

Structural Determinants of Health, Community Power Building, and Advancing Health Equity in South Korea

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Abstract

Health inequities in South Korea persist despite overall gains in life expectancy and a universal health insurance system. This perspective applies scholarship on the structural determinants of health to analyze how societal rules and power dynamics produce and maintain health inequities in South Korea. Moving beyond depoliticized approaches to the social determinants of health, structural determinants were recently defined as written and unwritten rules—values and norms, governance arrangements, laws and budgets, and institutional practices—shaped by those with power and reciprocally reinforcing existing power hierarchies. Drawing on national and international evidence, we examine three interrelated forms of structural oppression that underlie contemporary health inequities in South Korea: structural economic exploitation, structural regional inequity, and structural sexism. We illustrate how growth-first economic norms, concentrated corporate power, weak labor protections, market-oriented healthcare governance, metropolitan-centered resource allocation, and gendered labor and care regimes translate into unequal health outcomes by income, employment status, region, and gender.

We argue that these inequities persist not due to a lack of technical solutions, but because prevailing power dynamics limit meaningful changes to the rules that shape health-relevant conditions. To demonstrate how power can be contested and reshaped, we present a brief case study of healthcare policymaking in South Korea, highlighting the role of civil society organizations, labor movements, and community-based initiatives in challenging healthcare commodification and seeking to expand democratic control over health governance, while also revealing the limits of reforms that fail to redistribute decision-making power. Advancing health equity therefore requires strategies that intentionally build community power, democratize governance, and reconfigure institutional rules alongside improvements in community conditions. Repositioning public

health as a project of political and structural transformation is essential to achieving sustainable equity in South Korea.

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I. Structural determinants, Societal Rules, and Power

Over the last five years, the term structural determinants of health has been used increasingly by health equity advocates wanting to focus attention on the root causes of health inequities (Heller et al., 2024). A recent definition of the term differentiates it from current usage of the term social determinants of health (SDoH); while an early definition of SDoH included the “forces and systems shaping the conditions of daily life,” the term has been depoliticized to only include the conditions themselves, obfuscating how those conditions are created and who creates them (Heller et al., 2024; Karatekin et al., 2024; World Health Organization, 2023).

This recent definition of structural determinants clarifies that community conditions are created by a set of written and unwritten rules by those with power to set, implement, and enforce those rules (Heller et al., 2024). The societal rules include “values, beliefs, worldviews, culture, and norms; governance; laws, policies, regulations, and budgets; and institutional practices” (Heller et al., 2024). A reciprocal relationship exists between the rules and power: those with power create the rules and the rules determine who has power. If community conditions result in health inequities, then to advance health equity, the rules that create those conditions must be changed, and this requires that power dynamics be changed. The power of communities facing inequities must be built and the power of those working to maintain the status quo or to deepen inequities must be broken or limited

(Michener, 2022).

Public health practitioners often have negative or, at best, conflicted feelings about power. These feelings are typically based on a definition of power that focuses on domination and control. Many definitions and frameworks for understanding power, however, provide useful conceptual reframing. Dr. Martin Luther King defined power as “the ability to achieve a purpose” (King Jr., 2013). He believed that power could be used for good or for bad purposes. Others, including feminist scholars and activists, have introduced terms including “power to,” “power with,” and “power within” to counter conceiving of power simply as “power over” (Allen, 1998; Popay et al., 2021; VeneKlasen et al., 2007). Community power was recently defined as “the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity” (Pastor et al., 2020). These reframings support public health engaging in work that addresses power imbalances in order to advance health equity.

Importantly, structural determinants should not be understood as a collection of upstream factors. Rather, they refer to political processes through which certain actors gain the authority to define societal rules, allocate resources, and determine whose interests are prioritized in decision-making arenas. In this sense, health inequities are not accidental by-products of social conditions but predictable outcomes of unequal

power distributions. Therefore, health inequities persist not because specific policies are absent or incomplete, but because decision-making power itself remains concentrated.

