Caring by Example: Assessing South Korea's Knowledge Sharing Initiative for Universal Health Coverage in Low and Middle-Income Countries

by

Hyeyoung Kang

Submitted in partial fulfilment of the requirements
for the degree of Master of Arts

at

Dalhousie University
Halifax, Nova Scotia
August 2017

DEDICATION PAGE

This thesis is dedicated to my parents for their endless love, guide and support throughout my life.

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ABSTRACT

South Korea, once one of the poorest countries in the world, achieved universal health coverage (UHC) in 1989 in a record 12 years. Based on this success, the country now shares its expertise through its training course for policymakers in low-and middle-income countries (LMICs). This thesis analyzes the effectiveness of this knowledge-sharing initiative and argues that it falls short of being an effective capacity building program for stakeholders in LMICs to develop and implement UHC programs within their countries. A lack of emphasis on the economic and socio-political contextual factors that enabled South Korea's successful UHC achievement limits opportunities for trainees to draw transferable and applicable lessons from South Korea's experience to their own healthcare systems. An analysis such as this may be of particular interest to other emerging donor countries that offer aid programs for UHC in the form of shared expertise based on its own development experiences.

LIST OF ABBREVIATIONS USED

CEA	Cost-Effectiveness Analysis
CMA	Cost-Minimization Analysis
CUA	Cost-Utility Analysis
DAC	Development Assistance Committee
DRC	Democratic Republic of the Congo
DUR	Drug Utilization Review
EE	Economic Evaluation
FHCI	Free Health Care Initiative
GDP	Gross Domestic Product
HIRA	Health Insurance Review & Assessment of Republic of Korea
HTA	Health Technology Assessment
ICER	Incremental Cost-effectiveness Ratio
ICT	Information and Communication Technology
ISSA	International Social Security Association
KDI	Korea Development Institute
KOFIH	Korea Foundation for International Healthcare
KPIS	Korean Pharmaceutical Information System
KSP	Knowledge Sharing Program
LMICs	Low-and middle-income countries
MOHW	Ministry of Health and Wellness of Republic of Korea
MOSF	Ministry of Strategy and Finance of Republic of Korea
MOU	Memorandum of Understanding
NHIA	National Health Insurance Authority of Ghana
NHIS	National Health Insurance Service of Republic of Korea
ODA	Official Development Assistance
OOP	Out-of-pocket
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
UHC	Universal health coverage
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNICO	Universal Health Coverage Study Series
WHO	World Health Organization
WPRO	World Health Organization Regional Office for Western Pacific

ACKNOWLEDGEMENTS

First and foremost, I would like to express my sincere gratitude to my supervisor Dr. Robert Huish for his constant support and guidance. Completion of this thesis might not have been possible without your valuable advice and continuous encouragement. I was lucky to have you as a supervisor.

To my committee members, Dr. David Black and Dr. Ryoa Chung, thank you for the time you invested in reviewing my thesis. Thank you for letting my defense be an enjoyable moment, and for your brilliant comments and suggestions.

To Nicole and Marian, staffs in the Department of International Development Studies, thank you for keeping your office door open and available for all the times when I needed it. Your kindness and excellent service made my life at Dalhousie and in Halifax so much better.

To my mom and dad who have been a source of encouragement and inspiration to me throughout my life, a very special thank you for always believing in me from day one when I first started my studies in Canada.

To my dear fiancé and my best friend, John JongGwan Lee, thank you for your smile, your mochaccino, and all the funny stories you told me whenever I was stuck writing my thesis.

I also would like to thank my friends for their love and support throughout the writing process. Your support means the world to me.

Finally, I thank my God, my good Father, for letting me finish my degree. I have experienced Your guidance day by day. Thank you, Lord.

CHAPTER 1 INTRODUCTION

With growing disenchantment with vertical, disease-specific global health initiatives, the importance of establishing universal health coverage (UHC) in low-and middle-income countries (LMICs) has received greater attention over the past decade. UHC is now a top item on the global health agenda as more than a hundred low-and middle-income countries (LMICs) have set it as a priority (WHO, 2015a). Multilateral organizations, most notably the World Health Organization (WHO), and other global leaders, such as the Bill & Melinda Gates Foundation, which is the biggest private donor to global health programs, and the U.S. government, which is the world's biggest public funder of global health programs, explicitly make efforts to help LMICs achieve "Health for All."

There is one country that joins this global effort to promote UHC for LMICs by sharing its own experience of achieving UHC: South Korea. The country opened a unique chapter in the history of global health by achieving UHC at an extraordinary pace (12 years), as compared to Germany (127 years), Belgium (118 years), Austria (79 years), and Canada (40 years) (Carrin & James, 2005). South Korea, once one of the poorest countries in the world, now has one of the most efficient and affordable health care systems on the planet (Griffin et al, 2016, p.11). This raises a strong desire among LMICs to learn from South Korea's example, and South Korea meets this demand in offering its unique expertise and knowledge about UHC through its annual International Training Course on Social Health Insurance (SHI). The training course targets high-level officials and experts in LMICs who are actively involved in introducing and developing government-initiated health care or health insurance programs in their countries.

Approximately 470 officials and experts from 53 different developing countries have visited South Korea to participate the training course since 2004. With collaboration from the World Bank, WHO Regional Office for Western Pacific (WHO/WPRO), and the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), the training course enjoys a great deal of popularity among the health care policymakers in LMICs.

However, its effectiveness is less clear. Little is known about how effectively this knowledge-sharing initiative contributes to building capacity for stakeholders in LMICs to develop and implement their UHC programs in their own countries. Although South Korea's success story with its health care system may serve as a remarkable source of inspiration to LMICs that aspire to achieve UHC (Howe, 2010), sharing the technical knowledge over the political knowledge of this story does not guarantee successful capacity building opportunities to the stakeholders in LMICs. Kim et al (2015) address the need for research concerning the impact of rapidly rising activities of the South Korean government's global health cooperation (p.345). Aboubacar (2014) more specifically points out a lack of critical assessment on South Korea's "burgeoning knowledge-sharing programs" in terms of effectiveness (p.1).

The purpose of this thesis is to contribute to an informed, but critical understanding of South Korea's knowledge-sharing effort in helping LMICs shape a sustainable health care system to achieve UHC. LMICs face many daunting challenges to achieving UHC, from undue financial hardship in securing sustainable health financing, to a lack political will to push health reforms, to shortages in, and poor distribution of, appropriately qualified health professionals. This study examines whether South Korea's

cross-cultural knowledge-sharing initiative provides transferable and applicable development lessons to effectively address these local health care challenges facing LMICs. Qualitative methods and a comprehensive knowledge-sharing model are used to answer the central question of this thesis: Is South Korea's knowledge-sharing initiative on UHC effective in building capacity for stakeholders in LMICs to design and implement UHC programs within their countries?

This thesis argues that South Korea's knowledge-sharing initiative falls short of being an effective capacity building program. It is because of a lack of attention to upstream determinants of UHC, and also the method by which technical knowledge is delivered. South Korean stakeholders' de-contextualized knowledge cleanses out the broader social, political, and cultural contextual factors that enabled the country's successful achievement of UHC. An excessive emphasis on technical knowledge of health insurance systems, without making an effort to address cross-cultural rigidities of those upstream contextual factors, limits opportunities for the stakeholders from LMICs to draw transferable and applicable policy lessons from South Korea's experience to their own health care systems. An analysis such as this may be of particular interest to other emerging donor countries that offer non-monetary aid programs for UHC in the form of shared expertise based on its own development experiences.

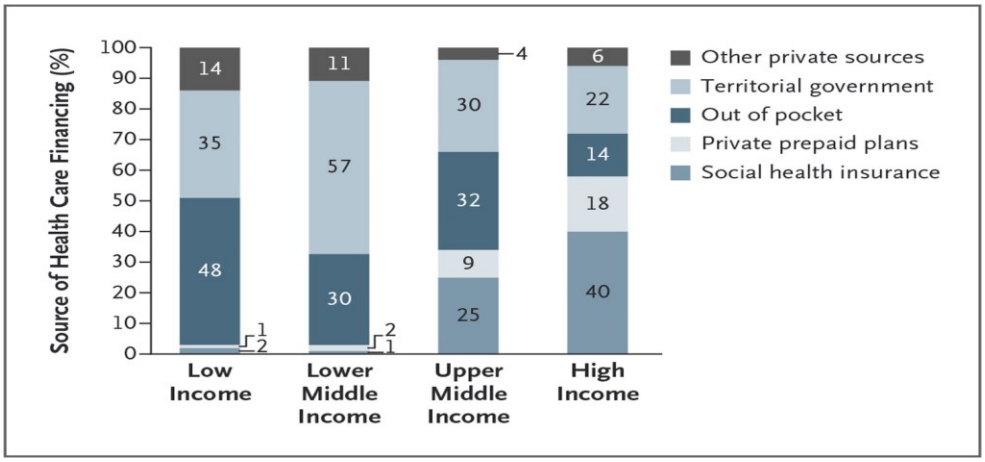
1.1 STATE OF UHC IN LMICS

In her 2012 reconfirmation speech, Margaret Chan, Director-General of WHO, asserted that "UHC is the single most powerful concept that public health has to offer" (Chan, 2012). Achieving UHC is now an important target for the United Nations

Sustainable Development Goals (SDGs). More than a hundred LMICs, home to almost three-quarters of the world's population, have now taken steps to deliver UHC (WHO, 2015a). The landscape of the international community's global health aid has also changed from providing substantial funding for LMICs' disease-specific programs, such as HIV, tuberculosis, and malaria, to strengthening broader health systems in areas such as human resources, medicine supplies, information systems, financing and governance (WHO, 2009).

However, despite that the world's proposed commitment to UHC in recent years shows a move away from reactive disease-specific aid to primary care, LMICs still face many daunting challenges to achieving UHC. One of them is a lack of financial support for those who need health care, deterring service use and burdening household budgets. Figure 1 shows the sources of health care financing according to country income. A significant proportion of health care financing in low-income countries comes from out-of-pocket (OOP) expenditure, nearly 50%, when compared to middle-income countries (30%) and high-income countries (14%).

Figure 1 Sources of Health Care Financing According to Country Income



Source: Mills, A. (2014). Health Care Systems in Low- and Middle-Income Countries. *The New England Journal of Medicine, 370*(6), p. 555.

Thus, the key financing issue for LMICs is how to provide increased financial protection for households, and each country has different ways to do it. Thailand, for instance, adopted a tax-based revenue model to finance health care spending (Resenburg & Weintraub, 2015). Other countries, such as Vietnam, implemented voluntary social health insurance programs (Seperhi et al., 2011). However, many studies found that many of these schemes failed to reach a large proportion of their target population, and in the absence of subsidies most schemes exclude the poor (Ekman, 2004; Allegri, Sanon, Bridges, & Sauerborn, 2006; Schneider & Hanson, 2006; Jowett & Hsiao, 2007; Lieberman & Wagstaff, 2009). Ghana is often cited for its efforts to expand health care coverage with a national health insurance program. It is mandatory for the formal sector and voluntary for the informal sector. However, the country struggles with problems in making premiums affordable and determining the payment method (i.e. one-time payment or annual payment) with different interests and needs of different stakeholders (Abiiro & McIntyre, 2013).

Health care financing is not the only issue in LMICs' move toward UHC. At the level of service delivery, shortages and poor distribution of appropriately qualified health professionals is a major challenge in relation to UHC goals. Even an advanced UHC program may not be effective without sufficient health workers, especially at the primary care level. Table 1 provides the global landscape of physician density by country income and geographical region. Low income countries have only 5.8 physician per 10,000 individuals, five times fewer than high income countries. By region, South-East Asia has 6.4 physicians per 10,000 individuals. Sub-Saharan Africa has only 0.9 physicians per 10,000 individuals, which is 30 times fewer when compared to Europe and Central Asia.

Considering that South-East Asia and Sub-Saharan Africa experience the highest proportion of the global burden of disease (29% and 24% respectively) (WHO, 2006), this human resource deficiency in health care is a critical barrier to facilitating the transition of countries towards UHC in these regions.

Table 1 Physician density by country income and geographical region

	Physicians (density per 10,000)
Income Group	
Low-income countries	5.8
Low- and middle income countries	8.7
Upper middle income countries	15.6
High income countries	28.5
Geographical region	
East Asia and Pacific	14.2
Europe and Central Asia	26.8
Latin America and Caribbean	17.2
Middle East and North Africa	17.4
South Asia	6.4
Sub-Saharan Africa	0.9

Source: WHO Global Health Observatory. Data retrieved from http://apps.who.int/gho/data/ (accessed 11 May, 2017)

1.2 South Korea's Pathways to UHC

South Korea has its own unique recipe for its UHC development. First, the country's extraordinary economic growth was a major driving force behind its rapid achievement of UHC. It contributed to the rapid extension of health insurance by improving employers' and employees' capacity to pay contributions and the South Korean government's capacity to provide health care services. One thing that should be noted is that South Korean economic development took a very unique trajectory that

experts have not typically observed in many LMICs today. First, South Korea obtained its economic results under the yoke of a very repressive regime that had the backing of the United States during the Cold War. The United States provided over USD 3.1 trillion in non-repayable grants from 1945 to 1961 (KOICA, 2004, p.25). From 1962 to 1966, U.S. grants amounted to 70% of the inflowing capital of South Korea (Lee, 2014, p.18).

A unique relationship with the World Bank was another feature of South Korean economic development. The country's economic success story was achieved thanks to the regime's non-payment of grants, that runs contrary to economic model advanced by the World Bank, of demanding repayment terms and structural adjustments, and nevertheless the Bank's continued support of the dictatorship. It was far from being a virtuous accumulation of wealth through the advantages of free-market forces. To borrow J-P Peemans' words (2002), the 'Miracle on the Han River' came about by "a brutal primitive accumulation achieved by the most coercive methods, in order to produce virtue by force" (p.373). The country's industrialisation was based on export substitution, which represented the World Bank's alternative to the industrialisation model through import substitution (Haggard et al., 1991; Westphal, 1990; Vieira, 2014). Instead of producing what it imported, South Korea channelled its export activities towards meeting the demands of the world market while successfully developing industries that yield high added value. The military government established by the coup led by Major-General Park Chung Hee in 1961 reinforced the State's intervention in the economy, specifically around finance and the heavy industry sector. The regime managed the public enterprises and drafted a series of Five-Year Plans in order to shape long-term economic development. This was not the World Bank's official version of economic development.

Moreover, in the mid 1970s, when Park's government was on the way to developing a powerful heavy industry sector, the World Bank once again voiced its doubts about the chosen strategy. The World Bank felt that South Korea was over-ambitious and suggested that the country scale down its efforts in this sector (Kim, 1997, p.46). Yet, the Korean authorities chose not to follow these recommendations, and for two years from 1977 to 1979, 80 % of all state investments were devoted to heavy and chemical industries, such as automobile and ship production, iron and steel, and petrochemicals (Kim, 1997, p. 35). This served to further stimulate economic development and contributed decisively to forming the foundation of the majority of key industries that currently support the South Korean economy.

Despite the country's 'counter-World Bank' move, the military dictatorship, buttressed by U.S. support, gained continued economic and political assistance from the World Bank. The World Bank's political support, in particular, allowed the dictator to consolidate his position both in the country and on the international scene with his single-minded pursuit of economic development. Mahn-Je Kim (1997), who had been Deputy Prime Minister of South Korea in the 1980s, wrote that:

> The World Bank gave a favourable assessment of the dictatorship. The Bank helped dictator Park to gather support on the domestic as well as on the international level. Such recognition from the Bank - the world's most authoritative international development organization - positively influenced [South] Korea's international relations, but was even more important domestically. It provided a powerful and persuasive justification to the [South] Korean public for the existence of a dictatorial government devoted to economic development (p.46).

Indeed, South Korea's real gross domestic product expanded from USD 2.7 billion in 1962 to USD 230 billion in 1989 (World Bank, 2016). During the repressive military

regime from 1962 to 1971, the average annual growth rate of South Korea's real GDP was 11.5% (Chung, 2007, p.14).

It was in this context of the authoritarian regime's successful economic development that the country introduced its national mandatory Social Health Insurance (SHI) scheme in 1977. The significant increases in both national and household income, coupled with a rapid growth of employment in the formal sector, boosted by the heavy industry during the 1970s and 1980s, were the driving force enabling the development of a social security system in South Korea and its sustainable implementation. The authoritarian government had a strong motivation for political legitimation, which was translated into its energetic support for health care for its citizens. Unlike other strongman politics that set UHC as a development goal, such as those in Zimbabwe, Turkey, and the Democratic People's Republic of Korea, the authoritarian regime of South Korea enjoyed economic vitality to sustainably fund and support its UHC programs. The rapid economic growth played a vital role in allowing the strong political leadership to ambitiously plan and effectively implement the quality UHC programs in South Korea.

Another success factor of South Korea's attainment of UHC is that the country has enjoyed a sufficient supply of trained health workers. Since the 1980s, the number of doctors has multiplied 3.6 times by the beginning of the 2000s, the number of nurses two times, and the number of medical institutions 12.3 times (Kim, 2012, p.121). The physician density increased from 0.5 per 1,000 population in 1981 to 1.6 in 2003, and now the country enjoys 2.2 physicians per 1,000 (OECD, 2015). Health systems can only function with health workers; improving health service coverage and health outcomes depends on a fit-for-purpose and fit-to-practise health workforce. These quantitative

increases in health care professionals have enhanced citizens' access to medical care in South Korea, which became a backbone of the quality services that the country's SHI scheme provides.

1.3 SOUTH KOREA'S GLOBAL QUEST FOR UHC IN LMICS

South Korea identifies its foreign policy as "trust diplomacy" – for South Korea to be perceived as a responsible middle-power that acts as a facilitator on global issues such as poverty eradication and global health (Lee, 2009, p. 202). An aid recipient less than two decades ago, South Korea is now an Organization for Economic Cooperation and Development (OECD) - Development Assistance Committee (DAC) member, and the world's 14th largest Official Development Assistance (ODA) provider in terms of volume. Its global public health ODA continually increases, and is now one of the three largest outreach areas of South Korea's foreign aid programmes (Kim, Ha & Kwon, 2015). At the heart of this global health outreach is the country's recent experiences of building an effective health care system accumulated throughout its successful development process that is recognized globally as 'Miracle on the Han River'.

The International Training Course on Social Health Insurance (SHI) is part of a large picture of South Korea's Knowledge Sharing Program (KSP). The Korean Ministry of Strategy and Finance (MOSF) and the Korea Development Institute (KDI) launched this program in 2004 to share the country's development experience and to assist its developing country partners. The goal of this program is to offer a deeper and wider understanding of South Korea's development experience with the hope that South Korea's past can offer lessons for developing countries in search of sustainable and

broad-based development (MOHW, 2012). It builds case studies that explore various development-oriented themes such as industrialization, government administration, human capital development, Information and Communication Technology (ICT), agricultural development, and environment.

