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1.0 INTRODUCTION

The COVID-19 pandemic laid bare the intensity of the differences in national health system structures. All nations faced the same rapidly spreading virus, yet their responses—how they were organized, who was in control, and how quickly they acted—were remarkably different. These divergences did not arise in a vacuum; they were rooted in each nation's political traditions, leadership styles, and the degree of centralization in the health system. Spain, South Korea, and Canada represent three salient examples.

Their approaches to health-system organization and crisis governance took very different forms, making them an excellent set of cases to illustrate how structure and leadership combined to shape pandemic outcomes. As the pandemic unfolded, their divergent trajectories made clear that the architecture of the health system, its culture of readiness, and how leaders decided all interacted to determine how well each nation coped (WHO, 2020; Kluge et al., 2020; Greer et al., 2020).

1.1 RATIONALE FOR COMPARING SPAIN, SOUTH KOREA, AND CANADA

Spain's health system is highly decentralized, with much autonomy residing in its regions. When COVID-19 arrived, Spain suffered a huge surge in cases early on, and the central government came in for heavy criticism for moving too slowly. Early messaging from Health Minister Salvador Illa did not help: he downplayed the risks even as evidence of community spread piled up (Lapuente & Van de Walle, 2020).

Coming into the pandemic, South Korea had painful memories of the 2015 MERS outbreak and thus already had a strong infectious-disease response system in place. The fast-moving Prime Minister Chung Sye-kyun was focused on transparency, citizen involvement, and ramping up public health efforts. The strong state capacity, centralized coordination, and readiness to adapt in line with the evolution of the crisis earned South Korea international praise for its early containment.

Canada tells a different tale. It is a very decentralized federation wherein most of the authority on health care lies in the provinces. This made coordination hard to achieve, and decision-making was slower compared to other countries. Public-health measures did not precisely fit from one province to another. Prime Minister Justin Trudeau tried to bring the provinces together for a coordinated response. Still, Canada came under fire due to its slow vaccine.

1.2 PURPOSE AND OBJECTIVES

This report takes a close look at Spain, South Korea, and Canada, comparing how their health-system structures and leadership styles shaped their pandemic responses. The analysis draws on health-leadership theories—like transformational, adaptive, and complexity leadership—and systems thinking, zeroing in on the decisions and governance styles of Illa, Chung, and Trudeau (WHO, 2016; Northouse, 2021).

1.3 STRUCTURE OF THE REPORT

The structure of this report follows a clear analytical pathway. Section 2 provides a comparative overview of the organization of Spain, South Korea, and Canada in terms of health-care systems, particularly focusing on centralisation and crisis-response structures (Kluge et al., 2020). Section 3 will delve into the leadership styles of Illa, Chung, and Trudeau, using established frameworks (WHO, 2016).

Section 4 synthesizes the findings and explores how structure and leadership interacted to influence each country's pandemic response. Finally, section 5 concludes with key messages and their implications for the management of future global health crises.

Not all health systems around the world are created equal. Governance structures, funding, authority, and operational strength all vary from country to country. And those differences have made all the difference in how governments have prepared for and managed COVID-19. Health-system resilience is based on a set of core components: governance, workforce, infrastructure, digital tools, and emergency preparedness (WHO, 2016; Kluge et al., 2020).

2.0 OVERVIEW OF HEALTH SYSTEMS

Not all health systems around the world are created equal. Governance structures, funding, authority, and operational strength all vary from country to country. And those differences have made all the difference in how governments have prepared for and managed COVID-19. Health-system resilience is based on a set of core components: governance, workforce, infrastructure, digital tools, and emergency preparedness.

Spain, South Korea, and Canada offer three very different blueprints for organizing a health system. Spain runs a decentralized national health system, handing real power to its regions. South Korea, on the other hand, keeps things tightly centralized with advanced technology and strong infectious-disease oversight. Canada splits the difference, with a federal setup that gives provinces a great deal of autonomy.

2.1 CENTRALISATION AND DECENTRALISATION IN HEALTH

Where centralisation means the gathering of authority at the national level, decentralisation is the spreading of power to regional or local governments. This is not merely a technical distinction but affects the speed with which a government can act in a crisis, the ability of the government to coordinate across sectors, and whether policies remain consistent everywhere. For example, countries with centralised systems tended to respond faster during COVID-19 and establish clear, consistent policies. By contrast, decentralised systems saw much greater variation in the implementation of policies and in regional outcomes (WHO, 2016).

