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Physicians' perspectives on the government-led first action plan for healthcare reform: the medical payment system in South Korea

Sun Mi Lim¹, Kye-hyun Kim¹, Ji Yeun Lim¹ and Seog-Kyun Mun^{1,2*}

Abstract

Background Health care payment systems are a central component of health reform efforts worldwide, as they shape provider behavior, financial sustainability, and access to care. The Korean government plans to change the payment system for medical expenses from the existing fee-for-service system to an alternative system such as pay-for-performance and value-based payments. This study aims to compare the perceptions of clinic- and hospital-based physicians regarding the reform agenda and draw lessons relevant to international health policy contexts.

Methods This study used the member data from the Korean Medical Association to conduct an online survey of physicians. In total, 765 physicians participated in the final analysis. The differences in perceptions between physicians working in clinics and hospitals were examined using cross-tabulation analyses and Pearson's chi-squared tests.

Results According to the results of a survey on awareness of the government's planned payment system reform, doctors from clinics (94.8%) and hospitals (87.5%) responded that the reform would not contribute to improving the quality of medical care or reducing medical costs ($P < 0.001$). In addition, as a result of investigating the domestic applicability of payment models, such as the Accountable Care Organization (ACO), many doctors in both clinics (60.2%) and hospitals (57.8%) responded that the ACO model was not applicable ($P = 0.001$). The most frequently cited reason for the difficulty in applying the ACO model was "uncertainty about its performance and effectiveness"; however, there was no significant difference between hospitals and clinics ($P > 0.05$). The fee-for-service system (81.1% of clinics, 73.8% of hospitals) and performance-based payment system (24.7% of clinics, 36.6% of hospitals) were the preferred payment systems suitable for future clinics and hospitals.

Conclusion This study confirmed that both clinic and hospital doctors had a negative perception of the government's proposed payment system reform. When introducing a new payment system, it is necessary to analyze its impact on doctors and patients in detail and devise alternatives that reflect this. Particularly, it would be effective to design a structure that provides appropriate compensation so that the payment method does not hinder the quality and equity of medical care.

Keywords Health policy, Healthcare reform, Payment system, Physicians' perspectives, Survey, Korea

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Background

The medical payment system is an important factor that directly and indirectly influences the structure and quality of medical service delivery and refers to the compensation system for services provided by healthcare providers. This system applies to all healthcare providers participating in the public health insurance program and significantly affects both healthcare providers and patients. Designing an efficient payment system for medical care improves the quality of healthcare services, reduces unnecessary costs, and enhances the sustainability of healthcare systems [1–3].

Medical payment system methods are categorized by payment target (payment to a doctor or hospital), payment unit, and timing of fee determination (advance or post-compensation). The payment unit classifications include fee-for-service, case-based payments, capitation, and global budgets. These payment methods have their respective advantages and disadvantages and play an important role in improving the efficiency and quality of healthcare services. Each country uses different payment systems to account for these factors.

The main payment method for medical service providers in Korea is a fee-for-service system, which compensates doctors for all input resources, including medical services, medicines, and material costs. This system has contributed to the introduction and development of new medical technologies and has played a positive role in providing quality medical services to patients. However, because this system mainly focuses on compensation for treatment, it emphasizes treatment over preventive care, which encourages doctors to offer more services in an environment without restrictions [4–6]. This system has the limitation of potentially increasing medical costs. To address this issue, the Korean government has implemented a medical fee review system to regulate costs and prevent unnecessary medical services.

The Korean government announced its plan to transition to an alternative payment system (pay-for-performance and value-based payments) through the first action plan for healthcare reform (August 30, 2024). In an attempt to transition from Korea's existing fee-for-service system to a new payment model, this reform plan aims to enhance the quality and efficiency of medical services. More importantly, it seeks to control medical costs and moderate the pace of spending growth. The new paradigm of performance-based incentives for achieving government-proposed goals resembles payment methods, such as global budgets and diagnosis-related groups. Many countries are implementing various payment systems to control healthcare costs and moderate the pace of spending growth [7].

