Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 16-Aug-2023 | Report No: PIDA276039

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Chile	P179785	Chile: Program for Universal Primary Healthcare Coverage and Resilience	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	29-Aug-2023	25-Oct-2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Republic of Chile	Ministry of Health	

Proposed Program Development Objective(s)

The Program's PDOs are to improve coverage, quality, and efficiency of PHC and the health system's resilience.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	2,307.53
Total Operation Cost	200.00
Total Program Cost	199.50
Other Costs	0.50
Total Financing	200.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	200.00
World Bank Lending	200.00

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Chile is in a social and political transition to build a more equitable society**. This was marked by massive protests and bursts of social demonstrations throughout the country starting in October 2019. Protesters' demands included better access to quality social services such as health, education, and pensions. An agreement signed by a wide spectrum of the political establishment in November 2019 charted a path towards a new constitution as the existing constitutional framework, originated under the 1970-80s dictatorship, was seen as an obstacle to enabling the required social and political consensus. In December 2021, Chile elected its youngest and most left leaning candidate since the return to democracy with a mandate to deliver greater equity. On September 4, 2022, Chile held a referendum on the draft constitution prepared by a democratically elected, gender balanced and indigenous inclusive convention. Reflecting a sense that the document overstepped the public demands, 62 percent of voters rejected the Convention's constitutional proposal. A second election process was held in May 2023 that elected a new Constitutional Convention, which 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 referendum will be held to accept or reject the proposed Constitutional text.

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) slightly increased to eight percent in 2020, meaning that over 1.5 million people were considered poor in 2020. However, using the national definition of poverty, 10.8 percent of the population (more than 2.1 million people) were living in poverty in 2020. The pandemic also reversed gains in shared prosperity in the country. The average per-capita income of the bottom 40 percent of the income distribution grew by 1.9 percent annually between 2015 and 2020, while the average per-capita income nationwide grew by 2.5 percent. Accordingly, the Gini index increased to 44.9 percent in 2020. High-Frequency Phone Surveys 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 deceleration started in 2022.** High inflation has triggered fast monetary tightening. Real Gross Domestic Product (GDP) growth peaked in the third quarter of 2021. After growing 11.7 percent year-on-year in 2021, GDP is expected to grow 1.8 percent in 2022 and contract 0.5 percent in 2023, while a gradual acceleration is expected afterwards. Inflation accelerated to 13.1 percent year-on-year in July 2022, the highest reading since 1994. Inflation started to increase mid-2021, driven by strong demand pressures amid an overheated economy. High energy prices and global supply shocks added new price pressures. Since the start of the Ukraine war, inflation drivers switched to a larger contribution from food prices. In response, the Central Bank hiked interest rates from 0.5 to 9.75 percent in one year. Inflation remained high in the second half of 2022, further fueled by the recent currency depreciation. Pressures would wane in 2023, as macroeconomic imbalances are addressed, and the external shock subsides. Chile and its economy are highly vulnerable to climate change (e.g., through wildfires

during hot spells) and according to the Global Climate Risk Index 2021, the country is in the top 25 of countries most vulnerable from extreme weather changes.[1]

4. **Progress has been made in shared prosperity, but Chile's Multidimensional Poverty Index 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 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.

Sectoral and Institutional Context

5. **Chile has some of the best health outcomes in Latin America & the Caribbean and a long history of successful health sector reforms, but the country faces new challenges in achieving Universal Health Coverage due to a significant shift in disease burden towards non-communicable diseases (NCDs).** Despite considerable improvements in recent decades, the health status of the population remains consistently below the OECD average.

6. **Health outcomes in Chile are also characterized by major inequalities, with individuals of lower socioeconomic status more likely to experience worse health indicators and higher multimorbidity**. 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 those with public health insurance compared to those with private insurance.

7. **The unequal distribution of resources between the public and private subsectors contributes to Chile's large health outcome inequalities.** Additionally, the configuration of the bipartite health insurance model results in an underinvestment in preventive care and PHC in the private sector, and a concentration of patients with worse health in the public sector**.** Chile's health system is financed by 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, almost 20 percent of the population are insured by one of the seven ISAPREs. ISAPREs charge individual risk-based insurance premiums, thereby performing a risk selection of their insures. This practice has led to a significant segmentation of the population across subsystems, with most elderly and chronically sick patients covered by FONASA because they cannot afford the risk-based premiums of an ISAPRE or would not be accepted by another ISAPRE due to existing conditions.

8. **ISAPREs have had limited incentives to invest in prevention and public health programs because most elderly patients are covered by FONASA, and ISAPREs used to manage their insurees' health risks by adjusting insurance premiums.** As in many countries, a hospital-centric care model has been sustained in the health sector,

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

particularly in the private sector where hospitals are perceived as providing high-quality care This perception leads to frustration amongst the population when hospital care is not available (e.g., due to insufficient supply) resulting in a perceived need for more specialists. As a result, ISAPRE beneficiaries make greater use of services such as specialist visits, dental care, imaging, and hospitalization. In contrast, FONASA beneficiaries have free (i.e., without any copayments) access to public PHC, but about 1.5 million FONASA members are not enrolled with a PHC facility, and FONASA members frequently skip PHC and instead visit emergency care departments.