South Korea is a real textbook case of centralized infectious-disease governance. The Korea Disease Control and Prevention Agency (KDCA) is in charge, with powerful national authority. Spain is the polar opposite: its National Health System spreads power out over 17 autonomous communities, each in charge of its own health services. Canada's federal system puts provinces in charge of healthcare, meaning pandemic responses varied significantly from region to region (Greer et al., 2020; OECD, 2020).

2.2 EMERGENCY PREPAREDNESS AND PUBLIC HEALTH INFRASTRUCTURE

Emergency preparedness is about being ready to spot, respond to, and contain new health threats. The countries most effective at early containment had surveillance systems in place, solid digital tools, and good interagency teamwork (Kluge et al., 2020). The pandemic really exposed the value of investing beforehand—in labs, stockpiles, and systems for getting honest risk information out to the public. South Korea's experience with MERS spurred reforms that paid off: stronger laws for data sharing, rapid testing, and fast public-health action. Spain and Canada both had strong universal health coverage, but their infectious-disease governance wasn't as tightly integrated, and that slowed down their early responses.

2.3 LEADERSHIP AS A HEALTH-SYSTEM COMPONENT

Leadership is not a nice-to-have but an imperative in health system resilience. According to the WHO leadership framework, crisis leaders should clearly communicate, draw in expertise from various sectors, make decisions openly, and take the public on board (WHO 2016). The COVID-19 pandemic demonstrated that even the most well-resourced of health systems falter if people at the helm are unable to lead their teams through uncertainty and galvanize a collective response.

Spain's Salvador Illa, South Korea's Chung Sye-kyun, and Canada's Justin Trudeau each took a different approach—drawing on transformational, adaptive, or distributed leadership models. Their leadership styles didn't just set the tone; they shaped how their countries responded in real time (WHO, 2016; Northouse, 2021).

3.0 HEALTH SYSTEM ORGANISATION - SPAIN

The Spanish health system, the Sistema Nacional de Salud, is highly decentralized, with powers diffused among 17 autonomous communities under the 1986 General Health Law and successive reforms. This leaves regional governments in control of financing, service delivery, and day-to-day decisions. The outcome is large variation in public-health capacity across the different regions and a hard time mobilizing a coordinated national response to COVID-19 (Greer et al., 2020; Lapuente & Van de Walle, 2020).

3.1 GOVERNANCE DYNAMICS AND CENTRAL-REGIONAL TENSIONS

The COVID-19 pandemic brought longstanding tensions into full view in Spain's decentralized governance. Even as the Ministry of Health tried to move various national strategies forward, regional governments had a lot of latitude in carrying out lockdowns, testing strategies, and school closures. Greer et al., 2020. Thus, during the early phases of the pandemic, their responses diverged, from the variance in the ways lay containment measures were implemented to the delay in coordinated decision-making.

In response to surging COVID-19 cases in March 2020, Spain invoked a state of alarm, temporarily centralizing authority within the national government. The Ministry of Health, under the leadership of Salvador Illa, was thus empowered to harmonize public health interventions, distributing resources and PPE supplies and instituting nationwide mobility restrictions. This centralization came only after weeks of sustained transmission growth, thereby fuelling public perceptions that the government's actions were "too little, too late" (Lapuente & Van de Walle, 2020).

3.2 PUBLIC-HEALTH INFRASTRUCTURE AND PREPAREDNESS

Prior to COVID-19, Spain was often cited as an exemplar in its robust primary-care system and universal health coverage. However, the country still suffered from years of underinvestment in public health and emergency planning. Following the 2008 financial crisis,

public-health budgets were cut. That meant less money for surveillance and a health system that lacked adequate staffing. When the pandemic hit, these weaknesses made it hard for Spain to ramp up testing, tracing, and isolation.

Spain didn't have an integrated, digital surveillance system that fed data automatically. Data could not flow rapidly across regions. When cases surged, hospitals in places like Madrid and Barcelona ran short of ICU beds and ventilators. Decentralized planning and patchy preparedness put the whole system under strain; it was tough to respond as one country (OECD, 2020; Greer et al., 2020).

3.3 SPAIN'S VACCINATION STRATEGY AND LATER RESPONSE

Early in the pandemic, Spain's COVID-19 response was poorly coordinated. When the vaccines became available, however, that changed. Spain's national government assumed a coordinating role by implementing a national vaccination program via the Technical Working Group for Vaccination. The group was responsible for the logistics, including the purchase and distribution of vaccines (European CDC, 2021). Communication at all levels of national and regional governments improved, thus leading to an increase in public trust and contributing to high vaccine intake.

