Original Research Article

Comparative Historical Analysis of Public Health System Transformation in South Korea and the United States (1918-Present)

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ABSTRACT

The public health systems of South Korea and the United States developed under different historical, political, and cultural factors, which have produced distinct strengths and weaknesses during health crises. The research examined the system structures, pandemic responses, and long-term health outcomes of both countries from 1918 to the present, using historical case studies and policy analysis. South Korea achieved quick insurance expansion and effective pandemic management through centralized governance, collectivist culture, and its post-MERS reforms, which led to high public compliance. The United States adopted a decentralized, market-based system based on individualism, which resulted in delayed coordination and elevated COVID-19 death rates, despite its higher healthcare expenditures. The research demonstrated that emergency preparedness depends equally on governance structure, cultural values, and public trust as it does on funding and technology. The study recommended that the United States should improve its national coordination systems and that Korea should enhance equity in the hospital sector while implementing reforms that balance efficiency with inclusivity. The study of how historical and cultural elements shape public health systems offered valuable insights to strengthen crisis readiness for future global health emergencies.

Keywords: South Korea; United States; Public health systems; Health policy; Pandemic response; Cultural values; Centralized healthcare; Market-based healthcare

INTRODUCTION

Global healthcare systems are complex, and each country's history, culture, and politics shape that complexity. Countries such as the United States and South Korea share both similarities and significant differences (1). For example, while the United States is known for its medical innovation, its system often has accessibility challenges. For instance, Kenneth Thorpe has called the U.S. insurance model unsustainable due to rising costs and uneven health outcomes (2). In contrast, South Korea developed a universal health insurance system after the Korean War, built through a combination of internal reform and foreign influence. As Kim and Lee, Sang-Yi *et al*. explained, military medical training during the war, especially from the United States, was significant in introducing modern techniques and establishing long-term structures that later developed into a national system (3, 4).

Public health systems reflected the political decisions, cultural values, and societal needs of the time. Culture and history have influenced how both countries have

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responded to more recent crises. For instance, during the COVID-19 pandemic, COVID-19 highlighted major differences in how South Korea and the United States coordinated public health responses (5). These structural differences led to different health outcomes. South Korea implemented quick and unified COVID-19 measures because its cultural values emphasized group responsibility. The U.S. experienced significant opposition to health regulations because its society valued personal liberties (5). South Korea kept its death toll low while the U.S. lost more than one million people to the pandemic.

In addition, another study by Song *et al*. showed national health policy updates across OECD and BRICS countries following the COVID-19 pandemic. According to their research, South Korea was one of the few countries that updated its policies to place a greater emphasis on "One Health," emergency response, and surveillance (6). Meanwhile, the U.S. showed less progress in updating its national plans. Hence, these comparisons are significant as they demonstrate how long-term system structures and their values influenced whether countries were prepared for future health threats.

This research examined the development of public health systems in South Korea and the United States from 1918 to the present. It focused on how both countries responded to major health crises and how those responses shaped long-term policy choices, system structures, and public perspectives on public health. This topic was important because it demonstrated how crises impacted societies, how governments protected their citizens, and how individuals responded to new developments. Thus, public health systems reveal what each country believes and prioritizes.

Overall, this research examined how the health systems of both countries were shaped by crisis, culture, and political structure. It also demonstrated how history has shaped public and policy choices in each country. While referencing both the past and the present, this research aimed to help readers understand how the U.S. and South Korea developed distinct health systems and what their differences can teach us about the future of public health.

This study offers a comprehensive historical analysis by examining both South Korean and American systems throughout their entire century-long period of crisis management. The research connects cultural values to political systems and crisis responses through a single timeline, revealing patterns that individual studies of specific time periods often overlook. This study explains how past choices continue to shape the current readiness of public health for new challenges through analyzing historical development over a long time period.

LITERATURE REVIEW

The healthcare systems in South Korea and the United States evolved along separate paths. South Korea established a healthcare system through government-led reform, but the U.S. maintained its market-oriented approach. During international crises, such as war and pandemics, healthcare systems undergo their most significant transformations. Observing national responses to major events demonstrated how their present-day operational models had evolved and why their health care systems differed.

