
WHO Special Programme on Primary Health Care

Chile case study



WHO/DGO/EVL/2024.5

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1. Purpose

Three country case studies (in Chile, Kenya and Tajikistan) were conducted as part of the preliminary evaluation of the WHO Special Programme on Primary Health Care (SP-PHC).

The overall purpose of the case studies was twofold:

- 1. To generate evidence for the evaluation questions, including opportunities to strengthen the SP-PHC support to countries in achieving the objectives and mandate; and**
- 2. To generate learning on how SP-PHC is working in practice to support countries in operationalizing selected strategic and operational levers of the WHO/UNICEF Operational Framework for Primary Health Care (PHC) (1), and/or how SP-PHC has applied an innovative approach or best practice, which could be learned and replicated elsewhere.**

This case study in Chile focused on the following two strategic levers of the WHO/UNICEF PHC Operational Framework during the implementation period 2022–2023: “Political Commitment and Leadership” and “Governance and Policy Frameworks”. This included examining how support from the three levels of the Organization (WHO headquarters, Pan American Health Organization (PAHO)/WHO Regional Office for the Americas and PAHO/WHO Chile Country Office)^a has been coordinated and operationalized. The case study also explored how, through these two strategic levers, catalytic actions have been planned and implemented in relation to other operational levers, in particular “Models of care”.

The specific levers were agreed upon through a collaborative process involving key stakeholders. Criteria included the potential to harvest wisdom on best practices and/or current challenges from country experiences (even if not yet related to SP-PHC support) that were relevant to WHO’s work in supporting other countries or in collaborating with Chile in the future.

^a PAHO wears two institutional hats: it is the specialized health agency of the Inter-American System and also serves as Regional Office for the Americas of the World Health Organization (WHO), the specialized health agency of the United Nations.

2. Methods and approach

2.1 Data collection and analysis

The case study used mainly qualitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews (KIIs) undertaken from 21–25 August 2023 with key stakeholders from national and subnational levels involved in PHC.

Key stakeholders were purposely selected to take part in KIIs to collect relevant evidence and information and to encourage experience sharing for learning. Altogether, 14 one-on-one interviews with key informants (KIs) were conducted. 10 KIs were external to WHO. These included representatives from the Ministry of Health (MoH) involved in the Health Reform, members of the different bodies advising the Health Reform (Universalization of PHC and Health Sector Reform councils) and informants from the academic world, National Health Fund (FONASA) and Chilean Municipalities Association. Additional information on KIs is available upon request to the WHO Evaluation Office.

KIIs were conducted using a semi-structured interview guide that listed a predetermined set of questions related to the themes of this country case study. The interview guides (internal/external to WHO/PAHO) are available in Annex 2.

Data from KIIs were recorded in notes, analysed, and organized according to themes and content. Analytical approaches included data triangulation and content analysis.

The best practices and learnings were explored with emphasis on key enablers, critical factors, specific results, and their potential for replication, scale-up and sustainability.

2.2 Limitations

The SP-PHC was established in 2020, the year the COVID-19 pandemic started. Furthermore, contacts between the SP-PHC and the MoH Chile started in May 2022, 16 months prior to the country case study visit. This time period saw large political setbacks for President Boric's Government, who came to power in March 2022 (2, 3).^b The president brought with him an agenda of drastic social reforms, including a fiscal reform and the intention to pool funding through a National Health Fund (4), which was part of the proposal for a new constitution. This was rejected by a referendum. The political setbacks on these two agenda points occurred within six months of the new government investiture. This obliged the actors, including the PAHO/WHO and the SP-PHC as a whole, to change strategy and adapt to the situation in support of PHC. The short timeframe and challenging period mean that the outcomes or impact of the support provided by the SP-PHC cannot be confidently assessed. However, some concrete outputs were achieved, highlighting good practices and lessons learned.

^b The chamber of deputies rejected a tax bill in March 2023 that would have financed social programs to reduce inequality and boost social services — the key policies that swept Boric into office.

Both the number of KIs and the time dedicated to undertaking this case study were limited. The study used a purposive sampling strategy by which KIs were selected to bring forward perceptions on the selected themes and learnings to be documented from a variety of stakeholders. At least one KI per key area of interest was interviewed. This approach, however, has an inherent risk of bias, particularly observer bias^c and selection bias. The study applied standardized tools for data collection and triangulated evidence in an effort to mitigate bias; however, bias might not have been completely eliminated.

Primary Health Care service users were purposefully not interviewed as the case study focused on the strategic levers of the operational framework, “Political Commitment and Leadership” and “Governance and Policy Frameworks”. An interview with the SP-PHC and with Universal Health Coverage Partnership (UHC-P) at WHO Headquarters about their support to Chile would have provided a more complete picture but was not pursued as the evaluation focused on the country perspective. A few national actors were not available for interviews, such as the current Minister of Health, who was managing the health crisis following heavy flooding in central Chile.

Interpretation of report findings should take into consideration these limitations. Nevertheless, important information, learnings, opportunities and gaps are presented in this report.

3. Background

3.1 Government of Chile’s progress on PHC for UHC (c)

The Chilean health system is a mixed public and private system for financing, insurance and service provision. Seventy-eight percent of the population receives health services through the public and solidarity-based insurer FONASA and 14% through the private health insurers, the Instituciones de Salud Previsional (private insurance institutions, ISAPRES).

The health sector is coordinated by the National Health Services System (NHSS). The NHSS consists of the Minsal (MoH), the Network of Health Services, FONASA (the public insurance fund), ISP Services (laboratories), Cenabast (the Central Supply Centre of the National Health Services System) and the institutions under agreement.

