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Bridging Recovery Support and Early Screening: A Comparative Analysis of Postpartum Depression Care Systems in Korea and the United States

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ABSTRACT

Postpartum Depression (PPD) is one of the most common issues that women face after giving birth. In the United States, the PPD diagnosis rate within one large integrated health system roughly doubled from 9.4% in 2010 to 19.0% by 2021. Researchers are identifying gaps in diagnosis and treatment as well as racial disparities in whether mothers who are diagnosed actually receive care. The United States has national screening recommendations but no federally mandated paid recovery period and no reliable pathway from screening to treatment. Korea is close to the opposite, with a long institutionalized recovery period but only voluntary screening that reaches a small share of mothers. This study compares two paradigms addressing postpartum depression: Korea's recovery-support model and the United States' early screening model, with the purpose of drawing out policy implications that incorporate the strength of both. The aim is to identify which parts of Korea's recovery-support model could realistically be adapted into the United States system, and to build policy recommendations from that.

Based on prior research, four key variables were identified: (1) postpartum leave and caregiving period, (2) specialized postpartum care infrastructure, (3) social and cultural support systems, and (4) access to screening and treatment. The current status of both countries was compared, and focus group interviews (FGIs) were then conducted with two pediatric specialists and two obstetrics and gynecology specialists practicing in Korea.

The results indicate that Korea's postpartum care system, where new mothers spend several weeks focused on recovery and rest supported by family or professional caregivers, supports emotional and physical recovery. Participants also raised the possibility that better outcomes for care facility users may partly reflect underlying factors such as family support and financial stability rather than the facility itself. The United States' pediatrician-based early screening system shows strength on early detection, but falls short in ensuring that mothers receive adequate treatment afterwards. This study proposes short, medium, and long term policy recommendations for the United States that integrate the strengths of both countries.

1. INTRODUCTION

1.1 Research Background

Childbirth is one of the most significant physical and emotional transitions in a woman's life. At the same time, this period is also when women are most vulnerable to a mental health crisis known as postpartum depression (PPD). PPD is a very common condition that affects approximately 10% to 20% of postpartum women in low- and lower-middle-income settings (Fisher et al., 2012). If not treated properly, it can negatively affect the bonding between mother and the baby. It can also negatively impact the infants' growth as well as the functioning of the family as a whole (Earls et al., 2019).

According to Khadka et al. (2024) who analyzed 442,308 pregnancies in a large Southern California health system, the PPD diagnosis rate in the US roughly doubled from 9.4% in 2010 to 19.0% in 2021. Even more concerning is the wide gap between diagnosis and treatment. Only about a quarter of women who experienced PPD were able to get a formal diagnosis, and about half of those diagnosed received mental health care. Clear disparity of accessibility to treatment along racial and socioeconomic lines is still evident (Haight et al., 2024).

This reality in the United States presents a striking contrast to Korea. Korea guarantees a 90 day maternity leave for employed mothers under the Labor Standards Act, and also provides specialized care immediately after childbirth through postpartum care centers (Ministry of Health and Welfare, 2024). The Ministry of Health and Welfare's 2024 Postpartum Care Survey showed that 85.5% of mothers used a postpartum care center during their recovery period. This institutionalized postpartum care system is regarded as a rare and unique model worldwide.

Estimates of prevalence between the two countries are not directly comparable because they rely on different instruments, different cutoff scores, and different case definitions. CDC PRAMS 2018 data placed US prevalence of self-reported PPD symptoms at 13.2%, ranging from 9.7% to 23.5% across states (Bauman et al., 2020). No matching national detection rate exists for Korea. Korea does operate screening through public health centers using the Korean version of the Edinburgh Postnatal Depression Scale, but participation is voluntary and opportunistic rather than universal. So there is no denominator of all mothers and therefore no national screening rate to place beside the United States figures. What is available is a count of mothers screened at public health centers, which peaked at 68,972 in 2017, and a formal PPD diagnosis rate of 6.8% from the national postpartum care survey (Kim et al., 2022; Ministry of Health and Welfare, 2024). The figures consistently show that neither system has eliminated PPD, and that in both countries a significant number of mothers never reach formal diagnosis or treatment. The specific gap this study addresses is that the United States has built screening recommendations without the recovery infrastructure that would support mothers before and after those screenings, while Korea has built the recovery infrastructure without a screening framework that reaches enough mothers to identify who needs clinical care.

1.2 Research Purpose

The purpose of this study is to produce policy recommendations for improving postpartum depression care in the United States, by examining what Korea's recovery-support system provides that the United States system does not. The objective is pursued in three steps. First, it compares and analyzes Korea's recovery-support model with the United States' early screening model across four variables drawn from prior research. Second, it examines those four variables through focus group interviews with physicians practicing in Korea, and explores the strengths and limitations of both models in clinical practice. Third, it proposes a policy model directed primarily at the United States, one that keeps the screening infrastructure the United States already has while adapting the elements of Korea's recovery-support system that are realistic and beneficial to transfer.

1.3 Research Scope and Methodology

This study limits the comparison to the United States and Korea. The reasoning behind selecting these two countries specifically is set out in Section 2.4. The research was conducted using literature analysis and qualitative research. Domestic and international research and statistics related to PPD were analyzed to elicit the four key variables, and the current status of both countries was compared. Based on the variables, focus group interviews (FGIs) with two pediatric specialists and two obstetrics and gynecology specialists, all of whom practice in Korea, were conducted, and later analyzed using thematic analysis.