The medical community has expressed concern about the potential impact of discussions on medical expense

payment reform in the healthcare sector. Specifically, the medical community has expressed apprehension that the proposed payment system reform may increase physicians' workload and focus solely on curbing medical expenses without adequately recognizing physicians' expertise in determining appropriate treatment protocols for patients [8]. This situation increases the burden on physicians and ultimately risks lowering the quality of medical services provided to patients.

In discussions on reforming the medical fee payment system, it is important to consider reasonable compensation for the expertise and efforts of medical providers. A desirable medical payment system should be designed to accurately reflect the consumption of medical resources, minimize unnecessary expenditures, maintain the quality of medical services, and not hinder the advancement of medical technology [9]. In particular, since the payment methods for medical services directly affect the quality and outcomes of medical care, many countries use a combination thereof [10].

This study aims to investigate physicians' perceptions of the government's direction for reforming the medical expense payment system and provide foundational data for future policy improvements. The findings will enhance academic understanding of the topic and offer valuable insights for policymakers in managing future medical payment systems in South Korea.

Methods

Data sources and study population

The study population consisted of 56,434 physicians who, among approximately 110,000 physicians registered with the Korean Medical Association (KMA) as of 2020, consented to the collection and use of personal information for research purposes. An online survey was distributed to the entire study population via email and text message. The survey period was from October 7, 2024 to October 13, 2024, and 993 respondents participated. Among the respondents, 147 were classified as "incomplete responses" and excluded because they left $\geq 30\%$ of mandatory items unanswered or did not finish the questionnaire. Of the remaining responses, 846 participants completed the full survey. After excluding those whose practice settings did not meet the study criteria (i.e., physicians not working in clinics or hospitals), 765 respondents were included in the final analytic sample (Supplementary Material 1).

A comparison of the KMA population and the final sample of 765 respondents showed similar distributions in sex, age, and geographic region (Supplementary Material 2). Although the sample was formed through respondent-based participation rather than probabilistic sampling, the alignment between the respondent profile and the source population indicates that the potential for

selection bias was limited. The final sample was therefore considered sufficiently representative for the purposes of this study.

Study setting

South Korea's healthcare delivery system features a clear structural distinction between clinics and hospitals. Clinics function as primary care institutions and are largely established and operated by physicians using their own capital. As owner-practitioners, clinic physicians manage both clinical and business operations, and their income is directly influenced by the national provider payment system. In contrast, hospitals—including secondary and tertiary care institutions—generally employ physicians as salaried staff, resulting in a markedly different economic relationship to payment reforms. This distinction is particularly important in South Korea, where participation in the National Health Insurance program is mandatory for all healthcare providers, and reimbursement levels, payment rules, and most operational regulations are determined by the government. Consequently,

physicians—especially clinic owner-practitioners—tend to be highly sensitive to changes in the payment system and may perceive government-led reforms as exerting strong regulatory control over medical practice.

Investigation details and analysis

The questionnaire used in this study is provided in Supplementary Material 3 to ensure full transparency of the survey items. The survey for this study assessed healthcare providers' perceptions of the government's provider payment system reforms. The main items included awareness of the reform plan and various payment models (performance-based and value-based payments); evaluation of the impact of each payment method on treatment processes, including medical quality, patient outcomes, patient satisfaction, and medical cost reduction; opinions on the feasibility of applying Accountable Care Organization (ACO) models in Korea and reasons for perceived infeasibility; and preferences for future payment models for primary care clinics and hospital-level institutions, including fee-for-service, Diagnosis Related Groups (DRG), bundled payment, pay-for-performance (P4P), and population-based payment. Demographic variables included sex (male/female), age group (≤ 39 , 40s, 50s, ≥ 60), practice region (Seoul metropolitan area, other metropolitan cities, provincial areas), and specialty (medical, surgical, other).

The collected data were analyzed using frequency and cross-tabulation analyses. Pearson's chi-squared test was used to analyze the gaps between clinic and hospital physicians in their perceptions of the medical payment system. Statistical tests with P-values less than 0.05 indicate statistically significant results. All statistical analyses were performed using SAS version 9.4.