The provision of health care services is the responsibility of the 29 Health Services (decentralized state agencies under the supervision of the MoH), which are distributed throughout the country, and of municipal primary care services. They are responsible for carrying out integrated health actions ranging from health promotion and protection to treatment, rehabilitation and palliative care.

^c Observer bias: researcher’s expectations, opinions or prejudices influence what they perceive or record in a study.

In turn, the Health Care Network of each Health Service is made up of a set of public health care facilities, whose base are the municipal primary care facilities (Atención Primaria de Salud municipal, APS) in its territory. These are complemented by other public or private facilities that have agreements with the respective Health Service to carry out health actions.

The network of each territory is organized with a first level of primary care, which refers patients to a second or third level of the Health Service, according to the technical norms set by the MoH.

In the context of the 2005 Health Reform, PHC began to be implemented in Chile through the Integrated Health Care Model (MAIS), which is defined as

"A model of the relationship between the members of the health teams of the health system and individuals, their families and the community of a territory, in which people are placed at the center of the decision making, thus recognizing them as members of a diverse and complex sociocultural system, where its members are active in caring for their health and where the health system is organized according to the needs of its users, the best possible state of well-being, through comprehensive, timely, high quality and responsive health care across the entire network of providers, which is also socially and culturally accepted by the population, as it considers people's preferences, social participation in all of its actions including in the intersectoral actions, and the existence of indigenous health systems."^d

In this model, health is understood as a social good and the health network as the articulated action of the network of providers, the organized community and intersectoral organizations. This MAIS may be defined as a PHC-oriented model of care.

In Chile, primary care is implemented mostly through the municipal PHC mechanism, which is administered by the municipal health administration entities and their network. The resources allocated to the provision of public health care (municipal PHC and public hospitals) represented 66.9% of the total national health budget in 2017 (6), of which hospital spending accounts for 68.7% and PHC for 30.2%. Municipalities complement the financing of PHC.

Despite excellent progress in health indicators since 1990 (see Table 1), some inequalities persist in access and population outcomes (7, 8).^e

Table 1: Chile country profile (9)

Key demographic and health indicators 1990 and 2021		
	1990	2021
Population, total (millions)	13.34	19.49

^d Estado de la Atención Primaria de Salud en Chile Serie Minutas N° 34-22, 22/06/2022, (https://obtienearchivo.bcn.cl/obtienearchivo?id=repositorio/10221/33350/1/N_34_22_Estado_de_la_Atencion_Primary_de_Salud_en_Chile.pdf)

^e Ejes reforma 28/07 -- THIS IS NOT ENOUGH INFO FOR ME TO WRITE UP INTO A REFERENCE... Reforma al Sistema de Salud UNA AGENDA DE TRANSFORMACIONES (<https://www.minsal.cl/wp-content/uploads/2023/11/Documento-Reforma-251023.pdf>)

Key demographic and health indicators 1990 and 2021		
Poverty headcount ratio at US\$ 2.15 a day (2017 purchasing power parity) (% of population)	10.7	0.7
Gross national income (GNI) per capita, purchasing power parity (current international \$)	4200	26 680
Income share held by lowest 20%	3.4	5.5
Life expectancy at birth, total (years)	73	79
Fertility rate, total (births per woman)	2.6	1.5
Adolescent fertility rate (births per 1,000 women aged 15–19)	68	24
Births attended by skilled health staff (% of total)	99	100
Mortality rate, under-5s (per 1,000 live births)	19	7
Immunization, measles (% of children aged 12–23 months)	97	92
School enrolment, primary (% gross)	102.6	101.5
School enrolment, secondary (% gross)	74	104
School enrolment, primary and secondary (gross), gender parity index	1	1
Prevalence of HIV, total (% of population aged 15–49)	0.1	0.6
Gross domestic product growth (annual %)	3.3	11.7
Inflation, gross domestic product deflator (annual %)	22.5	6.8
Mobile phone subscriptions (per 100 people)	0.1	136.3
Individuals using the Internet (% of population)	0	90.2
Net migration (thousands)	-5	114
Personal remittances, received (current US\$) (millions)	0	66
Foreign direct investment, net inflows (current US\$) (millions)	661	15 933
Net official development assistance received (current US\$) (millions)	109.1	..

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 outcomes in the public sector. In fact, the private health insurance institutions (ISAPREs) charge individual risk-based insurance premiums, thereby performing a risk selection of those they insure. This practice has led to most elderly and chronically sick patients being 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.

The health system is also characterized by long waiting lists in the public sector, disarticulation of primary care with the rest of the care network, and clear insufficiencies in the care model for dealing with the problems of an aging population and the new epidemiological situation in which chronic degenerative diseases dominate. The burden of chronic diseases, including mental health and disability, is worsening in particular for people living in a situation of socioeconomic vulnerability (including migrants). Out-of-pocket and catastrophic health expenditures remain very high for the poorest population groups. Catastrophic health expenditures affect 4.1% of households in Chile each year, for whom health spending represents an average of 35.1% of their total expenditure.

The proposed Health Reform guaranteeing universal access to health is one of the four structural reforms proposed in the President Boric's Government Programme for the period 2022–2025. It emphasizes the development of an intersectoral health strategy at the local level, based on the PHC system, capable of ensuring universal access and zero

discrimination in the public health network, and focused on people and their diversities as well as the role of communities.^f The measures it proposes include some to modernize health management and to improve both access to the public health system and the efficiency of public spending in this area.

