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A Comparative Look at the Success of the Chilean Universal Coverage Program with a Focus on Diabetes and Oral Health Treatment and Its Potential Application to the United States Healthcare System

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I. INTRODUCTION

Chronic diseases, such as diabetes and oral health diseases, are a growing problem worldwide and are responsible for fifty percent of the total worldwide burden of disease in 2005.[1] In order to combat chronic diseases, some countries, like Chile, have implemented universal health care,[2] while others, like the United States have attacked only certain chronic conditions through various health care initiatives.[3] Despite the fact that the United States has the most expensive health system in the world, the U.S. ranks thirty sixth for life expectancy, likely caused by the chronic diseases that plague many Americans.[4] In 2007, the diabetes and oral health burdens in the U.S. amounted for more than $116 billion in estimated annual direct

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1. Ricardo Bitran, et al., *After Chile's Health Reform: Increase in Coverage and Access, Decline in Hospitalization and Death Rates*, 29 HEALTH AFF. 2161 (2010).

2. *See generally id.*

3. *See generally* KAISER FAMILY FOUND., MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS, 1 (August 2012), *available at* http://www.kff.org/medicaid/upload/8340.pdf [hereinafter *Health Homes*]. The various health care initiatives in the U.S. include chronic disease prevention programs that focus on the individual's well being, policy promotion, health equity, research translation and workforce development. NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, THE POWER OF PREVENTION: CHRONIC DISEASE. . .THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY, 11-12 (2009), *available at* http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf [hereinafter *Power of Prevention*].

4. Everette James & Arthur S. Levin, *The Inevitability of Health Reform*, 50 DUQ. L. REV. 235, 237 (2012).

medical expenditures.[5] Driven by an aging population and a struggling economy, government-sponsored health care is expected to increase to more than fifty percent of all health spending in the U.S.[6] To combat the rising costs of health care, the U.S. Congress passed the Patient Protection and Affordable Care Act (PPACA), which, in part, focuses on reducing the cost of chronic condition treatment.[7]

This article seeks to compare Chile's universal care model and its impact on two specific chronic conditions, diabetes and oral health diseases, to the U.S. healthcare system. Within the list of Chile's prioritized conditions, two are of particular interest compared to the U.S.; one, diabetes, is frequently covered under U.S. health policy, while another, oral health diseases, gets far less attention.[8] This article also discusses what the U.S. can learn from Chile's universal care model as the Unite States moves forward to reduce the impact of chronic conditions on its' healthcare beneficiaries.

II. DISTINCT FEATURES OF CHILE'S HEALTH SYSTEM

Chile is one of South America's top economic performers, with an estimated GDP per capita of $16,100 for 2011.[9] In recent years, Chile has experienced a rise in life expectancy and a reduction in the number of

5. *Power of Prevention*, *supra* note 3, at 7.

6. James & Levin, *supra* note 4, at 237.

7. *Health Homes*¸ *supra* note 3, at 1 (explaining that the PPACA established a new state option in the Medicaid program to implement "health homes" for Medicaid beneficiaries with chronic conditions). The concept of health home builds on the patient-centered medical home model and seeks to foster a "whole person" orientation to care for persons with chronic conditions through enhanced integration and coordination or primary, acute, mental and health, and long-term services and supports across the lifespan. *Id.*

8. *Id*.; *see also* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, CHILDREN AND ORAL HEALTH: ASSESSING NEEDS, COVERAGE AND ACCESS 1 (2012) *available at* http://www.kff.org/medicaid/upload/7681-04.pdf [hereinafter *Children and Oral Health*].