The rapid pace at which South Korea built its health system infrastructure was the main factor in its success. According to Lee Sang-Yi *et al*., the Korean government has implemented an exceptional insurance expansion program that achieves fast universal healthcare coverage through its public-private healthcare system (4). The current body of research focuses on state control of funding as the essential factor that allowed system coordination through private hospital ownership. The system enabled Korea to establish broad healthcare access through its existing provider network, which became a key factor for maintaining system stability for many years.

Research on the U.S. healthcare system shows that it operates with structural fragmentation due to its employer-sponsored insurance system and limited federal authority. Ridic *et al*. describe this system as uniquely expensive and unequal in healthcare access, stemming from political opposition to national health system unification (7).

METHODS AND MATERIALS

This research employed a comparative historical case study approach. It purposefully selected cases from South Korea and the USA that highlighted the transformation of public health systems. The research illustrated how South Korea and the United States modified their health systems in response to global crises between 1918 and the present day. The study employed a timeline structure to organize essential health reforms and transformations, which were divided into five distinct periods marked by significant events. The research also analyzed each period by comparing both countries to understand

induced loading under the simulated boundary conditions.

how government decisions, along with historical circumstances and cultural beliefs, affected public health outcomes.

The research analyzed major crises that led to substantial policy changes and institutional developments in each nation. This study selected South Korea's MERS outbreak (2015) because it triggered significant legal changes in emergency response systems, strengthened digital surveillance infrastructure, and reshaped national crisis-management policies. COVID-19 was selected for analysis in two countries because it offered the most comprehensive and comparable data regarding political, cultural, and institutional factors. The timeline is divided into five historical periods, which track significant developments in governance, public health legislation, and national crises. The analysis focused on how political choices, in conjunction with cultural beliefs and institutional systems, contributed to the outcomes of each historical period. The research drew its data from peer-reviewed journal articles, official government documents, and international health reports from the WHO and OECD, ensuring reliable and consistent data inclusion.

The research incorporated three case studies that examined the transformation of South Korea's National Health Insurance (NHI) between 1977 and 2000, as well as the development of U.S. Medicare and Medicaid programs. The selected events demonstrated how each nation developed its healthcare system in its distinct historical context and national priorities.

This research collected its data from academic databases, including PubMed, as well as official government websites of the U.S. Centers for Disease Control and Prevention (CDC) and the Korean Ministry of Health and Welfare (MOHW). The analysis of international health data and health outcomes was supported by reports from the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD). The data included both primary and secondary sources. Peer-reviewed articles and policy documents supported the analysis of long-term system development. The analysis of findings was conducted over time, across both countries, and within their historical and political contexts. The synthesis of findings identified patterns in the historical transformations of public health systems across both countries, explored and expanded upon underlying mechanisms, and discussed the implications of the findings.

The research method demonstrated how cultural values and political systems affected health reform and development in different countries. Furthermore, the research examined how two countries handled identical crises using various approaches to reveal features that developed in their healthcare systems. Thus, this method enables the linkage of historical policy decisions to current outcomes and future opportunities for reform.

Timeline-Based Historical Comparison

Public health systems in South Korea and the United States developed differently due to their distinct historical backgrounds, political structures, and cultural characteristics. During the Spanish Flu pandemic, which spanned from 1918 to the 1930s, the United States lost more than 675,000 citizens to death. The nation strengthened its local health departments instead of creating a national healthcare system, according to the CDC Archives (8). During that time, Korea existed under Japanese colonial governance. The lack of a Korean-led public health system allowed Japanese colonial authorities to run healthcare services primarily for colonial administrators and officials. The authors, Lee, Sang-Yi *et al*., explained that during this period, Korean health development ranked low in priority, while public healthcare delivery remained severely underdeveloped (4).

The period from the 1930s to 1945 exhibited distinct expansion patterns in both countries. The federal government of the United States increased its involvement in healthcare services following World War II. The Hill-Burton Act of 1946 established the basis for federal funding of hospital construction and access to services for underprivileged areas (9). During the period of Korean colonization, the healthcare system denied access to public health services for Korean civilians. The healthcare system under Japanese control primarily provided services to Japanese officials and settlers, while neglecting the Korean population, according to Kim and Lee (3, 4).

