



Comisión  
Nacional de  
**Evaluación y  
Productividad**

# EXECUTIVE SUMMARY

Efficiency in Primary Health Care Management

2022

## Efficiency in Primary Health Care Management

During the past 70 years, the health system in Chile reduced infant and maternal mortality (by 93% and 94%, respectively), childhood malnutrition in children under 5 (from 63% to 0.5%), and increased life expectancy from 50 to 80 years (one year more than the United States). However, despite these enormous advancements, obstacles and barriers prevent providing an efficient and effective health system at all levels of care.<sup>1</sup> Currently, the health system in Chile, particularly Primary Health Care (PHC), faces the challenge of problems specific to countries with a higher level of development. These are population aging and noncommunicable chronic diseases (NCDs). Evidence suggests that 11 million people in Chile currently suffer from at least two chronic diseases (56% of the population) and require effective and timely lifelong health care. In this sense, PHC should have the capacity to address the main health problems of the people in a preventive manner and be the gateway to the health system while also being the axis of development of health systems. In her seminal work, Dr. Barbara Starfield<sup>2</sup> outlines Primary Health Care (PHC) as a form of care that is characterized by four fundamental attributes:

1. **Accessibility and First Contact:** This underscores the importance of providing a health system that offers easy and timely access to all individuals.
2. **Continuity:** This feature highlights the need for establishing an ongoing relationship between patients and their clinical team, ensuring that care is consistent and tailored to the individual's evolving health needs.
3. **Comprehensiveness:** This attribute signifies the ability of the health system to address a broad range of common health issues within the community, providing holistic and comprehensive care.
4. **Coordination:** This involves effective collaboration between primary care physicians and specialists from various fields, ensuring a cohesive, multi-disciplinary approach to patient care.

Her work articulates these core principles as fundamental to effective and comprehensive primary healthcare delivery. However, evidence (both international and national) indicates that PHC has

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<sup>1</sup> As evidenced in the CNP study on Efficiency in Operating Rooms and Waiting List Management (2020).

<sup>2</sup> Starfield, B. (1994). Is primary care essential?

evolved in directions that do not achieve the expected health outcomes. Therefore, its contribution to equity and social justice could be more significant. Deficiencies in management and lack of coordination within the health sector and between it and other sectors had already been identified during the Alma Ata Conference.<sup>3</sup> It also needs to improve community participation in decision-making processes and financing problems. In this context, Chile is no exception. PHC in Chile shows gaps in human resources, coverage, competencies, and infrastructure, among others, with broad areas for improvement. In this backdrop, the Chilean Presidency, in September 2020, tasked the National Commission for Evaluation and Productivity with undertaking the study titled "Efficiency in the Management of Primary Health Care". This comprehensive examination offers an insightful diagnosis of the existing state of Primary Health Care, illuminates various gaps, and introduces an ensemble of 56 critical findings alongside 36 targeted recommendations. These recommendations aim to bring about significant enhancements in the management, infrastructure, and funding of Primary Health Care. Ultimately, this endeavor is expected to bolster the health system, fostering a conducive environment for the ongoing development and improvement of the well-being of the Chilean populace.

### Characterization of Primary Health Care in Chile.

In Chile, the management of Primary Health Care depends on four levels: at the central level, there is the Ministry of Health (MINSAL), represented by the Division of Primary Health Care (DIVAP), which is dependent on the Undersecretary of Health Networks (SSRA). At the territorial level, there is the Health Service. At the communal level, there are municipalities, and finally, at the local level, there are the health care facilities: CESFAM, COSAM, CECOSF, PSR, and others.