Health care reform became increasingly important among these themes of KSP as many LMICs desire to achieve UHC. National Health Insurance Service (NHIS), a public corporation managing health care in South Korea, joined KSP in 2004, and began to offer the training course every year for policymakers in developing countries who are actively involved in developing and implementing UHC programs in their own countries. After 13 years, however, there is no careful analysis of the effectiveness of this knowledge-sharing initiative on UHC. This study explores whether this training course can be an effective capacity building program for stakeholders in LMICs to develop and implement their own UHC programs.

1.4 OUTLINE

This thesis first discusses why capacity building is essential to achieve UHC and why knowledge-sharing is important for capacity building in health care systems. After placing the knowledge-sharing initiative in a broader development context for capacity building, Chapter 2 provides background information about South Korea's knowledge-sharing initiative for UHC in LMICs.

Chapter 3 introduces three overarching theoretical lenses for this research. First, in order to frame my conceptual approach toward UHC, the human security paradigm will be introduced, shedding light on fundamental guiding principles that the paradigm

provides for UHC. Second, Richard Roses' (1991) theory of lesson-drawing will build understanding of the rationale behind transnational knowledge-sharing in public policy, such as national health insurance systems, and provide insights into what a knowledge-sharing initiative should promise the knowledge recipient. Third, the chapter introduces Cummings' (2003) knowledge-sharing model, which will be utilized as a useful analytical framework to give a comprehensive understanding of the dynamics of the knowledge-sharing process in more detail. This model was developed from his extensive reviews of the network and organizational learning literature, and identified five primary contexts that affect successful knowledge-sharing implementations: relational, knowledge, recipient, source and upstream context.

Chapter 4 will provide a brief explanation of the qualitative approach of this research project and analysis of the 13th Training Course that was primary focus of this research. This chapter also discusses the data collection methods this study used to analyze the effectiveness of the training course: document review, observation, semi-structured interviews, and questionnaire survey. The analytical framework is based on Cummings' knowledge-sharing model.

Chapter 5 discusses the core of the research findings from each context of the knowledge-sharing. First, the *relational context* is the relationship between South Korea and participant countries in the training course. Consistency in administrative controls, physical distance, and the knowledge gap between the source and recipient, and credibility of South Korea's knowledge with the trainees will be addressed under the relational context. *Knowledge context,* which is contents and characteristics of knowledge transferred in the training course, analyzes explicitness and embeddedness of South

Korea's knowledge in the training course, and examines its applicability and transferability into the trainees' local context for lesson-drawing. *Recipient context* is the trainees' motivation, intent, empirical knowledge, and retentive capacity. It discusses how these contextual factors affected the effectiveness of the knowledge-sharing initiative in building LMICs' policy capacity. *Source context,* which is defined as characteristics of a knowledge giver, highlights South Korea's teaching and learning culture, knowledge-sharing capability, and the country's strategic intent behind the knowledge-sharing initiative. Lastly, *upstream context* is understood as the broader social, cultural, and political environment where knowledge is applied. This will primarily focus on the broader contextual factors of South Korea's successful UHC achievement that the training course failed to address – the country's unique political economy that brought about the 'Miracle on the Han River' and a sufficient provision of trained workforce of health professionals. I will discuss how this failure to address broader contextual factors impedes effective capacity building for the trainees.

The final chapter reiterates the findings and highlights the opportunities and challenges of South Korea's knowledge-sharing initiative for UHC in LMICs. The thesis reveals that South Korea's remarkable success on UHC did not necessarily make the country the 'best teacher' to help the stakeholders in LMICs develop their capacity to design and implement effective health care systems within their countries. This was because of South Korean stakeholders' de-contextualized knowledge, which neglects important social, political, and cultural contextual factors that drove the country's successful achievement of UHC. This failure to address the upstream contexts of its health care system prevented effective lesson-drawing for LMICs. In other words, the

challenges were less about the value of South Korea's knowledge and experience per se, and more to do with cross-cultural rigidities that hindered applicable and transferable policy lessons to effectively address local conditions in the trainee's own health care system to achieve UHC. Unfortunately, the training course was closer to simply providing 'policy manuals' for techniques and mechanisms that South Korean national health insurance systems use, rather than sharing the country's success and failure in the course of achieving successful UHC within contexts of economy, politics, society, and culture. Simply put, South Korea's unique UHC program is based on a unique socio-economic geography, and an inimitable development history. It cannot easily transfer into UHC capacity building of LMICs today. This shortcoming in South Korea's knowledge-sharing initiative hinders its effectiveness in building capacity for the stakeholders in LMICs to develop and implement their health care systems for achieving UHC in their countries. Finally, this thesis concludes with some reflections on the challenges of the UHC project, but also discusses important lessons for other emerging donor countries that offer non-monetary support in the form of shared expertise for UHC development in the global South.

CHAPTER 2 LITERATURE REVIEW

This chapter serves two purposes: to provide background information about South Korea's knowledge-sharing effort for UHC and to place this case within the broader development objective of capacity building. Serving these roles assists in identifying a literature gap, and in turn developing the research question of this project: "Is South Korea's knowledge-sharing initiative on UHC effective in building capacity for stakeholders in LMICs to design and implement UHC programs within their countries?"

2.1 Capacity Building for Improvement of Health System

Why is capacity building essential to achieve UHC?

As illustrated in Alley and his colleagues' (2015) research and many other studies (Annear et al., 2013; Adam et al., 2011; Forest et al., 2015; Pitayarangsarit & Tangcharoensathien, 2009; MENA Report, 2015; Legge & Gleeson, 2015), capacity building and institution-building is an often-sought goal to improve health care systems. Leadership and governance of health systems, also called 'stewardship', is described as the most complex, but critical, building block of any health system (WHO, 2010). The World Health Organization (WHO) states that the feasibility of UHC depends on, and indeed demands, the strong and concerted commitment of a broad spectrum of actors and sectors (2010). Many scholars, including Marmot (2013), Uneke et al. (2012), Kwamie (2015), and Keynejad et al. (2016), identify the lack of effective coordination and collaboration across different parts and sectors of health systems as one of the major challenges that many LMICs faces for moving towards UHC. Marmot (2015) analyzed that this was in part because of the limited leadership capacity to successfully implement

intersectoral initiatives that address the social determinants of health, and this advances the notion of "stewardship." Stewardship refers to the wide range of functions carried out by governments to achieve national health policy objectives that are conducive to UHC, such as improving overall levels of population health and promoting equity, coverage, access, quality, and patients' rights (WHO, 2015a). It is not just a product of government functionaries in ministries of health, but a political process that involves balancing competing influences and demands of diverse stakeholders in the intersectoral, socio-political environment within the health system operates (WHO, 2002). Stewardship requires a capacity to

> [maintain] the strategic direction of policy development and implementation; [detect] and [correct] undesirable trends and distortions; [articulate] the case for health in national development; [regulate] the behaviour of a wide range of actors - from health care financiers to health care providers; and [establish] effective accountability mechanisms ("Health systems", 20).

Building this capacity needed to carry out stewardship functions effectively is a key concern in many countries (Tangcharoensathien & Evans, 2013). Denis et al. (2014) defines policy capacity as "the capacity of government and other public actors to plan, develop, implement, and evaluate purposeful solutions to collective problems" (p.3). It is the combination of knowledge, skills, organizational resources, and experience necessary to identify, formulate, implement, and evaluate solutions to public problems (Frank et al., 2012). It is an essential determinant for transformative change in health reform (Frank et al., 2012). Policy capacity is thus viewed as a way of improving the ability of governments to understand and manage complex realities and to steer strategically with the aim of improving policy coherence (Parsons, 2004). In this sense, capacity building for UHC refers to enhancement of the knowledge, skills, organizational resources, and

experience of the stakeholders working towards UHC. South Korea, as an emerging donor, embraces capacity building as part of its foreign policy of development assistance in global health. Its knowledge-sharing initiative for UHC aims particularly to enhance the policy capacity of the leadership in LMICs.

2.2 KNOWLEDGE-SHARING FOR CAPACITY BUILDING

Why does knowledge matter for South Korea's global quest for UHC in LMICs? How should the knowledge be translated?

2.2.1 Knowledge-based Development

In the conceptualization of its knowledge-sharing initiative, knowledge of UHC is a desired commodity controlled by South Korea, and it is sought after by LMICs. This knowledge is a key source of South Korea's development assistance program to support capacity building of the stakeholders in LMICs working toward UHC. Many scholars have vigorously addressed 'knowledge' as an indispensable part of capacity building (IDRC, 1989; Dahlman, 1999; Kingo, 2004; King & McGrath, 2004; Persoon et al., 2007; Borda-Rodriguez & Johnson, 2013; Ariff et al., 2014; Osei-Bryson el al., 2014; and Enns, 2015). Ludin (2003) argues that we are entering into the era of *"knowledge-based development"*, a new paradigm that defines development co-operation not only in terms of the transfer of material resources, but also the transfer of 'knowledge' (p.1). As one of the forerunners in developing an understanding of capacity building, the United Nations Development Programme (UNDP) believes that knowledge is the foundation of capacity (UNDP, 2003). To strengthen policy capacity of stakeholders in LMICs, the UNDP has established "Knowledge Networks" and has provided "Knowledge Services" since 1999 through which the organization shares advice, expertise, and experiences with

programme countries regarding development issues (Henderson, 2005, p.21). The World Bank (2005) also highlighted that capacity effectively translates into the knowledge of what to do and how to do it, and the capability to transform that knowledge into effective decisions and actions to solve development problems for both the short and long-term.

2.2.2 Type of Knowledge in Development

Many types of knowledge have a role to play in improving policy and practice in development. Jones et al (2009) categorized development knowledge into three different knowledge types by the source of knowledge: research-based knowledge (driven by academia), project and programme knowledge (driven by state development agencies and non-governmental organizations), and participatory knowledge (driven by citizens and community at grass roots level) (p.7-8). It is technical project and programme knowledge among these groups that South Korea's knowledge-sharing initiative on UHC aims to share, labelling it as "expert knowledge."

Project and programme knowledge is the "knowledge generated during the implementation of development projects and programmes, often generally from public policies of the state," such as health care (Jones, Datta & Jones, 2009, p. 7). It can be valuable source of policy advice. Ramalingam and Jones (2008) state that project and programme knowledge, generally focused on learning and/or accountability, can inform policymakers about the viability of a development model, and give implementing agencies a means of monitoring progress or generate solutions to a specific problem. This sort of 'feedback', they argue, is critical to ensuring the effectiveness of development work (p.27).

Nevertheless, mobilizing this technical project and programme knowledge also faces several challenges. Knowledge of this nature is often relatively context specific (Jones, Datta, & Jones, 2009). In other words, strategic know-how that works in one place may not work in another. How to overcome cross-cultural rigidities is a key challenge to be addressed for the successful translation of project and programme knowledge. Internalization of the knowledge may also be hindered by power structures in development agencies, with pressures for staff to filter, regulate and fit information into prevailing management processes and frameworks (Mosse, 2006). Moreover, information about 'failed' development projects is rarely published. As discussed in the previous chapter, South Korea's UHC programs were driven by its unique upstream political and economic factors, such as extraordinary economic growth, the authoritarian government's strong political leadership, introduction of social security system as a source of political legitimacy, and a sufficient provision of trained health workers. While these upstream factors cannot be separated from the success of UHC in South Korea, the "knowledge" being shared as development assistance is entirely technical, and fails to address broader social, economic, and political contexts.

2.2.3 Knowledge Translation

When development experts mobilize project and program knowledge, the knowledge goes through the process of repackaging to make it more applicable and transferable to potential users. This process is called "knowledge translation," and it is achieved by synthesising results in a way that fits with an audience's way of seeing the world and promoting activities to encourage knowledge sharing and exchange (Jones,

Datta, & Jones, 2009, p. 30). In other words, knowledge translation is informed by a desire to bring about positive developmental changes rather than assume that knowledge is merely out of the creator's hands once it is published. Knowledge translation strategies therefore need to be tailored to specific audiences, contexts and stages of the policy process.

However, little is known about how South Korean stakeholders translate the knowledge about their UHC programs for their knowledge-sharing initiative. The initiative targets stakeholders in LMICs who are actively involved in introducing and developing government-initiated health insurance programs in their countries. The question remains as to whether South Korean stakeholders translate their knowledge about the country's successful UHC programs in a way that enables this knowledge to empower these key actors in LMICs. Does the knowledge-sharing initiative encompass appropriate knowledge translation strategies that lead to effective capacity-building for these stakeholders in LMICs to develop and implement UHC programs in their own countries?

2.3 "Miracle on the Han River" in Global Health

Why does the global South want to hear from South Korea about UHC?

South Korea has a remarkable development history as one of the world's most rapidly industrializing countries. After the Korean War (1950-1953), the country was devastated and its GDP per capita was only $64, making it one of the poorest countries in the world. Economically, in the 1960s it lagged behind the Democratic Republic of the Congo (DRC), and was approximately at the same level as Ghana and Sudan. For most of the post-war period, South Korea was an aid recipient. The country received USD 12.7

billion between 1945 and the late 1990s, primarily provided by the United States, Japan and the European DAC members (OECD, 2008). The Korean government successfully utilised this financial assistance to overcome domestic poverty and to spur economic development through state-led projects (Kim, 2011; Evans, 1995). Finally, South Korea, in just five decades, became the world's 11st largest economy with $25,022 per capital income (World Bank, 2017). In the year 2000 the country was removed for the final time from the recipient list of the OECD-DAC. After ten years, South Korea became a donor nation after a long history of being a recipient nation. The country became the 24th member of the OECD-DAC, marking the first time that a country transitioned from aid recipient to DAC member since the OECD was established in 1961 (OECD, 2008; Roehrig, 2013).

This "Miracle on the Han River" also happened to the country's public health care systems. From the introduction of social health insurance in 1977, it took only 12 years to bring coverage to its entire population (Chun et al., 2009). South Korea's national health care system that achieved UHC within such a short time period has been operating sustainably to this day. Indeed, it is recognized as one of the most efficient health care systems in the world, having ranked fourth on the Bloomberg Health-Care Efficiency Index[1], after Hong Kong, Singapore, and Spain (Bloomberg, 2016).

[1] Using sources from World Bank, International Monetary Fund, World Health Organization, Hong Kong Department of Health, Bloomberg ranked countries based on the efficiency of their health-care systems. Each country was ranked on three criteria: life expectancy (weighted 60%), relative per capita cost of health care (30%); and absolute per capita cost of health care (10%). Within each criterion, 80% of the score was derived from the most recent health-care system assessment and 20% to changes, if any, over the previous year. Relative cost is health cost as a percentage of GDP. Absolute cost is total health expenditure, which covers preventive and curative health services, family planning, nutrition activities and emergency aid. Changes were measured by baseline-adjusted life

What, then, enabled South Korea to succeed in providing health insurance to the whole nation within 12 years? Literature highlights general facilitating factors that speed up the transition to UHC: economic factors (level of income, structure of economy), demographic factor (distribution of population), social factor (ability to administer), cultural factor (solidarity), and political factor (stewardship) (McIntyre et al., 2013; Kwon, 2009; WHO, 2004; GTZ, 2005; Carrin & James, 2005; Ensor, 1999). South Korea demonstrated itself to be an "outstanding example" of achieving UHC in the shortest period of time in history, based on these contextual factors (Do, Oh, & Lee, 2014). There was strong leadership to move UHC forward in Korea under the authoritarian political regime (Kwon, 1999). This was coupled with sufficient conditions of economic development driven by a series of 5-year Economic Development Plans commencing in the early 1960s. This brought greater income for the government, enterprises and households, which resulted in a higher capability to contribute to health insurance. More employment in formal sectors created by rapid industrialization and the consequent urbanization also facilitated the government's premium collection (Kwon, 2009). In addition, strong public aspirations for better and affordable health care created a high level of solidarity within Korean society for UHC. It was active public advocacy work by civic groups founded in the 1980s that highly contributed to raising the awareness of such social citizenship rights (Chun et al., 2009, p.31). Citizens began to actively ask governments to provide social protection for the population, explicitly addressing 'right

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expectancy improvements, relative health-care cost increase, cost increase relative to increase in general income and consumer prices, and absolute per capita health-cost increase in U.S. dollar terms. Countries were scored on each criterion and the scores were weighted and summed to obtain their efficiency scores. Included were countries with populations of at least five million, GDP per capita of at least $5,000 and life expectancy of at least 70 years.

to health'. The hard-working culture of newly established public sector organizations in South Korea also contributed to the active enforcement and collection of premium contributions from local residents (Kwon, 2009). Two important organizations were newly founded to fulfill their own stewardship responsibilities: NHIC (National Health Insurance Corporation)[2] in 1997 to set the strategic direction of development and implementation of national health insurance scheme, and HIRA (Health Insurance Review and Assessment Service) in 2000 to monitor undesirable trends and distortions and regulate the behaviour of a wide range of stakeholders in health care.

To summarize, the key underlying elements to the upstream context of successful UHC programs in South Korea are unprecedented economic growth (economic factor), strong political leadership (political factor), a boom in urban populations and formal sectors employees (demographic factor), and solidarity for the creation of a strong social security system among the citizens and bureaucrats (social and cultural factor). All of these economic, political, demographic, social, and cultural factors meant that Korea was able to drastically slash the transitional period needed to achieve UHC in South Korea from historic norms.

2.4 "SHARE THE KOREAN RECIPE", BUT UNMET DEMAND

How does South Korea respond to growing demands to share knowledge about UHC from the global South?

This dramatic success of South Korea in achieving UHC means neither that its health care system is flawless nor that it is the best model to secure progress towards UHC for other LMICs today. The moral foundation of UHC may differ from country to

[2] Now called NHIS (National Health Insurance Service)

country. For example, the moral foundation of South Korea's UHC is 'universal access.' That is, health benefits should reach all the citizens without financial, social or political barriers. Access to health insurance must be guaranteed regardless of an individual's socio-economic status or pre-existing conditions. Thus, South Korea's national health insurance system was primarily designed for complete population coverage (Na & Kwon, 2015). The country's Social Health Insurance (SHI) program, which is the backbone of UHC in South Korea, requires mandatory enrollment. Moreover, from the beginning, the SHI adopted family-based membership by which dependents become members of the scheme that their household head was enrolled in (Kwon, 2009, p.64).

However, this model may not be the best fit for other LMICs. They may have different moral foundations for their UHC programs, such as protecting people from financial risk associated with ill health, enhancing primary health care (PHC), achieving health equity, driving better health and development outcomes, and increasing the quality of health services. Thus, there is no "one size fits all" design for governance and structures of health care systems that is conducive to attaining UHC (Missoni, 2010, p.14). A country's UHC program is likely be designed differently based on its moral foundations, which are in turn driven by its social values, laws, traditions, cultures and best professional practices. South Korea's strong focus on universal access to health care of the total population imposes inevitable trade-offs in other principles of UHC, such as full financial protection (therefore requiring co-payments, user fees, user charges, and other direct out-of-pocket payments), and a comprehensive benefit package that meets the full range of health care needs.

