Mapping the implementation of formal cross-border patient migration from Eswatini to South Africa through the Phalala Fund: an interpretive policy analysis

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Plagiarism declaration

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Abstract

The rise of pandemics and epidemics underscores the global nature of health systems, transcending national boundaries across low- and middle-income countries (LMICs). This study delves into Eswatini's health system's challenges in implementing formal cross-border patient migration to South Africa through the Phalala Fund. This is a flexible qualitative study conducted in two phases. Evidence was gathered from primary, secondary, and grey literature to conduct a scoping review and an interpretive policy analysis (IPA) on cross-border patient migration and the Phalala Fund. Key stakeholders in implementing Phalala Fund's cross-border patient migration and their influence on the policy implementation process were identified. This was key in understanding the inter-subjective meanings shared across stakeholders.

In implementing Phalala Fund's cross-border patient migration, stakeholders had varied systems of meaning shaped by their values and reality judgements. This influenced stakeholder actions, priorities, resource allocation strategies, and communication approaches, which have presented various challenges in implementing Phalala Fund's cross-border patient migration. Some challenges have further strained stakeholder relations, resulting in limited negotiation power of the Government of Eswatini with South African health providers. Although regional cooperation policy frameworks of the Southern African Development Community (SADC) were seen as necessary in shaping cross-border patient migration, they do not necessarily mirror the legal and regulatory provisions that address the specific changing needs in health migration. The findings echo the importance of longer-term strategising in implementing Phalala's cross-border patient migration and recognising the complexities and varied meanings across stakeholders. Policymakers in similar contexts should consider the existing stakeholder relations and use them to strengthen the implementation of cross-border patient migration. Further areas of research on 'systems overlap' is suggested.

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Acronyms and abbreviations

AfCFTA	African Continental Free Trade Area
AG	Accountant General
ASEAN	Association of Southeast Asian Nations
COMESA	Common Market for Eastern and Southern Africa
CTA	Central Transport Authority
EAC	East African Community
EU	European Union
FY	Financial year
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPSR	Health Policy and Systems Research
HTA	Health Technology Assessment
IPA	Interpretive Policy Analysis
JPP	Journal of Public Policy
KPMG	Klynveld Peat Marwick Goerdeler
LLDC	Landlocked Developing Country
LMIC	Low- and-Middle-Income Country
MeSH	Medical Subject Headings
MGH	Mbabane Government Hospital
MoH	Ministry of Health
NCD	Non-Communicable Disease
ORCID	Open Researcher and Contributor ID
REC	Regional Economic Community
RSA	Republic of South Africa
SACU	Southern African Customs Union
SADC	Southern African Development Community
SDG	Sustainable Development Goal
TB	Tuberculosis
U.S.	United States
UCT	University of Cape Town
UHC	Universal Health Coverage
WHO	World Health Organization

Glossary

Cross-border patient migration	Cross-border patient migration is defined as a situation where patients, through an individual decision, formal (documented) arrangement(s) or government-sponsored programmes through bilateral/multilateral agreements, cross the borderline to another country to specifically receive health care services not met in one's home country because of access (such as unavailability or unaffordability)(Legido-Quigley et al., 2012)
Interpretive policy analysis	Views phenomena through the interpretation(s) of multiple actors and stakeholder groups (Yanow, 2000). This is based on the presupposition that our social world and the policies that govern it are characterised by multiple interpretations (Yanow, 2000). 'Meaning-making' in interpretive research seeks to understand how various actors make sense of an issue, event or phenomenon (Schwartz-Shea & Yanow, 2013)
Landlocked	Refers to a country with limited territorial access to the sea and (somewhat) isolated from global markets, therefore, dependent on neighbouring countries for trade, development, skills training, health care and more (World Health Organization, 2017)
Overlapping health-system	This is a type of transnational health in which multiple actors (public and/or private) who are located in different countries and are directly or indirectly involved in the provision of health services coexist to deliver health services that are usually not available or limited in the national health system supply chain to ensure coordinated delivery of health care services between and across countries (Bell et al., 2015)
Phalala Fund cross-border patient migration	This is the formal move of a patient(s) from Eswatini funded (fully or partially) by the Phalala Fund to access specialised health services in the South African health system (either in the public or private health sector)
Responsiveness	The health system's ability to be cognisant of users' health needs (including non-clinical) and appropriately respond to the legitimate expectations of people by implementing relevant changes (De Silva, 2000)
Small state	We use the World Bank (2021) classification of 1.5 million in population or less to define a small state
Specialist	A medical practitioner registered with the Health Professions Council of South Africa or Eswatini Medical and Dental Council with training in a specific area of medicine (Nxumalo, 2014)

List of symbols

The table below provides details of all currency values and symbols used.

Currency symbol	Currency name	Definition
$	United States Dollar (USD)	The official currency of the United States
E	Swazi Emalangeni (SZL)	The official currency of Eswatini
R	South African Rand (ZAR)	The official currency of South Africa - also used in Eswatini concurrently with the SZL

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Study protocol

Introduction

As governments of low-and-middle-income countries (LMICs) continue to commit to progressing towards reforming their health systems to better align with universal health coverage (UHC) (Mcintyre & Meheus, 2013) and the 2030 United Nations (2015) Sustainable Development Goals (SDGs), the manifestations of 'globalised' health systems cannot be overlooked. Globalisation has changed the epidemiological profile of diseases as far as effective prevention, control, and treatment are concerned – this has had a direct and/or indirect impact on population health and has weakened the ability of health systems to respond effectively to disease outbreaks (Raza et al., 2020). However, globalisation has also strengthened health systems' physical, sociocultural, and economic interdependency between and across country borderlines (Rai et al., 2014). Furthermore, the influences of international trade, international aid, and global cooperation networks such as international organisations and public-private initiatives have all manifested a globalised world (Gilson, 2013). This has increased the availability of health information between and across countries and conceptualised health systems as complex systems that are not only containerised within a specific setting or geography but 'overlap' beyond national borders (Labonté et al., 2011).

Health systems are defined as "all organisations, people, and actions whose primary intent is to promote, restore or maintain health" (World Health Organization, 2007, p. 2) at a micro (individuals such as providers and citizens), meso (organisational and local), and macro (global and national contexts) levels of the health system (Van Damme et al., 2010). The wider goals of health systems are directed at equity, fair financing, and responsiveness to the population's expectations, including promoting the dignity of persons interacting with the health system (World Health Organization, 2007). The provided definition of health systems points out the comprehensiveness of health systems. It builds on the idea that such systems do not *only* contain health facilities and curative or preventative services but are holistically shaped by multiple interacting and interrelated building blocks (governance, financing, information, service delivery, medicines and technologies, and human resources) of the health system (World Health Organization, 2000). Therefore, limiting our health system analysis only within national borders may blur the complete understanding of the existing complexities of health systems, including the burden of diseases (Durham & Blondell, 2017). This is primarily because epidemics such as COVID-19, Ebola, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and malaria, among others, have demonstrated that health systems face cross-cutting and transnational challenges that borderlines cannot confine (Suk et al., 2014). Governments are realising that attaining robust health systems is unachievable if health systems are fragmented with poor integration mechanisms between and across countries (Lee et al., 2019). Therefore, a systems-thinking lens that looks beyond country borderlines is important (more below). This means taking account of the intertwined relationships, interconnections, and interactions that extend between and across the various actors in the health systems located in different countries (Helble, 2011).

The World Health Organization (WHO) estimates that 30% of the world's population, particularly in LMICs, are disenfranchised by their national health systems without regular access to essential medical services (Lee et al., 2019). Some of those disenfranchised by their national health systems are travelling to neighbouring countries to access health services that are unavailable at home - a phenomenon commonly called 'cross-border patient migration' (Liverani et al., 2020). Adapting Legido-Quigley et al. (2012), cross-border patient migration is a situation where patients, through an individual decision, formal arrangement(s) or government-sponsored programmes through bilateral/multilateral agreements, cross the border to another country primarily to receive health care services that are not sufficiently met in their country of residence because of lack of access (such as availability and affordability).

Cross-border patient migration is a type of health system overlap whereby certain health services not locally available are sought from another country's health system, enabled by bilateral or multilateral agreements[1] - thus a useful tracer to understanding how health systems interact or overlap. However, there is barely any literature on the overlap of health systems in cross-border patient migration, especially in LMICs. There is some literature exploring health system overlap as part of public-private engagements and partnerships (Whyle & Olivier, 2016), health practice (Russell & McIntyre, 2009), and global health (Ng & Ruger, 2011), but these are limited. To our knowledge, few health policy and systems research (HPSR) studies describe and explore health systems overlap, or this type of cross-border patient migration.

The South African public health system encounters numerous challenges but provides more higher quality health services and treatment compared to many of its neighbouring countries including a private health system that provides high quality health care comparable to that of many high-income countries (Hanefeld et al., 2024). This has thus made South Africa a destination for patients seeking healthcare services. South Africa's advanced health infrastructure in comparison with its neighbouring countries has become a shelter and support for the Southern African Development Community (SADC) and the broader sub-Saharan region (Crush, 2012; Walls et al., 2015). This has partly been influenced by cross-cutting challenges such as the lack of sufficient resources, poor human resources, and the overburden of non-communicable diseases (NCDs)[2] (Crush, 2012), including factors around poverty, armed conflict, and economic instability (McAuliffe & Khadria, 2019). Hence, the Kingdom of Eswatini (previously Swaziland) – a landlocked state surrounded mainly by South Africa – like other SADC and sub-Saharan countries with resource constraints, has formed bilateral alliances with the South African Government to (formally) harmonise cross-border patient migration for specialised health services unavailable or limited in the Eswatini health system (World Bank, 2012). This is a trend that fits within a broader trend of increasing global cross-border patient migration that has been witnessed in Europe, Asia, South and Central America, and the Middle East (Hanefeld et al., 2024; Lunt et al., 2015). And in so much as there is a growing interest in cross-border patient migration (Frenk & Moon, 2013), the literature on cross-border patient mobility has largely focused on describing patient experiences, risk, and regulation, however, issues of global health governance have not been addressed.

The 2010 intergovernmental agreement on '*Cooperation in the Field of Health between Eswatini and South Africa'* has, amongst other things, eased the process of cross-border patient migration for Eswatini patients seeking specialised health services in South Africa (Khumalo, 2010; United Nations Office of Legal Affairs, 2011). This is because although there are health specialists in Eswatini's private health sector to whom public sector patients are sometimes referred, there are on-demand specialised services such as oncology, cardiology, maxilla facial, neuro and plastic surgery, ophthalmology, heart surgery, chemotherapy, hip and knee replacement, bone-related problems, brain/neurology, and dermatology that are more available in the South African health system (especially the private sector) (Parliament of the Kingdom of Swaziland House of Assembly, 2018). To meet the increasing demand for specialised health services not available or limited in Eswatini's national health system, in 2001, the Government of Eswatini established the Specialist Medical Aid Care Fund (also known as the Phalala Fund). This is a government-funded health scheme for ordinary EmaSwati (citizens of Eswatini) from both the private and public health sectors (excluding civil servants already

[1] Health systems can also overlap even without any formal bilateral or multilateral agreement(s) in place. This is typically a situation where patients migrate between and/or across national health systems through 'informal' means such as traveling without a passport, medical visa, or any type of formal (migration) paperwork. This research specifically focuses on a 'formalised' type of cross-border patient migration (more operationalisation of complex ideas below).

[2] Between 2003 and 2008, it was reported that 1.9 million of the 34 million visitors who travelled to South Africa from the SADC region were cross-border patients who had travelled to access health care services (Crush, 2012).

benefitting from the Civil Servants Medical Scheme) who would otherwise not have access (mainly due to finances and availability) to specialised health services in the country (World Bank, 2012).

Kruk et al. (2018) note that reforming and strengthening any health system involves various intersectoral changes, such as robust economic policies, investment in health systems and infrastructure, and governance. However, landlocked and resource-stretched Eswatini - one of the 42 small states of the World Bank (2021) - has unique challenges due to its small population of 1.2 million (World Bank, 2022b) and slow developing economic base with a Gross Domestic Product (GDP) of United States (U.S) $4.7 billion, thus particularly vulnerable to internal and external shocks (World Bank, 2023c). Being landlocked, (somewhat) isolated from global markets due to its geographic position, and having a reduced fiscal space for health has limited Eswatini's investment and delivery of a *full* range of specialised health services (World Bank, 2020), thus compelled to depend on neighbouring South Africa to import and export general goods and services (World Bank, 2023c), as well as specialised health services. Such dependency creates what Tremblay (2012) called the 'neighbourhood effect' for small states. In the context of Eswatini-South Africa relations, this is an effect that emanates from the influence of South African foreign policy and socioeconomic development (as a larger country in real GDP and population[3]) (World Bank, 2023a) on Eswatini's developmental trajectory[4] (Bischoff, 1986) and this has included the formation of various binational developmental projects (Ngubentombi, 2004). In so much as such binational cooperations have been positive in other developmental areas; however, in other areas such as health, it has created a dependency on South Africa, thus somewhat limiting Eswatini's ability to attain some of its national health priorities (Greer, 2023).

It is in the context of such conflicting dynamics that this study sets out to describe the challenges faced by Eswatini's health system in the implementation of formal cross-border patient migration from Eswatini to South Africa through the Phalala Fund with specialist health services as a tracer for broader health systems overlaps.

Literature review

A rapid scoping review of the literature (Table 1) was conducted to describe and explore (i) cross-border patient migration in LMICs (including small and landlocked states), (ii) what was known about Phalala Fund's cross-border patient migration from Eswatini to South Africa, and (iii) whether the broader literature held insights on the health systems of small landlocked states overlapping with the health systems of large states (more in the methodology below).

