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Obama Healthcare Reform Plan for Americans: Challenges and Constraints

Mahmoud Kamal Abouraia[1] Benjamin Balbuena Aguenza[2, 3, *]

1. Business Administration Department, Ibn Rushd College for Management Sciences, PO Box 447, Abha 61411, Saudi Arabia
2. School of Health Science, Management and Pedagogy, Southwestern University, Villa Aznar, Urgello St., Cebu City, Philippines 6000
3. Support Studies Department, Ibn Rushd College for Management Sciences, PO Box 447, Abha 61411, Saudi Arabia

* E-mail of the corresponding author: botchie1005@hotmail.com

Abstract

Healthcare reform is a set of criteria, employed for describing significant components of health policy development or changes but most cases, governmental policy that influences health care delivery in a place provided. In the United States, President Obama approved an inexpensive Health Care Act into law in March 2010, to capture adjustments in healthcare systems. Such changes, is to enhance the amount of people covered with insurance as well as to boost the quality of treatment while attempting to balance or decrease expenses. Under this legislation, everyone ought to have health insurance independently but majority of the employees in the United States depend on their companies' healthcare coverage. In this issue, the accurate understanding of healthcare protection would appear to be essential for making clear decisions in selecting the finest plans that match the distinct requirements of a family. Various literatures revealed that most of the employees have little understanding of the scope and value of healthcare reform plans. Therefore, the purpose of this paper is to examine the effect of Obama healthcare plans to American employees and discuss the significance, challenges and constraints of the policy to attract and maintain talented individuals. Generally, companies need to remain updated in the newest healthcare reform requirements and provide healthcare strategies to support employees make better choices in regards to the insurance coverage.

Keywords: American employees, healthcare reform plan

1. Introduction

Within the health economic advancement, healthcare reform has become a buzzword in scientific studies and numerous comments and content articles criticizing the aspects of the reform. Furthermore, various pharmaceutical scholars and scientists brought up this matter in the framework of costs such as U.S. healthcare costs (Kaiser Family Foundation, 2007), control prices and expenditures (Schweizer & Comanor, 2007), and measurements of costs and trends (Rice, 2007). But a narrow attention on the passage of healthcare reform is not clear, despite the fact that some authors take advantage of the phrase healthcare reform. Mullikin (2011) explained that affordable care implies "shared risk". Risk is being exposed to economic reduction along with probability levels of loss. Risk is characterized by danger such as an illness or injuries. As providers, our system of care mitigates that hazard and the amount of loss hinges on the fully allocated costs of care. The two main distinct types of financial risk that the healthcare reform plan tests upon: performance risk such as "bundling" where the reimbursement is based on the cost of care delivered with a greater connection between the payment and clinical outcomes. The other type of financial risk is utilization risk which provides for new incentives to reduce the volume of care delivered. Residing between and overlapping these two types of risk is the quality of care or pay-for-performance from the Hospital Impatient Value-Based Purchasing Program (Health Care Advisory Board, 2010).

Based on Frank's exploration (2009), healthcare reform plan is a law passed by congress that was designed to help people in various income levels, employment situations and health status access health care. It goes by many names such as Patient Protection and Affordable Care Act (Public Law 111-148) or simply called "health reform". This law is intended to make sweeping changes to healthcare in the United States. Many of the law's provisions are already in effect, while others will come in the next few years. Healthcare reform typically attempts to: provide universal access to healthcare for Americans, control the rising costs of healthcare, regulate

the private insurance industry through things like state-based private exchanges, improve the quality of healthcare, and make healthcare choices more consumer friendly and easier to understand. Healthcare reform is the main priority for the president and the Democrats in congress, but bruising debates also loom later this year on climate change and financial services legislation (Sederstorm, 2012). The debate regarding healthcare reform includes questions of a right to health care, access, fairness, sustainability, quality and amounts spent by government. According to World Health Organization (2009) the mixed public-private health care system in the United States is the most expensive in the world, with health care costing more per person than in any other nation, and a greater portion of gross domestic product (GDP) is spent on it than in any other United Nations member. The advent of healthcare plan signalling to many that a transformational and reforming policy remains uncertain. There is a risk that the improvements in healthcare may lose significance when up against bigger issues.