2. LITERATURE REVIEW

2.1 Definition and Clinical Characteristics of Postpartum Depression

Postpartum depression is a Major Depressive Disorder that occurs after childbirth. Through the 'peripartum onset' specifier, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines it as depression with onset during pregnancy or within four weeks after childbirth (American Psychiatric Association, 2013). However, in clinical or research settings, a broader criterion that includes onset up to one year after childbirth is often used as well.

PPD is different from 'baby blues,' a temporary mood change, in that while baby blues is a mere emotional change that resolves by itself within a few days after childbirth, PPD persists for two weeks or longer and entails depressed mood, loss of appetite, sleep disturbances, and lethargy requiring professional help. PPD is understood to result from interaction of various factors such as abrupt hormonal changes during childbirth, sleep deprivation, stress, and lack of social support (Earls et al., 2019; Khademi & Kaveh, 2024).

2.2 Review of Prior Research

The factors influencing PPD were identified through extensive research worldwide. The four variables used in this study were all derived from this body of prior research.

First is the effect of postpartum leave and caregiving duration on postpartum depression. Hidalgo-Padilla et al. (2023), in a synthesis of 23 studies, confirmed that longer periods of paid leave tend to reduce postpartum depression. Kornfeind and Sipsma (2018), in a study of American mothers, stated that among those with leave of 12 weeks or less, even one additional week of leave can noticeably lower the likelihood of PPD. That is, taking adequate rest itself helps in preventing postpartum depression. Heshmati et al. (2023), in a systematic review of parental leave and mental health, also found that longer leave provision was associated with improved parental mental health outcomes.

Second is the effect of specialized postpartum care facilities. Cho and Jeong (2021), based on the observation of 101 mothers in the care facility, confirmed that the level of PPD was significantly lower at discharge than at admission. Song et al. (2020) stated that the period when the first time mothers receive professional support at the care facilities is crucial for their adjustment to childcare. Song et al. (2023) reported that communication and support from the care facilities staff was also shown to have a positive effect on mothers' psychological stability.

These studies, however, observe only mothers who already used care facilities, so it leaves open whether the improvement reflects the facility itself or the family and financial circumstances that made facility use possible in the first place. This study returns to that question through expert interviews.

Third is the effect of support from family and those around. Khademi and Kaveh (2024) stated that greater support from spouses and family leads to less occurrence of PPD and faster recovery. Norazman and Lee (2024) found that social support, such as home visits and peer support from other mothers, has a positive effect on improving PPD as well.

Fourth is the effect of accessibility to screening and treatment. The U.S. Preventive Services Task Force (USPSTF, 2023) officially proposed that PPD screening be conducted regularly. However, according to a study by Haight et al. (2024), only 1 in 4 mothers with symptoms get a chance to receive a diagnosis, and only about half of those receive treatment. In particular, respondents from several racial and ethnic minority groups such as Asian, Native Hawaiian and Pacific Islander were far less likely to receive treatments than white women (Haight et al., 2024). Earls et al. (2019), in a technical report from American Academy of Pediatrics (AAP), recommended that when infants come in for regular checkups (at 1, 2, 4, and 6 months of age), the mother's depression should also be screened at the same time. While this approach is very practical in that it makes use of the opportunity when the mother is already at the clinic, the actual implementation rate was fewer than 50% (Lamere & Golova, 2022).

2.3 Deriving Research Variables

Based on prior research reviewed above, this study derived four key variables that can influence PPD. Each variable and its supporting prior research are shown in Table 1.

Table 1. Derivation of Research Variables Based on Prior Research

Category	**Content**	**Prior Research**
Postpartum leave and care giving period	A time secured for mothers with the purpose of their physical and emotional recovery after childbirth. Includes paid maternity leave and professional care support.	Hidalgo-Padilla et al. (2023); Heshmati et al. (2023); Kornfeind & Sipsma (2018)
Specialized postpartum care infrastructure	System of specialized facilities and personnel that supports mother's physical recovery, newborn care, and adjustment to the maternal role after childbirth.	Cho & Jeong (2021); Song et al. (2020, 2023)
Social and cultural support system	Emotional support provided to the mother through spouse, family and community.	Khademi & Kaveh (2024); Norazman & Lee (2024)
Screening and treatment accessibility	Standardized screening system for early detection of postpartum depression, and its linkage to treatment services after diagnosis.	U.S. Preventive Services Task Force (2023); Earls et al. (2019); Haight et al. (2024)

2.4 Necessity of This Study

The prior research reviewed above addresses each variable individually, and most studies are either quantitative or focused on a single country. More importantly, Korea and the United States are rarely examined together, even though the two systems sit at opposite ends of the same problem. Korea guarantees 90 days of statutory maternity leave and has an institutionalized postpartum care industry used by 85.5% of mothers, but only a permissive and opportunistic screening framework and a formal diagnosis rate of 6.8% (Kim et al., 2022; Ministry of Health and Welfare, 2024). The United States has screening recommendations from both the USPSTF (2023) and the AAP (Earls et al., 2019), but no federally mandated paid leave and no equivalent recovery infrastructure. Comparing two countries that share the same weakness would not generate a transferable policy that can make improvements, whereas comparing two countries whose weaknesses are the other's strength does. Moreover, Korea's postpartum care center system is close to unique worldwide, which means the pool of countries offering a different model of recovery support is small to begin with.

The strengths on each side were already documented in prior research, and this study used the interviews to test them rather than to discover them. On the Korean side, prior research shows lower depression levels at discharge from care centers (Cho & Jeong, 2021), better adjustment to the maternal role among first time mothers who use them (Song et al., 2020), and a strong association between spousal and family support and lower PPD (Khademi & Kaveh, 2024). For the United States, prior research shows that mandated screening measurably increases case identification, which is shown in the sharp increase in diagnosis rates following California's 2019 universal maternal mental health screening requirement (Khadka et al., 2024). The FGIs in this study were built around these documented strengths in order to check whether physicians observe them in practice, and to surface the limitations that quantitative studies do not capture.