The DIVAP influences the management of Primary Health Care by developing guidelines for care standards, programming activities, and implementing the Integral Model of Family and Community Health Care (MAIS), among other actions. Additionally, it is responsible for developing national indicators and setting goals related to health processes, coverage, and outcomes related to the Family Health Plan (PSF). It also influences the development of reinforcement programs for Primary Health Care that seek to complement and strengthen certain

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<sup>3</sup> Alma Ata Conference, a meeting organized by the WHO and UNICEF between September 6 and 12, 1978, where the foundations of what is known today as Primary Health Care were established.

activities.<sup>4</sup> The development of specific national indicators and goals is directly linked to the Health Service's main-level contributions to municipalities<sup>5</sup> through the per capita financing, reinforcement programs, and collective benefits (nearly 90% of annual municipal Primary Health Care resources come from the main level). A poor evaluation of the goal fulfillment may result in possible reductions in per capita financing and other reinforcement program plans. A similar logic applies to benefits by reducing the value of benefits that reach healthcare personnel.

The Health Service, among other things, sets goals at the communal level associated with per capita financing and collective benefits. It also has a counterpart role in the transfer agreements of resources related to reinforcement programs developed at the central level. These contracts, along with their associated processes, can be compromised by inefficient management practices, potentially disrupting the seamless execution of individual health actions.

The management at the communal level depends on the municipality in 321 of the 345 communes in the country. In these cases, each manages human and financial resources, makes purchases of goods and services, and is responsible for maintaining infrastructure and equipment.

Finally, at the local level, Primary Health Care facilities (primarily CESFAM, CECOSF, and PSR) plan and carry out health activities. Efficient management largely depends on access to and handling of better information about users, as well as efficiently organizing work teams, having competencies and tools that strengthen the integral model, and using technological devices that allow for more significant health impact and efficient use of resources, among other things.

Efficient management of Primary Health Care, conducive to providing effective and timely primary care, depends on several dimensions: fluidity, transparency, interoperability, and responsiveness, among others; within and between these four levels play a fundamental role.

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<sup>4</sup> Each of these reinforcement programs has a set of indicators that determine the performance of a specific dimension of Primary Health Care.

<sup>5</sup> They manage Primary Health Care, except for those who receive fixed funding based on rurality and difficulty, both in providing and accessing healthcare services.

## The Study

This study is divided into four sections<sup>6</sup> and is written in enumerated paragraphs to simplify its overall understanding. The analysis uses public information sources, specialized literature, expert support, and the participation of representatives from the different levels of the public network. The first section analyzes the organization of resources for primary care management. The second section examines the infrastructure supporting primary care, including civil and technological aspects. The third section explores the financing of primary care. The fourth section offers final comments, indicating roles and prioritizing measures based on feasibility, expected impact, and implementation time. The study's objective is to present public policy recommendations to increase primary care prevention capacity efficiently. The proposed actions aim to enhance accessibility and continuity to achieve better coverage and enhance the comprehensiveness and coordination of care so that resources generate the most significant possible health value.

The first section deals with the organization of primary care resources, which includes the revision of relevant actions for this purpose. Firstly, implementing an attention strategy through training and using Information and Communication Technologies (ICT)<sup>7</sup> is analyzed. In this sense, the rise of the internet and mobile devices has eliminated physical and bureaucratic barriers in all sectors, including healthcare. This results in better use of people's available time and a better care process, increasing access and timeliness. Next follows a revision of different aspects that lead to enhancing the primary care model concerning the fact that current demographic analyses show that patients, in general, exhibit various conditions simultaneously. Research indicates that the comprehensive understanding and treatment of multimorbidity and complex needs are more effectively achieved within an integrated framework that involves multidisciplinary professionals of diverse profiles and specialties. This collaborative approach optimizes value in patient care. Thus, the way to enhance the attention of interdisciplinary teams through competencies and coordination tools is analyzed.

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<sup>6</sup> Additionally, there is an annex that covers the historical background of Primary Health Care, which is provided to contextualize the healthcare and preventive efforts of the country over the past century.

<sup>7</sup> The evidence (OCE, 2020; Almalki & Simsim, 2020) indicates that the efficient use of technology results in more efficient and coordinated primary health care.