9. S.A. Southbridge, *Health in Chile*, NZ TRADE AND ENTERPRISE, 3 (February 2012), *available at* http://www.nzte.govt.nz/explore-export-markets/market-research-by-industry/Services/Documents/Health%20Market%20Profile%20Chile%20Feb%202012.pdf [hereinafter *Exporter Guide Health in Chile*].

citizens afflicted with chronic conditions.[10] The large majority of Chile's health system beneficiaries receive care in public hospitals.[11] These beneficiaries use the *Fondo Nacional de Salud* (FONASA)[12], the government health insurance program that provides coverage for people who cannot afford private insurance, while approximately fourteen percent of the population uses Chile's well-developed private health insurance system known as the *Instituciones de Salud Provisional* (ISAPRES).[13] Chile continues to develop health reforms to ensure that every person afflicted with a chronic disease receives timely and high-quality care.[14]

After decades of bias in accessing health care and problems with organization and investment[15], in 2000, the Chilean government identified four main challenges in their health system: the population's progressive aging, the increasing cost of health services, the inequalities in the access of different socio-economic groups, and a gap in the health conditions of those groups.[16] Between 2000 and 2006, Chilean President Ricardo Lagos

10. Bitran et al., *supra* note 1, at 2162. In 2005, the average life expectancy for Chileans was 78.2 years, and infant mortality rate was 8 per 1,000 live births. *Id.* Chile's health indicators such as life expectancy and infant mortality rate are among the best in the region and are similar to those of highly industrialized countries. *Id.*

11. *Exporter Guide in Chile*, *supra* note 7, at 3.

12. Bitran et al., *supra* note 1, at 2161.

13. *Exporter Guide in Chile*, *supra* note 7, at 3- 4 (explaining that the remaining population is employed by the military and government and is covered under government provided insurance).

14. *Id.* at 11.

15. Eduardo Missoni and & Giorgio Solimano, WORLD HEALTH REPORT, TOWARDS UNIVERSAL HEALTH COVERAGE: THE CHILEAN EXPERIENCE 18 (2010) *available at* http://www.who.int/healthsystems/topics/financing/healthreport/4Chile.pdf [hereinafter *World Health Report*]. (discussing that the Inter-ministerial Committee on Health Sector Reform, representing various Chilean government entities further indentified four objectives for the 2000-2010 decade. They included (a) improving existing health indicators; (b) addressing the new demands derived from the ageing and the changing health profile of the population; (c) closing health gaps and inequities across socio economic groups; and (d) improving the scope, access to, and quality of services according to the expectations of the population. *Id.*

16. *Id.* at 18.

initiated a reform that aimed to address the country's four major challenges to its health system.[17] The reform intended to ensure universal access to care and financial protection against the most prevalent health problems that represented sixty to seventy percent of the Chilean population's disease burden.[18] By 2005, the Chilean Parliament approved a number of health reform laws including the Universal Access Plan with Explicit Guarantees (AUGE Plan).[19] The AUGE Plan includes both coverage and payment for pre-defined health conditions in order to provide better access to care.[20] The AUGE Plan's key elements include universal coverage for all citizens and a medical benefits package consisting of a prioritized list of diagnoses and treatments.[21] The AUGE Plan gradually increased the amount of health conditions prioritized under Chile's universal healthcare plan, and now there are over sixty-six covered conditions.[22] In addition, the AUGE Plan defines a maximum waiting period for receiving services; the set of activities, procedures, and technologies necessary for treating the covered conditions; and the maximum amount that a family can spend per year on health care.[23]

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17. *Id.* at 10.
18. *Id* at 11.
19. *Id.*
20. *Id.* at 11. The AUGE Plan also created the new Health Superintendence which took over the functions of the previous Superintendence of ISAPRES and also was in charge of the FONASA budget regarding the treatment and services of guaranteed list of conditions. *Id* at 16. Thus, the AUGE Plan was the first body in Chile to supervise public and private funds together. *Id.*
21. *Id.*
22. *Id* at 13-14 (stating that to allow for gradual introduction of prioritized health conditions, in 2005 AUGE was applied to twenty-five pathologies, which later increased to fifty-six by 2007, and sixty-six by 2010).
23. THE WORLD BANK GROUP, SOCIAL DEVELOPMENT DEP'T, REALIZING RIGHTS THROUGH SOCIAL GUARANTEES: AN ANALYSIS OF NEW APPROACHES TO SOCIAL POLICY IN LATIN AMERICA AND SOUTH AMERICA, (2008), *summarized in Chile: Regime Explicit Guarantees (Plan AUGE)* §12 *available at* http://siteresources.worldbank.org/EXTSOCIALDEV/Resources/3177394-1168615404141/3328201-1192042053459/Chile.pdf?resourceurlname=Chile.pdf

