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Original Article

Bilateral health agreements of South Africa: an analysis of issues covered

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Abstract

The bilateral agreements signed between South Africa and countries in Southern and Eastern Africa are a rare example of efforts to regulate health-related issues in a world region. As far as we know, there are no comparable bilateral health governance mechanisms in regions elsewhere. Furthermore, the rapidly growing literature on global health governance and governance for global health has to date not addressed the issue of patient mobility and how to govern it. In this study, we examine the issues included in these agreements, highlight key issues that they address, identify areas of omission and provide recommendations for improvement. This analysis should inform the development of such governance agreements both in Southern Africa and in regions elsewhere. We obtained 13 bilateral health agreements between South Africa and 11 neighbouring African countries as part of a broader research project examining the impact on health systems of patient mobility in South Africa, and thematically analysed their content and the governance mechanisms described. The agreements appear to be solidarity mechanisms between neighbouring countries. They contain considerable content on health diplomacy, with little on health governance, management and delivery. Nonetheless, given what they do and do not address, and how, they provide a rare insight into mechanisms of global health diplomacy and attempts to address patient mobility and other health-related issues in practice. The agreements appear to be global health diplomacy mechanisms expressing solidarity, emerging from a post-apartheid period, but with little detail of issues covered, and a range of important issues not addressed. Further empirical work is required to understand what these documents mean, particularly in the Covid-19 context, and to understand challenges with their implementation. The documents also raise the need for particular study of bilateral flows and experience of patients and health workers, and how this relates to health system strengthening.

Keywords: Governance, health, trade, South Africa

Key Messages

- These bilateral agreements signed between South Africa and neighbouring African countries are a rare example of efforts to regulate health-related issues in a region.
- The agreements appear to be solidarity mechanisms between neighbouring countries.
- What they do and do not address, and how, provides rare insight into mechanisms of global health diplomacy and attempts to address health-related issues in practice.

Background

In today's globalized world many issues of health and healthcare transcend country boundaries. Partnerships and more complex engagement between countries and different settings is important for addressing such issues, in terms of prevention, treatment and care. The cross-border nature of many health issues and the complexity of addressing these is encompassed in the concept of 'global health', itself overlapping with and derived from the concepts of 'public health' and 'international health' (Koplan *et al.*, 2009). International health regulations and mitigating the spread of infectious disease at borders and ports was the historic focus of cross-border health issues (Howard-Jones, 1950), but ease of international trade and other processes of globalization have led to the need for a different approach. This new approach is, as Chanda (2002) describes, reflected in the growing cross-border delivery of health services, the movement of health workers and patients, and in an increasing number of collaborative arrangements (Chanda, 2002). An important aspect of this globalized approach to health is trade in health services. The World Trade Organization's General Agreement on Trade in Services (GATS) defines trade in health services via four modes: the cross-border supply of health services,

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through electronic and other means; the consumption of services abroad; foreign direct investment (FDI), involving the establishment of hospitals, clinics, diagnostics, treatment centres and nursing homes; and the movement of health professionals (Smith *et al*., 2009). Trade in health services has received relatively little research attention, despite including highly contentious issues such as the cross-border movement of patients or patient mobility (Hanefeld and Smith, 2019). This is often a particularly contentious issue in low- and middle- income countries, including in South Africa.

The South African public health system faces many challenges, but offers greater availability and quality of health services and treatment than many of its neighbouring countries (Cooradia *et al*., 2009; Crush and Chikanda, 2015). The shortage of health workers and other capacity limitations in many countries of sub-Saharan Africa is well documented (Kinfu *et al*., 2009; Willcox *et al*., 2015). In addition, South Africa's private health system provides high-quality care comparable to that of many high-income countries, and thus attracts medical travellers from abroad and within the continent paying out-of-pocket for treatments (Mazzaschi, 2011). South Africa has also been the destination for large numbers of migrants from the African continent and beyond, seeking a better life and economic opportunities, as well as a destination for refugees fleeing conflict within the region (Vearey, 2012).

