systems are adequate to effectively manage the E&S risks and impacts of the Program.** The E&S systems applicable to the Program are aligned with the core principles and key planning elements set out in the PforR Financing Policy and Directive. Chile has a well-developed legal and regulatory framework on general and sectoral E&S matters, as well as an institutional framework with clear, delimited functions, and resources to implement E&S management. The E&S systems applicable to the Program activities incorporate

[27] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099090523084030483/p1797850b2b41d0bc0b9dd0bedfac4d9b08
[28] https://www.minsal.cl/wp-content/uploads/2023/08/Program-for-Universal-Primary-Healthcare-Coverage-and-Resilience.pdf

recognized elements of good practices in E&S assessment and management (see Annex 5 and the full ESSA for more details).

68. **The MoH has sufficient institutional capacity to ensure compliance with Chile's existing E&S regulatory framework, based on the ESSA findings.** The MoH has departments and units that regulate and oversee Environmental Health and Safety (EHS) aspects of its operations, some of which are involved in the PforR, such as the EHS Management Department, the Works Monitoring Department, the Sub-secretariat of Assistance Networks, the Emergencies and Disaster Risk Management Department, and the Climate Change Office in the ministerial cabinet, among others. The corresponding Health Services Entity with authority in the municipality where the included PHFs will be located will be responsible for the construction, and corresponding EHS management, of the new PHFs. EHS management requirements will be aligned with relevant national regulations and core principles set out in the PforR Financing Policy and Directive and supervised by the MoH through its Department of Physical Resources and Investments. The Regional Ministerial Health Secretariats *(Secretarías Regionales Ministeriales de Salud,* SEREMIs) will be responsible for granting the new PHFs the Sanitary Authorization required for operation. During the operation of the new PHFs, the supervision of compliance with EHS requirements will be overseen by the SEREMIs and by the local authorities where the facility is located. The SEREMIs have specialized departments and units to supervise and address issues of environmental quality (air, waste, chemicals, and contaminated sites) and occupational health for any project in the country.

69. **In the social area, Chile has a general and sectoral regulatory framework that explicitly guarantees the provision of social and health services to the entire population living in the national territory**, as well as: citizen participation, mechanisms for dissemination of patient rights, mechanisms for requesting information, making claims and suggestions, and sanctions for discrimination. Likewise, the MoH has a solid internal regulatory framework that establishes protocols and technical guidelines for the cultural and territorial adaptation of its activities, considering the attention required for special care groups, such as indigenous and tribal peoples, gender diversity, the elderly, people with physical or mental disabilities, migrants, and people living in extreme poverty. All this allows the MoH to adequately manage the risks and social impacts that the Program could have.

70. **The ESSA has identified specific actions and recommendations to support the effective management of E&S risks during Program implementation** (see Annex 5 and the full ESSA for the list of specific actions). The ESSA also includes recommendations for strengthening E&S capacity amongst the relevant health agencies, particularly the Health Services Entities, and regional and local authorities where the infrastructure financed by the PforR will be located.

71. **Grievance Redress.** Communities and individuals who believe that they are adversely affected because of a WB supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing grievance mechanism or the WB's Grievance Redress Service. The Grievance Redress Service ensures that complaints received are promptly reviewed to address pertinent concerns. Program-affected communities and individuals may submit their complaint to the WB's independent Accountability Mechanism. The Accountability Mechanism houses the Inspection Panel, which determines whether harm occurred, or could occur, because of WB non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at any time after concerns have been brought directly to the WB's attention, and WB Management has been given an opportunity to respond. For information on how to submit complaints to the WB's Grievance Redress Service, please visit *http://www.worldbank.org/GRS*. For information on how to submit complaints to the WB's Accountability Mechanism, please visit *https://accountability.worldbank.org.*

E. Gender

72. **The Program has a strong gender perspective through its efforts to improve quality and efficiency in the provision of health services for the LGBTIQA+ community.** There is evidence of gender inequities in health conditions in Chile, despite several specific commitments to gender equality for the LGBTIQA+ community. From misplaced questions or stigmatization for sexual practices, to lack of knowledge, misinformation, and denial of some procedures; these are just some of the many violations that LGBTIQA+ people face when attending certain medical specialties. According to the study *Being Lesbian in Chile,*[29] by the lesbian group *Rompiendo el Silencio*, more than 33 percent of the women surveyed reported having felt discriminated by the medical staff and 68 percent stated that they did not go for a cervical smear test for fear of discrimination. In the *First Survey for Transgender People in Chile,*[30]conducted in 2017 by Organizing Trans-Diversities, 95 percent of transgender people stated having suffered discrimination in health centers; questioning of their identity, denial of care or even suffering from sexual advances, harassment and mockery.

73. **In 2011, the MoH issued indications on the care of transgender people, through Circular No. 34,**[31] **which recognizes the need to break down inequities.** Subsequently, in 2012, Circular No. 21,[32] reaffirmed, reiterated, and deepened the instructions on the care of transgender people in the care network, especially those referring to open outpatient care. This Circular was complemented with specific guidelines[33] for its implementation in 2019, which instructed hospitals on the need to develop protocols that guide the work of health teams in the care of LGBTIQA+ people, promoting user satisfaction within the framework of rights. However, little progress has been made at PHC in this regard.

74. **The UPHCP includes a strategic area related to gender perspective and the control of violence, considering LGBTIQA+ individuals.** The PforR will support training with a critical analysis of gender perspective and cultural disparities in Chile. The aim is to promote cultural and structural transformations that result in equal rights for women and the LGBTIQA+ community. DLR 2.1 will supervise trainings for women and people identifying as women to become "Community Health Agents" to prevent GBV. The trainings will provide tools to: (a) analyze inequalities, considering perspectives related to social determinants of health, gender, and intersectionality; (b) analyze the impact of violence on LGBTIQA+ people's and women's health; (c) reflect on prevention strategies for violence, with a focus on identifying actionable opportunities, and (d) identify effective communication tools to address GBV. In addition, training for health teams will take place and enhance their capacity in providing care to individuals identifying as LGBTIQA+. This training aims to: (a) recognize differences in sexuality and its importance; (b) identify ways to provide affirmative care to the LGBTIQA+ population, and (c) destigmatize perspectives of diverse identities, expressions and orientations. DLR 2.2 will monitor progress regarding quality of care of the LGBTIQA+ community. Specifically, the first action in 2024 will be to incorporate gender identity and sexual orientation variables into the survey that evaluates user experience under Law No. 20,645, and from 2025 onwards, improvements in the perception of user experience in the LGTBIQA+ community will be evaluated.

[29] *Ser Lesbiana en Chile - Agrupacion Lesbica Rompiendo el Silencio*,2018. Available at https://www.rompiendoelsilencio.cl/
[30] *Primera Encuesta Nacional Trans de Chile - Organizando trans diversidades*, 2017. Available at: https://otdchile.org/primera-encuesta-nacional-trans-arroja-datos-reveladores/
[31] MINSAL, 2011. Available at: https://diprece.minsal.cl/wrdprss_minsal/wp-content/uploads/2015/01/CIRCULAR-34-Atenci%C3%B3n-de-personas-trans.pdf
[32] MINSAL, 2012. Available at: https://diprece.minsal.cl/wrdprss_minsal/wp-content/uploads/2015/01/CIRCULAR-21-Reitera-Atenci%C3%B3n-de-personas-trans.pdf
[33] MINSAL, 2019. Available at: https://www.minsal.cl/wp-content/uploads/2019/03/Orientaciones-t%C3%A9cnicas-protocolo-personas-trans.pdf

F. Climate Change

75. **The Program was screened for climate disaster risks and found to be highly exposed, while the risk to the expected outcomes of the Program was found to be low.** The Program location has experienced climate and geophysical hazards in the past and is expected to experience these in the future with high intensity, frequency, or duration, which are likely to significantly impact the infrastructure's structural integrity, materials, siting, longevity, and overall effectiveness of the investments. As a result, health infrastructure risks are high. Women have been identified as a group particularly vulnerable to climate disaster risks. However, Program activities include risk alleviation to women from climate and geophysical hazards.

76. **The PforR will support the Chilean health sector in assuming its important responsibility in terms of climate change** (i.e., to contribute to efforts to achieve carbon neutrality and to increase resilience in the face of the environmental stresses that the country will face). Among other things, the PforR will contribute to sectorial initiatives to: (a) formulate and implement climate change and health policies, programs, plans and actions; (b) generate risk information at municipality level with indicators for monitoring, evaluation, and reporting; (c) design and implement training programs for key stakeholders, and (d) define areas of greatest urgency to advance response capacity. The modern technologies and approaches to improve health interventions supported by the PforR (for example, mobile communications, telemedicine, and interoperability of information systems to increase the speed and volume of health data collection) will enhance the sector's climate resilience.

77. **The proposed PforR would support measures to adapt Chile and the health system to climate shocks and mitigate greenhouse gas emissions** (see Table A3.1 in the Summary Technical Assessment).

G. Citizen Engagement

78. **The proposed PforR would also boost measures to improve citizen engagement in PHC.** The current low satisfaction of the population with public healthcare services has prompted the MoH to include a strong emphasis on enhancing citizen participation and patient or user experience in the design of the UPHCP. Reflecting this effort, one of the PDO indicators of the PforR assesses participating municipalities with positive user experiences. In particular, the development and implementation of the Virtual Health Management Platform supported by the PforR will improve opportunities for citizen engagement related to PHC. The virtual platform aims to provide citizens with various benefits expected to improve citizen engagement such as: (a) access to their own health information; (b) access to general healthcare information and the opportunity to interact with a health worker for counseling and risk triage and crucially, and (c) the ability to provide feedback on their experiences with the PHC services received. In addition, and in order to better collect and act on citizen feedback, one of the activities of the UPHCP supported under RA1 includes citizen townhalls. Finally, the activities related to the treatment of the LGBTIQA+ population in the health system will allow this population group to engage with decision makers from the health system and healthcare workers to address issues of discrimination and bad treatment.

79. While there are already existing mechanisms for citizen participation in place (such as the dissemination of patient rights, information requests, claims, and suggestions, as well as sanctions for discrimination), the PforR will enable the continuous and systematic measurement of user satisfaction as a vital tool for assessing the effectiveness of activities at the local, regional, and national levels and for closing the feedback loop.

V. RISKS

80. The overall risk rating for the Program is **Moderate**.

81. **Political and Governance risks are assessed as Substantial.** The Government is preparing two ambitious reforms: a tax reform, aiming to raise revenue by 4.1 percent of GDP over four years to finance its policy priorities (which was rejected by Congress in its first attempt), and a pension reform that was introduced in Congress in early November 2022. Also, in December 2023, a second Constitutional referendum will be held. Depending on the outcome of the referendum, the government's ability to keep implementing key reforms in health and other sectors may be affected. In addition, political uncertainty may impact investments in the supported UPHCP and thereby the speed of its implementation. In terms of the government's health reform itself, the UPHCP is the area with the most transversal support within the country. A WB-financed project supporting the health sector[34] was approved by the WB Board of Executive Directors in 2018 but was never signed by the Government and was subsequently canceled in January 2019. However, the impact of COVID-19 has enhanced political awareness about the importance of having a strong and resilient health sector. In addition, the Government has a strong interest in WB lending and technical assistance support to advance on its complex health reform agenda. To mitigate the risk of the PforR eventually not being implemented, the timeline to achieve the approval and effectiveness of the PforR has been chosen to coincide with the first half of the four-year term of the current Government, thereby ensuring that the same administration will be in charge of initiating Program implementation. The Government will proactively engage with key sector stakeholders, including participating municipalities, to ensure a strong buy-in throughout the implementation period.