Both the national and international policy communities have praised the design of Chile's complex process for setting healthcare priorities.[24] The AUGE Plan's purpose was to introduce an element of continuity into the Chilean health system and to introduce prioritized lists of conditions aimed at guaranteeing equal access to care.[25] Within the list of prioritized conditions, diabetes and oral health are especially interesting for sake of comparison to the U.S. model.[26]

III. CHRONIC CONDITIONS: DIABETES

Both Chile and the U.S., through their government sponsored insurance plans, provide nearly-universal coverage for diabetes treatment (including dialysis therapy).[27] Within the prioritized lists of diagnoses and treatments covered under Chile's AUGE Plan, chronic renal insufficiency, diabetic retinopathy, diabetes types one and two, and prevention of renal disease are included.[28] It has been estimated that savings from using the AUGE Plan reaches up to $1,000 per year for diabetic patients,[29] which is nearly full

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[hereinafter *Plan AUGE*] (stating that "[t]hese maximums differ depending on the family's income, thus protecting the principles of equity, inclusion and redistribution").

24. Gabriel Bastias et al., *Health Care Reform in Chile*, 179 CANADIAN MED. ASSOC. J. 1289, 1291 (2008), *available at* http://www.cmaj.ca/content/179/12/1289.full.pdf [hereinafter *CMAJ]*

25. *World Health Report*, *supra* note 15, at 20.

26. *See id.; see also Children and Oral Health*, *supra* note 8.

27. *See* Roberto Pecoits-Filho et al., *Policies and Health Care Financing Issues For Dialysis in Latin America: Extracts From the Roundtable Discussion on the Economics of Dialysis and Chronic Kidney Disease*, 29 PERIT. DIAL. INT. S222, S225 (February 2009), *available at* http://www.pdiconnect.com/content/29/Supplement_2/S222.full.pdf+html [hereinafter *PDI*]. *See also Health Homes*, supra note 3, at 1.

28. *CMAJ*, *supra* note 24, at App'x 1: *see also World Health Report*, *supra* note 12 at 13. There are two major forms of diabetes; type one diabetes is characterized by a lack of insulin productions and type two diabetes results from the body's ineffective use of insulin. INTERNATIONAL DIABETES FEDERATION, http://www.idf.org/types-diabetes (last visited November 3, 2012).

29. Bitran et al., *supra* note 1, at 2164. Savings for type two diabetes was estimated to be $286, while savings for type one diabetes was estimated to be $1,255 for type one diabetes. *Id. See also World Health Report*, *supra* note 15, at 21. 500,000 pesos is

coverage as the average per capita cost of diabetes in 2000 was $703.[30] Also, twenty-eight percent of respondents to a recent survey concerning the AUGE Plan mentioned that at least one member of their household has been diagnosed with one of the guaranteed medical conditions[31] related to diabetes.[32] In 2007, hyperglycemia accounted for 2.3 percent of the total burden of disease in Chile and was considered one of the most important risk-factors to chronic disease prevention.[33] Chile is successfully helping to combat this risk-factor through the AUGE plan.[34] Under the plan, Chile's 350 municipalities are responsible for outpatient services, including stand-alone outpatient centers and general outpatient centers that both provide procedures for hemodialysis (HD) therapy and diagnosis.[35] Additionally, the AUGE Plan mandates coverage for a set of interventions for children and adults aimed at the prevention and early detection of types one and two diabetes.[36]

The AUGE Plan's impact has been significant; during the initial period that AUGE was implemented (2002-2007), there was a forty-eight percent increase in Chileans seeking treatment for type two diabetes.[37] This increase indicated that Chileans who had previously forgone treatment for diabetes were now able to afford it. Under Chile's public insurance system FONASA, type one diabetes cases nearly quadrupled and under the private

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approximately $1,000.