A new era for public health in South Korea began during the 1950s and 1960s, coinciding with the Korean War. The Korean War marked a significant shift in the direction of Korea's healthcare system. Military training programs sent Korean doctors to the U.S. for medical training in new procedures. The authors stated that medical training served as a platform that disseminated basic medical knowledge, advancing Korean medical practice (3). These medical professionals returned to Korea to establish leadership positions at both hospitals and universities. Their efforts contributed to

the development of Korean medical practices, which eventually influenced future healthcare reform initiatives. Foreign influence during the war provided Korea with a strategic advantage in modern healthcare development, resulting in leaders who would shape future healthcare changes. During the war, many Korean medical doctors received training in the United States through the Medical Field Service School. Military surgeons who served during the war encountered advanced medical technology, including preliminary artificial heart machines and modern surgical procedures (3). After their return, they worked to establish new medical educational standards for Korea while developing institutional capabilities. Lee, Sang-Yi *et al*. indicated that the U.S. military intervention between 1950 and 1953 established the fundamental structure that would become Korea's healthcare system (4). During the Cold War period, the United States established its private insurance-based system (7). Although Medicare and Medicaid were established in 1965-66, the nation never achieved full universal healthcare coverage. Health policy decisions continued to be controlled by restricted federal power, while the country experienced a rising influence of the private sector (7).

Between 1970 and 1990, Korea initiated its nationwide health initiative. Park Chung-hee's regime established a corporatist SHI (Social Health Insurance) system in 1977, which initially covered workers in large companies. Insurance coverage expanded throughout rural and urban areas until it achieved universal coverage by 1989 (4). The year 2000 was a significant milestone for Korea, as it transitioned to a single national insurer, which ultimately evolved into the present-day National Health Insurance (NHI) system. Despite strong insurance planning, most hospitals in Korea remained privately owned, making the country's system unique compared to other countries (4). The United States experienced increasing healthcare expenses while maintaining its opposition to government-controlled healthcare solutions. According to Kenneth Thorpe, the U.S. healthcare system became unsustainable due to its high healthcare costs, uneven access to healthcare, and poor national coordination (2). The WHO concluded that the United States failed to achieve universal healthcare coverage despite spending more than other countries (10).

Since 2000, the divergence between the South Korean and U.S. public health systems has become more apparent during the COVID-19 pandemic. The government of South Korea established a unified national response system that combined surveillance systems, contact tracing, and One Health strategies (6). The government took these actions because the 2015 MERS outbreak triggered legal and institutional changes that created more effective emergency response systems and improved data exchange (6). The United States encountered two significant problems: national coordination missed its deadlines, and public health measures across states were implemented at different times. The pandemic resulted in more than one million deaths throughout the United States while Americans resisted both government-ordered mask mandates and vaccine restrictions (5, 8). Song *et al*. found that South Korea implemented significant post-pandemic policies focused on disease prevention and emergency response, whereas the United States made only minimal changes to its policies (6) (Table 1).

Table 1. Significant Public Health System Developments in South Korea and the United States (1918-Present)

Period	South Korea	United States
1918-1930s	Under Japanese colonial rule, a Korean-led public health system did not exist; instead, services focused on the needs of Japanese administrators (4)	Spanish Flu killed>675,000 Americans; strengthened local health departments instead of creating a national system (8)
1930s-1945	Continued colonial system; severe neglect of Korean civilian health access (3, 4)	Federal role expands after WWII; Hill-Burton Act (1946) funds hospital construction in underserved areas (9)
1950s-1960s	Korean War; U.S. military medical training modernizes Korean medical practice; foundation for later reforms (3)	Cold War era: insurance remains employer-based; Medicare & Medicaid created (1965–66), but not universal
1970s-1989	Social Health Insurance (SHI) was introduced in 1977 for large firms and subsequently expanded to rural and urban populations, achieving universal coverage by 1989 (4)	U.S. cost escalation; opposition to national health insurance; rising private sector influence (7)