After Obama signed the law, this piece of legislation has been heralded as the biggest change in healthcare system since Medicare and Medicaid were enacted in 1965 (White, 2010; Wingfield *et al.,* 2010). With such historic reform underway, public opinion is divided on the law and its implication. Substantial polling of the general public has been conducted. According to a Pew Research Center Poll, which was completed shortly prior to passage of the healthcare reform, 48% of Americans opposed the legislation while 38% favoured it (Pew Research Center, 2010). Simultaneously, a Kaiser Family Foundation poll showed 46% of Americans support the bill and 42% oppose it (Kaiser Family Foundation, 2010a). National polls have also reflected what Americans view as the strengths and weaknesses of the bill. Some view the reform as an opportunity to care for the uninsured or lower-income groups or provide needed oversight of the health insurance industry, while others believe the budget deficit will increase under the new law or create too much government involvement (Blendon & Benson, 2010). All of these polls have sought to capture public perceptions of the healthcare reform and track changing opinions over time.

Physician attitudes regarding healthcare reform have been previously documented (Kocher *et al.,* 2010; Keyhani & Federman, 2009). There has not, however, been a similar drive to evaluate the attitudes of future physicians, who will enter practice during or shortly after the implementation of many of the provisions outlined in the legislation. On top of that, most consumers rely on their employers for healthcare coverage. In 2003, employers provided 60.4% of Americans with health insurance (DeNavas-Walt *et al.,* 2004). It is a specific characteristic of the healthcare system in the United States that employees have to choose among several healthcare plans, (OECD, 2004) commonly divided into basic and supplemental medical expense insurance (Reijda, 2003). These health insurance plans are extremely important in providing financial security to employees and their families. In making sound decisions about the specific healthcare needs of a family, accurate knowledge about the scope and the monetary value of healthcare plans would seem to be crucial (Hira & Loibl, 2005). The purpose of this paper is to examine the effect of Obama healthcare plans to American employees and discuss the significance, challenges and constraints of the policy to attract and maintain talented individuals.

2. Antecedents of Obama healthcare proposals

In a previous study, Saldin (2010) mentioned that elections were molded by global crises and conflicts in particular. Obviously, as the 2010 midterms illustrate, conflicts usually do not control the campaigns and elections, even though the United States is positively linked to them. The continuous unclear issues between Iraq and Afghanistan, and having influenced of previous U.S. elections were non-factors this time. In this regard, healthcare reform will probably recalled in performing a significant function within the governmental prospects of these two parties. Further, like conflicts as well as other issues in the past, healthcare reform's role in this election period features the delicacy of partisan regimes specifically people that have been prematurely labelled as realignments, whether it is academic or well-known observers.

Setting the scenario wherein the Obama healthcare discussion performed and in which the 2010 elections held, it is actually beneficial to fully grasp, at least, the fundamental shape of health policy background. For instance, it was not pleasant to fine oneself in a hospital because it meant you were poor and about to die. People that have even modest means paid doctors in a reasonably priced for home appointments. The initial demands for health insurance started within the Modern Period, however these overtures had been the maximum amount of attuned to impairment settlement for ill-induced work absences because they were actually for the expense of the healthcare itself, which continued to be fairly reduced (Berkowitz, 2010). As a result, various private employers and states started to offer disability insurance that complimented national programs already in place. In this context, liberal reformers came to embrace the idea of nationalized, government-sponsored health insurance to cover healthcare costs, though over time and as costs increased. The first significant chapter in this particular

drive arrived in the discussion around the Social Security in 1935. There seemed to be a prospective window of chance for common health insurance to create its distance to bill, however it was eventually kept out from the version where Franklin Roosevelt signed (Blumenthal & Morone, 2009). In this article-1935 vacuum, where insurance was progressively viewed as needed and the private insurance industry bolstered by favourable federal incentives and investments were developed and filled the gap.

The modern desire of universal insurance coverage offered by the federal government, nevertheless, never expired. Amongst increasing healthcare costs, President Harry Truman for a countrywide health-insurance policy but was compelled to abandon his initiatives when the Korean War shattered out (Blumenthal & Morone, 2009). It was thwarted as well, when President John Kennedy made a major push for reform. Progressives ultimately received some traction under Lyndon Johnson in 1965 using the enactment of Medicare, a governmental program to protect the senior citizens (Oberlander, 2003). Knowing that any proposition for common insurance coverage would be lifeless on the introduction in Congress, Johnson was content with this incremental phase. Although it did not offer universal, government-sponsored health care, progressives discovered Medicare as a foundation in the direction of that supreme objective. The next phase in this direction happened in 1972 when Medicaid was introduced to improve coverage towards poor and disabled (Olson, 2010). However, in a period of growing costs and limited budgets, development toward universal coverage again stalled. President Jimmy Carter's efforts to enact universal coverage failed. And, most recently, President Bill Clinton's plans met with disaster (Hacker, 1997). Throughout this several years of expansion, numerous other proposals for universal healthcare were actually drafted in Congress but failed to become law. Modest incremental actions continued to be made, most recently with the George W. Bush-sponsored expansion of Medicare to provide a prescription drug entitlement. However, these boosts in the governmental role in American healthcare fell well short of the long-coveted liberal perspective of universal coverage.