30. Alberto Barecelo et al., *The Cost of Diabetes in Latin American and the Caribbean*, 81 BULLETIN OF THE WORLD HEALTH ORG. 19, 24 (2003), *available at* http://www.who.int/bulletin/Barcelo0103.pdf.

31. *Plan AUGE*, *supra* note 23, at §21 (explaining that the most frequently mentioned medical conditions included both type one and type two diabetes).

32. *Id.*

33. Bitran et al., *supra* note 1, at 2162.

34. *Id.*

35. *Exporter Guide Health in Chile*, *supra* note 9, at 6. Municipalities are local government administrative divisions with defined territories and populations. *Id.*

36. Bitran et al., *supra* note 1, at 2163.

37. *Id.* at 2166.

ISAPRE plans, they nearly doubled.[38] During the same period, there was a seven percent drop in hospitalization from complications due to type one diabetes, especially among patients older than thirty.[39] There was also a thirteen percent increase in hospitalization for type two diabetes, especially among patients older than sixty-five.[40] The increase in hospitalization for type two diabetes was due to patients seeking out care more often because of the increase in access and treatment options.[41]

However, there are some limitations to the coverage of AUGE with regards to end stage renal disease, as the protocol for adult patients is guaranteed access to HD, but not peritoneal dialysis (PD).[42] Even if a patient and doctor agree on peritoneal dialysis, AUGE will not cover it.[43] Due to the priority setting, "non-AUGE" conditions, estimated at fifty-two percent of the total demand at any given time, may suffer delays in care.[44] The Jamie Guzmán Foundation, a private, non-profit foundation in Chile focused on public service, found that the AUGE Plan puts excessive emphasis on advanced or curative care and that fifty percent of its spending

38. *Id.* The large contrasts between the FONASA and ISAPRE plans may partly be the result of lower initial treatment rates in FONASA, where access to care was generally more restricted by waiting lists than ISAPRE plans. *Id.*

39. *Id.* at 2167-68.

40. *Id.*

41. *Id.* (stating that the 13percent increase could be explained because of better access to care or, to some extent, population aging). *Id.* There was also a 48percent drop in case fatality rate for type 1 diabetes, while the hospital death rate for type 2 diabetes in Chile dropped 5 percent. *Id.* This is an impressive finding given that this is an older, higher-risk population. *Id.* This may also be attributable to improved quality of care made possible through the implementation of standard treatment protocols. *Id.*

42. *World Health Report*, *supra* note 15, at 25. There are two main types of dialysis: hemodialysis and peritoneal dialysis. NATIONAL INSTITUTE OF HEALTH, http://www.nlm.nih.gov/medlineplus/dialysis.html (last accessed November 3, 2012). Both types filter blood to ride the body of harmful waste, extra salt and water. *Id*. Hemodialysis does that with a machine, while peritoneal dialysis uses the lining of a patient's abdomen, called the peritoneal membrane. *Id*.

43. *World Health Report*, *supra* note 15, at 25.

44. *Id*.

is focused on three preventable diseases including type two diabetes.[45] Furthermore, Chile's National Health Superintendency found that nearly one-third of all type one diabetes patients waited for treatment longer than the maximum time defined by the AUGE plan.[46]

On the other hand, the AUGE Plan has left space for continuous improvement and mandates regular protocol reviews to add new disorders and incorporate new evidence for treatment of covered conditions.[47] Recently, policymakers started an initiative to increase access and coverage to PD because PD has higher patient satisfaction ratings and lower global costs than HD.[48] As a whole, the AUGE Plan led to a considerable increase in the number of individuals seeking regular treatment for both type one and type two diabetes.[49]

In comparison, to address the nearly twenty-six million Americans with diabetes, the U.S. has specified under the PPACA a list of chronic conditions, including diabetes, that are to be covered by Medicaid.[50] Since 2010, people with diabetes have begun to benefit from the PPACA.[51] The treatment services for diabetes include: comprehensive care management; care coordination and health promotion; comprehensive transitional care