[34] Chile – Public Health Sector Support Project (P161018).

ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework
COUNTRY: Chile
Chile: Program for Universal Primary Healthcare Coverage and Resilience

Program Development Objective(s)

The objective of the Program is to improve coverage, quality, and efficiency of primary healthcare and the health system's resilience.

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	End Target
Coverage and Quality of PHC			
Decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities (Text)	DLI 3	TBC (see description)	2% reduction
Resilient PHC			
Participating municipalities have participated in at least one drill for PHEs and climate change preparedness conducted by Comprehensive Surveillance and Response Teams. (Number)	DLI 5.2	0.00	127.00
Efficiency of PHC			
Participating municipalities with positive user experience (Number)	DLI 8.2	0.00	127.00

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Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	End Target
Expand coverage and quality of care at PHC level			
Newly registered population at the national level increased (Text)		TBC	30% increase
Participating municipalities with a reduction in the percentage of users who do not get a response in <72 hrs when using the TeleSalud portal (Number)		0.00	127.00
Participating municipalities with available healthcare personnel trained in GBV (Number)		0.00	127.00
Participating municipalities that have locally adapted protocols for the inclusive care of LGBTIQA+ people (Number)		0.00	127.00
Resilience			
Participating municipalities that have a health sectorial plan which includes 'Emergency risk surveillance and preparedness on public health and climate change in universal PHC' (Number)		0.00	127.00
Efficiency			
Participating municipalities have municipal managers knowledgeable in crucial areas for PHC management (Number)		0.00	127.00
Participating municipalities with interoperability in the electronic clinical record (Number)		0.00	127.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities	Reduction of two percent in the number of hospitalizations of people with multimorbidity from municipalities participating in the UPHCP. The indicator will be measured in three different cohorts that correspond to: (i) the population of those municipalities that join the UPHCP by the end of 2024 (cohort 1), (ii) the population of those municipalities that join the UPHCP during 2025 (cohort 2), and (iii) the population of those municipalities that join the UPHCP during 2026 (cohort 3). The baseline remains to be confirmed, as the exact municipalities that will join the program in 2024 are not yet known. The baseline will be determined using 2024 data and after the municipalities joining the program in 2024 will have	Annual. Measured for 2025, 2026, and 2027.	Electronic clinical records and registry of hospital admissions/discharges.	The PCT will evaluate hospitalization trends of the pateint groups with multimorbidity.	DIVAP, Secretary of Health Care Networks, MoH.

	been determined. The baseline will be stated in the Operation Manual once known and calculated following the OECD protocols for avoidable hospital admissions. The target reduction of 2 percent for each cohort has been defined based on an interpolation of historical data at the national level and using the same OECD protocols. The reduction will be calculated as follows for a given year: Numerator: Number of avoidable hospitalizations (following the OECD protocols for avoidable hospitalizations) of people with multimorbidity (as per the ECICEP definition) within participating municipalities. Denominator: People with multimorbidity (as per the ECICEP definition) within participating municipalities.				
Participating municipalities have participated in at least one drill for PHEs	Number of participating municipalities that have	Annual	Reports by SEREMIs and	The Department of Emergency and Disaster	SEREMIs and Health Services Entities.

and climate change preparedness conducted by Comprehensive Surveillance and Response Teams.	participated in at least one drill done for PHEs and climate change preparedness.		Health Services Entities.	Risk Management (DEGREYD) at the MoH will ask SEREMIs and the Health Service for reports including means of verification (list of attendees, photographic records, certificates, etc.).	
Participating municipalities with positive user experience	Number of participating municipalities that have at least 75 percent positive answers declared regarding the user experience survey. This survey will be conducted using Lickert scales.	Annual	Surveys with Lickert scales collected through virtual platform and sent through Health Services Entities.	DIVAP will request IT for the reports and aggregate data for the PCT.	DIVAP, Secretary of Health Care Networks, MoH.

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Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Newly registered population at the national level increased	Nominator: Newly registered population (FONASA + ISAPRES + Armed Forces and Order) / Denominator: Total unregistered population at the national level at the effectiveness date.	Bi-annual	FONASA records	FONASA will present the bi-annual reports to the PCT with regards to the number of newly enrolled population. PCT will be in charge of reporting this to the verification entity.	FONASA
Participating municipalities with a reduction in the percentage of users who do not get a response in <72 hrs when using the TeleSalud portal	Number of participating municipalities with at least a 20 percent decrease in a calendar year in the number of people who consult the TeleSalud system at PHC level and do not receive a response within 72 hours. *Reduction of 20 percent during a period T calendar year in participating municipalities in relation to a baseline to be estimated for the participating municipalities by the end of previous calendar year, agreed between the Borrower and WB and reflected in the Operation	Bi-annual	IT Team at the MoH will develop a statistical record specifically for this indicator within the Monthly Statistical Record Series (*Serie de Registros Estadísticos Mensuales*, REMs) A.04 "Consultations and other attention in the network". This is	PCT request reports to the DIVAP, Secretary of Health Care Networks, Chilean MoH.	DIVAP

	Manual. So for example, those incorporated in 2023 (7 pilot municipalities) will be measured during 2024, taking baseline at the end of 2023.		currently being developed and will be finished by December 2023 and ready for PforR implementation. This is common practice within the IT Team at the MoH. Similarly to other REMs, this is directly reported to DIVAP.		
Participating municipalities with available healthcare personnel trained in GBV	Number of participating municipalities that have at least 20 percent of their Health Workers trained with a gender perspective to address GBV with territorial and cultural relevance.	Bi-annual	SEREMIs and Health Services (Districts)	Reports will be requested from SEREMIs and/or Health Services (Districts) on the courses taken by Dept. Human Rights and Gender, Secretary of Public Health, MoH and report back to the PCT.	Dept. Human Rights and Gender, MoH
Participating municipalities that have locally adapted protocols for the inclusive	Number of participating municipalities with	Bi-annual	Protocols for the Good	Request and compilation of protocols by the	Department of Human Rights and Gender, MoH

care of LGBTIQA+ people	protocols for the treatment of LGBTIQ+ persons in accordance with Circular No. 21/2012.		Treatment of LGBTIQ+ people in the municipalities made official by resolution of the Municipal Health Directorate.	Department of Human Rights and Gender, MoH and submission to the PCT.	
Participating municipalities that have a health sectorial plan which includes 'Emergency risk surveillance and preparedness on public health and climate change in universal PHC'	Number of participating municipalities that have a health sectorial plan which includes an 'Emergency risk surveillance on public health and climate change in universal PHC', within the larger 'Communal plan for disaster risk reduction', as established in Law 21364. *The Communal plans for disaster risk reduction is approved and published by mayoral decree.	Bi-annual	The SNSS will report to DIVAP who will collect the information and sent it to the PCT. Verification means: mayoral decree.	Request for reports by DIVAP, Secretary of Health Care Networks, Chilean MoH to the SNSS on the cut-off date (August - December).	DIVAP, Secretary of Health Care Networks, MoH.
Participating municipalities have municipal managers knowledgeable in crucial areas for PHC management	Number participating municipalities that have 60 percent of the municipal managers trained in FM and data use. The indicator measures the deployment and development of FM	Bi-annual	SNSS reports	DIVAP requests reports to the Health Services Entities on the cut-off dates that coincide with the PRAPS for PHC Training and Education.	DIVAP

	and data use competencies in municipal managers (in the context of the creation and operation of a formal and structured training program) related to PHC management.				
Participating municipalities with interoperability in the electronic clinical record	Number of participating municipalities that refer at least 70 percent of their patients through digital referral. Formula: (Number of people referred through digital referral / total number of people referred to secondary care)	Bi-annual	Reports from electronic medical record providers (PHC providers and hospitals) on referrals with digital IC (unique ID per patient), quantifying the total number of individuals recorded in the electronic medical record interoperability.	The Information and Communications Technology Department of the MoH requests reports from the Health Services Entities on the cut-off date and reports back to the PCT.	The Information and Communications Technology Department of the MoH.

ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS

Disbursement Linked Indicators Matrix				
DLI 1	Gradual Implementation of the UPHCP coverage			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	50,999,984.00	26.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	see DLR 1.1 & 1.2			
01/01/2024-12/31/2027	see DLR 1.1 & 1.2		50,999,984.00	see DLR 1.1 & 1.2
DLI 1.1	Municipalities participating in the UPHCP, increased			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Number	23,000,040.00	11.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	7.00			
01/01/2024-12/31/2027	187.00		23,000,040.00	1 signed participation agreement = 127,778 USD

DLI 1.2	Participating municipalities with increased population receiving PHC services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	27,999,944.00	14.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		27,999,944.00	1 municipality = 220,427 USD

DLI 2	Gender perspective and violence control, considering women and LGBTIQA+ people			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	9,999,980.00	5.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	see DLR 2.1 & 2.2			
01/01/2024-12/31/2027	see DLR 2.1 & 2.2		9,999,980.00	See DLR 2.1 & 2.2

DLI 2.1	Participating municipalities with each at least 15 available community health agents trained in GBV			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	4,999,990.00	2.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		4,999,990.00	1 municipality = 39,370 USD

DLI 2.2	Participating municipalities with positive user experience amongst LGBTIQA+ community			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Number	4,999,990.00	2.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		4,999,990.00	1 municipality = 39,370 USD

DLI 3	Decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	21,999,999.00	11.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	TBC			
01/01/2024-12/31/2027	See DLR 3.1 - 3.3		21,999,999.00	See DLR 3.1 - 3.3

DLI 3.1	Cohort 1 (Participating Municipalities that adhered to the UPHCP as of December 31, 2024)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	7,333,333.00	3.66
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	To be measured once all participating municipalities in the cohort have signed the Participation agreement.			

01/01/2024-12/31/2027	2% reduction		7,333,333.00	1,833,333 once reached a minimum of 0.5%, and thereafter 366,666 per each 0.1%

DLI 3.2	Cohort 2 (Subsequent Participating Municipalities that adhered to the UPHCP as of December 31, 2025)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	7,333,333.00	3.66
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	To be measured once all participating municipalities in the cohort have signed the Participation agreement.			
01/01/2024-12/31/2027	2% reduction		7,333,333.00	1,833,333 once reached a minimum of 0.5%, and thereafter 366,666 per each 0.1%

DLI 3.3	Cohort 3 (Subsequent Participating Municipalities that adhered to the UPHCP as of December 31, 2026)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	7,333,333.00	3.66
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	To be measured once all participating municipalities in the cohort have signed the Participation agreement.			
01/01/2024-12/31/2027	2% reduction		7,333,333.00	1,833,333 once reached a minimum of 0.5%, and thereafter 366,666 per each 0.1%

DLI 4	Participating municipalities with an increase in the number of people using high-value healthcare services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	14,999,970.00	8.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		14,999,970.00	1 municipality = 118,111 USD

DLI 5	Surveillance and Preparedness for PHEs and Climate Change Risks in Universal PHC			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	14,999,980.00	8.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	See DLR 5.1 & 5.2			
01/01/2024-12/31/2027	See DLR 5.1 & 5.2		14,999,980.00	See DLR 5.1 & 5.2

DLI 5.1	New Ministerial Guide for 'Surveillance and Preparedness for PHEs and Climate Change Risks in Universal PHC'			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	No	Yes/No	5,000,000.00	2.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
01/01/2024-12/31/2027	Yes		5,000,000.00	Act = 5,000,000 USD

DLI 5.2	Participating municipalities have participated in at least one drill for PHEs and climate change preparedness conducted by Comprehensive Surveillance and Response Teams			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	9,999,980.00	5.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		9,999,980.00	1 municipality = 78,740 USD

