International Journal of Health Systems and Policy
ISSN(Online): 3109-5267
Vol 1 no 1 (2025): June 2025
https://journal.as-salafiyah.id/index.php/ijhsp/index
Email: editorijhsp@gmail.com

Evaluating Emergency Preparedness And Health System Resilience: A Cross-Country Analysis Of COVID-19 Responses In OECD And LMIC Contexts

[1]Muh Ibnu Sholeh, [2]Himad Ali
[1]STAI Kh Muhammad Ali Shodiq Tulungagung, Indonesia, [2]Shaanxi Institute of International Studies, China.
[1]indocelllular@gmail.com, [2]himad9406@gmail.com.

Correspodence Email: indocelllular@gmail.com.

Abstract: *The COVID-19 pandemic provided an unprecedented stress test for health systems and governance structures across both high-income (OECD) and low- and middle-income countries (LMICs). This study aims to evaluate how countries with differing economic capacities responded to the pandemic by analyzing three key dimensions: health system capacity, governance and emergency response, and recovery and adaptation policies. Using a mixed-methods comparative approach, we examined data from WHO, OECD, World Bank, and the COVID-19 Health System Response Monitor, supplemented by in-depth case studies of selected countries including Germany, South Korea, Indonesia, and Nigeria. Findings reveal that while OECD countries generally had higher baseline capacities such as hospital bed density and workforce ratios outcomes varied significantly due to differences in policy timing, public trust, and crisis coordination. Some LMICs, despite limited infrastructure, mobilized resources effectively through strong community engagement and past epidemic experience, notably in Vietnam and Rwanda. Governance quality, transparency, and prior exposure to health emergencies emerged as more critical to resilience than economic status alone. The study concludes that health system resilience is a multidimensional construct shaped by institutional adaptability, citizen compliance, and leadership capacity. These insights underscore the importance of integrating equity, trust-building, and cross-sector coordination into future global health preparedness strategies.*
Keywords: Emergency Preparedness, Health System Resilience, OECD, LMIC, Recovery Policy.

INTRODUCTION

The COVID-19 pandemic has profoundly tested the resilience of health systems, disrupted economies, and reshaped governance dynamics around the world. As the virus spread rapidly across borders in early 2020, countries faced a common threat but responded with varying degrees of success. This global crisis exposed deep disparities in emergency preparedness and systemic capacity, even among nations with seemingly robust health infrastructures. In this context, the

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pandemic served not only as a public health emergency but also as a stress test for institutional functionality, leadership quality, and social cohesion (Legido-Quigley et al., 2020; Greer et al., 2021).

At the onset, countries in the Organisation for Economic Co-operation and Development (OECD) characterized by their advanced economies, technological assets, and well-funded health systems were anticipated to fare better in pandemic control. These countries typically reported higher ratios of hospital beds, intensive care units (ICUs), and healthcare professionals per capita (OECD, 2021). However, the outcomes revealed considerable variation. Nations like New Zealand and South Korea were globally praised for their swift, coordinated, and transparent responses (Wilson et al., 2020; Kim et al., 2021). In contrast, high-income countries such as the United States, Italy, and the United Kingdom experienced systemic overloads, inconsistent messaging, and significant loss of life, challenging the assumption that economic wealth guarantees health system resilience (Katz et al., 2021; Bambra et al., 2020).

Conversely, many low- and middle-income countries (LMICs) demonstrated surprising resilience despite longstanding structural vulnerabilities. Countries such as Vietnam, Rwanda, and Ghana, with limited fiscal and technical resources, implemented highly effective community-based interventions, early lockdowns, and digital contact tracing systems (Dinh et al., 2021; Binagwaho et al., 2020). These outcomes suggest that while economic capacity plays a role in pandemic response, it is neither a sufficient nor exclusive determinant of effectiveness. Governance quality, public trust, previous epidemic experience, and societal cohesion also emerged as central factors (Abimbola et al., 2019; Hale et al., 2021).