45. *Id.*
46. Bitran et al., *supra* note 1, at 2168.
47. *World Health Report*, *supra* note 15, at 25.
48. *PDI*, *supra* note 27, at S224. The HD and PD groups did not show differences in quality-of-life index, but annuals global costs for HD were $20,810, while PD cost $20,750. *Id.*
49. Bitran et al., *supra* note 1, at 2169. Since the adoption of the reform, there have been sizeable improvements in treatment of chronic conditions and disease detection has improved, thus allowing more timely treatment. *Id.*
50. *Health Homes*, *supra* note 3, at 1.
51. AM. DIABETES ASS'N., HOW HEALTH CARE REFORM IS HELPING PEOPLE WITH DIABETES ASSOC 1, *available at* http://www.diabetes.org/assets/pdfs/advocacy/aca-2nd-anniversary-brief.pdf [hereinafter *ADA Overview*]. Benefits that are currently enjoyed by diabetics under the PPACA include: new coverage options for individuals with pre-existing conditions; no pre-existing condition exclusions for children, free coverage of preventative care, and new program to prevent type 2 diabetes. *Id.*

from inpatient to other settings, including appropriate follow-up; patient and family support; referral to community support services; and use of health information technology.[52] By 2014, people with diabetes will no longer be denied insurance or forced to pay more for coverage simply because they have diabetes.[53] In addition, Medicare participants are now able to receive a free annual wellness visit to identify health risks such as diabetes or diabetes-related complications and to develop an individual prevention plan.[54] This wellness visit is noteworthy because it can help modify a diabetic's risky health behaviors such as lack of physical activity and poor nutrition.[55] Similarly, the National Diabetes Prevention Program (NDPP) was established to expand the reach of community-based programs which have a proven track record of preventing type two diabetes and recently received ten million dollars from the Prevention and Public Health Fund.[56] While the long-term impact of the PPACA in the U.S. is to be

52. *Health Homes*, *supra* note 3, at 1. These changes are significant considering that more than one in ten adult Medicaid enrollees have been diagnosed with diabetes, and diabetes costs in the United States grew greatly between 2002 and 2007 to more than $174 billion. *Id.* at 4*;* NAT'L CONF. OF STATE LEGISLATURES, FED. HEALTH REFORM PROVISIONS RELATED TO DIABETES 1 (2011), *available at* http://www.ncsl.org/portals/1/documents/health/DiabetesinHR511.pdf [hereinafter *Federal Health Reform Related to Diabetes*].

53. *ADA Overview*, *supra* note 51, at 2. Beginning January 1, 2014, the PPACA prohibits insurers in the individual and group markets from imposing preexisting condition exclusions. FOCUS ON HEALTH REFORM: HEALTH INSURANCE MARKET REFORMS: PRE-EXISTING CONDITION EXCLUSIONS 3 (September 2012) *available at* http://www.kff.org/healthreform/upload/8356.pdf. The PPACA's prohibition on pre-existing condition exclusions will enable diabetic patients to access necessary benefits and services, beginning from their first day of coverage. *Id.* The PPACA will also require insurance companies to guarantee issue health plans to any applicant regardless of their health status and impose limitations on how much insured can vary premiums based on an individual's health status. *Id.*

54. AM. DIABETES ASS'N., QUESTIONS AND ANSWERS ABOUT HEALTH REFORM AND DIABETES ASSOC. 2, *available at* http://www.diabetes.org/advocate/our-priorities/health-care/QA-Health-Reform-and-Diabetes.pdf.