Building off this recent scholarship on structural determinants, societal rules, and power imbalances, what are key drivers of health inequities in South Korea today? What rules keep health inequities in place? And what power dynamics keep these rules from changing? While it is beyond the scope of a single perspective to fully answer these complex questions, after reviewing key health inequities in South Korea today, this perspective provides some illustrative examples of answers and discusses the implications for public health research and practice in South Korea.

II. Current Status of Health Inequities in South Korea

Life expectancy in South Korea has increased overall over the past few decades, but health inequities by socioeconomic status, region, and gender persist. First, recent data clearly show health gaps by income level. Between 2008 and 2020, South Korea's health-adjusted life expectancy (HALE) increased from 68.89 years to 71.82 years overall, but the gap between high- and low-income groups remained significant and even widened in some years (Jung et al., 2024). Similar results have been consistently reported in previous studies using national representative data on

health inequities by socioeconomic position (Lim et al., 2020).

In particular, a 2018 report from the Korean Society for Equity in Health found that within regions, health inequities also existed according to socioeconomic status. Across 248 local levels (cities, counties, and districts), the income gap in HALE was greater than the income gap in life expectancy. Since life expectancy reflects mortality and HALE reflects both mortality and morbidity, this suggests that inequities exist in both death and disease in South Korea (Bahk, 2018).

Health inequities are also observed according to employment conditions. Workers in unstable jobs and small workplaces have poorer health status than those in regular employment or large corporations (Jung, 2021). Workers in precarious forms of employment often experience multiple, overlapping disadvantages that accumulate over time and translate into poorer health outcomes.

Regional health disparities in South Korea are clearly evident in both quantitative indicators and qualitative studies. According to the Korea Healthcare Quality Report, although overall mortality improved over the past decade (2010-2021), regional disparities in premature mortality (under age 75) from amenable causes—particularly cancer, respiratory diseases and so on—have widened (Kim et al., 2022). In amenable mortality—deaths that are preventable through timely and effective healthcare—some regions recorded substantially more excess deaths compared with Seoul.

Empirical studies indicate that improving healthcare accessibility alone is insufficient; comprehensive

policies addressing social determinants of health are also needed (Kim & Lee, 2017). Regions with higher levels of deprivation¹ showed consistently higher overall mortality. Notably, preventable mortality demonstrated a strong positive association with deprivation ($R^2 = 0.495$), while amenable mortality showed only modest explanatory power ($R^2 = 0.122$), indicating that upstream socioeconomic conditions, rather than healthcare treatment capacity, are the primary drivers of regional inequities.

Korean women live longer and have lower mortality rates than men, yet their subjective health—measured by self-rated health, activity limitation, and quality of life—is poorer (KDCA NIH, 2023). The income and regional gaps in HALE are also greater among women (Jung et al., 2024), suggesting that socioeconomic or regional resource constraints may have more adverse effects on women.

III. Rules that Maintain Health Inequities

The structural determinants of health “enshrine and encode” forms of structural oppression (Heller et al., 2024). Here we provide examples of societal rules in South Korea associated with three forms of structural oppression—structural economic exploitation, structural regional inequity, and structural sexism.

1. Structural Economic Exploitation

Table 1 provides examples of written and unwritten rules that maintain inequities related to income and employment conditions in four categories: values, beliefs, worldviews, culture, and norms; governance; laws, policies, regulations, and budgets; and institutional practices. The examples described are intended to be illustrative, not comprehensive.

At the level of values and norms, South Korea’s development trajectory has been shaped by a strong emphasis on economic growth as the primary indicator of societal success, while redistribution and labor protection have remained secondary concerns. This growth-first orientation contributes to the normalization of inequality by framing precarious employment and limited worker protections as necessary trade-offs for competitiveness and productivity (OECD, 2019). Within this normative context, workers’ inability to rest when sick is often treated as an individual issue rather than a systemic failure of social and labor institutions (Kim et al., 2024).

Governance structures further reinforce these inequalities through the concentration of economic and political power among a small number of large conglomerates (“*chaebol*”). Empirical evidence shows that politically connected *chaebol* firms use systematic advantages in government procurement, illustrating how economic power translates into political influence (Cho, 2024). Such governance arrangements restrict

¹ The deprivation index incorporated nine socioeconomic indicators including substandard housing conditions, low educational attainment, an aging population structure, low occupational social class, single-person households, lack of private vehicle ownership, apartment residence, female-headed households, and divorced or widowed status.