Cross-border patient migration in low- and-middle-income countries

There are various types of cross-border patient migration, and very few studies systematically map this terrain – which Connell (2013) notes is rife with data gaps, conceptual discrepancies, and unreliable data sources. There are various types of mobile patients such as intra-bound patient migration where patients migrate between or across domestic borders (for example, from one province to another); inbound/outbound which is a temporary cross-border to a foreign country for health services (Keckley & Underwood, 2008); medical tourism whereby patients travel to other countries for medical care yet combine their travel with other activities such as a vacation (Ormond, 2014); undocumented migrant patients (irregular) are usually already

[3] South Africa's GDP totals $405.27 billion, which is $400.57 billion times larger than Eswatini's GDP (World Bank, 2023a) with a population of 59.8 million, thus making South Africa an 'inevitable' force of influence on Eswatini's socio-economic development.

[4] This is such that South Africa's economic changes (positive or negative) have a direct influence on Eswatini, for example, the 2015 depreciation of the South African Rand (ZAR) negatively impacted Eswatini's external debt which increased from .02% of GDP to 13.35% (Greer, 2023).

in a foreign country (often without residential paperwork) when needing to access health services or cross the border to access health services of another country without the required migration paperwork (Hacker et al., 2015); and cross-border patients who travel to specifically access health services that are not available or limited in their countries through *formal* (documented) or government-sponsored programmes facilitated by bilateral/multilateral agreements[5] (Crush, 2012). The latter is the focus of this research study. Busse et al. (2006) further outlined four types of cross-border patient migration arrangements, which are: border area emergency; provider-to-provider; insurer/purchaser in one country and provider(s) in another; and administrative (government to government) arrangements. The last two fit the focus of this study.

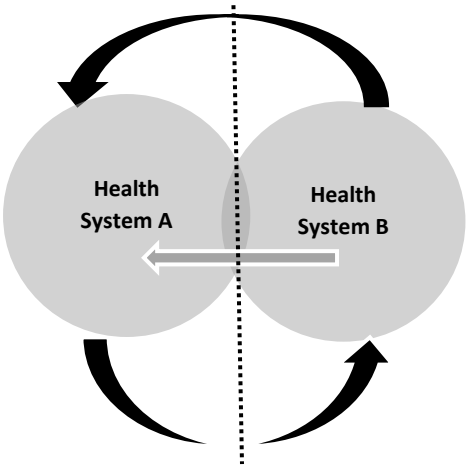

Figure 1. Health system overlap (Source: Author)

As noted above, the cross-border interactions of the health systems of two or more countries (through bilateral or multilateral agreements) lead to a health system overlap, whereby the health system actors in different countries interact between and across national borderlines. As shown in Figure 1, health system overlap can be unidirectional *(grey arrow flow),* with patients crossing the border (*broken vertical line*) to access health services from a single direction *(from health system B to A)*[6]; while bi- or multidirectional *(black arrow flow)* where the health systems not only overlap but also complement each other with a *rotational* cross-border patient migration flow from one health system to the other[7]. Although the conceptualisation of cross-border patient migration (as unidirectional/bi- or multidirectional) tends to focus on biomedical interventions. However, some literature also references migration relating to non-biomedical interventions such as promoting health and well-being through physical, psychological, and/or spiritual activities (Ormond & Lunt, 2020).

To provide a snapshot of cross-border patient mobility trends at a global level - a Klynveld Peat Marwick Goerdeler (KPMG) report (2014) showed that the worldwide travel of people to other countries to seek health interventions was valued at $10.5 billion with a projected increase reaching $32.5 billion by the year 2019 (Memon et al., 2014). Ganji (2015), on the other hand, cited a publication by Patients Beyond Borders, which estimated that the global market size of medical travellers was around $38.5 - $55 billion from an estimated 11 million migrating patients with some LMICs (especially in Asia) taking patient mobility as a chance to improve their health systems to attract more patients (John & Larke, 2016).

As international travel and economic activities get interwoven within globalised health systems, multiple evidence sources are showing that there is a growing focus by governments, the public and private sectors, and researchers in LMICs in building resilient and migration-aware health systems that are sensitive and

[5] The complexity of the subject of cross-border patient migration means that some patients travel voluntarily, while some do not (depending on different factors and situations). Unless specified, this study specifically focuses on formal (government-sponsored) cross-border patient migration where patients voluntarily (through the Phalala Fund) make such travels.

[6] An example of a unidirectional health systems overlap in LMICs includes the unidirectional cross-border migration of patients from Libya to access specialised health services in Tunisia (Lautier, 2008); and patients crossing the border to Thailand for health services not available in Myanmar (Noreer et al., 2016).

[7] The multilateral agreement between the member states of the European Union (EU) and the European Economic Area under Regulation 883/2004 also known as the European Directive allows the cross-border migration of patients to receive health services *across* all EU member states. This is an example of a multidirectional health system overlap (European Parliament, 2011).

cognisant of the multiple stakeholder interactions overlapping beyond national borderlines (Crush, 2012; Kangas, 2007; Lautier, 2008; Maung & Walsh, 2014; Whittaker et al., 2017). Governments are awakening to the reality that their national health systems are more responsive to the needs of the domestic population when they operate within a cooperation network with other countries and do not function in fragmentation (Boudville et al., 2020). Hence, the emergence of Regional Economic Communities (RECs) - such as the SADC, East African Community (EAC), Common Market for Eastern and Southern Africa (COMESA), Southern African Customs Union (SACU) (Crush, 2012), European Union (EU) (Azzopardi- Muscat et al., 2014), Association of Southeast Asian Nations (ASEAN) (Guinto et al., 2015) and other larger regional blocs such as the African Continental Free Trade Area (AfCFTA) (Olaniyan, 2021) - has seen the formation of bilateral and multilateral agreements to harmonise trade relations with cross-border health a part of the agenda.

In context, South Africa's well-resourced health system (especially the private health sector) (Young, 2016), compared to its neighbouring countries, has been essential in health systems strengthening of cross-border patient migration in the SADC region as many SADC member states have limited resources to invest in certain specialised treatments such as cancer, cardiovascular diseases, and kidney and thyroid problems (White & Rispel, 2021). This is primarily because of the health systems burdened by rising communicable and NCDs across SADC (Crush, 2012). Other leading drivers of SADC's cross-border patient migration include (i) specialist health services that may not be available in a country (service availability) (Hunter-Adams et al., 2017); (ii) the epidemiological profile of SADC as a result of HIV/AIDS with the rise of other complex opportunistic infections such as tuberculosis (TB), pneumonia, fever, anaemia, toxoplasmosis, and cancers (Crush, 2012). In other situations and contexts, there are, however, other reasons people may cross country borders to seek health care services, including the perception of the quality of care across the border, affordability, and residing at a borderline (Footman et al., 2014); distrust in local health systems, inadequate insurance coverage, doctor recommendations, and sociodemographic status (John & Larke, 2016).

Table 1. Most relevant literature on cross-border patient migration

Source	Title	Methodology/Type	Focus
Boudville et al. (2020)	Overseas medical referral: The health system challenges of Pacific Island Countries	Mixed method study analysis of quantitative and qualitative data	Small island countries with bilateral agreements with countries for unidirectional cross-border patient migration
Liverani et al. (2020)	Cross-border medical travels from Cambodia: Pathways to care, associated costs and equity implications	Qualitative study using the pathway to care model	South-south flow of patients seeking health services not available at home (unidirectional pathway)
Ormond and Lunt (2020)	Transnational medical travel: Patient mobility, shifting health system entitlements and attachments	Literature Review	The movement of patients across national borders to meet health needs unavailable at home including the drivers of such travel
Whittaker et al. (2017)	Regional circuits of international medical travel: Prescriptions of trust, cultural affinity and history	Participant observation and interviews	Unidirectional cross-border patient travel from Indonesia to Malaysia
Hunter-Adams and Rother (2017)	A qualitative study of language barriers between South African health care providers and cross-border migrants	Qualitative study - using secondary data analysis of semi-structured in-depth interviews	Challenges faced by cross-border patients when accessing the South African health system
John and Larke (2016)	An analysis of push and pull motivators investigated in medical tourism research published from 2000 to 2016	Quantitative study using content analysis of peer-reviewed articles	A classification of the motivations of people to travel outside their home countries to access health services
Bell et al. (2015)	Transnational healthcare, cross-border perspectives	Case study	Conceptual tools for transnational healthcare practices
Noree et al. (2016)	Medical tourism in Thailand: A cross-sectional study	Cross-sectional survey and patient records	Health systems overlap between neighbouring countries

Ganji (2015)	Hub healthcare: Medical travel and health equity in the United Arab Emirates	Mixed method (quantitative and qualitative)	Patients crossing international borders to access healthcare services
Guinto et al. (2015)	Universal health coverage in 'One ASEAN': Are migrants included?	Scoping review	The inclusion of mobile populations in universal health coverage at a regional scale
International Organization for Migration (2015)	2015 regional forum on HIV/AIDS, TB and non-communicable diseases among migrants and mobile population in Southern Africa region – legal and policy framework for actions towards universal health coverage	Position paper on cross-border health migration	The importance of knowledge-sharing platforms on cross-border patients in Southern Africa
Azzopardi-Muscat et al. (2014)	Challenges and policy concerns for health systems in small European states	Systematic literature review	The implications of European policies on the health systems of small states in Europe
Maung and Walsh (2014)	Decision factors in medical tourism: Evidence from Burmese visitors to a hospital in Bangkok	Quantitative research study (cross-sectional survey)	Unidirectional cross-border patient migration from Myanmar to Thailand
Memon et al. (2014)	Medical value travel in India	Mixed method (qualitative and quantitative)	Patients seeking healthcare services in the Indian health system
Ormond (2014)	Medical tourism	Document review of contexts that send and receive medical tourists	Conceptual definition and how medical tourism is framed in LMICs
Connell (2013)	Contemporary medical tourism: Conceptualisation, culture and commodification	Scoping review	The history of medical tourism from a global perspective
Mamun and Andaleeb (2013)	Prospects and problems of medical tourism in Bangladesh	A mixed-method research study (primary and secondary data)	The reasons Bangladeshi patients seek health services in neighbouring countries
Crush (2012)	No. 57: Patients without borders: Medical tourism and medical migration in Southern Africa	Review of regional and international research studies	Cross-border patient migration across and between countries in Southern Africa (both unidirectional and multidirectional)
Legido-Quigley et al. (2012)	Analysis arrangements for cross-border mobility of patients in the European Union: A proposal framework	Conceptual analysis of various case studies	A framework for understanding cross-border patient mobility in the European Union
European Parliament (2011)	Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare	Policy directive document	Establish rules for facilitating multidirectional cross-border patient migration across the European Union including addressing logistical issues
Lautier (2008)	Export of health services from developing countries: The case of Tunisia	Case study	Health service trade and bilateral agreements between Tunisia and Libya
Keckley and Underwood (2008)	Medical tourism: Consumers in search of value	Quantitative survey	The focus is on the growth of unidirectional and multidirectional cross-border patient mobility globally including associated costs
Kangas (2007)	Hope from abroad in the international medical travel of Yemeni patients	Qualitative research study drawing on interviews	Perspectives of Yemeni patients who travel to Jordan to access health services unavailable at home
Muscat et al. (2006)	Sharing capacities – Malta and the United Kingdom	Case study	Referral of Maltese patients (a small state) to access healthcare in the United Kingdom (with an advanced health system compared to Malta)
Chikanda (2005)	Medical leave: The exodus of health professionals from Zimbabwe	Mixed-method study	The migration of patients and health professionals from Zimbabwe to South Africa

Crush et al. (2005)	Degrees of uncertainty: Students and the brain drain in Southern Africa	A quantitative study using the Potential Skills Base Survey	The migration of professionals and health students from Southern Africa to work abroad
Simelane and Crush (2004)	Swaziland moves: Perceptions and patterns of modern migration	Qualitative study through interviews	Migration patterns in Eswatini and the regional approach for migration
Bicknell et al. (2002)	Economic study of referral health services in Lesotho: The future of Queen Elizabeth II Hospital	Mixed-method study, including patient surveys, and referral study	Provides a perspective on unidirectional cross-border health service referrals from Lesotho to South Africa

Cross-border patient migration and health systems responsiveness

Drawing from the World Health Report 2000 (World Health Organization, 2000), the three intrinsic goals of health systems are (i) good health, (ii) fair financing, and (iii) responsiveness. However, responsiveness remains the least studied of the health systems goals as most of the HPSR research and interventions have focused on good health and equitable health financing with limited research on responsiveness (Lodenstein et al., 2017; Mirzoev & Kane, 2017).

'Health systems responsiveness' is focused on the health system's ability to adapt to both clinical and non-clinical needs of health users (Khan et al., 2021). Responsive health systems impact the other goals of the health system, including access, acceptability, patient satisfaction, and improved health-seeking behaviour, ultimately improving population health (Ughasoro et al., 2017). Thus, health systems responsiveness is a crucial foundation in understanding inclusive and accountable health systems that prioritise human rights (Mirzoev & Kane, 2017). Röttger et al. (2015) indicated that the factors that contribute to health system responsiveness, such as dignity, choice, confidentiality, support, communication, and prompt attention, could be categorised into two major health system responsiveness categories: (i) respect for persons entailing the subcategory of dignity, confidentiality, autonomy and communication; (ii) client orientation which takes into consideration elements of social support, prompt attention, choice, and the quality of basic amenities (Murray & Frenk, 2000).

Health systems responsiveness is crucial due to the slow economic growth, widening health inequalities coupled with fragile institutions of governance and accountability (Azzopardi- Muscat et al., 2014), especially in contexts like Eswatini – resulting in the formation of bilateral/multilateral agreements that facilitate cross-border patient migration. This is because fostering health systems' responsiveness in cross-border patient migration is not just a strategic necessity but a moral imperative founded on global health principles of justice, equitable access, and human dignity - transcending geographical boundaries (Benatar & Brock, 2011). Health systems responsiveness is integral in providing patient-centred care for cross-border patients – ensuring seamless coordination between the health systems of the home country and destination country (Durham & Blondell, 2017). Therefore, the overlapping nature of health systems in the context of cross-border patient migration sparks scholarly curiosity on Eswatini's health system's capacity to respond to patients needing health services in bordering South Africa. Hence, this research adapts and integrates the categorisations of health systems responsiveness by Röttger et al. (2015) (as discussed above) to understand how Eswatini's public health system responds to the clinical and non-clinical needs of patients crossing the border to access health services in the South African health system (both public and private sectors) through the Phalala Fund.