55. *Id.* at 3. The Prevention and Public Health fund was established by the PPACA to address wellness and prevent and make some preventive services available for free. *Id.*

56. *Power of Prevention*, *supra* note 3, at 5-6. Physical activity has been shown to control type 2 diabetes while good nutrition can control a diabetic's insulin and blood sugar levels. *Id.*

determined, the universal coverage in Chile has dramatically improved the health of its diabetic citizens.[57]

IV. CHRONIC CONDITIONS: ORAL DISEASES

Oral diseases are some of the most common chronic diseases and constitute a major public health problem because of their high prevalence, impact on an individual's health, and high cost of preventative care and treatment.[58] In most rural localities around the world, populations have little access to dental care and have high rates of risk-factors, such as poor diet and the absence of prevention and educational programs.[59] In order to prevent the spread of oral health diseases such as cavities and gingivitis, educational programs should be established to promote oral health as well as to increase resources to treat patients and decrease the negative impact of oral diseases in the future.[60]

In Chile, the AUGE Plan covers comprehensive oral health of pregnant women and children, integrated adult oral health, and outpatient dental emergencies.[61] Within Chile's public healthcare sector, primary care services are relatively well organized, delivering free dental services at local health centers administered and owned by local municipalities.[62] The Chilean government prioritizes oral health to such a degree that, in 2008, it implemented a national health program that reviews the main barriers and

57. *See generally* Bitran et al, *supra* note 1. The case fatality rate among patients with type one diabetes dropped forty eight percent after the implementation of AUGE while the hospital death rate for type two diabetes dropped five percent – a noteworthy finding given that this is an older, higher risk population. *Id.* at 2167.

58. Cesar Andres Rivera Martinez, *Pre-school Child Oral Health in a Rural Chilean Community*, 5 INT. J. ODONTOSTOMAT. 83, 86 (2011), *available at* http:// www.ijodontostomat.com/2011_v5n1_013.pdf .

59. *Id.*

60. *Id.* at 85.

61. *Exporter Guide Health in Chile*, *supra* note 9, at 27-29.

62. *CMAJ*, *supra* note 24, at 1289.

social determinants that generate inequities in oral health provision and proposes solutions to address those issues.[63] Of the 2,290 public health facilities in Chile, twenty-one are Mobile Dental Clinics, capable of performing outreach work in rural areas and small towns.[64]

Furthermore, in order to promote dental health, the Chilean Health Ministry authorized a variety of health initiatives including the fluoridated milk program, a program that targets primary school children.[65] This program has seen a major decrease in the prevalence of cavities after three years, including a twenty four percent reduction in cavities amongst nine-year-olds[66] through twelve-year-olds.[67] The fluoridated milk program was a primary example of Chile using a public health approach to promote oral health benefits such as cavity prevention and overall dietary well-being.[68] The Ministry of Health also developed "An Integral Clinical Oral Health Guide for six-year-old children," which attempts to manage cavity development through a variety of less invasive techniques.[69] Chile uses non-invasive techniques at a significantly higher rate than the U.S.; Chile's

63. *Social Determinants of Health,* WORLD HEALTH ORG., http://www.who.int/social_determinants/thecommission/countrywork/within/chile/en/index.html.

64. *Exporter Guide Health in Chile*, *supra* note 9, at 5.

65. RODRIGO MARINO ET AL., MALMO UNIV., FLUORIDATED MILK PROGRAMME FOR RURAL PRIMARY SCHOOL CHILDREN IN CHILE (2006), *available at* http://www.mah.se/CAPP/Country-Oral-Health-Profiles/AMRO/Chile/Information-Relevant-to-Oral-Health-and-Care/Special-Projects-of-Interest/Fluoridated-Milk-Programme/.

66. *Id.* (explaining that the program targeted 35,000 primary school children between the ages of six to fourteen, living in twenty five municipalities of Chile). Under the program, each child drinks 200ml of prepared fluoridated milk for 200 days. *Id.* The program was repeated for three years and the results were a cavity reduction decrease twenty four percent for six year olds, and twenty six percent for twelve year olds. *Id.*

67. *Id.*

68. *Id.*

69. *See* Oswaldo Ruiz & Jo E. Frencken, *ART Integration in Oral Health Care Systems in Latin American Countries as Perceived by Directors of Oral Health*, 17 J. OF APPL .ORAL SCI. 106, 107 (2009) (explaining that the program manages cavity development and progression through sealing pits and fissures, using additional cavity control measures and ART restoration of tooth cavities). The restorative component of the ART approach is based on using only hand instruments to eliminate soft, pre-cavity tissue. *Id.*

dental programs use non-invasive techniques 31.6 percent of the time, while the U.S.' dental programs only do so five percent of the time.[70] Chile's greater use of non-invasive cavity management procedures compared to the U.S. illustrates how much more advanced Chile is in providing sufficient oral health care to its citizens, as non-invasive procedures are part of Chile's progressive dental health system.