Regarding the organization of resources for primary care management, it is necessary to have indicators<sup>8</sup> to evaluate the comprehensive functioning of care. This section analyzes the determination, inclusion, and evaluation of health indicators and goals to meet the attributes of transparency, relevance, and evidence. This promotes, to a large extent, all primary care characteristics, better orienting efforts, and actions for promotion and prevention. Finally, this section analyzes the Programs for Reinforcing Primary Care (PRAPS). These were surveyed according to their validation processes and the transfer of resources from the central level. The objectives of these programs are diverse: some are aimed at financing primary emergency care activity (SAPU, SAR, SUR), while others reinforce activities related to the Family Health Plan (PSF). There are also programs to finance improvements to infrastructure and others. Funding of the PRAPS comes from the main level by transferring resources to municipalities through agreements. Their proper elaboration and management affect various preventive and promotional actions of primary care. This section presents 21 recommendations.

The second section analyzes primary health care (PHC) concerning the infrastructure supporting it, including civil works (and equipment) and technological aspects. In the Chilean model, the healthcare network of each health service is based on the primary care level. Over 80% of health facilities in the country belong to the primary care level. They comprise establishments that provide care functions within a particular territory and with a population in charge. Greater complexity levels only receive referrals from the primary care level (except in emergencies). In this care model, primary care is the gateway to the system and must cover most people's pathologies. An efficient primary care system centered on people, which is also accessible, and continuous in care must, therefore, meet the characteristics of proximity, schedules, and resolution capacity according to the level of care.

In this context, this chapter analyzes the physical infrastructure (including equipment) and technology to identify gaps and propose improvements, understanding that good infrastructure is fundamental to ensuring and facilitating equitable, close, and comprehensive health care for the entire population, offering an adequate portfolio of health services (from promotion to prevention). This section presents seven recommendations.

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<sup>8</sup> See Ramalho et al. (2019), Mainz (2003), Lester and Campbell (2010), OECD (2004), among others.

The third section analyzes PHC financing. This chapter aims to provide guidelines for greater cost-effectiveness of the PHC by promoting that funding<sup>9</sup> should consider better information on the local population's health profile and improve the cost estimation process. Funding from the main level to the municipal PHC consists (mainly) of a payment mechanism called per capita, which consists of a uniform annual payment for each beneficiary enrolled in the municipal PHC establishments (baseline per capita), determined by the Ministry of Health. Additionally, increases are considered based on criteria or indexers. These seek to capture the local conditions of each commune, such as economic needs, population age, and rurality, among others.

Financing from the central level to the municipal PHC represents around 90% of the annual budget for primary care.<sup>10</sup> In turn, of the total resources that the central level allocates to the municipal PHC, approximately 70% depends on the per capita mechanism, managed by each municipality's Health Departments or Municipal Health Corporations. Finally, municipalities themselves can also contribute to primary activity financing, representing, on average, around 10% of the total budget for a year. Thus, by addressing improvements to the per capita determination process (baseline per capita and indexers that adjust it), the primary source of financing for the municipal PHC, which represents (approximately) 60% of its annual budget, is being affected. In total, this section presents eight recommendations.

These sections present findings and recommendations to support a better capacity for the PHC. Based on these findings and recommendations, the National Evaluation and Productivity Commission offers final comments and proposes an implementation strategy detailing roles, timelines, and approximate costs.

### **Main findings and recommendations of the study**

The study identifies 56 findings based on the collected information, which approximates the current state of the capacity of the PHC. Based on these findings, interviews, and evidence from

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<sup>9</sup> This section is focused on municipal primary health care (APS). Today, in 320 out of 345 communes, municipalities manage APS. Out of these, 276 receive income through per capita funding, while the remaining 44 receive fixed transfers.

<sup>10</sup> The remaining 10% finances the Primary Health Care linked to the Health Services.

good national and reference countries' practices, this study proposes 36 recommendations to support better PHC management.<sup>11</sup> Findings and recommendations are broken down by section.