An overview of the Eswatini health system

Eswatini is an LMIC with a population of 1.2 million (World Bank, 2022b). It is landlocked by South Africa and Mozambique (Figure 2).

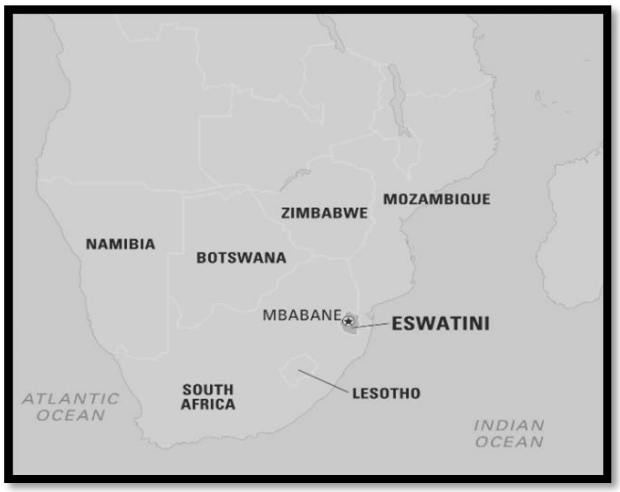

Figure 2. Location of Eswatini
Source: Masson (2022)

Eswatini's general socioeconomic standard of living is low, and its poor health status is characterised by high levels of poverty and inequality compared to other countries with similar income levels (Mamba, 2021). Estimates show that 63% of the country's population lives below the national poverty line while 29% live below the extreme poverty line (Swaziland Ministry of Health, 2017).

Despite Eswatini having the 11th highest GDP per capita in Africa (Statista, 2023), adult HIV prevalence remains the highest in the world (27%), which has been coupled with a growing burden of NCDs such as hypertension, diabetes, and cancers (Swaziland Ministry of Health, 2017). However, incorporating a primary healthcare approach in the health system has improved Eswatini's health status, such as life expectancy at birth and decline in multi-drug resistant TB (World Health Organization, 2018).

As a landlocked country with a slowly growing economy[8] (World Bank, 2023b), 85% of Eswatini's imports and 60% of exports of goods and services depend on its large neighbour[3], South Africa (World Bank, 2022a). Furthermore, Eswatini has a minimal knowledge and education capacity to supply the necessary health specialists as no institution of higher learning produces a critical pool of health professionals required by the health system (Box 1). These are some of the primary reasons Eswatini's health system has overlapped with South Africa's health system (especially the private sector), which is technologically advanced and resourced in specialised health services compared to Eswatini's.

Box 1. Overview of Eswatini's health system

Health system structure*:* Eswatini's health system is characterised by both the informal health sector (traditional, religious, and alternative health providers) and the formal health sector (public and private health providers) (Mamba, 2021)

Health facilities: 55% of Eswatini's health facilities are privately owned, with some hospital licenses regulated in South Africa, while 19.7% are owned by doctors; 14.8% are owned by missions; 12.6% are owned by industries; non-governmental organisations own 5.4%; and nurse-owned health facilities make 2.7% of the health facilities (Parliament of the Kingdom of Swaziland House of Assembly, 2018)

Institutional capacity: The University of Eswatini does not offer any programmes in medicine and pharmacy, although nursing is offered in its programmes (University of Eswatini, 2021). The Eswatini Medical Christian University does not offer medicine in its programmes; however, nursing and pharmacy are offered (Eswatini Medical Christian University, 2022)

[8] Eswatini's annual GDP growth (%) for a 10-year period (2012 – 2022) has averaged 3.02% (World Bank, 2023b).

Phalala Fund's cross-border patient migration

The Government of Eswatini has committed to strengthening the country's public health system. One of Eswatini Ministry of Health's (MoH) mid-term objectives is *"to work collaboratively with key sectors to influence health actions within these sectors to strengthen health systems capacity and performance"* (Eswatini Ministry of Health, 2023, p. 1). To deliver on this mandate, the Eswatini MoH has established cross-border health alliances with various South African health providers and specialists (public and private) (Box 2) through the *Cooperation in the Field of Health*[9] - a bilateral agreement that formalises cross-border patient migration for specialised health services (Khumalo, 2010; United Nations Office of Legal Affairs, 2011).

Box 2. Some South African health providers used by Phalala Fund (Parliament of the Kingdom of Swaziland House of Assembly, 2018)

- Clinix Solomon Stix Morewa Memorial Hospital
- Tshepo Themba Private Hospital
- Concordia Lodge (used as a residence for Phalala patients during their treatments)
- EYE Specialist Centre
- Zuid-Afrikaans Hospital: Cardiac and Lung Specialist Hospital
- Netcare Group of Hospitals
- Busamed Modderfontein Private Hospital Orthopaedic and Oncology Centre
- Arwyp Medical Centre (Kempton Park)
- Life Brenthurst Hospital
- Chris Hani Baragwanath Hospital

Note: All these providers are based in the Gauteng province (Specifically Johannesburg and Pretoria)

Eswatini's unidirectional cross-border patient migration (Figure 1) is facilitated through a government-funded health scheme, the Specialist Medical Aid Care Fund, also known as the Phalala Fund (the Fund). The Fund was established in 2001 under the Administration of the Specialist, Medical Aid Fund Regulations of 2001 Section 12(4), the Finance Management and Audit Act No. 18 of 1967 - to pay for specialised medical treatment (emergency and non-emergency) of "deserving" EmaSwati who would otherwise not have access to specialised health services due to unaffordable costs and the unavailability of such treatment in the country[10] (Nxumalo, 2014; World Bank, 2012).

Phalala's establishment occurred just over a year after Eswatini ratified the *1999 SADC Protocol on Health*. To date, South Africa has signed 11 bilateral health agreements with SADC countries[11] with a focus on human resources for health, patient mobility and collaboration between and across the countries (Hanefeld et al., 2024). This SADC regional policy instrument encourages the establishment of a systematic regional referral process for patients, including cross-national efforts to respond to public health concerns (Southern African Development Community, 1999). However, the bilateral agreements are *high-level* documents thus not specific (or too specific) on the logistics, treatment pathways, costs and reimbursement, the referral process (from the sending and receiving country's perspective), and continuity of care (Hanefeld et al., 2024).

Looking at cross-border patient migration from Eswatini to South Africa through Phalala is crucial, primarily because most of the research focus has been on Eswatini's bidirectional (Eswatini and South Africa) and multidirectional (Eswatini, South Africa, and Mozambique) cross-border collaboration on specific health programmes such as malaria (Tejedor-Garavito et al., 2017) and HIV/AIDS (Silvestre et al., 2016), and not so much on cross-border patient migration in the context of the Phalala Fund.

[9] The *Cooperation in the Field of Health* allows for the Government of Eswatini to make referrals to both the public and private health sectors in South Africa. However, the Eswatini MoH has recently contracted Healthshare (a South African private company) to manage all Phalala referrals to South African private hospitals and specialists (Parliament of the Kingdom of Swaziland House of Assembly, 2018). Noteworthy, some referrals are made to the public health sector in South Africa (especially tertiary hospitals).

[10] The Fund does sometimes make domestic referrals, however, most of the referrals are for specialised health services available in South Africa (limited referrals are made to Mozambique).

[11] These countries are Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Mozambique, Namibia, Seychelles, Zambia, and Zimbabwe.

Phalala Fund's leadership constitutes a committee[12] responsible for assessing all referral requests, including deciding on patients who meet the 'criteria'[13] to be referred for specialist treatment in South Africa. The general criteria used to assess each case are (i) the exhaustion of all medical capacity at the Mbabane Government Hospital (MGH), (ii) the treatment must be for a life-threatening condition that results in undue hardship, and (iii) the patient is not a beneficiary of any other health insurance scheme (Parliament of the Kingdom of Swaziland House of Assembly, 2018).

Healthshare Integrated Solutions (also Healthshare) has been a contracted intermediary body working with the Phalala Fund committee, Eswatini MoH, South African private health providers and some public health tertiary hospitals (Box 2) (Parliament of the Kingdom of Swaziland House of Assembly, 2018). Contracting Healthshare to oversee the cross-border patient migration from Eswatini to South Africa is reported to have tightened control measures, resulting in a 75% cost reduction in Phalala's R60 million annual budget (Healthshare Solution, n.d.). However, despite tighter control measures in place, Phalala is said to have been continuously plagued by irregularities, mismanagement, and the lack of information systems, with a Commission of Enquiry report indicating that the multimillion Fund had never been audited and faced a financial crisis (Crush, 2012).

As shown in Table 2, there are prevailing irregularities and evidence of mismanagement of Phalala's cross-border patient migration. For example, in 2010-2013, the former Auditor General of Eswatini reported that 51.09% of South African health providers treated Phalala's cross-border patients without authorisation from the Government of Eswatini (Nxumalo, 2014). This contradicts the stipulated Phalala Fund's regulations, which indicate that there should be authorisation by the Government of Eswatini before any services and/or payments could take place with a South African health provider (Ministry of Finance, 2001). As a result, R6.8 million was paid between 2010 and 2013 to health service providers who did not have the authorisation of the Eswatini MoH to treat Phalala referrals (Nxumalo, 2014); including a R4.6 million fraud case where a nurse submitted false medical claims to Phalala (Dlamini, 2012).

It has been argued that due to poor financial governance and the manual management of invoices, Phalala has erroneously made multiple payments, with 297 invoices found to have been paid twice or thrice, resulting in the overpayment of R1 million in 2010/11; R6.4 million in 2011/12; and R1.5 million in 2012/13 - totalling to an overpayment of R8.9 million (World Bank, 2012). When using the average service charge of R70 000 per patient, approximately 128 patients could have benefited from the R8.9 million financial waste (Nxumalo, 2014).

Nxumalo (2014) further pointed out that there have been unnecessary delays in Phalala's cross-border patients receiving treatment - with a wait of up to nine months after the committee approves a referral. A local news publication reported the case of a patient with colon cancer who urgently needed R60 000 to undergo specialist treatment in South Africa. Still, he was placed on Phalala Fund's waiting list for three years (Hlatshwayo, 2021). Another news publication reported that a patient requiring highly specialised treatment in South Africa for a heart condition was kept on the waiting list for three months (Hlatshwayo, 2022); a patient requiring an urgent throat operation was also put on a waiting list (Gama, 2022); and another patient with

[12] Appointed by the Minister of Health and Social Welfare, the committee entails the director of health services, a senior medical officer at the Mbabane Government Hospital (MGH), a representative of the nursing staff, a representative of the special health unit, and a medical practitioner in private practice responsible for establishing and maintaining internal controls for the Fund, ensuring the Fund's effectiveness and efficiency, and the use of resources in the most cost-effective way possible (Nxumalo, 2014).

[13] Although there is a general criterion, the there is no specific (evidence-based) criterion that is used by the committee of the Phalala Fund to determine case referrals to South African health providers.

cerebral oedema had to wait for assistance due to depleted resources at Phalala (Mohammed, 2022). Indeed, this practice diverges from norms established in international law recognising states' obligation to ensure timely and acceptable health care provision (World Health Organization, 2022) – and this has resulted in a decline in the health status of Eswatini patients requiring specialised medical services from South Africa through the Phalala Fund (Nxumalo, 2014)

The delay in referrals is said to have a ripple effect on the payments of South African private health providers (Parliament of the Kingdom of Swaziland House of Assembly, 2018) and some public sector health providers (Mkhwanazi, 2023). The Administration of the Specialist Care Medical Aid Fund Regulations 2001(8) stipulates that all claims should be cleared one month after Phalala has received invoices from the health service provider in South Africa (Nxumalo, 2014). Where payments are not made within four months, payments cannot be made without the approval of the Accountant General (AG) with an explanation of the delay, including a certificate that the account had not previously been paid[14] (World Bank, 2012). However, Nxumalo (2014) reported that payments of R6 million, R1.1 million, and R3.4 million in 2010/11, 2011/12, and 2012/13, respectively, were paid beyond the stipulated timeframe - between 4 and 38 months. These payments were without the authorisation of the AG as per regulation (Parliament of the Kingdom of Swaziland House of Assembly, 2018). This has left Phalala in a debt trap. For example, Kunene (2019) reported that Phalala's debt to South African health providers (both public and private) from 2012 to 2019 was over R66 million. This has pushed South African health providers (both public and private) to 'blacklist' Phalala Fund patients (Mkhwanazi, 2023; Parliament of the Kingdom of Swaziland House of Assembly, 2018) – thus unfairly disadvantaging already disfranchised patients who require specialised health services in South African hospitals. Another example, in 2011, the *Eswatini Observer* reported that 300 Phalala Fund patients referred for cancer treatment were denied treatment by South African health providers (public and private sectors) because they were blocked due to Phalala Fund's unpaid medical bills (Crush, 2012); Mdluli (2018) reported a similar case where patients were denied treatment by South African health providers (public and private sectors). The blocklisting of patients has recently seen 23 cancer patients being left desperate in South Africa without treatment or residential lodges (Mkhwanazi, 2023). This has continued to violate the respect for persons and client orientation (as previously discussed) – the core of health systems responsiveness (Murray & Frenk, 2000)

Furthermore, Tsabedze (2011) notes the deliberate inflation of medical bills by some South African health providers (especially in the private sector) treating Phalala patients, including faking illnesses or payments made to non-existent hospitals. Eswatini's former Minister of Health, Dr Benedict Xaba, said that such irregularities had included the receipt and payment of invoices for gynaecological medical procedures for (biologically) male patients, including the payment of R8 million to a South African health provider for merely bandaging a Phalala patient (Tsabedze, 2011). Nonetheless, there has been improvement in Eswatini's health specialists' care, including the official opening of the Eswatini Cancer Clinic, which has taken some chemotherapy referrals previously made to South Africa (Eswatini Ministry of Health, 2014). However, there are still concerns that Phalala serves a small segment of the country as the World Bank (2012) reported that only 760 EmaSwati (representing 0.06% of the population) benefited from the Phalala Fund on an expenditure of over R32.8 million. Even when using Healthshare's report averaging 2 297 patients referred to South Africa for specialised health services between 2013 and 2016 (representing 0.21% of the population), it is still a minority of Eswatini's 1.2 million population (Parliament of the Kingdom of Swaziland House of Assembly, 2018). And this places questions on the Fund's equity, equality, and responsiveness, especially given the reports showing that over 40% of Phalala's cross-border referrals have died (Crush, 2012; World Bank, 2012).