By the middle of 2021, Spain boasted some of the highest full-vaccination rates in Europe. There was a real difference brought about by the country's strong primary-care network and widespread public trust in vaccines. Moving from a shaky early response to one of Europe's most successful vaccination campaigns showed how adaptable the Spanish health system can be when national and regional leaders pull in the same direction.

3.4 SUMMARY OF SPAIN'S STRUCTURAL STRENGTHS AND WEAKNESS

This decentralization of Spain's health system has many advantages: regions can respond to local needs, and care remains focused on patients. Yet during COVID-19, this same structure delayed national coordination, hindered the sharing of data, and postponed unified public-health decisions. The experience in Spain illustrates that decentralization may become a liability in fast-moving crises unless strong national leadership, solid surveillance systems, and clear emergency plans are set (Greer et al., 2020; Kluge et al., 2020).

4.0 HEALTH SYSTEM ORGANISATION – SOUTH KOREA

South Korea has a hybrid health-care system that combines universal insurance with national control over public health while leaving most provision to the private sector. In the lead role is the Ministry of Health and Welfare, supported by the Korea Disease Control and Prevention Agency, KDCA. This centralized infrastructure has thus far enabled the country to implement a rapid and organized response to COVID-19.

With a single, unified approach, South Korea differs from many countries whose systems for fighting infectious diseases are decentralized. Strong laws associated with central surveillance also reflect the cultural orientation to technology innovation. Each of these features combined to uniquely position South Korea when COVID-19 hit (Moon, 2020; You, 2020).

4.1 POST-MERS REFORMS AND NATIONAL PREPAREDNESS

The outbreak of MERS, or Middle East respiratory syndrome, in 2015 forced South Korea to reconsider public-health policy. Lawmakers updated the Infectious Disease Control and Prevention Act, giving greater authority to the KDCA, increasing the number of epidemiologists, and improving data-sharing. According to Moon (2020), this made some kind of institutional memory so that the country knew what to do when the next outbreak came.

After MERS, South Korea had invested in top-flight labs, digital contact tracing, and emergency communication tools. So, when COVID-19 materialized, they acted quickly: drive-through testing, mass PCR diagnostics, and real-time data analytics were all up and running in short order (Moon, 2020; You, 2020).

4.2 CENTRALISED GOVERNANCE AND RAPID DECISION-MAKING

What marked the response of South Korea to COVID-19 was a very tight, centralized crisis management system. At the very center of this system, KDCA managed everything, from testing to contact tracing, isolation rules, and public updates. This allowed the leaders to move with great speed and ensured policies across the country were in concert with each other. You (2020) add that scientific leadership, political consensus, and a command chain helped them take action at remarkable speed. Prime Minister Chung Sye-kyun did much to hold the government together and win public trust. Daily briefings, open communication, and explanations of why each measure was necessary kept people on board and prevented the swirl of misinformation that tripped up so many other countries (Moon, 2020; Park et al., 2020).

4.3 PUBLIC-HEALTH INFRASTRUCTURE AND TECHNOLOGICAL CAPACITY

South Korea's public-health system is built for this kind of crisis. The country relies on a nationwide infectious-disease surveillance network, connected labs, and strong digital tools. Fast contact tracing drew on mobile phone data, CCTV footage, and credit card records, all made possible under emergency public health laws. While some worried about privacy, most of the public accepted these steps as both legitimate and needed (Park et al., 2020). This tech-driven approach let South Korea contain outbreaks early, without having to lock down the whole country.

4.4 COMMUNITY ENGAGEMENT AND CULTURAL FACTORS

What mattered was institutional strength, but also civic participation. High public trust, a collectivist culture, and well-established communication methods produced popular adherence to public-health advice. Community engagement underpinned central governance to such an extent that non-pharmaceutical interventions like mask-wearing, social distancing, and voluntary testing could be rapidly rolled out (Park et al., 2020; Moon, 2020).

Instead, South Korea was able to avoid full national lockdowns using flexible containment. The resilience of the country has made it a global example of how preparation and clear coordination, along with tech innovation, could soften the blow of a pandemic.

4.5 SUMMARY OF SOUTH KOREA'S STRUCTURAL STRENGTHS AND LIMITATIONS

Centralised command with strong legal backing, digital readiness, and lessons from MERS formed the backbone of South Korea's health system in its fight against COVID-19. What Korea's experience underlines is how all these factors—institutional memory, committed leadership, and deep public trust—can make a system far more resilient during global health crises (Moon, 2020; You, 2020; Park et al., 2020).