Some advocates of Obama-style healthcare reform evidently neglected to appreciate this stressed policy legacy. As Berkowitz (2010) has asserted that academics have too often capitulated to a "simplistic and ideologically predetermined framework" in which universal, national health insurance is supposed to be globally preferred, merely to be thwarted by nefarious factors including the American Medical Association and insurance company lobbyists willing to distribute death and disease from sea to shining sea. Those Obamacare proponents considered ignorant with the hostility towards the new legislation would manage to also match Berkowitz's model. Undoubtedly, there is much reality in assertions that arranged interests performed a vital role in squelching different iterations of healthcare reform. However, the same holds true in other policy areas, too. A particular need remember the occurrence where Rode Page, Secretary of Education under President George W. Bush, mentioned to a prominent teachers union as a "terrorist organization" shortly after 9/11 to understand that arranged interests have frequently unsatisfied reform efforts emanating from points across the partisan and ideological spectrum. Nevertheless, sanctimoniously concentrating exclusively on sinister factors opposing healthcare reform is because they experience suffering and pain. In this regard, confuses the more basic and fundamental problems experiencing healthcare reformers: the American political program has numerous veto details, and several residents, in addition to prepared interests, choose the status-quo to new guidelines with unclear ramifications.

These aspects that long repelled progressive attempts to change American healthcare create the Affordable Care Act's passage even more impressive. While it tumbles short of the liberal desire of universal coverage, the program signifies a massive element in that direction. Elections have implications, and the 2006 and 2008 periods placed Democrats in a position to successfully pass Obamacare with or without the American public's recommendation. Such is regulating within a representative democracy but governing decisions by elected politicians also have consequences.

3. Significance of Obama healthcare reform

On March 23rd, 2010, President Obama signed into law the most significant piece of social policy legislation in almost fifty years. The Patient Protection and Affordable Act (PPACA) or healthcare reform will ultimately provide health insurance coverage to 32 million of the nation's uninsured, and improve the security of insurance for millions more who are one accident away from losing coverage. It does so in a fiscally responsible fashion by actually reducing the deficit by over $100 billion in the first decade and over $1 trillion in the next. And it includes a host of innovative ideas for cost control that offer our best chance to date to "bend the cost curve" and save the United States from fiscal ruin (Royal Statistical Society, 2010).

The healthcare reform, as amended, includes provisions both to expand health insurance coverage among the

population and to reduce the cost of the healthcare system. The law establishes a health insurance mandate for individuals and expands the means by which affordable coverage can be obtained. Employers will remain a primary source of health insurance coverage, and insurance exchanges will be established in the market for individually purchased plans. Dependent coverage for offspring up to age 26 is mandated for all individual and group health plans. In addition, government-provided health insurance plans will be modified. Medicaid eligibility will be expanded to include childless adults and persons with income up to 133% of the federal poverty level. The cost of these coverage expansions will be offset by savings in the Medicare program and by fees on health-related goods and sectors (Leigh & Wheatley, 2010). There is also a tax penalty for those who do not obtain health insurance, unless they are exempt due to low income or other reasons (Grier, 2010). The Congressional Budget Office estimates that the net effect of both laws will be a reduction in the federal deficit by $143 billion over the first decade (CBO, 2010).