Ethical approval and consent to participate

Ethical approval for this study was obtained from the Institutional Review Board of the Research Institute for Healthcare Policy, Korean Medical Association (IRB No. KMAA 2025-01-04). The Institutional Review Board waived informed consent to participate, as the study involved secondary analysis of anonymized data posing minimal risk in accordance with national regulations.

Results

General characteristics of the participants

The results of the cross-analysis examining whether the physicians worked in hospitals or clinics are presented in Table 1. In total, 765 physicians were included in the analysis, with 445 (58.2%) and 320 (41.8%) working in clinics and hospitals, respectively.

A higher proportion of both male (58.5%) and female (57.2%) respondents worked in clinics; however, the difference was not statistically significant ($P=0.762$). There

Table 1 General characteristics of survey respondents

Characteristics	Total <i>n</i> = 765	Clinic (Ratio, %) <i>n</i> = 445 (58.2%)	Hospital (Ratio, %) <i>n</i> = 320 (41.8%)	<i>P</i> value
Gender				
Male	578	338 (58.5)	240 (41.5)	0.762
Female	187	107 (57.2)	80 (42.8)	
Age (years)				
0–39	236	109 (46.2)	127 (53.8)	<0.001
40–49	235	152 (64.7)	83 (35.3)	
50–59	159	99 (62.3)	60 (37.7)	
60 and older	135	85 (63.0)	50 (37.0)	
Region ^a				
Capital area	525	308 (58.7)	217 (41.3)	0.602
Metropolitan city	106	64 (60.4)	42 (39.6)	
Province area	134	73 (54.5)	61 (45.5)	
Specialty ^b				
Internal medicine	367	222 (60.5)	145 (39.5)	0.431
Surgery medicine	229	130 (56.8)	99 (43.2)	
Other	169	93 (55.0)	76 (45.0)	

Data are presented as numbers and %

^aRegional is categorized into three (Capital area, Metropolitan city, Province area). The capital area includes Seoul, Gyeonggi, Incheon; Metropolitan cities include Busan, Daegu, Gwangju, Daejeon, and Ulsan; and the provinces include Kangwon, Chungbuk, Chungnam, Jeonbuk, Jeonnam, Gyeongbuk, Gyeongnam, Jeju, Sejong, and others

^bSpecialty is categorized into three (Internal medicine, Surgical medicine, Other). Internal medicine includes internal medicine, neurology, psychiatry, pediatrics, dermatology, physiology, rehabilitation, family medicine; Surgical medicine includes general surgery, orthopedics, neurosurgery, plastic surgery, obstetrics and gynecology, ophthalmology, otolaryngology, urology, and emergency medicine; and other includes anesthesia, radiology, radiation oncology, pathology, laboratory medicine, preventive medicine, nuclear medicine, occupational and environmental medicine, or no specialty certification (primary care)

was a statistically significant difference in age distribution between clinics and hospitals. In particular, among physicians aged 40 years or older, the proportion of those working in clinics was higher than those working in hospitals. Conversely, in the age group of 0–39 years, the proportion working in hospitals was 53.8%, which was higher than that in clinics ($P < 0.001$). Across medical specialties, the proportion of physicians working in clinics was higher in internal medicine (60.5%), surgical specialties (56.8%), and other specialties (55.0%); however, these differences were not statistically significant ($P = 0.431$).

Physician awareness of the medical payment system reform plan

According to the survey results regarding awareness of the government's proposed payment system reform (including performance- and value-based compensation), a high proportion of respondents from both clinics (94.8%) and hospitals (87.5%) indicated that they believed the reform would not contribute to improving healthcare quality or reducing medical costs. These results showed a statistically significant difference between the two groups ($P < 0.001$), and the details are presented in Fig. 1.

[Figure 1] Perceptions of the impact of government payment system reforms.