[14] As per Financial and Accounting Instruction of 1970 No. 0812 I and II.

Table 2. Literature on Phalala Fund's cross-border patient migration from Eswatini to South Africa

Source	Title	Methodology/Type	Focus
Eswatini Ministry of Health (2023)	Ministry of Health	Government website	The objectives of the Eswatini Ministry of Health
Eswatini Medical Christian University (2022)	Eswatini Medical Christian University 2022/2023 prospectus	University prospectus	Overview of the courses that are offered in health sciences
Hlatshwayo (2022)	Girl (6) needs E400 000 for heart treatment in South Africa	News report	Health providers' reluctance to treat patients because of outstanding debts
Gama (2022)	Woman needs E50 000 for urgent throat operation	News report	The extreme measures patients take for specialised treatment
Mohammed (2022)	Plea for child with rare disease	News report	The challenges limiting the referral of patients
Hlatshwayo (2021)	Life not easy – colon cancer patient	News report	Phalala Fund's referral waiting list
Mamba (2021)	The perceived needs and challenges of family caregivers in providing palliative care for relatives living with cancer in Hhohho Region, Kingdom of Eswatini	An exploratory descriptive qualitative study	The study explored the needs and challenges faced by family caregivers providing palliative care for Phalala patients living with cancer
University of Eswatini (2021)	Prospectus undergraduate programmes	University prospectus	Overview of the programmes offered in health science
World Bank (2022a)	Gross domestic product per capita – Eswatini	Economic report	Overview of Eswatini's developmental trajectory
The Global Fund (2020)	Results report	Institutional report	HIV burden in Eswatini
Eswatini Ministry of Health (2014)	First quarter performance report for 2019-20	Mixed method	Reports on quarterly Phalala's performance
Kunene (2019)	Phalala Fund in E66 million mess	News report	Outstanding bills of Phalala Fund from 2013
Mdluli (2018)	Phalala patients stranded as SA hospitals reject them	News report	Health service actors' impact on specialised health service delivery
World Health Organization (2018)	World Health Organization cooperation strategy at a glance: Swaziland	Institutional report	The health situation, health policies and systems in Eswatini
Parliament of the Kingdom of Swaziland House of Assembly (2018)	Select Committee investigating irregularities of the administration of the Phalala Fund Select Committee	Written and oral submissions	Stakeholder submissions on Phalala Fund's cross-border patient migration
Swaziland Ministry of Health (2017)	Service availability and readiness assessment	Cross-sectional survey	Service availability assessment
World Health Organization (2017)	Landlocked developing countries health and World Health Organization	Institutional report	The challenges faced by the 32 landlocked developing countries
Nxumalo (2014)	Performance audit on the utilization of Phalala Fund	Performance report	An in-depth understanding of the Fund including the challenges faced
Dlamini (2012)	Phalala E4.6m fraud	New report	Governance challenges of Phalala
World Bank (2012)	Swaziland's funding of referrals abroad: Assessment of the Phalala and civil servants' medical schemes and options for improvement	Institutional report	Phalala Fund's expenditure, the governance loopholes, and recommendations for improvement
Crush and Tawodzera (2011)	Medical xenophobia: Zimbabwean access to health services in South Africa	In-depth interviews and focus group discussions	Focused on issues affecting cross-border Zimbabwean migrants
Tsabedze (2011)	SA hospitals view Phalala as a blank cheque	News report	The importance of standard charges for Phalala patients

United Nations Office of Legal Affairs (2011)	No. 48072. South Africa and Swaziland	Bilateral agreement	This sets the tone for cross-border patient migration
Khumalo (2010)	South Africa, Swaziland sign health agreement	News report	Cross-border health interaction between the countries
Southern African Development Community (1999)	Protocol on health in the Southern African Development Community	Multilateral regional agreement.	Raises the importance of regional health collaboration in Southern Africa

Problem statement and study objectives

Health systems face cross-cutting and transnational challenges that overlap beyond national borders. Lunt and Mannion (2014) argue that as the integration of global and regional markets expands, including the commodification of health, interventions should be strengthened to ensure that geo-political territorial boundaries do not limit health systems. And given the limited governance mechanisms for cross-border patient mobility, the Phalala Fund provides an opportunity to understand the overlap of health systems including issues of health system governance between countries. We argue that for Eswatini's health system to achieve responsiveness regarding cross-border patient migration, there must be an awareness of the health system interactions that overlap beyond national borderlines, especially as a small state dependent on South Africa. This is particularly important as previous work on this subject has mainly focused on high-level patient mobility including the contents of cross-border patient migration agreements (Crush, 2012) without an analysis of the challenges faced in the implementation of cross-border patient migration.

This study aims to describe the challenges faced by Eswatini's health system in implementing formal cross-border patient migration from Eswatini to South Africa through the Phalala Fund. The study further seeks to understand Eswatini's health system's ability to respond to the clinical and non-clinical needs of patients crossing the border to access health services in the South African health system (both public and private sectors) through Phalala. Hopefully, this will contribute to understanding the policy implementation of cross-border patient migration, including bringing to light the challenges faced by Phalala Fund's cross-border patients who have difficulty accessing specialised health services in South Africa.

Operationalisation of key concepts in Table 3.

Research question

How is implementation facilitated in a formalised cross-border patient migration agreement through the Phalala Fund from Eswatini to South Africa?

Sub-questions

- What are the challenges faced in facilitating Phalala Fund's cross-border patient migration from Eswatini, whose health system overlaps with South Africa?
- Has the implementation of Phalala Fund cross-border patient migration enabled or inhibited Eswatini's health system's responsiveness to patients requiring travel from Eswatini to South Africa for health interventions?

Table 3. Operationalisation of key concepts

Term	Definition
Cross-border patient migration	Cross-border patient migration is defined as a situation where patients, through an individual decision, formal (documented) arrangement(s) or government-sponsored programmes through bilateral/multilateral agreements, cross the borderline to another country to specifically receive health care services not met in one's home country because of service unavailability, affordability or any reason(s) possible(Legido-Quigley et al., 2012)

Landlocked	This is a country with limited territorial access to the sea and (somewhat) isolated from global markets; therefore, dependent on neighbouring countries in terms of trade, development, skills training, health care and more (World Health Organization, 2017)
Overlapping health-system	This is a type of transnational health in which multiple actors (public and/or private) who are located in different countries and are directly or indirectly involved in the provision of health services coexist to deliver health services that are usually not available or limited in the national health system supply chain to ensure coordinated delivery of health care services between and across countries (Bell et al., 2015)
Phalala Fund cross-border patient migration	This is the formal move of a patient(s) from Eswatini funded (fully or partially) by the Phalala Fund to access specialised health services in the South African health system (either in the public or private sector)
Responsiveness	The health system's ability to be cognisant of people's health needs, including non-clinical needs, and appropriately respond to the legitimate expectations of people by implementing relevant changes (De Silva, 2000)
Small state	We use the World Bank (2021) classification of 1.5 million in population or less to define a small state
Specialist	A medical practitioner registered with the Health Professions Council of South Africa or Eswatini Medical and Dental Council with training in a specific area of medicine (Nxumalo, 2014)

Methodology

This is a flexible qualitative study applying an interpretive policy analysis (IPA) to multiple sources of primary and secondary publications of publicly available documents and data on Phalala Fund's cross-border patient migration to iteratively map the implementation of Phalala Fund's cross-border patient migration. This is relevant as IPA approaches phenomena through the interpretation(s) of multiple actors and stakeholder groups (Yanow, 2000) by using qualitative research methods (Charmaz, 2000). It is based on the presupposition that our social world and the policies that govern it are characterised by multiple interpretations (Yanow, 2000). 'Meaning-making' in interpretive research is important in the scientific inquiry as it seeks to understand how various actors make sense of an issue, event or phenomenon (Schwartz-Shea & Yanow, 2013).

The research project will be conducted in two iterative phases: an initial rapid scoping review and an IPA (Figure 3). In both phases of the study, the data that will be integrated will be sourced from journal articles, institutional reports[15], government reports, conference reports, books, academic theses, and news publications. Grey literature, unpublished work, and archival data will also be considered. Multiple literature was sourced from journal articles, database (PubMed), Google Scholar, and Google, including the websites of the governments of Eswatini and South Africa; the World Bank, United Nations Library; WHO; and SADC without restriction to methodology or date of publication. Key search terms (Table 4) will be used to get relevant literature per the research question and study objectives. The key terms will be continuously expanded to include corresponding Medical Subject Headings (MeSH) terms for a robust search. Boolean operators "AND" and "OR" will be used to identify index terms. Furthermore, the UCT Library will be continuously consulted to ensure a comprehensive search. Data and methodological triangulation will allow the validation and cross-checking of the data collection, analysis, and reporting to achieve consistency and reliability (Creswell & Clark, 2017).

Study phases	
Phase 1 **Scoping review of broader literature**	• Mapping of key research concepts on (i) cross-border border patient migration in LMICs, (ii) cross-border patient migration from Eswatini to South Africa, and (iii) landlocked LMICs whose health systems overlap with larger (country) health systems • Context mapping using the stakeholder mapping framework for a comprehensive understanding of the various actors involved in the implementation of the Phalala Fund
Phase 2	• Sourced data will be purposefully sampled based on the research question and study objectives. This will be done to understand stakeholder inter-subjective meanings in the policy process

[15] Institutional reports include developmental reports, policy reports, and country reports.

Interpretive policy analysis	through an inductive and deductive thematic analysis of multiple literature on Phalala Fund's cross-border patient migration • Thematic analysis will be applied to allow for the development of three-level category codes: priori themes, emerging themes, and analytical themes (unpacked below) • The use of the judgement framework will be used to characterise stakeholders' systems of meaning

Figure 3. Study design phases (Source: Author)

Phase 1: Scoping review of broader literature

Peters et al. (2015) indicated that, unlike a systematic review, which seeks to answer a specific research question guided by a rigid criterion, a scoping review aims to map existing literature on a particular subject to address a broader research question. A rapid scoping review was conducted to explore three main areas in the broader literature: (i) cross-border patient migration in LMICs (including small or landlocked states), (ii) the cross-border patient migration process from Eswatini to South Africa, and (iii) LMIC literature on the health systems of small landlocked states whose health systems overlap with the health system of large states. The rapid scoping review was done by mapping key research concepts (Table 4) while assembling evidence from journal articles, institutional reports, government reports, conference reports, books, academic theses, and news publications.

Guided by the work of Mak and Thomas (2022), we reviewed multiple literature was sourced from journal articles, database (PubMed), Google Scholar, and Google, including the websites of the governments of Eswatini and South Africa; the World Bank, United Nations Library; WHO; and SADC without restriction to methodology or date of publication.. The primary researcher developed a search strategy. Assistance from a librarian at the Faculty of Health Sciences, University of Cape Town (UCT) was also sought using key search terms in Table 4. The search terms were continuously expanded to include corresponding MeSH terms for a robust search and did not have restrictions on the publication date. Boolean operators "AND" and "OR" were used to identify index terms and find articles containing search terms. The search was standard throughout; however, this was tailored as per the requirements of each database. To determine the relevance of the literature scoped in the search, the title, abstract, or executive summary were assessed to determine the relevance of each study based on the research question and objectives. The remaining publications were read in full, and small case summaries were produced. The summaries were later collated into a coherent report.

Table 4. Key search terms (Source: Author)

Term	Examples of search term variations
Cross-border patient migration	Cross-border health, cross-border mobility, health tourism, cross-border patient movement
Eswatini	Swaziland, Kingdom of Swaziland
Low- and middle-income countries	Developing countries, least developed countries, landlocked developing countries, global south
Phalala Fund	Specialist medical aid fund
Small states	Fragile states, small country
Specialised health	Specialist, doctor, health professional

We acknowledge that there is a possibility that not all relevant literature was explored and assessed because of the variation in the terms used to describe cross-border patient migration. However, the review considered grey literature, including government websites and organisations such as the World Bank, the United Nations, and the WHO. A few relevant studies that analysed patient migration from high-income countries to LMICs were included in the scoping review. The rapid scoping review process mapped publications (n=53) on cross-border patient migration from multiple sources (Appendix 2), providing an overview of the phenomenon and how health systems responsiveness is shaped in this context.

As mentioned earlier, one of the focus areas of the scoping review is to have a better contextual understanding. The context comprises various components such as political, geographic, socioeconomic and other 'context' factors that shape and influence a phenomenon within a specific space or environment (Visser

et al., 2005). Mapping the context was useful to elicit a contextual understanding and emphatically apply a human-centred design that shows a holistic understanding of the research inquiry in its context. Yin (2009) noted that considering the context is crucial because, in a real-life setting, the boundaries between the context and phenomenon tend to be blurred. The context of the research phenomenon was analysed and mapped using a stakeholder mapping framework (Appendix 5), which generated a knowledge base of the health system actors' interrelations, interests, and the influence they each have in the implementation of Phalala's cross-border patient migration from Eswatini to South Africa.