As a result of these dynamics, South Africa has over the past decade received increasing numbers of patients from abroad into its health care system (Crush *et al*., 2012). Patient mobility into South Africa is characterized by a spectrum covering informal travel for healthcare from the sub-Saharan African region and planned travel from within the region and beyond (Crush and Chikanda, 2015). This includes relatively wealthy 'medical tourists', predominantly from high-income countries, or wealthy elites from within low- and middle-income countries, travelling with the intent to access treatment in the South African private sector; patients from neighbouring countries crossing overland borders to access treatment and care informally in the public sectors; and patients referred formally from neighbouring public health systems to the South African public health care sector (Mazzaschi, 2011; Connell, 2013; Crush and Chikanda, 2015; Walls *et al*., 2016). In addition to this are refugees or migrants to South Africa requiring health care services whilst in South Africa.

The increasing number of people seeking health care in South Africa fits within a broader trend of increasing global travel for the purpose of medical treatment (Hanefeld *et al*., 2014). Other key destinations for mobile patients include several countries in Europe, Asia, South and Central America and the Middle East (Ackerman, 2010; Bustamante, 2014; Hanefeld *et al*., 2014; Lunt *et al*., 2015). Whilst there are few reliable estimates of actual patient numbers, the overall growing trend in patient mobility is associated with increased globalization and inter-connected trade; new forms of political cooperation; technological developments, especially communication through the internet; and a burgeoning international market in medical care and health services (Lunt and Mauniion, 2014). Whilst some patient mobility takes place primarily within the private medical sector (e.g. medical tourism), limited attention has so far been paid to the public sector governance arrangements covering movements of patients from one country to another to access treatment.

Literature on patient mobility has mainly focused on description of the patient experience, with some focus on risk and regulation (Hanefeld *et al*., 2014). The one exception has been a research focus on patient mobility in the European Union (EU) (Glinos and Baeten, 2006; Legido-Quigley *et al*., 2012). The EU as a common economic and political unit consisting of individual nation states, has dealt with the issue of patient mobility through an EU Directive (Legido-Quigley *et al*., 2011), the equivalent of a law, which came into force in 2013. Equally, while there is a rapidly growing literature on global health governance and governance for global health (Frenk and Moon, 2013), this has to date not addressed the issues of trade in health services and how to govern it.

Related to this issue of cross-border health governance is a growing literature on global health diplomacy, which addresses the areas of global health as well as international relations (Drager and Fidler, 2007). Its focus has been in areas where health intersects with foreign affairs. This includes trade and its relation to health, initially focused on access to medicines but then expanding to a focus including nutrition and non-communicable diseases (Lopert and Gleeson, 2013; Milsom *et al*., 2020). Moreover, a strong focus has been on the way in which countries engage around responses to common threats and the governance mechanisms to address these; foremost amongst these are the International Health Regulations (Wenham *et al*., 2019). (Kickbusch, 2011) provides a framework for global health diplomacy based around global health security, economic interest and social justice as three key frames in global health diplomacy.

Issues of social justice, equity and solidarity are also salient to discussion of cross-border health issues including trade in health services, and particularly so in South Africa, with its apartheid history still today shaping its political economy, health and social outcomes (Cooradia *et al*., 2009). Within the traditions of the people of Southern Africa is a culture of solidarity, termed *ubuntu*. As Ndebele & Sikuza (2020) describe, *umntu ngumtu ngabantu* (in Xhosa) is an African philosophy, a way of being and a moral principle (Ndebele and Sikuza, 2020). It means 'humanity', but is often translated as 'I am because we are'. *Ubuntu* recognizes our shared humanity and interconnectedness. With patient mobility, *ubuntu* is a reminder of communal obligations and is consistent with recognizing the interdependence and interconnectedness of people from different countries. The pandemic of Covid-19, as an infectious disease in no way respecting country borders, highlights the concept of *ubuntu* on a global scale. The Covid-19 pandemic is a reminder that we are all interconnected, interdependent and mortal (Ndebele and Sikuza, 2020).

Following the 1999 Protocol on Health of the Southern African Development Community (SADC), which established a mechanism for the referral of patients for tertiary care (SADC, 2004), South Africa signed agreements relating to health and including a focus on patient mobility with 11 countries in Southern and Eastern Africa (SADC, 2004). International instruments provide the normative foundation for developing such bilateral agreements. With the good governance of labour migration and the protection of migrant workers, for example, these include the following.