Continued Table 1. Significant Public Health System Developments in South Korea and the United States (1918-Present)

Period	South Korea	United States
1990s-2000	2000: SHI merged into a single national insurer → National Health Insurance (NHI). Hospitals remain privately owned (4)	Market-based expansion continues; growing inequality and unsustainable spending (2)
2000-2015	Continued centralization; strong data systems; MERS (2015) triggers major emergency law reforms and digital tracing (6)	Fragmented public health infrastructure; PHIN and BioSense fail to unify national preparedness (8)
2015-2020	Post-MERS reforms strengthen national coordination, surveillance, and emergency planning (6)	Pre-COVID political polarization intensifies; weak federal–state alignment
2020-Present	COVID-19: strong compliance; low mortality; "One Health" updates; expanded surveillance and unified response (6)	COVID-19: decentralized response; inconsistent messaging; >1 million deaths; limited policy updates post-pandemic (6)

RESULTS

Governance Structure and System Coordination

South Korea built its governance system through historical development, which merged central authority with previous crisis management systems to achieve quick national responses during public health crises (4, 6). The research findings show that organizations that established unified command systems at their beginning developed better emergency readiness, and their crisis response policies were executed more efficiently in subsequent emergencies.

The United States operated with decentralized authority and market-based organization for many years, which created structural fragmentation that blocked its path to establishing unified emergency response capabilities (7). The research findings demonstrate that the division of federal-state authority led to inconsistent execution of public health measures and prevented national emergency coordination at the right time (8).

The effectiveness of each nation's emergency responses depended on its governance system, social values, and institutional management practices (5, 7). The United States failed to meet its obligations and exhibited inconsistent policy implementation due to its system of decentralized governance, which operates independently of individualistic cultural values (5, 7, 8). The century-long timeline revealed that the emergency management capabilities of both nations were shaped by their historical policy developments and cultural traditions (4, 5).

Comparative Analysis

Both South Korea and the United States responded to major health crises through different long-term system designs. The three elements that interacted to determine national results included government leadership and reform strategy, cultural values, public trust, and power in public health infrastructure (4, 5, 7, 8). The following section demonstrates how these elements led to varying degrees of coordination, emergency preparedness, and compliance across nations.

Government leadership and market reform

The public health reforms in South Korea emerged from a government-controlled system that focused on creating a unified national framework while rapidly expanding the healthcare system. Research on Korean development shows that state financial control enabled the government to implement rapid reforms by owning most hospitals, while maintaining private hospital ownership (4). The U.S. healthcare system evolved through limited federal power, leading to increased reliance on employer-sponsored and private health insurance plans that limited national, population-wide policy coordination (7). The leadership models followed different paths for educational reform: Korea used centralized planning to achieve rapid policy changes, while the United States faced institutional barriers that prevented it from implementing unified reforms.

Cultural values and public trust

While governmental structure explained much of

the difference, cultural values and public trust were equally decisive in potential outcomes. The results of public health in these nations can be attributed to the cultural and social values prevalent in each society. The Korean population followed government health directives due to their Confucian values and collectivist mindset. South Koreans accepted mask mandates, contact tracing, and quarantine rules because they believed it was their social responsibility to protect their community (5). U.S. responses to the crisis were delayed due to political disagreements and individualistic attitudes among the public. Many Americans viewed mask requirements and vaccination mandates as infringements on personal autonomy (5). The success and failure of public health initiatives directly resulted from the differing cultural norms that existed between these two countries (5).

Beyond cultural norms, the information environment and political polarization shaped public trust and compliance during COVID-19 (5). The public response to COVID-19 was influenced by cultural values as well as political conditions and information systems. The South Korean government achieved uniform messaging by utilizing centralized leadership and KCDC briefings, resulting in higher compliance rates and reduced misinformation spread. The government gained public trust through its daily national updates, its ability to maintain stable party support for public health policies, and its control of media outlets (5). The United States experienced growing political polarization, resulting in increased disagreements over mask mandates, vaccination requirements, and school lockdowns. The public lost trust because federal and state leaders provided conflicting information, while the CDC provided unclear updates during the initial phase of the pandemic. The U.S. media environment disseminated false information through the use of multiple news sources and social media platforms, leading to public disagreement and reduced adherence to guidelines (5). The varying levels of trust, communication methods, and political backing between the two nations led to distinct national responses to COVID-19, suggesting that cultural factors do not entirely account for the differences in their pandemic management.