The knowledge gap this study addresses is the absence of research that treats the two systems as complementary rather than separate. The United States does not have a consistently implemented screening system. As Section 2.2 showed, recommendations exist but fewer than half of mothers are screened at well child visits, and most symptomatic mothers never reach treatment. The recovery period that Korean mothers receive through a combination of law, industry, and custom has no United States counterpart at all. Accordingly, this study compares Korea's recovery-support model with the United States' early screening model in order to determine which components of the Korean model could be adapted into the United States. It also draws on physicians with direct experience of the Korean model to assess which of those components would be adequate and beneficial to transfer.

However, research that compares Korea's postpartum care model with that of the United States directly, as well as qualitatively examining its implications from the clinical experts' perspective, is very limited. Thus, this study has originality and necessity in that it compares Korea's recovery-support model with the United States' early screening model and explores potential policy implications that integrate the strength of both models.

3. CURRENT STATUS OF POSTPARTUM DEPRESSION IN KOREA AND THE UNITED STATES

3.1 Postpartum Depression in the United States

3.1.1 Prevalence Trends

The Postpartum Depression Diagnosis rate in the United States is increasing rapidly. Khadka et al. (2024) analyzed 442,308 pregnancies in the Kaiser Permanente Southern California health system, and found that the PPD diagnosis rate roughly doubled from 9.4% in 2010 to 19.0% in 2021. Although this figure only shows the trend rather than a national prevalence estimate as it only includes a single insured population, it demonstrates a substantial increase in diagnosed PPD within this health system.

As shown in Figure 1, the rates plateaued around 12% between 2014 and 2017, then showed a significant increase in 2018 and 2019. Khadka et al. (2024) attributed this jump to California legislation, which required universal maternal mental health screening by July 2019. This suggests that mandatory screening can directly affect how many cases are identified.

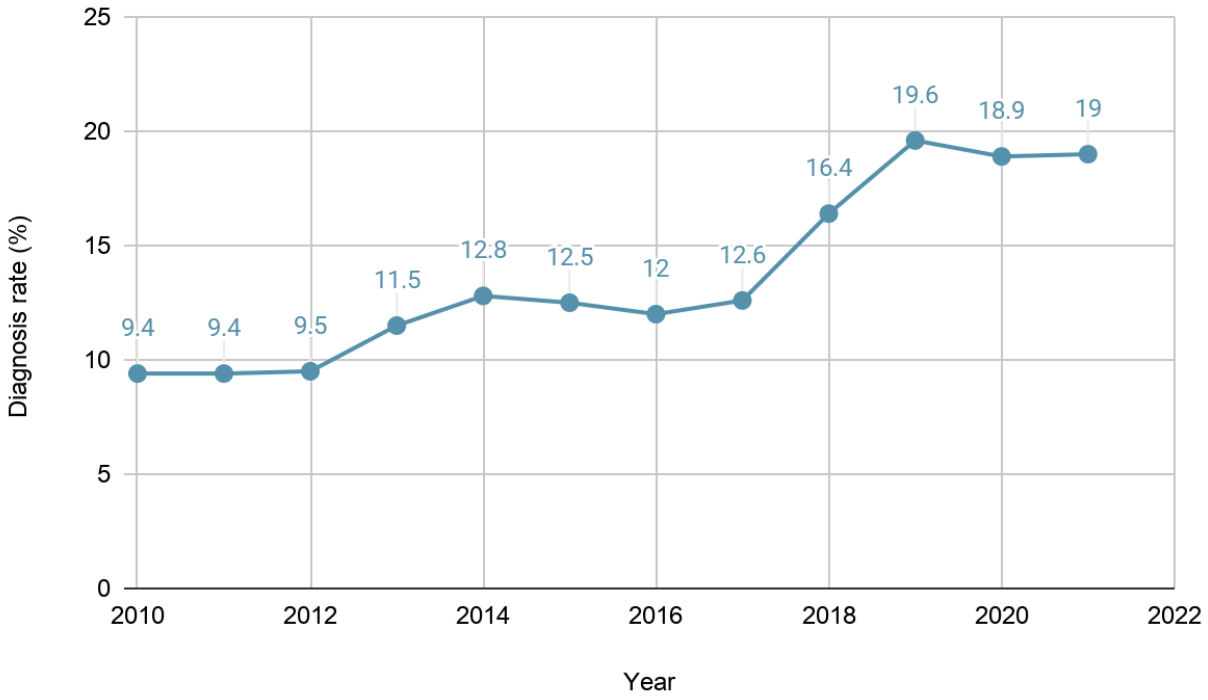

Figure 1. Annual Postpartum Depression Diagnosis Rates, Kaiser Permanente Southern California, 2010-2021. Data from Khadka et al. (2024), Table 2.

3.1.2 Equity of Access in Diagnosis and Treatment

The main issue with postpartum depression in the United States is the gap between diagnosis and treatment. Haight et al. (2024), using postpartum survey data from seven US jurisdictions, found that only 25.4% of mothers who showed early symptoms of PPD received a perinatal mood and anxiety disorder diagnosis, and only 52.8% of those received any form of postpartum mental health care. Taken together, only about 13% of mothers with symptoms actually reach the treatment stage.

The same study found that women of color were significantly less likely than white women to receive mental health care, though no significant differences in diagnosis rates were found. The clearest inequality therefore shows not in the occurrence of symptoms itself, but whether the identification actually leads to treatment.