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(1) Nine UN universal human rights instruments and associated protocols.
(2) Eight International Labour Organization (ILO) Core Conventions on fundamental principles and rights at work, pertaining to forced labour, freedom of association, child labour and discrimination.
(3) Three international migrant worker specific conventions.
(4) All other labour standards that apply to migrant workers including particularly the ILO Conventions on Private Employment Agencies, 1997 (Number 181) and the Domestic Workers Convention, 2011 (Number 189).
(5) The 'ILO Multilateral Framework on Labour Migration: Non-binding principles and guidelines for a rights-based approach to labour migration' is a compendium of principles and guidelines on labour migration based on the above instruments and negotiated through tripartite consultations (International Labour Organization, 2006).

Given the limited number of governance mechanisms for cross-border health issues including trade in health services, these 13 bilateral health agreements involving South Africa provide an opportunity for better understanding how to govern issues of trade in health services within one world region. In regard to patient mobility, these agreements also represent an effort to formalize patient movements and obtain payment for the cost of treating non-residents (Crush and Chikanda, 2015). In prior work, the agreements were reviewed for their content in relation to patient mobility, but have not been fully analysed (Crush *et al.*, 2012). In this study, we examine the key issues included in the bilateral health agreements between South Africa and SADC countries, highlight key health issues that these agreements address, point to areas of omission and provide recommendations for improvement based on this analysis.

Methods

Study design

This study involved qualitative content analysis (Krippendorff, 2004; Mogalakwe, 2006) of bilateral heath agreements between South Africa and neighbouring SADC countries.

Data collection

We obtained the bilateral health agreements between South Africa and neighbouring SADC countries from the South African National Department of Health, as part of a broader research project examining the impact of patient mobility on health systems in South Africa (Walls *et al.*, 2016). Only bilateral health agreements involving South Africa and other national governments were included. We excluded 'twinning' health agreements between hospitals of the respective countries. The bilateral documents that we obtained are primary documents; there is not detailed implementation guidance that supports each individual bilateral exchange.

Table 1. Health agreements and memoranda of understanding between South Africa and Southern African Development Community (SADC) countries

Country	Document name	Date signed
Angola	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Angola on Health Matters	29 Jan 2004
Botswana	Memorandum of Understanding between the government of the Republic of South Africa and the Government of the Republic of Botswana on Cooperation in the Field of Health	27 Oct 2005
Democratic Republic of Congo	Agreement between the Government of the Republic of South Africa and the Government of the Democratic Republic of Congo on Health Matters	31 Aug 2004
	Agreement between the Government of the Republic of South Africa and the Government of the DRC on Health Services	
Eswatini (formerly Swaziland)	Agreement between the Government of the Republic of South Africa and the Government of the Kingdom of Swaziland on Cooperation in the Field of Health	10 May 2010
Lesotho	Memorandum of Understanding between the Government of the Republic of South Africa and the Government of the Kingdom of Lesotho on Cooperation in the Field of Health	10 Nov 2005
Malawi	Agreement between the Republic of South Africa and the Government of the Republic of Malawi in the Field of Health	12 Feb 2009
Mozambique	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Mozambique on Health Matters	8 Dec 2005
Namibia	Agreement between the Government of Republic of South Africa and the Government of the Republic of Namibia on Cooperation in the field of health	5 Aug 2008
Seychelles	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Seychelles on Health Matters	31 Aug 2006
Zambia	Memorandum of Understanding between the Government of the Republic of South Africa and the Government of the Republic of Zambia on cooperation in the field of health	9 Dec 2009
Zimbabwe	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Zimbabwe on Health Matters	21 Apr 2009
	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Zimbabwe on Health Matters	29 Aug 2017

Source: The South African National Department of Health, 2015 and Crush *et al.* (2012) (Hanefeld and Smith, 2019).
Note: SADC countries for which there are no agreements include Comoros, Madagascar, Mauritius and Tanzania.

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Data analysis

Table 1 lists the 13 agreements we examined between South Africa and members of SADC. Each of these documents was written in English. To understand the impact of these agreements in practice, we undertook a content analysis of each of the 13 agreements (with 11 neighbouring countries). Content analysis is a qualitative research technique for making replicable and valid inferences from data to their context (Krippendorff, 2004; Mogalakwe, 2006) and is widely used in health research (Elston and Fulop, 2002; Weishaar *et al*., 2012). We are cognizant that the documents to which content analysis is applied have usually been developed for a particular purpose that may be very different to that of the research being undertaken. We examined the text of each agreement against a framework we developed, following the 'framework method' of qualitative content analysis (Gale *et al*., 2013). This allows for the development of themes, which can then be populated with data to create more visible links between the content of documents and research questions. It assists in translating qualitative data into an empirically valid data set.