There are thirty findings regarding resource organization in the PHC (first section). At the local level, we identified a clinical management strategy implemented as a pilot in mid-2020 in two CESFAM and expanded in 2021 to 10 more establishments belonging to 7 communes in the country, called the Triage Strategy. By training personnel and using TIC, this care strategy allows for scheduling and prioritizing appointments in the PHC based on clinical criteria, generating benefits for both establishments in terms of streamlining and certainty of processes and improvements in efficiency in resource utilization, as well as for patients by flexibilities in appointment scheduling, adding remote consultations, and improving coverage and timeliness. On the other hand, MINSAL also implemented a pilot messaging system for appointment management<sup>12</sup> between 2015 and 2018, which showed a reduction in the no-show rate by up to 5 percentage points and cancellations by up to 6 percentage points. Implementing these management strategies needs to be complemented with adequate competencies, especially regarding TIC, but currently, there are gaps in this regard, according to studies.<sup>13</sup>

There is evidence<sup>14</sup> that the health outcomes of patients attended in a care context are maximized when multidisciplinary with the appropriate competencies carry them out. Indeed, team care has the potential to generate significant efficiencies, reducing (in some cases) 8.5% of direct costs per visit. International experience shows positive results from developing competencies and enabling methodologies for health promotion and prevention in this direction, understanding that these differ from the traditional ones used for treating specific conditions. The type of promotion given at the local level needs to be clarified, understanding that MAIS plays a central role in APS in Chile.

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<sup>11</sup> Their specific objective is to, with a similar level of human resources but with better support (through recommendations), improve care processes in such a way that ultimately leads to an impact on people's health status.

<sup>12</sup> Specifically, for the cardiovascular program, managing approximately 8 million appointments.

<sup>13</sup> See FCh (2021).

<sup>14</sup> See Medical Economics (2017), Patel et al (2005), O'Reilly et al (2007), Reiss-Brennan et al (2016).



The success of the PHC largely depends on the level of coverage it achieves. In this sense, using information from FONASA, we estimated that the coverage rate<sup>15</sup> of the APS in Chile is approximately 50%, while international references suggest rates above 65%.<sup>16</sup> The main gaps are in young and adult populations in Chile, especially men, with coverages hovering below 40%. There is international evidence<sup>17</sup> of improvements in coverage rates and savings through screening (early detection strategies), which could be carried out in strategic centers with high floating populations.

Regarding the central-level findings, the study focused on analyzing the indicators used to measure the performance of activities in APS. The correct determination of these indicators has the potential to improve care processes and health outcomes.<sup>18</sup> The Primary Health Care Activity Index (IAAPS)<sup>19</sup> gathers part of the leading APS indicators (18), and their main objective is to assess whether the committed services are being provided adequately according to four elements: strategy, production, adequate coverage, and impact. In this regard, the benchmarks<sup>20</sup> point at the necessary criteria for selecting APS indicators (20). These are:

1. Feasibility: having routine and verifiable information that evaluates the performance in question.
2. Validation: having documented scientific evidence highlighting the health importance related to the indicator.
3. Importance: demonstrating the relevance of public policy that the activities related to the indicator have.
4. Relevance: justifying if the actions behind the indicator can influence the health objective.
5. Acceptance: having the validation of the executing team on the indicators.

However, the development of IAAPS in Chile primarily meets the Feasibility criterion, while the level of compliance is low for the other criteria. On the other hand, the procedure by which

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<sup>15</sup> To be clear, the proportion of the FONASA beneficiary population seeks care at the primary level throughout the year.

<sup>16</sup> See Health at Glance (OECD, 2019); Van Doorslaer et al (2006).

<sup>17</sup> See OMS (2014), Glass et al (2017), Clark et al (2020).

<sup>18</sup> Ramalho et al (2019).