9. **The health system in Chile does not meet the expectations and needs of FONASA and ISAPRE affiliates in terms of financial protection, quality of care, accessible and timely health care, and dignified treatment.** 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 global 70 percent OECD and 55 percent LAC averages.[2] Waiting times for healthcare is the primary source of dissatisfaction for both FONASA affiliates and ISAPRE insurees. Discrimination is also common among minorities, especially the LGBTIQA+ community, A significant percentage of the LGBTIQA+ respondents report feeling discriminated against by medical personnel, and many have not received necessary healthcare services due to fear of discrimination[3].

10. **The current governance and financing models for PHC also lead to an inefficient and untransparent use and allocation of resources, hindering the public service delivery system from becoming more PHC-centric and focused on prevention.** PHC in Chile is largely public, including the funding devoted to it. 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: (i) outdated per capita calculation methodology, (ii) limited capacity to adjust capitations to the epidemiological reality in various parts of the country, and (iii) 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 also threatens Chile's population, as the country's unique geography and topographical features result in a wide range of climates and environments that are highly exposed and vulnerable to multiple hazards.[4]** In recent years, events of intense rains in the north of the country have caused respiratory diseases, diseases caused by the consumption of contaminated water and food, resulting in loss of lives and economic losses for the affected population[5]. Between 1965–2019, 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, could expose Chile to increased periods of drought. Furthermore, rising average

[2] 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).

[3] 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).

[4] https://climateknowledgeportal.worldbank.org/sites/default/files/2021-07/15916-WB_Chile%20Country%20Profile-WEB%20%281%29.pdf

[5] 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/

temperatures and a higher likelihood of acute pollution episodes in the central part of the country are expected to lead to increases in cardio-respiratory and allergic diseases.[6] For example, in 2018, over nine million people were exposed to high concentrations of fine particulate matter above the annual limit value for PM2.5. In this context, PHC will be critical to prevent, detect and treat NCDs.

12. **The Government of Chile began to design of a major reform of the national health system in 2022, with the Universal PHC program as the most widely supported component.** The Health System Reform is structured in five fundamental axes that comprise the Universal Health System: the institutional strengthening of the health authority; the establishment of a Universal Health Fund (single-payer model); the regulation of the Voluntary Health Insurance market that will provide complementary/supplementary private insurance; a reform of the Preventive Medicine and Disability Commission; and the implementation of the Universal PHC system. The Universal PHC component of the reform enjoys broad technical and political support and is the most advanced, with the National Commission for the Universal PHC created in July 2022., Since then, the main PHC guidelines have been established, together with an implementation strategy that promotes the availability of comprehensive and timely high-quality PHC services.

Program-for-Results (PforR) Scope

13. **The PforR will support the Universal PHC program over the four-year period of 01/01/2024 to 12/31/2027[7]** 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 government program targets both the population currently not covered by FONASA (i.e., mainly ISAPRE insurees and Armed and Security Forces affiliates), as well as the population covered by FONASA that does not use any PHC services and 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 ISAPRE members. Thereby the government program will mainly benefit the former.

14. **The MoH has assigned an initial budget for each of the four strategic lines of the Universal PHC program.** The Program is designed with the following four objectives: (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 that supports the PHC strategy. The program has a projected budget of US$2308 million, which annually represents about 11.3 percent of the country's budget for PHC.

15. **The Universal PHC program is being implemented progressively over several years, based on analytical work that lays the basis for the strategy's rollout.** The Universal PHC program has begun implementation with a pilot in seven municipalities as of 2023. These pilot municipalities have been chosen following a 'scalability strategy,' which sets the way forward in a way that the lessons from the pilot can offer the most insights about the future feasibility and implementation (e.g., regulatory aspects, resource needs, the functioning of the healthcare network). Also, 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

[6] https://mma.gob.cl/wp-content/uploads/2017/02/Plan-de-Adaptacion-al-CC-para-Salud-Version-Final.pdf
[7] Closing date of the PforR by June 30, 2028.

not) or the availability of service delivery infrastructure in PHC. At present, there is no other external financing for the health sector.

16. **RA1 - Coverage and Quality of PHC:** This RA focuses on establishing a new model of care where all people[8], regardless of their health insurance status, are effectively covered by PHC and can access quality PHC services. This RA would: (a) close gaps in the quality of care, with a special focus on the prevention and control of NCDs and the care needs of women and persons identifying as LGBTIQA+; (b) strengthen the implementation of a new Comprehensive People-Centered Care Strategy (*Estrategia de Cuidado Integral Centrado en las Personas*, ECICEP), a new Health Benefits Package, and a patient navigation system; and (c) support strategies to improve citizen participation in decision making.