The pattern may also reflect factors outside the clinic. Iturralde et al. (2021) ran focus groups with 30 pregnant and postpartum women of Asian, Black, Latina, and White backgrounds who had all screened positive for depression. What was distinct for non-White women was cultural messaging that discouraged treatment, along with low social support and difficulty taking time off work. Additional barriers included limited cultural competency and language differences. This helps explain the Haight et al. (2024) result, which found no significant difference in diagnosis rates between women of color and white women, but a large difference in who received care. Iturralde et al. (2021) offers one explanation, since a mother who has received cultural messages discouraging treatment may turn down a referral even when she was correctly identified as needing care. This distinction matters for policy. If the barrier is on the provider side, the fix would be a simple policy change such as building referral pathways and paying for follow-up care. If it is patient reluctance, the fix is outreach, with treatment offered in the mother's own language and personal setting. This study cannot separate the two, so this is noted for future research rather than claimed as a finding.

Sidebottom et al. (2021) also found lower screening rates among non-native English speakers and publicly insured patients, suggesting that language barriers and insurance status can also influence who gets to be screened in the first place.

Even though the American Academy of Pediatrics (AAP) recommends screening during regular checkups within six months postpartum, fewer than half of mothers are actually screened at these visits (Lamere & Golova, 2022) further worsening the situation.

3.2 Postpartum Depression and Care in Korea

3.2.1 Prevalence Trends

According to the Ministry of Health and Welfare's 2024 Postpartum Care Survey, 68.5% of mothers reported experiencing postpartum depressive feelings after childbirth, with the depression lasting an

average of 187.5 days postpartum. However, only 6.8% of them actually ended up receiving a formal "diagnosis" of PPD (Ministry of Health and Welfare, 2024). These two figures measure different things. The 68.5% is a self-reported depressive feeling rather than a formal diagnosis, so it should not be read as a prevalence estimate.

The distance between 68.5% reporting depressive feelings and 6.8% receiving an actual diagnosis is the clearest indication available that Korea's recovery infrastructure is not matched by a system that identifies mothers who need treatment. Section 3.2.3 demonstrates what Korea's screening system actually covers and where it breaks down.

3.2.2 Use of Postpartum Care Centers

The most distinctive feature of postpartum care in Korea is the use of care facilities. As shown in Figure 2, usage rates by location were highest for postpartum care centers at 85.5%, followed by one's own home at 84.2%, the mother's parents' home at 11.2%, and the in-laws' home at 1.0% (multiple responses allowed). The average postpartum care period was 30.7 days, and the average duration of care center use was 12.6 days, an increase from 12.3 days in 2021. Average spending at the care centers was reported at 2.865 million KRW (Ministry of Health and Welfare, 2024).

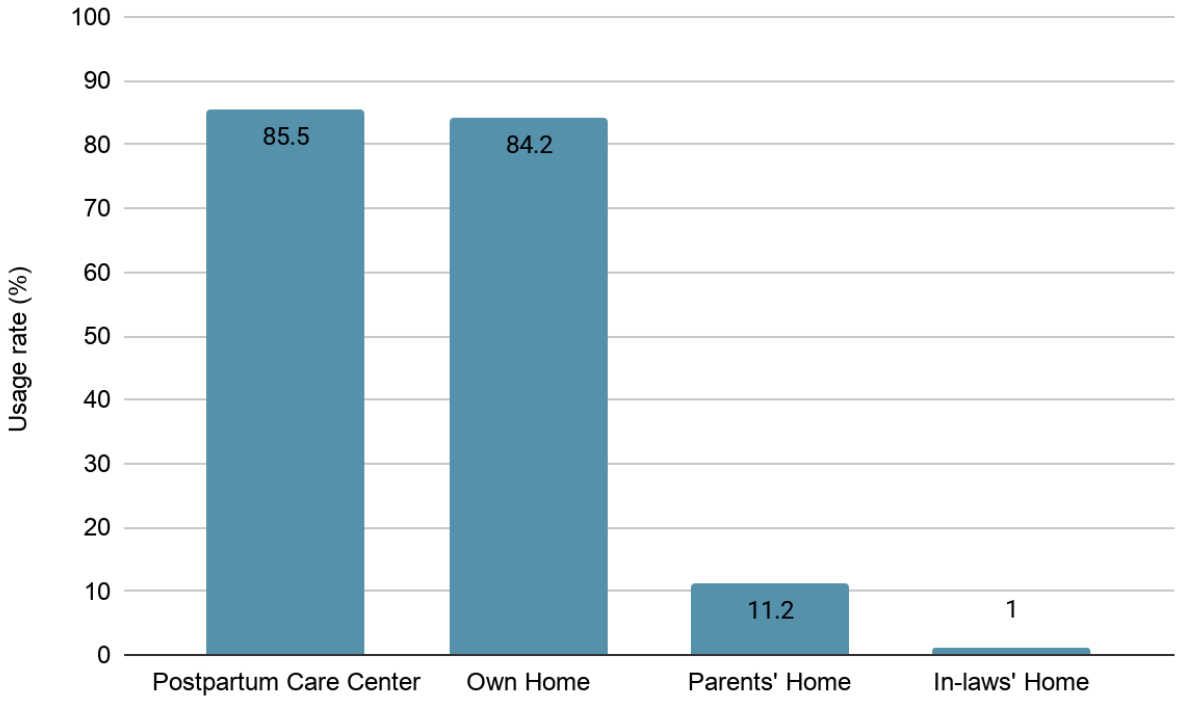

Figure 2. Postpartum Care Location Usage Rates in Korea, 2024. Data from Ministry of Health and Welfare (2024).