<sup>19</sup> The degree of achievement of these goals is subject to reductions in per capita contributions.

<sup>20</sup> See Royal Statistical Society (2005), United States Institute for Medicine (2006), National Health Service (2017), OECD (2004)

MINSAL formulates the IAAPS is not straightforward, nor are the content and rationale of its decisions. Furthermore, although the acts and resolutions of the State are public, there needs to be more information identifying the process and justification by which this set of indicators is arrived at and its prioritization. In conclusion, it remains to be seen whether the selection of indicators and goals is the most pertinent and, therefore, whether the level of compliance with IAAPS relates to health improvements for the population. Further, MINSAL annually establishes the National Health Goals and Improvement of Care for municipal health administration entities. As with the previous situation, the foundations (e.g., regarding relevance) for which MINSAL sets these indicators and their goals need to be clarified. This opacity is also present in Primary Health Care Reinforcement Programs (PRAPS). Although the PRAPS identifies elements to understand the sectoral policy, not all have transparent backgrounds, displaying significant heterogeneity, where some programs present evidence of impact. In contrast, the justification for others is more general. Delays occur in the transfer of the program's first installment, affecting the continuity of certain services and forcing the municipality (in some instances) to reallocate its resources to support the continuity of care. Additionally, since the respective Health Services and the municipalities in their territory must sign the agreements<sup>21</sup> on the PRAPS, their approval shows a four-month<sup>22</sup> latency period. Regarding the organization of resources, we recommend implementing 21 recommendations in favor of strengthening (at the local and central level) the dimensions analyzed in this section (Teletriage, appointment management, population screening, local team skills and tools, development of indicators and goals (IAAPS and Health Goals), and foundation (as processes) linked to the PRAPS).

Regarding the Teletriage strategy, three recommendations promote the scaling up and reinforcement of this tool, incorporating human resources, training, infrastructure, and TIC services support components in the PRAPS of Local Management Support in Municipal Primary Care and Health Services. Likewise, we recommend scaling up this strategy nationally by incorporating it into Hospital Digital. Along with scaling up the Teletriage strategy, it is necessary to reintegrate and scale up the appointment management project and incorporate it into Hospital Digital, thus promoting greater user adherence. A fourth recommendation seeks to implement

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<sup>21</sup> Through an exempt resolution.

<sup>22</sup> With a high degree of heterogeneity for this timeframe.

screening actions in areas with high floating populations,<sup>23</sup> allowing for first contact and evaluation of a significant proportion of people in the context of this mandate distant from primary health care. A fifth recommendation seeks to provide TIC support in healthcare facilities that allow for the release of clinical team hours for administrative tasks and support for analyzing care processes. Additionally, considering the benefits found regarding the incorporation of multidisciplinary teams in patient care, four measures are proposed to identify not only the level of prevention and promotion competencies but also to implement these profiles, as well as competencies to increase coordination of teamwork leading to the provision of comprehensive care.

The different indicators seek to measure the performance of primary health care and, therefore, impact general management. However, evidence suggests that the indices may yield different results. In addition, interviews carried out within the framework of this project point out objections concerning the determination of specific indicators. Moreover, evidence points out that the procedure by which MINSAL formulates indicators and goals is unclear, as is the content and basis of the decisions adopted. Thus, in this regard, we present ten measures that lead to a better elaboration of indicators and goals for IAAPS and Sanitary Goals, as well as for the foundation of PRAPS, with greater transparency and accountability. Suggestions point out that MINSAL should consult an advisory committee, which issues well-founded reports on its proposals, to formulate indicators, making both their elaboration and evaluation visible in the case of IAAPS. Likewise, establishing Sanitary Goals should also be transparent and based on evidence. In line with this, and considering international evidence, the incorporation of the avoidable hospitalizations indicator for IAAPS as a Sanitary Goal<sup>24</sup> is also recommended. Additionally, concerning PRAPS, they should specify, at least, their evidence and relevance. Finally, two recommendations are presented to reduce the latencies associated with the transfer agreements of resources related to PRAPS.