Evaluation of the impact of different payment methods for medical expenses

Table 2 presents the descriptive distribution of physicians' perceptions regarding the potential effects of various payment models—bundled payment, pay-for-performance (P4P), and population-based payment—across clinics ($n = 445$) and hospitals ($n = 320$). Overall, respondents in both settings most frequently reported

negative impacts of the payment models on domains related to care quality, patient outcomes, and patient satisfaction. However, the intensity and pattern of these perceptions varied across models and between clinics and hospitals.

For bundled payment, negative perceptions predominated across clinical quality, outcomes, and satisfaction. In clinics, 83.6% of respondents indicated a negative impact on quality of care, 80.5% on patient outcomes, and 71.9% on patient satisfaction; hospitals reported similarly high proportions of negative responses (80.6%, 77.5%, and 66.9%, respectively). Despite these concerns, bundled payment was viewed somewhat more favorably with respect to reducing medical costs. Positive responses for cost reduction were reported by 29.4% of clinic physicians and 35.9% of hospital physicians, although substantial shares still expressed negative views.

In contrast, P4P elicited comparatively more positive evaluations, yet negative perceptions remained substantial. Roughly half of clinic respondents reported negative impacts on quality, outcomes, and satisfaction, while hospitals showed slightly lower negative proportions (40.0%, 37.8%, and 39.4%, respectively). Across domains, hospital physicians tended to express more favorable views than their clinic counterparts. Positive assessments of P4P's potential benefits—particularly regarding quality improvement—were more frequent than under bundled payment, though uncertainty remained notable in both settings.

Perceptions of population-based payment reflected a similar pattern of concern, with negative responses dominating most domains. In clinics, 74.4% reported negative impacts on quality of care, 72.4% on outcomes, and 70.6% on patient satisfaction; hospitals reported

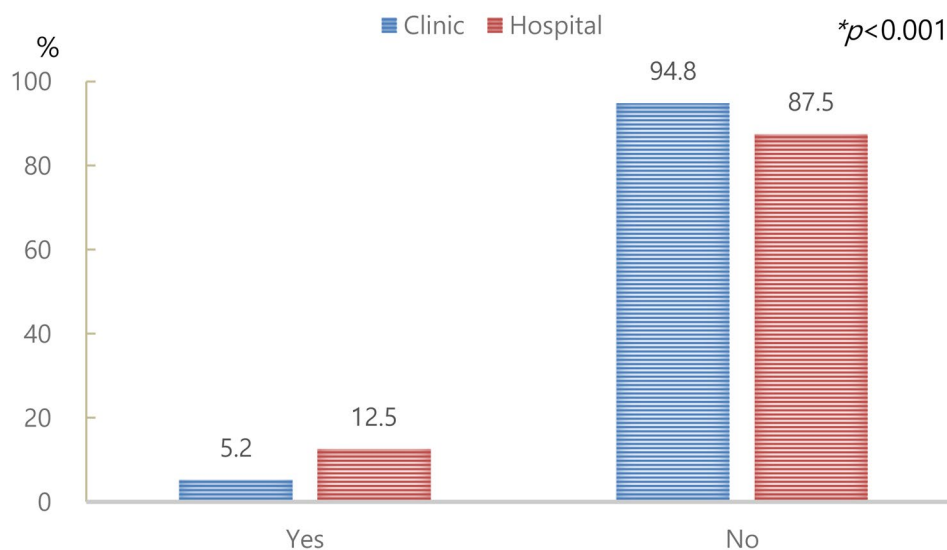


Fig. 1 Perceptions of the impact of government payment system reforms

Table 2 Impact of payment models by healthcare institution type ($n = 765$)

