

Chilean Health Reform and the AUGE Plan:  
Lessons for the United States in Implementing  
PPACA

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I. INTRODUCTION

Healthcare spending in the United States continues to grow at an unsustainable rate.<sup>1</sup> Today, one-fifth of the national gross domestic product is spent on healthcare.<sup>2</sup> The Patient Protection and Affordable Care Act (PPACA) aimed to create a more efficient and less expensive healthcare system.<sup>3</sup> Unfortunately, unless the manner in which Americans pay for healthcare undergoes fundamental change, the noble intentions of the PPACA's coverage expansions will ultimately prove wasteful.<sup>4</sup>

One of the keys to achieving true cost savings is altering the way in which chronic conditions are prevented and treated.<sup>5</sup> Some estimates indicate that as much as seventy to eighty percent of all healthcare expenditures are devoted to treating patients with chronic conditions.<sup>6</sup> Studies have shown the potential to improve the quality of care of chronic

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1. *Bending the Healthcare Cost Curve with Accountable, Patient-Centered, Coordinated Care*, W.P. CAREY SCHOOL OF BUSINESS ARIZONA STATE UNIVERSITY (Dec. 21, 2009), <http://knowledge.wpcarey.asu.edu/pdf.cfm?aid=171> [hereinafter *Bending the Healthcare Cost Curve*].

2. *Id.*

3. David Cutler, *Analysis & Commentary: How Health Reform Must Bend the Cost Curve*, 29 HEALTH AFF. 1131, 1131 (2010).

4. Jane Sarasohn-Kahn, *It's Time for a Chronic Healthcare Bailout*, KAISER HEALTH NEWS (Sept. 24, 2009), <http://www.kaiserhealthnews.org/Columns/2009/September/092409SarasohnKahn.aspx>.

5. *Id.*

6. *Bending the Healthcare Cost Curve*, *supra* note 1.

illness, while realizing \$800 billion in annual savings.<sup>7</sup>

The United States is not the only country struggling to reduce the amount of resources it wastes through inefficient management of chronic conditions.<sup>8</sup> In fact, the cost of treating chronic disease is a worldwide problem.<sup>9</sup> The South American country of Chile recognized the need to address chronic disease in the early 2000s.<sup>10</sup> Chilean leaders implemented vast health reform, including an extensive plan for guaranteeing care for individuals with certain chronic conditions.<sup>11</sup> Chile called its plan Explicit Guarantees and Universal Access (AUGE),<sup>12</sup> and since AUGE went into place in 2005,<sup>13</sup> Chile has learned a number of valuable lessons that can prove instructive as lawmakers consider ways to improve the delivery of care to patients with chronic conditions in the United States.

## II. CHILE'S HEALTH SYSTEM: BACKGROUND

Chile is one of the most economically stable Latin American countries,<sup>14</sup> and achieves health outcomes comparable to those of highly industrialized nations.<sup>15</sup> The success of Chile's health outcomes means that the country faces problems similar to those of highly industrialized nations, including a significant burden of caring for chronic illness.<sup>16</sup>

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7. Sarasohn-Kahn, *supra* note 4.

8. Ricardo Bitran, Lilian Escobar & Patricia Gassibe, *After Chile's Health Reform: Increase in Coverage and Access, Decline in Hospitalization and Death Rates*, 29 HEALTH AFF. 2161, 2161 (2010).

9. *Id.*

10. *Id.*

11. Veronica Vargas & Sergio Poblete, *Health Prioritization: The Case of Chile*, 27 HEALTH AFF. 782, 783 (2008).

12. *Id.*

13. Bitran, Escobar & Gassibe, *supra* note 8, at 2161.

14. *Id.* at 2162. In 2006, 13.7% of the Chilean population was considered poor. This is much lower than the Latin American, which is 40%.

15. *Id.*; see Vargas & Poblete, *supra* note 11, at 782. Life expectancy of for women is 80, and 73 for men. Infant mortality rate is 8.6 per 1,000 live births.