Unlike Chile, tooth decay remains the most common chronic disease among children ages six through eighteen in the U.S.[71] About one in four non-elderly adults have untreated tooth decay in the U.S., about twenty-six percent of Medicare beneficiaries have no natural teeth due to poor oral health, and for every adult without health insurance, an estimated three lack dental coverage.[72] Furthermore, in 2010, one in five Medicare beneficiaries had not visited a dental provider in the prior five years, and a larger share delayed or did not get dental care due to cost concerns.[73] The PPACA specifically includes pediatric oral health care among the ten "essential health benefits" that all qualified health plans will be required to cover for children beginning in 2014, but adult benefits are not included.[74] Compared to children's oral health, the oral health of low-income adults is less widely recognized by government policies.[75] Hence, millions of adults without dependent children are left uninsured for the treatment of their oral health

70. *Id*. at 110.
71. *Children and Oral Health*, *supra* note 8, at 1.
72. KAISER FAMILY FOUND., ORAL HEALTH IN THE UNITED STATES: KEY FACTS 1 (2012), *available at* http://www.kff.org/uninsured/upload/8324.pdf; KAISER FAMILY FOUND., ORAL HEALTH AND MEDICARE BENEFICIARIES: COVERAGE, OUT OF POCKET SPENDING, AND UNMET NEED 1 (2012), *available at* http://www.kff.org/medicare/upload/8325.pdf [hereinafter *Oral Health Medicare Beneficiaries*].
73. *Oral Health Medicare Beneficiaries*, *supra* note 74, at 3-4.
74. *Children and Oral Health*, *supra* note 8, at 1.
75. *Id*.

needs.[76]

Despite the PPACA's expansion of publicly-funded insurance that now covers dental care for children, the U.S. still faces an important problem because private insurers are not required to provide oral health coverage.[77] Even with stand-alone private dental insurance, many adults will still be uninsured due to the high costs of private insurance.[78] In following the guidance of Chile's universal coverage along with the PPACA and its initial steps, the U.S. should expand its oral health coverage even further by mandating dental coverage for both private and public insurers of adults and children through the essential benefits package.[79]

V. LESSONS THE UNITED STATES CAN LEARN FROM CHILE

Overall, Chile has developed a comprehensive rights-based system that avoids solely judicial protections of health rights.[80] The system integrates those who require the most support into a universal system with the young and healthy, so the poor can access goods and services on equal terms with the rest of the population.[81] The United States can learn from Chile's focus on access and financial protection and can implement these targeted reform strategies when treating chronic conditions.[82] Yet, Chile's model for universal care has flaws that the U.S. can improve on. Unlike Chile, the U.S. should explicitly guarantee continuous care and make service options

76. *Id.*
77. *Id.*
78. *Id.* at 3.
79. *Id* at 6. Included within the PPACA's provisions are increased funding for health centers, public education to promote oral health, grants for school-based sealant programs and workforce training and development programs. *Id.*
80. *World Health Report*¸ *supra* note 15, at 29.
81. *Id.*
82. *Plan AUGE*, *supra* note 23, at Table 2.

well known to the public to increase awareness.[83] This increased awareness will ensure that these service options are fully utilized by the populations that need them. Also, the U.S. should continue to make it a priority to establish explicit quality standards, as done under the PPACA, and create functional systems for quality certification, accreditation and compliance, which is something Chile has yet to do in the implementation of the AUGE Plan.[84] One key impact measure that the U.S. should consider for chronic disease prevention is to reduce the rate of hospitalization from medically uncontrolled cases.[85] A successful "preventative" program minimizes chronic diseases' effects on a patient's health while averting costly hospitalizations.[86]