The Health Reform is guided by a Health Reform Advisory Board

The Government of Chile Programme for the Universalization of PHC is one of the fundamental steps to begin the transformation of the Chilean health system into a Universal Health System. It is the main strategy of the Government of Chile to improve effective and timely access to high-quality health services for the entire population. This Programme is advised by the National Council for Universal PHC.

The universal PHC programme has four objectives:

- (a) expanding effective coverage through PHC optimization
- (b) making PHC more resilient
- (c) improving the health and social care model, with dignity and quality
- (d) optimizing resources and implementing a performance monitoring and evaluation framework that supports the PHC strategy.

Implementation began in 2023 with pilot programmes in seven communes. These pioneering municipalities were chosen following a "scalability strategy", a roadmap for ensuring that the lessons of the pilot programmes can provide as much information as possible on future feasibility and implementation (e.g. on regulatory aspects, resource needs, the functioning of the health network). This will allow coverage to be increased annually to reach half of the communes by the end of the President's term. The seven municipalities also reflect the diversity and heterogeneity of Chile's different territories, including, but not limited to, location (urban versus rural), composition of the population (already covered/reached by PHC or not) and availability of infrastructure for delivering PHC (8).

The construction of a new social security system has been put on hold following the rejection of the fiscal reform. Nevertheless, the Chilean government took a step with establishing the "Co-Pago Cero" strategy. Since September 2022, all FONASA beneficiaries can attend the public system free of charge (no more co-payment), regardless of their income bracket. This makes public PHC and care in hospitals free of charge for an additional five million Chileans.

^f The 4 axes of the Health Reform are: Axis 1: Dignifying and modernizing the public health system; Axis 2: Guaranteeing universal PHC coverage; Axis 3: Generating equitable healthy living conditions; and Axis 4: Building a new social security system for health.

3.2 PAHO/WHO Country Office Chile structure, strategy and workstreams in relation to health systems, PHC approach and UHC

Historically, the PAHO/WHO Country Office in Chile has been connected to the WHO's PHC work, in particular since the Astana Conference and the development of the Operational Framework for PHC. Currently of the team of 20 persons in the PAHO/WHO Country Office, three (including the WHO Representative) work directly on PHC.

PAHO/WHO Chile Country Office and SP-PHC relations and interactions

From March 2022 onwards, the PAHO/WHO Chile Country Office health systems and services advisor and PAHO/WHO Representative have coordinated the Chilean delegation visit to the World Health Assembly in May 2022 (and again in May 2023) as well as the high-level visit of the Director, WHO SP-PHC and the Regional Health System and Services Director to Chile in August 2022. The PAHO/WHO Country Office in Chile has been following up on the commitments made during the high-level visit in August 2022. Cooperation grew closer in early 2023, with the appointment of a UHC-P grant to Chile and the invitation of the PAHO/WHO Chile Country Office health systems and services advisor by the SP-PHC to bi-monthly dialogues with the UHC-P (which since 2021 has been under the auspices of the SP-PHC) in Geneva. A US\$ 400,000 grant was allocated to be executed between June 2023 and December 2024, of which US\$ 130,000 have been received to date and US\$ 106,000 have been executed. The organization of the September 2023 United Nations General Assembly (UNGA) side event further strengthened the cooperation between the Country Office and the SP-PHC.

PAHO/WHO Chile Country Office support to the Chilean Government on PHC

The PAHO/WHO Chile Country Office has been supporting all four Health Sector Reform axes in Chile.

Efforts started in 2020 with the review and provision of recommendations to national authorities on the "Better FONASA" Law Proposal and the Policy Dialogues with key actors on the Health System challenges. When building a new social security system (Axis 4) became politically difficult following the rejection of the fiscal reform and the draft constitution, PAHO/WHO efforts were directed towards the other three reform axes, in particular the universalization of PHC, which has more political support. The universalization of PHC process uses the PHC operational framework; the UHC-P contribution is exclusively financial so far, channelled from the SP-PHC through the PAHO/WHO Regional Office for the Americas. The main responsibility for technical cooperation lies within the PAHO/WHO Chile Country Office team, with support from the PAHO/WHO Regional Office for the Americas.

In December 2022, the PAHO/WHO Chile Country Office and the PAHO Regional Office contributed to concept papers on the integrated health services networks and essential public health functions. Work also started on supporting the development of concrete models of care, as part of the concept of universal PHC, in very diverse settings (seven pilot

communes) in Chile. It is hoped that the success of these models (achieving population and health professionals' acceptance, health services utilization, mayors' approval, reduction of waiting lists, better management of noncommunicable diseases, etc.) will cement support for the universalization of PHC and for its financing.

PAHO/WHO Chile Country Office and the Regional Office for the Americas staff sit on the National Council for the Universalization of PHC and on the Health Sector Reform Advisory Board. They participate in all five Health Sector Reform working groups. The Chilean government has requested that they help synthesize and document the results of the five working groups for publication. PAHO/WHO Chile Country Office and Regional Office for the Americas also supported five decentralised regional and municipal "Consultation days", whose results still need to be synthesized and published. These working groups and regional and municipal consultation days all contributed to the strategic lever "Governance and Policy Frameworks".

Upon government request, PAHO/WHO offered three national consultants to strengthen the Health Reform and PHC national teams; international speakers to provide expertise on the various Health Reform areas; facilitators; and methodological approaches for consultation days. PAHO/WHO furthermore funded the participation of speakers in the working groups and consultations as well as logistical costs of the consultations, including simultaneous interpretation, travel of participants and food costs. However, these were not WHO SP-PHC allocated financial resources.