16. Bitran, Escobar & Gassibe, *supra* note 8, at 2162.

Chile's health insurance system is a joint public and private system.<sup>17</sup> FONASA, the public insurer, covers sixty-nine percent of the Chilean population.<sup>18</sup> The ISAPRE plans, or the private plans, cover about seventeen percent of the population.<sup>19</sup> Both plans are financed through a seven percent tax on the salaries of Chile's employed.<sup>20</sup> FONASA copayments are relatively small and correspond to an individual's income.<sup>21</sup> Alternatively, individuals who choose an ISAPRE plan pay additional premiums for better coverage.<sup>22</sup> While the theory behind the joint system is that citizens can freely choose public or private coverage, in reality an individual's income ultimately determines which plan he chooses.<sup>23</sup> An individual's gender influences which plan an individual chooses as well. ISAPREs require high premiums from women of childbearing age, rendering ISAPREs unaffordable for many Chilean women who traditionally earn substantially less than their male counterparts.<sup>24</sup> Therefore, traditionally, the ISAPREs are overwhelmingly populated by men.<sup>25</sup> Additionally, ISAPREs use risk selection to reduce costs, which results in the sicker and riskier populations obtaining FONASA insurance.<sup>26</sup> This in turn means that a greater number of individuals with chronic conditions are on the FONASA plans. Ultimately, the dual-system creates

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17. Vargas & Poblete, *supra* note 11, at 782.

18. *Id.*

19. *Id.*

20. Walker Elliot Rowe, *Is Chilean Health Insurance Better Than That of The USA?*, THE SANTIAGO TIMES (July 2, 2011, 2:12pm), <http://www.santiagotimes.cl/blogs/146-walker-elliott-rowe/21835-is-chilean-health-insurance-better-than-that-of-the-usa>.

21. Ricardo Bitran & Liliana Escobar, *The Politics of the AUGE Health Reform in Chile: A Case Study Prepared for the Results Development Institute*, BITRAN Y ASOCIADOS 9 (May 2008), available at <http://www.resultsfordevelopment.org/publications/politics-auge-health-reform-chile-case-study> [hereinafter *The Politics of AUGE*].

22. Bitran, Escobar & Gassibe, *supra* note 8, at 2162.

23. *The Politics of the AUGE*, *supra* note 21, at 9.

24. *Id.* at 853-4.

25. Charles Dannreuther & Jasmine Gideon, *Entitled to Health? Social Protection in Chile's Plan AUGE*, 39 DEVELOPMENT AND CHANGE 845, 853 (2008).

26. Bitran, Escobar & Gassibe, *supra* note 8, at 2162.

an inequitable approach in which the wealthiest Chileans receive better care and the poorer Chileans are guaranteed healthcare, but of a lower quality.<sup>27</sup>

### III. THE AUGE PLAN

Given the inequity in the healthcare system and the growing cost of treating chronic disease, the Chilean government began to focus its attention on controlling certain conditions.<sup>28</sup> A 2003 health survey conducted by the Chilean government revealed a high prevalence of chronic disease, and further concluded that very few of these patients were effectively managing their diseases.<sup>29</sup> To address these concerns, the government developed AUGE. With AUGE, the Chilean government aimed to create a more equitable system, which guaranteed certain services to all users regardless of insurance plan or socioeconomic status.<sup>30</sup> Additionally, the government sought to create a system which emphasized prevention, early examination of symptoms, and primary care.<sup>31</sup> The legislation establishing AUGE states that the plan guarantees enrollees four things: 1.) access; 2.) quality; 3.) opportunity; and 4.) financial protection.<sup>32</sup>

Guaranteed access ensures enrollees will receive identified curative services for certain prioritized diseases.<sup>33</sup> In an effort to guarantee quality, the law mandates that the services must be provided by certified providers in accordance with established guidelines.<sup>34</sup> The law also limits the waiting

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27. Dannreuther & Gideon, *supra* note 25, at 852.

28. Bitran, Escobar & Gassibe, *supra* note 8, at 2163.

29. *Id.*

30. 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*, REPORT NO. 40047- GLB (2008), summarized in *Chile: Regime Explicit Health Guarantees (Plan AUGE)* §12, <http://siteresources.worldbank.org/EXTSOCIALDEV/Resources/3177394-1168615404141/3328201-1192042053459/Chile.pdf?resourceurlname=Chile.pdf> [hereinafter *Plan AUGE*].