Nevertheless, having witnessed South Korea's rapid achievement of UHC, policymakers in many LMICs are willing to learn lessons from South Korea's experience to develop their policy capacity. Recently, there has been active knowledge-sharing partnerships between South Korea and many LMICs in many different forms, including policy consultation for partner countries, modularization projects, collaborative research, memorandums of understanding (MOU), and training programs. Indeed, South Korea actively, and officially, endorsed knowledge-sharing in its development cooperation efforts through the *Strategic Plan for International Development Cooperation* enacted in October 2010. The enactment explicitly highlights the strategies pursued to share the country's unique development experience to make meaningful contributions to LMICs' capacity development for their own sustainable development (Kim & Tcha, 2012).

Despite the spur in knowledge-sharing initiatives, however, a recent study shows that these efforts do not satisfy the partner countries' needs for capacity development. Alley and his colleagues (2015) examined perspectives from partner countries on South Korea's health aid governance. They conducted a survey where 26 government officials from 22 different countries (54% South-Eastern Asia, 31% Africa, 8% Central Asia, and 8% Western Asia) were asked questions about the types of support that they actually receive from South Korea's agency and the types of support they would like to receive. The top three types of support where the highest number of respondents would like to have received were "*providing equipment, vehicles, supplies, and services"* (91%), "*supporting training and institution-building related to enhancing health"* (91%), and "*strengthening national capacities for policy and strategy development for health"* (82%) (Alley et al., 2015, p.151). Despite the strong demand placed on capacity development,

the assistance they actually received in this sector fell significantly short of their demands. The percentage of respondents who noted that they "actually received" assistance in *"supporting training and institution-building"* and *"strengthening national capacities for policy and strategy development for health"* was 73% and 9%, respectively. The authors explained this discrepancy by the fact that provision of capacity development services requires a donor itself to have a very high level of capacity, which in the case of a new donor like South Korea, may still be developing (Alley et al., 2015).

In a nutshell, "Miracle on the Han River" did not happen twice. While getting support on capacity development and institution-building are of key interest to LMICs for their health care systems, South Korea has yet to meet these LMICs' interest. Alley and his colleagues' study (2015) gives significance to not only South Korea's knowledge-sharing initiative for UHC itself, but also their effectiveness in tackling the issue of limited "policy capacity" in LMICs.

2.5 Summary

Far too little work has been done on the effectiveness of knowledge-sharing initiatives in global health that build capacity for stakeholders in the global South. Moreover, what deserves more attention is emerging donor countries' knowledge-sharing initiatives, capitalizing on their own recent development experiences and knowledge in their international development cooperation. Little attention has been given to the conceptual dynamics, empirical challenges, and opportunities of emerging donors' knowledge-sharing activities in global health. This thesis attempts to address this gap by providing critical and insightful analysis on the effectiveness of South Korea's global

promotion of UHC from multiple angles of cross-cultural knowledge-sharing, such as health aid, diplomacy, organisational learning, and capacity building, beyond simply writing a program evaluation. The next chapter outlines overarching theories this study makes use of, to fully understand those angles and to situate the challenges and opportunities of South Korea's knowledge-sharing initiative for UHC in the context of global health cooperation.

CHAPTER 3 THEORETICAL FRAMEWORK

This study analyzes how effective South Korea's knowledge-sharing initiatives on UHC have been in building capacity for stakeholders in LMICs to design and implement programs within their countries. First, in order to frame the conceptual approach toward UHC, this chapter introduces the "human security" paradigm, shedding light on fundamental guiding principles that the paradigm provides for UHC as a development strategy. Before investigating the effectiveness of the initiative, the nature of a transnational knowledge-sharing initiative in public policy needs to be fully understood. For this, Richard Rose's (1991) theory of lesson-drawing will be utilized. Finally, Cummings' (2003) knowledge-sharing model serves well as a theoretical and analytical framework of this study to examine the effectiveness the Korean UHC knowledge-sharing initiative in capacity building. The model implies that knowledge-sharing is not merely giving out knowledge and information. Instead, it is a complex political, social and cultural process of interactive knowledge exchange and development. The model's approach to a knowledge-sharing framework based on the dynamics of contextual factors lends itself well to the perspective that 'knowledge' cannot be separated from the context of 'knowers' and so it is developed and transmitted essentially in social situations (Berger & Luckmann, 1966; Schutz & Luckmann, 1985). These three theoretical lenses – the *human security paradigm, Rose's lesson-drawing,* and *Cummings' knowledge-sharing model* – effectively situate the main research question of this study in the narratives of global health and international development.

3.1 LENS OF HUMAN SECURITY

Achieving UHC is an ambition of many LMICs, and an important target for the United Nations Sustainable Development Goals. However, there is no unanimity when it comes to its conceptual definition or scope, or how to move towards it. As a legal concept, UHC implies the existence of a legal framework to ensure that every resident gets access to affordable health care (Stuckler et al., 2010; Bárcena, 2015; Scheil-Adlung & Bonnet, 2011). As a humanitarian social concept, UHC is the notion of universal population coverage under health-related social security or risk protection systems (Savedoff et al., 2012; Knaul et al., 2012; WHO, 2010). It can also be viewed as a broader means to improve population health, such as in Cuba. Cuba's health system is based on primary health care (PHC) and focuses on health promotion and disease prevention (Huish, 2013). The country's special efforts to extend health services by establishing rural medical services were designed to prevent disease and to provide health services to rural, underserved communities, notably poor and vulnerable populations (Abiyemi-Benita, 2016, p.326). As a health economics concept, UHC can be a means of financial protection against the catastrophic and impoverishing consequences of out-of-pocket expenditure, through the implementation of pooled prepaid financing systems (Palmer et al., 2004; Xu et al., 2003). Here, different countries may adopt different modes of health care financing; for example, tax-based revenues[3] versus social health insurance (SHI) contributions[4]. Many LMICs are developing hybrid health financing systems that mix SHI contributions and general taxation revenue (Maeda et al., 2014).

[3] So-called the "Beveridge model" in the UK, Sweden and New Zealand (Immergut, 1992).
[4] So-called the "Bismarck model" in Germany, Australia, Canada, Japan, Singapore and South Korea (Barnighausen & Sauerborn, 2002; Kutzin et al., 2009).

Regardless of its ideological concepts and modes, the lens of "human security" (Axworthy, 2001) offers some useful and fundamental guiding principles for the moral foundations of UHC as a development objective. This paradigm for understanding global vulnerabilities, first coined in the early 1990s, argues that the emphasis of security should be on the well-being of the individual rather than the state. While some scholars such as Krause (1998), Mack (2004), Macfarlane (2006), Suhrke (1999) and Paris (2001) argue for the narrow conceptuatlisation of human security, "*freedom from fear*", privileging violence as the primary threats in the security thinking, other scholars such as Leaning (2000), Alkire (2003), Thakur (2004), Bajpai (2000), and Winslow and Eriksen (2004), advocate its broad conceptualization, "*freedom from want*". They argue that human security is something more than safety from violent threats, emphasizing a broader understanding of human vulnerability including poverty, disease and environmental disasters. This study takes the wide conception of human security since it effectively addresses the linkages among different sources of health threats and calls for structural interventions so as to build and sustain health resilience at the individual, community, and institutional levels as a path toward health for all through UHC (Korc et al., 2016).

3.1.1 People-centred Approach

Human security shares many principles with UHC. First, human security is an intrinsically people-centred approach. This is well articulated by the former Canadian Foreign Minister Lloyd Axworthy, known as one of the founding fathers of human security, in his work "Human Security and Global Governance: Putting People First" (2001). The emergence of the norm of human security prioritizes individuals' security

over national security and conceptualizes illness and its consequential financial crisis as the real threat to the security of "individuals". Putting people first, human security advances a rights-based approach for UHC (Gruskin et al., 2012). This suggests that UHC could be anchored in the 'right to health' as was clearly portrayed in the goal of the Alma Ata Declaration, "health for all" (Stuckler et al., 2010; Oxfam, 2013; Forman et al., 2013; Fried, 2013; Hammonds & Ooms, 2014). However, the implementation of UHC is often done through a framework of cost and benefit.

3.1.2 Context-specific Approach

The context-specific approach of human security also provides a guiding principle for designing and implementing UHC policy. As a people-centred approach, not security-centred or system-centred, the human security paradigm emphasizes the importance of contextualized solutions that require decentralized systems and capacity at the local level (Korc et al., 2016). This is because human insecurities vary as they are uniquely shaped by complex forces in each community and in each nation, which suggests that a one-size-fits-all approach will not be the best way to mitigate people's insecurity. Thus, the important question in designing UHC programs is: "what is the local-specific context of the region's public health care and how do health decisions take that context into consideration?" Many scholars note that internationally recognized health care systems might contradict a country's national health policies and priorities for its people, and their cultural practices (Korc et al., 2016; Bredenkamp et al., 2015; Marchal, Cavalli, & Kegels, 2009; Abiiro, Mbera, & De Allegri, 2014; Scammell et al., 2016). LMICs are not a homogeneous group, and the root causes of their vulnerability in health care are very

country-specific and local-specific. A human security approach recognizes this reality, and provides insights into the ways different health threats and vulnerabilities interconnect in different countries. Thus, the key to successful UHC programs is how to effectively tackle these challenges in the local setting and in the context of other related challenges, such as poverty, political insecurity, unemployment, lack of education, and geographic disparity in both quantity and quality of health care facilities and services.

3.1.3 Preventive-Oriented Approach

Such contextualized solutions are fundamentally aimed to prevent both financial and health threats from becoming sources of insecurity. In other words, human security is preventive-oriented approach (Brown & Rosecrance, 1999). Its concern is "early prevention" as opposed to "late intervention" (UN Human Security Unit, 2009, p.14). Moving towards UHC is a fundamental reformation of health system to prevent people from both being impoverished by illness and further deterioration of their health. For example, Sierra Leone took an ambitious approach to reducing financial barriers on access to health care by introducing the Free Health Care Initiative (FHCI) in 2010, which offers free care in public facilities for pregnant and lactating women and under-fives. The country, which has one of the highest maternal mortality ratios in the world (857 per 100,000) (MOHS, 2010), took an approach to offer free care for high priority users, protecting them from the financial burden of using necessary medical care. However, this selective and targeted health insurance scheme could lead to unintended consequences, such as undermining the improvements in maternal and child health services, and crowding out other sectors of public health spending (Witter et al., 2016).

3.1.4 Comprehensive Perspective and Multisectoral Framework

Human security and UHC also share a comprehensive perspective and multisectoral framework to address human insecurity (Korc, Hubbard, Suzuki & Jimba, 2016). Human insecurity, including disease and poverty, is rooted in interrelated and interdependent economic, societal, cultural, demographic, and geo-political factors. UHC is to be achieved when all health service dimensions, including financing systems, administrative capacity, and local service delivery capacity, are addressed interdependently and through a multidisciplinary vision at the individual, community, and national level.

All of the components of human security discussed above lend themselves well to the fundamental reasoning of UHC. It is important to note that achieving all those components requires careful and strategically designed actions through the establishment of the rule of law and social protection instruments by governments. Thus, the lens of human security gives substantial weight to the importance of 'capacity' of those actors, discussed in the previous chapter, whose responsibility is to protect and provide services to achieve the sustainable development goal for health.

3.2 Richard Rose's Lesson-drawing

The human security paradigm shows that challenges in a nation's health care system are very local-specific and context-specific, but they require a comprehensive approach to address, with careful and strategically designed policy actions that are driven by collective policy ideas of the relevant stakeholders. The question then arises as to how the stakeholders garner ideas about how to best tackle their current challenges.

Richard Rose (1991) argues that policymaking is often a result of 'lesson-drawing' of state actors using previous experience to develop solutions to current policy problems. He defines 'lesson' as an "action-oriented conclusion about a programme or programmes in operation elsewhere"; because policymakers are action-oriented, a lesson focuses upon specific programmes that governments have adopted or may adopt (Rose, 1991, p.7). Lessons are drawn through policymakers' dissatisfaction with the status quo and decisions that a programme elsewhere may be capable of being put into effect in their environment (Rose, 1991). Throughout his best-known works, including, "Lesson-drawing in public policy: A guide to learning across time and space" (1993), "Future governance: Lessons from comparative policy" (2001) and "Learning from comparative public policy: A practical guide" (2005), Rose established ways in which policymakers use foreign examples as sources of inspiration and establish new ones more adapted to the modern era. The formation of knowledge-sharing networks for this cross-national practice of policy advice gives South Korea an opportunity to develop a powerful narrative of the country's successful pathway to UHC and to share this with LMICs aiming to achieve UHC. This is the core strategy of South Korea's 'trust diplomacy' in global health, discussed in the previous chapter.

Lesson-drawing can take many different forms. Rose suggests several ways of lesson-drawing, from "copying", to "emulation", "hybridization", "synthesis" and "inspiration" (Rose, 1991, p.21-22). 'Copying', in the context of South Korea's knowledge-sharing initiative, would mean that the trainees from LMICs use South Korea's National Health Insurance Service (NHIS) literally as a blueprint. 'Emulation' would be adoption of NHIS with adjustment for contextual differences, taking their own

national circumstances into account. The trainees can also pursue 'hybridization', by combining elements of South Korea's NHIS with their existing UHC programs. They can even create a new UHC program by combining familiar elements from South Korea's NHIS with other countries' successful UHC programs, which Rose would call 'synthesis.' Finally, South Korea's health care system may not be used to suggest any specific and direct policy actions, but instead provide an intellectual stimulus to develop a novel UHC program in the trainees' countries, that is, serving as 'inspiration'. These dynamics of lesson-drawing practice provide an insightful framework to look into how South Korea's experience in achieving UHC can be utilized by the policymakers in LMICs as a promising source of copying, emulation, hybridization, synthesis, or inspiration to develop their own UHC programs in their country.

The concept of lesson-drawing explains the rationale behind South Korea's knowledge-sharing programs for UHC. The country tried to take the initiative in formulating global knowledge of UHC. South Korea's evidence-based policy recommendations for other LMICs derived from its own UHC achievement experience represent the country's highly specialised expertise. This proven expertise throughout the last four decades enables South Korea to make legitimate claims to being the main producer of knowledge in health care systems. However, a distinguishing feature of lesson-drawing is concern with the *transferability* of a programme from one place to another (Rose, 1991). In other words, the critical question in lesson-drawing is whether a programme that is successful in one setting can be transferred to another. Policymakers take into account various factors for transferability, from policy content, structure, instrument, and administrative techniques to the broader context, such as the policy's

overarching goals and ideology. Thus, how South Korean stakeholders present these various factors of their UHC programs in their cross-cultural knowledge-sharing initiative will be an important analysis to measure its success as an effective capacity building program for LMICs, especially concerning upstream determinants of UHC.

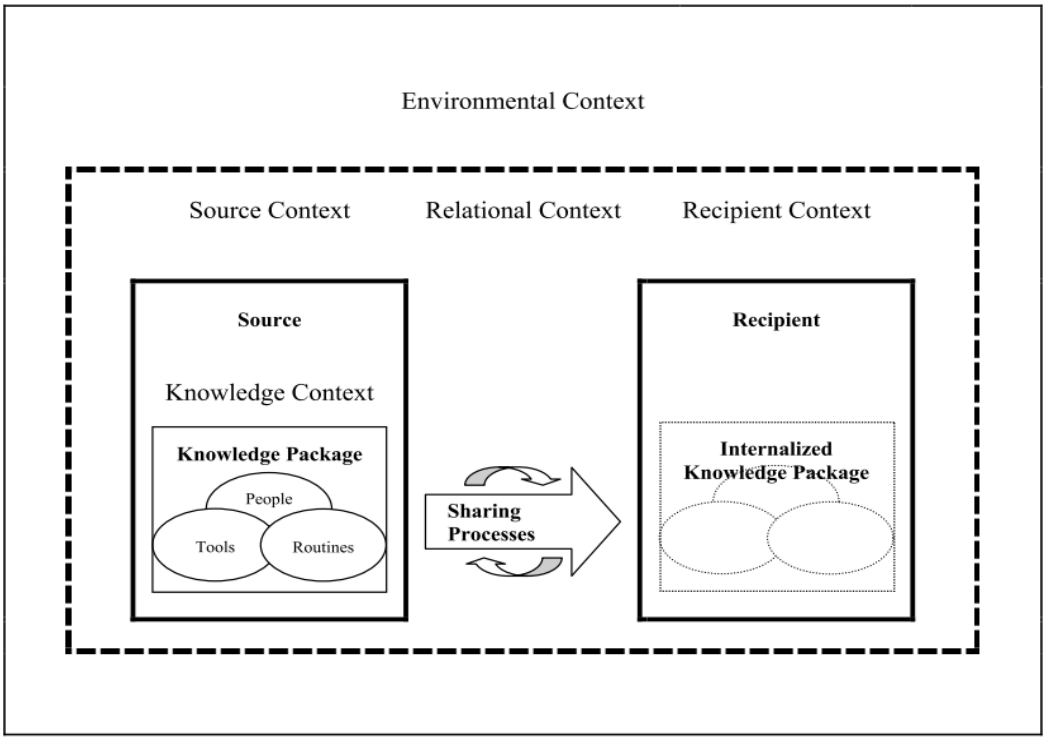
3.3 Cummings' Knowledge-sharing Model

The ultimate destination of lesson-drawing through the knowledge-sharing initiative is capacity building of the stakeholders in LMICs who are actively involved in developing UHC programs in their own countries. Kostova (1999) argues that *knowledge internalization* is the indispensable process necessary to achieve this ultimate goal. In other words, only when a recipient internalizes knowledge can it be sufficiently understood and adapted by the recipient to allow for its effective re-creation and, ultimately, its appropriate use in their own local contexts. A genuine capacity building of the trainees is realized when the knowledge becomes *theirs*. This suggests that South Korea's role in its knowledge-sharing program is not just enumerating a series of policy options the country took to achieve UHC, but making sure the implications and lessons from this experience are properly delivered in such a way that the stakeholders from LMICs effectively internalize this knowledge.

The question is, then, whether South Korea successfully facilitates their knowledge internalization. Cummings' knowledge-sharing model (2003) provides valuable insights to answer this question. This model was developed from his extensive reviews of the network literature and organizational learning literature, but it also serves well as a useful theoretical framework to analyze the effectiveness of knowledge-sharing

practices in international development. As illustrated in Figure 2, he identified five primary contexts that affect successful knowledge internalization: *relational* context, *knowledge* context, *recipient* context, *source* context, and *environment* context (Cummings, 2003). Again, the degree of a recipient's internalization of knowledge is one of the most compelling criteria to gauge the success of knowledge-sharing since it directly affects the capacity building of the knowledge recipients (Kostova, 1999). The details of each of these five contexts and why they matter to capacity building of the stakeholders from LMICs will be discussed below.