17. **RA2 - Resilient PHC:** This area focuses on strengthening PHC to build a resilient health system that can effectively respond to, and withstand, future public health emergencies such as epidemics and pandemics, as well as climate change consequences, natural disasters, fragility, conflict, and violence. The aim is to incorporate lessons learned from the COVID-19 pandemic. Activities mainly include developing a guide for 'Surveillance of Public Health Emergency Risks and Climate Change in Universal PHC', training staff for Emergency Risk Surveillance, creating "Comprehensive Response Teams" appointed and georeferenced to participating municipalities, and designing and constructing a new infrastructure model that is adjusted to climate-related hazard exposure, geographic distribution, and energy efficiency standards.

18. **RA3 - Efficient and transparent PHC:** This area focuses on improving the use of resources in healthcare, leading to more efficient and effective care. Activities would include: (a) modernizing the allocation of PHC funding based on health and social risks, (b) training municipal PHC managers to develop effective leadership and PHC budget execution skills, (c) developing and implementing an interoperable referral and counter-referral digital system between PHC facilities and their correspondent hospital network, and (d) generating a dual virtual health management platform. This platform, which includes a web portal and mobile app, will allow citizens to access their health and health services information, schedule appointments, receive reminders and information about healthy lifestyles, and evaluate PHC services received. It is also expected that: (a) an evaluation framework will be built with sentinel indicators of health and epidemiological management for decision-makers at the local level and central levels; and (b) the PHC accreditation model will be changed to create a single comprehensive performance evaluation instrument.

Table 1. Boundaries of the PforR vs. the Government's program

	Government program	Program supported by the 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	Support investments and activities aimed at improving the equitable coverage and quality of PHC, improving the contribution of PHC to a resilient health system,	Government and PforR objectives are aligned. PforR will support most of the activities of the Government program (see Annex 3)

[8] including FONASA non-registered, non-FONASA and other special care groups, such as migrant and incarcerated populations.

	the use of resources for PHC and implement a performance M&E framework	and obtaining efficiency gains in the use of resources for PHC	
Duration	2023-2029	01/01/2024 to 12/31/2027	The PforR supports the initial phase of the government program based on available funding.
Geographic coverage	Incremental per year, with the aim of reaching the whole country by 2029. Some actions, however, will have a national impact starting in 2025.	Mainly 187 municipalities, with some actions throughout the country.	The PforR supports the initial phase of the government program based on available funding.
Results areas	Areas 1 to 3	Areas 1 to 3	N/A
Overall Financing	USD 2308 million	USD 200 million	The PforR supports key transformation aspects of the government program

C. Proposed Program Development Objective(s)

19. **The PDOs of the Program are to support improvements in: (a) the equitable coverage and quality of PHC, (b) the contribution of PHC to a resilient health system, and (c) the efficiency and transparency of the use of resources for PHC.** The PforR would primarily benefit those people living in the areas where the Universal PHC program is subsequently being implemented, but certain transversal activities will benefit the entire population of almost 20 million people[9].

20. **The proposed Program Development Indicators (PDIs) 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 multi morbidity in Participating municipalities.

(b) for the contribution of primary healthcare to health system resilience: Participating municipalities have a Health Sectorial plan (which includes a Public Health Emergency and Climate Change Risk Surveillance)

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

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

Program Development Objective(s)

21. The PDOs of the Program are to support improvements in: (i) the equitable coverage and quality of PHC, (ii) the contribution of PHC to a resilient health system, and (iii) the efficiency and transparency of the use of resources for PHC.

D. Environmental and Social Effects

22. **The WB carried out an Environment and Social Systems Assessment (ESSA) as per the WB Policy – PforR Financing (OPS 5.04-POL 107)**, that is currently in a draft version for consultations**.** The draft ESSA provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. The ESSA describes the extent to which the applicable government environmental and social policies, legislation, program procedures and institutional systems are consistent with the core principles of OPS 5.04-POL 107. Finally, the ESSA includes recommendations and Program Action Plans to address the gaps and to enhance performance during Program implementation.

23. The methodology for the preparation of the draft ESSA report consisted of: (i) 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; (ii) meetings with representatives of the government agencies involved and associated with the E&S aspects related to the Program; (iii) a field visit to two types of primary care facilities; and (iv) socialization and validation of the analysis and obtained results with relevant government officials within MoH. Following the appraisal step for the operation, the draft ESSA report will be further consulted on among relevant stakeholders, and the final ESSA report will be prepared reflecting relevant comments and observations from these consultations. The final report will be disclosed prior to Board approval on the MoH and World Bank websites.

E. Financing

Table 2. Program Financing

Sources	Amount (USD Million)	% of Total
Counterpart Funding	**1,413.47**	**82.49**
Borrower/Recipient	1,413.47	82.49
International Bank for Reconstruction and Development (IBRD)	**300.00**	**17.51**
Total Program Financing	**2.307.53**	

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Borrower/Client/Recipient

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Implementing Agencies

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