The development of the framework involved an iterative process informed by the literature, including on patient mobility and cross-border governance of health care, and an initial review of the agreements. The framework development was also informed by the four modes of trade in health services as defined under the General Agreement of Trade in Health Services (Smith *et al*., 2009) to help frame the relevance of the findings to these broader issues. The agreements were examined separately by two authors (JH and HW) for key issues and themes; the authors then compared and discussed themes developed before deciding on initial categories for review of agreements. We identified three broad categories, namely: (1) human resources for health; (2) patient mobility; and (3) collaboration/information exchange and technical assistance on specific issues such as for example HIV, and also identified a number of sub-categories. The two authors (JH and HW) then analysed the agreements separately before again comparing the analyses and reflecting on the categories used in the framework. The categories were further refined following this initial step to improve the framework for a more relevant and detailed review of the agreements.

Once the framework was complete, the content of the bilateral health agreements was coded and categorized using a constant comparative approach (Maykut and Morehouse, 1994). The two authors (JH and HW) reviewed and coded each of the agreements and any differences between reviewers were resolved through discussion. Once this coding had been completed the results were shared and triangulated with the other study authors.

Results

Table 2 presents the issues covered in each agreement, based on the categories of the framework. The main issues covered by these agreements fit into three broad categories: 'human resources for health', 'patient mobility' and 'collaboration/information exchange and technical assistance'. In addition, the documents can be interpreted as expressions of South Africa's solidarity with neighbouring countries. Overall, there is a marked lack of detail across all issues covered in these agreements. Furthermore, there is considerable variation in what is covered—and not covered—between the different agreements.

Human resources for health

The issue of human resources for health is addressed in all of the agreements. It often refers to training and education, as well as exchange visits between health professionals, lecturers and students of neighbouring countries and South Africa with the expressed purpose of building capacity. Information on types of training and education is not included, nor is the form of exchange visits addressed.

In all, 4 of the agreements—between the Republic of South Africa and Botswana, Lesotho, Malawi and Zambia, respectively—address the issue of professional registration by medical professionals. The other 7 agreements do not cover this issue. The 4 agreements that do address professional registration of medical professionals commit to recognizing registration and accreditation of medical professionals between the different countries. The agreements do not address the issue of what is often termed 'brain drain', resulting from inequitable movement of human resources for health between countries.

Patient mobility

In regard to patient mobility, the agreements address the referral of patients in loose terms They generally refer to a promise in principle for South Africa to accept patients from the public health system of the other country. None of the agreements detail South African patients being referred for treatment to the other country. While the referral of patients is mentioned, logistics, treatment pathways, referral and recipient organizations, are not described. Whilst costs are largely not well described, some of the agreements do describe the types of costs that will be reimbursed, for example whether they include accommodation or not. The agreement with one country (Zambia) sets out the mechanism for reimbursement, while several provide some information regarding the type of service or institutions at which referrals are undertaken—e.g. the agreement with Mozambique is between public hospitals and public health institutions of the two counties, that with Angola is simply described as between hospitals of the two countries, and with Zambia patients will be referred to any appropriate hospital in South Arica for treatment, depending on the required services. Agreements with Mozambique, Angola, Eswatini and Zambia make provision for planning and agreement regarding actual patient numbers. However, overall in terms of patient mobility little specific information is provided on how the referral will be implemented, arranged or overseen.

Agreements with four countries make provisions for appraisal and evaluation missions but the issue of quality assurance overall is not well addressed in any of the documents. There is not a list of prescribed institutions or detail regarding where patients may be referred. Importantly in this context, medical records, continuity of care and redress in cases of malpractice are not mentioned in any of the agreements.