Figure 2 Conceptual Model of Knowledge-sharing (Cummings, 2003)



Source: Cummings, J. (2003). *Knowledge Sharing: A Review of the Literature*, Washington, DC: Operations Evaluation Department (OED), World Bank.

3.3.1 Relational Context

The *relational context* refers to the relationship between the knowledge source and recipient. First, this relationship is affected by "the quality of common past experience of the knowledge source and recipient" (Cummings, 2003, p.17). Trust, which develops best from their past experiences with each other, is considered "the single most important precondition for knowledge-sharing" (Snowden, 2000, p.239) since it is a key factor affecting a knowledge recipient's willingness to accept the knowledge shared by a knowledge source (Roberts, 2000). The trust may develop at the individual level, organizational level, and/or national level. Thus, it is important to look at how the trainees from LMICs and their organization joining South Korea's UHC capacity-building program perceive their past development work experience with South Korean stakeholders or the affiliated organizations. The relational context emphasizes the importance of credibility of South Korea's policy advice in global health diplomacy with LMICs.

The "free-flow of communication and consistency in administrative controls of both the source and recipient" is also an important determinant of relationship context (Cummings, 2003, p.11). According to Cummings (2003) knowledge internalization is likely to be greater to the degree that the units interact through defined, structured organizational arrangements, rather than through ad hoc processes (p.11). Quality of communication, including language, matching organizational culture, norms, and styles between the knowledge recipient and source, can facilitate or hinder effective knowledge-sharing process in cross-cultural knowledge-sharing programs.

The knowledge gap between source and recipient matters too (Cummings, 2003, p. 15). If the gap is too large, it is very likely the intellectually limited stakeholders cannot assimilate the received knowledge, thus hinder knowledge internalization. Capacity building of the stakeholders in LMICs is done through their active analysis and evaluation of South Korea's UHC programs and voluntary application to their local health care context. If the knowledge gap is too large, this is not likely to happen.

3.3.2 Knowledge Context

Another important context of Cummings' knowledge-sharing model is *knowledge context* (Cummings, 2003). The model addresses two major factors of knowledge context: knowledge *embeddedness* and *explicitness*. Knowledge embeddedness can be understood as where the knowledge is embedded. The expert knowledge shared in South Korea's knowledge-sharing initiative is embedded in many different groups of people who were actively involved in developing the nation's health care system in South Korea throughout the last thirty years. The question is 'whose' knowledge is shared in the knowledge-sharing initiative (i.e. that of policymakers, administrators, academics, or health professionals) and to what extent it can be internalized into the counterpart group of LMICs.

In terms of knowledge explicitness, researchers distinguish between two main types of knowledge: tacit and explicit (Nonaka, 1994; Polanyi, 1996). Tacit knowledge is hard to communicate and deeply rooted or embedded in action, involvement, and commitment within a specific context, such as 'know-how' (Nonaka, 1994; Cohen & Bacdayan, 1994). Explicit knowledge is knowledge that can be readily verbalized, written,

drawn or otherwise articulated (Zander & Kogut, 1995). The logic behind this taxonomy is that explicit knowledge is more easily transferable than tacit knowledge. However, does this mean that explicit knowledge is more helpful to build capacity of the stakeholders from LMICs than tacit knowledge? What type of knowledge do the stakeholders from LMICs want to see being shared in the knowledge-sharing initiative? What are the values of this hard-to-transfer tacit knowledge of South Korean stakeholders who directly experienced development of UHC programs? All these questions raise the issue of how effectively South Korean stakeholders translate the country's unique experience of achieving UHC into a desired type of knowledge that can provide valuable lessons for capacity building of the stakeholders from LMICs.

3.3.3 Recipient Context

Recipient context, which includes the knowledge recipient's motivation, intent, empirical knowledge, and retentive capacity may also affect the extent and effectiveness of knowledge internalization (Cummings, 2003). South Korea attracts an average of 250 health policy officials from 30 countries each year, providing them with different health insurance courses and training programs. What matters is whether the knowledge shared in these courses and programs are aligned with the needs of LMICs to achieve their aim of health for all. Sharing program-specific knowledge might not effectively address the local health care challenges that LMICs face. In other words, the search for key elements of South Korean UHC programs may be a step back from the broad goals of UHC as human security. South Korea's experience becomes less about how to make health for all, and more about how to fix gaps in existing systems.

Successful knowledge internalization also must involve the recipient's ability to invest significant time or other resources in new knowledge (Cummings, 2003). When knowledge is transferred to a willing recipient, the transfer will only be effective when the knowledge is retained (Glaser et al., 1983; Druckman & Bjork, 1991). Such retentive capacity allows the knowledge recipient to apply the newly acquired knowledge into his or her country's own health policy and systems. It is important to look at the extent to which South Korea's knowledge-sharing initiative helps improve the LMICs' retentive capacity, since this capacity might be a key prerequisite for them to put policy lessons – *ideas* – in their own health care system – *practice*.

3.3.4 Source Context

The main elements that constitute *source context* of knowledge-sharing efforts are the source's teaching and learning culture, knowledge-sharing capabilities, and strategic intent (Cummings, 2003). The source's teaching and learning culture affects the way in which knowledge is shared. Different knowledge-sharing methods based on different pedagogy can be employed in a knowledge-sharing program, and one might be more effective than another in facilitating the recipient's knowledge internalization. How South Korean stakeholders disseminate their expert knowledge of health care systems will be an important factor affecting the effectiveness of the knowledge-sharing initiative. Successful knowledge internalization through a knowledge-sharing program in global health also must involve the source's advanced knowledge-sharing capabilities, including competence in program design, coordination, and cross-cultural communication. South Korea tries to become a valuable knowledge source for health care systems so that the

country can step up to become the next global health and medical care service expert. The employment of appropriate knowledge-sharing methods and strong capabilities to run effective knowledge-sharing programs constitute an important element to realize this ambition.

At the same time, the knowledge source's strategic intent has an impact on knowledge-sharing effectiveness in capacity building (Hamel, 1991). Many knowledge-sharing situations are reciprocal rather than one way (Cummings, 2003, p. 30). The source's motivation to share knowledge for the recipient's capacity building might not be just for humanitarian reasons. Even if there are no strings attached to its knowledge-sharing initiative, South Korea expects to expand the country's medical industry to the emerging economies in the global South. Its strategic intent behind the UHC knowledge-sharing initiative is materializing and actualizing what the partner countries want in favour of its own interests in the health care industry, including pharmaceuticals, medical devices, and health-related ICT systems. This strategic intent behind the knowledge-sharing initiative is an important factor shaping the context of knowledge-sharing practices between South Korea and LMICs. The analysis on the source context of the knowledge-sharing initiative will provide a discussion on the extent to which the strategic intent of South Korea is aligned with that of LMICs and its local context, and how this affects the overall effectiveness of the initiative in building their capacity.

3.3.5 Upstream Context

The broad economic, cultural, political, and institutional environments surrounding the source and recipient of the knowledge-sharing efforts inevitably affect

the recipient's ability to internalize shared knowledge (Cummings, 2003). These upstream variables need to be examined to analyze how these factors play a role in affecting the micro-context variables of knowledge-sharing, such as knowledge context, recipient context, and source context. As discussed in Chapter 2, South Korea achieved UHC under very unique economic and political contexts (i.e. unprecedented economic growth from dire poverty to the world's eleventh largest economy and establishment of social security systems by the authoritarian regime). Given that many experts do not see these contexts as replicable in LMICs today, the question then is how South Korea enables LMICs to separate 'best practices' from such particular contexts and provides them with transferable and applicable policy lessons, not just simply advise them on how successful UHC programs require sufficient financial support and strong political will.

Cummings' knowledge-sharing model serves well as a useful theoretical and analytical framework that provides the overarching guidance to examine the broader context of knowledge-sharing efforts as well as their micro-context. The model helps better understand the comprehensive aspects of policy transfer in global health, and effectively situates this understanding in solving the key research problem of this study: the effectiveness of South Korea's knowledge-sharing initiative in building capacity for stakeholders in LMICs. The model's contextual dynamic lends itself well to this study's perspective on knowledge-sharing, emphasizing that it cannot be separated from the context of 'knowers' and so is shared essentially within their context.

3.4 SUMMARY

Is South Korea's cross-national knowledge-sharing initiative on UHC effective in building capacity for stakeholders in LMICs to design and implement UHC programs within their countries? A journey to find the answer to this question is aided by the synthesis of three theoretical lenses discussed in this chapter. The human security paradigm helps frame the complex concept of UHC providing guiding principles to move toward it. The paradigm's call for careful and strategically designed intervention to tackle human vulnerability also advances the significance of policy capacity of the policymakers that was examined in the previous chapter. The idea of Rose's lesson-drawing provides the rationale behind why health care policymakers in LMICs get together with South Korea and provides insights into what the knowledge-sharing initiative should promise them. Cummings' knowledge-sharing model lends itself well as a useful analytical framework to give a comprehensive understanding of the dynamics of knowledge-sharing process in more detail. These theoretical frameworks guide this empirical study on the effectiveness of South Korea's knowledge-sharing initiative, which will now be introduced in further detail in the next chapter with its focus on research design and methodology.

CHAPTER 4 METHODOLOGY

4.1 QUALITATIVE CASE STUDY

Qualitative methods were used to answer the central question of this research; "Is South Korea's knowledge-sharing initiative for Universal Health Coverage (UHC) effective in building capacity for stakeholders in the global South?" As illustrated in Cummings' knowledge-sharing model, the nature of knowledge-sharing dynamics is inevitably value-laden and context-based, which can be best investigated through a qualitative approach (Pawson et al., 2005; Walker & Duncan, 2007; Walker, 2004; Wang et al., 2005).

This research is an exploratory case study, which is used to examine those situations in which the intervention being evaluated has no clear, single set of outcomes (Yin, 2003). The intervention is explored through a variety of lenses which allows for multiple facets of the phenomena to be revealed and understood (Baxter & Jack, 2008). Knowledge-based development assistance encompasses complex phenomena of cross-cultural interactions within their contexts. The effectiveness of South Korea's knowledge-sharing initiative should be analyzed based on a thorough understanding of the economic, political, social, and cultural contexts of UHC programs in both South Korea and participating countries.

This study chose to closely look at the country's International Training Course on Social Health Insurance ("training course" hereafter) as a case that best represents the initiative, among other forms of activities such as a policy consulting program, collaborative research, and memorandum of understanding (MOU). It is a 2-3 week-long policy learning course on UHC targeting officials and experts in developing countries

who are actively involved in introducing and developing government-initiated health care or health insurance program in their countries. One of the reasons why I chose the training course is that it has the longest history in South Korea's knowledge sharing initiative for UHC. In close collaboration with the World Bank, World Health Organization Regional Office for Western Pacific (WHO/WPRO), and the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), the government has organized the training course every year, since 2004. It has been a consistent knowledge sharing activity for 13 years, being well recognized by the countries in the global South which aspire to achieve UHC. For this reason, this knowledge sharing activity boasts of the largest number of participants from the global South and the broadest geographic partnership, at a level that other activities have not reached. Approximately 470 officials and experts from 53 different developing countries have visited South Korea to participate in the training course since 2004.

The training course also explicitly sets out the aims of building "policy capacity" of stakeholders in the global South. They are high-level officials working for key organizations of health care systems in their countries, for example, Ministry of Health and national health insurance agency. The underlying theme of the training course is the concept of 'lesson-drawing' that Rose (1991) developed. Trainees aim to enhance their policy capacity through what many scholars have termed as 'policy band-wagoning' (Ikenberry, 1990), 'policy borrowing' (Cox, 1999), 'policy shopping' (Freeman, 1999) or 'systematically pinching ideas' (Schneider & Ingra, 1988). The training course was the best place to observe how one's knowledge is shared and transferred for another's policy capacity.

In addition, the training course is a collaborative event, which best represents South Korea's approach to knowledge-sharing initiatives. It is organized by all four key government entities in South Korea involved in the initiative, which are Ministry of Health and Wellness (MOHW) of Republic of Korea, National Health Insurance Service (NHIS), Health Insurance Review & Assessment (HIRA), and Korea Foundation for International Healthcare (KOFIH). Stakeholders from each entity have brought their own expertise and insights into the pathway for UHC.

4.2 Analytical Framework and Data

As discussed in the Chapter 2, Cummings' knowledge-sharing model (2003) provides a systematic lens to look into the knowledge-sharing dynamics and to analyze their effectiveness in terms of the lesson-drawing required for capacity building. Based on this model, this study examines relational, knowledge, recipient, source, and upstream contexts of the training course. Table 2 summarizes the specific qualitative data and information needed to understand each context. The study discusses how each contextual variable advances or hinders effective development of the trainees' capacity to internalize the transferred knowledge to put it into practice for UHC in their countries. These analyses on the effectiveness of the training course in turn will present the opportunities and challenges of South Korea's knowledge-sharing efforts for UHC in LMICs, and also give valuable lessons to other emerging donor countries that offer non-monetary support in the form of shared expertise for UHC development in the global South.

Table 2 Contextual Factors of Knowledge-sharing and Analysis Items

Contextual factors of knowledge-sharing	Qualitative information items
Relational Context	Quality and extent of common past experience
	Consistency in administrative controls
	Knowledge gap between trainees and South Korean stakeholders
	Credibility of South Korea's knowledge with trainees
Knowledge Context	Extent of knowledge explicitness (tacit/explicit)
	Knowledge embedded in where (people/tools/routines)
Recipient Context	Trainees' motivation
	Trainees' intent
	Trainees' empirical knowledge
	Trainees' retentive capacity
Source Context	South Korea's teaching/learning culture and knowledge-sharing capability
	South Korea's strategic intent
Upstream Context	Economic environment
	Political environment
	Institutional environment

4.3 DATA COLLECTION METHOD

4.3.1 Document Review

I reviewed the original copy of the Power Point slides of thirteen lectures and twenty-four country presentations by the trainees looking for the detailed contents of the knowledge shared in the training course. The former was of great help to understand the 'source' context of the knowledge-sharing initiative, and the latter for the 'recipient' context. The official invitations, promotional materials, and program reports from previous years were also reviewed to better understand the other contextual factors of the training course.

4.3.2 Critical Observation

I received permission to join the 13th Training Course which was held in Seoul, South Korea from July 12th to 21st, 2016. I went on-site and had an opportunity to observe every programs and workshops throughout the training course. Not only were the material and content of lectures, seminars, and discussion observed, but also the interaction and communication dynamics between the South Korean lecturers and the trainees from LMICs. I attempted 'critical observation' in order to address the research problem; whether the training course offers an effective capacity building opportunity for the trainees from LMICs to develop and implement their national health insurance systems. The main critiques included whether the lectures gave the trainees what they needed to improve their national health care systems, and whether the programs of the training course were designed in ways that facilitated the trainees' knowledge acquisition, lesson-drawing, and ultimately the application of the knowledge in their local context, as desired. These critiques constitute an important part of the analysis to evaluate the cross-cultural effectiveness of South Korea's knowledge-sharing effort.

4.3.3 Semi-structured Interview

Knowledge "originates and is applied in the minds of knowers" (Davenport & Prusak, 1998, p. 4). It often becomes embedded not only in documents or repositories but also in the "knower's routines, processes, practices, and norms" (Susanty et al., 2012, p.24). I conducted first person semi-structured interviews with 13 senior staff members from the NHIS (5), HIRA (4), and KOFIH (4), who are highly involved in organizing the

training course.[5] Identification of key senior staff came from the organization chart indicated on the agencies' websites and from chain referral sampling. Table 3 is a list of interviewees with their background. All names in text are pseudonyms, and information on where they belong to among the aforementioned three organizations is undisclosed to protect the anonymity of the participants. The interviews allowed a deeper understanding of the relational, knowledge, recipient, source, and upstream context of the overall knowledge-sharing initiative of South Korea as well as the training course, and provided South Korean stakeholders' genuine perspectives on the initiative.

Table 3 List of Interviewees

ID	Name	Years of experience & Background	Date
# 1	Kim	20 years, Social Health Insurance, Africa, Latin America	July 2016
# 2	Jung	15 years, Korean health ODA programs	Aug 2016
# 3	Park	8 years, South East Asia, International Organizations	Aug 2016
# 4	Ahn	10 years, researcher, medical insurance fee	Aug 2016
# 5	Lee	8 years, international trend of health insurance system	July 2016
# 6	Yun	9 years, policy consulting, hospital operation, Africa, Latin America	July 2016
# 7	Lim	3 years, knowledge-sharing program, Latin America	Aug 2016
# 8	Han	19 years, global health policy, Social Health Insurance	Aug 2016
# 9	Kwon	7 years, maternal health care, Korean health ODA, Africa	July 2016

[5] It would have been more desirable if I had been able to interview the trainees who participated in the Training Program, not only South Korean stakeholders. Although information on South Korea's knowledge-sharing activities was not of highly political nature, and the anonymity of the interview was fully explained, many trainees declined the interview request with much regret. They were not fully comfortable with expressing their individual opinions on the training course and their home organization. In most cases, there was information policy that every researcher who wants to interact with the organization's staff members will have to go through, such as writing a letter to the CEO for his or her approval before the staff member becomes my interviewee. However, the response rate was zero, and other organisations' procedures were also cumbersome and lengthy beyond my capabilities.

ID	Name	Years of experience & Background	Date
#10	Min	22 years, Korean health ODA, joint learning program, medical audit	July 2016
#11	Choi	8 years, policy consulting, policy training, Africa	July 2016
#12	Jo	13 years, Social Health Insurance, pension, Africa	Aug 2016
#13	Yoo	7 years, health policy management, policy consulting, South East Asia, Africa	Aug 2016

4.3.4 Questionnaire Survey

I also utilize the results of NHIS' evaluation questionnaire survey (a mixture of open-ended and close-ended) of a total of 43 trainees who participated in the 13th Training Course. This anonymous survey was conducted on the last day of the program, and the respondents were asked to evaluate the 1) achievement of their goals; 2) satisfaction with the training course (lecturers, lectures, field trips, facilities, etc.); 3) overall organization, coordination and operation of the training course, and 4) effectiveness of the training course (applicability to their countries). The survey results helped me understand the trainees' perspective on the training course provided insight to the recipient context of South Korea's knowledge-sharing initiative. The survey was also useful to cross-check my interpretation on what I observed. Table 4 is a list of the trainees of the 13th Training Course. They are also the survey respondents.