Technical assistance has been provided for the universalization of PHC in Chile in the following areas with PAHO/WHO Chile Country Office and Regional Office for the Americas resources; this technical assistance will be scaled-up with a recent UHC-P grant (channelled from the SP-PHC through the PAHO/WHO Regional Office for the Americas) in the seven pilot communes:

- 1. Integrated health services networks:** updating the health facilities list; prepared a mapping of networks and analysing availability and accessibility finalizing the tools for the network planning and operational programming model in the Biobio Health Services; technically assisting the adaptation of the model and tools used for planning and operational programming of demand, and strengthening referral and counter-referral processes (including liaison) in networks; technically assisting the implementation of the productive management methodology for health services examining hospitalizations for conditions amenable to outpatient management.
- 2. Tele triage – telemedicine (free application/training/scaling up):** implementing the Demand Management Model using Tele triage (Telehealth).
- 3. Rural health:** completing the situational diagnosis of the rural health programme; technically assisting the formulation of development plans to close the gaps; systematizing experiences, developing protocols and operating manuals for the implementation of care modalities at the community level.
- 4. Model of care and PHC strategy training (based on using the PAHO virtual campus):** generating training courses for priority topics and publishing them in the National Node of the Public Health Virtual Campus.
- 5. Communities of practices** (collaborative workspaces) that accompany the implementation of PHC universalization (free to use on the PAHO virtual campus).
- 6. Experience exchange with Costa Rica** (and also with Brazil in the near future).
- 7. Equity:** including the equity and social determinants of health approaches and intersectoral action for health, while working with local governments. Making online course for local governments available; developing a module for

health in the Local Social Management System, to include intersectoral interventions on social determinants of health and strengthening social participation.

8. One health fund (limited technical assistance) and PHC system financial efficiency: adapting new tools; technically assisting with revising, updating and costing the Family Health Plan; technically assisting with the “zero co-payment strategy”; proposing a visit to the WHO Barcelona Office for Health Systems Financing to learn about health systems financing.

3.3 Direct support received by Chile from the WHO SP-PHC since 2020

For this case study, it is important to note that in most cases the support to the Chilean government referred to in section 3.2 above came from the PAHO/WHO Country Office in Chile or the PAHO/WHO Regional Office for the Americas, and not the WHO SP-PHC as such. However, some activities directly involved or were initiated by the SP-PHC:

- The SP-PHC has engaged in policy dialogue with the Chilean MoH and other national health authorities on health system reform based on PHC.
- The SP-PHC has provided high-level political, policy and technical support, notably through a joint mission including the Director, SP-PHC and the Health Systems and Services Regional Director at the inception of these reforms. The three-level mission was organized to review and assist the formulation of technical guidance to the MoH on the reform agenda.
- UHC partnership funding. A US\$ 400,000 grant was allocated in 2023 to be executed between June 2023 and December 2024.
- The planning, technical assistance and partial financing of a UNGA side event session (September 2023).

4. Key findings

Key findings are reported against evaluation questions.

4.1 Design of the SP-PHC – Relevance and coherence

1 Design (relevance and coherence): These questions are concerned with the design of the SP-PHC and the extent to which the SP-PHC design and objectives respond to global, regional, country and partner needs, and support the achievement of the SP-PHC mandate. The coherence of the design, objectives and interventions of the SP-PHC and the

degree to which this supports the PHC approach internally within WHO and with external partners also need to be examined.

1.1. How relevant and appropriate is the design of the SP-PHC for achieving its aims and objectives and for supporting the wider aims of the GPW13?

Overall evidence strongly affirms that the design and objectives of the SP-PHC have responded to Chile's needs and are supporting the achievement of the wider aims of the GPW13.

- **Operationalization of the PHC Operational Framework (the SP-PHC “compass”)**

The PHC Operational Framework has been found to be very helpful in Chile for reflecting on the implementation of PHC universalization. The Operational Framework has also been a valuable analysis framework for all PAHO/WHO units, and for all PAHO/WHO country visits as a starting point for discussions and for concrete actions. It has additionally been useful for discussing differences in approaches to PHC, while respecting regional strategies. SP-PHC and PAHO have different points of view on the relative importance of reaching universal health coverage versus universal health access and the weight of the social determinants of health (10, 11)¹. In 2021, the PHC Operational Framework was translated into Spanish to make it more accessible for Hispanophone professionals and countries (12).

“Since 2022, there have been regular activities between PAHO/WHO Regional Office for the Americas and the SP-PHC to harmonize the framework, tools and technical assistance. The SP-PHC has been flexible and agile. It has clear objectives and expected results. It has supported the PAHO/WHO Regional Office for the Americas.”

PAHO/WHO Regional Office for the Americas and Chile Country Office consider the Operational Framework to be the SP-PHC compass. However, it needs to be more widely known and used by PAHO's numerous technical departments. The new PAHO Regional Director started this process in 2023, focusing on two priorities (out of five): 1. All the work undertaken by PAHO must be integrated within PHC, with the objective of overcoming the different silos existing within PAHO; and 2. All the work undertaken must relate to the transformation of health systems based on the PHC approach.

¹ In essence, universal health coverage is the obtainment of good health services de facto without fear of financial hardship. It cannot be attained unless both health services and financial risk protection systems are accessible, affordable and acceptable. Yet universal access, although necessary, is not sufficient. Coverage builds on access by ensuring actual receipt of services. Thus, universal health coverage and universal access to health services are complementary ideas. Without universal access, universal health coverage becomes an unreachable goal. Addressing the broader social determinants of health will also improve access to health services.