One notable finding is that the sources mothers identified as helpful in relieving postpartum depressive feelings were, in order: spouse (57.8%), friends (34.2%), family other than the spouse (23.5%), and medical professionals/counselors (10.2%) (Ministry of Health and Welfare, 2024). This shows that family and social bonding can support postpartum care in Korea.

3.2.3 National Screening System and Its Limits

Korea provides support for postpartum care based on the Maternal and Child Health Act, and offers postpartum care worker services to households with income at or below 150% of the median income through the Maternal and Newborn Health Management Support Program (Ministry of Health and Welfare, 2024).

Korea does have a screening framework, and it is more developed than the 6.8% diagnosis rate suggests. Article 10-5 of the Maternal and Child Health Act lets national and local governments fund prenatal and postpartum depression screening. Public health centers give the Korean version of the Edinburgh Postnatal Depression Scale (K-EPDS), either in person or as a self-test on the center's website. Since August 2020, the EPDS has been billable under national health insurance, up to twice a month. A central counseling center for fertility and depression opened at the National Medical Center in 2019, with five regional centers running alongside it as of 2022 (Kim et al., 2022).

The problem is that none of it is required. It permits screening support rather than mandating it. Public health centers only reach mothers who show up for something else, such as a vaccination or a subsidy application. The support stops at screening and does not extend into treatment (Kim et al., 2022).

Kim et al. (2022) report that public health centers screened 29,219 mothers in 2015, 68,972 in 2017, and 65,748 in 2018. High risk cases rose from 3,201 to 8,747 over the same period. Korea was finding more at-risk mothers. But the share of those mothers actually referred to a mental health center fell from about 69% to about 34%, so a smaller fraction of them reached any follow-up.

Treatment figures point the same way. Using Health Insurance Review and Assessment Service data for births between 2007 and 2016, Kim et al. (2022) report that an average of 1.6% of mothers received PPD treatment within six months of delivery. Prevalence estimates sit between 10% and 20%. The 2015 National Fertility and Family Health and Welfare Survey found that only 2.6% of married women who had given birth were ever diagnosed with or counseled for PPD.

The available data therefore describes the pathway rather than the outcome. Korea has no national screening rate because screening is not applied to every mother, so there is no denominator to calculate one from. What the figures do show is that identification and treatment are not linked. Screening rose and the number of high risk mothers identified rose with it, while the share of those mothers referred to follow-up fell, and treatment rates remain far below any prevalence estimate.

3.3 Comparison of Postpartum Care Systems in Korea and the United States

The most fundamental difference between the two countries in postpartum care is the amount of time given for postpartum recovery and care. The United States does not have any federally mandated paid maternity leave, and survey data on a small subsample of FMLA leave-takers reported by Lerner (2015) indicate that about one in four employed mothers usually return back to work within two weeks of childbirth. Korea, by contrast, guarantees 90 days (about 13 weeks) of legally mandated maternity leave, including an additional average 30.7 days of postpartum care on top of that. It is worth noting that the United States does provide up to 12 weeks of unpaid, job-protected leave under the Family and Medical Leave Act (FMLA), though this leave is not universally available since it excludes many part-time and small-business employees. Also, its unpaid nature often makes it financially unfeasible for lower-income mothers.

A second structural difference lies in how healthcare is paid for. Korea reached universal health coverage in 1989 and merged its insurance funds into a single national insurer in 2000 (Kwon, 2018). The whole population is covered, so prenatal care, delivery, and infant checkups are covered regardless of employment. The United States relies on a mix of employer based insurance, individually purchased plans, and Medicaid. Coverage for prenatal, delivery, and postpartum care therefore varies by job, by income, and by state. This has a direct consequence for the proposals in Section 6.3. A screening requirement in the United States needs a payment mechanism attached before it can work. Korea already has one, since the EPDS became billable under national health insurance in 2020 (Kim et al., 2022).

Universal coverage does not mean everything is free. Kwon (2018) notes that Korea prioritized covering the whole population over covering a wide range of services, which left a limited benefits package and high out-of-pocket costs. Postpartum care centers fall outside insurance entirely. The average stay costs 2.865 million KRW, paid by the family (Ministry of Health and Welfare, 2024). The most visible part of Korea's recovery system is therefore a private market, which matters for the access concerns participants raised in Section 6.2 and for the cost of the proposals in Section 6.3.

This institutional difference affects how well mothers can physically and mentally recover and how well they can adjust to maternal roles. In the next section, this study will explore how this difference affects the occurrence and recovery of postpartum depression through interviews with clinical experts.

4. METHODS

4.1 Research Design and Participants

This study adopts a qualitative research method, since the relationship between PPD and the postpartum care system involves clinical contexts that are difficult to understand using numbers alone. Thus, a qualitative approach was used, so that experts' reasoning and observations could be examined directly. Focus group interviews (FGIs) were used to gather rich data through shared perceptions of a group of experts.

Purposive sampling was used to select the participants. The selection criteria were: (1) physicians who are currently practicing in Korea (2) physicians whose practice involves routine contact with mothers during the postpartum period, either through delivery, follow-up, or newborn well child visits (3) individuals with sufficient experience in maternal care. A total of four clinical experts participated: two pediatric specialists, and two OB/GYN specialists. Pediatricians were included in order to provide a comparison with the pediatrician-based screening system used by the American Academy of Pediatrics (AAP) in the United States. Characteristics of research participants are shown in Table 2. All four participants practice in Korean clinical settings. None of them practices in the United States, and the study does not include Korean origin physicians working in the US system.