DLI 6	PHFs adjusted to the geographic distribution of the population and energy efficiency standards			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	57,774,952.00	30.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	See DLR 6.1 & 6.2			
01/01/2024-12/31/2027	See DLR 6.1 & 6.2		57,774,952.00	See DLR 6.1 & 6.2

DLI 6.1	New PHC infrastructure model adjusted to the geographic distribution of the population, energy efficiency and climate resilience standards			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	33,775,000.00	16.90
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			

01/01/2024-12/31/2027	Yes		33,775,000.00	ACT = 33,775,000 USD
DLI 6.2	New PHFs available and operating according to the basic requirements for the new PHC infrastructure model			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	23,999,952.00	12.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		23,999,952.00	1 facility = 188,976 USD
DLI 7	Improved Purchasing of Health Services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	9,500,163.00	5.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	See DLR 7.1 & 7.2			
01/01/2024-12/31/2027	See DLR 7.1 & 7.2		9,500,163.00	Act
DLI 7.1	Costing the PHC HBP preventive services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	4,500,163.00	2.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			

01/01/2024-12/31/2027	Yes		4,500,163.00	Act = 4,500,163 USD
DLI 7.2	Updated PHC financial resource allocation mechanisms			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	5,000,000.00	2.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
01/01/2024-12/31/2027	Yes		5,000,000.00	Act = 5,000,000 USD
DLI 8	Virtual Health Management Platform			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	17,999,972.00	9.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	see DLR 8.1 & 8.2			
01/01/2024-12/31/2027	see DLR 8.1 & 8.2		17,999,972.00	see DLR 8.1 & 8.2
DLI 8.1	Virtual Health Management Platform operational			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	4,000,000.00	2.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			

01/01/2024-12/31/2027	Yes		4,000,000.00	Act = 4,000,000 USD

DLI 8.2	Participating municipalities with positive user experience			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Number	13,999,972.00	7.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
01/01/2024-12/31/2027	127.00		13,999,972.00	1 municipality = 110,236 USD

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Gradual Implementation of the UPHCP coverage
Description	See DLR 1.1 &1.2
Data source/ Agency	see DLR 1.1 &1.2
Verification Entity	see DLR 1.1 &1.2
Procedure	see DLR 1.1 &1.2
DLI 1.1	Municipalities participating in the UPHCP, increased
Description	A municipality will be considered included to the UPHCP when it has signed a Participation Agreement with a National Health Services Entity and participates in the UPHCP in accordance with the eligibility criteria set forth in the Operation Manual.
Data source/ Agency	Participation Agreement between a National Health Services Entity, and a Municipality which shall include, inter alia, the Participating Municipality's obligations to carry out the Universal PHC.
Verification Entity	TBC
Procedure	DIVAP will present the reports to the PCT with regards to the number of the municipalities which have been incorporated with the required documentation. PCT will be in charge of reporting this to the verification entity.
DLI 1.2	Participating municipalities with increased population receiving PHC services
Description	Participating municipalities with at least 50 percent of the registered population receiving at least one PHC service*. *(Number of registered people receiving at least one PHC service / total population of the municipality).
Data source/ Agency	Data retrieved from File Transfer Protocol used for the management commitment (Compromiso de Gestion - COMGES) 15.3 which administers data from the electronic clinical records of healthcare providers.
Verification Entity	TBC
Procedure	Management Control Department at DIVAP provides information to the verification agent and MoH in an excel spreadsheet, as of December 31, including the variables of the formula and identification of the unique ID per patient.

DLI 2	Gender perspective and violence control, considering women and LGBTIQA+ people
Description	See DLR 2.1 & 2.2
Data source/ Agency	See DLR 2.1 & 2.2
Verification Entity	See DLR 2.1 & 2.2
Procedure	See DLR 2.1 & 2.2
DLI 2.1	Participating municipalities with each at least 15 available community health agents trained in GBV
Description	Number of participating municipalities that have at least 15 Community Health Agents available and trained with a gender perspective and violence control to address GBV with territorial and cultural relevance.
Data source/ Agency	SEREMIs and Health Services at District Level.
Verification Entity	TBC
Procedure	The Human Rights and Gender Department within the Public Health Secretary at the MoH will request SEREMIs and/or Health Services (Districts) on the courses taken that include verification means (list of attendees, photographic records, qualifications of the trained workers, certificates, etc.). The Human Rights and Gender Department, Public Health Secretary, MoH will then report to the PCT.
DLI 2.2	Participating municipalities with positive user experience amongst LGBTIQA+ community
Description	Participating municipalities that have at least a 20 percent increase in their assessment regarding the evaluation of LGBTIQA+ community in the national User Treatment Survey, in relationship with a baseline from the 2024 survey, which will have incorporated sexual orientation and sexual identity as part of the variables of analysis.
Data source/ Agency	User Treatment Survey according to Law No. 20,645.
Verification Entity	TBC
Procedure	Dept. Human Rights and Gender within the Secretary of Public Health at the MoH alongside the User Treatment Survey Application Committee (DIVAP) will collate the data and sent it to the PCT.

DLI 3	Decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities
Description	See DLR 3.1 - 3.3
Data source/ Agency	See DLR 3.1 - 3.3
Verification Entity	See DLR 3.1 - 3.3
Procedure	See DLR 3.1 - 3.3
DLI 3.1	Cohort 1 (Participating Municipalities that adhered to the UPHCP as of December 31, 2024)
Description	Reduction of two percent in the number of hospitalizations of people with multimorbidity for this cohort of municipalities in relation to a baseline to be estimated, agreed between the Borrower and the WB and reflected in the Operation Manual. FORMULA: [Number of hospitalization of people with multi morbidity (as per ECICEP strategy) within this cohort during a period T] / [Total people with multi morbidity (as per ECICEP strategy) within this cohort] *The indicator will be adjusted if the hospitalizations recorded are for causes other than multimorbidity (for example, an epidemic). ** The target is based on data reported to the OECD by the MoH. The overall percentage change in the data series was calculated, which was used to estimate the average reduction in avoidable hospitalizations in Chile.
Data source/ Agency	Electronic clinical record (with risk stratification data) and hospitalization registry.
Verification Entity	TBC
Procedure	Electronic clinical record (with risk stratification data) and hospitalization registry sent by DIVAP to PCT. PCT will evaluate hospitalization trends of the groups with multimorbidity before and after.
DLI 3.2	Cohort 2 (Subsequent Participating Municipalities that adhered to the UPHCP as of December 31, 2025)
Description	Reduction of two percent in the number of hospitalizations of people with multimorbidity for this cohort of municipalities in relation to a baseline to be estimated, agreed between the Borrower and the WB and reflected in the Operation Manual. FORMULA: [Number of hospitalization of people with multimorbidity (as per ECICEP strategy) within this cohort during a period T] / [Total people with multi morbidity (as per ECICEP strategy) within this cohort]
Data source/ Agency	Electronic clinical record (with risk stratification data) and hospitalization registry.
Verification Entity	TBC

Procedure	Electronic clinical record (with risk stratification data) and hospitalization registry sent by DIVAP to PCT. PCT will evaluate hospitalization trends of the groups with multimorbidity before and after.
DLI 3.3	Cohort 3 (Subsequent Participating Municipalities that adhered to the UPHCP as of December 31, 2026)
Description	Reduction of two percent in the number of hospitalizations of people with multimorbidity for this cohort of municipalities in relation to a baseline to be estimated, agreed between the Borrower and the WB and reflected in the Operation Manual. FORMULA: [Number of hospitalization of people with multimorbidity (as per ECICEP strategy) within this cohort during a period T] / [Total people with multi morbidity (as per ECICEP strategy) within this cohort]
Data source/ Agency	Electronic clinical record (with risk stratification data) and hospitalization registry.
Verification Entity	TBC
Procedure	Electronic clinical record (with risk stratification data) and hospitalization registry sent by DIVAP to PCT. PCT will evaluate hospitalization trends of the groups with multimorbidity before and after.
DLI 4	Participating municipalities with an increase in the number of people using high-value healthcare services
Description	Participating municipalities with at least a 20 percent increase in the number of people using high-value healthcare services. Baseline calculation: Number of target population receiving high-value preventive healthcare services/ total target population of the municipality. This is followed by a subsequent calculation of the variations in the percentage. "High-Value Healthcare Service" means a service of high health value included in the PHC Health Benefit Package or in a PRAPS, selected in accordance with the criteria set forth in the Operation Manual.
Data source/ Agency	Existing REM will be used. In addition, a specific REM will be created in 2024 if new high-value healthcare services are included among the services provided in PHC.
Verification Entity	TBC
Procedure	IT Team at the MoH will develop a statistical record specifically for this indicator within the REM if new services are included. This is common practice within the IT Team at the MoH. Similarly to other REMs, this is directly reported to DIVAP. DIVAP will then send the information to the PCT to be presented to the Verification Entity.
DLI 5	Surveillance and Preparedness for PHEs and Climate Change Risks in Universal PHC
Description	See DLR 5.1 & 5.2

Data source/ Agency	See DLR 5.1 & 5.2
Verification Entity	See DLR 5.1 & 5.2
Procedure	See DLR 5.1 & 5.2
DLI 5.1	New Ministerial Guide for 'Surveillance and Preparedness for PHEs and Climate Change Risks in Universal PHC'
Description	MoH has issued a resolution approving a New Ministerial Guide for 'Risk Surveillance and Preparedness for PHEs and Climate Change in Universal PHC'.
Data source/ Agency	Ministerial resolution
Verification Entity	TBC
Procedure	PCT presents the ministerial resolution from the MoH to the Verification Agents.
DLI 5.2	Participating municipalities have participated in at least one drill for PHEs and climate change preparedness conducted by Comprehensive Surveillance and Response Teams
Description	Number of participating municipalities that have participated in at least one drill for PHE and climate change risks response.
Data source/ Agency	Reports by SEREMIs and Health Services Entities.
Verification Entity	TBC
Procedure	The Department of Emergency and Disaster Risk Management (DEGREYD) at the MoH will ask SEREMIs and the Health Services Entities for reports including means of verification (list of attendees, photographic records, certificates, etc.).
DLI 6	PHFs adjusted to the geographic distribution of the population and energy efficiency standards
Description	See DLR 6.1 & 6.2
Data source/ Agency	See DLR 6.1 & 6.2
Verification Entity	See DLR 6.1 & 6.2
Procedure	See DLR 6.1 & 6.2

DLI 6.1	New PHC infrastructure model adjusted to the geographic distribution of the population, energy efficiency and climate resilience standards
Description	The MoH is developing a new infrastructure model adjusted to the geographic distribution of the population, energy efficiency and climate resilience standards. The first ongoing stage was the mapping/study of current infrastructure gaps at the national level. Subsequently a new infrastructure model for PHC will be designed which will be climate friendly, following resilience guidelines to natural disasters such as earthquakes, and with energy efficiency standards (mitigation) including 20 percent energy efficiency gains vs. previous models and optimal geographical distribution.
Data source/ Agency	Ministerial resolution approving the basic requirements for the new PHC infrastructure model design.
Verification Entity	TBC
Procedure	PCT will present the ministerial resolution from the MoH to the Verification Agents.
DLI 6.2	New PHFs available and operating according to the basic requirements for the new PHC infrastructure model
Description	Number of PHFs built and operating according to the basic requirements for the new PHC infrastructure model design across participating municipalities.
Data source/ Agency	SNSS
Verification Entity	TBC
Procedure	Department of Health Statistics and Information and Ministry of Social Development requests reports from SNSS and reports to the PCT.
DLI 7	Improved Purchasing of Health Services
Description	See DLR 7.1 & 7.2
Data source/ Agency	See DLR 7.1 & 7.2
Verification Entity	See DLR 7.1 & 7.2
Procedure	See DLR 7.1 & 7.2

DLI 7.1	Costing the PHC HBP preventive services
Description	Publication of the PHC HBP preventive services costing study with forward and signature of the Minister of Health on the website of the MoH.
Data source/ Agency	Report of results and recommendations of the HBP preventive services costing study.
Verification Entity	TBC
Procedure	DIVAP and MoH Reform team are working on the technical and administrative foundations of the study's bidding process. Both entities serve as counterparts to the institution leading the study to ensure the fulfillment of objectives, schedules and deliverables.
DLI 7.2	Updated PHC financial resource allocation mechanisms
Description	Decree approving the updated financial resource allocation mechanism for PHC published in the Official Gazette.
Data source/ Agency	Decree in the Official Gazette.
Verification Entity	TBC
Procedure	PCT will send the Decree in the Official Gazette to the Verification Entity.
DLI 8	Virtual Health Management Platform
Description	see DLR 8.1 & 8.2
Data source/ Agency	see DLR 8.1 & 8.2
Verification Entity	see DLR 8.1 & 8.2
Procedure	see DLR 8.1 & 8.2
DLI 8.1	Virtual Health Management Platform operational
Description	This indicator measures the process of designing and developing the architecture/ecosystem for a virtual health management platform for citizens. The MoH will issue an administrative communication (Ordinario) informing the availability of the Virtual Health Management Platform with the technical guidelines for its use.