31. *Id.*

32. Bitran, Escobar & Gassibe, *supra* note 8, at 2163.

33. *Id.*

34. *Id.*

periods that enrollees experience when trying to access care.<sup>35</sup> Moreover, AUGE is uniform for all beneficiaries regardless of whether their healthcare is paid for through FONASA or ISAPREs.<sup>36</sup> FONASA and ISAPREs have to reimburse at a guaranteed level for the mandated services so that the out-of-pocket costs to enrollees do not exceed a predefined share of household income.<sup>37</sup>

The Chilean government organized what is likely the most thorough prioritization-analysis ever undertaken to determine for which conditions and diseases it should guarantee access.<sup>38</sup> An intricate algorithm was devised for determining which conditions to include.<sup>39</sup> Those diseases with the highest rates of mortality and disability received priority.<sup>40</sup> Then, the government determined which of the conditions it could effectively treat for all individuals regardless of socioeconomic status.<sup>41</sup> Essentially, the prioritization was based on the danger of a disease and the ability to cure or control the disease. Despite the extensive review, some criticized the prioritization. For example, a report by the Fourth Women's Parliament was critical of the final prioritization for its failure to account for gender

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35. *Id.*

36. Mari Edlin, *Chile's Healthcare Offers Public and Private Plans*, MANAGED HEALTHCARE EXECUTIVE (Dec. 1, 2009), <http://managedhealthcareexecutive.modernmedicine.com/mhe/Managed+Care+Outlook/Chiles-healthcare-offers-public-and-private-plans/ArticleStandard/Article/detail/647865>.

37. Britan, Escobar & Gassibe, *supra* note 8, at 2163.

38. Vargas & Poblete, *supra* note 11, at 790.

39. *Id.* at 783. The algorithm is as follows: "1) indicators measuring the burden of disease of different conditions: incidence, prevalence, and mortality rate; 2) inequity measured by gaps in mortality across socioeconomic groups; 3) effectiveness of different treatments – health conditions were stratified into high, medium, and low treatment effectiveness, and those conditions with high or medium treatment effectiveness were preselected; 4) evaluation of the capacity of public and private systems to deliver the services – the group of conditions for which there were enough available resources was preselected; 5) estimation of cost per case and total cost per condition based on treatment protocols suggested by experts and national scientific associations; 6) high-cost conditions – identified as those with annual treatment costs greater than or equal to annual minimum wage; and 7) people's preferences were elicited such that reformers could use the information and prevent special-interest groups from defining the health plan."

40. *Plan AUGE*, *supra* note 30, at §13.

41. *Id.* at §14.

differences which contribute to health, ignoring many of the diseases with the highest rates of female morbidity.<sup>42</sup> After much debate and analysis, fifty-six chronic conditions were chosen.<sup>43</sup> The list was later expanded, in 2010, to sixty-six conditions.<sup>44</sup> In addition to the list conditions, the government also defined curative services that were mandated to treat beneficiaries of AUGE.<sup>45</sup> Further, the government mandated coverage for early detection and intervention for hypertension, type 1 and type 2 diabetes, HIV/AIDS, cervical cancer, and other chronic diseases.<sup>46</sup>

Beneficiaries in AUGE can opt for care by a “closed” mode or a “free-choice” mode.<sup>47</sup> Individuals who choose closed mode receive care for little to no copayment.<sup>48</sup> Free choice mode requires a higher copayment, but usually offers faster, better quality care.<sup>49</sup> Moreover, given that the costs of many of the mandated services in AUGE are expensive, the copayments are devised to ensure that providers are compensated at a level that ensures they continue to treat patients in the program.<sup>50</sup>

Before AUGE could be implemented, it had to be funded. The debate around funding AUGE explored various funding sources.<sup>51</sup> AUGE is ultimately funded from four sources: 1.) a four year increase in consumer tax; 2.) a tobacco tax; 3.) customs revenues; and 4.) sale of the state’s shares in public health enterprises.<sup>52</sup> In preparation of implementation of AUGE, the government established a new entity to supervise public and private

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42. Dannreuther & Gideon, *supra* note 25, at 856.

43. Bitran, Escobar & Gassibe, *supra* note 8, at 2163; *The Politics of AUGE*, *supra* note 30, at 11.

44. Bitran, Escobar & Gassibe, *supra* note 8, at 2169.

45. *Id.* at 2163.

46. *Id.*

47. *Id.* at 2164.

48. *Id.*

49. *Id.*

50. Dannreuther & Gideon, *supra* note 25, at 857.

51. *Plan AUGE*, *supra* note 30, at §15.