The FGIs were conducted in May 2026 in Korean across 4 sessions, each lasting approximately 30 minutes to an hour, held online. Sessions were audio recorded with participant consent and were later transcribed into an FGI interview sheet. Quotations in this paper were translated into English by the author, and translations were checked against the original transcripts for accuracy. Coding and theme development were carried out by the author following the six phase procedure of Braun and Clarke (2006).

Table 2. Characteristics of Research Participants

Participant	Affiliation	Clinical Experience	Notes
Participant A	Private Pediatric Clinic	30 years	Pediatric specialist, in charge of newborn outpatient care
Participant B	Private OB/GYN clinic	23 years	OB/GYN specialist, primarily outpatient
Participant C	General Hospital, OB/GYN department	24 years	OB/GYN outpatient
Participant D	Private pediatric clinic	22 years	Pediatric specialist, newborn outpatient

The collected data were analyzed using the six phase thematic analysis of Braun and Clarke (2006). All participants were informed of the purpose of the study beforehand, and consent to use their response to the study was obtained. They were also informed that they could withdraw from the study at any time. Information that is personal or could identify the participants was anonymized (Participants A, B, C, D).

4.2 Interview Guide

The FGI questions were derived from the Korea US status analysis in Section 3 and the four variables in Section 2.3. Each question was constructed to examine the effectiveness of Korea's postpartum care system through the clinical experience of OB/GYN and pediatric specialists practicing in Korea. The questions and their supporting prior research are shown in Table 3.

Table 3. FGI Question Guide and Supporting Prior Research

Question	Supporting Prior Research
1. Postpartum leave and caregiving period (US: No federal paid leave mandate vs. Korea: 90 days of statutory leave plus an average 30.7 days of postpartum care)	
Q1. What clinical differences have you observed between mothers who had a sufficient postpartum recovery period and those who did not?	Kornfeind & Sipsma (2018)
Q2. Do you believe that specialized care during the first four weeks postpartum substantively contributes to the mother's emotional recovery?	Hidalgo-Padilla et al. (2023)
2. Specialized postpartum care infrastructure	
Q3. Did you observe differences in postpartum depression patterns between mothers who used care facilities and those who did not?	Song et al. (2020)
Q4. Do you believe specialized care infrastructure affects not only the mother's physical recovery but also her mental health?	Song et al. (2023)
3. Social/cultural support system	
Q5. How did clinical outcomes differ between mothers with sufficient family support and those without?	Khademi & Kaveh (2024)
Q6. Do you believe Korea's family-centered postpartum care culture contributes to prevent postpartum depression?	Norazman & Lee (2024)
4. Screening/treatment accessibility	
Q7. Compared to the United States' pediatrician-based early screening system (AAP recommendation, CPT Code 96127), what do you see as the strengths and limitations of Korea's screening system?	Earls et al. (2019); Lamere & Golova (2022)
Q8. If the United States' pediatrician-based early screening system were introduced in Korea, what advantages and limitations do you think it would	USPSTF (2023)

have?	
5. Other	
Q9. Between Korea's recovery-support system and the United States' pediatrician-based early screening system, are there elements from each that could be introduced into the other country?	Hidalgo-Padilla et al. (2023); Cho & Jeong (2021)

5. RESULTS

This study conducted FGIs with four clinical experts in May 2026. Analysis of the collected data following the thematic analysis procedure of Braun and Clarke (2006) yielded five key themes.

Theme 1. Relationship Between Caregiving Duration and Postpartum Depression

Participants agreed that having a sufficient time for recovery directly affects the mother's mental stability.

> *"Mothers who had a postpartum recovery period tend to be in better physical health, and they also appear more emotionally stable." (Participant D,* Private Pediatric Clinic*)*

> *"There were cases of fatigue, emotional instability, sleep deprivation, and even aggressive behavior during medical visits." (Participant A,* Private Pediatric Clinic*)*

Theme 2. Specialized Care Infrastructure and Its Connection to Reduced Depressive Symptoms

Participants observed that mothers who used postpartum care facilities showed fewer depressive symptoms at follow-up visits, and attributed this in part to peer networks formed among mothers during their stay.

> *"The community that forms among mothers at care facilities, and the peer support that comes with it, are seen to help with recovery from postpartum depression." (Participant A,* Private Pediatric Clinic*)*

Theme 3. Facility Use May Reflect, Rather Than Cause, Protective Factors

Several participants raised the possibility that mothers who are able to afford and use postpartum care centers already tend to have more family support and better financial circumstances, and these underlying factors may account for their better outcomes rather than the facility itself.

> *"Mothers who used postpartum care centers were shown to have higher family support and better financial stability, so they showed less depressive feeling overall." (Participant D,* Private Pediatric Clinic*)*

> *"Care center costs are substantial, so mothers who use them are likely to be more financially stable, which may protect them from future childcare burden rather than the effect of the facility itself." (Participant B, Private OB/GYN clinic)*

Theme 4. The Relationship Between Social Support Networks and Depressive Symptoms

Participants agreed that family support, especially spouses, can directly affect a mother's depressive symptoms.

> *"Spousal involvement and support in childcare were the most important factors. Expectations around childcare involvement often differ between spouses, and when that gap gets larger or left unresolved, it can potentially become a source of conflict." (Participant B, Private OB/GYN clinic)*

> *"In cases where the mother has lack of parental support or is in a conflict with her husband, the frequency of postpartum depression is markedly higher." (Participant C, General hospital, OB/GYN department)*

Theme 5. Clinical Limitations of Screening and Treatment Accessibility

Participants viewed the accessibility of the US paediatrician-based early screening system positively, but pointed to weak linkage.