Beginning in 2014, private insurers will no longer be able to exclude any person with a pre-existing condition from coverage or charge them more for coverage. Tax credits starting at 35% and going up to 50% will be given to small firms. The US private health insurance market will be fundamentally changed by the introduction of a set of organized Health Insurance Exchanges, which will be established in each state and will require insurers to offer standard packages of benefits. Even though all states have a somewhat different set of eligibility requirements and coverage arrangements under Medicaid, the benefits are quite comprehensive and generous, though compensation to providers is not. For instance, in 2010, over 60 million Americans (one in four children) received insurance under this program. In 2008, $340 billion was spent on the health care of Medicaid beneficiaries; the program accounts for nearly 16% of all personal health care spending and almost 45% of spending on nursing home care (Haveman & Wolfe, 2010). On October 1, 2013, Obama administration launched health insurance marketplaces, which were key provisions of the healthcare reform. These marketplaces are intended to be structured as online web sites featuring listings and sources where people without health insurance can shop for coverage at competitive rates. In some cases, certain qualified patients are even supposed to be allowed to use government subsidy payments to purchase their coverage via these online marketplaces (Reiboldt, 2013). In various reports, the Centers for Medicare and Medicaid Services has estimated that by 2014, approximately 7 million people will be expected to purchase health insurance at competitive rates through the health insurance marketplaces (Kliff & Somashekhar, 2013).

According to Kaiser Family Foundation (2010b), this PPACA would expand health insurance coverage by: mandating (with tax penalties) that individuals acquire health insurance, establishing state-based American Health Benefit Exchanges that would allow consumers to compare and shop for health insurance at competitive prices, creating the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies in all 50 states and Washington, DC to offer qualified health plans, requiring the Office of Personnel Management (OPM) to contract with insurers to offer at least two multi-state plans in each Exchange. Also, establishing a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions, requiring guaranteed issue and renewability of health insurance coverage (as a way to eliminate insurance exclusion), allowing rate variations among health insurance plans to be based only on factors such as age, family structure, and geography, providing premium credits and cost-sharing subsidies (or credits) to enable eligible low- and middle-income individuals to purchase plans from the insurance exchanges, establishing a "pay or play" mandate for employers, with exceptions allowed based on size of firm (50 or fewer employees) or payroll, establishing Small Business Health Options Program (SHOP) Exchanges from which small businesses can acquire health insurance for their employees, providing tax credits to small businesses (with no more than 25 employees) that purchase health insurance for their employees, creating a temporary reinsurance program to reimburse employers who provide coverage to retirees over the age of 55.

4. Challenges and constraints of Obama healthcare reform

Despite the benefits and contribution of healthcare reform to Americans as mentioned above, the U.S. healthcare system has numerous inefficiencies and market imperfections. For instance, the system places inadequate emphasis on prevention and rewards the use of medical inputs such as procedures, rather than the generation of medical outputs or health outcomes. Information asymmetries abound between patients and providers, as do high administrative costs, in part due to the multiple payers (individuals, insurance companies, governments) for services received within the healthcare system. In addition, adverse selection in the insurance market makes it difficult for healthy individuals to purchase insurance priced at actuarially reasonable rates. These other characteristics have contributed to rising costs within the system, inadequate access to insurance coverage (and to needed care) among individuals and families, and poor health outcomes for many in nation. Slowing the

growth of healthcare costs and improving the access of all the optimal care (and good health) are necessary for nation's economic stability (Leigh & Wheatley, 2010).

Since 1980, healthcare expenditures in the United States have increased markedly as a percent of gross domestic product (GDP) increasing from less than 10% in 1980 to a projected 17% in 2009 and 19% by 2019 (Center for Medicare and Medicaid Services, 2010). Costs of this magnitude constitute a challenge to the economy overall but, in particular, for the federal government and its budget deficit. Almost half of healthcare spending is by federal, state and local governments through programs such as Medicare, Medicaid, and Children's Health Insurance Program. The fraction of healthcare expenditures borne by governments is expected to grow in the near future as early waves of the Baby Boom Generation become eligible for and sign up for Medicare and as many also become eligible for and enroll in Medicaid (Council of Economic Advisers, 2009). It is cause stresses not only at the macro level but also at the micro level for employers and individuals. The cost of employers, especially those with 100 or fewer employees, to provide health insurance continues to rise, as does the share of this cost borne by employees. As a result, some employers cease offering health insurance coverage, and some employees do not enroll in the health insurance coverage that is available through their employers. The proportion of non-elderly individuals with employ-sponsored health insurance coverage has steadily declined in recent years from 64.2% in 2000 to 59.3% in 2007 and 58.5% in 2008 (Families USA, 2009a; Gould, 2009). In addition, between 1996 and 2008, the average annual premium for family coverage grew from $6,462 to $12,298, a 90% increase in real terms (Council of Economic Advisers, 2009; Kaiser Family Foundation, 2009).