5.0 HEALTH-SYSTEM ORGANISATION - CANADA

Canada's health system is highly decentralized and publicly funded, with provinces and territories fully responsible for planning, financing, and delivering care. The federal government sets national standards through the Canada Health Act and finances the system through the Canada Health Transfer, but it delegates day-to-day decision-making powers and

the creation of public-health regulations to the provinces. This fragmented arrangement set the context for Canada's response to COVID-19, which affected how well the country was able to coordinate and maintain consistency across policies and the speed with which it could take action in an emergency (Fafard & Forest, 2020; Naylor et al., 2021).

5.1 FEDERAL-PROVINCIAL DYNAMICS AND POLICY COORDINATION

Canada's system, by contrast, during COVID-19 depended more on collaboration rather than any imposition by the federal government. So, while the Public Health Agency of Canada did issue pan-Canadian guidance, the provinces called their own plays on whether and how to test, close schools, lock down, or impose other restrictions (Naylor et al., 2021). There thus emerged tremendous divergence in the public-health measures taken across the country.

Prime Minister Justin Trudeau adopted a collaborative approach to federal–provincial cooperation throughout the pandemic. He relied on daily briefings and a collaborative style to keep provinces in lockstep. But the federal government could not unilaterally impose national public health orders, so provinces proceeded at their own pace.

5.2 PUBLIC - HEALTH INFRASTRUCTURE AND PREPAREDNESS CAPACITY

At the outset, Canada had universal health coverage, but a variety of cracks in its public-health infrastructure began to appear. Surveillance systems were archaic, lab capacity fell short, and the long-term care sector had weak governance. The national surveillance system had not been updated since warnings after the 2003 SARS outbreak (Fafard & Forest, 2020). This made data sharing across provinces cumbersome and difficult, impeding the ability to detect early community transmission.

Preparedness varied province by province. Ontario and Quebec were beset by major outbreaks in long-term care homes—problems rooted in staffing shortages and old infection-control practices. By contrast, British Columbia had a more robust public-health system, and the province was able to act faster with containment and keep transmission down during the first wave.

5.3 FEDERAL ROLE IN PROCUREMENT AND VACCINATION STRATEGY

While provinces set most of the frontline policies, the federal government handled vaccine procurement, PPE supplies, and border controls. Ottawa acted early by purchasing vaccines from several manufacturers as a way of guarding against supply-chain problems. Government of Canada, 2021. Though the early deliveries were slow, strong federal-provincial coordination and public trust in vaccines eventually pushed Canada's vaccination rates into the world's top tier. At first, Canada's rollout trailed behind both the U.S. and the U.K., in part because the country doesn't have vaccine production of its own. But by mid-2021, it boasts one of the world's highest rates of fully vaccinated people, thanks to using primary-care networks, pharmacies, and community health centers to get shots into arms everywhere (Government of Canada, 2021).

5.4 STRENGTHS AND WEAKNESSES OF CANADA'S HEALTH-SYSTEM STRUCTURE

Canada's decentralized system enables provinces to shape public-health strategies according to regional needs and local data. The pandemic has made the downside all too apparent: policy was inconsistent, surveillance fragmented, and readiness uneven. COVID-19 showed that decentralization slows national coordination if strong federal leadership, up-to-date surveillance, and good intergovernmental teamwork aren't in place (Naylor et al., 2021; OECD, 2020).

6.0 LEADERSHIP ANALYSIS—SALVADOR ILLA (SPAIN)

Salvador Illa was the Minister of Health in the first phase of the COVID-19 pandemic and led Spain through this period of viral spread, varied regional responses, and high public anxiety. Looking at this performance in light of established leadership theories enables the identification of strengths and weaknesses of his approach. One will get a better view of his leadership by looking into his traits, behaviours, responsibilities, and adaptation to fast-changing situations (Northouse, 2021).

6.1 TRAIT THEORY AND ILLA'S PERSONAL QUALITIES

Trait theory postulates that inherent qualities within a person will allow him or her to be an effective leader. A number of positive traits were expressed by Illa: calmness, stability, and reliability. During the press briefings and debates in parliament, he managed to strike a steady and measured tone, reassuring in light of rising uncertainty.

His calm demeanor matched expectations that stability and emotional control are values during crisis situations (Northouse, 2021). However, Illa had no background in health, and this limited his technical confidence at the outset of the pandemic. From a traits perspective, this gap in sector-specific expertise would make his early strategic decisions more cautious.