- **Communication and advocacy**

The high-level PHC engagement (WHO headquarters, PAHO/WHO Regional Office for the Americas and Chile Country Office) is seen in Chile as a strong advocacy instrument for the Chilean government's Health Reform.

The UNGA event (September 2023) matched the country and PAHO/WHO regional and global objectives. It was jointly organized by Chile and all three levels of the WHO. The PAHO/WHO Regional Director started the process in April 2023, seeing the UNGA meeting as an opportunity for advocacy on PHC. President Boric accepted the invitation to participate in a UNGA event about the importance of the PHC approach for health systems resilience (as was demonstrated during the pandemic in Chile). The first version of the concept note was developed by the Chilean government with contributions from PAHO. Following President Boric's visit to the WHO headquarters where he met the Director-General and the Director of the SP-PHC, a parallel event on PHC financing was discussed. After further coordination between the three WHO levels, the decision was taken to organize a single event. The concept note was then reviewed by the SP-PHC and the agenda worked out collaboratively between the three WHO levels and the Chilean authorities (Foreign Affairs and MoH). The event is expected to give visibility to Chile's Health Reform towards the universalization of PHC, at a global level. This will be of great value for Chile and for WHO/PAHO. Discussions on PHC financing are expected to be useful for the reform of the Health Fund in Chile.

- **Leadership, visibility (including how well the SP-PHC leverages the Director-General and senior leadership team of WHO to promote the work and vision of the SP-PHC)**

Since May 2022, the WHO Director-General, the PAHO/WHO Regional director and the PAHO/WHO Representative to Chile with their teams have consistently collaborated with the SP-PHC and UHC-P staff in WHO headquarters to respond to Chile's country needs. They have brought together different technical and financial resources (PAHO and UHC-P) to support Chile's Health Reform needs, including high level and decentralised policy dialogues, PAHO/WHO Regional Office for the Americas and Chile Country Office expertise, digital tools, national consultants, trainings and South-to-South learning strategies (Costa Rica, Brazil). These complementary regional and local resources have all contributed to the Health Reform in Chile. They would not have been dedicated if there was no consensus or synergy at the different levels of the Organization to achieve country impact, in line with the SP-PHC work and vision and the WHO GPW13.^h The SP-PHC supported the PAHO/WHO Regional Office for the Americas and the Country Office in achieving a common goal in Chile.

No evidence has been found that the following specific areas from the SP-PHC **Evidence and Innovation Unit of the SP-PHC** have directly responded to Chile's country needs:

- PHC measurement framework and indicators
- "implementation solutions"

^h The SP-PHC was created in 2020, in the context of wider WHO transformation, as a holistic cross-cutting platform to provide better integration of the PHC Approach across all levels of the Organization. As envisaged in the SP-PHC Manifesto, the programme is intended to be an "agile, integrated platform to connect the Triple Billion strategic goals, enhance technical coherence and synergies and thus present an opportunity for adopting a new way of working". Ref SP-PHC Manifesto: On the road to Universal Health Coverage [unpublished]. Geneva: World Health Organization; n.d. In this context, the SP-PHC is intended to provide a 'one stop' network for PHC implementation support to Member States. This support is based on an agile network approach across WHO's three levels of organization (country, regional and global), supporting the operationalization of the PHC approach and leveraging opportunities to reorient health systems. This is currently articulated through the SP-PHC's functions and three interrelated workstreams which continue to evolve.

- country case study compendium
- scaling Innovation

However, there is strong evidence that the PAHO/WHO Regional Office for the Americas and the Chile Country Office have supported Chile's needs through the PAHO virtual academy (which is the WHO academy branch in Latin America and the Caribbean) by establishing and scaling-up communities of practices, and through various trainings.

Limited evidence has been found that the **Policy and Partnership Unit of the SP-PHC** has directly responded to Chile's country needs. However, some activities were planned for August 2023 with the Barcelona WHO Country Office following Chile's initial request. These were delayed, first due to changing priorities within Chile's government and then due to other political considerations regarding the status of the Barcelona WHO Country Office.

Policy and Partnership Unit activities

- PHC-Accelerator/The Global Action Plan for Healthy Lives and Well-being for All (SDG3 Global Action Plan) and other partner engagement and collaboration, e.g. with UHC 2030
- PHC-Global Health Initiatives
- Living Partnerships for PHC, specifically Collaborating Centres on PHC
- Strategy Advisory Group on PHC

Strong evidence has been found that the **Country Impact Unit** responded to Chile country needs, namely through UHC-Partnership and Joint Working Teams; one network for putting into action the Operational Framework; and reinforcement of regional priorities.

First, through the attribution of a significant UHC-P grant in 2023 (US\$ 400,000). The August 2022 SP-PHC mission highlighted that the Health Reform would have to address several levers to be successful.² The UHC-P grant will support the following levers (13)³ towards the universalization of PHC: Models of care, PHC workforce; funding and allocation of resources strategy for the pioneer (pilot) municipalities (see above, section 2.3)

Second, the establishment of new ways of working by the SP-PHC, directly involving the country level health systems and services advisors with the Geneva based UHC-P, has been innovative and responsive to PAHO suggestions. However, there are no Health Policy Advisers in the Region of the Americas. Through these regular working groups, the SP-PHC is more aware of the country situation, and the country office better understands the SP-PHC's work and vision.

1.2. How coherent is the design of the SP-PHC (its objectives, activities, products) "internally" across WHO at global, regional and country levels?