Collaboration/information exchange and technical assistance

All of the agreements cover a wide spectrum of collaboration, information exchange and technical assistance. This ranges

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Table 2. Issues covered in bilateral health agreements[a] between South Africa and other Southern African Development Community (SADC) countries

Category of collaboration	Sub-category	Country bilateral agreement
Human resources for health	Professional registration	Botswana, Lesotho, Malawi, Zambia
	Exchanges/capacity-building (medical/non-medical)	Angola, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Seychelles, Swaziland, Zambia, Zimbabwe
	Training/education	Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Namibia, Seychelles, Zambia, Zimbabwe
	'Brain-drain' issues	-
Patient mobility	Referral of patients	Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Zambia, Zimbabwe
	Transfer of patients	Namibia
	Detail of cost covered	Angola, Democratic Republic of Congo, Eswatini, Malawi (value not specified but sets out accommodation and travel of accompanying person), Mozambique, Namibia, Seychelles, Zambia
	Detail of reimbursement	Zambia
	Type of service/institution to which the patient is referred	Angola, Mozambique, Seychelles
	Planning of patient numbers	Angola, Mozambique, Swaziland, Zambia
	Quality assurance (appraisal and evaluation missions)	Angola, Namibia, Seychelles
	Medical records	-
Collaboration/information-exchange and technical assistance	Twinning between hospitals	Angola, Democratic Republic of Congo, Eswatini, Malawi, Mozambique, Namibia, Seychelles, Zimbabwe
	Twinning between institutions	Angola, Mozambique, Zimbabwe
	Medical products (including pharmaceuticals)	Lesotho, Zambia, Zimbabwe
	Other issues[b]	Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Namibia, Seychelles, Zambia, Zimbabwe
	Tele-medicine	Angola, Eswatini, Malawi, Mozambique, Namibia, Seychelles, Zambia
	[In person] technical assistance	Lesotho, Namibia, Seychelles
	Disease surveillance	Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Namibia, Seychelles, Zambia, Zimbabwe
	Information sharing	Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Mozambique, Namibia, Seychelles, Zambia, Zimbabwe
	Research	Angola, Botswana, Eswatini, Malawi, Mozambique, Namibia, Seychelles, Zambia, Zimbabwe
	Health systems management	Botswana, Democratic Republic of Congo, Malawi, Namibia, Seychelles, Zimbabwe

[a]Each of the agreements has provisions addressing agreement dispute settlement, agreement amendment, and agreement force, duration and termination. Other important topics not included in the agreements include issues around patients following domestic laws, and visa requirements for staff, patients and students.
[b]The 'other issues' category includes: health promotion, health legislation and regulations, emergency situations/disaster relief, movement of radioactive waste, food control, and laboratory services.

from 'twinning' between institutions within countries—such as for example between Steve Biko Hospital at the University of Pretoria and the Democratic Republic of Congo—to much broader commitments to collaborate. Specific areas of collaboration mentioned include communicable and non-communicable disease prevention, control, management surveillance and research, laboratory, forensic pathology and blood transfusion services, telemedicine, and traditional medicine. Exchanges on health systems management and health systems reforms are also referred to in a subset of agreements, as are specific diseases and conditions such as HIV/AIDS.

Ubuntu, social justice and solidarity

The documents can be interpreted, particularly given some of the language included in them and use of words such as 'solidarity', 'friendship' and 'equality', as high-level statements of intent to collaborate and expressions of solidarity. An example of this type of language is the text forming part of the preamble of several of the agreements:

> "*Willingness to contribute to establish and develop a diversified relationship in the health field, in the spirit of solidarity and friendship between the two countries.*"

Another example is cooperation being described 'on the basis of equality and mutual benefit' in the agreement with Namibia.

Discussion

The 13 bilateral health agreements between South Africa and neighbouring countries in the SADC region represent one of

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a small number of governance mechanisms aimed at addressing challenges arising from trade in health services, patient mobility and other health-related issues within a world region. Reciprocal healthcare agreements commonly exist between countries in other world regions [e.g. between the UK and the EU as well as many non-EU countries (Department of Health and Social Care (UK), 2021)], and health worker migration is often covered in bilateral agreements of countries elsewhere, including between South Africa and the UK (Buchan *et al.*, 2014). However, as far as we know, there are not comparable bilateral health governance mechanisms in regions elsewhere. Thus, these bilateral health agreements between South Africa and its neighbouring countries represent an important opportunity to analyse and learn from the implementation of such mechanisms in practice.