6.2 BEHAVIORAL LEADERSHIP: TASK VS RELATIONSHIP ORIENTATION

Behavioural leadership theory approaches leaders through their behaviours rather than their personal traits. It categorizes leaders into two main styles: task-oriented behaviours and relationship-oriented behaviours. In the task behaviours at the start of the pandemic, Illa was not particularly task-oriented. He mainly assured the public that the health system was ready. The Ministry of Health acted in cautious and reactive ways.

The regional governments took their own responses, thus showing inconsistency in the measures taken. In relationship behaviours the more the crisis escalated, the better Illa's behaviours were relation-oriented. He started giving regular daily briefings. His communication became more coherent and consistent. Improved collaboration with regional health authorities. This shift from low task orientation to more relationship orientation showed an increasing focus by Illa on public reassurance and teamwork in decision-making.

6.3 SITUATIONAL / CONTINGENCY LEADERSHIP

According to situational leadership, the leaders should adjust their style based on what their followers are ready for and need. The leadership style has changed a lot for Illa in the different phases of the pandemic. Early Stage: Participative style; he allowed regional governments to take the lead, as they have more autonomy and experience. State of Alarm: After invoking emergency powers, he applied the directing style to formulate national restrictions and marshal resources. Vaccination Rollout: He then moved to a coaching style, providing strategic direction while giving support to regional efforts (Hersey et al., 2013; Northouse, 2021).

6.4 FUNCTIONAL LEADERSHIP

Functional Leadership Theory places emphasis on the proper execution of functional tasks. According to this theory, Illa was only able to become effective once he was granted emergency powers to coordinate the national distribution of PPE, standardise mobility restrictions, and improve communication channels. Leadership became more coordinated and

effective under Illa across Spain's 17 autonomous communities once he was empowered to handle functional tasks at the national level (Northouse, 2021).

6.5 SUMMARY

In all, the leadership of Illa showed a combination of personal traits, changing behaviours, situational adaptation, and better functional coordination. His calm demeanor aided public communication, with leadership that turned more resolute when central authority increased. Whereas early difficulties with Spain's decentralized system were in evidence, later actions did demonstrate a stronger degree of coordination and direction (Lapiente & Van de Walle, 2020; Northouse, 2021).

7.0 LEADERSHIP ANALYSIS—CHUNG SYE-KYUN (SOUTH KOREA)

Chung Sye-kyun undoubtedly played an important role in shaping South Korea's effective pandemic response. First, his leadership style fit into the centralized public health framework of South Korea and was supported by fast decision-making processes with strong institutional memory from the MERS outbreak. Drawing on established leadership theories, one can make sense of his approach based on personal traits, behavioural style, functional coordination, and adaptation to new circumstances (Moon, 2020; Northouse, 2021).

7.1 TRAIT THEORY

Trait theory focuses on the qualities of leadership, including integrity, confidence, composure, and decisiveness. Chung had a character marked with discipline, calmness, and hard work. His regular presence in press briefings assured his competencies through clear reasoning. Such traits have helped foster public trust and encourage people to follow health measures (Northouse, 2021).

7.2 BEHAVIOURAL LEADERSHIP: TASK VS. RELATIONSHIP ORIENTATION

He demonstrated a "high-high" leadership style in accordance with behavioural theory. His task-focused actions included ensuring rapid scaling of PCR testing, coordinating national ministries, KDCA, and private labs, implementing contact tracing and isolation procedures, and standardizing clear national guidance (Moon, 2020). At the same time, Chung fostered strong relationship-oriented leadership through clear daily communication, a respectful,

reassuring public tone, cooperative engagement with experts and focus on collective responsibility (Park et al., 2020).

7.3 FUNCTIONAL LEADERSHIP

From a functional leadership perspective, Chung excelled by ensuring that the essential things were carried out efficiently. Real-time surveillance, a fast flow of information, strong coordination among agencies, consistent public messaging, and smoothening of testing and tracing operations (You, 2020). The fact that lockdowns have been avoided in South Korea shows that the major leadership functions have been successfully completed.

7.4 SITUATIONAL LEADERSHIP

Chung has adjusted his leadership style according to the contingencies. Early phase: Directive style; the focus is on strong containment. Mid-phase: Coaching style, guiding health agencies and technical teams. Later phase: Supporting style, empowering KDCA and regional teams. This flexibility in leadership style demonstrates effective situational leadership, where actions were matched with public understanding and organizational capacity at each stage.

7.5 FIVE-LEVEL LEADERSHIP

In terms of Maxwell's Five-Level Leadership model, Chung demonstrated behaviours across all levels of leadership. At Level 1—Position—he exercised the formal authority of the Prime Minister to coordinate ministries and public-health institutions. At Level 2—Permission—he strengthened relationships through transparent communication and respectful engagement with citizens, experts, and civil servants.