4.4 SUMMARY

This exploratory case study that adopts a qualitative approach has its own methodological advantages and limitations. My first-hand observations of the training course are the greatest strength and the fundamental weakness of the analysis of this study. Having sat next to the trainees throughout the two weeks of the training course, I

witnessed what they experienced in the knowledge-sharing program offered by South Korea. Observations of their excitement, curiosity, discontent and frustration expressed inside and outside the lecture room, allowed me to provide a better understanding of the context of the challenges and opportunities that the health care stakeholders in the global South were dealing with. This in turn helped me to critically analyze the effectiveness of South Korea's knowledge-sharing initiative from the perspective of knowledge recipients. However, human observations are inevitably influenced by the observer's view of the world and often biased toward confirming his or her conscious and unconscious expectations (Shermer, 2002). This study's analysis and conclusions largely based on my critical observation and interpretation of the interviews with Korean stakeholders, therefore, require careful examination and consideration before they can be generalized to the absolute and incontrovertible assessment on the South Korea's knowledge-sharing efforts in global health outreach.

In addition, Cummings' knowledge-sharing model I adopted served well as a comprehensive analytical framework to discuss each contextual factor of the training course. However, not every contextual factor could go through a thorough investigation. For example, it was beyond my capability to fully examine the knowledge gap between South Korean stakeholders and every trainee as well as each of their strategic intent and institutional retentive capacity. I also had to rely on Korean respondents to evaluate their credibility with trainees, which would be likely to present a somewhat or very different narrative from that of the trainees. In order to make up for these weaknesses, this study referred to partner countries' press releases and their own agency reports.

Table 4 List of Trainees of the 13th International Training Course on Social Health Insurance

Continent	Country	Position	Department	Organization
Africa	Egypt	Health Ecoomist	Health Systems Department	WHO Egypt Office
		Manager of School Health	Headquater	Health Insurance Organization
	Ehiopia*	General Manager	Debere Birhan Branch	Ethiopia Health Insurance Agency
		Branch Manager	Jimma Branch Office	Ethiopia Health Insurance Agency
	Ghana*	Director	Department of Claims	National Health Insurance Authority
		Senior Manager	Provider Payment	National Health Insurance Authority
	Kenya	Senior Benefits Officer	Benefits and Quality Assurance	National Hospital Insurance Fund
		Management Accountant	Finance & Investment	National Hospital Insurance Fund
		Officer	Benefits & Quality Assurance Department	National Hospital Insurance Fund
	Sudan*	Medical Claim Officer	Claim System Department/Medical Claim	Health Insurance Corporation
		Executive Manage of NHIF	Headquater	National Health Insurance Fund
		Director	Directorate of Human Resources	National Health Insurance Fund
	Swaziland*	Senior Economist	Planning Unit	Ministry of Health
		Principal Secretary	Administration	Ministry of Health
	Tanzania	State Attorney	Legal Service Unit	Ministry of Health & Social Welfare
		Assistant Director	Department of Policy and Planning	Ministry of Health & Social Welfare
	Tunisia	Central Inspector / Head	Hospital Organization	Ministry of Health
	Uganda*	District Health Officer	Health Department	Luwero District / Ministry of Health
		Senior Medical Officer	Quality Assurance	Ministry of Health
		Senior Health Planner	Planning	Ministry of Health
	Zimbabwe	Principal Director	Policy, Planning, Monitoring and Evaluation	Ministry of Health and Child Care
Asia (South /East)	Cambodia*	Official	Insurance and Pension Department	Ministry of Economy and Finance
		Lecturer	Department of Social Protection	National Institute of Social Affairs
		Official	Insurance and Pension Department	Ministry of Economy and Finance
	Lao DPR*	Head of Planning Division	Department of Planning and Finance	Ministry of Health
	Malaysia*	Principal Assistant Director	Pharmaceutical Services Division	Ministry of Health
	Myanmar	Assistant Secretary	Ministry of Health and Sport	Ministry of Health and Sport
	Nepal*	Junior Consultant	ONCO Surgery	Bhaktapur Cancer Hospital
	Taiwan*	Officer	Enrollment Division	National Health Insurance Administration
		Senior Executive Officer	Medical Affairs Division	National Health Insurance Administration
	Thailand*	Statician Professional Level	Bereau of Policy and Strategy	Ministry of Public Health
		Section Head	Fund Allocation and Reimbusement	National Health Security Office
	Vietnam*	Deputy Manager	Health Insurance Review Department	Social Security Office of Ho Chi Minh City
		manager of School Health	Review Department	Ha Noi City Social Insurance Security
Middle East	Afghanistan*	National Health Accounts Team Leader	Health Economics and Financing Directorate (HEFD)	Ministry of Public Health
	Bahrain	Computer Systems Analyst	Programs Management Office	Ministry of Health
		Systems Analyst	ICT Department	King Hamad University Hospital
		Health Planner	Office of the Secretary General	Supreme Council of Health
		Head of Costing & Insurance	Finance Department	Bahrain Defense Force - Royal Medical Services
South America	Ecuador*	Technical and Legal Director	Regulatory Affairs	Asuntos Regulatorios Tecnicos
		Technical and Legal Director	Regulatory Affairs	Asuntos Regulatorios Tecnicos
	Mexico*	Specialist Physician	Medical Direction	Social and Security for State Workers
	Peru*	Vice minister	Insurance of Health	Ministry of Health
Total	23 (16*)	43		

(* Participated in the Training Course before)

CHAPTER 5 FINDINGS AND DISCUSSION

The findings in this chapter are based on interviews with thirteen South Korean senior staff members who were highly involved in organizing the training course and critical observation throughout the program. The key question sets for interviews had three layers: content, organizational, and broader social considerations. The content layer consisted of questions regarding the main characteristics of the knowledge and information being exchanged in the training course (i.e. knowledge explicitness, codifiability, and embeddedness). The organizational layer included questions about the structures, capabilities, and constraints of the governmental units of LMICs involved in the training course. The broader social layer corresponded to questions regarding the broader context of the training course at the national level (i.e. cultures, political support, and socio-economic contexts of UHC initiatives in the trainees' countries). This question set of three layers and the responses assisted the search for what South Korea is doing well and what is not in strengthening capacity building for the trainees from LMICs to develop and implement their own UHC programs in their countries. Several prominent themes run through the responses, including being proud of sharing its successful UHC experience as an emerging donor country. However, there is a lack of detailed strategies for sharing applicable and transferable knowledge in the local context of LMICs for their capacity building.

5.1 Relational Context

5.1.1 Quality and Extent of Common Past Experience

Among the 24 countries that participated in the 13th Training Course, 16 countries had previously had representatives on the training course (see Table 4 in Chapter 4). Some of

them further built cooperative bilateral relationships with South Korea in the development of health insurance systems. For example, the Vietnamese Ministry of Health and NHIS worked on the "Project for Strengthening Capacity of Health Insurance Legislation, Policy and Management in Vietnam" for two years after November 2011. The purpose of this project was to help the Vietnamese government efficiently accomplish its goal of universal health coverage through providing policy consultations to the country based on Korean experiences with health insurance systems. In an effort to implement the project, the NHIS invited policy makers and working-level staff from Vietnam twice to a series of training courses in Korea. In addition, the NHIS held three workshops and two seminars in Vietnam and deployed health insurance professionals to Vietnam nine times.

Other participating nations in the training course, such as Ghana, Ethiopia, and Tanzania, were involved in intensive cooperation programs with South Korea for their national health care systems. NHIS and KOFIH had conducted a pilot project in collaboration with academia since 2013 to expand the health insurance system for more local subscribers. According to Mr. Eliot Akototse, the Volta Regional Director of the National Health Insurance Authority (NHIA) of Ghana, "the collaboration has yielded positive results. [They] have started seeing significant rise in the number of new entrants and those who are renewing their memberships."[6] Among the participant countries, health authorities in Mexico, Peru, Ecuador, Bahrain, Uganda, Kenya, Ethiopia, and Laos also have signed memoranda of understanding with NHIS for systematic collaboration on health insurance service and projects for future official development assistance (ODA) programs.

[6] Quotes from Mr. Eliot's interview at a press conference (16th January, 2017) to welcome the president and officials of KOFIH to the region. Retrieved from http://www.ghananewsagency.org/health/nhis-and-kofih-collaboration-yields-results-112355

At the national level, a special bond based on social and historical ties has played a significant role in bridging relationship distance between South Korea and some participant countries. For example, many of the interviewees (Respondent #1 Kim, #5 Lee, #6 Yun, #8 Han, #9 Kwon, #11 Choi, and #12 Jo) mentioned that Ethiopian stakeholders often proudly said that their country once helped South Korea by fighting in the Korean War in the 1950s as one of only two African nations and by far the least-wealthy nation to contribute troops. They are often delighted to express their country's friendship with South Korea, saying "brothers in blood help each other when needed. Now, South Korea is helping us" (Respondent #1 Kim, personal interview, July 2016). The trainee from Thailand also mentioned during the welcome dinner that "Thailand was the first country in Asia to send food aid and troops to South Korea during the Korean War." In addition, one interviewee stated that the fact that many of the participant countries suffered from a period of colonial rule like South Korea under Imperial Japanese rule during much of the early twentieth century also contributed to the historical bond between the two parties (Respondent #4 Ahn, personal interview, July 2016).

Previous experience with South Korean health agencies at the individual and institutional level, coupled with a close bond and historical ties from common past experience at the national level, are more likely to provide a better chance for the trainees to listen to South Korean expertise and put more credit in the country's knowledge of UHC. This effectively contributes to the trust between them, which is the single most important precondition for knowledge exchange, as Snowden (2000) addressed.

5.1.2 Consistency in Administrative Controls

Administrative controls can be understood as the organizational systems and procedures by which one entity uses power, authority (Etzioni, 1965) and bureaucratic, cultural, and informal mechanisms (Baliga & Jaeger, 1984) to influence the behavior and output of another entity (Ouchi, 1977). Simply put, it is the extent to which one entity has autonomy in decision-making. The key issue regarding the administrative operations of the training course was an inconsistency in administrative controls. All interviewees in this study pointed to this barrier. Two respondents among them highlight that:

> Even if the trainees valued the shared knowledge [during the training course], it seemed difficult for them to apply the shared knowledge to their existing UHC program when there were changes in the leadership of their home institution. (Respondent #8 Han, personal interview, August 2016)

> Sometimes, we also had to start from scratch, from building communication with a new leader to identifying the organization's demand and inviting the organization's trainees. Personally, I have found this is the most challenging part of this work where I think a continued partnership is a key determinant of effectiveness. (Respondent #6 Yun, personal interview, July 2016)

In other words, when the trainee has limited autonomy from the upper-level bureaucracy, this is more likely to reduce the degree of free flow of communication between the trainee's organization and South Korean agencies regarding the training course. Then, there is less chance of establishing officially defined and structured follow-up communication channels or networks for the training course, which could facilitate the knowledge internalization of the trainees. It seemed like the organizational distance between South Korean agencies and their counterparts in the trainees' countries could arbitrarily change, depending on who serves in leadership positions in the latter's institutional structures.

5.1.3 Knowledge Gap

This research could not fully examine the knowledge gap between South Korean stakeholders and the trainees since looking into knowledge capacity of each and every trainee was beyond the scope of my research. However, what was clearly observed was lectures on highly specialized knowledge that highlighted the knowledge gap. This in turn hampered the process of drawing lessons from the lectures and discouraged the trainees from getting involved in follow-up discussions. For example, one of the lectures was on theory and application of Economic Evaluation (EE) in Health Technology Assessment (HTA), and it required substantial prior knowledge in health economics, which most of the trainees did not seem to possess. The lecturer, a Korean health economist, spent most of his time in explaining different types of formula to measure the cost-benefit effectiveness of health care systems, including CMA (Cost-Minimization Analysis), CEA (Cost-Effectiveness Analysis), CUA (Cost-Utility Analysis), and ICER (Incremental Cost-effectiveness Ratio). Understanding of these concepts was heavily dependent on professional knowledge in health economics, and they were presented without practical examples. More importantly, the lecturer failed to suggest what all these concepts would mean to the design process of health insurance mechanisms in the trainees' countries, which could have been more helpful to their capacity building than trying to teach very complicated formula in two hours. The lecture only highlighted the knowledge gap between the academics and practitioners, and in turn, did not engage the trainees in a way that would enable them to identify their own issues with their health care systems nor provoke any productive discussions with each other.

5.1.4 Credibility of South Korea with Trainees

South Korea enjoys high credibility with the trainees from LMICs. Many interviewees pleasantly highlighted that the 'Miracle on the Han River', South Korea's dramatic and rapid transformation from one of the poorest countries in the world to the world's eleventh largest economy. This experience brings not just credibility to South Korea's knowledge but also strong motivation, inspiration, and self-confidence to the trainees. As one respondent noted, the trainees often remind themselves that *"If South Korea can do it, surely we can too"* (Respondent #12 Jo, personal interview, August 2016). Seeing South Korea's UHC achievement in a record 12 years, which took over a hundred years for traditional Western donors, the trainees often put credibility on South Korea's UHC knowledge and experience, which helps provoke willingness to learn lessons from the country's success. Moreover, South Korean stakeholders' personal testimony about their first-hand experience with the nation's hard times after the Korean War and subsequent 'miracle' also appeared to have been leveraged to strengthen this credibility with the trainees. One respondent highlighted this, saying that:

> Many of the senior staff members like me in NHIS and HIRA went through a tough time growing up in a war-torn nation, in the late 1950s and 1960s…We do "know" how it is like to be sick in a situation where your parents cannot get a medicine for you…cannot take you to the hospital because they cannot afford to. I lost two brothers before their first birthday…It was not unusual then…We deeply and sincerely sympathize with many health issues in the global South. But, we are the ones who rebuilt the nation, [and] who made it affordable and accessible for even the poor to see a doctor without worrying about money. I often share my experience with them [the trainees], and emphasize that we had a similar past… and I believe this has played a part in gaining an advantage in the global health ODA market, which is so competitive…Even if we have a short experience of development aid cooperation as a donor country, our bilateral consultation programs have been chosen over other prestigious traditional donors' ODA programs. (Respondent #8 Han, personal interview, August 2016)

It should be noted that, however, it is one thing to demonstrate high credibility to the trainees and another thing to facilitate their knowledge internalization. The findings imply that high credibility did not necessarily result in more willingness or ability to assimilate and apply the source's knowledge to the recipient's own systems. The source's efforts to ensure the transferability and applicability of its trajectory for UHC considering the recipient's social, economic, political, and cultural context seemed to be a more influential factor to knowledge internalization and consequently capacity building than credibility. The following section *5.2 Knowledge Context,* and later *5.4 Source Context* and *5.5 Upstream Context* will analyze these efforts in more detail.

5.2 KNOWLEDGE CONTEXT

A broad range of both theoretical and practical knowledge concerning UHC was covered throughout the training course, mainly through classroom learning in the form of lectures (Table 5). Topics included health care financing, management, service delivery, strategic purchasing, benefit design, and administrative reform. This section analyzes the contents and types of knowledge that was shared in the training course by themes of the lectures, and discusses how they contributed to or hampered effective capacity building for the trainees.

5.2.1 General Theory of Universal Health Coverage (UHC)

The first lecture (*Lecture 1: Universal Health Coverage and the new Sustainable Development Goals*) introduced a general overview of UHC and situated it in the SDGs. The lecturer was a Senior Health Specialist of Health, Nutrition and Population Global Practice at

Table 5 List of the Lectures and Lecturers in the 13th International Training Course on Social Health Insurance

No.	Lecture Title	Lecturer
1	UHC and the New Sustainable Development Goals (SDGs)	Senior Health Specialist, The World Bank
2	Going Universal: How 24 developing countries are implementing UHC from the bottom up	Senior Health Specialist, The World Bank
3	Administrative capacities to extend health insurance Health promotion and the challenge of chronic conditions	Head of the Office of the Secretary General, International Social Security Association (ISSA)
4	Transforming operational systems for securing administrative efficiency, financing equity and service quality	Professor, Yonsei University
5	Strengthening Cost Coverage and Priority Setting in Health Services	Professor, Seoul National University
6	Priority Setting for Benefit Design: HTA Systems in Asia and South Korea	Professor, Seoul National University
7	Introducing Korea Pharmaceutical Industry - Present and the Future	Senior Staff, Korea Health Industry Development Institute (KHIDI)
8	National Health Insurance System in the Republic of Korea	Senior Staff, National Health Insurance Service (NHIS), Republic of Korea
9	Introduction of HIRA: HIRA's Role & Function	Senior Staff, Health Insurance Review & Assessment Service (HIRA), Republic of Korea
10	Sustainable Healthcare Financing	Health Economist, WHO
11	Strategic Purchasing in Health Care Financing	Chief of Health Sector Group, Asian Development Bank (ADB)
12	Improving Health System Performance: Experiences and Lessons	Professor, Seoul National University
13	Healthcare System of Republic of Korea	Senior Staff, Ministry of Health and Wellness (MOHW), Republic of Korea

the World Bank. He highlighted the global trend of health care financing, asking the trainees how much a country should spend on UHC. He suggested theoretical normative answers, but ultimately changed the question into a practical question, "how much is a country *willing* and *able* to spend on UHC?". This question emphasized the need for health care reform to enable a country to succeed in health financing transition. A substantial part of this first lecture was a conceptual framework of financing mechanisms, which was explicitly articulated with charts, drawing, and clearly defined vocabulary. This explicit knowledge seemed to help the trainees to become equipped with a clear understanding of the theoretical knowledge of health financing, and indeed this was proven at the questionnaire survey where 95% of the trainees responded "strongly agree" to the statement that *"The training course explained theories of health insurance systems clearly."* During the Q&A and comment session following the lecture, some trainees identified their countries' current challenges in health financing, such as adverse selection, moral hazard, principal-agent problems, and risk amenability, in the light of the theories that lecturer explained.

The second lecture (*Lecture 2: Going Universal: How 24 developing countries are implementing UHC from the bottom-up*) was conducted by the same lecturer from the World Bank who gave *Lecture 1*. While his first lecture focused on the theoretical aspect of health financing systems, the second lecture shared empirical case studies on UHC within developing countries. The lecturer introduced Universal Health Coverage Study Series (UNICO) where 26 health insurance programs with a bottom-up approach in 24 developing countries were examined. The studies covered key aspects of "how" UHC programs are implemented, including covering people, expanding benefits, managing money, improving supply, and strengthening accountability. The lecturer highlighted that although there is no

evidence of a “best practice”, the cross-cutting themes of those programs were active use of constitutional mandates to enforce a “right to health” through legal mechanisms and common use of a “stepping stone” for bottom-up expansion of coverage in the journey to UHC. He noted that “big bang” health reforms are uncommon; rather the reforms require policy convergence in many areas and involve new risks. Such knowledge embedded in systems and mechanisms was explicitly articulated to share with the trainees, and this turned out to be a valuable learning experience for most of them as illustrated in the survey (89.7% of the respondents “strongly agree” or “agree” that “the training course clearly and effectively provided information on the recent trends and experiences of other health insurance agencies.”)