Variables	Clinic $n = 445$ (58.2%)				Hospital $n = 320$ (41.8%)			
	Positive Impact	No Impact	Negative Impact	Not Sure	Positive Impact	No Impact	Negative Impact	Not Sure
Bundled payment								
Improving quality of care	10 (2.3%)	31 (7.0%)	372 (83.6%)	32 (7.2%)	11 (3.4%)	30 (9.4%)	258 (80.6%)	21 (6.6%)
Improving patient outcomes	11 (2.5%)	40 (9.0%)	358 (80.5%)	36 (8.1%)	12 (3.8%)	38 (11.9%)	248 (77.5%)	22 (6.9%)
Increasing patient satisfaction	23 (5.2%)	49 (11.0%)	320 (71.9%)	53 (11.9%)	19 (5.9%)	50 (15.6%)	214 (66.9%)	37 (11.6%)
Reducing medical costs	131 (29.4%)	54 (12.1%)	193 (43.4%)	67 (15.1%)	115 (35.9%)	60 (18.8%)	103 (32.2%)	42 (13.1%)
Pay for performance								
Improving quality of care	95 (21.4%)	80 (18.0%)	223 (50.1%)	47 (10.6%)	108 (33.8%)	49 (15.3%)	128 (40.0%)	35 (10.9%)
Improving patient outcomes	83 (18.7%)	100 (22.5%)	217 (48.8%)	45 (10.1%)	79 (24.7%)	83 (25.9%)	121 (37.8%)	37 (11.6%)
Increasing patient satisfaction	73 (16.4%)	105 (23.6%)	208 (46.7%)	59 (13.3%)	70 (21.9%)	80 (25.0%)	126 (39.4%)	44 (13.8%)
Reducing medical costs	59 (13.3%)	96 (21.6%)	209 (47.0%)	81 (18.2%)	48 (15.0%)	93 (29.1%)	120 (37.5%)	59 (18.4%)
Population based payment								
Improving quality of care	22 (4.9%)	42 (9.4%)	331 (74.4%)	50 (11.2%)	24 (7.5%)	47 (14.7%)	212 (66.3%)	37 (11.6%)
Improving patient outcomes	22 (4.9%)	52 (11.7%)	322 (72.4%)	49 (11.0%)	25 (7.8%)	58 (18.1%)	202 (63.1%)	35 (10.9%)
Increasing patient satisfaction	23 (5.2%)	48 (10.8%)	314 (70.6%)	60 (13.5%)	19 (5.9%)	47 (14.7%)	216 (67.5%)	38 (11.9%)
Reducing medical costs	111 (24.9%)	62 (13.9%)	185 (41.6%)	87 (19.6%)	116 (36.3%)	53 (16.6%)	95 (29.7%)	56 (17.5%)

Data are presented as n (%)

Table 3 Feasibility of applying the ACO model in Korea

Categories	N	Feasible	Not Feasible	Not Sure	P value
Clinic	445	11.9	60.2	27.9	0.001
Hospital	320	20.9	57.8	21.3	
Total	765	15.7	59.2	25.1	

Data are presented as numbers and %

somewhat lower but still substantial negative proportions (66.3%, 63.1%, and 67.5%, respectively). As with the other models, perceptions of cost reduction under population-based payment were more mixed. Notably, 24.9% of clinic respondents and 36.3% of hospital respondents viewed this model as having a positive impact on cost containment.

Across all payment models, hospital physicians tended to report more favorable or less negative perceptions than clinic physicians, though negative impacts remained the most commonly selected category in both groups. Collectively, the descriptive findings indicate that physicians perceive meaningful policy trade-offs across alternative payment designs, with persistent concerns about quality and patient experience, but somewhat greater optimism regarding the potential for cost reduction.