When comparing the universal health care of Chile with the health care in the U.S., one can see similarities between the programs. For example the coverage of diabetes-related health issues is similar, but one can also see stark differences, such as oral health coverage. The lesson learned from Chile's AUGE Plan model in regards to diabetes is for the U.S. to continue its extensive coverage, as the impact of diabetes will continue to decline as more patients seek treatment.[87] The lessons learned from the AUGE plan with respect to oral health should be even more apparent. Oral health diseases cause pain for millions of Americans each year and are some of the

83. *Id.* (explaining that although AUGE stipulates that treatment services should be provided for the time necessary for the recovery of health, only some services have precisely defined treatment durations). The United States should understand that explicit definition of duration will allow for ease and certainty. *Id.* Furthermore, despite the fact that the general Chilean population knows of the AUGE Plan, there are problems communication service options to the public. *Id.*

84. *Id.*

85. Bitran et al., *supra* note 1, at 2165.

86. *Id.*

87. *Power of Prevention*, *supra* note 3, at 3. Tremendous progress has been made in managing diabetes and its complications. *Id.* Because of public health efforts, higher percentages of people with diabetes are monitoring their blood sugar daily and receiving, through health professionals, annual foot exams, eye exams, and influenza. *Id.*

most under-covered chronic conditions in the Unites States health system.[88] As seen by Chile's success in preventative treatment in oral health care, the U.S. should extend its oral health coverage as well.[89]

Despite the importance of Chile's health reform and its universal care focused AUGE Plan, there has been a striking lack of evaluation.[90] Unlike Chile, the U.S. should maintain an evaluation system that regularly collects data and contrasts its health reform's achievement with the reform's cost.[91] Additionally, close monitoring and analysis of changes in coverage, access, and utilization for chronic conditions will be instrumental in tracking progress towards improved health for everyone in the U.S.[92] Unfortunately, while Chile has accepted the clear notion that health is a human right, the U.S. has yet to accept that viewpoint in the political arena.[93] The U.S. continues to debate on the proper system of health care and is divided on whether further expansion of health care is the best option for the Unites States.[94] Until a consensus is made, the hope for a universal care model in the U.S. will continue to remain only a hope, and not a reality.

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88. *Id.* at 5. More than ninety percent of adults aged twenty to sixty four have experienced tooth decay. *Id.*

89. Oswaldo Ruiz & Jo E. Frencken, *supra* note 71, at 110.

90. Bitran et al., *supra* note 1, at 2168.

91. *Id.*

92. *See Children and Oral Health*, *supra* note 8, at 6.

93. *Plan AUGE*, *supra* note 23, at §24. Minister of Health, Osvaldo Artaza, stated "a health system based merely on purchasing power or targeted and paternalist assistant programs generates inequity, inefficiency and quality discrepancies. On the contrary, a system that is able to offer universal (basic and modern) services in priority areas, defined through cost benefit analysis, can promote greatly the sustainable exercise of the human right to health. . .The guarantee of the right to health similar to other social guarantees, has meaning only in a democratic society. Democracy is increasingly conceived not only as a political but also a social and economic system that allows for simultaneously for growth and equity, for economic development and quality of life. . ." *Id.*

94. Saulny, Susan, *Few Minds are Changed by Arguments in Court*, NY TIMES, Mar. 28, 2012, *available at* http://www.nytimes.com/2012/03/29/us/health-care-debate-ripples-across-us-as-hearings-end.html?_r=0.

VI. CONCLUSION

Chronic diseases plague the wallets and spirits of citizens of the entire world, not just the United States. Furthermore, despite the recent improvement and innovation of Unites States' health reform, other countries have enjoyed even greater success at providing health care for their citizens. Chile's success with its universal healthcare system under the AUGE Plan in treating chronic diseases, such as diabetes and oral health diseases, can be a comparative model for future health reform in the U.S. The AUGE Plan can provide important insight, including what measures to take in providing universal care and which to avoid. Moreover, although Chile and the U.S. might differ politically and economically, if the U.S. seeks to improve the health of its population, it can do so effectively if they learn and adapt from Chile's established universal healthcare model.