52. *Id.*

health plans together to ensure that the program was executed effectively.<sup>53</sup> The new entity was the first of its kind in the country.<sup>54</sup> The success of AUGE also required an interdisciplinary network of providers, as well as involvement from the external community and corporate contributions.<sup>55</sup> Care for the prioritized conditions is provided in a team-based setting through a network of Non-Governmental Organizations (NGOs).<sup>56</sup> Due to the need for contribution and buy-in from various stakeholders, development of AUGE brought together trade unionists, academics, physicians and other service providers, the private health insurance companies, the ISAPREs, and NGOs including grassroots women's groups and neighborhood associations.<sup>57</sup>

AUGE faced opposition from various stakeholders as well.<sup>58</sup> The Chilean Medical Association opposed reform, fearing AUGE would restrict the physician-community's freedom to make decisions for patients.<sup>59</sup> ISAPREs feared that, because both they and FONASA had to pay into a compensatory fund based on clients' actuarial risk, they would end up paying more than FONASA and would essentially subsidize FONASA.<sup>60</sup> Following the extensive work that went into devising AUGE and reconciling the opposition, AUGE went into effect in 2005.

#### IV. THE RESULTS OF AUGE

Since its inception, 3.2 million Chileans have used AUGE.<sup>61</sup> Between

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53. *Id.* at §16.

54. *Id.*

55. Geoffrey Meads et al., *The Management of New Primary Care Organizations: An International Perspective*, 19 HEALTH SERVICES MANAGEMENT RESEARCH 166, 170 (2006).

56. *Id.*

57. Dannreuther & Gideon, *supra* note 25, at 855.

58. *The Politics of AUGE*, *supra* note 21, at 4.

59. *Id.*

60. *Id.*

61. *Plan AUGE*, *supra* note 30, at §19.

2006 and 2009, alone, AUGE grew to over two million cases per year.<sup>62</sup> The country has seen a rapid and significant increase in access to care for the mandated services.<sup>63</sup> Notably, Chile has experienced improved health outcomes since the beginning of AUGE. Mortality rates for several types of cancer on the prioritization list have declined.<sup>64</sup> Studies have also found that AUGE participants have benefited from earlier detection and more timely treatment.<sup>65</sup> Moreover, case-fatality rates for hypertension, type 1 and type 2 diabetes, HIV/AIDS, epilepsy, and depression have all dropped since AUGE's inception.<sup>66</sup> Surveys of public perception also indicate that AUGE is working and that Chileans like it.<sup>67</sup> In fact, sixty-nine percent of individuals surveyed reported that Chilean healthcare has improved.<sup>68</sup>

Evidence suggests that more public health insurance beneficiaries are utilizing AUGE than private beneficiaries.<sup>69</sup> In fact, in AUGE, FONASA beneficiaries outnumber ISAPRE beneficiaries by four to one.<sup>70</sup> Additionally, FONASA beneficiaries outnumber ISAPRE beneficiaries in services performed by twenty to one.<sup>71</sup> Evidence has also shown that “[t]he higher the perceived economic benefit of an AUGE service, the higher [the] propensity to demand care under AUGE.”<sup>72</sup> This likely means that the sicker the individual is, the more likely he or she is to choose to use AUGE. When ISAPREs customers have used AUGE, it has been primarily for high-cost treatments.<sup>73</sup> Ultimately, those individuals most in need of

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62. Bitran, Escobar & Gassibe, *supra* note 8, at 2163.

63. *Id.* at 2168.

64. *Id.* at 2163.

65. *Id.* at 2168.

66. *Id.*

67. *Plan AUGE*, *supra* note 30, at §21.

68. *Id.*

69. Bitran, Escobar & Gassibe, *supra* note 8, at 2163.

70. *Id.* at 2164.

71. *Id.*

72. *Id.*

73. *Plan AUGE*, *supra* note 30, at §19.

controlling chronic illness are receiving the care they need; however, consistent use across all income levels is the surest way to bend the cost curve.