² A comprehensive approach to the reform is required, where multiple levers such as governance, financing, health workforce, determinants of health, digital technology, research, monitoring and evaluation work with each other in a synergetic manner. Managing technical levers within a process of political change in such a way that technical elements are configured at the right time in the right way will determine the success of the reform.

³ Apoyo UHC-P para Iniciativas Inter programáticas en País basadas en la Atención Primaria de Salud y Servicios de Salud Integrados – Plan de trabajo: Chile. (UHC-P support for in-country cross-programmatic initiatives based on Primary Health Care and Integrated Health Services – Workplan for Chile) [unpubl.]. Pan American Health Organization, 2022.

Strong evidence was found to conclude that the design features of the SP (its main activities supporting Chile) are coherent “internally” across WHO at regional and country levels, while also allowing for region and country contextualization. No dissenting voices were heard. PAHO/WHO Regional Office for the Americas is quite autonomous and has its own traditional approach to PHC. PAHO/WHO Regional Office for the Americas Technical Departments were referred to in some instances as working in silos. The PHC Operational Framework offers an opportunity to integrate the work of the Technical Departments and to further adjust the differing weight accorded to certain concepts (coverage versus access, social determinants of health).

1.3. How coherent is the design of the SP-PHC (its objectives, activities, products) “externally” with wider development partners and country partners (e.g. UNICEF, other UN agencies, Global Fund, GAVI, World Bank, governments, non-governmental organizations, civil society organizations, others)?

There was limited evidence that the design of the SP-PHC is coherent “externally” across Latin America and the Caribbean and Chile. Synergies with the World Bank have been achieved in Chile, led more by the government itself than by WHO-PAHO. Nothing notable has been achieved with UNICEF, other UN agencies, non-governmental organizations, civil society organizations, etc. All Kis agree that more attention needs to be given to these aspects. However, strong evidence has been found that the PHC Operational Framework has been very helpful in Chile to reflect on the implementation of PHC universalization.

4.2 Implementation – Efficiency and effectiveness of the SP-PHC

2: Implementation (efficiency and effectiveness): These questions are concerned with the implementation of the SP-PHC, including the efficient use of funds, progress implementing the SP-PHC activities, results achieved and key factors that are helping or hindering SP-PHC performance.

2.1 What evidence is there to suggest that resources are adequate for the SP-PHC to achieve its mandate?

The UHC-P grant is significant for achieving PHC in Chile. Without it, despite the support offered through different PAHO/ WHO funding sources, progress on PHC would be much more challenging and slower. The World Bank has provided a complementary four-year loan through the Program-for-Results Financing instrument to support the scaling up of the PHC models developed in the seven pilot *communes*. Nevertheless, there is still a need for funding to support developing governance and policy frameworks, models of care, local financing mechanisms, and to train, consult, inform, document and disseminate good practices nationally and internationally. This is where the UHC-P grant is significant. It is hard to quantify whether these resources will be adequate. However, for a high-income country to receive US\$ 400,000 over two years from the WHO/PAHO seems to underscore the importance attributed to achieving the PHC agenda in Chile. At this moment, no WHO Headquarters staff support Chile directly.

2.2 To what extent are SP-PHC activities being implemented as intended and achieving or expecting to achieve their objectives and results?

Activities have been implemented in a very short period of time while having to adapt to the complex national context with its changing priorities. The SP-PHC has demonstrated its agility and flexibility in reacting to Chile's change of focus from supporting the One National Health Fund to providing UHC-P funding to strengthen the PHC work in pilot *communes*; in the UNGA side event; and by including the health systems and services advisers to the Health Policy Advisers group).

At the moment, the national political context in Chile could prove challenging. However, there is high potential for the UHC-P and PAHO/WHO Regional Office investments (see above) to achieve results in the pilot *communes* in the short-term and at national level in the longer-term, in tune with the current and historical support provided by PAHO/WHO to PHC in Chile and the existing consensus on the importance of applying a PHC approach.

2.3 How efficiently are SP-PHC resources being utilized (e.g. are activities being implemented in a timely and economic way)?

No evidence has been gathered to confidently assess whether those activities are being implemented in an efficient way. However, the PAHO/WHO Regional Office and Country Office have been providing timely, concrete, relevant technical assistance, pulling resources (human and financial) from regional and country levels in line with the SP-PHC vision objectives and have obtained UHC-P funding through the SP-PHC to continue supporting the Health Reform, in particular PHC universalization. The UHC-P grant of US\$ 400,000 was allocated to be executed between June 2023 and December 2024. US\$ 130,000 have been received to date and US\$ 106,000 have been executed (as of 28 September 2023).

Table 2 Overview of SP-PHC financial support to Chile 2020–2023 via the UHC-P

Start and status of implementation of activity	LPHC operational framework ever	Description of activities and actual or potential achievements and results	Potential funding source (in US\$)
May 2023 to June 2024	Models of care	Model of care (health services utilization and improved resolution capacity) High potential for results in pilot <i>communes</i>	100,000 from UHC-P
May 2023 to June 2024	Models of care	Rural Health High potential for results	75,000 from UHC-P
May 2023 to December 2024	Models of care	Integrated health services networks High potential for results in pilot <i>communes</i>	75,000 from UHC-P
July 2023 to December 2024	Funding and allocation of resources	PHC financing and accountability High potential for results in pilot <i>communes</i>	50,000 from UHC-P
April 2023 to December 2024	PHC workforce	PHC teams' capacity building High potential for results in pilot <i>communes</i>	50,000 from UHC-P
April 2023 to December 2024	Models of care	% of noncommunicable diseases patients controlled High potential for results in pilot <i>communes</i>	50,000 from UHC-P

2.4 How is the SP-PHC adding value to the work of WHO and external partners at country level?

At this crucial political moment for PHC universalization in Chile and the UHC agenda for WHO, the SP-PHC has been adding much value to the Chilean government (technically, politically and financially) and to PAHO-WHO Regional Office for the Americas (strong operational framework, strong support). However, so far, the SP-PHC does not seem to have brought value to external partners, such as the Economic Commission for Latin America and the Caribbean or other UN agencies.