Brugha and Varvasovszky (2000) noted that stakeholder analysis is a crucial research tool in complex policy analysis to comprehensively understand a wide range of actors (individuals and/or groups) involved in a policy space. Hence, a stakeholder map was fit for this Phase of the study as it considers the context to determine the stakeholder interactions, including the existing power dynamics between and across the stakeholders (Buse et al., 2012). This will be done in a 3-stage process (Appendix 5) to assess each stakeholder's involvement and challenges experienced in implementing Phalala's cross-border patient migration, including understanding stakeholders' sites of power (Topp et al., 2021) and influence in the policy implementation process.

Phase 2: Interpretive policy analysis

Policy analysis entails explaining policy events and processes within the contextual interpretations of policy stakeholders (Klein et al., 2022). The primary goal of IPA is meaning making in the policy processes. Thus, in an attempt to understand policy processes, the context and stakeholders that create and interpret such meanings must be understood (Klein et al., 2022). Meaning does not merely refer to the subjective understanding of an individual stakeholder but also considers the inter-subjective meanings shared across the stakeholders – the dominant meanings (Scauso, 2020). IPA has been applied in several HPSR-relevant studies – such as migrants' interpretive understanding of the Affordable Care Act (McElfish et al., 2016), policy narrative construction by political elites to respond to COVID-19 (Biswas Mellamphy et al., 2023), the understanding policy gaps in the implementation of national guidelines in HIV testing (Sheikh & Porter, 2010), and the perspectives of experts on the harm of tobacco and e-cigarettes (Hawkins & Ettelt, 2019; Klein et al., 2022) to mention a few - to analyse the inter-subjective (dominant) meanings shared across stakeholders in the policy process.

The scoping review of broader literature (Phase 1) mapped the broader understanding of cross-border patient migration. It contextualised the stakeholders involved in cross-border patient migration from Eswatini to South Africa through the Phalala Fund. Thus, Phase 2 of the study will consist of an IPA of multiple literature sources from journal articles, institutional reports, government reports, conference reports, books, academic theses, and news publications on Phalala Fund's cross-border border patient migration. This phase aims to understand the stakeholder meanings in implementing Phalala Fund's cross-border patient migration. Phase 2 uses IPA for an in-depth understanding of the policy implementation process, including the context and stakeholders that create, participate, and interpret the meanings in these policy processes. Importantly, IPA's intention is not merely to understand *what* the meanings are but to further understand *how* those meanings are shared across the stakeholders within the policy implementation space (Yanow, 2015), as this is important in the activation of policy solutions (Klein et al., 2022). Hence, within the scope of the study, we will apply IPA to multiple literature on the Phalala Fund's cross-border patient migration.

An inductive and deductive thematic analysis of the sourced literature (Appendix 3) will be conducted in a 6-step process (Table 5) to understand stakeholder meanings in implementing Phalala Fund's cross-border patient migration. A three-level category of codes will be developed: priori, emerging, and analytical themes (Table 5). To ensure consistency with the IPA approach, the inter-subjective stakeholder meanings in the implementation of the policy process will be systematically categorised as per the cross-cutting 'judgements'

of Vickers (1965) framework: (i) reality and value judgements which are focused on the facts of the policy process, thus keen to answer the question about 'what is supposed to happen?' to produce meaning(s); (ii) both reality and value judgements inform the actions (action judgements) that must be taken in response to the policy implementation processes (Sheikh & Porter, 2010) (discussed further in the results section).

Table 5. Steps followed in IPA thematic analysis (Braun & Clarke, 2006)

Step in IPA thematic analysis	Explanation
Familiarising with the contents of the publication document(s)	• This will start with selecting relevant publications (some identified in the literature review), categorised as journal articles, institutional reports, government reports, books, news publications, and theses will be included in the analysis. The research question and study objectives will guide the selection of publications for analysis. The initial assessment will be an overview of the title and abstract of each publication • Each publication deemed fit as per the research question and study objectives will be read and re-read to gain familiarity
Coding	• Priori themes relevant to the IPA approach based on the literature review (Phase 1), the research question, and study objectives will be identified • The order of analysis: each publication will be analysed sequentially, starting with journal articles, institutional reports, government reports, books, news publications, and academic theses. The researcher will ensure a thorough analysis of each publication before moving to the next • Guided by the research question and study objectives, all selected publications (journal articles, institutional reports, government reports, books, news publications, and academic theses) will be assigned codes (visible by different colours) directly related to the predetermined priori themes, and new themes emerged. The emerging themes will be captured into a Microsoft Excel sheet and categorised into broader categories based on similarities. Some categories are expected to align with the priori themes, while others will represent newly emerging patterns • An in-depth analysis within each category will allow the researcher to explore relationships, patterns, and connections between and across codes as guided by the research question and study objectives. After that, from the categories, overarching analytical themes of high-level, in-depth interpretations will be done
Identification of common themes	• Patterns from the data captured on Excel, including recurrent ideas, will be identified to create and categorised as per the priori themes that rightly reflect the meaning of the data • Coded data will be organised from one theme to the next to have a systematically organised flow of data
In-depth analysis and sense-making of themes	• This will include the cross-comparison of the various themes from the data to explore relationships, including conflicts across the data set, to have a better understanding of the meanings
Developing a coherent narration of the themes	• This will be a storytelling of the themes and the overlapping relationships between and across the themes, including explaining the information in a systematic and organised manner. Themes will be continuously reviewed and refined, ensuring that they accurately represent the data and are aligned with the research questions while addressing the research question
Validation	• The analysis will be an iterative process that will be reviewed and discussed with the researcher's primary supervisor to ensure consistency and validity of the analysis. The research will also return to the data and codes to check interpretations and refine the themes where necessary

Rigour and analysis

This study is characterised by a continuous iterative process (flexible design), thus making rigour a crucial part of the research to ensure the legitimacy and academic quality of the study. Scandura and Williams (2000) noted that considering rigour is at the core of the research question, data collection, research analysis, and reporting. For this research project, rigour will not be simplistically reduced to multiple technical processes and procedures but will be holistically analysed within the scope of understanding the assumptions and rationale that form the foundation of the research study (Yin, 2009).

To achieve data and methodological triangulation, different data collected from different sources and methodologies will be constantly compared and contrasted (Gilson et al., 2011).

The data analysis will be iteratively discussed with the researcher's supervisor to achieve investigator triangulation. The supervisor will use her expertise to bring their perspective, which will continuously be discussed. Creswell and Clark (2017) indicated that by comparing and discussing the interpretations, the researcher(s) can easily identify patterns of divergence and convergence and reach a comprehensive consensus, enhancing the study's credibility. The investigator triangulation will be coupled with a theoretical triangulation, which Creswell and Clark (2017) pointed out allows for a comprehensive understanding of the phenomenon in question. For this study, the different phases will integrate different theories to make sense of the research issue while ensuring that all interpretations have a theoretical basis.

A transparent chain of documentation (audit trail) will allow other researchers to replicate the study from its initial phase to the conclusion. The chain of the research processes will be reported by having a clear problem statement, research question and sub-questions, and the different phases of the study, including the data collection process, analysis, and reporting (Tashakkori & Teddlie, 2009). This will enable a clear and transparent articulation of the research design and decision(s) taken as each phase will be described in detail.

Furthermore, the researcher will use a 'constant comparative method' to allow constant testing-out of the study's provisional understandings (Gibbert & Ruigrok, 2010) across the various themes emerging from the multiple data sources in each phase. The comparison will identify emerging themes across the various data sources, thus forming patterns and trends of cross-border patient migration. This will be supported by a 'comprehensive data treatment' by comprehensively incorporating all relevant data in the analysis of the study – this will be done iteratively and discussed with the researcher's supervisor. Such will be expected to ensure that the study analysis is analytically generalisable within its context. Hence, a transparent reporting of the rationale, the selection, and a clear contextual understanding of the research question and objectives will be transparent (Creswell & Clark, 2017). Transparency will be enhanced through precise and careful documentation of all the procedures followed in the study, including the data analytical techniques used in each phase.

Risks and benefits

This is a desk-based study utilising publicly available data without human subjects; it is a no (or minimal) risk study. In the 2022 budget speech, the Minister of Finance, Mr Neal Rijkenberg, said that the Government of Eswatini is committed to improving spending to restructure the Phalala Fund. He highlighted that the Government's focus is growing local domestic capacity to address the country's health challenges to reduce Phalala Fund's dependence on South Africa for specialised health services (Eswatini Ministry of Finance, 2022). This research study will benefit the Government of Eswatini, researchers, and policymakers in strengthening Eswatini's aim to bolster its domestic capacity for specialised health services. Furthermore, civil society will benefit from the results of this study as its influence in the policy space is expected to restructure Phalala's cross-border patient migration, thus improving access to specialised health services in Eswatini. The research is also crucial in understanding the health systems fragility of small landlocked and the importance of harmonised cross-border health systems' interactions. It will be essential to open discussions in similar contexts.

Ethical considerations

As a desk-based study with no (or limited) risk using multiple sources of publicly available evidence without human subjects, ethical consideration is thus limited. Vulnerable groups such as children (below 18 years) will not participate in any stage of this study. Only the researcher and supervisor will have access to the data, which will be stored on the researcher's personal computer with a security password.

'Migration' is a politically charged subject in South Africa, and the political landscape regarding 'illegal' migration is a polarised issue with various controversies (Machinya, 2022). On the other hand, Phalala Fund's cross-border patient migration from Eswatini to South Africa is a highly politicised subject with various vested interests of different parties, groups, and stakeholders. Hence, the researcher will ensure that the existing stakeholder relationships are not harmed. This includes ensuring that Eswatini and South Africa's health systems are not misrepresented during and after the research project. Continuous reflexivity and supervision will ensure a productive engagement with the health system and concerned stakeholders. Evidence deemed by the primary researcher and supervisor to be controversial and potentially harm stakeholder relations will be rephrased to focus on strengthening the health systems interactions between Eswatini and South Africa.

Any unintended negative consequences of the research study will be monitored carefully. Hence, the research findings will be concisely communicated to policy actors, researchers, and civil society without misrepresentations. This study intends to strengthen a harmonious health system interaction between the Kingdom of Eswatini, the Republic of South Africa, and other LMICs. Furthermore, the intention is to make the study valuable to policy actors, researchers, and civil society in small, developing, landlocked countries with vulnerable and overlapping health systems.

Dissemination of findings

After completion, the research findings will be shared on the UCT Open Access database to ensure free access. A manuscript will be submitted to the Journal of Public Policy (JPP) for publication. This is anticipated to positively influence Phalala Fund's cross-border patient migration for specialised health services in Eswatini, ensure evidence-based decision-making, and inform future research on this issue. The published journal article will be provided to experts and other health professionals interested in Phalala's cross-border patient migration.

Copies of the final study will be emailed to relevant stakeholders, including the Office of the Phalala Fund, Eswatini MoH, Eswatini's Institute for Health Measurement and other identifiable stakeholders working or embedded in Eswatini's health system.

Research study limitations

The study will be set within a specific context – Phalala Fund's cross-border patient migration from Eswatini to South Africa for specialised health services with little to no applicability in other contexts. The study should not be generalised to other contexts and settings without this consideration. Furthermore, the study aims to engage with multiple evidence sources thoroughly. However, it is known from the outset that such sources are limited. In addition, primary (first-hand) perspectives of patients crossing the border to access health services in South Africa will not form part of the study.

As much as there will be data triangulation to increase the robustness of the data and study rigour, there is still a risk of investigator bias because of the researcher's assumptions, expectations, and prejudices, which may manifest through reporting and confirmation bias. Reflexivity (as discussed above) will be used throughout the research study to mitigate the influence of investigator bias.

The decision to exclude an 'expert checking' phase in the study because of time constraints and complications of navigating ethics in the Eswatini MoH (within the study's timeline) limits the study. Experts would have provided a thorough check of the study's findings, and it is recommended that future research studies on this subject consider this.

Research timeline

All the proposed activities of the research project are in Table 6.

Table 6. Research timeframe (Source: Author)

	Proposed research timeline						
Activity	**Feb – Nov. 2022**	**Jan – Feb. 2023**	**Mar - Apr. 2023**	**May – Jun. 2023**	**July – Dec 2023**	**Jan 2024 - Feb 2024**	**July 2024**
Protocol write-up							
Conduct literature review							
Data synthesis and analysis							
Thesis write up							
Submission for examination							
Study dissemination							

Budget

There will be no funding to conduct the study. The researcher declares no conflict of interest.

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Journal article

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Mapping the implementation of formal cross-border patient migration from Eswatini to South Africa through the Phalala Fund: an interpretive policy analysis

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Abstract

The rise of pandemics and epidemics underscores the global nature of health systems, transcending national boundaries across low- and middle-income countries (LMICs). This study delves into the challenges faced by Eswatini's health system in implementing formal cross-border patient migration to South Africa through the Phalala Fund. This is a flexible qualitative study conducted in two phases. Evidence was gathered from primary, secondary, and grey literature to conduct a scoping review and an interpretive policy analysis (IPA) on cross-border patient migration and the Phalala Fund. Key stakeholders in implementing Phalala Fund's cross-border patient migration and their influence on the policy implementation process were identified. This was key in understanding the inter-subjective meanings shared across stakeholders.

Identifying key stakeholders in Phalala Fund's implementation revealed diverse systems of meaning influencing actions, priorities, resource allocation, and communication. These complexities have posed challenges, including strained stakeholder relations and limited Eswatini's negotiation power with South African health providers. Although regional policy frameworks are deemed vital, they often fail to address evolving health needs in cross-border patient health. The study emphasises the importance of long-term strategising and understanding stakeholder dynamics for effective cross-border patient migration implementation, suggesting further research on 'systems overlap'.

Keywords: Phalala Fund, cross-border patient migration, specialised health services, small state, Eswatini, South Africa

[1] Appendix 7 for author's instructions.

[2] For thesis examination purposes, the student is the first and sole author of the paper.