In addition, the speed and adaptability of governance became a key differentiator across country responses. Governments that acted early and decisively, communicated transparently, and fostered trust were generally more successful in flattening infection curves and preserving health system capacity. For instance, South Korea's early deployment of digital surveillance technologies and expansive testing stemmed from its lessons learned during the 2015 MERS outbreak (Park et al., 2020). Similarly, Vietnam leveraged its existing community health infrastructure, built during

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its battle with avian influenza, to deploy door-to-door contact tracing and localized quarantines (Nguyen et al., 2021). These countries demonstrated that prior experience with infectious disease outbreaks could serve as a valuable institutional asset.

Meanwhile countries with high levels of political polarization, such as Brazil and the United States, faced significant obstacles in implementing cohesive public health strategies (de Oliveira et al., 2021; Greer et al., 2021). In these settings, misinformation, weak intergovernmental coordination, and public mistrust in health institutions severely hindered mitigation efforts. Studies show that lack of trust in government directly correlates with lower compliance to non-pharmaceutical interventions and vaccine hesitancy (Brennen et al., 2020; OECD, 2021).

In the post-peak phase of the pandemic, countries also varied in their recovery planning and ability to adapt to new challenges. While some OECD nations quickly rolled out national vaccination programs and allocated resources for long-term health system reforms, others struggled with equitable vaccine distribution and public resistance (Clarke et al., 2021; Hale et al., 2021). LMICs, in contrast, often relied on COVAX-supported programs, but demonstrated innovation in outreach, including mobile vaccination units and grassroots engagement strategies (WHO, 2022). The experience of Indonesia, which combined religious outreach with mass vaccination efforts, underscores the importance of sociocultural alignment in recovery strategies (Yufika et al., 2021).

Given this complexity, a purely economic or biomedical assessment of pandemic preparedness is insufficient. A holistic, multi-dimensional approach is needed—one that considers governance structures, health financing models, digital infrastructure, social trust, and community participation (Abimbola et al., 2019; Kluge et al., 2020). Such an approach is especially critical as the world prepares for future pandemics and contemplates reforming global health governance frameworks.

This article aims to compare the performance of selected OECD and LMIC countries in managing the COVID-19 pandemic across three core domains: health system capacity, governance and response strategies, and recovery and adaptation policies. By integrating quantitative

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indicators with qualitative insights, the study seeks to identify best practices, structural gaps, and lessons learned. In doing so, it contributes to the broader discourse on health system resilience—defined as the capacity to prepare for, manage, and learn from health emergencies (Blanchet et al., 2017).

Ultimately understanding the complex interplay of resources, leadership, and societal dynamics is crucial for informing future global health strategies. The pandemic has shown that no country is immune to systemic failure, and that innovation, solidarity, and responsive governance are as important as hospitals and ventilators. Building equitable, sustainable, and resilient health systems must therefore be a global priority.

METHOD

This study employed a mixed-methods comparative approach to evaluate health system preparedness and resilience across countries in both the OECD and LMIC groups during the COVID-19 pandemic. The analysis integrated quantitative indicators and qualitative case studies to capture both structural and contextual dimensions of pandemic response. Quantitative data were extracted from reputable global databases including the World Health Organization (WHO), World Bank, Organisation for Economic Co-operation and Development (OECD), and the COVID-19 Health System Response Monitor (HSPM) (OECD, 2021; WHO, 2022; World Bank, 2021). Countries were selected based on geographic diversity, data completeness, and comparability across economic groups, leading to a representative sample that included nations such as Germany, South Korea, Indonesia, and Nigeria.

Three major domains of analysis were established. First, health system capacity was assessed using indicators such as hospital beds per 1,000 people, intensive care unit (ICU) capacity, healthcare workforce density, and testing availability (Legido-Quigley et al., 2020). Second, governance and policy response were evaluated through variables such as the timeliness of lockdown implementation, public communication strategies, testing protocols, and social safety net deployment (Greer et al., 2021; Hale et al., 2021). Third, recovery and adaptation strategies

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were measured using indicators like vaccine distribution rates, fiscal health spending, and long-term reform policies (Clarke et al., 2021).