<Table 1> Examples of rules that maintain structural economic exploitation

Type of rule	Examples that maintain income inequity	Examples that maintain inequitable working conditions
Values, beliefs, worldviews, culture, and norms	The dominant logic of “growth first, redistribution later”; Economic growth is the primary measure of how well South Korea is doing	Precarious workers are unable to take sick leave and must continue working even when ill
Governance	Concentration of economic power among a few <i>chaebol</i> [*] restricts fair competition and limits opportunities for smaller firms and workers	A small number of large corporations such as <i>chaebol</i> [*] have excessive influence on politics
Laws, policies, regulations, and budgets	Tax policies that allow for wealth concentration (e.g., limited progressive taxation, generous corporate tax exemptions, deregulation of businesses)	No law requiring corporations to provide workers with sickness benefits
Institutional practices	Wage structures that depress low income workers’ earnings (e.g., reliance on subcontracting, segmented labor markets, and wide executive–worker pay gaps)	Corporations encourage workers to work in ways that result in occupational injuries (e.g., long hours, outsourcing of hazardous work, violations of the two–person safety rule)

Source: Ahn et al.(2019), Cho(2024), Kim et al.(2024), Lee et al.(2025), OECD(2019; 2023)

* A *chaebol* refers to a business conglomerate in which the largest shareholder and their family collectively own more than 20% of the company’s shares and are actively involved in its management (Cho, 2024).

fair competition and weaken the bargaining position of smaller firms and workers, limiting the political space for policies that would strengthen labor protections or reduce inequality.

At the policy level, income inequality and inequitable working conditions are sustained by gaps in redistribution and social protection. Korea’s tax and welfare system has limited capacity to counteract market-generated inequity, while statutory paid sick leave and comprehensive sickness benefits remain absent or insufficient for large segments of the workforce (Lee et al., 2025; OECD, 2023). As a result, the economic risks associated with illness are shifted onto workers, particularly those in non-standard or precarious employment.

These structural conditions are realized through institutional practices within workplaces. Subcontracting, indirect employment, and segmented labor markets depress wages and expose workers to higher occupational risks. Comparative evidence demonstrates that indirectly employed workers in Korea experience poorer working environments

and significantly higher rates of occupational injury than directly employed workers, indicating that risk is systematically externalized down employment chains (Ahn et al., 2019). In the absence of enforceable sick leave protections, these practices compel many workers to continue working while ill, embedding health inequities into the routine organization of work (Kim et al., 2024).

Taken together, Table 1 demonstrates that income inequality and inequitable working conditions are not isolated outcomes but mutually reinforcing products of layered social rules. Normative priorities legitimize unequal outcomes, governance structures entrench power asymmetries, policy frameworks fail to provide adequate redistribution and protection, and institutional practices operationalize these inequalities at the workplace level. As a result, insecure employment and health risks become structural features of the labor market rather than temporary or exceptional conditions.

Similar rules can be found globally and lead to similar health inequities. Neoliberal worldviews,

centering economic growth and free market ideology, dominate (Gilmore et al., 2023). Deregulation, weak anti-trust enforcement, and corporate consolidation have given rise to monopolies and concentrated corporate power in the United States (Stoller, 2019) and elsewhere (Gilmore et al., 2023). Tax cuts on the wealthy and corporations have reduced resources available for government programs and created huge wealth disparities (Freudenberg, 2021; Gilmore et al., 2023). And the misclassification of jobs and executive pay packages have depressed wages for low-income workers (Gilmore et al., 2023). All these “rules” maintain income inequity.

2. Structural Regional Inequity

While regional inequity in South Korea can be found across many social determinants of health, we focus on healthcare as an illustrative example. Despite the country’s single-payer system under the National Health Insurance Service (NHIS), regional health inequities persist due to a set of interlocking structural rules that systematically privilege metropolitan areas. Table 2 illustrates how these rules operate across normative, governance, policy, and institutional levels

to maintain regional disparities.