ACO applicability in Korea

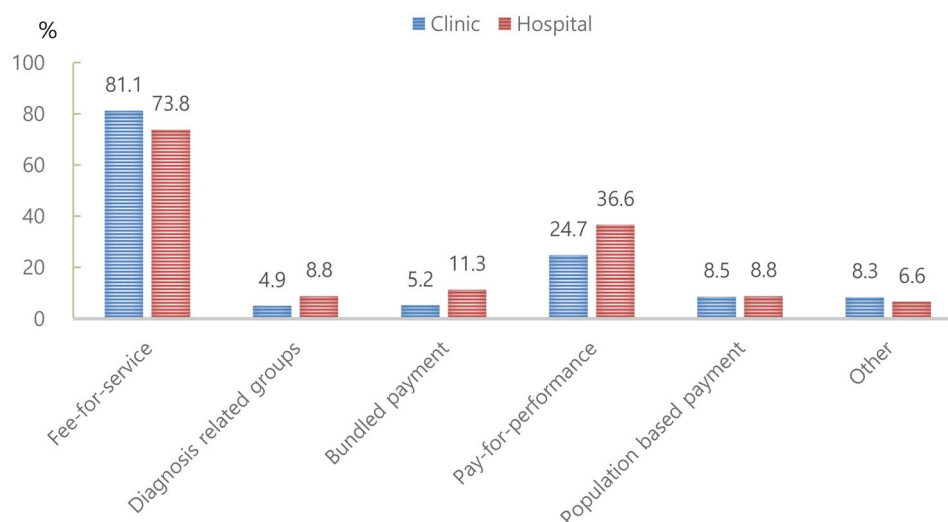
The Korean government announced plans to pilot a new payment model that links healthcare outcomes to reimbursement for population groups, modeled after the United States ACO model. Table 3 presents the results of a survey on whether a payment model similar to the ACO could be applied in Korea. Both clinic- (60.2%) and hospital-based physicians (57.8%) indicated that the ACO model was not applicable in Korea, a statistically significant finding ($P = 0.001$).

An analysis of the reasons why the ACO model should not be applied in the Korean context is presented in Table 4. Uncertainty regarding performance and effectiveness was slightly higher in those working in clinics (30.6%) than in hospitals (25.0%); however, the difference was not statistically significant ($P = 0.092$). Low patient engagement and cooperation were reported at 27.4% and 27.5% in clinics and hospitals, respectively, with no significant differences observed between the two groups ($P = 0.979$). The proportion of respondents indicating difficulties in building networks between medical institutions was 25.8% and 24.7% for clinics and hospitals, respectively, with no significant differences between the two groups ($P = 0.717$). Difficulty in understanding payment models was 16.2% and 14.1% for clinics and hospitals, respectively, with no significant difference between the two groups ($P = 0.422$). The lack of experience with team-based care systems was 8.8% in both clinics and hospitals, with no significant difference observed between the two groups ($P = 0.995$).

Table 4 Reasons the ACO model is not feasible in Korea

Categories	N	Difficulty in understanding payment models	Difficulties in building networks between medical institutions	Low patient engagement and cooperation	Lack of experience with team-based care systems	Uncertainty about performance and effectiveness	Other
Clinic	445	16.2	25.8	27.4	8.8	30.6	5.8
Hospital	320	14.1	24.7	27.5	8.8	25.0	7.8
Total	765	15.3	25.4	27.5	8.8	28.2	6.7
P value		0.422	0.717	0.979	0.995	0.092	0.281

Data are presented as numbers and %

**Fig. 2** Future-proposed medical payment system model

Desirable model for the future payment system

Among the physicians working in clinics ($n = 445$), 81.1% responded that the fee-for-service system was the most desirable payment system model for primary care institutions. The next most preferred payment systems were pay-for-performance (24.7%) and population-based payments (8.5%). Regarding physicians working in hospitals ($n = 320$), the fee-for-service system was the most frequently selected (73.8%), and the pay-for-performance payment system was the second most frequently selected system (36.6%). However, physicians working in hospitals showed a different response trend than those working in clinics, showing a relatively higher preference for the bundled payment system (11.3%) and diagnosis-related groups (8.8%) (Fig. 2).

[Figure 2] Future-proposed medical payment system model.

Discussion

This study aimed to examine the differences in perceptions between clinic and hospital physicians regarding the direction of the government's medical fee payment system reform. The current Korean health insurance system is based on the fee-for-service system, with the inclusive diagnosis-related groups applied as an exception. The

new diagnosis-related groups are being piloted in some hospitals; therefore, we hypothesized that there would be differences in opinions between clinic doctors and hospital doctors regarding the government's payment system reform.