To complement these metrics, qualitative case studies were developed for selected countries to offer insights into the socio-political and institutional factors that shaped policy decisions. Data triangulation combined statistical trends with document analysis and existing literature to validate findings and draw nuanced conclusions regarding systemic resilience and preparedness (Kluge et al., 2020; Dinh et al., 2021).

RESULT AND DISCUSSION

Health System Capacity: A Comparative Analysis

The comparative analysis of health system capacity between OECD and LMIC countries during the COVID-19 pandemic reveals notable disparities in infrastructure, resource availability, and emergency response outcomes. OECD countries, by virtue of their economic advantage, generally reported stronger baseline health capacities. On average, these nations had 4.8 hospital beds per 1,000 people, compared to 1.3 in LMICs (OECD, 2021; WHO, 2022). Similarly, the healthcare workforce density measured in physicians, nurses, and midwives per 1,000 population stood at 12.5 for OECD countries and only 3.2 in LMICs (World Bank, 2021). Testing capacity also reflected this imbalance: OECD members conducted up to 1,500 tests per 1,000 people, while LMICs averaged around 320 tests per 1,000 (Hale et al., 2021).

Despite this structural advantage, several OECD countries experienced system overloads, particularly during the first wave of the pandemic. For instance, Italy and the United States struggled with delayed lockdown measures, poor inter-agency coordination, and public resistance, which led to hospitals operating beyond capacity, shortages of ventilators, and high mortality rates (Remuzzi & Remuzzi, 2020; Katz et al., 2021). These challenges highlight that infrastructure alone cannot ensure resilience without timely governance and public compliance.

On the other hand, some LMICs demonstrated remarkable efficiency in utilizing limited resources. Vietnam, for example, quickly activated community health networks, implemented localized quarantines, and maintained a low infection rate throughout 2020 despite having only

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2.6 doctors per 10,000 population (Dinh et al., 2021). Rwanda utilized mobile health platforms and data-driven surveillance to optimize hospital referrals and resource allocation, demonstrating adaptability in low-resource settings (Binagwaho et al., 2020).

A key factor enabling LMICs to compensate for capacity constraints was strategic partnerships and community engagement. Indonesia collaborated with private sectors and NGOs to expand testing labs and distribute PPE, while Kenya leveraged telemedicine and decentralized care to reduce hospital burden (Clarke et al., 2021; Abimbola et al., 2019). These practices not only preserved system functionality but also built trust between citizens and healthcare providers, a critical element in managing health crises.

The chart below illustrates the comparative indicators of health system capacity among selected OECD and LMIC countries:

Indicator	OECD Countries	LMIC Countries
Hospital Beds per 1,000 people	4.8	1.3
Health Workforce per 1,000	12.5	3.2
COVID-19 Tests per 1,000 people	1,500	320
ICU Beds per 100,000 population	12–35	0.7–2.5

Table 1. *Health System Capacity Indicators (OECD vs. LMIC Averages)Sources: WHO (2022); OECD (2021); World Bank (2021); Hale et al. (2021)*

From this data, it is evident that quantitative superiority in health system capacity does not automatically translate into effective pandemic response. Countries that had weaker systems but stronger local governance and community integration often managed the crisis more coherently than those with abundant resources but fragmented leadership.

This analysis reinforces the idea that resilience is dynamic, shaped by more than static metrics. Adaptive capacity how well systems respond, reorganize, and learn in the face of shocks is just as crucial as physical infrastructure (Blanchet et al., 2017). For future pandemic preparedness, especially in LMICs, emphasis should be placed not only on increasing beds and doctors but also on investing in early warning systems, emergency logistics, and digital health

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infrastructure that support flexible responses. The COVID-19 crisis has highlighted both the value and limitations of traditional health system indicators. Moving forward, global health policies must expand the definition of capacity to include agility, coordination, and community resilience as essential pillars of emergency preparedness.

Governance and Response: A Comparative Evaluation

Governance quality and crisis responsiveness emerged as decisive factors in shaping the trajectory of COVID-19 outcomes across countries, often more significant than material health system capacities. This section analyzes how the timeliness of interventions, transparency in public communication, inter-sectoral coordination, and leadership coherence influenced national pandemic responses in both OECD and LMIC contexts.