Regarding the chapter on infrastructure, we identified 14 findings that reveal significant gaps hindering adequate Accessibility, Continuity, Integrality, and Coordination, thereby reducing

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<sup>23</sup> Mainly in workplaces.

<sup>24</sup> They are hospitalizations that can potentially be prevented through timely and effective care at the primary level of healthcare.

coverage and health outcomes. In the case of ICT infrastructure, the main gap, which mainly affects Integrality and Coordination, is related to the level of interoperability implementation, understood as the ability of two or more systems to exchange and use information. This gap is mainly due to the need for clear institutional leadership capable of coordinating and aligning the various actors and transcending governments. An example is that there are at least seven public entities related to the matter in the country that need more coordinated efforts. Management has been inefficient because there needs to be clear leadership from a higher authority. For example, Health Services and municipalities need to follow homogeneous guidelines for hiring, which puts up barriers to exchanging information. Although the country has been working on adopting an interoperability strategy for over a decade, a dominant criticism of the specialized media has been the need for a robust, coordinated, and stable system over time. Thus, the Commission presents four recommendations to promote better institutionalism (and therefore initiate the implementation of interoperability) and implement a clinical information repository. In this sense, as a first instance, we suggest granting the Chilean Public Health Institute Dr. Eugenio Suárez Herreros powers in the field of information and communication technologies in the health sector and creating a Health ICT Department, dependent on the Institute's direction. This Health ICT Department must propose an interoperability strategy and coordinate its implementation, as well as dictate technical standards, update them, ensure compliance, and carry out activities related to quality control. The approach adopted in this area should be long-term and subject to the general principles regarding electronic means of the Digital Transformation of the State Law, such as Technological Neutrality, Updating, and Cooperation. Considering that this recommendation requires a legal change, the Commission also suggests a short-term alternative that allows for mitigating the current lack of interoperability and, in particular, benefiting the user. A repository of care records, exams, diagnoses, and other documents in a non-unified format should be implemented. Thus, through ClaveUnica, the user can access and share information with the treatment team through a digital platform or Digital Clinical Home. The Ministry of Health already has the power to request clinical information from public and private establishments, taking technical and administrative measures to protect this information. In total, there are four recommendations associated with ICT infrastructure.

Regarding the chapter on infrastructure, we identified 14 findings that reveal significant gaps that hinder adequate accessibility, continuity, comprehensiveness, and coordination, thus diminishing healthcare coverage and outcomes. In the case of ICT infrastructure, the central gap, which mainly affects comprehensiveness and coordination, is related to the level of interoperability implementation. Interoperability refers to the ability of two or more systems to exchange and utilize information. This gap is explained by the need for clear institutional leadership capable of coordinating and aligning different stakeholders beyond government transitions. For instance, in the country, there are at least seven public entities related to the matter that make uncoordinated efforts. The absence of clear leadership from a higher authority has resulted in inefficient management. For example, we have found that Health Services and municipalities do not follow homogeneous guidelines for contracting, which creates barriers to information exchange. Although the country has been working for over a decade on adopting an interoperability strategy, a general critique from the specialized field has been the lack of a robust, coordinated, and stable long-term strategy. As a result, the Commission presents four recommendations to promote better institutional capacity (and thus initiate interoperability implementation) and establish a clinical information repository. As a first step, we suggest granting the Institute of Public Health of Chile, Dr. Eugenio Suárez Herreros, the authority in information and communication technologies in the health sector, and creating a Health ICT Department under the Institute's direction. This Health ICT Department should propose an interoperability strategy, coordinate its implementation, issue technical standards, update them, ensure compliance, and perform activities related to quality control. We recommend that the approach adopted in this matter be long-term and aligned with the general principles regarding electronic means of the Digital Transformation of the State Law, such as technological neutrality, updating, and cooperation. Considering that this recommendation requires legal changes, the Commission also suggests a short-term alternative to mitigate the current lack of interoperability, mainly benefiting the user, by implementing a repository of records of care, exams, diagnoses, and other documents in a non-unified format. Thus, through ClaveUnica, the user can access and share information with the treating team through a digital platform or Digital Clinical Address. It is worth mentioning that the Ministry of Health already has the authority to request clinical information from public and private establishments, taking technical and administrative measures to protect this information. In total, there are four recommendations associated with ICT infrastructure.