Data source/ Agency	Administrative communication (Ordinario) informing the availability of the Virtual Health Management Platform with the technical guidelines for its use.
Verification Entity	DIVAP, TIC
Procedure	PCT will send the administrative communication (Ordinario) to the Verification Entity.

DLI 8.2	Participating municipalities with positive user experience
Description	Number of participating municipalities that have at least 75 percent positive answers declared regarding the user experience survey evaluating their PHC service delivery. This survey will be conducted using Likert scales through the Virtual Health Platform.
Data source/ Agency	Platform report
Verification Entity	TBC
Procedure	PCT asks DIVAP, IT MoH for reports.

ANNEX 3. TECHNICAL ASSESSMENT SUMMARY

This annex summarizes the key aspects of the Program's Technical Assessment, which has been prepared by the WB to meet the requirements of the PforR Financing Policy and Directive.

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

1. **From a technical point of view, the UPHCP 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.**[35] 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 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 UPHCP.

2. From a strategic perspective, the UPHCP and the PforR are well-balanced with respect to the focus on supporting improvements in the municipalities that will gradually join the UPHCP 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. **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. The full Technical Assessment shows the scope of the UPHCP and its correspondence with PforR RAs. 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 consist of a total of up to 38 subcomponents, each with its corresponding activities. However, seven of these subcomponents are provisionally included under the UPHCP, contingent upon the availability of resources for their implementation. The proposed PforR will support all four strategic lines of the UPHCP and in particular all subcomponents under the UPHCP with an assigned estimated budget.

4. **Results under the PforR help Chile and the health system to better adapt to climate shocks and mitigate greenhouse gas emissions (see Table A3.1 for an overview of different adaptation and mitigation measures).**

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

Table A3.1. Climate Adaptation and Mitigation Measures in the Program

DLI	Description
DLI 4 (US$14.99 million): Use of high-value health services	**DLI 4 will support the use of high-value health 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 health services amid extreme weather events (flooding) and PHEs (such as lockdowns during pandemics) that limit access to PHFs. This will allow continuation of health 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 Preparedness for 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 from 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 PHEs and Climate Change response. 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 infrastructure standards for PHFs, a national-level mapping/GAP-Study 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[36] to bring close care during an emergency, and (c) adaptation and

[36] 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 a nearby healthcare facility.

	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 PHFs are resilient to climate shocks and will outline locally specific measures which go beyond standard practice for PHFs. This will help PHFs adapt to the impacts of climate shocks and climate change. These might include but not be limited to: (i) location of the PHFs: PHFs 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 PHFs, including measures for potable water, water tanks, water treatment, waste management, and atmospheric pollutants; (iii) general requirements for the design of PHFs, 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 greenhouse gases emissions; (d) efficient heating equipment to reduce consumption and greenhouse gases 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 PHFs 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 PHFs delivering essential health 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).**

B. INSTITUTIONAL ARRANGEMENTS AND MONITORING & EVALUATION

5. **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.

C. RESULTS MONITORING AND EVALUATION

6. **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.

7. **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.

D. PROGRAM EXPENDITURE FRAMEWORK

8. **The financial sustainability of the UPHCP is ensured by the existing fiscal and budgetary provisions.** The key role of the MoH in financing the UPHCP contributes to a high predictability of funding, consistent with the country's medium-term fiscal framework. In addition, recurrent revenues from the state budget follow a stable growth trajectory, which ensures the predictability of the part of the UPHCP financed by the state budget. The UPHCP to be supported by the PforR represents an adequate budget in view of the desired results. Furthermore, the programs and activities included correspond to core functions of the MoH and have been historically well executed by the MoH. 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 percent, 96.5 percent and 97.3 percent, respectively.

9. **The cost of the UPHCP is estimated at US$2.58 billion from 2023 until 2029. The WB will support the UPHCP' with a financial contribution equivalent to US$200 million for the period from 2024 to 2027, during which period the corresponding budget for the UPHCP is estimated at US$ 1.51 billion** (see Table A3.2). The UPHCP's expenditure framework includes the budget lines necessary to achieve the results that are supported by the PforR. At the national level, program funding from the MoH will be allocated to: (a) Trainings; (b) Internal and external consultancies; (c) Equipment of PHFs; (d) expenses for construction of health centers and minor infrastructure investments, and (e) operational expenses.

Table A3.2. Preliminary Expenditures under the UPHCP (amounts expressed in USD million)

		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.[37]

- 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.

E. ECONOMIC JUSTIFICATION OF THE PROGRAM

10. 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).

11. **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 UPHCP and PforR, 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.

12. **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 A3.3.

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

Table A3.3. Key Inputs and Assumptions used for the Cost-Benefit Analysis

Key Inputs	Baseline Scenario Assumptions	Sensitivity Analysis	
		Low scenario	High Scenario
Monetary value of DALY	1 x GDP per capita	1 x GDP per capita	1.5 x GDP per capita
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.

13. 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 A3.4 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 A3.4. 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: WB estimates

F. TECHNICAL RISKS AND MITIGATION MEASURES

14. The Program 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 Fiscal Year 2023 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 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.

ANNEX 4. FIDUCIARY SYSTEMS ASSESSMENT

A. CONCLUSION

1. **The Fiduciary Systems Assessment (September 2023) was carried out consistently with the WB Policy, Directive and Fiduciary Systems Assessment Guidance Note for PforR Financing.** Presential and virtual meetings were conducted with the MoH, and documentation relevant for the assessment was also obtained electronically.

Reasonable Assurance

2. **The Fiduciary Systems Assessment for this operation has concluded that the FM and procurement systems of the reviewed Program are adequate to provide reasonable assurance that the funding will be used for its intended objectives.** The Fiduciary Systems Assessment has considered key principles, such as economy, efficiency, effectiveness, transparency, and accountability. Overall, the assessment has found that the Program's fiduciary systems are robust, ensuring proper utilization of the financing proceeds.

Risk Assessment

3. **Considering the risks identified, the fiduciary risk is rated Moderate.**

4. **From the FM perspective, the fiduciary risk is rated Moderate.** The assessment identified the following FM risks, which have the potential to impact the Program's development outcomes: (a) the MoH has limited experience with the PforR Instrument. Consequently, the financial and administrative subdivision may require additional support to ensure effective implementation of the Program; (b) the introduction of new procedures for coordinating and informing financial activities between Subsecretaries and the new unit may result in a learning curve for the PCT and subsecretaries; (c) the MoH lacks prior experience in reporting on project funds, including results, under instruments such as the PforR instrument, and (d) in a sample of external audit reports of the Municipalities, certain internal control weaknesses have been identified.

5. **The proposed measures to mitigate the risks mentioned above include:** (a) the appointment of a FM Specialist for the Program. Additionally, the WB's fiduciary team will prepare training sessions on fiduciary issues in the short term and provide close support during implementation to ensure that the MoH is equipped with the necessary knowledge and skills to manage the Program's finances effectively, (b) the MoH will establish detailed processes that describe how to operate and coordinate internally among the Subsecretaries directly involved in executing the Program, and (c) the WB team and MoH have agreed on the format and operative procedures to use the SIGFE database[38] to prepare the semiannual and annual reports on the financial statements required for the Program. The utilization of SIGFE as the primary reporting tool for the WB and for audit purposes has been deemed appropriate. To mitigate risks associated with weaknesses in internal controls, proposed measures include strengthening system capacity through a joint effort with the internal and external auditors (i.e. the Office of the Comptroller General of the Republic of Chile) to develop an action plan aimed at improving internal controls.

6. **From a procurement perspective, the fiduciary risk rating is considered Low.** The key risks to the development outcomes of the Program that underpin the Low-risk rating are the following: (a) non-application of the WB's fraud

[38] The execution of public funds by the MoH is recorded in SIGFE by each Health Service. SIGFE is the official country system for budget recording and is used by all institutions that have a role in the implementation of the UPHCP.

and corruption clauses in all Program procurements; (b) the risk of awarding a contract to firms and/or individuals debarred or suspended by the WB, and (c) the lack of clear definition of procurement planning regarding goods and consulting and non-consulting services. This includes the size of procurement packages, timelines of procurement implementation, and the corresponding resources needed to perform these properly.

7. **The proposed actions to mitigate the risks mentioned above include:** (i) inclusion of the WB's ACGs fraud and corruption provisions, as appropriate, in the bidding documents and contracts; (ii) conducting eligibility verification to ensure that any person or entity debarred or suspended by the WB, or by another multilateral institution with which the WB has signed a cross debarment agreement, is not awarded a contract under the Program during the period of such debarment or suspension, and (iii) strengthening the unit that will implement procurement activities by staffing it with experienced personnel, aligned with the nature and volume of the planned procurement activities. Specific actions related to this risk, are detailed in "Fraud and Anti-corruption Arrangements" section below.

Procurement Exclusions

8. **The Borrower confirmed that it does not foresee any high-value contract under this Program.** It is not expected that the proposed Program will finance any contract at or above Operations Procurement Review Committee thresholds considering the activities under Low risk, which at the time are at minimum of: (a) US$200 million for works; (b) US$125 million for goods, information technology and non-consulting services; and (c) US$40 million for consulting services.

Scope

9. **The Program will be executed by the MoH and its dependent agencies. The fiduciary activities will be divided into three units within the MoH:** A newly established PCT unit, which will include a financial/administrative subdivision. This unit will work in coordination with DIFAI and Department of Financial Programming and Budget *(Departamento de Programación Financiera y Presupuesto,* DPFP), as well as with the Internal Audit Department. The MoH, through these units, will carry out all activities related to fiduciary responsibilities related to the PforR, such as planning and budgeting, control systems, accounting and reporting, treasury and flow of funds, fraud and corruption systems, and auditing. At the municipal level, under the supervision of MoH, Health Services Entities, the municipalities are directly responsible for providing healthcare to the Program's beneficiaries based on agreements signed with the respective Health Services Entity. The agreements cover all legal, technical, financial, and administrative aspects of municipal participation in the UPHCP, following established accountability mechanisms to the Health Services Entities and the Comptroller General of the Republic of Chile, respectively. For goods, consultant and non-consultant services, all procurement processes will be implemented by DIFAI. For works to be awarded, procurement process will be implemented by the 29 Health Services Entities. These entities will be responsible for implementing procurement processes and managing the awarded contracts.