Countries with proactive governance and coordinated responses achieved better control of transmission rates and minimized health system disruptions. South Korea, for example, swiftly activated its Central Disease Control Headquarters, implemented mass testing, and deployed an advanced digital contact tracing infrastructure based on legal reforms made after the 2015 MERS outbreak (Kim et al., 2021). Similarly, New Zealand's government, led by Prime Minister Jacinda Ardern, adopted a clear "go hard, go early" strategy, locking down the country within weeks of its first detected case. Daily briefings and consistent risk communication bolstered public trust, leading to strong compliance with health mandates (Wilson et al., 2020).

In contrast, governance gaps and political polarization undermined pandemic responses in countries like the United States and Brazil. Despite having robust health systems, delayed lockdowns, conflicting messages between federal and state authorities, and the spread of misinformation eroded public confidence. Studies have shown that these factors directly contributed to lower adherence to guidelines and increased excess mortality (Greer et al., 2021; de Oliveira et al., 2021).

Interestingly, some LMICs exhibited governance efficiency despite limited fiscal and technical resources. Vietnam's centralized response model, built on strong political will and a culture of compliance, allowed rapid implementation of quarantines and real-time public updates.

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Rwanda, under a highly disciplined governance framework, utilized drones for public messaging, enforced curfews early, and conducted localized testing to curb outbreaks (Binagwaho et al., 2020). These examples challenge the assumption that only wealthier countries can demonstrate governance efficacy during crises.

The role of intergovernmental coordination and decentralization was also crucial. Germany's federal model, despite its complex structure, allowed states (Länder) to adapt public health interventions contextually while following national standards. This flexible approach contributed to relatively successful early containment (Kluge et al., 2020). In contrast, Indonesia's decentralized governance posed initial challenges in aligning national COVID-19 strategies with local execution, but was later adjusted through integrated task forces and community-based surveillance (Clarke et al., 2021).

To illustrate these governance dynamics, the following graphic compares selected OECD and LMIC countries on four key governance indicators: response speed, policy coherence, public trust, and enforcement effectiveness, using a 0–10 scale based on data from Oxford COVID-19 Government Response Tracker and WHO country reports.

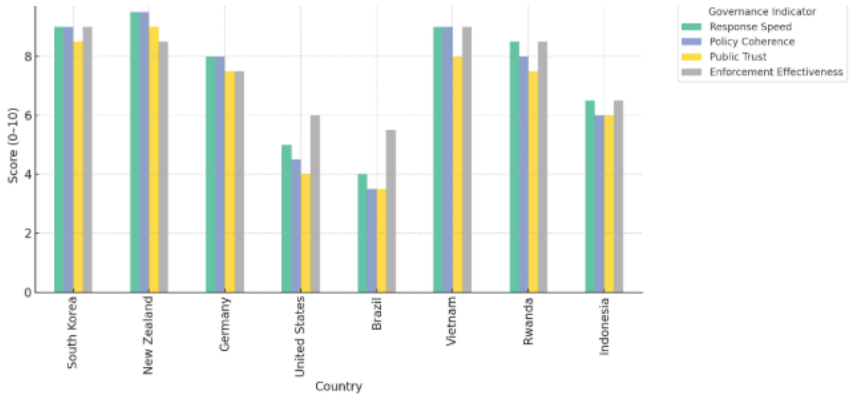

Figure 2. *Comparative Governance Indicators during COVID-19 Response. Sources: Hale et al. (2021); WHO (2022); Clarke et al. (2021); Greer et al. (2021)*

The table and accompanying analysis emphasize that governance factors particularly clarity, coordination, and public legitimacy are central to crisis management, regardless of income level. The correlation between early action and lower peak caseloads has been confirmed across multiple

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comparative studies (Legido-Quigley et al., 2020; Blanchet et al., 2017). Importantly, communication strategies played a critical role; countries with transparent, science-driven messaging achieved higher public adherence to non-pharmaceutical interventions such as mask-wearing and social distancing (OECD, 2021). While infrastructure and resources are essential, governance agility and trust-building are foundational for resilience. Pandemic response success depends not only on what governments do, but on how and when they do it, and whether their populations believe and comply. Future preparedness efforts must include governance strengthening through transparent leadership, community dialogue, and institutional coordination as a core pillar of global health strategy.