At the normative level, healthcare in South Korea is implicitly framed as a market commodity, with service provision driven by purchasing power rather than population health needs (Yim, 2021). This market-oriented worldview normalizes the concentration of medical services in affluent metropolitan areas and devalues healthcare provision in rural and deprived regions. The extremely low share of public hospital beds (9.6%, the lowest among OECD countries) further limits the state’s capacity to counteract market-driven regional inequalities (Na et al., 2025). As a result, regional disparities are often interpreted as an efficient market outcome rather than as a problem of social justice or equity. Moreover, policy discourse frequently portrays non-metropolitan areas as “deficit” spaces defined by what they lack—beds, providers, or accessibility—reducing inequities to technical service gaps and obscuring the broader socio-economic structures that produce uneven development (Park & Kim, 2024).

Governance structures reinforce these dynamics. Although local public health institutions are publicly financed and established in each local government, their role in addressing regional health inequities remains constrained. Within a centralized and

<Table 2> Examples of rules that maintain regional inequity

Type of rule	Examples that maintain structural regional inequity (e.g., rural, areas of deprivation)
Values, beliefs, worldviews, culture, and norms	Healthcare is implicitly framed as a market commodity, and peripheral regions are consequently constructed as deficit spaces, depoliticizing structural inequities and legitimizing metropolitan concentration of resources and decision-making power
Governance	Regional public health governance with limited intersectoral collaboration and citizen participation
Laws, policies, regulations, and budgets	Budget allocation and insurance reimbursement structures that weaken primary care and concentrate resources in metropolitan tertiary hospitals
Institutional practices	Concentration of advanced hospital beds, medical professionals, and high-cost services in metropolitan areas

Source: Heo et al.(2025), Na et al.(2025), Park & Kim(2024), Yim(2021)

administratively elite-driven governance system, local public health systems face limited capacity for intersectoral collaboration, citizen participation, and context-sensitive decision-making (Heo et al., 2025). Consequently, local public health systems struggle to function as platforms for integrated, population-based health governance, particularly in deprived areas where health needs are complex and multi-dimensional.

Healthcare laws, policies, and budgetary mechanisms further entrench inequity by incentivizing capital-intensive investments in large tertiary hospitals. Insurance reimbursement and regulatory frameworks disproportionately reward overinvestment and overtreatment in metropolitan hospitals, weakening the primary care function of the national health insurance system and undermining early detection and chronic disease management in local communities (Na et al., 2025).

At the institutional level, intensified competition among providers accelerates the concentration of advanced hospital beds, specialized services, and healthcare professionals in the Seoul metropolitan area. Large urban hospitals attract medical personnel from other regions and expand high-cost services, hollowing out healthcare capacity in less affluent areas (Yim, 2021). The institutional practices thus capture how everyday operational decisions by healthcare organizations reproduce structural inequities across regions.

Overall, regional health inequities in South Korea are not simply issues of unequal access but reflect a system of interlocking rules—normative assumptions about markets, centralized governance structures,

incentive-distorting policies and budgets, and profit-oriented institutional practices. Addressing regional health inequity therefore requires not only redistributing resources but also fundamentally reconfiguring the rules that govern how healthcare is valued, financed, governed, and practiced at the national and local levels.

Worldviews that promote the privatization and commodification of healthcare delivery are not just an issue in South Korea, but rather are a global health equity issue. Recent studies find that both healthcare quality and patient outcomes often worsen when systems are privatized, while efficiency and profitability rise (Alayed et al., 2024; Goodair & Reeves, 2024). Differing governance structures, laws and policies, and institutional practices are at fault in different countries, but access to quality healthcare in rural areas is a global problem (Scheil-Adlung, 2015), even in high-income countries like the United States (Center for Disease Control and Prevention, 2025).

3. Structural Sexism

Table 3 provides illustrative examples of written and unwritten rules that maintain inequities related to gender.