The World Bank will also be financing the coverage, quality and efficiency of PHC and health system resilience in Chile (loan of US\$ 200 for 2024–2027 to progressively increase the number of *communes* to 187). The complementarity of the World Bank support is managed by the government and not by

PAHO/WHO. World Bank and PAHO/WHO staff meet at “working tables” but no other links have been mentioned.

2.5 How sustainable are the interventions of the SP-PHC?

The interventions by the SP-PHC appear sustainable in the long run. The technical assistance provided builds upon government leadership, governance and ownership, and national plans. Human resources contracted by PAHO/WHO Regional Office for the Americas and Chile Country Office (national consultants) are temporary until the government’s budget is approved. Subsequently, they are expected to be absorbed by the MoH. These resources are crucial in bridging national budget periods and allowing the government to drive its agenda and show results.

The UHC-P funds build upon existing initiatives, strengthening and scaling them up. Again, this sustains progress and achieves results, which is crucial to government and WHO agendas. Developing a set of scalable models of care is likely to make the interventions of the SP-PHC sustainable.

Investment in professional training (technical and change management) for a PHC approach is a sustainable strategy as it builds a critical mass of professionals committed to the PHC approach, who will advocate for it and implement it.

Nevertheless, PHC universalization is political. If it is not embedded in the constitution, its progress may be hampered by changes in the government.

4.3 Gender, equity and human rights considerations

3. Gender, equity and human rights. This question is concerned with how well the SP-PHC is addressing the most vulnerable populations in its promotion of PHC.

3.1. How well has the SP-PHC supported the inclusion of gender, equity and human rights considerations across its core functions and technical products? (Examples and reflections)

All KIs mentioned that the gender, equity and human rights considerations are implicit in the PHC approach and the PHC operational framework. There was limited evidence to assess this component beyond this finding. Yet one example includes equity-based targets for access and coverage that are found under the

rural health interventions in the UHC-P grant. Isolated rural populations are considered to be living in conditions of vulnerability.

However, other equity, gender and human rights findings not related to the SP-PHC as such include the following: Evidence of recent training for Chilean PHC professionals on gender, equity and human rights is found in the PAHO virtual academy; PAHO Chile included equity and social determinants of health approaches while working on PHC with local governments; the Government Health Reform is itself based on the principles of equity, gender and lesbian, gay, bisexual, trans, intersex or queer equality and human rights. The World Bank has explicit gender, equity and human rights requirements linked to its funding.

4.4 Lessons learned and best practices related to advancing selected PHC levers in Chile

Strategic levers: “Political Commitment and Leadership” and “Governance and Policy Frameworks”.

Catalytic actions planned and implemented in relation to the operational lever “Models of care”.

Introduction/Background

Eighteen months after President Boric’s government came to power with its Health Sector Reform agenda, and following two important political setbacks, the MoH has learned some lessons and is better equipped. It has a clearer policy framework, good governance processes and relatively more resources to operationalize the Health Reform and develop more equitable, responsive, efficient and impactful models of care based on the PHC approach.

Lessons learned

- National political commitment and leadership are crucial. The donors and international institutions support the process but the government leads and owns it.
- The importance of participatory governance mechanisms and decentralized consultative-informative processes to input to the policy framework.
- More specifically, in Chile, PHC is in the hands of the municipalities. The MoH needs to pursue a dialogue with mayors and their teams.
- Strong conceptual and technical frameworks are needed to sustain a Health Reform.
- The PHC approach does not have to be uniform and should adapt to diverse geographies, communities and resources (while respecting its three principles).
- The health workforce needs to embrace and co-create the PHC approach in their geographies and communities with their local resources.

- Financial resources are required to implement a Health Reform (experts, studies, research, evaluations, publications, training, change management, processes of strategy and guideline development, citizen participation, construction of new infrastructures, etc.).

Best practices

Governance structures such as the National Council on the Universalization of the PHC and the Health Reform Advisory Board (with their working tables) have been set up and are offering the MoH multisectoral platforms. Their work will feed into new policies/strategies in support of PHC, while building consensus and partnerships within and across sectors such as unions, users and professional associations, academy, parliamentarians, mayors, etc.

The decentralised information and consultation days in the regions and at municipal level have been much appreciated. They provide a way to clarify concepts, express doubts, propose solutions and engage all actors, in particular the mayors, in favour of PHC universalization and other Health Reform axes.

The MoH has reached out to the SP-PHC at WHO Headquarters to help clarify ideas and concepts. The SP-PHC, PAHO/WHO Regional and Country offices have offered timely and relevant, concrete technical assistance, foreign experts' inputs, examples from other countries, etc., to strengthen the conceptual and technical frameworks. They also have offered catalytic financial support.

The MoH has chosen an incremental approach starting in diverse pilot communes to explore the feasibility of PHC universalization at local level and in different contexts, providing information on implementation needs and issues (e.g. regulatory aspects, resource needs, the functioning of the health network).

The authorities are not only investing in the training of health professionals (Health nodes) but also in change management (communities of practices), funding the learning process and offering dedicated time to the health workers to learn and share their experiences.