A high-level staff member from the International Social Security Association (ISSA) gave the third lecture (*Lecture 3: Administrative capacity to extend health insurance, Health promotion and the challenge of chronic conditions*). As an international organization for social security institutions, government departments and agencies, the ISSA promotes social security administration through professional guidelines, expert knowledge, services and support to enable its member institutions to develop dynamic social security systems and policy throughout the world. The first part of this lecture was about strategies to extend coverage through SHI schemes emphasizing gradual extension to different groups and to the dependents of scheme members. However, the strategies were too broad and normative to draw lessons. For examples, the lecturer’s main points that different population groups need to be treated differently, or government commitment and economic growth are one of the most influential factors on incremental coverage extension, provided the trainees with few useful principles for their health insurance systems.

The second part of this lecture, where he explained ways to tackle the challenge of chronic diseases through health promotion and prevention also did not effectively address the structural problems in health care systems. He pointed out that "chronic diseases develop from excessive exposure to certain risk factors, such as tobacco, low fruit and vegetable intake, alcohol, physical inactivity, and stress." There was a lack of discussion on social determinants of chronic disease, the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources, which are themselves influenced by policy choices, at global, national, and local levels. Nevertheless, there was not much discussion on social justice regarding such policy choices in which the trainees are highly involved. Although the lecturer's point was explicitly articulated with lots of quantitative data, his suggestions to tackle the challenge of chronic diseases based on his data seem unlikely to be effectively transferred and applied into the context of developing societies. This failure in turn drew out limited implications for SHI schemes for UHC in LMICs.

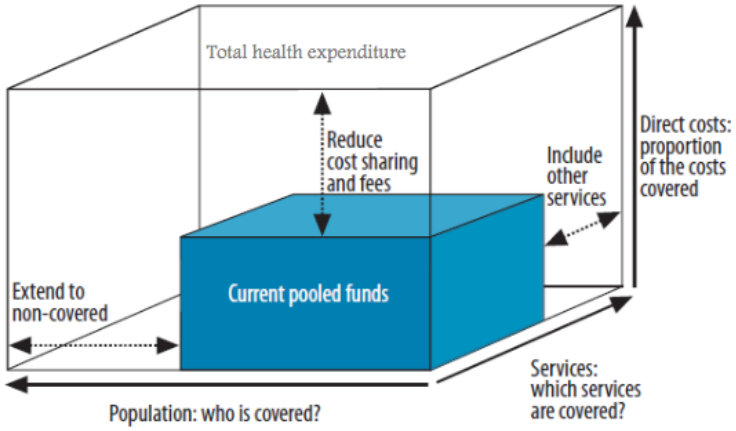
There was one more lecture on general theory of UHC later in the training course: *Lecture 10: Sustainable Healthcare Financing.* The lecturer was from Health Policy Financing at the WHO Regional Office for the Western Pacific. She situated health financing in a broader context of UHC and SDGs, and identified determinants and trends in health spending in LMICs. Strategies for fiscal sustainability were discussed with a specific focus on the issues like conducive macroeconomic conditions, reprioritization of health within the government budget, efficiency improvement and cost control, earmarked funding, and predictability of foreign aid. Before opening a group discussion, she highlighted that financial sustainability is key to a sustainable health system, but a sustainable system goes

beyond financial sustainability. In other words, cost control is not a goal, but a means for achieving efficiency. She made a point that efficiency not just in financing but also in service delivery contributes to the whole system's sustainability. Trainees were given the opportunities to apply the UHC framework to a current health system in one of the group members' countries to identify key challenges and analyze the root causes. The groups were randomly made up, and they were given time to present their discussion to other trainees for comments. Active exchanges of comments were observed, especially among the trainees from African countries. They identified similar issues with each other, but also found different causes and action plans they came up with. This group work seemed to help the trainees internalize the theory they learned and transfer this explicit theoretical knowledge embedded in financing systems into a useful analytical tool to conceptualize and systematize their practical challenges in moving toward sustainable health care financing.

5.2.2 South Korea's Experience of Achieving UHC

In explaining the process of moving towards UHC, the WHO utilizes the image of a three-dimensional cube (Figure 3): population coverage ("breadth" – who is covered), services coverage ("depth" – which services are covered), and direct costs ("height" – proportion of the costs covered). Some lectures were explicitly focused on South Korea's experience in one specific dimension while others broadly covered all three dimensions.

Figure 3 Three Dimensions of UHC (the "UHC Cube")



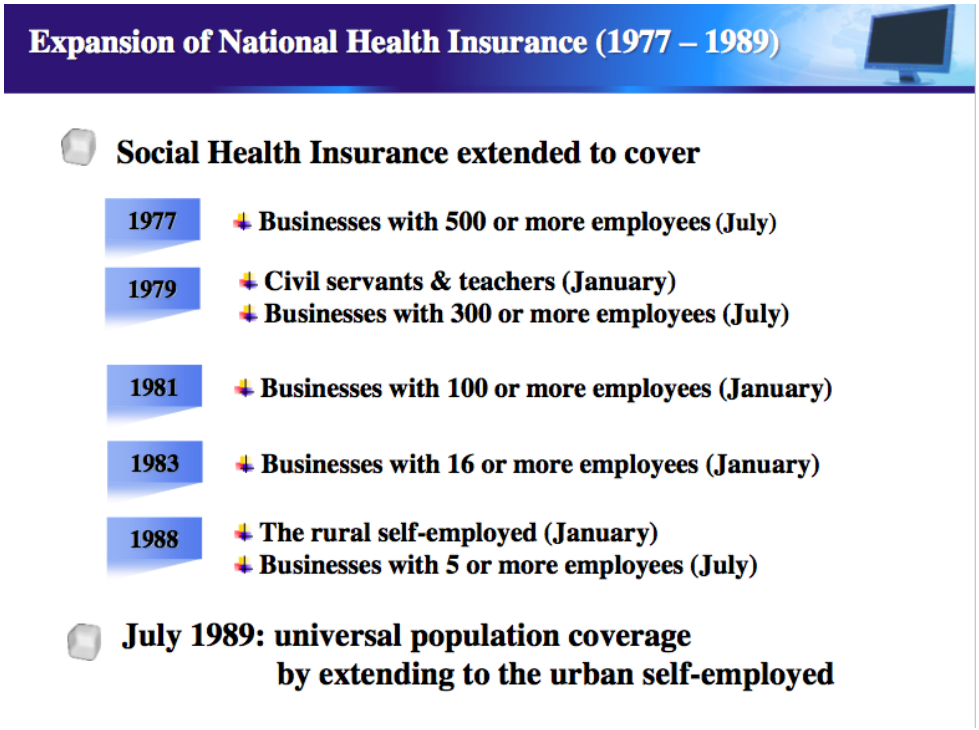
Source: WHO website, http://www.who.int/health_financing/strategy/dimensions/en.

Dimension 1: Population coverage – South Korea's incremental expansion strategy

Lecture 4 specifically covered the strategies that South Korea implemented to broaden population coverage. A Korean professor at Yonsei University, one of the most prestigious universities in South Korea, introduced the country's journey of incremental expansion of population coverage. It started from businesses with 500 or more employees in 1977, expanded to the rural self-employed and businesses with 5 or more employees in 1988, and finally reached the urban self-employed in 1989, the last group towards universal population coverage (Figure 4).

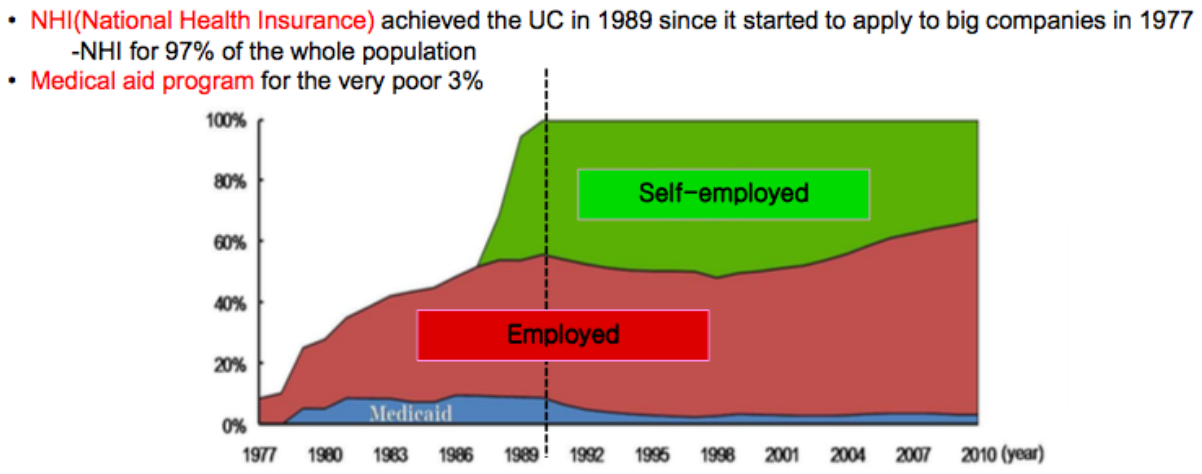
The knowledge that the lecturer shared was mostly highly explicit, and clearly written, verbalized, and drawn as illustrated in Figure 4 and 5. This explicit knowledge embedded in the system was clearly articulated. However, this was not enough to fully satisfy the expectations of the trainees. There was a lack of effort placed on sharing 'tacit knowledge' regarding this incremental expansion of population. During the Q&A session, many

Figure 4 Expansion of National Health Insurance of South Korea (1977-1989)



Source: Slide #14 of Lecture 4 (International Training Course on Social Health Insurance)

Figure 5 Universal Population Coverage of South Korea (1977-1989)



Source: Slide #15 of Lecture 4 (International Training Course on Social Health Insurance)

trainees showed their interests in the 'social context' behind this expansion list and chart, which would have been transferred through knowledge embedded in people and organizational routines. For example, a trainee from Cambodia asked whether the government of South Korea faced any resistance from the informal sector against this mandatory SHI scheme, citing her country's current situation. Indeed, this is a very common challenge that many other countries in the training course have been facing in moving toward UHC. Despite the fact that South Korea also did struggle with tough resistance from the self-employed in the early stages of introducing their national health insurance scheme, how the country overcame this challenge was not fully shared.[7] In fact, the case of South Korea could have provided the trainees with insight into social inclusion strategies and the value of the bureaucrats' attitude and approach toward marginalized communities to achieve UHC. These insights might have been shared only through tacit knowledge embedded in people, value, norms, and routines.

In a similar vein, a trainee from Uganda asked what privilege the civil servants in South Korea had enjoyed regarding their health insurance service, and how they reacted to the expansion of the service. A trainee from Swaziland asked whether the South Korean bureaucrats involved in the steps toward UHC believed in a trickle-down effect of this incremental expansion strategy, and if yes, why they believed in it. It was observed that the

[7] The government of South Korea back then wanted employees and the self-employed to be covered by separate insurance societies to avoid problems associated with different degrees of income assessment between the two groups. Then, farmers requested an increase in government subsidy to their health insurance scheme and an expansion of health care facilities in rural areas for better access to medical care. Consequently, the government subsidized the health insurance contribution of the self-employed and provided financial support for hospitals to open in rural areas. The amount of tax subsidy to the self-employed was initially about the half of the total revenue of the health insurance scheme for the self-employed.

trainees were mostly curious about the social context of the bureaucrats' decisions behind certain policy settings, which unfortunately had not been covered in the lecture. Due to the short time allowed, even the Q&A session did not allow the lecturer and the trainees to have meaningful discussion on this aspect of South Korea's incremental expansion strategy for universal population coverage. A few respondents in the survey noted that the lectures and discussion relied too much on talking about the results and outcomes of the South Korean government's policy decisions in health care (NHIS, July 21st, 2016). They suggested that it would have been more helpful if the direction of discussions had been focused on the social process and political struggle to achieve UHC. Without having been able to fully understand the social context, it must have been difficult for the trainees to decide what to take from the experience of South Korea in broadening population coverage. They must have been unsure about which component of the strategies could be applied to their systems at the home institution. Lesson-drawing to enhance their policy capacity was inevitably limited in this lecture.

Dimension 2: Service coverage – South Korea's priority setting in benefit package and strategic purchasing

Lecture 5 and *Lecture 6* featured the issue of service coverage of UHC, and introduced South Korea's experience in priority setting to decide which benefits are covered. Both lecturers were academics at Seoul National University, South Korea's most prestigious university. *Lecture 5* was about public involvement in setting health benefit package priorities in South Korea, and *Lecture 6* was about the country's Health Technology Assessment (HTA) system for priority setting in pharmaceutical spending. Although both topics came under the same dimensional umbrella of the "UHC Cube," – *service coverage* –

the knowledge shared in each lecture showed stark differences in terms of the type of knowledge, embeddedness, transferability, and applicability.

First, *Lecture 5* was one of a few lectures in the training course that actually provided applicable and transferable policy lessons. The lecturer shared specific contexts of South Korea that led to successful priority setting mechanism, highlighting the significance of lay public participation in health care benefit decision-making process. Then, he suggested valuable guidance to the trainees for designing a framework of priority setting in benefit packages, based on three fundamental questions: "*How to set it," "Who should do it,"* and *"Based on what principle or philosophy."* Concluding his case study on "South Korean Citizen Committee for Participation 2012", he summarized his findings as:

> Lay people were sufficiently sensitive and wise enough to distinguish different cost-benefit analysis once they got informed and had sufficient deliberation (collectively rational choice); people could be neither greedy nor selfish, but rather rational and altruistic for us all…The committee was officially consultative; however, it contributed as if it had been almost decisive body. Two policy lessons can be learned here. First, [there is] no need to try to cover all services but to cover appropriately based on priority setting using social value judgement… Second, lay people's participation would decrease policy failure in benefit coverage decision. (Lecture 5, July 14)

It might be more difficult in resource-limited settings to decide which services should be covered and which ones should not. The lecturer argued that people in LMICs can wisely set priorities based on their own social value judgement by integrating their willingness to pay and value for money. The trainees were given time to think over the social values that would be predominant in their societies regarding health care, and discussed some priority values, such as financial risk protection, disease severity, health outcome, size of unmet need, cost-effectiveness, and scientific evidence of effectiveness. A large part of this social judgement is in the realm of tacit knowledge embedded in people's routines, values, and norms, which was

relatively hard for the lecturer as well as the trainees to clearly articulate compared to explicit knowledge about systems and policy. Despite this challenge, instead of enumerating the outcomes and results, the lecturer tried to share the country's institutional "know-how" in the early stages of the initiative, regarding the committee selection procedures, provision of up-to-date information/knowledge to the committee, and relevant coordinating work. It was understood as the efforts to enhance transferability and applicability of the initiative into the trainees' countries. Indeed, a trainee from Tunisia asked for advice on how to enhance the representativeness of a public committee. A trainee from Ecuador was curious if there had been any tension between the committee and other stakeholders in the health industry due to the conflict of interests. A trainee from Malaysia also wanted to know how South Korea solved the challenges around the lay public's difficulty with the technical terms of the benefit package. Although only a few trainees' countries have a similar public involvement initiative for benefit package priority setting, *Lecture 5* might at least contribute to the 'inspiration' that Rose (1991) addresses as one of the ways of lesson-drawing. In other words, the trainees could use South Korea's experience with public involvement as an intellectual stimulus to develop a novel program in priority setting in their countries.

While *Lecture 5* emphasized tacit knowledge embedded in people and routines, *Lecture 6* was mostly focused on explicit knowledge embedded in systems and theories. The main topic of *Lecture 6* was Health Technology Assessment (HTA) system of South Korea in priority setting for benefit package and pharmaceutical spending. The system was based on Economic Evaluation (EE), which the lecturer defined as "comparative analysis of alternative courses of action in terms of both their costs and consequences." He gave a lecture on the conceptual framework of EE and its application to health care systems, and

finally South Korea's use of its HTA system. However, this explicit knowledge embedded in the systems and theories had two major problems that struck the trainees.

First, without extensive prior knowledge in economics (which most trainees did not seem to have), the lecturer's explanations on complicated concepts of EE seemed hard to understand for the trainees. Too much jargon was used to articulate this explicit knowledge, and a considerable amount of time was spent to go over graphs, charts, and metric formulas on his Power Point slides. Not surprisingly, it was frequently observed that many trainees were a bit too unfocused and distracted. This visual aid only highlighted the knowledge gap between the knowledge source and knowledge recipient. This was more likely to hinder lesson-drawing, and, in turn, hampered knowledge internalization and effective capacity building for the trainees.

Another problem was the lecturer's narrow perspective on health services, mostly confined to economic value and cost-effective solutions. Priority setting in benefit package and pharmaceutical spending in a society should consider its potential social consequences and ethical issues. This narrow economic interpretation of a successful health care system did not seem to contribute to transferability and applicability of South Korea's HTA system into the global South context. Indeed, a trainee from Ethiopia noted that:

> Even though EE provides information on efficient, or best resource use for decision making, and analyzes every resource dollar used, HTA should be carefully used in drug purchasing and benefit package design. People in a developing country like Ethiopia are more vulnerable to market volatility on certain drug. [They are] more prone to certain disease and certain determinant of health. Especially the benefit package in public health service should not be designed solely based on economic principles and analyses. Much more complicated social context and ethical issues are

> intertwined. It is not the same as selecting the most cost-effective wine in your plane.[8] (Q&A recording, Lecture 6, July 14)

Designing health insurance schemes involves a holistic and multi-disciplinary method which integrates a wide range of structural and behavioral analysis across diverse stakeholders in a country's health care. The process of finding an optimal model to move forward UHC by utilizing HTA system and EE framework should be understood as part of an effort to formulate effective health insurance schemes. 'Health for all' is not accomplished by a numbers game. Application of EE should be discussed not only with its economic implication but also with its political, social, and cultural implications in a larger narrative of people's health-care-seeking behaviors. Although a great deal of focus on economic efficiency did contribute to the country's fast achievement of UHC, the country should diversify its ideological approach to "people's" health if it aims to increase the effectiveness of lesson-drawing and capacity building for the trainees.