Introduction

The World Health Organization (2007) defines health systems as "all organisations, people, and actions whose primary intent is to promote, restore or maintain health" (p. 2). This echoes the idea that health systems do not only contain health facilities or specific health programmes such as curative or preventative services but are holistically shaped by multiple and cross-cutting building blocks of the health system such as governance, financing, information, service delivery, medicines and technologies, and human resources (World Health Organization, 2000). The rise of pandemics and epidemics in our globalised and interconnected world has made it clear that national health systems face challenges extending beyond their national borders (Suk et al., 2014). And governments are realising that attaining strengthened health systems is unachievable if health systems are fragmented with poor integration mechanisms between and across countries (Lee et al., 2019). Thus, we argue the importance of a systems-thinking lens that looks beyond country borderlines - considering the intertwined relationships, interconnections, and interactions that extend between and across the various health system actors in different countries (Helble, 2011).

The health systems of the Southern African Development Community (SADC) are faced with diverse, unique, and transnational challenges primarily because of poor resource availability, unaffordable health care, and the overburden of communicable and non-communicable diseases (Janse van Rensburg et al., 2021). And SADC, as a Regional Economic Community (REC), has a fairly week integration – which has serious implications for the development and implementation of regional policies (Southern African Development Community, 2021). The weak integration of SADC affects policy development and implementation, impacting regional economic growth, trade, and political stability (Tanyanyiwa & Hakuna, 2014). For example, the inconsistent COVID-19 regulations among SADC member states showcase the challenges and implications of weak regional coordination.

South Africa's relatively advanced health infrastructure (especially the private health sector) has been viewed as a 'shelter' and support for many patients from other SADC countries who are crossing national borderlines (formally or informally) to access specialised health services in South Africa[3] (Crush, 2012; Walls et al., 2015). This has resulted in what could be considered an 'overlap' of health systems between SADC countries, with patients travelling over borderlines primarily to access health services that are not available at home. This phenomenon is commonly called 'cross-border patient migration' (Liverani et al., 2020) – a health system overlap whereby certain health services that are not available in the national or local health system are sought from the health system (private or public health sectors) of another country through bilateral or multilateral agreements.

There is, however, barely any health policy and systems research (HPSR) literature on overlapping health systems – especially relating to cross-border patient migration in low- and middle-income countries (LMICs). This is primarily because there have been minimal strides to develop policy frameworks to enhance health systems cooperation across countries (Ssengooba et al., 2022). Another facet of health system cooperation in HPSR literature (which may sometimes overlap) has focused on diverse groups, including migrants, refugees, asylum seekers, stateless persons, tourists, or international students/workers, who, driven by various factors, find themselves in need of health services in a new country (Zimmerman et al., 2011). This study, however,

[3] Between 2003 and 2008, it was reported that 1.9 million of the 34 million visitors who travelled to South Africa from the wider SADC region were cross-border patients who had travelled to access health care services and an average of 47 000 patients were from Eswatini (Crush, 2012).

focuses explicitly on formalised cross-border patient migration—one facilitated through government agreements, enabling patients to access specialised health services from another country's health system, intending to return home after care is provided.

Background: Phalala Fund's cross-border patient migration

The Kingdom of Eswatini (previously Swaziland) is an LMIC that is landlocked by South Africa and Mozambique with a population of 1.2 million (Mamba, 2021); it is classified as one of the 42 small states of the World Bank (2021). Eswatini has a small economic base with a Gross Domestic Product (GDP) of the United States (U.S) $4.7 billion (World Bank, 2023a) and is (somewhat) isolated from global markets. These factors mark Eswatini with unique socioeconomic challenges (World Bank, 2022a), which have contributed to Eswatini's limitation in investing in the full delivery of a range of specialised health services within the domestic health system – hence relying on South Africa for the import (85% of GDP) and export (60% of GDP) of general goods and services (World Bank, 2022a) including health services (Crush, 2012).

The 2010 intergovernmental agreement on '*Cooperation in the Field of Health between Eswatini and South Africa'* signed by both governments has, amongst other things, formalised the process of cross-border patient mobility from Eswatini to South Africa for patients seeking specialised health services such as oncology, cardiology, maxilla facial, neuro and plastic surgery, ophthalmology, heart surgery, chemotherapy, hip and knee replacement, bone-related problems, brain/neurology, and dermatology amongst others, that are largely unavailable in the domestic health system (Khumalo, 2010; United Nations Office of Legal Affairs, 2011). To meet the increasing demand for these specialised health services unavailable in the country's public and private health sectors, in 2001, just over a year after the ratification of the '*1999 SADC Protocol on Health'* (Southern African Development Community, 1999), the Government of Eswatini established the Specialist Medical Aid Care Fund, known as the Phalala Fund (also the Fund) (World Bank, 2012).

The Phalala Fund is a government-funded health scheme for ordinary EmaSwati (citizens of Eswatini) who would otherwise not have access to specialised health services because of the unaffordability and unavailability of such treatments (World Bank, 2012). The Fund operates under the Eswatini Ministry of Health (MoH) with an annual budget of R60 million[4]. Through Phalala, South African health providers in both the public and private health sectors (Box 1) have been critical in providing specialised health services unavailable or limited in Eswatini (Crush, 2012). However, this arrangement has been unable to sufficiently meet the needs of patients requiring specialised health services in South Africa due to issues of governance and management, such as delayed payments of South African health providers (Mkhwanazi, 2023) or duplicated payments (World Bank, 2012); treatment of Phalala patients by South African health providers without authorisation by the Eswatini MoH (Nxumalo, 2014); fraud (Dlamini, 2012); and delayed patient referrals of up to nine months (Nxumalo, 2014). The impact of the Phalala situation on patients has been largely negative, leading to a decline in their overall health conditions, further impacting patients' dignity, choice, confidentiality, support, and communication.

This study describes the challenges faced by Eswatini's health system in implementing formal cross-border patient migration from Eswatini to South Africa through the Phalala Fund. The study answers the question: How is implementation facilitated in a formalised cross-border patient migration agreement through the Phalala Fund from Eswatini to South Africa? This is intended to contribute to understanding the policy

[4] The currency symbol R is the South African Rand (ZAR). 1 United States Dollar (USD) = 18.89 ZAR.

implementation of cross-border patient migration from an LMIC perspective, highlighting Phalala Fund's cross-border patients' challenges in accessing specialised health services in South Africa.

Methodology

This is a flexible qualitative study analysis of multiple publicly available data sources on Phalala Fund's cross-border patient migration. The study was conducted in two iterative phases (Appendix 1). In both phases, the integrated data was sourced from journal articles, institutional reports, government reports, books, academic theses, and news publications. Grey literature, unpublished work, and archival data were also considered.

Box 1. Some South African health providers used by Phalala Fund (Parliament of the Kingdom of Swaziland House of Assembly, 2018)

- Clinix Solomon Stix Morewa Memorial Hospital
- Tshepo Themba Private Hospital
- Concordia Lodge (used as a residence for Phalala patients during their treatments)
- EYE Specialist Centre
- Zuid-Afrikaans Hospital: Cardiac and Lung Specialist Hospital
- Netcare Group of Hospitals
- Busamed Modderfontein Private Hospital Orthopaedic and Oncology Centre
- Arwyp Medical Centre (Kempton Park)
- Life Brenthurst Hospital
- Chris Hani Baragwanath Hospital

Note: All these providers are based in the Gauteng province (Specifically Johannesburg and Pretoria)

Phase 1 of the study was a rapid scoping review that followed the steps outlined by Mak and Thomas (2022). The rapid scoping review looked at (i) cross-border patient migration in LMICs (including small and/or landlocked states), (ii) the cross-border patient migration process from Eswatini to South Africa, and (iii) LMIC literature on the health systems of small landlocked states whose health systems overlap with the health systems of large states. The scoping review was done through the review of multiple literature: journal articles, database (PubMed), Google Scholar and grey literature without restriction to methodology and date of publication. The key research concepts were continuously expanded to include corresponding Medical Subject Headings (MeSH) for a robust search. Boolean operators "AND" and "OR" were used to identify index terms and find articles containing search terms. The key search terms were cross-border patient migration (with variation of cross-border health, cross-border mobility, health tourism, and cross-border patient movement); Eswatini (varied by Swaziland; Kingdom of Swaziland); low- and middle-income countries (varied by developing countries, least developed countries, landlocked developing countries, global south); Phalala Fund (with a variation of specialist medical aid fund); small states (varied by fragile states); and specialised health (varied by specialist, doctor). A search strategy was developed by the primary researcher, and assistance from a librarian at the Faculty of Health Sciences, University of Cape Town (UCT) was also sought using key search terms. Relevant studies were identified, and their title, abstracts, or executive summaries were screened to ensure relevance to the research question and study objectives. After the screening, the remaining publications were read in full and small case summaries were produced. The case summaries were then collated into a coherent report. 53 publications were included in the scoping review (Appendix 2).

The scoping review was key in having a better contextual understanding of the political, geographical, and socioeconomic landscapes in Eswatini's cross-border patient migration and the Phalala Fund as far as the research question and objectives were concerned. This was crucial because, as Yin (2009) highlighted, a contextual understanding is crucial as the boundaries between the context and phenomenon usually get blurred in a real-life setting. Hence, the stakeholder mapping framework discussed by Buse et al. (2012) was crucial for mapping actors' interactions, interests, and their influence in implementing Phalala Fund's cross-border patient migration. The stakeholder mapping process was a 3-stage process (Appendix 5) that followed the work of Brugha and Varvasovszky (2000) – assessing each stakeholder's involvement and challenges

experienced in the implementation of Phalala's cross-border patient migration, including understanding stakeholders' sites of power (Topp et al., 2021) and influence in the policy implementation process.

Building on the previous phase and drawing from the stakeholder analysis, Phase 2 applied an interpretive policy analysis (IPA) on multiple literature on Phalala Fund's cross-border patient migration. This was done to understand the inter-subjective stakeholder meanings in implementing Phalala Fund's cross-border patient migration. The IPA is based on the understanding that multiple interpretations and meanings characterise the social world and the policies that govern it, and this is important in making sense of a policy issue, event or phenomenon (Schwartz-Shea & Yanow, 2013). Although it is an emerging approach, IPA has found resonance in HPSR-relevant studies, using diverse data sources such as interviews, focus groups, and documentary material. For instance, a study by McElfish et al. (2016) which conducted qualitative focus groups to explore migrants' interpretive understanding of the Affordable Care Act; content analysis of policy narrative construction by political elites to respond to COVID-19 (Biswas Mellamphy et al., 2023); the understanding of policy gaps in the implementation of national guidelines in HIV testing through qualitative interviews (Sheikh & Porter, 2010); and the perspectives of experts on the harm of tobacco and e-cigarettes (Hawkins & Ettelt, 2019; Klein et al., 2022). IPA's intention is not merely to understand *what* the meanings are but to further understand *how* those meanings are shared across the stakeholders within the policy space (Yanow, 2015), as this is important in the activation of policy solutions (Klein et al., 2022). However, we acknowledge that integrating primary data such as interviews could have enriched the analysis by providing first-hand accounts of stakeholders' experiences and perspectives.

Box 2. Unique identifying categories

Journal articles #J
Institutional reports #I
Government documents #G
Books #B
News publications #N
Theses #T

The IPA was sourced from multiple literature sources, including journal articles, institutional reports, government reports, books, academic theses, and news publications on Phalala Fund's cross-border border patient migration. Guided by the research objectives and research question, 36 publications (Appendix 3) were included, and each publication was coded with a unique identifying category (Box 2). An inductive and deductive thematic analysis of the sourced literature was conducted in a 6-step process (Appendix 6) to understand stakeholder meanings in implementing Phalala Fund's cross-border patient migration. A 4-level category of codes was developed: priori, emerging, and analytical themes (Appendix 6). To ensure consistency with the IPA approach, the inter-subjective stakeholder meanings in the implementation of the policy process were systematically categorised as per the cross-cutting 'judgements' of Vickers (1965) framework (Figure 1): (i) reality and value judgements which are focused on the facts of the policy process, thus keen to answer the question about 'what is supposed to happen?' to produce meaning(s); (ii) both reality and value judgements inform the actions (action judgements) taken in the policy process.

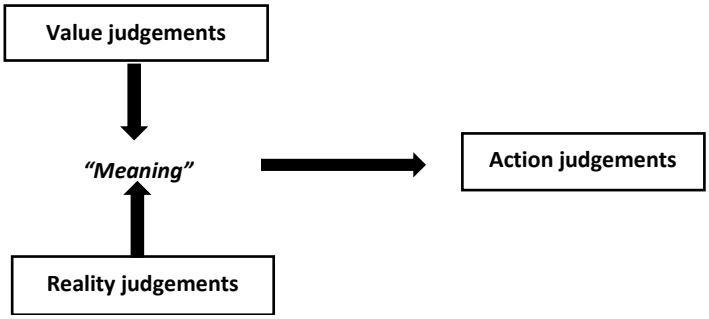

Figure 1. Judgement framework to characterise stakeholders' systems of meaning (Sheikh & Porter, 2010)

Care was taken to ensure that the varied stakeholder perspectives represented in the implementation of Phalala Fund's cross-border patient migration were captured. Furthermore, controversial evidence from the literature that could harm stakeholder relations was rephrased to focus on strengthening the interactions of the health systems.

Ensuring data saturation was crucial to comprehensively capture all relevant themes and insights in this study. During Phase 1, our extensive scoping review incorporated a wide range of sources, including journal articles, institutional reports, government documents, books, theses, and news publications. We achieved data saturation when additional literature reviews yielded no new themes or insights on cross-border patient migration and the Phalala Fund. In Phase 2, the IPA involved coding and thematic analysis of 36 publications. We continuously monitored for new themes, confirming data saturation when no new stakeholder meanings emerged. This iterative approach ensured that our findings were robust and comprehensive despite the sole reliance on documentary evidence. Reflecting on our approach, the rigorous process of achieving data saturation strengthened the credibility of our findings and ensured a thorough understanding of the research topic (Schwartz-Shea & Yanow, 2013).

This research is, however, not without limitations; first, the study focuses on Phalala Fund's cross-border patient migration from Eswatini to South Africa for specialised health services, limiting its generalisability to other contexts. While efforts were made to engage with multiple evidence sources, the lived experiences of patients were not analysed. Furthermore, despite data triangulation, investigator bias was not utterly preventable. However, continuous reflexivity was vital throughout this study.