The urgency for reform in the U.S. healthcare system was illustrated by the results of the 2007 National Health Interview Survey, which demonstrated that at least 46 million Americans lacked health insurance coverage (Adams et al., 2008). More recent data that reflect the impact of the national recession show a continuation of this trend. Additionally, the U.S. Department of Health and Human Services highlighted a March 2009 report by Families USA and Lewin Group that showed that one in three Americans under the age of 65 lacked health insurance at some point during 2007-2008 (USDHHS, 2010). Even those with secure health insurance could benefit from reform, as the institute of medicine determined that there is a spillover effect from the cost of taking care of the millions of uninsured Americans that in turn detrimentally affects the healthcare of those with health insurance (Families USA, 2009b; Mitka, 2009). Without changes to healthcare system, this number is projected to grow to 72 million by 2040 (Council of Economic Advisers, 2009).

In terms of finance, the problems in health care are not restricted to the uninsured, fragmented and inadequate payment system causes tremendous suffering among insured Americans as well. Research undertook with Harvard Law School and Ohio University found that more than half of all US bankruptcies are due, at least in part, to medical illness or medical bills (Himmelstein et al., 2005; Himmelstein et al., 2009). This headline from the study was widely cited in the 2009-2010 health reform debate. But another of findings received much less attention in the overwhelming majority of medical bankruptcies, the patient had health insurance, at least when they first got sick. In most recent study on bankruptcy filers in 2007, 78% of those who illness caused a medical bankruptcy had health insurance. In some cases patients started the illness with insurance, only to lose it along with their job after they became sick. In many more cases, people had insurance usually private health insurance which they held on to throughout the bankrupting illness. Yet they were bankrupted anyway by gaps in their coverage, like co-payments, deductibles, and uncovered services. Similar results, surveyed by Commonwealth Fund found that even among Americans who were insured all year, 16% report being unable to pay their medical bills, 15% had been called by a collection agency about medical bills, 10% changed their way of life to pay medical bills, and 10% were paying off medical bills over time (Doty, 2008).

Various literature revealed, about one-third of Americans are inadequately insured, either completely uninsured or underinsured, such that a major illness would likely bankrupt them. They often denied care, and they are sicker and die younger than the well-insured. At the same time that many are denied access to vital care and have tremendous overuse of medical services. The Dartmouth Group has documented huge variations in health spending in different regions of the country; high-cost areas such as Florida, New York City, or Boston have health care spending 60% higher than low cost areas, like Minnesota or Northern California after adjusting for the health of the population. One very high spending area is along the border between Texas and Louisiana. There, per capita spending is nearly twice what it is in Minnesota. They say with 100% certainty that the quality of medical care is not higher in Louisiana than it is at Minnesota. The group concluded that the quality of care is actually higher in parts of the U.S. that spend less per capita (Woolhandler & Himmelstein, 2011).

5. Innovation as management tools for healthcare reform

Healthcare reform has been a major topic of debate in the U.S. national stage. It is an important component of change that continues to be less noticeable: improvement in the delivery of medical services. Health care managers are definitely the missing link in debate over reform. Their skills and ideas are necessary to improve and sustain after several developments in the delivery of healthcare for the benefit of patients. Rethmeier (2010) included that healthcare managers at all levels should be prepared to eliminate the thinking and behaviours of their previous as well as to understand new approaches in order to adapt the possibilities prior to them. To put it briefly, purposeful reform in healthcare is determined by innovation. Innovation is primary and essential leadership proficiency for continual excellent performance. Moreover, utilizing the best available medical expertise to deal with the difficulties of individual patients that offer massive potential to support patients and the U.S. healthcare system overall. Healthcare reform could be displayed in many different viewpoints and might originate using the practical attempts of specific healthcare organizations or activities required by a central governmental agency. In any case, an organizational measure begins with leaders having the capacity and resources to take part in an efficient discussion and solution-finding process.