Results/expected results

The development of strong frameworks discussed and agreed upon through the governance structures and decentralized consultations should provide a solid basis for the implementation of the Health Reform and the universalization of PHC. The feedback from the governance structures and consultative processes will be incorporated into pragmatic draft policies and strategies.

The progressive piloting of PHC models in diverse settings, while resolving bottlenecks and sharing learnings, will also allow the MoH to build strong models that are more responsive to local needs and more efficient, impactful and acceptable. The ultimate objective is to make the universalization of PHC a reality, with adequate funding and population support. The ongoing processes are building arguments and evidence in support of the universalization of PHC and its financing.

Gaps and challenges

- The universalization of PHC should be embedded in the constitution or institutionalized in some form. However, Chile's new constitution is currently being drafted ; private and conservative interests are leading the changes, which could compromise the whole Health Reform. There are some safeguards in place, but it remains a fraught process.
- The rejection of the fiscal reform and the uncertainty about next year's health budget are a constraint.
- Working across competent teams, which do not always have the same ideas and represent different national geographies, challenges MoH authorities. However, they see themselves as learners.
- There needs to be social communication to change the mind of the population on the public sector and towards healthy lifestyle.

Obstacles

- Insufficient health infrastructures and land for these infrastructures;
- Insufficient human resources;
- Long waiting lists for health care;
- Limited understanding of the profound changes needed within the MoH;
- In certain sectors, partial demand for change from the biomedical model to an integrated preventative, promotional, curative, rehabilitative model of care that is centred on the family and the community; and
- Incoherence in health information systems between the different health systems and the health insurance schemes.

Potential of replication, scale-up and sustainability

The establishment of a renewed health system – resilient, responsive to the new epidemiological transition and population demand, more equitable and with sustainable financing based on solidarity, with improved governance and updated health care models – is meant to improve the health outcomes of all Chileans and the long-term sustainability of the health system. The conceptual and governance frameworks in place are solid. The proposed incremental, participatory and learning-based process has good potential for replication and scalability in Chile. The country is known to have successfully driven several health sector reforms. PHC enjoys broad technical and political support. Nevertheless, the Health Reform – including the universalization of PHC – may suffer from the changing political and economic climate and be delayed.

5. Conclusions and opportunities for future SP-PHC support to Chile

5.1 Conclusions

This case study covers the period from March 2022 to August 2023, a period that saw challenging political events unfold, which forced Health Reform to change priorities.

Overall, strong evidence confirms that the design and objectives of the SP-PHC have responded to Chile's needs and are supporting the achievement of the wider aims of the GPW13. The objectives have been described as “internally” coherent across PAHO/WHO at regional and country levels while allowing for regional and country contextualization. However, the objectives were found not to be “externally” articulated across the UN, donors, financing institutions and non-governmental actors, beyond the Chile government. This is a gap to be filled.

The PHC Operational Framework especially has been found to be conceptually very helpful for the MoH authorities and for the PAHO/WHO staff from the Regional Office and the Chile Country Office. However, there is still a need to make the Framework more widely known and more widely used by PAHO/WHO staff in the Region of the Americas.

The WHO Director-General, the PAHO/WHO Regional Director, the PAHO/WHO Representative to Chile and their teams are reported to have worked together consistently and synergistically with the SP-PHC and UHC-P staff in WHO Headquarters in responding to Chile's country needs since March 2022. This coordinated three-level support – from headquarters, the region and the country – has resulted in agile, coherent and relevant advocacy and policy, technical and financial support to Chile in line with the SP-PHC Manifesto.

Furthermore, the establishment of new ways of working by the SP-PHC by directly involving the country level health systems and services advisors with the Geneva-based UHC-P is considered innovative and responsive to PAHO suggestions. Through regular working groups, the SP-PHC is more aware of the country situation, and the WHO Country Office better understands the SP-PHC's work and vision.

Strong evidence was found that the PAHO virtual academy, which is the WHO academy branch in Latin America and the Caribbean, has been a strong tool for the training of health professionals and scaling-up of communities of practices in PHC.

The current national political context can be challenging. However, there is high potential for the investments made by the SP-PHC and PAHO/WHO Regional Office and Chile Country Office to achieve results in the short-term in the pilot *communes*. Likewise, the longer-term investments have good potential to achieve results at national level, in tune with the current and historical support provided by PAHO/WHO to PHC in Chile and the existing consensus on the importance of applying a PHC approach.

At this critical political moment for the universalization of PHC in Chile and the UHC agenda for WHO, the SP-PHC has added much value to the Chilean government (technically, politically and financially) and to

PAHO/WHO Regional Office for the Americas. The SP-PHC does not seem to have brought value to external partners, such as the Economic Commission for Latin America and the Caribbean or the wider UN.

The interventions by the SP-PHC seem sustainable in the long run. The technical assistance provided builds upon government leadership, ownership and national plans.

5.2 Opportunities for the SP-PHC to support Chile's PHC agenda

- continuing high-level political advocacy;
- sharing other countries' experiences related to PHC transformation;
- engaging all UN agencies in the PHC effort
- knowledge management: helping to digest the existing research on PHC
- donor management: assisting in coordinating donors' agendas, strategies and resource- mobilizing mechanisms to reduce the burden on small country teams, and supporting countries to develop quality proposals for different donors;
- mitigating the "distance" between WHO Headquarters and the country level by improving communication and mutual understanding;
- ensuring that reference literature is translated into Spanish, French and Portuguese in a timely fashion; and
- documenting Chile's PHC experience.

6. Annexes

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