Content analysis of the 13 bilateral health agreements revealed that they addressed various issues under the three framework categories developed: human resources for health, patient mobility, and collaboration/information exchange and technical assistance. While each of these headline categories is addressed by a wide range of specific issues in the agreements, the specific issues described in the agreements are lacking in detail, and some important issues are not covered—or covered only very superficially. For example, collaboration on addressing health challenges such as HIV/AIDS or learning between countries in areas such as health systems management are mentioned, but as statements of intent rather than in regard to the specifics or details as to what this may entail.

It is worth noting the intention of solidarity within which the agreements appear to be framed. However intention of solidarity does not necessarily translate into good systems and processes. There is an urgent need to revisit and reimagine what those documents should be and say, particularly in light of Covid-19. With this, understanding the commitments included and not included, and country and institutional relationships, is key. Analysis of these agreements has also highlighted the extent to which health issues not included in the agreements may be particularly important in considering relations in health between the countries in question.

Whilst the documents were lacking in detail throughout, we noted a particular lack of detail in the agreements relating to issues such as the cost of services provided and any reimbursement required. Furthermore, despite South Africa's position in the African region as a hub for the migration of health professionals (Connell *et al.*, 2007), there were no specific provisions in place to address this (other than general statements regarding capacity building and training of health professionals), and no detail regarding the nature of any reciprocity. The migration of health professionals is a critical issue for many countries neighbouring South Africa. For example, of 1200 physicians trained in Zimbabwe between 1990 and 2001, only 360 remained in the country in 2006 (Taylor *et al.*, 2011). Thus, there is considerable scope for the agreements to be adapted to follow the recommendations of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel, adopted by the 193 member states of the World Health Assembly in 2010. This Global Code established a framework for the ethical recruitment of health personnel, and proposes that conditions for the recruitment of health personnel should be set out in bilateral agreements between source and destination countries—to create win–win situations for both parties, including, e.g. reimbursement of the source country for each migrating health professional (Taylor *et al.*, 2011; Aluttis *et al.*, 2014).

Agreements with Angola, Namibia and Seychelles covered appraisal and evaluation missions, but in general there was no provision made in the agreements for quality assurance. No provisions were made for the sharing of medical records or promotion of consistent patient care, and the agreements provided little information on planning regarding the numbers of patients involved. This is of particular interest and relevance as quality assurance and accreditation of facilities is a key area of concern in regard to patient mobility and the portability of health services; however it may also reflect the lack of a global body for accreditation of hospitals such as through the UN or WHO (Lunt *et al.*, 2015; Walton-Roberts, 2015; Suzana *et al.*, 2018). In prior qualitative research focused on experiences of patients who have crossed borders, the accreditation and quality of services abroad is commonly mentioned as a key concern and is a key determinant of where patients travel (Suzana *et al.*, 2018). In addition, the agreements do not refer to medical records and the continuity of care—a further major area of concern for mobile patients (Suzana *et al.*, 2018; Chiesa *et al.*, 2019).

Patient mobility and use of services is only covered in regard to planned travel to obtain services and treatment abroad. 'Planned' in these agreements refers to the non-emergency character of the care and to the planning which statutory insurers or health authorities undertake when contracting treatment outside of the public system (Glinosa *et al.*, 2010). Planned patient mobility is often the result of a lack of available specialists and specialized equipment in home countries. This type of medical travel differs markedly from individuals travelling for care of their own initiative, or situations where people are mobile for leisure or business purposes and require care and treatment in a country other than where they are ordinarily resident. The origin and procedures of the examined patient mobility are based on explicit contractual agreements between purchasers and providers. Such patients typically travel short distances and contracted services (both public and private) may be subject to stringent safety audits and quality monitoring (Lunt and Carrera, 2010). While there are no published estimates of the planned patient mobility that has taken place under these agreements, it is likely that the high levels of informal mobility of patients in and out of the South African health system exceed these (Crush and Chikanda, 2015). Given the importance of quality assurance, medical records and continuity of care where patients are mobile or migrating, the omission of these issues in the agreements limits the extent to which the agreements can serve as actual mechanisms to address some of the key aspects of patient mobility.

In addition to the limited detail of issues covered within the agreements, there are areas which would potentially lend themselves to greater regional collaboration that are conspicuously absent. For example, among sub-Saharan African countries, only South Africa has pharmaceutical manufacturing capacity (Gray and Vawda, 2013; Owoeye, 2014); however, pharmaceuticals, or medical products, was an area only covered in two of the agreements (with Lesotho and Zambia).