Results

The results section highlights the systems of meaning of the different identified stakeholders navigating the implementation of Phalala Fund's cross-border patient migration. These results are integrated to describe how each stakeholder's reality (of what is happening) and value (of what is regarded as important) judgements are key in creating meaning, thus shaping their actions—more evidence in Appendix 4.

Table 1 starts by summarising the stakeholder analysis conducted in a 3-stage process (Appendix 5), after which each stakeholder is unpacked in the same order. For each stakeholder group, the logic in Figure 1 is followed – first presenting visible reality and value judgements of each stakeholder, which shape meaning-making. This is followed by a description of actions (action judgements) shaped by that meaning. Table 1 briefly outlines each stakeholder's role in implementing Phalala Fund's cross-border patient migration, including the challenges experienced in the process – all of which have a ripple effect across stakeholders. The 'power' column (Table 1) depicts an analytical assessment and understanding of the power dimensions of each stakeholder in the policy implementation process, including their influence (Topp et al., 2021) in the implementation of Phalala Fund's cross-border patient migration – power was determined as high, medium, low-medium, and low. This was based on the understanding of the cross-cutting sites of power, which are shaped by (i) stakeholder relationships and networks, (ii) power sources, and (iii) flows and expressions of powers, all of which include context, the structures of governance, and policy processes that are key in understanding stakeholder power (Topp et al., 2021) – this was part of the Phase 1 analysis and informed Phase 2 of the study.

Table 1. Stakeholder characteristics in the implementation of Phalala Fund's cross-border patient migration (Source: I4; I5; I6; G1; G2; G3; G4; G5; G6; G7; G8; B1; & T1)

Stakeholder	Involvement in the implementation of Phalala Fund's cross-border patient migration	Challenges experienced in the implementation of Phalala Fund's cross-border patient migration	Power
Government of Eswatini	Providing health services through the Phalala Fund involves interactions between South African health providers and the Government of Eswatini, facilitated through the Ministry of Health (MoH) and the Phalala Fund's committee. This collaboration focuses on delivering healthcare to cross-border patients. Referrals are made from the Mbabane Government Hospital (MGH). The Eswatini Treasury Department is responsible for processing and making payments for referral claims	The Eswatini Government is faced with budget, procurement, and capacity issues, including payment delays, unclear patient selection, duplications, and poor record-keeping, compounded by misunderstood referral criteria and communication challenges with the Treasury	High
South African health providers	Provide specialised health services for patients who are referred from Eswatini to South African health facilities (both public and private) from MGH by the Eswatini Government	Payments of patients' bills by the Phalala Fund office are delayed. Some service providers have blocked Phalala patients	Medium
Healthshare Integrated Solutions	This is a South African intermediary facilitating collaboration between health service providers in South Africa and the Government of Eswatini in the provision of health services for Phalala patients	Inability to make referrals because of outstanding payments by the Government of Eswatini. Some providers have blocked Phalala	Medium
SADC	Provides regional frameworks that are key in guiding national frameworks on cross-border patient migration	Slow progress on the coordination and application of regional frameworks.	Low-medium
Cross-border patients	These are the patients who are referred to South African health providers through the Phalala Fund	Limited access to follow-up treatments with long waiting times.	Low

Government of Eswatini

Reality judgements

The Government of Eswatini established the Phalala Fund to meet the medical costs of the citizens who cannot access specialised health care in South Africa because of the unaffordability and unavailability of such care (G3). Depending on the available funds, the government generally covers hospital fees, transport, accommodation, prescribed treatment, and equipment or medical supplies (G2) without any co-payments from the patient(s) or alternative donors (I4 & G6).

However, the reality in the implementation of Phalala Fund's cross-border patient migration is that despite the annual financial allocation by the Eswatini MoH - the Fund's annual budget of R60 million is not sufficient to match its high operational costs and accumulating debt of over R100 million (G2 and G3). This is primarily because the Fund does not have a budgetary ceiling for referrals, such as eligibility criteria or the number of monthly/annual visits per patient (G1). This means that patients travel to South Africa for treatment without any budget allocated to them, and when the finances are depleted, treatment can be stopped without notice (T1). This has mainly been a point of concern for the Government of Eswatini given the increasing number of cancer cases needing referral to South Africa – and without a budgetary ceiling, financial resources are allocated unfairly to patients (N7).

> *"The sad part of the story is that government's Phalala Fund, which was established to meet medical needs of those who cannot afford the costs of external specialist treatment, is currently unable to assist - due to lack of funds… Director of Health Services, Dr Vusi Magagula, in an interview yesterday, described this particular case as 'one of those that government was unable to fund at the moment due to the fiscal financial position it is faced with" (N3).*

Furthermore, the government's inability to make timely payments to South African health providers is primarily due to administrative bureaucracy (G1). For example, patients' files are managed manually, making updating them in real-time difficult, resulting in 'broken' communication among the actors responsible for

implementing Phalala (G1). Furthermore, limited staffing across government actors has translated to a backlog of unprocessed invoices.

> *"…the country [Eswatini] is committed to making payments 45 to 60 days from receipt of invoices. Due to the limited staffing in the Account's Office, the Fund hasn't performed too well in processing payments in the 45-to-60-day payment terms" (G3).*

Another reality is that the MGH is the main point for all Phalala referrals, where cases are assessed and referred to South African health providers (I6). The referral chain is, however, delinked. This means that there is no clear line of feedback between the MGH and (i) the hospitals or clinics where patients were initially admitted/treated (usually a clinic where they periodically access their medications or acute healthcare), (ii) South African health providers (G2). The delink in the referral chain is because there are no clear guidelines on patient information sharing across stakeholders (I3); there are poor systems for quality assurance of the health care received by Phalala Fund patients in South Africa; and there is no accreditation of South African health providers treating Phalala patients (G2). This has limited the availability of robust health technology assessment (HTA), standard pricing framework, expenditure planning, and general management of cross-border patient migration as seen in other contexts (J1; J2; & J6). Such limitations have resulted in exorbitant payment charges, negatively influencing the citizenry's trust in the Eswatini Government's ability to deliver cross-border health services through the Phalala Fund (N9 & I6).

> *"…the referral process starts with patients referred to Mbabane Government Hospital…there is no system of feedback whenever patients have been referred… irregularities in its [Phalala] administration dates back as far back as 2006, such that an inquiry was conducted by Parliament to investigate all operations, but this time it was more in operations of Mbabane Government Hospital which acts as a referral centre" (G2).*

Value judgements

The Fund's staff members place importance on the prioritisation of Phalala patients. This is mainly witnessed in cases where South African health providers deny Phalala patients access to health services because of Phalala's outstanding debt (N5); in response, Phalala staff members sometimes go beyond their scope of work to 'negotiate' to the point of 'begging' South African health providers on behalf of patients to admit and treat patients in critical health conditions (N7).

> *"We (Phalala) live on negotiations and begging doctors and hospitals to accept cancer patients because of the bad records we have in terms of paying outstanding debts…" (N7).*

Furthermore, Phalala and designated MGH staff members provide social support to patients, including contacting patients' families and arranging accommodation for patients in South Africa (I6). The social support aims to ensure that patients are holistically assisted and aware of Phalala Fund's cross-border migration process, including the required paperwork (G2). However, this is not a standard procedure; in other cases, patients lack the support needed (N3).

The Eswatini Government is also progressing in investing in local oncology treatments, which make most of all Phalala referrals to South Africa (G3). However, complex oncology treatments, including patients requiring a combination of radiotherapy and chemotherapy, are still referred to South African health specialists as such treatments are fully fledged in Eswatini.

> *"The reduction in the oncology treatments could be attributed to the increasing availability of cancer medicines at the chemotherapy unit in Mbabane and an increasing number of patients being treated*

at the unit since the Oncologist was recruited earlier this year. Almost all of the referred patients were sent for chemotherapy and/or radiation therapy…" (G3).

Reality and value judgements shape meaning (Yanow, 2000). In the case of the Eswatini Government as a stakeholder, the combination of financial constraints, administrative challenges, and a commitment to prioritising patient needs and investing in healthcare infrastructure shapes the understanding that improving patient care and addressing systemic shortcomings are essential goals in the implementation of Phalala Fund's cross-border patient migration. This subsequently influences the actions of the Government of Eswatini.

Action judgements

The Government of Eswatini has taken decisive actions against corruption and mismanagement in Phalala (N6) such as payment duplications and long waiting times (up to 9 months). And this has seen the appointment of a Select Committee of the Parliament of the Eswatini to investigate the irregularities of the administration of the Phalala Fund (G2). This investigation has gathered evidence through public hearings, site visits, and the analysis of government data to unearth the irregularities of the Fund and make recommendations to the Government of Eswatini (G2). The Government has further provided the Auditor General with the needed information to conduct a performance audit on the utilisation of the Phalala Fund (G1).

The government has also taken some actions to act on the administrative obstacles that have impacted Phalala. For example, contracting Healthshare Integrated Solutions (also Healthshare) by the Eswatini Government to coordinate the implementation of Phalala's cross-border patient migration has improved the transparency and tracking of Phalala's payment discrepancies that were previously untraceable. This has made it easier to record multiple payments and overcharges, verify the authenticity of health providers in South Africa, and delayed payments (G2). Furthermore, the Government of Eswatini has taken steps to clear some of Phalala's payment arrears (N2). However, there is evidence of manual review of invoices received from service providers in South Africa (these are older/backlogged invoices not managed by Healthshare), and this extensive exercise contributes to the payments backlog by Phalala.

"The accounting officers in the Phalala office and Accountant General's office diligently review invoices and facilitate the payment process. Much of this is a manual process with numerous forms to be filled…" (I6).

In implementing Phalala Fund's cross-border patient migration, financial constraints and administrative hurdles intersect with prioritising patient needs and governmental commitments to healthcare. These dynamics shape the understanding that enhancing patient care and addressing systemic deficiencies are crucial (Marquez & Marquez, 2020). Hence, the actions of the Government of Eswatini, which have included anti-corruption measures and collaborations with external entities, reflect efforts to rectify these issues and improve healthcare delivery for Phalala patients.

South African health providers

Reality judgements

Some South African health providers charge the Government of Eswatini additional 'hidden' costs, with Phalala being viewed as a 'blank cheque' (G2). This is mainly because there are no cooperation agreements between Eswatini and (specific) health service providers or a preferred network of health service providers. This makes it hard to have (or at least negotiate) standard medical charges for Phalala patients. This has a ripple effect on health providers as it makes it hard for the Eswatini Government to process payments for multiple service providers within the acceptable timeframe (G2)

> *"The Phalala Fund is viewed as a 'blank cheque' by South African private doctors and hospitals. This was said by the Minister of Health, Benedict Xaba, who said a lack of negotiating tactics, exposed the Phalala Fund to exorbitant charges, which only served to limit the effectiveness of the fund in the long run…Fees and other prices are not negotiated beforehand and are completely supplier-determined. Enquiries about fees are made at the point of need when government is at its weakest negotiating position" (N9).*

Value judgements

There is a regard for social responsibility by some South African health providers whereby the 'negotiation' and 'begging' by some Eswatini government staff members working in Phalala (discussed above) has seen other doctors compassionately 'helping' patients by providing the critical treatment needed by patients despite Phalala's standing debt (N7). This depends on whether the hospitals where the doctors work would be willing to admit Phalala patients (N7).

> *"...a specialist doctor may be willing to operate or attend to a patient's case, but if the hospital does not allow Swati patients then their efforts become in vain" (N7).*

The reality and value judgements create the meaning that the value placed on social responsibility shapes the understanding that patient care remains paramount in Phalala Fund's cross-border patient migration. However, this conflicts with the financial risks associated with treating Phalala patients. That is the primary reason South African health providers have taken action to address these issues.

Action judgments

Given the Eswatini Government's delayed payments, most health providers have been reluctant to admit and treat Phalala patients (N5). This is to the extent that some health providers have opted to initiate interim conditional treatment agreements with the Eswatini MoH which includes the settlement of the minimum debt before a certain number of patients may be admitted to their facilities, for example, in 2018, the Netcare demanded that Phalala pays at least R12 million (59%) of its R20.2 million debt, on the condition that only 5 emergency and critical patients would be admitted at any given time (G2). On the other hand, some health providers have completely stopped admitting Phalala patients (G2).

> *"South African health institutions are said to have stopped rendering health assistance to [Emaswati] under Phalala because government is said to be owing them huge sums of money...Over 100 Emaswati are affected by the situation as they are said to have been brought back home because of the non-payment...The Member of Parliament [Sandile Nxumalo] said the South African institutions stopped providing medical assistance to Emaswati with the hope that government would act fast in negotiating for continued treatment while looking for money to settle debts" (N5).*

> *"…Some specialists have cited that the history of poor payment is a challenge, and they would rather not engage with the Fund for referrals…Baragwanath Hospital is the service provider the Fund engages for chemotherapy of children. The hospital is seeing a few patients at the moment but is refusing to see new patients until they can meet with the Phalala team and iron out challenges they have seen in the referral & logistics process" (G3).*

Overall, the reality of financial constraints and the absence of formal agreements shape providers' actions. At the same time, the value placed on social responsibility influences their willingness to prioritise patient care amidst financial challenges. These interrelated judgments collectively influence the behaviour and decisions of South African health providers in the context of Phalala patient care.

Healthshare Integrated Solutions

Reality judgments

Despite the working relationship between the Eswatini Government and Healthshare Integrated Solutions, the reality is that the Government of Eswatini (G2) has owed Healthshare an additional debt of R12.7 million since 2017 and has not cleared it. One noted contributing factor to the debt is the delay in signing the contract between Healthshare and the Government of Eswatini (G2). If this is not attended to, it is likely to result in the accumulation of another Phalala debt in the long term.