At Level 3—Production—his leadership contributed to tangible achievements, including the rapid expansion of PCR testing, effective border controls, and strong national coordination that avoided a nationwide lockdown (Moon, 2020). At Level 4—People Development—he empowered the KDCA and public-health professionals by giving them autonomy, visibility, and resources. Finally, at Level 5—Pinnacle—Chung modelled disciplined, humble, and service-oriented leadership, earning public respect during one of the country's most critical health crises.

7.6 SUMMARY

Chung's leadership combined strong personal traits, balanced behaviors, high functional competence, and responsive situational adjustments. His approach was congruent with the strengths of South Korea's centralized health system and helped produce one of the most efficient early pandemic responses in the world (Moon, 2020; You, 2020).

8.0 LEADERSHIP ANALYSIS—JUSTIN TRUDEAU (CANADA)

Justin Trudeau's leadership during the COVID-19 pandemic was set within a decidedly decentralized federal system wherein provincial governments were tasked with and had the authority to make major public health decisions. It may be conceived theoretically through the tenets of trait theory, behavioral leadership, situational leadership, relationship leadership, and functional leadership. These theoretical perspectives help explain the strengths and limitations of his leadership in a system that required collaboration rather than central control (Fafard & Forest, 2020; Northouse, 2021).

8.1 TRAIT THEORY

Trait theory stresses personal attributes such as empathy, communication skill, emotional intelligence, and charisma. Trudeau exhibited these traits consistently and they are emotional connectivity with the citizens, visible concern for vulnerable groups and consistent reassurance through daily briefings (Naylor et al., 2021).

8.2 BEHAVIOURAL THEORY

In terms of behavioural leadership, Trudeau demonstrated a very strong relational approach. They were respecting engagement with the provincial leaders, being open and honest, and showing understanding and compassion, transparency and consultation in decisions/focused behaviours, vaccine contract acquisition, border control, and economic support packages. His leadership was significantly more relationship-centered than task-oriented because the federal government did not have the power to enforce many public health interventions.

8.3 SITUATIONAL LEADERSHIP

Trudeau made adjustments in leadership based on provincial autonomy and their different needs. With strong provincial capacity, he adopted a supportive and participative approach and a more directive style. When dealing with public anxiety, he adopted a coaching and highly communicative approach. This adaptive behavior chimes with situational leadership, reflecting responsiveness to varied provincial contexts and population needs (Northouse, 2021).

8.4 RELATIONSHIP LEADERSHIP

Relationship leadership emphasizes trust, collaboration, communication, and interconnectedness. Trudeau showed it with daily national briefings, partnerships with Indigenous and minority communities, cooperative decision-making with premiers, and empathetic and inclusive use of language.

8.5 FUNCTIONAL LEADERSHIP

Federally, Trudeau performed critical functional duties in doing the following, which included national vaccine procurement, financial relief programs, international border control, and PPE and supply-chain coordination (Government of Canada, 2021).

8.6 SUMMARY

Strong interpersonal traits, a relationship-oriented behavioral style, adaptive situational responses, and performance of effective federal functions shaped Trudeau's leadership. In addition, Trudeau's leadership was moderated by the decentralized governance of Canada, which required a collaborative rather than an authoritative approach (Naylor et al., 2021; Northouse, 2021).

9.0 COMPARATIVE DISCUSSION – LEADERSHIP AND SYSTEM STRUCTURES

This section compares the leadership approaches of Salvador Illa (Spain), Chung Sye-kyun (South Korea), and Justin Trudeau (Canada) by drawing on established leadership theories. This comparison underlines how leadership traits, behavioral tendencies, functional effectiveness, and situational adaptiveness have influenced the course of pandemic responses in each country. The analysis will show how the combination of leadership style and health-system structure determined the national outcomes from COVID-19 (Greer et al., 2020; WHO, 2020).

9.1 INFLUENCE OF HEALTH-SYSTEM STRUCTURES

Governance structures significantly influence the effectiveness of leadership. South Korea's centralized system supported rapid coordination and allowed Chung to apply a highly task-oriented, functional, and directive leadership style during the time of early containment. Spain's institutional decentralized structure, which limited the early effectiveness of Illa, meant

that fragmented authority constrained task leadership until emergency powers were introduced. The Canadian federal system obliged Trudeau to collaborate rather than direct, which occasions a relationship-led and participatory style. This means that the style of leadership is molded not only by personal capability but also by structural constraints that shape what a leader can actually accomplish (Northouse, 2021; Greer et al., 2020).