As stated before, management resources are provided to support leaders of all shapes and sizes make a variety of revolutionary strategies to the challenges and constraints of healthcare reform (Bolster, 2009). These tools are vision, can/cannot control matrix, brainstorming, systems thinking, and time-space assessment matrix. The concept of perspective is crucial in assisting an effortless transition in periods of healthcare reform and in the introduction of strategic initiatives suitable to create the direction for the organization. A vision is best described as picture of a long-term desired state for the healthcare organization. It represents exactly what the innovator and the management group need for the organization. In some respects, visions are both descriptive and prescriptive simply because they assist the organizations manage it to consider and respond in a different way. This tool can be used to stimulate an effective conversation to distinguish and define the organization's vision for healthcare reform. Second is can/cannot control matrix, leaders often face situations that make it difficult to differentiate what they can and cannot control process when responding to the challenges and constraints of healthcare reform. This produces specific challenges for initiatives to innovate because it is essential to know upfront no matter if development will get the chance to achieve success. This second tools gives innovator and organizations a straightforward procedure to help distinguish individual areas for which there are possibilities to expand and explore imaginative thinking in searching for development. This tool promotes an effective dialogue about innovations in healthcare reform which lead to high-impact change.

Third, brainstorming is actually a method utilized by organizations to build a collection of ways to resolve difficulty. It can be most valuable when organizations need to crack far from out-dated designs of thinking, to enable them to create new methods of looking at issues. In addition, it capitalizes on enhancing the different knowledge of the group to further improve the quality and richness of the concepts produced. The more ideas, the greater opportunity to find a better solution. As an example, leaders or organizations require innovative thinking to help resolve issues, particularly when confronted with the difficulties of healthcare reform. The effects from brainstorming sessions will offer an abundance of prospective areas for effective innovation of healthcare reform. Fourth, within the sophisticated arena of healthcare reform, systems thinking assists leaders deal with the influence of reform initiatives so their organization is most beneficial situated for continual excellent performance (Senge *et al.,* 1994). Systems thinking decreases complex challenges and issues into simple, easier to understand terms. It will help leaders and organizations discover improvements that will assist these people to change rather than just respond to the challenges and problems of healthcare reform. For instance, a couple of the objectives documented by most European countries with regard to their initiatives at healthcare reform are to move from lucrative medicine towards precautionary medicine and to find alternatives using the maximum degrees of entry to good quality medical professional services. These could only accomplish when leaders realign their thinking as well as the resources offered to them and their leadership groups (Rethmeier, 2010).

Fifth, time-space assessment matrix is definitely the last device that made to support leaders and their leadership teams to take advantage of the outcomes of their work in developing innovations for healthcare reform to ascertain where they can fit within the framework of the time-space principle. After creating the healthcare reform initiative they presume is most effective for that challenge their organization encounters, the process would be to examine its benefits meticulously depending on the time-space standpoint and to install it within the cells of the matrix. The entire objective would be to produce innovations that provide the most effective solutions to the process of healthcare reform and which can relocate the intellectual design from curative medicine towards preventive care while concurrently searching for transformational change.

6. Conclusion

The reform of healthcare is definitely evolving procedure that requires a substantial investment of time, private and public policy, and financial and human resources. Discussion of healthcare reform started in 1930s and was finally approved in congress within the presidency of Obama. To date, the healthcare reform has contributed to what can be considered important upgrades in both the health of American people and its healthcare structure. However, as a result of the recent political unrest, it is anticipated that healthcare reform will be negatively impacted. It is actually crucial for new government to organize for and invest in boosting the health of its citizens. Furthermore, insurance policies should be considered to conquer the persistent challenges that will continue to cause American's increasingly bifurcated healthcare process. The government should allocate financing curative care and increasing the resources available for preventive and primary healthcare. Robust incentives for customers to select less-costly insurance plan, in conjunction with dependable on their own quality and cost, could lead to better uptake of benefit designs that, like tiered drug coverage , offer much bigger financial incentives to customers who select more potent treatment. Providers and payers must consistently transfer towards a more comprehensive and coherent view of payment reforms. Moreover, a significant leadership time, effort and capital are needed for the majority of providers to put into practice the types of healthcare delivery reforms that could obtain systematic results on quality and cost.

Notes on Contributors

The first author, Mahmoud Kamal Abouraia is a full professor in economics and finance is currently attached to Ibn Rushd College for Management Sciences, Abha, Saudi Arabia. He has been in the academics for seventeen years. He obtained his doctoral degree from the University of Texas at Arlington, USA. Dr. Abouraia has published several articles in other international journals related to the field of economics and finance. The second author, Benjamin Balbuena Aguenza is a student in master of business administration major in human resource and organizational management from Southwestern University, Philippines, is specialized in human resource management, organizational behavior, social media, and organizational learning and culture. He is currently attached to the same institution in Abha, Saudi Arabia.

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