> *"OB/GYN follow-up visits happen only about twice, so postpartum depression screening is practically not feasible there. Pediatric clinics are visited more frequently because of the vaccination schedule, making them better suited for screening." (Participant B, Private OB/GYN clinic)*

> *"Because pediatric reimbursement rates are too low, it is difficult for each clinic to secure staff in this area, making follow-up care after screening difficult to sustain." (Participant C, General hospital, OB/GYN department)*

6. DISCUSSION

6.1 Interpreting the Prevalence Gap Between Korea and the United States

The contrast between Korea's 68.5% self-reported depressive feelings and the 13.2% symptom prevalence in US PRAMS data should not be interpreted as evidence that Korean mothers fare worse. The Korean survey asks broadly about depressive feelings at any point postpartum, while PRAMS applies a symptom threshold. The two measure different things.

What the Korean figure does show is that a supportive recovery environment itself does not prevent depressive symptoms from arising, and that Korea's 6.8% formal diagnosis rate points to the same gap between screening and treatment seen in the United States.

Prevalence data alone cannot explain why Korea's diagnosis rate is low. It could mean fewer clinically significant cases, or fewer chances to be identified. The screening data point toward the second. Kim et al. (2022) report that only about 1.6% of mothers received treatment within six months of delivery, far below any prevalence estimate.

6.2 Expert Perceptions of the Korean Postpartum Care Model

Participants commonly acknowledged that Korea's postpartum care system is an effective protective factor in terms of physical recovery and social support. At the same time, they assessed that the United States' pediatrician-based screening system has strengths in terms of accessibility and early detection. However, Participant B (Private OB/GYN clinic) pointed out that "although Korea's care infrastructure is excellent, there is a problem in that vulnerable groups such as unmarried mothers do not have equal access to it." Participant C (General hospital, OB/GYN department) raised the practical limitation that "pediatric reimbursement rates are low, making it difficult to secure follow-up care staff after screening." Participant D (Private Pediatric Clinic) emphasized that "a treatment system needs to be established first, before introducing screening linked to infant checkups."

6.3 Korea and US Comparison and Policy Recommendations

Based on the analysis and expert interviews, the postpartum care systems of Korea and the United States show clear differences across all four variables. This is summarized in Table 4 below.

Table 4. Comparison of Korea and US Postpartum Care Systems

Comparison Category	Korea	United States
Postpartum care period	90 days of maternity leave + average of 30.7 days of postpartum care	No federal paid leave mandate. FMLA provides up to 12 weeks of unpaid, job-protected leave, with eligibility excluding many part-time and small-business employees.
Specialized care infrastructure	Care facilities (usage rate 85.5%), postpartum care worker system. Largely privately paid, average cost 2.865 million KRW	No such care facilities; reliance on individuals and family
Social support system	Family-centered caregiving	Limited community support

	culture combined with institutional support. Peer networks formed among mothers during care center stays.	networks
Screening and treatment accessibility	Screening framework exists under the Maternal and Child Health Act, using the K-EPDS at public health centers. The EPDS is billable under national health insurance. Participation is voluntary, and support stops at screening (Kim et al., 2022). Diagnosis rate remains a challenge	AAP screening recommendation and CPT Code 96127 reimbursement mechanism (Earls et al., 2019); however, implementation rate is fewer than half (Lamere & Golova, 2022), and treatment linkage is inadequate
Healthcare financing	Single national insurer covering the entire population since 2000, though with a limited benefits package and high out-of-pocket costs (Kwon, 2018)	Employer based private insurance, individual plans, and Medicaid. Coverage varies by employment, income, and state.

Based on this comparison, this study proposes the following policy recommendations for improving PPD outcomes in the United States, organized by timeframe.

The three timeframes reflect how hard each measure is to implement. None of them expires once the next begins. Screening comes first because everything it needs already exists in the United States. There is a Grade B USPSTF recommendation, a validated instrument in the EPDS, a reimbursement code in CPT 96127, and a clinical touchpoint at infant well child visits. Screening could start soonest, and it will stay in place permanently, forming the base the medium and long term measures build on. Those later measures take longer because they need new funding, new staff, and in the case of paid leave, federal legislation.

Short term: Required postpartum depression screening

The most practical and immediate policy is to mandate postpartum depression screening. Screening for perinatal depression already carries a Grade B recommendation from the U.S. Preventive Services Task Force (2023), and validated tools such as the EPDS should be made a mandatory part of obstetric and pediatric checkups. A formal referral pathway to mental health care services after screening should be established, so that mothers who are diagnosed with PPD can actually receive proper treatment. In

particular, appropriate screening tools that reduce disparities by race and language should be introduced alongside this.

A study by Khadka et al. (2024) showed that diagnosis rates in California rose sharply within about a year of the state's 2019 screening requirement. Korea gives a warning of what happens when the legal basis exists but the obligation does not. Article 10-5 of the Maternal and Child Health Act permits screening support rather than requiring it. The law funds the screening itself but does not fund or mandate what happens after a mother screens positive, causing the referral rates to fall even as the number of mothers screened rose (Kim et al., 2022). Participant D made the same point from clinical experience, arguing that a treatment system has to be in place before screening is expanded. A mandate that identifies more mothers without expanding treatment capacity would widen the gap Haight et al. (2024) described. A United States mandate should therefore cover referral and follow-up care, not screening alone.

Medium term: Build community and peer support networks

The first medium term recommendation is structured peer and community support. Participant A observed that the community formed among mothers at Korean care facilities, and the peer support that came with it, appeared to help with recovery. The Ministry of Health and Welfare (2024) survey points the same way. Mothers ranked spouses (57.8%) and friends (34.2%) well above medical professionals and counselors (10.2%) as sources of relief. Norazman and Lee (2024) similarly found that peer support from other mothers improved PPD outcomes.