Dimension 3: Direct costs – South Korea's Cost Sharing Policy

One of the key financing issues for LMICs is how to provide increased financial protection for households. This is highly related to the third dimension of UHC – "*Direct costs: how to reduce cost sharing and fees*." No specific lecture exclusively covered this issue, but *Lecture 8*, *Lecture 11*, *Lecture 12*, and *Lecture 13* touched on South Korea's co-payment systems as part of its explanations of the country's overall health insurance system. However, none of these lectures went beyond merely providing numeric information on the co-payment rate of different types of care (in-patient, out-patient, pharmaceuticals, and

[8] The first slide of the lecturer's Power Point was a wine list that he took a picture of in an airplane. The list says each wine's price and ratings, and the lecturer used this as a metaphor for cost-effective decision making.

rare/serious diseases[9]) in South Korea. It was primarily 'know-what' rather than 'know-how', which limited opportunities for the trainees to separate "best practices" from particular contexts regarding cost sharing policy. It was explicit knowledge articulated in numbers and graphs, but its transferability and applicability was doubtful. It was far from providing meaningful lessons to the trainees from LMICs because South Korea actually has a relatively high co-payment rate (37.5%). According to the lecturers, it is 20% for in-patient care, 30-60% for out-patient care, 30% for pharmaceuticals (40-50% on drugs for minor illnesses prescribed from secondary care providers), and 5-10% for rare/serious diseases. This cannot be a promising cost sharing model especially in LMICs where a high proportion of citizens already suffer from high OOP (out-of-pocket) expenditure on health care. Trainees from Cambodia, Nepal, Afghanistan, and Ethiopia all addressed this issue of catastrophic OOP expenditure within their countries.

One of the purposes of the cost sharing policy is to control moral hazard[10]. It could be an effective tool to avoid over consumption of some kind of drugs and services in health insurance schemes. But, many studies have validated that the cost sharing policy had negative impacts on vulnerable populations, such as the people with low socio-economic status, chronic disease, disabilities, and the elderly (Mushi, 2014; Lee, 2015; Rasell, 1995; Lostao et al., 2007; Shigeoka, 2013; Hendryx et al., 2012; Tamblyn et al., 2001; Karaca-Mandic et al, 2010; Pesa et al., 2012; and Wright et al., 2005). Impoverished populations are more sensitive than the general population to the impacts of cost sharing policies. Thus, it is

[9] Rare diseases include hemophilia, chronic renal failure, mental illness, organ transplant recipients, etc. Serious diseases include cancer, cardiovascular or cerebrovascular diseases, tuberculosis and severe burn injury, etc.

[10] Moral hazard is the idea that people insulated from risk behave differently than people exposed to risk. In health care, it refers to excessive consumption of medical services by insured individuals. It is often the reason why there is co-payment and "caps".

a big challenge for the policy makers to balance the moral hazard and financial risk for populations. In order to find this balance, policymakers should analyze the risk level or health status of target populations given their particular economic, social and cultural environment. This is the policy capacity required to develop appropriate and effective cost sharing policy that would minimize unexpected adverse effects. Therefore, more efforts should have been made to share the knowledge on *how to* analyze these factors in order to facilitate lesson-drawing for the trainees.

5.3 Recipient Context

The third broad context in knowledge-sharing is recipient context. The trainees' motivation, intent, empirical knowledge, and retentive capacity was examined. Along with a 20-minute-long country presentation by each trainee at the training course, the interview with South Korean stakeholders provided insights into these constructs of recipient context. Many of these constructs are actually relational in nature as discussed earlier in the relational context, especially trainees' motivation and intent. Although the "trainees" were not a homogeneous group of people since different trainees from different countries are liable to have different values, beliefs, and experiences, it was outside of my capability to examine each and every trainee's motivation, intent, and empirical knowledge, and their organization's retentive capacity and learning culture. I could only rely on my observations during the training course and the interview respondents, who were all actually the knowledge 'source', not the 'recipient.' The following analysis on the recipient context, therefore, may inevitably have limitations in reflecting the actual recipient context of the

training course through the genuine perspective of the knowledge recipients. It should be noted that it is more like a 'perceived' recipient context by the knowledge source.

5.3.1 Trainee's Motivation

Every interviewee spoke with one voice on the trainees' motivation to participate in the training course. They said it was rooted in South Korea's unprecedented success in achieving UHC as once one of the poorest countries in the world. According to them, the trainees are highly motivated by the hope of finding innovative policies that could transform a country's landscape of its people's health, even in resource-poor settings, and finding the possibility of implementing those policies and initiatives into their home countries. One respondent said, "what they are looking for is transferable policies or the feasible secret of Korea's development to apply to their own development. That would be the greatest benefit for them, and the best thing we can give them as an emerging donor" (Respondent #13 Yoo, personal interview, August 2016).

One thing that some interviewees noted, however, was that this motivation might not be necessarily the individual trainee's motivation, but instead he or she may be doing what they were ordered to do by their institution. If this is the case, they are less involved in the overall programs throughout the training course. One interviewee addressed that this problem of passive attitude also sometimes pervades the institutional level. One respondent said:

> For me, the biggest challenge every year is fighting against the passive attitude of some institutions at the preparation stage when I am supposed to design classes of the training course based on what they specifically want to learn. We even send them an official document to fill out asking what knowledge of South Korea's health care system they would like to gain, but in many cases there was no reply, or some responses like "whatever you want to give us, whatever you can give us." It is hard to make the training course 100% customized learning. Then I found that the trainees from those

> institutions were often less interested in the training course, but more interested in the tour of South Korea. (Respondent #9 Kwon, personal interview, August 2016)

On the other hand, there were also some trainees that explicitly identified a lack of individual and institutional policy capacity as a critical challenge for their country to move towards UHC. In the Country Presentation Session, trainees from Cambodia, Sudan, Tunisia, and Ethiopia addressed their need for capacity building for policymakers and practitioners in their health care system, through both short-term and long-term training. Their perceived need for enhancing capacity building would give rise to a greater motivation to participate in the training course, which would be more likely to lead to a greater willingness to find take home messages about either what they should do or what they should not do.

5.3.2 Trainee's Intent and Empirical Knowledge

Each trainee might have different intent to participate in the training course. Although it was beyond my capability to examine each trainee's intent, according to the interview respondents and observations of the trainees' country presentations and discussions within the training course, a certain pattern of interest and intent was observed. It had much to do with the stage in which they were regarding the development of UHC. Among the countries that have SHI systems like South Korea, the higher the population coverage a country has achieved, the stronger the interests the country showed in specific tools and technology embedded in South Korea's SHI systems, such as the Drug Utilization Review (DUR) system, medical audit toolkits, and information and communication technologies (ICTs) in payment systems. These countries often "intend to scan these tools and technology and want to assess the room for bilateral cooperation with South Korea in the technical assistance to

enhance the efficiency of their existing SHI systems" (Respondent #4 Ahn, personal interview, July 2016). Among the participating countries, Bahrain is a good example of this case. This country consistently tops quality of health care system rankings in the Gulf, given its high levels of wealth and education, and enjoys the well-funded UHC programs and talented health care professionals. They sent four trainees to the training course; two of them were a Computer Systems Analyst at the Programs Management Office of the Ministry of Health and a System Analyst at the ICT Department at King Hamad University Hospital. They came with the Health Planner at the Supreme Council of Health and the Head of Finance Department at Royal Medical Services. During the training course, they showed great interest in the lectures on HIRA's big data analysis and its Korean Pharmaceutical Information System (KPIS). Indeed, after about 8 months, in March 7th, 2017, Bahrain signed a deal with South Korea for a joint project to implement health IT systems, which included a medication management review system, heath insurance IT scheme and the national e-medical filing ("Health delegation to visit South Korea", 2017). As one interview respondent stated, trainees from countries that have established a certain level of quality in their health care systems often "intend to pursue selective learning in the area they want, enjoying a high degree of ownership in the shared knowledge" (Respondent #1 Kim, personal interview, July 2016).

On the other hand, countries at the initial stage of developing SHI systems, or operating only a tax-based system or a mix of tax-based with community-based voluntary health insurance schemes, seemed to have different intents. According to many interview respondents, these countries are more interested in setting priorities for deciding where to

allocate resources across various aspects of SHI, such as financing, management, and service delivery. One respondent noted that:

> Many practitioners and policymakers, especially from low income countries among our partners, often ask us, "what would you do first if you were the Health Minister of my country? What would be the most urgent task you would do now?" They want our insights and know-hows to start their health care reform with such limited resources. Unlike middle-income countries, these countries want a full, comprehensive consultation, not just one particular project. (Respondent #2 Jung, personal interview, August 2016)

Such intent clearly highlights the need for capacity building for the trainees in the global South. The capability to set priority and coordinate a variety of efforts across the priorities is essential to sustainable development of their health care systems in the long term. This capability requires thorough and systematic analysis on the country's political, economic, social, and cultural context of the current state of health and health care. This might be the essential capacity needed to implement the most effective and appropriate health insurance scheme, and develop its design in the country. However, due to the lecturers' minimal emphasis on such contextual factors in South Korea's successful achievement of UHC, it is questionable how effectively the series of lectures contributed to building the trainees' capacity to set priorities beyond simply delivering information on South Korea's SHI systems. There were no helpful hints on these issues even in the Satisfaction Survey, unfortunately, since it did not incorporate questions that address such capacity.

In addition, this intent of the trainees from low-income countries to get insight into priority setting seemed more likely to be realized in a different type of knowledge-sharing activity. For example, a bilateral policy consultation would create a more intense environment for knowledge exchange focused on one specific recipient country, and thus

provide its stakeholders with more opportunities to have a deep-dive discussion with South Korean stakeholders on the issue of priority setting for UHC.

5.3.3 Trainee's Retentive Capacity

As Cummings (2003) addresses, high motivation and a wealth of related experience of the knowledge recipient does not necessarily result in knowledge internalization. Successful knowledge internalization must involve the ability to invest significant time or other resources in new knowledge (Cummings, 2003). In other words, without such adequate retentive capacity of the institution, the trainee may be simply incapable of developing the necessary degree of commitment and ownership toward the newly acquired knowledge from the training course to allow for its full internalization. Unfortunately, however, it was beyond my capability to examine every trainee's institutional retentive capacity. It inevitably involves the country's complex social and political environment regarding the issues that the shared knowledge addresses. With appropriate methodology and sufficient time, the trainee's retentive capacity at the institutional level should have been investigated to fully understand the diverse knowledge recipient contexts of the training course and their impacts on the effectiveness of capacity building.

However, this challenge also highlighted one of the limitations of South Korea's knowledge-sharing initiative for UHC in general. Many interview respondents addressed the fact that not every partner country possesses adequate retentive capacity to invest resources to incorporate the knowledge shared by South Korea into their action plans or policies. One of the reasons given is that some countries have "more urgent health priority than financing pooled funds for the SHI systems, such as building basic infrastructure for health care

facilities, training health care workers for maternal and child health, or procurement of essential drugs." (Respondent #8 Han, personal interview, August 2016). Another respondent noted that inadequate retentive capacity is attributed to "a lack of political will of the bureaucrats to invest time and resources to UHC achievement" (Respondent #1 Kim, personal interview, July 2016).

Moreover, it is often difficult to fully assess the participating countries' retentive capacity before initiating a program, not to mention the training course, but even in a bilateral consultation program. One respondent said,

> What we often found during the follow-up business trip [to the partner country] was that they have pulled ideas or concepts on specific UHC programs based on the knowledge we had shared, without actually implementing any relevant action plans. But, it is very tricky to assess and evaluate 'their' retentive capacity based on 'our' judgment…Many partner countries often do not want their retentive capacity to be assessed by "outsiders." One can say that rigorous assessment on their retentive capacity might enhance the applicability and transferability of our knowledge into their local system, but it can also create undesirable tension between us, which I believe is worse than the inadequate retentive capacity of the recipient country. (Respondent #4 Ahn, personal interview, July 2016)

Although this research could not fully examine the issue of retentive capacity in the recipient context, it seemed clear that the recipients' retentive capacity affected the extent to which the stakeholders in a recipient country internalize the knowledge shared by South Korean stakeholders. Looking at this issue of the knowledge recipients' retentive capacity from another angle, this highlights the source context of knowledge sharing. South Korean stakeholders need to share applicable and transferable knowledge based on a comprehensive assessment of the partner institution's retentive capacity, without necessarily compromising the degree of ownership the recipient country should enjoy in the knowledge-sharing initiative. This will be discussed in more detail in the next section *5.4 Source Context*.

5.4 SOURCE CONTEXT

5.4.1 South Korea's Teaching and Learning Culture and Knowledge-sharing Capability

One of the most notable issues in terms of source context was South Korean stakeholders' ineffective pedagogy in the knowledge-sharing program. The first problematic issue was its predominant culture of the 'teacher-centred approach' in teaching and learning. Inordinate lengths of one-way lecture of the training course on South Korea's experience did not really invite the trainees to reflect on what lessons could be drawn from the case. Many lecturers often used up the allocated two hours in delivering the content, and ended up having to cut off the trainees' follow-up questions as they ran out of time. This insufficient time for two-way communications deprived the trainees of opportunities to share their curiosities, insights and lessons learned. Under the strong influence of Confucianism, the dominant pedagogy of educational institutions of South Korea has been 'teacher-centred' direct instruction, rather than 'student-centred' inquiry-based learning or cooperative learning. Having left little opportunity for group interactions and mutual learning, such an authoritative teaching and learning environment seemed to negatively affect the trainees' ability to become more adaptive and flexible in the shared knowledge, which in turn is more likely to impede their knowledge internalization. In fact, this type of pedagogy is actively discouraged in many public health education programs. What they have been seeking is a learner-centred approach, which emphasizes the learner's critical role in constructing meaning from new information and prior experience (Heller et al., 2007). Problem-based learning and guided discovery learning (Spencer & Jordan, 1999), and inquiry-based learning (Kienzler & Fontanesi, 2017) are considered key instructional strategies that exploit the merits of a learner-centred approach. This refers to the process of teaching and learning in

which learners are at the heart of curriculum design and classroom interaction, which was unfortunately the exact opposite of the way the training course operated.

In addition, the series of lectures had many overlaps with each other, for example, theories of health care financing and general information on NHIS's role and HIRA's function. The curriculum could have been refined in a way that best addresses the needs and learning goal of the trainees. As found in the recipient context, each trainee's interests can vary from one country to another to some extent. Thus, South Korean stakeholders' capability to design an appropriate curriculum and strategic coordination of the whole course was essential to effectively compromise among the various needs of the trainees.

5.4.2 Strategic Intent of South Korea

Strategic intent can be understood as an agency's vision of what it wants to achieve in the long term. It is "what they want to do" and "why they want to do it." The answer to "why they want to do it" underlines the end result. When the South Korean senior staff members were asked *"What do you think is your agency expecting from the knowledge-sharing initiative including the training course in the long term?"* the most frequent answer was South Korea's medical industry's expansion to the global South, including the pharmaceutical industry, medical device, and IT systems. Indeed, according to the annual report of Korea Health Industry Development Institute (2016), exports of medicines, medical devices, cosmetics and medical care for foreign patients in 2015 totaled USD 8.8 billion (p.4). This is double the size of USD 4.4 billion in 2011, and there has been an average 19.1% increase every year over the past five years (KHIDI, 2016, p.4). Its market is currently centralized on Europe and BRIC countries (Brazil, Russia, India and China), and South

Korea is trying to diversify its market towards other emerging economies in the global South (KHIDI, 2016).

An important finding was that this pursuit of economic interests made a few sessions of the training course less instructive and less relevant to the trainees' capacity building to develop UHC programs in their local context. For example, Lecture 7 *"Introducing Korea's Pharmaceutical Industry*" somewhat explicitly revealed South Korea's strategic intent to expand its medical industry market. It rarely facilitated the necessary knowledge-sharing on various pharmaceutical issues in the trainees' country in moving toward UHC. The lecturer mainly talked about South Korea's rapid growth in the global pharmaceutical market and boasted of its "top class bio-pharma competency" introducing new drugs the country has recently developed. The strategic intent behind the knowledge-sharing initiative became even clearer when he shared *"Pharma Vison 2020: Pharmiracle on the Han River"*, which is the idea of South Korea becoming a top-tier nation in pharmaceuticals by 2020[11]. This was too far from the spirit of the capacity building for the trainees from countries in the global South, some of which have even struggled for access to essential medicines that satisfy the priority health care needs of the population in many cases. Given the fact that even UHC coverage is not a solution if people do not have access to affordable, safe and effective medicines, this lecture did not draw any meaningful lesson. It is a well known fact that the economic burden of pharmaceuticals disproportionately falls on many LMICs. While spending on pharmaceuticals represents 18% of total public and private health spending in countries of

[11] Pharma Vision 2020 details a number of ambitious goals, such as becoming a top seven global pharma powerhouse by 2020, ensuring KRW 10 trillion (USD 8.9 billion) between 2013 and 2017 allocated by Korean government for R&D, taking global market share to increase from 2 to 2.5 percent, and increasing pharma exports from 12.5 percent (2012) to 46 percent of total production by 2020 (KHIDI, 2012).

the Organisation for Economic Co-operation and Development, it represents 20 to 66% in LMICs (WHO, 2015b, v). There were few questions and comments from the trainees in this lecture. Only one trainee from Ethiopia made a comment highlighting that the lack of access to essential drugs, irrational use of drugs, and poor drug quality remain serious public health challenges to move toward UHC in many LMICs including his country. It was obvious that South Korea's strategic intent in economic incentives was not aligned with the trainees' needs, which hampered the effectiveness of the knowledge-sharing efforts in building capacity for the trainees.

5.5 Upstream Context

There are many other complex factors at play in the landscape of health care in LMICs. Whether South Korea's experience in achieving UHC would promise the trainees a transferable and applicable model to achieve UHC in their own country requires consideration of broader environmental contexts that shape this landscape. This section primarily focuses on two key upstream elements of South Korea's successful UHC achievement that the training course failed to address – the country's *unique political economy that brought 'Miracle on the Han River'* and *a sufficient provision of trained workforce of health professionals*. These two factors allowed the country to accomplish rapid extension of its SHI, and to sustainably operate it without compromising the quality of health care services. Then, is South Korea's unique economic development trajectory repeatable or even recommended in the trainees' own country? What does UHC mean to low-income countries where there has been a chronic shortage of well-trained health workers? What

lessons could South Korean stakeholders provide the trainees to help their capacity building? The following discussion addresses these concerns.

5.5.1 Economic and Political Environment

South Korea achieved UHC under the very unique economic and political contexts. Domestically, the country enjoyed extraordinary economic growth that led to the rapid extension of health insurance by improving employers' and employees' capacity to pay contributions. It also enabled the government to build sufficient health care facilities and train health professionals to provide quality medical services. This raised peoples' willingness to pay for health insurance and contributed to the sustainability of the country's UHC programs in terms of finance.

The fact that economic growth led to the expansion of health insurance schemes to a larger population is not unique though. Many empirical studies found that although countries have reached UHC by different paths and with varying health systems, the trajectory toward UHC regularly has a common feature, which is a growth in national income and a concomitant rise in health spending (Fan & Savedoff, 2012; Chernew et al., 2010; Gerdtham & Jönsson, 1991; Baltagi & Moscone, 2010; and Xu, Holley & Saksena, 2011). These studies explain that increases in household income allow people to purchase more health care and more health insurance, and governments are also able to raise taxes from a larger economy and mandate larger contributions by employers and households. Putting aside their political will, there is no doubt that governments in higher-income countries, too, enjoy more resources to invest in improving public health services that will increase peoples' willingness to pay for health insurance.