System infrastructure and speed of response

The efficiency of response depended on the system design principles that were implemented. The centralized infrastructure of South Korea enabled fast responses to pandemic situations. The 2015 MERS outbreak led Korea to implement digital contact tracing alongside emergency preparedness and "One Health" planning initiatives (6). The country's COVID-19 management improved due to these measures, resulting in maintaining low mortality rates (5). The United States maintained separate pandemic plans for different states and regions, rather than a fully unified national strategy. The Public Healthcare Information Network (PHIN) and BioSense initiatives, a nationwide program aimed at promoting the development of early detection skills, operated without nationwide coordination, which resulted in numerous widespread outbreaks (8). This pattern shows how fragmented surveillance and inconsistent national coordination can delay response even when a country has high medical spending (5, 8).

The centralized response model Korea used during the pandemic created permanent trade-offs that negatively affected public health outcomes throughout the infection period and beyond. Most hospitals operate as private facilities, leading to unequal medical services across different locations because rural areas lack sufficient medical facilities and limited healthcare choices (4). The COVID-19 pandemic required strict containment measures, which helped decrease virus spread but simultaneously created mental health problems for particular community groups. Digital contact tracing systems enabled rapid outbreak management but raised privacy concerns because they required access to and processing of extensive individual information (5, 6). The established boundaries demonstrate that national agency coordination for emergency response fails to address equity issues, mental health service delivery challenges, and surveillance requirements, even as it provides immediate emergency assistance.

Summary of the analysis

The analysis revealed that South Korea and the United States experienced distinct outcomes in health crises, mainly due to their fundamental institutional frameworks, combined with cultural values and governmental principles. The combination of South Korea's long-term investment in centralized infrastructure with its collective values has created strong public cooperation, which facilitates quick responses to health emergencies (5, 6). The United States prioritized market freedom, which resulted in diminished national emergency response coordination capabilities (7, 8). The long-term differences between these nations demonstrated that national health outcomes came from fundamental values within their systems (Table 2).

Table 2. Comparison of Public Health Systems in South Korea and the United States

Category	South Korea	United States
System Type	Centralized, single national insurer (NHI); government-led coordination	Decentralized, market-based; mixed federal–state system; private insurance dominance
Cultural Values	Collectivist, Confucian influence; public sees compliance as social responsibility (5)	Individualist; personal freedom prioritized; resistance to mandates common (5)
Policy Approach	Unified national directives; strong surveillance; rapid containment	Fragmented policy; state-by-state differences; inconsistent federal coordination
Crisis Responses	Fast, coordinated; post-MERS reforms enhanced preparedness; strong mask compliance	Delayed unified response; conflicting messages; political polarization reduces compliance
Health Communication	Clear, centralized KCDC briefings; stable messaging	Mixed federal vs. state communication; CDC messaging inconsistencies; misinformation spread
Pandemic Outcomes	Low COVID-19 mortality; strong national compliance	>1 million COVID-19 deaths; lower trust; high political disagreement
Strengths	Rapid response; unified data; strong public trust; consistent policies	Advanced medical facilities, innovation leadership, and a strong research sector
Weaknesses	Regional hospital inequity; mental health strain from strict quarantines; privacy concerns from digital tracing (5)	Fragmented system; inequitable access; slow coordination; politicization of public health
Key Reforms	SHI → NHI (2000); MERS-triggered legal reforms; "One Health" pandemic updates	Medicare & Medicaid (1960s); limited updates post-COVID; attempts at surveillance reform (PHIN/ BioSense)

CONCLUSION

This study highlighted how historical traditions, cultural beliefs, and governmental structures shaped the development of public health systems in South Korea and the United States. Differences in pandemic responses stemmed from key differences, such as centralized versus market-based governance, collectivist versus individualist values, and unified versus fragmented infrastructures (4, 5). The fundamental structures created the differences between national policy results and both public engagement levels and institutional preparedness.