Korean care facilities produce a cohort of mothers going through the same period at the same time. In the United States it could be built through hospital or clinic run postpartum peer groups or parent groups led by community health centers.

The advantages over a staffing based program, which will be discussed next, are clear. Cost per mother is far lower, and it also avoids the cultural barrier of letting a paid caregiver into the home. A group setting may be easier to accept for mothers who are reluctant to enter individual psychiatric treatment.

Medium term: Introduce a Korean style specialized postpartum care program

This study also proposes to adapt Korea's home visit care policy into the US healthcare system. Korea offers a home visiting program for pregnant women and infants, sending trained nurses into homes to cover breastfeeding, infant care, and postpartum depression (Kim et al., 2022). Since establishing specialized care facilities nationwide in the United States would be very costly and can also face cultural barriers, a program with specialized postpartum care staff who make home visits after childbirth and provide personalized care would be more realistic. This could also be linked with public insurance programs such as Medicaid, prioritizing low-income and underserved populations. This follows Participant D's suggestion that introducing postpartum care centers and providing financial support for their use is worth adapting from Korea's system, and Participant B's view that a home visit program would suit the US rather than directly replicating Korea's care center model.

Compared with peer support, this costs considerably more per mother. It also requires a workforce that does not exist currently at scale in the US. It is therefore most feasible as a targeted program rather than a universal one, aimed at mothers flagged as higher risk, with peer support serving everyone else.

Long term: Extension of paid maternity leave

A fundamental solution would be to change the existing unpaid leave under FMLA into paid leave at the federal level, as well as expanding its eligibility to the currently excluded part-time and small business employees. Based on prior research, a sufficient postpartum recovery period functions to protect new mothers against postpartum depression. Legislating at least 12 weeks of paid maternity leave would guarantee that mothers have enough time for physical and emotional recovery and adjustment to the maternal role.

This is also supported by Participant C, who identified paid parental leave, particularly paternity leave, as having a significant positive impact on both parents' ability to adjust to child caregiving. While Participant C's observation is centered on shared paternal leave rather than maternity leave specifically, it still functions to reinforce the broader principle that adequate paid leave for the family unit, not just the mother, can be a protective factor against postpartum depression.

6.4 Limitations of the Study

This study has several limitations. First, it is a qualitative study using a small sample of four experts, which limits how far the results generalize. Second, participants were limited to physicians practicing in Korea. No expert with direct experience of the US pediatric screening system was included, so the analysis of that model relies entirely on the literature and may not reflect how it works in practice. This also limits the discussion in Section 3.1.2, where cultural attitudes toward mental health treatment are raised as a possible factor in US racial disparities in care. That possibility could not be examined directly, as it relied on secondary literature rather than direct interviews with US physicians or mothers. Third, due to differences in cultural context between Korea and the United States, directly transferring the Korean style model would require careful attention and adaptation. This includes the financing difference described in Section 3.3. Fourth, this study's finding also leads to a potential confound: participants suggested that facility use may correlate with better outcomes, rather than causing it, since financial stability and family support likely influence both the decision to use a care facility and a mother's depressive symptoms. Future research should aim to disentangle these overlapping factors. Fifth, Korea's screening figures come from public health center records and cover only mothers who visited a health center. The detection comparison between the two countries is therefore structural rather than quantitative and cannot be stated as matched rates.

7. CONCLUSION

This study compared the postpartum care systems of the United States and Korea, and examined how Korea's postpartum care system may support postpartum recovery, with the purpose of deriving

improvement measures for the United States. Through prior research, four key variables were derived: postpartum leave and caregiving period, specialized postpartum care infrastructure, social and cultural support systems, and screening/treatment accessibility. The comparison showed that the United States has a larger institutional gap in paid postpartum leave and recovery infrastructure, while Korea falls behind in consistent screening and treatment linkage. The expert interviews supported the view that these institutional differences can influence how mothers recover and adjust to their postpartum period. Participants generally agreed that a sufficient recovery time and specialized care positively contributed to mothers' physical and emotional recovery, and that family support is also closely tied to the likelihood of postpartum depression. Participants also mentioned that the effect of specialized care infrastructure may be intertwined with broader factors such as family support and financial stability, rather than merely from the facility itself. At the same time, participants also pointed out Korea's own systems' limitations, such as unequal access to vulnerable and underprivileged populations and lack of linkage between screening and treatment.

The practical conclusion is directed at the United States. The United States already has the screening recommendations, the instrument, and the reimbursement code. However, it lacks the recovery period, the care infrastructure, and the treatment linkage that would make screening meaningful. Korea has the recovery period and the infrastructure, however, its screening framework is voluntary and the link from screening to treatment is weak. What the United States can take from Korea's model is the two things a care center produces, protected time for recovery and a cohort of mothers going through the same period at the same time. At the same time, Korea's experience warns against legislating screening without legislating the treatment that follows it.

Mandated screening with a working referral pathway, community based peer support built around existing well child visits, targeted home visiting for higher risk mothers, and federal paid leave form a sequence for the United States, ordered by how quickly each can realistically be implemented.

In conclusion, these findings suggest that Korea's recovery-support model and the United States' pediatrician-based early screening model each have distinct strengths and limitations, and that an integrated policy model that combines the strengths of both could offer a more effective approach to addressing postpartum depression.

Future research should include the following aspects. First, various stakeholders, including mothers themselves, should be included as interview subjects in order to accurately reflect the perspectives of both providers and recipients of care. Second, research that pilots a postpartum care program in select regions of the United States and longitudinally verifies its efficacy is needed.

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