However, unlike LMICs today, South Korea enjoyed rapid economic growth. As discussed in the literature review, South Korea obtained its economic results under the yoke of a very repressive regime that had the support of the United States in the framework of its containment of the so called "socialist" regimes. Substantial U.S political and financial support played a big role in legitimating the authoritarian military regime and its a high degree of intervention in the economy. South Korea also had the unique relationship with the World Bank and enjoyed its tolerance for the internal dictatorship despite the country's unorthodox approach to economic development in contrast to the World Bank's 'textbook principles'.

The issue is that all these contexts are clearly difficult to replicate today in the current LMICs context. If these contextual factors are less likely to be repeatable, what lessons then could be drawn from South Korea's experience for LMICs seeking to implement their own health insurance system? Looking back on the actions taken in the early stages that made it possible for the health insurance system to develop in South Korea, the government's strong leadership was the key factor that propelled the development and implementation of the social security system. Given that many different actors get involved in a country's health insurance sector, a successful health insurance system requires the government's active involvement in coordinating different ideologies and different interests of the various stakeholders. As many experts have addressed (Reich et al, 2016; Kelsall, Hart & Laws, 2016; Evans, Beyeler & Beith, 2015; The Lancet, 2012; Stuckler et al., 2010; and Maeda et al., 2014), UHC is intrinsically political. Greer and Méndez (2015) noted that "it is a political victory that UHC is discussed at all, and still more so that it has any veneer of consensus. UHC is a highly political concept" (p.637). In other words, the government's strong political

will to advance health policy and its capacity to enforce rules and incentive structures to influence the behavior of health sector actors are essential factors for a successful health insurance system to move toward UHC. Unfortunately, however, this important lesson was not adequately addressed in the training course. It should have provided the trainees with opportunities for discussion to reflect on how to successfully mobilize political support across the nation for UHC initiatives within their own country's political context.

5.5.2 Institutional Environment: Human Resource

There is no health system without health workers. A trained workforce of health professionals is essential for sustainable implementation of any health insurance system. As discussed in Chapter 2, South Korea enjoyed a sufficient supply of trained health workers when developing its national health insurance system. In most of LMICs, however, this is not the case. It was 0.85 physicians per 1,000, the average number of doctors in 21 countries that participated in the training course except for Taiwan and Thailand which have already achieved universal population coverage[12] (WHO, 2017). The average physician density of the participating countries excluding high-income country (Bahrain) and middle-income countries (Egypt, Malaysia, Maldives, and Mexico) was even 0.52 physician per 1,000.

Even if policymakers with advanced policy capacity would be able to devise a competent health insurance system, it may not be effective without sufficient health workers. Rather, it can create a downward economic spiral for households as they pay for insurance

[12] Number of physicians per 1,000 population (WHO, 2017): Afghanistan (0.3), Bahrain (0.93), Cambodia (0.16), Ecuador (1.66), Egypt (2.83), Ethiopia (0.03), Ghana (0.09), Kenya (0.19), Laos (0.18), Malaysia (1.28), Maldives (1.42), Mexico (2.02), Nepal (0.21), Peru (1.11), Taiwan (1.7), Sudan (0.28), Swaziland (0.14), Thailand (0.39), Tunisia (1.64), Uganda (0.12), Vietnam (1.18)

but cannot get appropriate services. Therefore, capacity building and training for UHC needs to be part of the picture to train health professionals to work under the insurance system. Not just focusing on knowledge of health insurance design itself, they should also touch on the issue of national capacity to improve the coherence between its education, health, finance, labour and employment strategies, progressively moving towards a health workforce adequate in numbers, quality, competencies, distribution and performance. Experts note that an exclusive or over-restrictive focus on numerical shortages carries a risk of policy misalignment (WHO, 2016). Improved performance, productivity and quality are equally important in devising and implementing effective workforce strategies. Without touching on these issues of human resources, the knowledge shared in the training course on health insurance systems might only alienate low-income countries. More comprehensive and inclusive knowledge should be shared to help them develop their policy capacity to mobilize domestic resources with appropriate macroeconomic policies at a national level. Thus, their funding levels reflect the value of effective human resources for health to the country's economy by factoring in the potential for improved worker productivity in other sectors, and the broader socio-economic returns of investing in health sector employment.

5.6 Summary

The *relational context* found that the trainees' direct or indirect positive experience with South Korea in the past, their mutual efforts to eliminate the physical distance between them, and South Korea's high credibility among the trainees seemed to enhance the their willingness to draw lessons from South Korea's experience and facilitate necessary socialization for a deeper understanding of the shared knowledge. On the other hand,

somewhat inconsistent administrative control in the trainees' institutions, and too specialized contents that only highlighted the knowledge gap, negatively affected the trainees' ability to internalize the shared knowledge into their home institutions. These findings suggest that South Korea may want to maximize its advantages as a now emerging donor that used to be a dependent donor aid recipient from the international community, even including some of the trainees' countries. At the same time, the findings address the call for South Korean agencies to secure communications and interaction channels regarding its knowledge-sharing initiative through defined, structured organizational arrangements, rather than through ad hoc processes by certain staff members in case of changes in personnel.

The analysis on the *knowledge contex*t of the training course revealed critical limitations of South Korea's knowledge-sharing efforts in terms of effectiveness in building policy capacity for stakeholders in LMICs to design and implement their UHC programs in their countries. Those limitations were not because of poorly articulated theories nor a lack of knowledge in health care systems. They were rather attributed to overly '*de-contextualized'* knowledge, which prevented effective lesson-drawing. Even though the explicit knowledge clearly articulated South Korea's health insurance system and policies in all three dimensions of the "UHC Cube," little was shared about the contextual factors that made these mechanisms work. Most of the lecturers shared South Korea's experience, cleansing out its social, political, cultural, and ethical contextual factors embedded in its people's routines, norms, beliefs, and values. This overly de-contextualized explicit knowledge often lost sight of the necessary UHC program designs that are specific between each region and country. Moreover, little effort was made in sharing tacit knowledge, which could offer more instructive 'know-how' rather than normative 'know-what' to achieve UHC. These in turn

hampered effective lesson-drawing and capacity building for the trainees in the training course.

The *recipient context* clearly showed that the "trainees" were far from a homogeneous group. The trainees' motivation to participate in the training course, their intent, and their ability to invest time and other resources in outside knowledge to be their own (i.e. retentive capacity) could vary from country to country. Depending on the developmental stage in which they are currently involved within their own country regarding health care systems, the extent to which a certain kind of knowledge shared in the training course can be transformed into their policy actions also varied. South Korean stakeholders identified the trainees' limited retentive capacity at the institutional level, due to a lack of political will as the biggest barrier to an effective knowledge-sharing initiative. How to overcome such a barrier seemed to be one of the key challenges that South Korean stakeholders face to enhance the effectiveness of the training course.

The *source context* revealed South Korean stakeholders' limited efforts to enhance the transferability and applicability of its knowledge to the trainees' local context. First, its predominant 'teacher-centred approach' in teaching and learning led to inordinate lengths of one-way lectures, and insufficient group interactions and mutual learning among the trainees. This ineffective pedagogy of the training course limited the trainees' opportunities to reflect on what lessons could be drawn from the journey of South Korea for UHC achievement, and to share the lessons, insights and curiosities with each other. Moreover, South Korea's strategic intent behind the UHC knowledge-sharing initiative was not aligned with the trainees' needs. South Korea wants to expand its medical device and pharmaceutical industry in the emerging economies' market. In the training course, the lecturers boasted about the

country's rapid growth in the global pharmaceutical market, and introduced newly developed drugs and its advanced pharmaceutical systems. However, this was far from contributing to the LMICs' efforts to make essential drugs available and accessible for all. It did not address either the structural problems in pharmaceutical systems LMICs facing.

Looking at the *upstream context,* broader contextual factors of South Korea's successful health insurance systems included extraordinary economic growth, strong political leadership under the authoritarian government, and a sufficient provision of trained health workers. Transferability and applicability of South Korea's path to achieving UHC into the context of LMICs might depend on to what extent these broader contexts of economy, politics, and human resources are repeatable in LMICs today. However, these unique contextual factors were not adequately explained in the training course, and this deprived the trainees of opportunities to draw useful lessons that might help them design and implement UHC programs within their countries.

Overall, there were many loopholes in the training course for it to become an effective capacity building program for stakeholders in LMICs aiming to achieve UHC. There is no such thing as the "best" health care system and national health insurance system in the world. Learning the technical knowledge of health care and health insurance systems of one country does not mean that it can be directly transplanted into another. Thus, the training course should have served as more than just a presentation on South Korea's successful health insurance system. It should have also provided the trainees with transferable and applicable policy lessons, so that they could apply these lessons learned to the development of UHC programs within their countries. A lack of emphasis on the

contextual factors of South Korea's success story throughout the training course limited effectiveness in building policy capacity for the trainees.

CHAPTER 6 CONCLUSIONS

This thesis answered the question: Is South Korea's knowledge-sharing initiative on universal health coverage (UHC) effective in building capacity for stakeholders in low-and middle-income countries (LMICs)? The key approach to this question was understanding UHC through the lens of human security as a moral commitment to meeting peoples interests. The study closely looked at the International Training Course on Social Health Insurance and analyzed whether South Korea's knowledge of UHC can offer transferable and applicable policy lessons for the stakeholders in LMICs into developing and implementing their health insurance systems in their countries. The effectiveness of the training course in building such a policy capacity was analyzed based on a comprehensive model of knowledge-sharing which examined the relational context, knowledge context, recipient context, source context and upstream context of the training course.

This thesis concludes that South Korea's knowledge-sharing initiative fell short of being an effective capacity building program for stakeholders in LMICs to develop and implement their own UHC programs in their countries because of a lack of attention to upstream determinants. Capacity building is more than simply providing technical knowledge; it is important to support knowledge-sharing around specific solutions in the local context. The knowledge shared in the training course, however, was closed to 'policy manuals' about South Korean national health insurance system, rather than complexities and contingencies of the country's process of developing UHC programs within its specific contexts of economy, politics, society, and culture. The little emphasis on the contextual factors resulted in limited opportunities for the trainees to draw transferable and applicable policy lessons from South Korea's experience to their own health care systems.

The biggest shortcoming of the training course was that it failed to strike a balance between 'de-contextualisation' and 'over-contextualisation' of South Korea's own journey to UHC. De-contextualisation tends to focus too much on outputs, results and impacts – blending out the contextual variables, while over-contextualisation over-emphasises the narrative, the 'how' of the success or failure of a certain intervention. South Korea has yet to find a balance between these two regarding its social health insurance mechanisms, systems, and policies. This caused the trainees in the training course sometimes to consider the 'Korean recipes' for UHC as too contingent upon the context. So, they could never make any generalisation about its potential utility in their local context (too over-contextualised). On the other hand, sometimes, the variables that make the Korean UHC case unique to the context in which it was achieved were not fully explained to the trainees (too de-contextualized). There was little emphasis in the program on the sight of the necessary program designs that are specific between each region and country, instead a tendency to focus on enumerating the outcomes and results of the country's successful health care reform. This impeded the capacity building for the trainees to design and implement their UHC programs in their countries by hindering them from drawing necessary policy lessons from South Korea's experience with UHC achievement.

The obvious challenges also lied in South Korean stakeholders' narrow vision of successful health care system and ineffective pedagogy of the knowledge-sharing. They often confined themselves to a narrow, mostly economic interpretation of UHC, emphasizing "cost-effectiveness" and "value for money" on every corner of a health insurance system, without fully considering its potential social consequences and ethical issues in various contexts of LMICs. If South Korean stakeholders aims to make the training course a genuine

and meaningful capacity building program, they will have to diversify their ideological approach to people's health and broaden their understanding of social determinants of health, especially in the LMICs context. They also need to develop an appropriate knowledge-sharing pedagogy to create a curriculum that could best address the needs and learning goal of the trainees and to employ more effective knowledge-sharing methods. The training course's teacher-centred direct instruction rather than student-centred inquiry-based learning left little opportunity for the trainees to have discussions to reflect on what lessons could be drawn from South Korea's experience with UHC achievement.

This research clearly revealed that having achieved UHC at an extraordinary pace did not necessarily make South Korea the 'best teacher' in this field. The training course failed to provide applicable and transferable policy lessons that can effectively break down the economic, political, and social barriers in their current health care systems towards achieving UHC. South Korea's knowledge of UHC in the training course was excessively technical and provided little context of upstream determinants of UHC. Because South Korea did not have the worry of debt repayment and structural adjustments, the knowledge it developed throughout the 1970s and 1980s was heavily technical. Political and economic knowledge of UHC was rarely shared in the training course, and this in turn provided little insight into realistic and effective road maps to achieving UHC in low-resource settings.

As an emerging donor that was once one the poorest countries in the world as a war-torn nation, South Korea enjoys the favorable historical and social ties with some countries in the global South. In addition, its dramatic transformation into a global economic power since then brings the credibility to South Korea's development knowledge including social security systems. There has been a strong desire among many LMICs to learn from South Korea's

example. However, South Korea's knowledge-sharing initiative on UHC accompanied by such a good relationship, high credibility, motivation, and inspiration does not necessarily guarantee successful capacity building opportunities to the stakeholders in the LMICs. What would be essential to help them design and implement effective UHC programs in their own countries is providing critical analyses on the contextual factors that drove South Korea's successful achievement of UHC. It would be equally important to share the policy failures and struggles that the country underwent so that the stakeholders in LMICs could learn lessons from what did not work as well as what worked. This learning opportunity in the knowledge-sharing program will help them separate "best practices" from particular economic, political, social and cultural contexts and apply them to their own systems.

This critical understanding of South Korea's knowledge-sharing initiative on UHC for LMICs gives an important lesson for other emerging donor countries that offer non-monetary support in the form of shared expertise from their own recent development. Most experts in developed societies did not necessarily directly experience the developing stage of their countries since the societies were established long before they were born. However, experts in emerging donors personally experienced development in their area during a resource-limited phase. Hence, emerging donors have a good herd of experts who remember how to efficiently develop their area of expertise with limited resources. These 'people' are the greatest asset. In order for the emerging donors to effectively contribute to the capacity building for stakeholders in other developing countries, it would be imperative to develop a strategy for how to best transfer this knowledge embedded in their people into applicable development policy actions in the current LMICs context. This would require an appropriate contextualisation of the knowledge, so that sharing this knowledge can provide the

stakeholders in LMICs with useful lessons and insights into innovative solutions to overcome their development challenges. Future research could further explore a holistic conceptual framework for developing such a contextualisation strategy.

A country's health care and insurance system evolves over time, along with its people's choices and national policies. It is unlikely that there is one single blueprint for an ideal health care system design or a magic bullet that will automatically remedy deficiencies. The strengthening of health care systems in LMICs must be seen as a long-term developmental process. Success and of failures, perhaps similar to those experienced in Korea, will be inevitable for any country that tries to institute its own system. Therefore, South Korea should remind itself that its knowledge-sharing initiative on UHC must not be a single-minded drive to define and operationalize its success story about UHC achievement, but a whole-of-society approach to explore and share its nuances, complexities, and contingencies. This should be an underlying principle embedded in its global quest for 'Health for All.'

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APPENDIX

INTERVIEW GUIDE

Section A: **Background Information**

A1. What is your position and job in your organization?

A2. How long have you been working in your team/organization?

A3. Could you briefly describe the knowledge sharing projects/programs you are involved in?

A4. What participating countries do/did you work with?

A5. How often do you visit the participating countries? For how long did/do you usually stay?

A6. What do you like most (and least, if you want) about your job personally?

Section B: **What Knowledge is Shared, and How?**

B1. What knowledge does your organization posses regarding social health insurance systems for Universal Health Coverage (UHC)?

B2. To what extent do you perceive such knowledge as a key organizational asset?

B3. In what form has the knowledge been accumulated? Is the knowledge embedded in codified data, information, reports, manuals, or files?

Or, is the knowledge more embedded in experience, values, emotions, routines, or competence, that is 'know-how'?

B4. What tools/projects/programs does your organization utilize to share such knowledge?

B5. Are they designed as short-term or long-term practices? What is average period length of each initiative?

B6. What is your organization's selection process for participating countries?

B7. With whom of the participating countries do you share the knowledge? Policymakers? Public administrators? Academics? Health practitioners? or Others?

B8. To what extent do you feel sensitivity and controversiality of South Korea's knowledge regarding social health insurance systems? To what extent does your organization share its knowledge with participating countries? (what you tell vs. what you do *not* tell)

B9. Does your organization have a standardized knowledge kit to be shared? Or, it is more likely to be customized from participating country to country?

Section C: Organizational Context of Knowledge Sharing Initiatives

C1. How would you describe the overall mission and goals of your organization?

C2. How does your organization learn participating countries' demand to share knowledge regarding social health insurance systems?

C3. Do you get support from other departments of your organization and/or external related organizations to facilitate your knowledge sharing practices? If yes, what kind of support? If no, why not?

C4. What do you think the biggest benefits of the knowledge sharing practices for your organization and/or the government of South Korea?

C5. What do you think the biggest benefits of the knowledge sharing practices for the participating countries?

C6. Is there any risks or potential risks of the knowledge sharing practices you perceive for each parties? If so, how those risks have been or will be mitigated?

C7. How would you describe the organizational culture (i.e. leadership styles, hierarchy, values, diversity, etc.) of your organization and the participating country's organization? How similar or how different? How does it affect the knowledge sharing practices between the two parties?

C8. Have you perceived any power dynamics or tensions between your organization and the participating country's organization during the knowledge sharing practices? If so, could you describe them more?

C9. Have you encountered any challenges regarding resource gaps (people, materials, assets, technologies, funding, etc.) between your organization and the participating countries? If so, how did you handle them?

C10. To what extent does your organization seek to evaluate the participating countries' perception of the relevance of the shared knowledge? Have you evaluated the impact of your knowledge sharing practices? If so, how did you evaluate it? If you want, would you share the results?

C11. To what extent and in what ways do you maintain and manage the knowledge sharing network to support future knowledge sharing flows with the participating countries?

Section D: National Context of Knowledge Sharing Initiatives

D1. How does the national culture (including language differences) of the participating countries affect your knowledge sharing practices?

D2. To what extent do you feel the history of past relations or level of trust with the participating countries influence the processes and outcomes of your knowledge sharing practices? In what particular ways?

D3. How would you describe the political interests of the participating countries? What are the impact on the knowledge sharing practices if any?

D4. Have you found any difficulties in coordinating your program with the existing laws and policies of the participating countries during the knowledge sharing processes?

D5. How do you think this knowledge sharing initiative regarding social health insurances affect the landscape of future relations between South Korea and the participating countries?