In interpreting the findings, the potential for response bias inherent in voluntary survey participation should be acknowledged. However, it is important to note that the Korean Medical Association (KMA) is a statutory organization to which all licensed physicians in Korea are legally required to belong. As such, there is no distinction between KMA members and the general physician population, and concerns regarding systematic differences between "KMA members" and "non-members" are not applicable in this context. While voluntary response patterns may still influence the range of opinions expressed, membership-related self-selection bias is unlikely to have affected the study results.

This study is the first to examine the perspectives of physicians working in healthcare institutions on payment system reforms in South Korea. The previous study [11] provided an overview of Korea's provider payment system and presented descriptive statistics (primarily frequency analyses) based on the entire survey population. In contrast, the present study is clearly differentiated

from that prior work in both its research objectives and analytical focus. Specifically, we restricted our analytic sample to physicians working in clinics and hospitals, and our primary aim was to compare and analyze differences in perceptions regarding payment system reform across physicians employed in different types of medical institutions. Such comparative analyses were not addressed in the previous study. By adopting this physician-centered approach, the current study extends the earlier descriptive findings and offers additional insights that may inform the development of more inclusive and balanced payment policies in South Korea.

This study confirms that physicians have a highly negative perception of the government's payment system reform plans, including performance- and value-based compensation models. Of the physicians working in clinics and hospitals, 94.8% and 87.5%, respectively, had negative perceptions of the direction of government reform. Physicians are not convinced that this system will make a real contribution to improving the quality of medical care or reducing medical costs and are concerned that it may negatively impact the existing medical system. Therefore, the government should address these concerns and ensure physicians' trust by clarifying how treatment autonomy and patient-centered care will be guaranteed in the new systems.

Regarding the evaluation of the impact of each payment method, more responses reported negative than positive impacts in terms of the improvement in quality of care, patient treatment outcomes, and patient satisfaction for all three payment methods (bundled payment, pay-for-performance, and population-based payment). However, regarding the reduction in medical costs, hospital-based physicians tended to report more positive impacts than clinic-based physicians. These results have important implications for understanding how payment methods affect the characteristics of medical institution types and the provision of medical services [12]. The differences observed in Table 2 between clinic and hospital physicians must be interpreted within the structural context of the Korean healthcare system. Clinic physicians in Korea are owner-practitioners who operate their practices with personal capital and rely directly on reimbursement from the national payment system. Consequently, changes to the provider payment mechanism can have immediate implications for their income and practice management, which may contribute to their more cautious or negative perceptions of reform. By contrast, hospital physicians are generally salaried employees whose income stability is less directly affected by payment system adjustments, potentially explaining their comparatively more positive responses. This systemic distinction—unique to the Korean setting—provides important context for understanding the divergent attitudes identified in this study.

Many countries are implementing bundled payment systems, but there have been no consistent results regarding quality of care and cost reduction, even in cases such as the Netherlands where bundled payment systems for chronic diseases were used [13, 14]. Previous studies have shown that this system may be disadvantageous in patient selection and [15, 16], when applied on a large scale, may hinder the equity of medical services [17–19]. Therefore, it is essential to evaluate the long-term impact of bundled payment systems on patient choice and recognize the potential for increased instances of unfavorable patient selection over time as physicians become more accustomed to these payment systems.

Pay-for-performance is mainly applied as a supplementary payment method. In the United States, improving the quality of medical services by paying additional costs to the existing fee-for-service system to encourage the participation of medical providers has been criticized as a structure that ultimately invests additional financial resources [20]. It is further unclear whether incentives have led to actual improvements since the introduction of the performance-based compensation system. In the UK's National Health System, ongoing efforts are aimed at enhancing efficiency by providing financial incentives to doctors. However, there is growing consideration that high-cost incentive systems may be counterproductive to policy objectives if they fail to deliver tangible improvements in the quality of care. The current focus of the Korean government's performance-based compensation system is to compensate patients based on health outcomes and performance. However, if the focus is only on "performance," medical providers may avoid risky patients, and the administrative burden for performance reporting may increase [21]. Supplementary payment methods should be designed to induce positive impacts on healthcare outcomes while maintaining quality of care.