9.2 TRAIT THEORY COMPARISON

The trait theory emphasizes differing personal characteristics. It was due to Chung's discipline, composure, and decisiveness that he could do things quickly and confidently. Illa was calm and emotionally stable, though his lack of health-sector expertise tended to limit early certainty. Trudeau was empathetic, communicating well and revealing emotional intelligence—tenets of reassurance. Personal characteristics across the three cases drove variations in public trust and communication styles, and thus perceived legitimacy of government actions (Northouse, 2021; Greer et al., 2020).

9.3 BEHAVIORAL THEORY ANALYSIS

The behavioral leadership theory makes a clear distinction between task-focused and relationship-focused behaviour. Chung exhibited strong high-task and high-relationship behaviour, resulting in timely coordination of testing and transparent briefings. Illa initially exhibited lower task orientation, then became more task-focused as authority increased, although maintaining relationship behaviours through communication.

Trudeau leaned heavily towards relationship-oriented leadership, employing empathy and collaboration to bind provinces together while performing his direct federal task responsibilities related to procurement. This comparison shows how leaders balanced task and relationship behaviors depending on structural demands and personal style (Northouse, 2021; Greer et al., 2020).

9.4 SITUATIONAL LEADERSHIP COMPARISON

Situational leadership is a theory based on how leaders change their style based on the changing conditions. Chung shifted from directive to coaching/supportive, reflecting high adaptation. Illa evolved from a participating style to a more directive approach once emergency powers were granted. Trudeau thus used a participative and supportive style consistently because of provincial autonomy, matching communications and collaboration to regional readiness. The degree of situational flexibility varied. Chung exhibited the greatest

situational adaptation, while Illa had the most significant change across time (Northouse, 2021; Greer et al., 2020).

9.5 FUNCTIONAL AND RELATIONSHIP LEADERSHIP

Functional leadership also contrasts sharply across the three leaders. Chung fulfilled all critical pandemic functions—coordination, communication, resource allocation, and surveillance. Illa became more functionally effective when central authority made coordinated action possible. Trudeau did his federal job well—procurement and economic support but couldn't control provincial health measures. The strength of relationship leadership was highest in Trudeau and Chung and lowest in early-phase Spain (Northouse, 2021; Greer et al., 2020).

9.6 SUMMARY

The leadership outcomes across the three countries reflect a combination of individual traits, behavioural patterns, functional capacity, and situational adaptability. Overall, the success seen with South Korea shows the advantage of high task leadership supported by centralisation, while Spain and Canada show how decentralisation requires leaders to rely more on communication, collaboration, and situational judgement (Northouse, 2021; Kluge et al., 2020).

10.0 CONCLUSION

A comparison of Spain, South Korea, and Canada illustrates that both leadership and system design determine pandemic outcomes. Leadership traits, behavioural patterns, situational adaptability, and functional competence combine in ways to interact with system structures to frame national responses.

In South Korea, the centralized system supported Chung's task-oriented and adaptive leadership. In Spain, decentralization limited the powers of Illa early in the crisis, but his leadership was enhanced as central powers were ramped up. Canada's federal system entailed Trudeau relying on relationship-building and collaborative decision-making rather than directive control.

In all, leaders who practiced balanced behaviours, strong interpersonal traits, functional coordination, and situational flexibility best coped with such complex public health challenges. Strengthening leadership capability and system integration will be imperative in any future global health emergency (WHO, 2020; Kluge et al., 2020).

REFERENCES

1. Boin, A., 't Hart, P., Stern, E. and Sundelius, B. (2017) *The politics of crisis management: Public leadership under pressure*. 2nd edn. Cambridge: Cambridge University Press.
2. Christensen, T. and Lægreid, P. (2020) 'Balancing governance capacity and legitimacy: How the Norwegian government handled the COVID-19 crisis', *Public Administration Review*, 80(5), pp. 774–779.
3. European Centre for Disease Prevention and Control (ECDC) (2021) *COVID-19 vaccination strategies and deployment plans in the EU/EEA*. Stockholm: ECDC.
4. Fafard, P. and Forest, P-G. (2020) 'The loss of public health capacity in Canada', *Canadian Journal of Public Health*, 111(3), pp. 338–343.
5. Gagnon, F., Paquet, M. and Bergeron, P. (2020) 'Pandemic responses and federalism: Canada in comparative perspective', *Journal of Canadian Studies*, 54(3), pp. 557–580.
6. Gershon, A.S. et al. (2020) 'Health system response to COVID-19 in Canada', *The Lancet*, 395(10230), pp. 1715–1716.
7. Government of Canada (2021) *Canada's COVID-19 response*. Available at: <https://www.canada.ca> (Accessed: 15 July 2021).
8. Greer, S.L., King, E.J., Massard da Fonseca, E. and Peralta-Santos, A. (2020) 'The comparative politics of COVID-19: The need to understand government responses', *Global Public Health*, 15(9), pp. 1413–1416.
9. Greer, S.L., Jarman, H. and Rozenblum, S. (2019) *Everything you always wanted to know about European Union health policies*. Copenhagen: WHO Regional Office for Europe.
10. Hersey, P., Blanchard, K.H. and Johnson, D.E. (2013) *Management of organizational behavior: Leading human resources*. 10th edn. Harlow: Pearson Education.
11. Kickbusch, I., Leung, G.M., Bhutta, Z.A., Matsoso, M.P., Ihekweazu, C. and Abbasi, K. (2020) 'Covid-19: How a virus is turning the world upside down', *BMJ*, 369, m1336.