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The lack of detail observed in these agreements may be due to them being high-level documents and high-level statements of intent to collaborate and expressions of solidarity, with the detail covered in other documentation, such as in agreements between specific hospitals of South Africa and neighbouring countries, and elsewhere. During the apartheid era, many of South Africa's neighbouring countries supported the anti-apartheid struggle, and thus the bilateral agreements can be interpreted in this historical sense as instruments of global health diplomacy and expressions of solidarity—whilst also being a part of a complicated modern world, with greater movement of people and resource-constraints within South Africa also shaping the countries' political economy. Indeed, Thorn (2006) described how the transnational anti-apartheid movement continues to influence present-day global politics (Thorn, 2006). Yet, the limited precision in the agreements also raises questions regarding the feasibility and consistency of implementation of the policies laid out in the agreements, and whether they allow for any institutional or systems learning from their implementation.

Of the GATS four modes of service delivery relevant to health systems, cross-border supply of health services, is addressed; the second issue (consumption of services abroad), on the movement of patients to consume services, is only covered in so far as it refers to planned medical travel (not informal medical travel), while FDI (e.g. to establish a new hospital, clinic or diagnostic facility) and the movement of health professionals, are not addressed at all. So while the agreements do seek to address some aspects of trade in health services, they do not address these comprehensively and do not provide sufficient detail on the issues that they do cover.

Conclusion

Our analysis of the 13 bilateral health agreements between South Africa and neighbouring countries presented here highlights the areas covered by these agreements, notes their spirit of solidarity, but equally identifies that the agreements side-step not only important issues that require urgent attention in relation to patient mobility but also other forms of trade in health services and cross-border health governance more generally. In particular, the omission of more tangible measures to address 'brain drain' of health professionals within the region, regulate quality control and continuation of treatment and care, and explore the potential for a regional market in pharmaceuticals seem missed opportunities.

The agreements analysed are a hybrid of political and economic documentation that appear reflective of historical relationships as well as current power imbalances between the country signatories and thus offer an insight into the political economy of health in the Southern African region. This is both in regard to South Africa's position both as a country with greater availability and quality of health services and treatment than its neighbouring countries—whilst with its own resource constraints and public health challenges (Cooradia *et al.*, 2009)—and in regard to these documents as instruments of global health diplomacy and solidarity in the historical context of the anti-apartheid movement and its support from many of South Africa's neighbouring countries. In terms of learning, to foster understanding of 'how to' govern cross-border health issues, the agreements particularly highlight the need to cover aspects of patient mobility that have financial implications, such as treatments covered, travel and accommodation, and issues of patient safety and care, such as continuity of care, medical records, quality assurance or redress.

In regard to these particular bilateral health agreements, looking in detail at the problems and how to improve effectiveness of these agreements, and undertaking redrafting, would be a way to reset collaboration, diplomacy and the spirit of *ubuntu* between the signatory countries. To further understanding of what is required for the governance of trade in health services, examining experiences of patients and health workers in practice, including the experience of bilateral exchanges, will be an important empirical next step.

Abbreviations

EU = European Union, FDI = foreign direct investment, GATS = General Agreement on Trade in Services, ILO = International Labour Organization, NCD = non-communicable disease, WHO = World Health Organization, SADC = Southern African Development Community.

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Author contributions

J.H. and H.W. conceptualised and designed the study. J.H., M.M. and H.W. undertook data collection. J.H. and H.W. undertook data analysis and all authors contributed to the interpretation. J.H. and H.W. led the drafting of the article. All authors contributed to critical revisions of the article and approved the submitted version of the manuscript.

Reflexivity statement

This study includes co-authors from South Africa (two authors), important for the focus of this work, and also the United Kingdom (four authors), which reflects the institutional base of the country holding the grant within which this study was undertaken. We have a balance of both women (three authors) and men (three authors). We also include authors from a range of seniority levels, from research fellow to senior professor. One of our co-authors holds a joint appointment between academia and the South African Department of Health, which was critical in supporting our access to these documents and supported interpretation.

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Ethical approval. Ethical approval for this type of study is not required by our institute.

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