Structural sexism in South Korea is sustained through a multilayered assemblage of rules—cultural norms, governance arrangements, policy designs, and organizational practices—that systematically allocate opportunity, burden, and health risk along gendered lines. As summarized in Table 3, gendered cultural schemas continue to position women as primary

<Table 3> Examples of rules that maintain structural sexism

Type of rule	Examples that maintain structural sexism
Values, beliefs, worldviews, culture, and norms	Caregiving and low-status services culturally assigned to women; Women's labor flexibility normalized; Younger men increasingly adopt zero-sum beliefs (women's gains as men's losses) and deny ongoing discrimination
Governance	Women underrepresented in political and corporate leadership, reinforcing male-centered institutional priorities, enabling policy regimes that tolerated neoliberal restructuring, such as mass layoffs and rehiring of women as precarious workers
Laws, policies, regulations, and budgets	Employment, welfare, and care-policy frameworks built around male-norm (e.g., careers uninterrupted by caregiving); Neoliberal restructuring policies shift women into irregular, low-paid care and service jobs
Institutional practices	High gender wage gap reflects organizational norms that devalue feminized labor, reinforced by younger men's widespread underestimation of gender bias

Source: Han et al.(2025), Kim(2019), Mo & You(2025)

caregivers; women perform approximately two to three times more unpaid care work than men and remain concentrated in feminized sectors such as health and social care (74.4%) and education (69.1%) (Han et al., 2025). These patterned allocations are reinforced by labor-market institutions that privilege uninterrupted male-norm careers and generate persistent economic penalties for women. In 2023, Korean women earned 29.3% less per month than men—2.6 times the OECD average gender wage gap of 11.3%, making Korea the country with the widest gender wage gap in the OECD. The proportion of female low-wage workers was 24.5%, exceeding the OECD average of 17.2% by 7.3 percentage points (Han et al., 2025).

A qualitative study of single parents' health determinants illustrates how these rules manifest in everyday life, as multidimensional systems of oppression—gendered discrimination, stigma, and “normal”-family ideology—intersect to shape health inequities (Heo & Sung, 2024). The study suggests that gendered structures operate differently for women and men yet produce shared vulnerabilities among single parents, revealing gender as a structural pressure rather than an individual disadvantage.

These findings highlight limitations in conventional SDoH frameworks that center paid work while rendering unpaid care work invisible, underscoring the need to refine conceptual models to fully capture how gender organizes life conditions and health risk. The single-parent health study further demonstrates that structural norms surrounding masculinity, sexuality, and the “normal”-family ideology determine which forms of care are socially recognized and which remain privatized, thereby reproducing poverty, overwork, and stigma among caregivers (Heo & Sung, 2024).

Younger Korean men increasingly deny gender discrimination and adopt zero-sum framings of gender equality (Kim, 2019; Mo & You, 2025). This pattern reflects the influence of neoliberal individualism, which obscures structural forces and reframes gendered disadvantages as matters of personal failure or intensified competition rather than systemic inequity.

Similarly to the rules that create economic exploitation and regional inequity, these rules that create structural sexism in South Korea can be found globally. With few exceptions, women in countries around the world continue to be assigned caregiving roles and particular occupations, underrepresented in political and corporate leadership, and valued less

for their work, including being paid less than male counterparts.

IV. Power Structures and Contested Rule-Making in South Korean Health Governance

If available data and evidence indicate that these rules lead to harmful community conditions and therefore poor health outcomes for some, why are they still in place? Advancing health equity requires that we investigate and work to change the power dynamics that keep these rules from being changed. More specifically, we can ask:

- Who has shaped and continues to shape dominant beliefs, worldviews, and norms about the economy, regions, and gender in South Korea? Who benefits from current beliefs, worldviews, and norms? What mechanisms are used to maintain them? Are there other, less dominant, beliefs, worldviews, and norms that would lead to improved outcomes? How might the narrative power (Dorfman et al., 2025) of those facing exploitation be built, and transformative narratives be amplified?
- How do corporations, the wealthy, urban dwellers, and men exert undue influence over politics and the economy? Who benefits from current governance structures? How might we shift power away from the private sector, urban areas, and the dominant gender so it is more equitably

distributed? How can Korea's democratic practices be strengthened and the state's regulation of corporations be enhanced? How can civil society have more direct control over economic enterprises (e.g., worker-owned cooperative social enterprises)?