Cross-Cutting Themes: Trust, Experience, and Social Cohesion

Beyond health system capacity and policy response, several cross-cutting themes played a pivotal role in shaping national outcomes during the COVID-19 pandemic. These themes—trust in government, community engagement, and prior experience with epidemics—proved to be powerful determinants of resilience, often outweighing economic or structural factors.

1. Trust in Government and Public Institutions

Trust emerged as a central pillar of pandemic control. Countries with high levels of public trust in governmental and scientific institutions tended to demonstrate greater compliance with public health directives, including lockdowns, masking, and vaccination (Devine et al., 2021; OECD, 2021). For example, New Zealand, Finland, and Norway—all of which scored high on the Edelman Trust Barometer and OECD institutional trust indices—showed relatively high adherence to restrictions and low infection fatality rates (Wilson et al., 2020; Greer et al., 2021).

In contrast, countries like Brazil, Russia, and the United States experienced widespread misinformation, political polarization, and declining trust in government. In these cases, even when infrastructure and resources were available, lack of public cooperation and fragmented messaging undermined policy effectiveness (Brennen et al., 2020; de Oliveira et al., 2021). The WHO Global Pulse Survey (2021) further highlighted that misinformation and low trust levels

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contributed directly to vaccine hesitancy and non-compliance with health measures in over 45% of countries surveyed.

2. Community Engagement and Localized Responses

The role of community-based engagement also proved critical. LMICs such as Vietnam, Ghana, and Rwanda successfully utilized pre-existing community health worker networks and decentralized health systems to disseminate health information, monitor symptoms, and implement quarantines (Dinh et al., 2021; Binagwaho et al., 2020). These strategies helped maintain effective outbreak containment despite limited national-level capacity.

In Indonesia, for instance, the government partnered with Islamic leaders and local organizations to promote vaccine acceptance and counter hesitancy, particularly in rural and underserved areas (Yufika et al., 2021). Similarly, in India, the ASHA (Accredited Social Health Activist) network played a key role in contact tracing and health education across vast rural populations (Sundararaman et al., 2021).

3. Prior Experience with Epidemics

A country's historical exposure to epidemics like SARS, Ebola, or MERS had a clear impact on its pandemic preparedness and response speed. South Korea rapidly activated legal protocols and health infrastructure built during MERS (Kim et al., 2021), while West African nations like Liberia and Sierra Leone adapted strategies developed during the 2014–2016 Ebola outbreak, including community surveillance and cross-border monitoring (Bedson et al., 2020).

In Singapore, Taiwan, and Hong Kong, prior experience with SARS cultivated a culture of hygiene, mask-wearing, and rapid governmental action. These countries implemented border screenings and quarantine facilities before many others, leading to significantly lower infection and death rates in the early stages of the pandemic (Chen et al., 2021).