10. The MoH, in collaboration with the WB, has identified the budget lines relevant to the RAs and the Expenditure Framework of the Program. The budget is expected to be sufficient to achieve the results supported by the PforR and to promote efficiency in their achievement (see the Technical Assessment). The budget for the UPHCP is composed of different budget lines that concentrate on key areas to improve PHC health service delivery. The focus is on training (subtitle 22), consultancies (subtitle 21 and 22), equipment (subtitle 29), minor infrastructure and rehabilitation (subtitle 29 and 33), training and assignment of specialists (subtitle 21) and operational costs (subtitle 29 and 33). The budget lines and detailed expenditures will be described in the Operation Manual.

B. REVIEW OF PERFORMANCE OF PUBLIC FINANCIAL AND PROCUREMENT MANAGEMENT CYCLE

Planning and budgeting

11. ***Budget formulation*:** The budget is prepared with regard to government policies and priorities. Budget formulation is the result of a systematic process of analysis, consultation, discussion, and sanction enacted by different actors and institutions (DIPRES, MoH and Municipalities) following the normative framework and calendar established by the Financial Administration Law and the annual instructions for budget execution from the DIPRES. Expenditures under the UPHCP will be financed through budget lines that historically have had high execution rates. Nonetheless, for each fiscal year, the number of municipalities to adhere to the UPHCP and hence the assigned budget will be determined as part of the overall budget negotiation between the DIPRES and the MoH. The outcome of this process is not known with certainty and hence the final additional yearly budget allocation to the UPHCP. This process could potentially lead to delays in Program implementation and consequently the achievement of DLIs and the respective disbursements. Still, public authorities have affirmed their commitment to the Program. Therefore, the WB will closely monitor progress, maintaining frequent communication between the Program Team, DIPRES, and MoH leadership to ensure the smooth implementation of the PforR.

12. ***Budget control.*** Before processing an actual payment transaction, the requested transaction is subject to a control, ensuring that it falls within the approved budget and a sufficient uncommitted budget balance is available. The MoH, through the Health Service, monitors the availability of the budget, its execution, and the outstanding balance of the municipalities on a monthly basis.

13. **Budget *utilization***. Table A4.1. below shows the budget utilization for the last three years. The actual results from the revised budget show minor deviations, mostly below five percent. Even when comparing these results to the original budget, the deviations remain around five percent. Based on this data, it can be assumed that the budget programs under the MoH are implemented in a predictable manner.

Table A4.1. Program PHC - Budget vis-à-vis Actual Expenditures, 2020-22

	FY 2020	FY 2021	FY 2022
Actual expenditures (Chilean pesos, millions)	2.095.328	2.297.186	2.523.273
Original Budget (Chilean pesos, millions)	1.993.086	2.186.409	2.398.726
Revised Budget (Chilean pesos, millions)	2.134.319	2.379.701	2.593.033
Actual expenditures as a % of Original Budget	105.13%	105.07%	105.19%
Actual expenditures as a % of Revised Budget	98.10%	96.50%	97.30%

Procurement Planning

14. **According to Chile's Procurement Law 19886 in its article 12 and the Procurement Law's Regulation in chapter X, all government institutions must prepare a procurement plan.** In the procurement plan, the PCT (through DIFAI and the Health Services Entities) provides a detailed description of the goods, works, consulting and non-consulting services to be procured. Among other information, it also provides estimated amounts and procurement methods. To prepare this procurement plan, the PCT shall provide the information related to upcoming institutional needs, with its corresponding market information.

Procurement Profile of the Program

15. The Program will support improvements in: (a) the coverage with and quality of PHC; (b) the contribution of PHC to health system resilience, and (c) the efficiency and transparency of PHC financing. From a procurement perspective, the Program will consist of hiring several consulting services, the procurement of goods and of contracting small civil works. Among the works to be performed, the development of a new infrastructure model, adjusted to the geographical distribution of the population and energy efficiency standards, will be supported. The type of health facility that achieves better performance when responding to health needs across different territories must be determined. In addition, necessary standards that PHFs must have in terms of infrastructure must be defined. Therefore, it is required to generate a novel guideline/standard for the new PHC infrastructure. It is estimated that 127 small civil works (approximately 1000 sqft. of infrastructure) will be built, averaging four to five sqft. per healthcare facility. This infrastructure will be equipped with basic medical goods and inputs, such as blood pressure monitor, oxygen monitors, stethoscopes, etc. Additionally, the Program will procure mobile medical units, consisting of vehicles adapted to provide healthcare to citizens.

16. This Program will also finance the mapping/study of infrastructure gaps at the national level, the design of a new PHC infrastructure and the training of health infrastructure specialists from Health Services Entities and municipalities regarding the implementation of this new model. Other consulting services to be hired are related to the design and rollout of a virtual health self-management platform for citizens. The platform will provide them with access to a variety of information sources, the possibility to interact more easily with health workers, book appointments and evaluate the care they are receiving.

Procurement Performance

17. **The MoH (through DIFAI and its Health Services Entities) possesses skilled and experienced procurement staff to perform all expected procurement activities under the Program.** MoH staff working on procurement has vast experience and knowledge implementing procurement activities following the country's procurement rules and procedures. The WB reviewed data of a great number of contracts for goods, consulting and non-consulting services awarded by MoH through DIFAI between January 2020-June 2023. On average 75 percent of the activities were procured using an open competitive bidding process. Overall, most procurement activities before January 2020 were related to goods, consulting and non-consulting services of low value and non-complex in nature.

18. **In the case of works contracted by MoH through the Health Services Entities, the WB reviewed a** sample comprised with the procurement of works carried out by six Health Services Entities between January 2020 and June 2023. On average 75 percent of these procurements were conducted through open competitive processes. The WB assessment revealed that works contracted by these Health Services Entities between January 2020 and June 2023 are of similar or greater value and complexity than those expected to be procured within the Program.

19. **Competitiveness.** From the data reviewed, it was observed that DIFAI received on average four bids per open competitive bidding process between January 2020 and June 2023. The WB observed that on average 3.8 bids were received per open competitive process. In both cases, the data revealed that direct contracting processes were used for around 25 percent of the procurement processes per year.

20. **Timeliness.** Regarding the time for implementation of open competitive processes reviewed by the WB, the DIFAI averaged an approximate 42 days from the date of publication of the procurement notice, to the date of contract award publication. Regarding the performance of procurement activities implemented by the Health Services Entities,

it was observed that it took 47 days from the publication of the procurement notice to the advertisement of contract award on average. Additionally, it was noted that in the cases of DIFAI and the Health Services Entities, the average period for preparation of bids was 14 and 22 days, respectively.

C. BUDGET EXECUTION

Treasury Management and Fund Flow

21. **Treasury and flow of funds arrangements are in place to transfer Program funding from DIPRES to the municipalities through MoH's Health Services Entities and FONASA.** This ensures that the funds are aligned with the implementation plans and disbursed in an organized and predictable manner.

22. **Overall, it is expected that the central government procedures will be used for treasury management of Program funds, using the Treasury Single Account (*Cuenta Unica Fiscal*), held at the Bank of the State of Chile (*Banco del Estado de Chile*) to manage all government financial resources.** The government cash management procedures are well-developed and Treasury balances are calculated and consolidated daily, weekly and monthly. The operation of the Treasury Single Account is tracked through SIGFE, as the main instrument used for recording, monitoring, and controlling the budget and tracking the financial execution of government expenditures and revenues. Each month the Health Service tracks the municipalities budget execution records related to PHC. It also monitors any outstanding balance that must be returned by the municipality to the Treasury respectively. For monitoring, the Accountability System (*Sistema de Rendición de Cuentas*, SISREC) platform is used, documenting transfers of public resources using electronic and digital documentation. It will also allow the Office of the Comptroller General of the Republic Chile to access the information to carry out a review of accounts as part of its auditing tasks.

23. **To meet funding requirements, the National General Treasury (*Tesorería General de la República*) prepares an annual financial program**. This annual financial program is based on the calculation of resources and the expenditure budget approved by the General Budget Law for the fiscal year; then a quarterly and monthly program is prepared for the various subperiods of the fiscal year. As a result, the fiscal, primary, and financial balances are calculated, followed by the financing gap (or cash surplus) per period and per currency.

24. **Disbursement of WB loan proceeds will be made to the Single Treasury Account (*Cuenta Unica Fiscal*) at the request of the Borrower upon achievement of results (DLRs) associated with DLIs.** Some DLRs are scalable, thus allowing for disbursements to be proportional to the progress towards achieving the targeted DLR value. Other DLRs are binary (achieved or not achieved). With the exception of DLRs related to DLI3, DLRs are not time-bound and do not have a firm achievement date attached to them. Funds not disbursed in one year will be available for disbursement in subsequent years. Depending on the eventual effectiveness date (expected in March 2024 or later), some DLIs may be achieved prior to effectiveness. Disbursements on the basis of DLRs achieved prior to the Signature Date of the Loan Agreement can only be made for DLRs achieved on or after January 1, 2024 (up to an aggregate amount of US$50,000,000). The operational arrangement for the transfer of resources will be described in detail in the Operation Manual.

25. **Verification protocols. Verification of the DLIs, including any Prior-Results will be undertaken by an Independent Verification Agent that will be contracted within three months of effectiveness.** This Agency will have the capacity to provide independent verification for the DLIs and to ensure credible verification of its achievement and needs to be acceptable to the WB with the necessary independence, experience, and capacity of ensuring a credible verification.

26. **The MoH will prepare technical reports to document the status of the achievement of DLIs.** The technical reports will be verified by the Independent Verification Agent, appointed by MoH, as per Terms of Reference agreed with the WB. On validation of the achievement of the DLIs by the Independent Verification Agent, the MoH - in coordination with DIPRES - will communicate the achievement of DLIs targets and corresponding values.

27. **Disbursement of Program funds from the WB to MoH will be made only upon achievement of the DLIs.** Upon achievement of the indicators, the MoH will inform the WB and provide evidence as per the verification protocols, as justification that results for the DLI have been met. Disbursement requests will be submitted to the WB using the WB's standard disbursement forms signed by an authorized signatory. The Program does not include advances. Details of the key disbursement issues will be spelled out in the Disbursement and Financial Information Letter. It is important to note that although PforR operations do not link disbursements to individual expenditure transactions, the aggregate disbursements under such operations should not exceed the total expenditures by the Borrower under the Program over its implementation period. As resources flow to the Government based on the achievement of results, it is important for the Government to closely follow and deliver its expected results.

Accounting and Financial Reporting

28. The accounting and financial reporting standards at the central level in Chile are generally robust. Over the last three years, Chile has issued the Financial Statements of the Public Sector as part of its public accounting and financial reporting system. The Financial Statements provide detailed information on the financial position of the Government and its related entities. In addition, the Chilean Government has recently introduced new accounting and reporting standards for the public sector, the Chilean Government Accounting Standards. These are based on the International Public Sector Accounting Standards (IPSAS) issued by the IPSAS Board. These new standards aim to provide a more transparent and unified financial reporting system for the Chilean public sector. However, challenges remain at the municipal level in terms of quality and timing of reporting. To address these weaknesses, there is a pending discussion about integrating SIGFE with the municipal accounting systems, which will enable municipalities to prepare comprehensive financial reports in a timely manner.