This study brought forth many opinions stating that it would be difficult for hospitals and clinics to introduce the ACO model in Korea. Physicians were skeptical about the ACO model adoption, citing a lack of patient engagement, uncertainty about the system, and difficulty in forming networks between medical institutions as the main reasons. These results suggest that, to introduce the ACO model, efforts such as patient education and participation, providing information on the specific operation method and compensation structure of the ACO model, strengthening cooperation between various medical institutions, and improving the understanding of the payment system are necessary. In the United States, ACOs attempt to strengthen the coordination and integration of medical practices and solve the problem of medical costs through various models proposed by medical providers with support from the Centers for Medicare & Medicaid

Services (CMS). Previous studies have emphasized that patient engagement is important for achieving positive outcomes through ACOs, and collaboration between providers and patients is necessary for the successful implementation of patient engagement strategies [22, 23].

The results of this study show that most clinic-based physicians agreed that the fee-for-service system was the most desirable payment model for primary care institutions. The second most commonly selected payment models were pay-for-performance and population-based payments. These results suggest that while traditional fee-for-service payment systems dominate primary care settings, there is some interest in complementary payment methods such as pay-for-performance payments. Meanwhile, hospital-based physicians most often chose the fee-for-service payment system as the payment model most suitable for hospitals, followed by the pay-for-performance system. However, hospitals showed a relatively higher preference for bundled payments and Diagnosis related groups systems. This finding suggests that the perception of an appropriate payment model may vary depending on the size and role of the medical institution.

Although the United States has proposed an alternative payment system model as a reform of its medical payment system, an assessment shows that the basic payment system is based on a fee-for-service system and is simply at the level of sharing savings and imposing penalties. Additionally, medical providers have consistently criticized the low predictability of medical expense compensation and the likelihood of the financial burden being shifted to them [24, 25]. Although we must consider the various attempts in the United States and their results, we should not overlook the fact that the government's unilateral policy model presentation can only lower the acceptance of the system by medical professionals and medical institutions.

The Korean government-led first action plan for healthcare reform contains directions for reforming the payment system through various terms, such as an alternative payment system, pay-for-performance, and value-based compensation. However, some are concerned about the introduction of a global budget system because no clear policy measures have been presented despite the use of terms such as “performance,” “value,” and “alternative” [26].

In the case of countries that are reorganizing their medical payment systems and seeking to reform their healthcare provision systems, differences cannot be ignored depending on the purpose and scale of the reorganization and the technical and political details [27]. Although countries may share a common direction for improving the medical payment system, the contexts in Korea and other countries are different.

Conclusions

This study confirms that physicians in both hospitals and clinics have negative perceptions of the government's proposed payment system reform. The medical payment system is a fundamental framework between doctors, medical consumers (patients), and insurers. The payment method is vital because it affects the quality of medical services and the scale of medical expenses. Therefore, introducing a new payment system should involve designing a structure that provides appropriate compensation to doctors to ensure that the quality and equity of medical care are not compromised. This approach is expected to provide effective policy directions.

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12913-025-13873-5>.

Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

Acknowledgements

None.

Author contributions

Concept and design: all authors. Data curation: Lim SM, Lim JY. Formal analysis: Lim SM, Lim JY. Drafting of the manuscript: Lim SM, Kim KH, Mun SK. Writing - review & editing: all authors. Supervision: Kim KH, Mun SK. All authors read and approved the final manuscript.

Funding

Not applicable.

Data availability

The data generated during and analyzed during this study are available from the corresponding request upon a reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the Institutional Review Board of the Research Institute for Healthcare Policy, Korean Medical Association (IRB No. KMAA 2025-01-04). The Institutional Review Board waived informed consent to participate, as the study involved secondary analysis of anonymized data posing minimal risk in accordance with national regulations.

Human ethics and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Received: 29 September 2025 / Accepted: 4 December 2025

Published online: 13 December 2025

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