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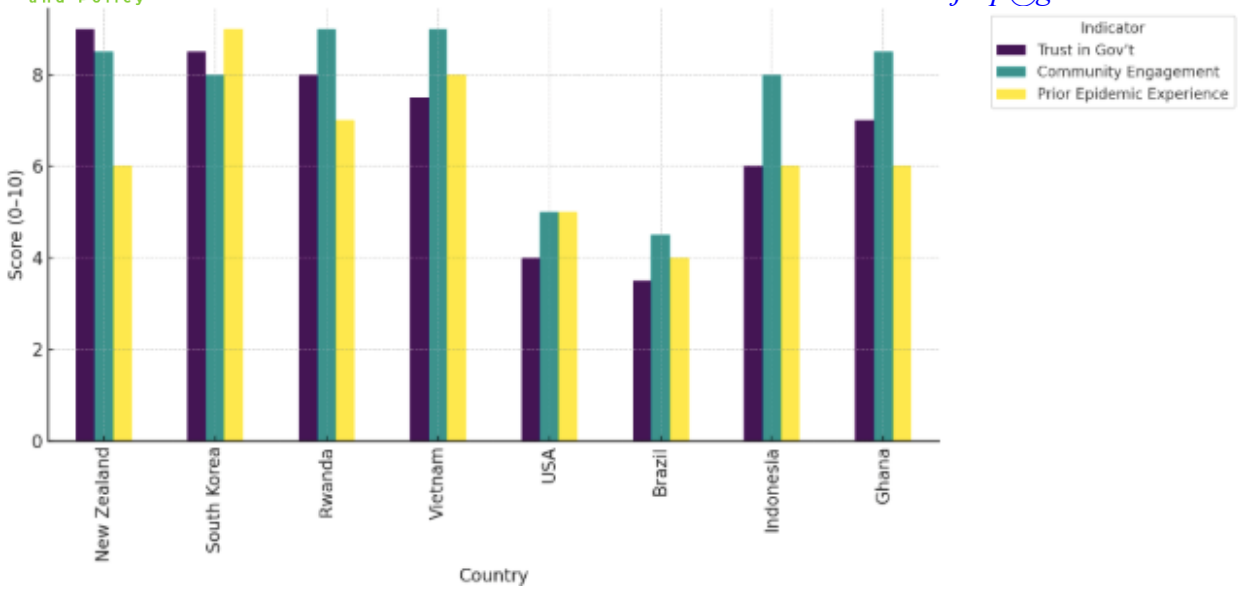

Figure 3. *Cross-Cutting Resilience Indicators in Selected Countries). Sources: WHO (2022); Edelman Trust Barometer (2021); Hale et al. (2021); OECD (2021)*

4. Social Cohesion and Equity Considerations

Social cohesion the degree to which individuals cooperate and trust one another—was also correlated with more effective collective action. Nordic countries, for instance, benefitted from high civic participation and egalitarian social norms, facilitating smoother implementation of health mandates (Greer et al., 2021). In contrast, countries with high social fragmentation or ethnic-political divisions struggled to generate unified responses, especially when policies were perceived to favor certain groups (Blanchet et al., 2017).

Equity in access to healthcare also emerged as a theme. In many OECD countries, structural inequities resulted in disproportionate impacts on migrant populations, ethnic minorities, and low-income groups, despite overall system strength (Kluge et al., 2020). In the UK, Black and South Asian communities experienced higher mortality rates due to comorbidities, occupational exposure, and delayed access to care (Patel et al., 2020).

Cross-cutting factors such as public trust, civic engagement, prior epidemic experience, and social cohesion significantly shaped the effectiveness, speed, and sustainability of national

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pandemic responses. These factors are not always captured in traditional health system metrics but are crucial for resilience. Moving forward, pandemic preparedness strategies must incorporate these intangible but influential dimensions, ensuring that governance, community trust, and historical learning are embedded in both policy design and practice.

CONCLUSION

The COVID-19 pandemic has underscored that health system resilience and emergency preparedness are shaped not only by economic strength or infrastructure, but by a broader set of interrelated factors including governance quality, public trust, community engagement, and institutional adaptability. While OECD countries generally possessed superior baseline capacities such as higher ratios of hospital beds, healthcare personnel, and testing facilities these advantages did not always translate into better outcomes, particularly when policy responses were delayed or poorly coordinated. Conversely, several LMICs demonstrated remarkable agility and effectiveness in mobilizing limited resources, driven by strong command structures, community-based interventions, and lessons learned from previous outbreaks like SARS and Ebola. Cross-cutting themes such as trust in government, societal cohesion, and decentralized governance were proven to be critical levers in navigating the crisis successfully. This comparative analysis highlights the need for a more holistic, equity-centered approach to global health preparedness—one that prioritizes not only physical capacity but also social infrastructure, communication systems, and collaborative leadership. As the world anticipates future public health emergencies, investing in flexible, inclusive, and trust-driven health systems will be essential for ensuring resilient and equitable responses across diverse national contexts.

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