- Who currently has the greatest ability to influence laws, policies, regulations, and budgets? Who currently benefits from these laws and budgets? What mechanisms do they use exert that influence? What are mechanisms available to those facing health inequities to influence laws, policies, regulations, and budgets? How can we strengthen those mechanisms and create new mechanisms to ensure that our laws and budgets reflect the needs of those facing inequities?

- Who currently has the ability to make decisions about institutional practices? Who benefits from these practices? How can workers, civil society, rural dwellers, and women play an increased role in corporate and institutional governance?

Case Study: Shifting Power Dynamics to transform Health Governance—Civil Society, Labor Movements, and Community Power Building in South Korea

To illustrate how these questions can be answered, we briefly review healthcare-related policymaking in South Korea. Currently, this policymaking is shaped by structural imbalances in political participation, whereby organized interests—such as healthcare providers, insurance, pharmaceutical, and technology capital—exert disproportionate influence over policy agendas through institutionalized access and lobbying (Na et al., 2025). Evidence from COVID-19 vaccination policy shows that, despite civil society organizations

(CSOs)' efforts to advocate for disadvantaged groups, decision-making remained government-led, with limited communication, tokenistic citizen participation, and minimal co-production of knowledge (Heo et al., 2021). These constrained political opportunity structures systematically weaken the capacity of healthcare policy to address health inequities.

The pursuit of health as a collective right in South Korea has historically unfolded through struggles against two dominant forces: a developmental state that has been ambivalent toward strengthening the public nature of health policy, and market power that has entrenched a private, market-dominated healthcare system. In response, CSOs and labor unions have formed powerful strategic alliances to challenge healthcare commodification and to frame health as a social right rather than a market good. The labor-civil society alliance that drove the integration of health insurance payers represents one of the most successful cases of welfare politics in modern Korean history (Kim & Lee, 2025), actively opposing healthcare commercialization while advancing policy agendas centered on expanding National Health Insurance coverage, strengthening public healthcare, and institutionalizing the right to rest when ill.

Although the insurance integration movement achieved institutional reform, decision-making authority within governance bodies such as the Health Insurance Policy Deliberation Committee remained dominated by state and provider interests. Thus, structural power asymmetries largely persisted. These experiences illustrate that policy reform does not automatically translate into power redistribution. Without transforming who sets the rules and controls

resources, structural inequities tend to re-emerge in new forms. Within party politics, healthcare-related civil society demands have been difficult to aggregate into coherent political platforms. Long-standing growth-oriented policy paradigms that prioritize minimizing social reproduction costs have relegated health—alongside labor rights, ecological sustainability, climate justice, and social protection—to a secondary political status, limiting the emergence of progressive parties capable of articulating health as a core societal value (Yim, 2021). As a result, health-focused CSOs have assumed a dual role: acting simultaneously as advocacy actors engaged in agenda-setting and political mobilization, and as quasi-public service providers partnering with the state to generate public value within constrained institutional environments (Heo et al., 2021).

Since the mid-2000s, new power dynamics have also emerged at the local level. Grassroots organizations, neighborhood associations, cooperatives, and social enterprises have increasingly collaborated with local governments and public health centers to implement community-based health promotion initiatives (Song et al., 2022). These community-based, participatory arrangements have enabled forms of collaborative governance that modestly expand community agency and contribute to localized improvements in health equity.

Reducing health inequities in South Korea requires strengthening civil society and community power within a healthcare system that remains heavily oriented toward medical treatment and professional-bureaucratic control. Shifting toward public health and primary healthcare repositions communities as

active agents in sustaining health in everyday life, rather than passive recipients of medical care. From this perspective, empowerment around the structural determinants of health is both a means and an objective of community organizing, making community power a central condition for transforming health governance and advancing health equity in South Korea.

V. Strategies for Redistributing Power in Public Health Research, Practice, and Policy

Building from this healthcare-focused case study, we can delineate the types of strategies and actions health equity advocates can take to shift power dynamics, to both build the power of those facing inequities and to break the power of those working to maintain the rules described above.