29. The MoH is able to prepare general-purpose financial statements following IPSAS on an accrual basis of accounting that is applicable to the public sector in Chile. This enhances its capacity to provide accurate, timely, and reliable financial information for sound decision-making, performance assessment, and resource allocation. The financial statements are prepared using SIGFE to collect and aggregate information. All transfers to the municipalities are considered as executed funds in terms of budget execution to MoH. Thus, the municipalities send monthly execution reports to the MoH Health Services Entities and report to the Comptroller General of the Republic of Chile through the SISREC to document the funds received. If there is an outstanding balance that needs to be returned to the Treasury, the municipality must return it within 15 days and document the funds to receive any future fund transfer.

30. As of October 2023, 309 (90 percent) of the 345 municipalities use the SISREC system to document the transfers received. Table A4.2 shows the coverage progress from 2019 to 2023.

Table A4.2. Coverage of the SISREC (2019 – 2023)

Year	Number of Health Services Entities	Number of municipalities
2019	3	17
2020	5	35
2021	13	141
2022	26	299
2023	27	309

31. For reporting purposes, the financial/administrative Sub-division of the PCT, in coordination with the DIFAI, DPFP and *División de Inversiones (DI)*, will be responsible for generating the Program's semiannual and annual financial statements, both in Chilean pesos and United States Dollars (US$), through the SIGFE. The Interim Financial Reports (IFRs) will be submitted no later than 60 days after the end of each reporting period.

Procurement Processes and Procedures

32. The MoH (through DIFAI and the Health Services Entities) according to the National Public Procurement Law, implements their procurement processes through Chile *Compra's* portal "*Mercado Público*" (Public Market). DIFAI is responsible for all procurement not related to construction (civil works). The 29 Health Services Entities across the country are responsible for procurement for civil works. The PCT will serve as a liaison between all actors to ensure quality and coordination of all procurements. Municipalities will coordinate the implementation of activities in the territory, primarily through their health workers, but no major products or services will be procured under the PforR activities. In *Mercado Público*, all government entities of Chile implement their procurement activities, using among others the following methods and procedures of *Mercado Público* (Public Market):

- **Agile Purchasing through Chile *Compra*:** It is a procurement procedure that allows the acquisition of goods and/or services for an amount equal to or less than 30 Monthly Tax Units, in a more dynamic and expedite manner through the Public Market System. A minimum of three quotations is required, without detriment to that, the requirement established by the regulation refers to requesting a minimum of three quotes and not obtaining them. Therefore, it is acceptable to continue with the respective procurement if less than that number of quotes are received.
- **Framework Agreements through the Public Market**: It is a contracting procedure to procure the direct supply of goods and/or services according to the form, terms, and other conditions established in such an agreement. This form of acquisition will be the first procurement mechanism that shall be applied under the Public Market; if this is not possible, the other purchasing mechanisms established in the regulations will be applied. However, when the purchase amount exceeds 1,000 Monthly Tax Units, an open competitive procurement process must be carried out, which entails a procurement notice to purchase to all suppliers awarded in Framework Agreements for the type of product required. This call must be made according to the conditions and deadlines established in this same article.
- **Public Bids through the Public Market**: As a general rule, when contracting through the Framework Agreement is not appropriate, entities must carry out their supply and/or service contracts through public bidding, a procedure where a public notice is advertised, inviting interested parties to submit bids/proposals in accordance with the established terms and conditions. The most suitable proposal will be selected and accepted. It is important to note that

when the proposed acquisition amount exceeds 1,000 Monthly Tax Units, public bidding is mandatory.

- **Private Bids through the Public Market**: If there are no interested parties in a public bidding or the offers received are inadmissible, a private bidding can be conducted after a justified resolution, by which an invitation will be extended to a minimum of three potential suppliers that have businesses of a similar nature, so that, subject to the established bases, they may formulate proposals from which the most convenient will be selected and accepted. If no new interested parties are found, or the offers are inadmissible, direct contracting may be carried out according to the mechanisms established in the national regulations.

33. **Publication.** For the procurement of goods, works, consulting and non-consulting services, the procurement notice is advertised through the Public Market portal. Such portal is well known among the private sector entities, creating a vast and attractive single site to explore potential business opportunities working with the Government.

34. **Standard procurement documents for different categories of procurements such as purchase of furniture, equipment, etc., are published in the Chile *Compra* Portal (National Procurement Entity's portal).** The general bidding conditions apply to all bidding documents published by MoH (through DIFAI and the Health Services Entities) and it's a standard bidding document of mandatory use developed by Chile *Compra* based on many years of experience of the country's procurement.

35. **Complaints.** Bidders who believe they have experienced an irregularity in a procurement activity can present a complaint using the dedicated "*Reclamos*" module in the Public Market portal. The reasons to justify a complaint, according to the portal mentioned above, are irregularities, deviations from the expected standards, or non-payment issues. Submitted complaints are publicly viewable in the portal, allowing interested parties to view and track the progress of the resolution process.

36. **Procurement information disclosure.** All documentation related to the implementation of procurement activities is publicly available to any interested party through the Public Market portal. Additionally, the Government, following their transparency law, makes data related to contract awards and contract execution available to any interested party through their Open Data portal *https://datos.gob.cl/*.

Contract Administration

37. **As part of the contract management function, the Public Market portal has a contract management module.** In this module, the requesting units (i.e., contract managers) record all actions related to the management of contracts and purchase orders for goods, works, consulting and non-consulting services. When necessary, DIFAI or the Health Services Entities advise the requesting units on matters related to contract management and the correct way to register such information in the portal. Some advantages that are observed when using the contract management module of the Public Market portal are the following:

(a) System relates to the FM system of the Government.
(b) Digitalization of actions that traditionally were performed manually.
(c) Transparency and availability of contract implementation data on the website.
(d) Evaluation of the contractual behavior of the providers, including administrative sanctions such as penalties, execution of guarantees and contract termination.

38. Specifically in the case of works, the Health Services Entities designate a government official to serve as Civil Works Technical Inspector who plays an important role regarding the supervision of works and hence in contract management of the same. The Civil Works Technical Inspector can be supported by other technical specialists and even consulting firms, in accordance with the scale and volume of the specific works.

Internal Control and Internal Audit

39. At the central level, the internal control framework is robust. The Public Management Control Division from DIPRES generates performance information and introduces practices to improve the quality of spending, increases the allocation efficiency and use of public resources in different programs, projects, and institutions, and promotes better management, transparency, and accountability. The MoH reports a series of performance indicators, institutional remuneration incentive mechanisms (Management Improvement Programs and Institutional Efficiency Goals), evaluation of government programs, the evaluation of program impact, the comprehensive evaluation of institutional spending, the evaluation of new programs, the comprehensive management balance sheet, and the public management modernization fund through the management evaluation and control system.

40. The PforR's internal control system will be documented in the Operation Manual, which will comprise descriptions, flow charts, policies, templates and forms, user-friendly tools, tips, and techniques to ensure that the approval and authorization controls continue to be adequate and are properly documented and followed with adequate safeguarding of the PforR assets. The Operation Manual will be prepared by the MoH, approved by the WB, and maintained/updated throughout the PforR's life.

41. **Internal audit: The Inspection Directorate, which is under the MoF, has the overall responsibility of ensuring that the internal audit units from each Health Service are staffed, trained, and monitored.** The internal audit unit at MoH is responsible for capacity building of internal auditors at the 29 Health Services Entities at the national level, and each Service follows up on its internal audit reports. Each Health Service Internal Audit prepares its annual work plans and conducts audits specific to its Service. An Internal Audit Manual is available at these Services for reference.

42. Due to capacity problems, around 250 auditors mostly focus on specific budget programs within PHC and other mandatory audits required by the General Internal Audit Council of the Government (*Consejo de Auditoria Interna General del Gobierno)*. Following the *Instr. Gab Presid. No 04/2022* of austerity policy, they need to review annually advertising expenses, salaries, tickets and travel expenses, acquisition and use of vehicles, consumer goods and services, and other related areas.

43. **At the municipal level, a sample of audit reports was reviewed which identified some deficiencies in PHC programs such as**:(a) non-compliance with timelines to submit reports and support to documentation to regulatory entities; (b) poor documentation and filing of accounting records; (c) non-compliance with established accounting procedures, and (d) lack of documentation referred to the definitive reception of some goods and equipment among others. These deficiencies have a concrete action plan and will be followed up for enhancement of internal controls.

44. **The Access to Public Information Law (Ley 20285) regulates the right of access to public information.** This law establishes the right of transparency of actions of government officials, right of access to all government information, the specific procedures to access information and the exceptions to not make certain information public.

45. **In addition, relevant procurement information (bidding documents, clarifications and amendments, bid opening records and award recommendation) is made publicly available through Public Market's portal and widely available website.**

Fraud and Anti-corruption Arrangements

46. **The Chilean Law 21.121 "Modifies the Criminal Code and other legal norms for the prevention, detection and prosecution of corruption" establishes new crimes for which legal persons may be found liable and increases the sanctions in case of conviction**. One of the key changes to the country legal framework included in this law, are the crimes of disloyal management and corruption among private entities, which makes prior practices that used to be unpunishable now a crime.

47. **The current Chilean Law 20.393 "Criminal Liability for Legal persons in Chile" establishes criminal liabilities regarding money laundering, terrorism financing, and corruption acts, among others.** The scope of the law applies to all companies, corporations, state-owned enterprises, and other type of legal persons. The law specifies several types of sanctions for the legal persons that are deemed criminally liable, such as prohibition to contract for certain time periods or indefinitely, financial penalties including the suspension of fiscal benefits, and/or the cancelation of the legal person.

48. **Public officials who become aware of a crime being committed while performing their duties, must report it to the authorities, in this case to the Public Prosecutor**. Enforcement authorities are legally required to commence the investigation once becoming aware of a bribery allegation.

49. **In Chile there are seven public institutions that play a role in the fight against corruption**. The Office of the Comptroller General of the Republic of Chile is an autonomous constitutional agency. It exercises control over the legality of administrative acts and safeguards the proper use of public resources. Among its functions are the legal, accounting, and auditing functions. They are regulated in Art. 98 and following the Constitution and its Organic Law (Law No. 10,336, consolidated in Decree No. 2421).

50. **The Public Prosecutor's Office is the body responsible for directing the investigation of crimes, bringing the accused to court and, if appropriate, providing protection to victims and witnesses.** Within its organizational structure, it has a Specialized Anti-Corruption Unit, responsible for providing advice, inter-institutional coordination and training on corruption offenses. There is a National Prosecutor's Office and throughout the country there are local Prosecutor's Offices, depending on the region.

51. **Public officials have the duty to report promptly to the Public Prosecutor's Office**, the police, or any court with criminal jurisdiction, the facts of which they become aware in the exercise of their duties, and which have the characteristics of a crime. Art. 61 letter k), of Law 18.8344 and Art. 175 Code of Criminal Procedure, letter b). The crimes that can be committed by public officials are typified in Law No. 21.1213 and are embezzlement, fraud against the treasury, incompatible negotiation, and bribery.

52. **State Defense Council (*Consejo de Defensa del Estado*), responsible for bringing criminal actions in the case of crimes that could result in economic damages to the Treasury or State agencies, as well as those committed by public officials in the exercise of their duties.** The Organic Law of the State Defense Council also provides that the Chilean Public Prosecutor's Office will inform it about the background information related to crimes that may give rise

to its intervention, and the State Defense Council may request the background information it deems necessary to determine whether it is necessary to file a complaint.

53. **The Financial Analysis Unit is an institution in charge of preventing and impeding the use of the financial system and other sectors of the Chilean economic activity for the commission of money laundering and terrorist financing crimes.** It was created by Law No. 19.913. To this end, it conducts financial intelligence, issues regulations, monitors compliance, imposes administrative sanctions and conducts training and dissemination activities.