As for civil infrastructure, we estimate that 5.4 million people (36% of the system's beneficiaries) have limited access, opportunity, quality, and continuity of care. This is due to various reasons, such as the distance to the nearest PHC center, which can be up to 4 kilometers away in some urban communes<sup>25</sup> such as, Tarapacá, Atacama, Metropolitana, O'Higgins, and La Araucanía. Furthermore, some communes have PHC facilities with more registered patients that surpass the capacity for which they were initially designed. The CNEP estimates that this is the case for 201 facilities (CESFAM, CECOSF, and PSR), many of which are located in the Metropolitan Region. Along with this, another issue mentioned by representatives of Primary Health Care relates to the lack of proper maintenance and insufficient equipment, particularly in terms of technology, or alternatively, the equipment being outdated or in poor condition. Closing these gaps requires investment with a significant alternative social cost and complex financing. Nevertheless, reducing these gaps would enhance Accessibility and Continuity and imply a lower rate of preventable hospitalizations.

According to a study by USS as part of this project,<sup>26</sup> one out of three avoidable hospitalizations ends with the deceased person. These hospitalizations generate an annual expense at the hospital level equivalent to 10% of the APS budget for 2022 (around 300 million dollars). Preventable hospitalizations represent approximately 11% of annual hospital discharges and use about 20% of hospital beds. Improving this aspect is crucial because Chile has avoidable hospitalizations due to chronic diseases and low-complexity acute situations (56% of the total). According to USS and CNEP estimates, additional PHC infrastructure, especially for emergency care, reduces preventable hospitalizations by 30%.

The Commission presents three recommendations in line with improving civil infrastructure (and equipment), particularly the design and construction of infrastructure for the primary (and secondary) level of care, considering the provision and installation of medical equipment and furniture, along with their efficient administration and maintenance. In this context, the

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<sup>25</sup> This implies that the individual is likely not registered at that healthcare facility, reducing the possibility of receiving care.

<sup>26</sup> See USS (2021).

Commission recommends evaluating the possibility of subjecting the primary and secondary levels of health infrastructure to the Concessions Law. If the assessment is favorable, it would be necessary to develop Mandate Agreements between the different municipalities, the respective Health Service, and the central level (MINSAL and MOP) for the primary level. In the case of the secondary level, the agreement would be between the respective Health Service and the central level.

Finally, in the third section, this study analyzed the principal financing mechanism of municipal primary health care (PHC),<sup>27</sup> understanding that an allocation that takes into account better information on the local health profile of the population and the best cost approximations allows for an increase in the cost-effectiveness of APS. In this case, we identified 12 findings. Financing from the central level to municipal PHC consists of a payment mechanism called per capita, composed of a homogeneous annual payment for each beneficiary registered in municipal PHC establishments (basal per capita), determined by the Ministry of Health (MINSAL). Adjustments or indexers are also applied to this basal value to capture specific local dimensions, such as poverty, rurality, and the elderly population. Among the findings identified is that the per capita contribution has a gap of 25 percentage points (pp) concerning CNEP estimates and other studies, meaning that the basal value should be increased by about 33%.<sup>28</sup> Thus, in the case of the 2022 basal value, it should be increased from \$9,048 to \$12,000. In this sense, decision-makers must seek viable alternatives to close the gap. For example, data from the United States indicate that investing 1% more in PHC reduces the ratio of emergency room visits by 0.18%, the percentage of hospitalized beneficiaries by 0.07%, and the proportion of avoidable hospitalizations by 0.16% (PCPCC, 2020). Thus, the Commission considers that greater transparency, accountability, and consensus methodologies help to reduce the gap and increase the effectiveness of PHC. It is necessary to highlight that in the context of this mandate, it was impossible to find consolidated information that described in detail the process of elaboration of the basal per capita, nor information that allowed replicating the estimation of the basal value.