This research showed how decades of institutional decision-making, shaped by war, colonization, democratization, and ideology, led to prolonged resilience or vulnerability in each nation's health system. South Korea achieved faster health system development through the expansion of its centralized National Health Insurance (NHI) and a unified pandemic management approach (4, 6). The combination of personal freedom with market competition in the U.S. healthcare system resulted in delayed federal coordination during the COVID-19 pandemic, leading to high mortality rates despite the presence of highly developed medical facilities (5, 7, 8). The long-term effects of policy choices extended beyond funding levels, as they determined how governments and citizens responded to emergencies.

The findings emphasized that cultural and political foundations, alongside funding, determined whether health systems could respond effectively in a crisis. Research by Ridic *et al*. and the World Health Organization (WHO) revealed that high spending alone failed to guarantee preparedness, as trust and consistent public investment, combined with long-term investment, were more important factors. The study demonstrated that combined central infrastructure with public trust produced rapid and successful health outcomes, as shown through South Korea's MERS reforms and pandemic response (3, 6).

Policymakers should evaluate both technical reforms and the historical and cultural values that sustained successful systems. Emergency preparedness in the United States could be enhanced through investments in national coordination mechanisms and efforts to build

trust between public officials and citizens. Korea's system should continue to improve equitable access, especially in its privatized hospital sectors (4). South Korea needs to handle its current problems, which include unequal hospital access and mental health issues from strict quarantine measures and privacy violations from digital monitoring systems. The WHO and OECD provided international support for reforms that merged efficiency with inclusivity through their collaborative guidance.

The historical timeline demonstrates that both nations require systemic transformations through the implementation of lessons learned from emergency responses to previous crises. The United States needs to establish a permanent national emergency coordination center, which will unify federal and state agencies during health crises, because past emergencies, such as the Spanish Flu and COVID-19, have demonstrated that disorganized leadership can lead to disastrous outcomes. The country needs to create a single health data system that connects CDC surveillance platforms to state reporting systems, thereby eliminating delays, as seen during the early COVID-19 testing and the development of PHIN and BioSense. The implementation of shared crisis protocols and standardized communication plans between federal and state governments will enhance national readiness while minimizing political disputes. The centralized planning system of South Korea delivered an efficient emergency response but exposed weaknesses in hospital supply chain operations. The government of Korea needs to increase financial support for hospitals located in underfunded regions while fixing the unequal healthcare access problems stemming from private hospital control. The government should assign specific health management responsibilities to local areas to enhance crisis response adaptability (4). Integrating mental health services into emergency planning is essential, since strict COVID-19 quarantines showed how rapidly containment measures can harm people's mental health. The government of Korea needs to revise its digital surveillance regulations to create more effective privacy safeguards that do not compromise the quick tracing system, which proved helpful during the MERS outbreak. The recommendations outline operational strategies for developing robust health systems by connecting them to historical and cultural patterns in the timeline of these two countries.

However, this research had its limitations. The research was unable to provide comprehensive health outcome assessments across different demographic groups, including those related to racial and socioeconomic differences. The study drew from published sources and peer-reviewed journals; however, additional interviews with policy experts and regional health officials would have strengthened its reliability and depth. Further research should have analyzed how Germany and Taiwan, as well as other hybrid healthcare systems, managed to merge governmental oversight with private healthcare delivery.

The research establishes a historical timeline that connects cultural values to political systems and institutional development over the past century. The research combines historical evaluation with public health results to reveal extended patterns that emergency response assessments during short-term crises fail to identify. The research method provides scientists with an analytical framework for examining how people respond to contemporary health crises in relation to their national identity and cultural values. The framework provides a systematic method that researchers can apply to study how past developments affect the present operational strengths and vulnerabilities of the public health system.

In conclusion, understanding how national identity and historical development shape health systems helps us learn from both achievements and failures, and better prepare for future global health threats.

CONFLICT OF INTEREST

The author declares no conflicts of interest related to this work.

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