Despite the evidence that AUGE is making strides in improving the health of Chilean citizens, no major healthcare overhaul is without problems after implementation. AUGE has improved access to care; however, problems with waiting lists for care and inequitable access to services persist.<sup>74</sup> Although AUGE legislation guaranteed that waiting periods for mandated services would not exceed certain limits, over half of AUGE beneficiaries report waiting periods beyond the stated threshold.<sup>75</sup> The availability of services negatively affects an individual's decision to use the AUGE plan.<sup>76</sup> In fact, public insurance beneficiaries who live in areas with a low supply of public hospitals are less likely to use AUGE because of their inability to access services conveniently, and therefore, AUGE is not yet achieving its goals for some.<sup>77</sup> Additionally, in some cases, increased waiting periods can lead to a worsening of the chronic condition, thus undermining the benefit AUGE was enacted to attain.<sup>78</sup> The waiting period is worse for low-income beneficiaries than for higher-income beneficiaries,<sup>79</sup> meaning the gap that Chile's dual-system creates between the service received by public and private beneficiaries persists as well.<sup>80</sup>

AUGE has created a new gap in access, one between those services

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74. *Id.* at §22.

75. *Id.*

76. Amanda Dawes & Felipe Gonzalez, *On the Importance of Hospital Supply in Health Reforms: the AUGE Plan in Chile*, POINTIFICIA UNIVERSIDAD CATOLICA DE CHILE 14 (Nov. 2010).

77. *Id.*

78. *Id.* at 1.

79. *Plan AUGE*, *supra* note 30, at §22.

80. Jean-Pierre Unger et al., *Chile's Neoliberal Health Reform: An Assessment and a Critique*, 5 PLoS MEDICINE 542, 546 (2008).

covered by AUGE and those that are not.<sup>81</sup> While waiting lists for AUGE-covered services are long, those for non-AUGE-covered services are even worse.<sup>82</sup> In fact, the problem became so worrisome that in 2008, the Minister of Health created a ninety-day plan to reduce the waiting lists.<sup>83</sup> The government was able to reduce the waiting lists considerably, but stated that a complete resolution of the problem would take several years.<sup>84</sup>

A second issue surrounding the successful implementation of AUGE is a lack of information available to Chilean citizens.<sup>85</sup> Surveys of Chilean citizens reveal that eighty percent of respondents did not know which diseases were covered by the plan.<sup>86</sup> Of those individuals surveyed who qualified for AUGE but did not use it, sixty-four percent blamed a lack of information about the benefits of the plan.<sup>87</sup>

The last major concern is the lack of valuable assessment of the program.<sup>88</sup> While AUGE has achieved major advances in health outcomes, there is little to no data to compare the achievements with the cost of the reform.<sup>89</sup> Without the ability to analyze cost-benefit data, it is difficult to determine whether the program's ability to achieve early intervention and detection actually saves Chile money. The government is eager to add more conditions to the list of prioritized diseases, and therefore it will be increasingly important to evaluate the system<sup>90</sup> in order to improve it and ensure that the most cost-effective services are used for the prioritized conditions.

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81. Bitran, Escobar & Gassibe, *supra* note 8, at 2164.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.* at 2163.

86. *Plan AUGE*, *supra* note 30, at §21.

87. *Id.*

88. Bitran, Escobar & Gassibe, *supra* note 8, at 2168.

89. *Id.*

90. *Id.* at 2169.

## V. THE UNITED STATES

The PPACA does not include an AUGE-like provision in the sense that the government has not identified certain conditions for which it will be mandating coverage. The PPACA does, however, attempt to achieve similar goals as AUGE; namely, greater equity in access and cost-effectiveness.<sup>91</sup> Cost-effectiveness is particularly important when it comes to treating the most expensive of conditions – chronic conditions. Thus, AUGE has achieved a valuable goal in making the receipt of care for those suffering from some of the most dangerous and difficult-to-control conditions more affordable. Unfortunately, an AUGE-like plan in the United States is likely politically infeasible. Given the difficulty in passing the PPACA, Congress is unlikely to take up further debates to create additional public health insurance programs.<sup>92</sup> Additionally, in times of economic recession, any program needing government funding or tax increases appears doomed to fail.

Nevertheless, there are provisions in the PPACA for which the Chilean government's experience with AUGE may be instructive. Certain provisions in the PPACA may face similar challenges to those faced by AUGE, most notably the Medicaid expansion and Accountable Care Organizations (ACOs). Medicaid expansion will vastly increase the number of individuals eligible to receive Medicaid assistance.<sup>93</sup> Many experts are already concerned that the increase in health coverage will not necessarily equate to an increase in ability to procure services due to a lack

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91. Cutler, *supra* note 3, at 1131.