Public health researchers can use the research process and findings to build community power. They can, for example: form research partnerships with CSOs that support and/or organize communities facing inequities, including labor unions and community organizing groups (Jimenez & Heller, 2025); focus research on topics and answer questions of interest to those communities rather than topics and questions sanctioned by existing power holders; include community knowledge as evidence rather than only using quantitative data often used to blame community members for their health problems; and use the research process to expand the membership and

build the leadership of members of those partner organizations. Public health researchers in South Korea have acted as intermediaries to connect public health centers with diverse community-based organizations (CBOs) and grassroots groups, representing a key strategy for strengthening community power (Heo et al., 2021). However, research-community partnerships are often discontinued following changes in local political leadership, underscoring the need for research capacity that can strengthen local leadership and help transform these structurally fragile arrangements. Additionally, researchers can use their findings, again in partnership with those facing inequities, to advocate for changes to society's rules, for example by testifying in front of decision-makers, informing elected officials, and writing for the general public (e.g., opinion pieces) in ways that shift worldviews. Knowledge itself is a form of power, and it can be brought together with people-power and the positional power researchers have to make change. Accordingly, this work must extend beyond single-discipline or program-specific studies toward interdisciplinary research that critically examines the nation's spatial development model and broader social policy framework, since many of the structural determinants shaping local health inequities originate from macro-level economic, fiscal, and planning decisions.

Public health practitioners can evaluate whether existing public health interventions reinforce or shift harmful power dynamics, and can design new interventions that intentionally shift those dynamics. While public health practitioners do not have decision making power on many interventions that address

the SDoH, they do offer many health programs and services. Those facing inequities—those who typically use more health services—can be partners in designing and evaluating those services. Interventions can be designed to not just provide services, but to bring those facing inequities together and help them organize to solve their own problems. Public health practitioners can model for others how to shift power dynamics and advance equity.

Last, policymakers can redesign policymaking processes to share their power and can work to pass policies that address power imbalances. In the economic domain, this includes strengthening labor protections, regulating corporate influence, and reforming taxation and social protection systems to reduce income insecurity and precarious work. In the regional domain, similar redistributive principles apply to territorial governance, such as rebalancing fiscal, educational, and social investments across regions and strengthening local decision-making capacity to counteract long-standing metropolitan concentration of resources. In the gender domain, policies that recognize unpaid care work, expand social care infrastructure, and promote women's representation in leadership are essential to dismantling institutionalized gender inequities. Across these domains, participatory mechanisms—including participatory budgeting and community co-governance—can expand democratic control over public resources and ensure that those most affected by inequities shape the policies intended to address them (Federation of International Association for Public Participation, 2024). Together, these approaches treat health equity not only as a service problem but as a question of redistributing power

across economic, spatial, and social systems.

The actions described here, while not comprehensive, provide a starting point for those interested in employing the ideas developed in this perspective.

VI. Conclusion

While the public health community has understood for several decades that health inequities result from inequitable community conditions, it has struggled to change those conditions in South Korea and around the world. Recent scholarship on the structural determinants of health—scholarship that focuses attention on societal rules and the power dynamics that create, maintain, or modify those rules—provides a path forward. Those interested in advancing health equity in South Korea can use this perspective as a starting point to help them analyze the rules that create the inequities they are focused on and the power dynamics that maintain those rules. From that analysis, they can then develop the strategies and actions needed to advance change. We do not claim that changing the structural determinants of health is easy. The beliefs, worldviews, norms, governance structures, laws, policies, and institutional practices that create inequity are deeply embedded in our societies and many will take years to change. Furthermore, those who currently hold power have no incentive give it up and will not do so easily. But this is the work that must be done if we want to advance equity. The path forward, while difficult, is clear. We

must start now, with rigorous analysis and strategy based on the concepts laid out here.

Ultimately, the persistence of health inequities in South Korea reflects not a lack of technical knowledge but a lack of political transformation. Effective solutions are already known; what remains contested is whose interests prevail in shaping societal rules. Thus, advancing health equity is fundamentally a question of democracy and power redistribution, and working with civil society movements is therefore a critical component of the work. Public health, in this sense, is not only a technical field but also an inherently political project.

Research Ethics

Not applicable.

Conflict of Interest

The authors declare no conflicts of interest.

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