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<sup>27</sup> Today, in 321 out of 345 communes, the municipality administers the Primary Health Care (APS), of which 277 receive income based on the per capita concept.

<sup>28</sup> See Montero et al. (2008), FONASA (2019), School of Public Health (UCh, 2015), among others.

Both international and national<sup>29</sup> evidence suggests that the population's morbidity burden is a good predictor of healthcare spending and should therefore be used as an indexer. Additionally, national studies<sup>30</sup> indicate better alternatives than the current adjustments applied to the basal per capita better to capture the morbidity and health risk of the territory. In this sense, the foundations of the indexers selected by MINSAL need to be clarified, and the evidence suggests more relevant alternatives. However, the main barrier to implementing indicators of this type is related to the consolidation of information at the primary level, with the budgetary issue being of secondary importance.

Either the Health Department or the Municipal Corporation<sup>31</sup> -in 321 out of 345 communes- manage the budget locally. This indicates that 50 municipal corporations, representing 16% of the communes nationwide, are responsible for administering resources designated for primary health care. These corporations receive 35% of the financing from the central level and are responsible for serving 38% of FONASA beneficiaries. Between 2016 and 2020, these corporations executed 41% of their expenditure on APS, resulting in state resources of 760 billion pesos executed in PHC (by 2020) which were not analyzed by the CGR or this Commission, revealing a lack of transparency and suggests possible inefficiencies not detected in the management of resources. There<sup>32</sup> needs to be more information about the corporations that perform complementary functions of some municipalities in education, health, and others.

Of the eight recommendations to support better financing of APS, six are particularly relevant to the per capita. This financing should incorporate improvements to its annual process of estimating the basal per capita and using better indexers. Specifically, MINSAL should be transparent and validate the calculation methodology and the assumptions and prices it uses to determine the basal per capita each year. On the other hand, it is recommended that MINSAL validates and uses better adjustments to capture the local context more precisely, considering the health risk and morbidity

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<sup>29</sup> See Juhnke et al. (2016), ACG Johns Hopkins (N.d.), Santelices et al. (2014), Santelices et al. (2016).

<sup>30</sup> MINSAL (2011), FONASA (2020) and Poblete and Vargas (2007).

<sup>31</sup> The remaining communes are managed by their respective Health Services. Out of the 321 communes administered by municipalities, 44 receive transfers based on fixed costs, while the other 277 receive per capita funding and its reductions.

<sup>32</sup> According to the 2020 report from the General Accounting Office (CGR) on the budgetary, financial, and asset situation of the State.



of the population of the commune, and thus achieve a more cost-effective allocation of financial resources and, therefore, improve the preventive capacity of APS. The last two recommendations seek greater efficiency in spending through greater transparency, integrity, and accountability on the part of municipal corporations that manage APS resources. Improvements in transparency and accountability of municipal health corporations, such as the calculation process of the basal per capita and the use of better indexers, make it possible to further orient resources according to the risk profile and morbidity of the population of the communes, enhancing the required health activities for each commune. Thus, this mandate's main findings show room for improvement in Primary Health Care. A better preventive policy given through more and better support to the APS center teams influences the entire health system. In this sense, if implemented alone, each of these recommendations would have a marginal impact but applied together, they can generate a positive and significant impact.

The study concludes with a fourth section that presents conclusions, an illustrative example of the impact of the measures, and a prioritization of these, considering feasibility, timing, and estimated cost.