92. Charles Krauthammer, *Obamacare: The Reckoning*, WASH POST (March 22, 2010) available at: [http://www.washingtonpost.com/opinions/obamacare-the-reckoning/2012/03/22/gIQALF1QUS\\_story.html](http://www.washingtonpost.com/opinions/obamacare-the-reckoning/2012/03/22/gIQALF1QUS_story.html)

93. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 271 (2010). PPACA extends coverage to all individuals with income levels at 133% of the federal poverty line or lower.

of providers.<sup>94</sup> As was the case in Chile, individuals with new health coverage will be more likely to access services if they are easily found. The PPACA attempts to address the issue of provider shortage in several ways, including increased funding to Federally Qualified Health Centers (FQHCs).<sup>95</sup> Ultimately, however, the Medicaid expansion will not improve the health outcomes in the United States unless people with chronic conditions actually have access to services. Further, the healthcare cost curve will remain similarly unchanged unless people with chronic conditions can access preventive services earlier. Based on the available evidence from Chile, even care to which individuals are entitled to receive will not be utilized in the face of waiting lists and overcrowded facilities. Even with a hypothetical surplus of providers of care, like Chileans, Americans will not seek care if it is not available in convenient places – in their communities.

Additionally, adequate information and education regarding eligibility and benefits will be the key to enrolling people in Medicaid and providing them care. In Chile, one of the major barriers to use of the AUGE plan was the lack of information available to Chilean patients. Similarly, in the United States some of the individuals who will have access to care through Medicaid expansion will be accessing the system for the first time, and therefore, information will prove crucial to enrolling individuals and providing them access to the care they need.

The PPACA emphasizes the creation of ACOs, which are perhaps the piece of the PPACA which most closely resemble AUGE. ACOs provide

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94. Leighton Ku et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, GEIGER GIBSON/RCHN COMMUNITY HEALTH FOUNDATION RESEARCH COLLABORATIVE POLICY RESEARCH BRIEF NO. 19 2 (2010).

95. *Id.* at 3.

coordinated care for patients in a team-based setting.<sup>96</sup> The team of providers is incentivized to provide efficient, cost-effective care.<sup>97</sup> ACOs promote primary care and control of chronic conditions in an effort to reduce costs and improve quality.<sup>98</sup> While ACOs differ from AUGE in several ways, including that they will not be mandated to treat certain conditions, there are lessons to be learned from AUGE in their implementation. For example, proper assessment and evaluation of ACOs will be critical to their success. One of the frustrations for policymakers trying to improve or refine AUGE is the lack of evidence relating to cost-effectiveness. In the United States, providers are beginning to create ACOs as pioneer organizations.<sup>99</sup> The Department of Health and Human Services believes that the pioneer ACO organizations can achieve \$1 billion in savings over five years.<sup>100</sup> The government and the providers involved will need to carefully document and evaluate the entire process in order to analyze whether ACOs achieve this goal. Additionally, ACOs will likely need refining, just as AUGE does, and assessment will be pivotal to determining what form the refinement takes.

While the ACO initiative does not involve identifying the most costly diseases, this may be a useful exercise for the United States. Identifying those diseases which are most dangerous, yet most treatable, can help the United States to prioritize the conditions that, when more actively managed, could have the greatest impact on improving the health of its citizens and bending the cost curve. If this project were to be undertaken, the United States should be careful not to duplicate the efforts of Chile, but rather to

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96. *Bending the Cost Curve*, *supra* note 1.

97. *Id.*

98. *Id.*

99. Press Release, U.S. Dep't of Health and Human Servs., Affordable Care Act Helps 32 Health Systems Improve Care for Patients, Saving up to \$1.1 Billion (Dec. 19, 2011), available at <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.

100. *Id.*

heed the lessons that the extensive process of implementing AUGE has already created.

## VI. CONCLUSION

The United States is not the only country facing great challenges when it comes to caring for chronic illnesses. Additionally, no country's reform efforts look the same as another's. The United States and Chile have similarities in their reforms, but, overall, they differ vastly. Moreover, the United States and Chile differ economically, culturally, and politically. This does not mean, however, that the United States cannot learn from the health reform implemented in Chile. The PPACA promises to fundamentally alter the way healthcare is delivered in the United States to patients with chronic disease, and stakeholders have a challenging time ahead in implementing and refining healthcare. The Chilean health reform and AUGE can provide valuable lessons, including the need for easily accessible, convenient care; the reliance of individuals on information before they will access benefits; and the value of thorough assessment and data.