54. Paragraph 6 of Article 3 of Law 19.913 establishes that "the superintendencies and other public services and bodies indicated in the second paragraph of Article 1 of Law No. 18,575, Constitutional Organic Law of General Bases of the Administration of the State, shall be obliged to report suspicious transactions that they notice in the exercise of their functions".

55. **Council for Transparency, in charge of ensuring proper compliance with the Law of Transparency of the Public Function and Access to Information of the State Administration**. To this end, it promotes and disseminates the principle of transparency and oversees compliance with the rules of access to information. It was created by Law No. 20.285.

56. **Judicial Branch**: It is a Power of the State together with the Executive and Legislative Branches. It is regulated by Article 76 of the Political Constitution of the Republic. At the top of the Judicial Branch is the Supreme Court and under it are 17 Courts of Appeals, located in the different regions of the country. These Courts of Appeals are responsible for 465 courts of first instance or courts of justice, distributed throughout the country.

57. **National Economic Prosecutor's Office (*Fiscalía Nacional Económica*,):** In relation to crimes, the competence of the National Economic Prosecutor's Office refers in particular to the crime of collusion. Title III, Art. 39, of Legislative Decree No. 211.10. In this regard, collusion investigations can only be initiated by a complaint filed by the National Economic Prosecutor's Office.

58. Considering the above, it can be concluded that there is the institutional capacity to monitor and address governance and corruption issues.

59. The WB's Institutional Integrity Vice-Presidency (INT) may also, jointly with the Borrower and/or the MoH or on its own initiative, investigate any allegations or other indications of Fraud and Corruption (as defined in the ACGs) in connection with the Program or any part of the Program. In all such cases the Borrower and MoH will collaborate with INT to obtain all records and documentation that INT may request from the operation regarding the use of the Program financing. If the Borrower or the WB determines that any person or entity has engaged in fraud and corruption (as defined in the ACGs) in connection with the Program, the Borrower will take timely and appropriate action, satisfactory to the WB, to remedy or otherwise address the situation and prevent its recurrence.

60. In order to implement the WB's Anticorruption guidelines for PforR operations, an ACG protocol has been agreed on and will be part of the Operation Manual. Also, the inclusion of the WB's ACGs fraud and corruption provisions, as appropriate, will be included in the bidding documents and contracts.

61. Any expenditures due to contracts given to individuals or firms debarred by the WB or under suspension by the WB are not eligible for WB financing under the Program. The external auditors' Terms of Reference will include a

requirement to review Program expenditures to confirm that contracts are not awarded to debarred or suspended firms.

62. The MoH will immediately inform the WB of any complaint, claim or allegation related to fraud and corruption which the MoH either receives or of which the MoH becomes aware; in addition, every semester (together with the Program Monitoring Reports) a report will be prepared containing all alleged cases, with an updated status of the respective actions taken. The MoH will immediately provide the WB with all the records, documentation and information that the WB may request with respect to such issues. In the event that the WB decides to conduct its own investigation, the WB may request the Government and/or MoH to exercise its/their legal rights and remedies (under the relevant contract/s) so as to obtain all information, records and documentation that the WB may request, and provide these to the WB. This process does not limit the rights of the WB to also make direct requests for information from individuals or contractors who are recipients of WB financing. In line with the obligations arising under the ACGs, the MoH should ensure that individuals or firms who are recipients of WB financing are aware that the WB may decide to exercise this option. If the WB determines that it has not been able to receive the documentation, records or information requested by the WB directly and/or through MoH, the WB may declare the relevant expenditure ineligible for WB financing under the Program. Furthermore, should the WB conclude that a sanctionable offense has occurred, it may decide to pursue sanctions against the individual or firm in line with WB procedures.

63. **In the case of municipalities participating in the UPHCP, the participation agreements between the Health Services Entities and the Municipalities will include the obligation to comply with the ACGs.**

Auditing

64. **For Program purposes, the external audit shall be conducted by the Comptroller General of the Republic of Chile due to its constitutional mandate.** The Comptroller General of the Republic of Chile will follow agreed Terms of Reference acceptable to the WB and will conduct the audit in accordance with the International Standards for Supreme Audit Institutions, a framework of standards formulated by the International Organization of Supreme Audit Institutions or national auditing standards if, as determined by the WB, these do not significantly depart from international standards.

65. **The auditors will be required to issue an opinion on the Program's annual financial statements and produce a management letter in which any internal control weaknesses are identified**, with a view to contributing to the strengthening of the control environment. The auditor's report will be submitted to the WB no later than six months after the end of the fiscal year. The WB will review the audit report and will periodically determine whether the audit recommendations are satisfactorily implemented.

66. **Regarding the Comptroller General of the Republic of Chile's performance over the last four years, it must be noted that the number of inspection products has been decreasing, primarily due to the impact of COVID-19**. In terms of tracking the resolution of audit findings, the Comptroller General of the Republic of Chile has reported an average rate of approximately 40 percent. Public Entities and the Comptroller General of the Republic of Chile are playing a key role in compliance with concrete actions and measures to improve the organization's operations and can potentially improve the effectiveness of internal control and risk management. This is shown in table A4.3:

Table A4.3: Inspection Products – The Comptroller General of the Republic of Chile

	2018	%	2019	%	2020	%	2021	%
Total Inspection Products	4,400	100	4,015	100	2,863	100	2,421	100
Audit Reference Services	3,309	75	2,870	71	1,995	70	1,580	65
Audits	700	16	729	18	637	22	668	28
Special Investigations	289	7	328	8	187	7	95	4
Public Works Inspections	102	2	88	2	44	2	78	3
Total Identified Findings	15,278		13,928		13,739		15,137	
Number of Follow-up Observations	4,191		4,223		4,691		4,655	
Average of Findings Resolved	46%		44%		41%		40%	

67. In the context of the health sector, a notable trend has emerged over the past four years, with an increase in audits & investigations and identified observations, except for fiscal year 2021. Specifically, the percentages related to high complexity and complexity observations identified by the Comptroller General of the Republic of Chile have exhibited variation, with figures of 70 percent (2018), 65 percent (2019), 42 percent (2020), and 47 percent (2021), respectively. It is worth highlighting a declining trend in these types of observations, as illustrated in Table A4.4.

Table A4.4: The Comptroller General of the Republic of Chile - Inspection Products in the Health Sector

	2018	%	2019	%	2020	%	2021	%
Audits & Investigations	108		154		171		107	
Total Identified Observations	1,353		1,850		2,409		1,611	
Highly Complex Observations	356	26	208	11	211	9	154	10
Complex Observations	591	44	992	54	807	33	602	37
Medium Complexity Observations	394	29	637	34	1,342	56	832	52
Low Complexity Observations	12	1	13	1	49	2	23	1

68. The WB also requires that the Borrower disclose the audited Program financial statements in a manner acceptable to the WB and following the WB's formal receipt of these statements from the Borrower. The WB will also make them available to the public in accordance with the WB Policy on Access to Information.

D. IMPLEMENTATION SUPPORT

69. The WB's fiduciary team will follow up on implementation progress by reviewing semiannual IFRs, annual audit reports and relevant progress reports on the implementation of PAP and DLIs. In addition, fiduciary specialists will participate in supervision mission and bi-annual Joint Review and Implementation Support Mission. The objective of the implementation support is to assess the achievement of agreed actions and DLIs, the continuing adequacy of systems, to monitor risks and mitigation measures and covenants and agreements.

ANNEX 5. ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT SUMMARY

1. This annex summarizes the key aspects of the Program's draft ESSA, which has been prepared by the WB to meet the requirements of the PforR Financing Policy and Directive, following the WB Guidance for the preparation of the ESSA (OPS5.04-GUID.118). The ESSA has been developed based on the overall principles of avoiding, minimizing, and/or mitigating potential adverse impacts and risks on people and the environment; promoting E&S sustainability in the PforR Program design; and promoting informed decision-making related to the Program's E&S effects.

2. **The purpose of the ESSA was to:** (a) identify potential E&S risks that may affect the achievement of the Program's results, excluding those activities with the capacity to generate significant adverse E&S risks; (b) assess the capacity of the Borrower's systems to manage those risks in a manner consistent with the core principles and key planning elements set out in the PforR Financing Policy and Directive, and (c) identify actions and recommendations to strengthen those systems, when necessary, as informed by the assessment. Some of these identified actions have been incorporated into the PAP and others will be included in the Operation Manual.

3. **The methodology for the preparation of the draft ESSA report consisted of:** (a) collection and analysis of relevant information provided by the client and/or obtained from the official websites of the relevant agencies of the Government of Chile; (b) meetings with representatives of the government agencies involved and associated with the E&S aspects related to the Program; (c) a field visit to two types of PHFs; and (d) socialization and validation of the analysis and obtained results with relevant government officials within MoH. Following the appraisal of the operation, the draft ESSA report was further consulted on among relevant stakeholders, and the final ESSA report will be prepared reflecting relevant comments and observations from these consultations. The draft ESSA report was disclosed on the WB's website prior to Appraisal,[39] as well as in-country.[40] The final report will be disclosed on both the WB's external website and in-country after negotiations and before Board approval.

4. **Potential E&S Benefits.** The PforR is expected to generate positive E&S benefits by providing improved primary health services to the public and communities, particularly in rural areas. The main positive environmental effects are related to the use of sustainability and climate change resilience standards in the construction and operation of a new model of PHFs. It is expected that the Program will also strengthen the environmental management and supervision capacity of the agencies in charge of the construction of the new PHFs, as well as relevant local authorities who will oversee their operation and maintenance, through specific relevant Program training activities, as is being detailed in the draft ESSA report. The main social benefits are related to the cultural and territorial adequacy of PHC services addressed to special care groups, such as women who suffer GBV, LGBTIQA+ population, elderly people, immigrants, rural residents and people belonging to indigenous and tribal peoples, among others, for which the sensitization and training of health personnel in the assistance to special care groups is contemplated, as well as the training of community agents to support cutting-edge approaches to GBV. In addition, the expansion of the PHC network, through a telematic platform for health management and the construction of new PHFs, is considered a crucial step forward in terms of coverage and accessibility, with a positive impact on the population.

5. **Potential E&S risks.** Based on the findings of the draft ESSA report, no significant adverse E&S impacts are expected because of the Program. The ESSA includes an exclusion list that screens out activities with a high or substantial E&S risk rating. This exclusion list includes, inter alia: (a) any construction in protected areas or priority areas for biodiversity conservation, as defined in national law; (b) construction in areas of high risk from natural

[39] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099090523084030483/p1797850b2b41d0bc0b9dd0bedfac4d9b08
[40] https://www.minsal.cl/wp-content/uploads/2023/08/Program-for-Universal-Primary-Healthcare-Coverage-and-Resilience.pdf

hazards (floods, landslides, earthquakes, tsunamis); (c) activities that have the potential to cause any significant loss or degradation of critical natural habitats, whether directly or indirectly, or which would lead to adverse impacts on these habitats, including urban or rural wetlands; (d) purchase or use of banned/restricted chemicals for medical use; (e) any activity affecting physical cultural heritage such as graves, temples, churches, historical relics, archeological sites, or other cultural structures; (f) activities that, due to their magnitude and scale, require an environmental impact assessment, per Chile's environmental impact assessment system; (g) activities that may cause or lead to forced labor or child abuse, child labor exploitation or human trafficking, or that employ or engage children, over the minimum age of 14 and under the age of 18, in connection with the Program; (h) any activity on land that has disputed ownership or tenure rights; (i) any activity that will cause significant physical and/or economic displacement; and (j) any activity that will require obtaining Free, Prior and Informed Consent from indigenous peoples.