12. Kluge, H.H.P., Jakab, Z., Bartovic, J., D'Anna, V. and Severoni, S. (2020) 'Refugee and migrant health in the COVID-19 response', *The Lancet*, 395(10232), pp. 1237–1239.
13. Lapuente, V. and Van de Walle, S. (2020) 'The effects of public administration and leadership on the management of the COVID-19 crisis', *Public Administration Review*, 80(5), pp. 761–769.
14. McKee, M. and Stuckler, D. (2020) 'If the world fails to protect the economy, COVID-19 will damage health', *BMJ*, 369, m1557.
15. Moon, M.J. (2020) 'Fighting COVID-19 with agility, transparency, and participation: Wicked policy problems and new governance challenges', *Public Administration Review*, 80(4), pp. 651–656.
16. Naylor, C.D., Phillips, K., Marchildon, G.P., Peckham, S. and McKee, M. (2021) 'Learning from the COVID-19 pandemic: Canadian federalism and public health', *Canadian Medical Association Journal*, 193(11), pp. E1–E5.
17. Northouse, P.G. (2021) *Leadership: Theory and practice*. 9th edn. Thousand Oaks, CA: Sage Publications.
18. OECD (2020) *Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic*. Paris: OECD Publishing.
19. OECD (2021) *Health at a glance 2021*. Paris: OECD Publishing.
20. Park, S., Choi, G. and Ko, H. (2020) 'Information technology-based tracing strategy in response to COVID-19 in South Korea', *Journal of Risk Research*, 23(7–8), pp. 872–879.
21. Peters, B.G. (2015) *Advanced introduction to public policy*. Cheltenham: Edward Elgar.
22. Pollitt, C. and Bouckaert, G. (2017) *Public management reform*. 4th edn. Oxford: Oxford University Press.
23. Saltman, R.B., Duran, A. and Dubois, H.F.W. (2011) *Governing public hospitals*. Copenhagen: WHO Regional Office for Europe.
24. Schein, E.H. (2017) *Organizational culture and leadership*. 5th edn. Hoboken, NJ: Wiley.
25. Stoker, G. (2018) *Governance as theory*. Oxford: Oxford University Press.

26. Thompson, J.D. (1967) *Organizations in action*. New York: McGraw-Hill.
27. Van Dooren, W. and Noordegraaf, M. (2020) 'Staging science: Authoritativeness and fragility of models and measurement', *Public Administration Review*, 80(4), pp. 610–615.
28. World Health Organization (WHO) (2016) *Leadership and management in health services: A training module*. Geneva: World Health Organization.
29. World Health Organization (WHO) (2020) *Strengthening preparedness for COVID-19 in cities and urban settings*. Geneva: World Health Organization.
30. World Health Organization (WHO) (2021) *COVID-19 strategic preparedness and response plan*. Geneva: World Health Organization.
31. You, J. (2020) 'Lessons from South Korea's COVID-19 policy response', *American Review of Public Administration*, 50(6–7), pp. 801–808.
32. Ansell, C., Sørensen, E. and Torfing, J. (2017) *Improving policy implementation through collaborative governance*. Cambridge: Cambridge University Press.
33. Heifetz, R., Grashow, A. and Linsky, M. (2009) *The practice of adaptive leadership*. Boston, MA: Harvard Business Press.
34. Maxwell, J.C. (2011) *The 5 levels of leadership*. New York: Center Street.
35. WHO Regional Office for Europe (2020) *Strengthening health systems response to COVID-19*. Copenhagen: WHO Europe.SSS