6. **Despite of the above, the construction and operation of the new model of PHF supported under the PforR may have potential negative environmental risks and impacts.** Main potential environmental risks and impacts that may derive from the construction and operation of these physical structures include: (a) nuisances related to dust generation, vibration, noise, and odors; (b) generation, and inadequate management and disposal of non-hazardous and hazardous solid waste; (c) generation and discharge of wastewater from civil works; (d) temporary disruptions of local traffic during the construction phase; (e) health and safety risks to the Program workforce and local communities, including from exposure to hazardous materials/wastes and COVID-19, as well as from potential fires; (f) inadequate management of cultural chance finds; and (g) those risks associated with the operation of the PHFs to be built, such as the inadequate management of medical equipment, inadequate management and disposal of non-hazardous and hazardous solid waste, generation and discharge of wastewater, and labor health and safety issues. These risks and impacts are envisaged to be moderate, temporary, and site-specific and are expected to be mitigated with readily available measures mandated by national regulations.

7. **The operation may have some adverse social risks and impacts**, mainly related to: (a) the incorporation to the primary care level of new users ascribed to ISAPRES, which may cause an increase in the demand for services at PHFs, an increase in the waiting time to obtain a medical appointment, as well as, an increase in the number of complaints and claims, and may even increase the level of dissatisfaction of the population; (b) the poor reputation the public health system historically has among the citizenry, including at the primary level, which is associated with long waiting lists, poor quality of care and discriminatory practices; (c) the capacity of the MoH to carry out standardization in the care, management and operation of PHFs, due to the diversity and heterogeneity of the municipalities in charge of managing 92.6 percent of PHFs, and (d) risk of exclusion of vulnerable populations in rural areas that do not meet the quantitative criteria on the number of people for the construction of a PHF. Nevertheless, these risks and impacts are well known to MoH and are expected to have limited impact. These will be mitigated through the ongoing assessment of social risks and impacts, in accordance with the PAP, and the implementation of adequate participatory and consultative processes with all stakeholders regarding key Program activities, based for example on the evaluation of user experiences and training for community health agents at the local level.

8. **The ESSA concluded that the national and sectoral E&S existing systems are adequate and have the capacity to manage the E&S risks and impacts of the Program. The E&S systems applicable to the Program are reasonably aligned with the core principles and key planning elements set out in the PforR Financing Policy and Directive.** Chile has a well-developed legal and regulatory framework on general and sectoral E&S matters, as well as an institutional framework with clear, delimited functions and resources to implement E&S management. The E&S systems applicable to the Program activities incorporate recognized elements of good practices in E&S assessment and management. Regarding the management of risks and impacts of civil works, it is expected that the small-scale infrastructure constructions considered in the Program will not require an environmental assessment under Chile's environmental

impact assessment system, according to Law No. 19,300 on General Environmental Rules and its regulations. However, construction will have to comply with the pertinent national, regional, and local EHS regulations required by the competent authorities, such as the Waste Management from Healthcare Establishments Regulation, the Health Code, MoH regulations for the storage of hazardous substances, the Regulation on Basic Sanitary and Environmental Conditions in Workplaces, and local regulations required by atmospheric decontamination plans, among others. The Health Services Entities dependent on the MoH, which will be in charge of the construction of the new PHFs, will process the bidding documents for the new works, and these documents will include technical specifications for the E&S management and supervision of the works, where the contractors will be required to comply with the relevant EHS regulations, and to have EHS risks specialists to execute EHS prevention, mitigation, and control measures during construction. A technical works inspector accredited by the Ministry of Housing and Urban Planning will supervise these measures. During operation, the municipalities in charge of the new PHFs, through their respective environmental directorates, will have to manage and supervise the compliance of these new PHFs with the necessary waste management and EHS regulations. The SEREMIs have specialized departments and units to supervise and address issues of environmental quality (air, waste, chemicals, and contaminated sites) and occupational health for any project in the country, and they will also oversee the compliance of the EHS matters during the operation of the PHFs.

9. Regarding the Program interventions with social impact, MoH has divisions, departments, and units in its two sub-secretariats responsible for designing, disseminating, and supervising public policies aimed at safeguarding the universal right to healthcare and access to decent and quality services, in addition to having mechanisms for citizen consultation and participation, and for resolving complaints. Thus, health programs at the primary care level are monitored by the Undersecretariat of Social Evaluation of the Ministry of Social Development and the Budget Directorate of the Ministry of Finance within the framework of the Monitoring System of the State Programmatic Offer, which analyzes their efficiency, effectiveness and targeting.

ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
The MoH shall assess citizen perceptions of PHC and conduct a study of the demand for PHC services, and thereby enable results under RA1.	Technical	DLI 1.2	MoH	Due Date	31-Dec-2024	Reports about the studies on the citizen's perception of PHC and the study the demand for PHC services.
The MoH shall identify support alternatives for ECICEP at the municipality and PHC facility levels and thereby enable results under RA1.	Technical	DLI 3	MoH	Recurrent	Continuous	Reports of activities supporting ECICEP implementation at the municipality and PHC facility levels.
The MoH shall analyze the new functions and roles that a resilient PHC should develop to prevent, prepare for, respond and adapt to future PHEs and climate change risks.	Technical	DLI 5	MoH	Due Date	30-Jun-2025	Report and dialogue activities related to PHC and resilience in Chile.
The MoH shall present a proposal for a system using artificial intelligence to schedule TeleSalud appointments and manage demand for these TeleSalud services, thereby enabling results under RA3.	Technical	DLI 8	MoH	Due Date	31-Mar-2025	Evaluation of piloting of a system using artificial intelligence to schedule TeleSalud appointments and manage demand for these TeleSalud services.
The MoH shall conduct a review of professional career paths at the municipal level and	Technical	DLI 7	MoH	Due Date	31-Dec-2024	Report on the review of professional career paths at the municipal level.

thereby enable DLI 7.1, as the cost of providing PHC services is largely determined by the cost of the human resources involved in the provision.						
The MoH shall operate and maintain, throughout Program implementation, a team within the MoH responsible for coordinating and monitoring the implementation of the strategic activities supported under the Program.	Technical		MoH	Recurrent	Continuous	Coordination and Monitoring Team is in place throughout the implementation of the PforR.
The MoH shall define the function, roles and responsibilities of the PCT with respect to the FM and control procedures for the Program's execution, administration, reporting and auditing in the Operation Manual.	Fiduciary Systems		MoH	Due Date	29-Dec-2023	Section of financial aspects completed in the Operation Manual.
The MoH shall ensure that no expenses under the Program arise from a contract awarded to a company or individual debarred or suspended by the WB. (Compliance with the eligibility requirements related to fraud and corruption (according to the WB ACGs)	Fiduciary Systems		MoH	Other	Throughout Program Implementation	List of contracts awarded to firms and individuals is sent to the WB annually.
The MoH shall	Fiduciary		MoH	Other	Throughout	Inclusion of the WB's ACGs

ensure the inclusion of the WB's ACGs fraud and corruption provisions, as appropriate, in the bidding documents and contracts.	Systems				Program Implementation	fraud and corruption provisions in the bidding documents and contracts.
The MoH shall inform the WB of allegations of fraud and corruption and provide information requested.	Fiduciary Systems		MoH	Other	Biannually throughout Program Implementation	Full information, records and documentation on the case submitted to the WB as the WB may request.
The MoH shall appoint within the PCT a FM specialist.	Fiduciary Systems		MoH	Due Date	31-Mar-2024	Notice of appointment of FM specialist.
The MoH shall appoint within the PCT a procurement specialist.	Fiduciary Systems		MoH	Due Date	31-Mar-2024	Notice of appointment of the procurement specialist.
The MoH shall appoint within the PCT an environmental specialist, with experience in occupational health and safety, as a focal point for RA2 to facilitate inter-institutional coordination.	Environmental and Social Systems		MoH	Due Date	31-Mar-2024	Notice of appointment of the environment specialist for the PCT.
The MoH shall appoint within the PCT a social specialist, with experience in public policies with a human rights approach and a gender and inclusion perspective, as a focal point for RA1 and 3 to facilitate inter-institutional coordination.	Environmental and Social Systems		MoH	Due Date	31-Mar-2024	Notice of appointment of the social specialist for the PCT.

ANNEX 7. IMPLEMENTATION SUPPORT PLAN

1. **The Implementation Support Plan is in line with the WB's PforR operational guidelines.** The Borrower is responsible for implementing all Program activities in support of achievement of the agreed DLIs and resolving bottlenecks identified in the fiduciary and E&S assessments. The WB will tailor implementation support in technical, fiduciary, E&S aspects to ensure the following:

(a) Review the Program implementation progress, and achievement of Program results, monitor and help the Borrower as needed with institutional capacity building and implementation issues;
(b) Provide technical advice to the implementation of the activities under the RAs as needed, the achievement of DLIs and the implementation of the PAP;
(c) Advise and review documentation prior to serving as evidence for the fulfillment of DLIs as may be appropriate (e.g., certification and accreditation manuals);
(d) Monitor compliance with legal agreements, keep records of risks and propose remedy actions to improve Program performance, if and as needed;
(e) Provide support in resolving any operational issues pertaining to the Program;
(f) Monitor the performance of fiduciary systems, potential changes in fiduciary risks of the Program.
(g) Monitor the Program financial statement preparation process and assist the Borrower as necessary; and,
(h) Review the Program annual financial audit report and discuss with the Borrower. Monitor the implementation of the auditor's recommendation and assess changes in fiduciary performance of the Program and propose remedial actions, as needed.

Main focus of Implementation Support

Time	Focus	Skills Needed	Resources Estimate	Partner Role
First twelve months	1. Operation Manual 2. Result and Monitoring Reports 3. IFRs 4. Documentation for submission of DLI's evidence according verification protocols 5. TA for the initial milestones of DLIs 6. Fiduciary 7. E&S	1. Operations and implementation support 2. M&E 3. Health financing 4. Health information systems 5. Quality of care 6. Fiduciary 7. Environmental (climate change) and social (Gender)	Three visits of the core team to review the Operation Manual and train on PforR implementation. TA support as needed by specialty areas	None expected.
12-48 months	1. Program operation and process 2. M&E 3. Health information system and big data 4. Documentation for submission of DLI's evidence	1. Operations and implementation support 2. M&E 3. Health financing 4. Health information systems	Regular supervision visits TA support as needed by specialty areas	None expected.

	according verification protocols 5. TA for the annual DLIs milestones and for implementing the activities under each RA 6. Fiduciary 7. E&S	5. Quality of care 6. Fiduciary 7. Environmental (climate change) and social (Gender)		
Mid-term review	Assessment of Program achievement at midterm, Potential restructuring	Operation, M&E, Program evaluation, Fiduciary, E&S systems expertise	Conduct visit for mid-term assessment	None expected.
Completion (last 12 months)	Technical, operational, fiduciary, E&S	Program management, M&E for preparing closing reports, fiduciary, and E&S specialists	Two visits ICR	None expected.

2. The WB's core task team will include the task team leaders (senior health specialist and senior economist), technical specialists (health specialists and economists), and procurement, FM, and E&S specialists. Team members are based in the country to provide prompt support and follow up on implementation of the Program. Other WB experts will be drawn upon as needed.

Task Team Skills Mix Requirements for Implementation Support (Per Year)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Senior Health Specialist (Task Team Leader)	10	2-3	Country based
Senior Economist (Task Team Leader)	10	2-3	Country based
Health Specialist	5	2-3	Region based
Senior Health Specialist	3	2-3	Region based
Technical Consultants (PHC, resilience, payment mechanisms, quality of care, benefit package design, and health information systems and digital tools)	As required	As required	International and in-country
Procurement Specialist	5	2	Region based
FM Specialist	5	2	Region based
Environment Specialist	3	2	Region based
Social Specialist	3	2	Region based