> *"There has been delay in the signing of the contract of the intermediary body [Healthshare]; this delay was caused by the need for cabinet approval and a Task Team, of doctors (Doctor's Council) report of this team was delayed to adoption due to problems which emanated on the issue of doctors' overtime…Swaziland owes 12.7 million rands to Healthshare… Healthshare has not been paid since early 2017…the Ministry is not responsible for making payments, rather it is the Ministry of Finance" (G2).*

Value judgements

Healthshare has also been key in centralising payments by using the health providers within the Healthshare network, reducing Phalala referral costs by approximately 75% (G2). This has promoted patient-centred care by ensuring that Phalala payments are paid timely, and patients get the care they need.

The reality of the outstanding debts highlights the continued financial strain in Phalala's cross-border patient migration. At the same time, the value placed on patient-centred care and efficiency suggests a prioritisation of service delivery. This creates meaning that emphasises the importance of fiscal responsibility in patient-centred care (David et al., 2018).

Action judgements

Healthshare Integrated Solutions has served as the 'middle person' between Eswatini stakeholders involved in Phalala cross-border patient migration and South African health service providers (I4). The Eswatini government's contracting of Healthshare Integrated Solutions in Phalala cross-border patient migration has improved transparency and tracking of previously untraceable payment discrepancies. This has made it easier to record multiple payments and overcharges, verify the authenticity of South African health providers, and track delayed payments (G1).

The Eswatini Government's debt to Healthshare underscores the financial strain of implementing Phalala's cross-border patient migration. This reality necessitates a strategic approach to financial management and accountability to ensure patient-centred care. Healthshare leverages its role as an intermediary to enhance Phalala's payment tracking systems and patient care.

Southern African Development Community[5]

Reality judgements

The reality of cross-border patient migration, from the SADC perspective, underscores the existence of shared regional health challenges, including HIV/AIDS, TB, and other ailments (N8). Consequently, a crucial necessity arises for harmonised regional health cooperation. As a small country with limited resources, Eswatini has dramatically benefited from health system collaborations and partnerships with South Africa. The regional policy frameworks influence the binational policies between Eswatini and South Africa, focusing on accessible

[5] SADC as a stakeholder refers to the intergovernmental organisation headquartered in Botswana of which Eswatini and South Africa are members states. SADC is also used interchangeably to refer to the 'SADC region.'

health systems and prioritising disease prevention and control while promoting equitable health services. This is one of the reasons that, at a macro-level, there is political will for cross-border cooperation, as both governments view it as beneficial (I4; I6; & N8).

> *"Collaboration among health institutions such as universities, research institutions, manufacturers and supplies of drugs and equipment in the two countries remain very strong…He added that Swaziland does not have adequate capacity to provide specialised health care and has benefited immensely from its partnership with South Africa" (N8).*

Value judgements

The regional policy frameworks prioritise accessible health services across the SADC through capacity building (I8). This has not only enabled the movement of patients seeking specialised health services across borders through Phalala but also the movement of health personnel who offer specialised health interventions, such as cardiologists and neurologists who are outsourced from the South African health system (both the public and private) to Eswatini's public health system (G2). Such cooperations provide shelter and support for the Eswatini health system (G1 & B2), which does not have the full human resource capacity for specialised health services. What is valued by the regional policy frameworks is cross-border health system collaboration that is human rights-centred provisions.

> *"…patients can be referred to the country's [South Africa] public hospitals with a minimum payment for health services rendered… The agreement [Cooperation in the Field of Health between Eswatini and South Africa] supports activities and obligations under the Protocol on Health in the SADC region, which, among others, entails the poaching of health workers from countries in the region and inter-country initiatives to combat diseases such as malaria and tuberculosis" (N8).*

The reality and shared value placed on accessible and equitable health services shape the understanding that regional cooperation is essential for addressing health needs, including strengthening national health policies (Amaya & De Lombaerde, 2021). The emphasis on human rights-centred health provision underscores the importance of collaboration in health systems – which has shaped SADC's actions.

Action judgements

SADC has strengthened regional cooperation across member states (I8). The existing policy frameworks encourage intercountry cooperation in addressing regional health challenges through harmonised health systems (I8). Emphasis has been placed on regional epidemic preparedness and responsiveness to health hazards, including HIV/AIDS, TB, and malaria, through having standardised regional guidelines on health system coordination between and across countries (I4). The draft regional policy frameworks recognise the importance of interlinked regional health systems and cooperation between and across SADC member states, which includes sharing health systems-relevant information, comprehensive disease prevention, access to health services, and respect for human rights and dignity (I9)

However, there is no clear information on patient entitlements and choices on the bi/national and SADC policy frameworks, for example, a transparent process on the manner patients should access cross-border health services, the duration of treatments, budget limits per patient, or payment mechanisms between Eswatini and South African governments. The regional policy frameworks provide a macro-level understanding of cross-border patient migration without the technical and logistical understanding of the implementation mechanism (I8; I9; & I5). This differs from the policy space of other regions where there is an explicit mention of the entitlements of cross-border patients, including cost-sharing mechanisms between the patient and the government(s) (J2; J3; J4; J5; J7; & I7). The lack of specifics and detail in the regional and national policy space leaves gaps that negatively impact the implementation of Phalala Fund's cross-border patient migration,

making it hard to make evidence-based decisions as the policy frameworks are vague and unclear in many areas.

The alignment of reality and value judgements has informed SADC's actions in promoting regional cooperation and addressing some shared health challenges. However, addressing policy gaps in implementation is crucial for ensuring the effective delivery of cross-border health services between Eswatini, South Africa, and other SADC member states.

Phalala patients

Reality judgements

Following the assessment at the MGH and qualifying for a Phalala referral, patients are often sent home to wait for the Office of the Phalala Fund to contact them on when they can travel to South Africa for treatment. This is a waiting that can last for 9 months to 3 years (G1), and this has severe implications for the health of patients, as by the time they finally get treatment (if they do), it is usually too late and very costly for the Fund (I6). The extensive waiting period is further exacerbated by the unclear line of communication between Phalala and patients (N4). This is to the point that some patients are unaware that Phalala has approved their referral to South Africa, while the treatment of other patients is abruptly halted (T1).

> *"Magaula (45) was diagnosed with a rare throat disease about 5 years ago, but the situation became worse a year ago as she could not take anything down her throat anymore… We tried to approach Phalala Fund, but the challenge is that we were put on the waiting list..." (N2).*

Value judgements

Patients are not included in the Phalala implementation process, and without notice, patients are sometimes informed that their (follow-up) treatment has been halted, and if they intend to return to South Africa for further treatment, they will have to pay for themselves (T1). However, patients generally do not have the financial means to pay for follow-up treatments with medical specialists in South Africa (N3), where, for example, an intensive care unit can cost up to R15 000 per day (N7). Patients are left in distress, unbearable pain, and without any solution. Therefore, there is a perception among most patients that the implementation process of Phalala Fund's cross-border patient migration does not value patients' rights and well-being (G2).

> *"…Masilela stated that life had not been easy such that he had wished for death since 2018 as he said that the pain had been unbearable and the fact that he could not provide for his family made it worse…" (N3).*

Although Phalala is considered a full cover (G6), following an initial diagnosis at the local hospital or clinic, patients are expected to cover their travel costs to the capital city of Mbabane to access the MGH, where further assessment is done before a referral to South Africa (N3). Other expenses that patients must cover include the application of travel documents and the medical visa fee (G2 & I6). This is usually money patients do not have, which inevitably harms their quality of life (N3).

The reality of prolonged waiting times and poor communication channels, coupled with the value judgment of neglecting patient rights and well-being, shapes the understanding that implementing Phalala's cross-border patient migration disregards patients' needs. As a result, patients have taken proactive actions.

Action judgements

Due to the unstable financial situation of the Phalala Fund (G1), some Phalala patients and their relatives are flexible in taking drastic actions to ensure they have access to the specialised health services they need in South Africa. The drastic actions are mainly through public means to raise the necessary funds for medical

procedure(s) (N2 & N4). The funds raised by patients and their families are generally used to access the first point of treatment in South Africa, and patients and their families are usually unable to raise funds for follow-up treatments in South Africa (G2 & T1).

> *"Due to her depreciating condition, her family is now seeking assistance of the public in order for her to undergo an operation in South Africa…they [the family] were informed that the operation would cost between R50 000 to R70 000 [6]…He said that the quotations they made amounted to approximately R100 000, but some people had already promised them R20 000… We will also host an event Hospital Bill Fundraising, where we invite everyone to participate at Dvokolwako Hall" (N2).*

Reality judgments, like long waiting periods and financial strains, instil urgency in patients' desire to access healthcare, while value judgments about patients' rights shape perceptions of fairness. This constructed meaning compels Phalala patients to take drastic actions, such as public fundraising, to access care.

Discussion

In LMICs, health system actors located at various levels of the health system have been viewed as instrumental in implementing public health policies (Gilson et al., 2017). Implementing cross-border patient migration is facilitated through various mechanisms through health system actors whose reality and value judgements shape meanings, influencing actions. We have shown that implementing the Phalala Fund's cross-border patient migration by the Government of Eswatini faces considerable challenges, including financial constraints, administrative inefficiencies, and stakeholder coordination issues. These challenges hinder the timely provision of healthcare services to patients needing care, impacting patient welfare and exacerbating financial burdens (Mkhwanazi, 2023). Despite government efforts to address corruption and mismanagement to streamline Phalala's administrative processes, outstanding debts to South African health providers remain unresolved, contributing to ongoing financial strain (Kunene, 2024). South African health providers exhibit mixed responses, with some refusing to treat patients due to Phalala's debt and payment delays (Mdluli, 2018). However, some South African health providers have agreed to provide critical care despite outstanding debts. These challenges have inhibited Eswatini's health system's responsiveness to Phalala patients who have endured prolonged waiting times, sometimes lasting up to several months or years, before receiving treatment in South Africa - due to administrative delays and unclear communication. These delays affect the timeliness of care and exacerbate patients' health conditions, leading to increased financial burdens and emotional distress (Parliament of the Kingdom of Swaziland House of Assembly, 2018). Furthermore, patients often bear additional travel and documentation costs–money they usually do not have.

These results have a few implications. Firstly, the Government of Eswatini's priority is delivering cross-border patient services through Phalala. However, this is challenged by cross-cutting challenges, including strained resources, infrastructure, and the lack of administrative structure to carry the weight of such an endeavour (Parliament of the Kingdom of Swaziland House of Assembly, 2018). This is a thread observed in other contexts where constrained fiscal space and inadequate national guidelines have led to reliance on cross-border collaboration programmes to access specialised health services that are not locally available, such as in the Pacific Island Countries (Boudville et al., 2020), Malta (Maung & Walsh, 2014), across Asia (Lee et al., 2019). However, the lack of organisation, including poor financial planning among implementing stakeholders, inhibits integrating cross-border patient migration into the broader health system structure (Busse et al., 2006). This is something that has also been noted in other SADC countries with bilateral health agreements

[6] The average annual per capita income of Eswatini is about $4 000 [approximately R72 704] (Statista, 2023). Thus, the medical operation would cost an average Swati their average annual income (excluding other related and non-related costs such as transportation and accommodation).

with South Africa where there is lack of detail with some key issues such as cost and reimbursement not covered in these agreements which raises questions about the feasibility and implementation consistency of cross-border patient migration in the region (Hanefeld et al., 2024). With poor integration of cross-border patient migration into the broader health system, there is a risk of the lack of treatment standardisations due to unstandardised treatment protocols (Johnston et al., 2010), which may also mean variations in the selection processes of cross-border patients. This further risks inequitable access to specialised health services by favouring those who can afford them while those who cannot are barred because of financial barriers (Helble, 2011).

Second, the 'stakeholder relationship' in Phalala cross-border patient migration is not conducive as trust has been violated. The lack of reciprocity has primarily perpetuated factors that have strained stakeholder relations and trust because of outstanding payments to South African health providers, unmet patients' needs, and the refusal by South African health providers to treat Phalala patients (Kunene, 2024). This brings about complexities in the power hierarchies between and across the implementing stakeholders - as Adam and Donelson (2022) highlighted the importance of a cooperative reciprocal relationship based on the common goals of furthering equitable health across health system stakeholders. However, in so much as the Government of Eswatini has been positioned at the centre of Phalala's implementation, it has failed to utilise its power to address the challenges; hence, health providers have opted to use their power to 'block' Phalala patients from accessing health services (Mdluli, 2018).

This has negatively impacted patients who do not influence Phalala Fund's cross-border patient migration processes. This is to the extent that patients no longer trust Phalala to meet their needs (both clinical and non-clinical), as some patients have been compelled to stop life-saving treatments abruptly. In contrast, others have taken the initiative to raise funds to pay South African health providers (Kunene, 2024). When looking at the tracers of health system responsiveness, precisely respect for persons and client orientation mentioned by Röttger et al. (2015), broken trust emanating from the various challenges in the implementation of Phalala Fund's cross-border patient have inhibited Eswatini's health system's responsiveness to patients' needs.

Furthermore, strained stakeholder relations have limited the negotiating power of the Government of Eswatini regarding prices or payment arrangements for the care of patients travelling to South Africa through the Phalala Fund. This is because, as the basis for any stakeholder relations, especially where there are conflicting priorities and interests, trust becomes one of the essential pillars of establishing negotiation power (Jeffery, 2009). Until the Government of Eswatini has negotiation power (by first being a trustworthy party) with *preferred* South African health providers, the Fund will continue to be a financial burden on the Government of Eswatini as multiple health providers (including unverified ones) will continue to be used – making it hard to have standard treatment protocols and pricing strategies (Ngcamphalala et al., 2021). This is because the absence of a government-preferred provider network poses a continuing burden, as establishing such a network is crucial for centralising Phalala payments and implementing standardised cross-border procedures with preferred health providers (World Bank, 2012). This approach would be pivotal in monitoring and evaluating the Fund's progress toward achieving its objectives (World Bank, 2012).

Third, regional cooperation is essential as regional policies and frameworks tend to be translated into national policies. This can help target the appropriate country setting and context in addressing cross-border policy challenges (Amaya et al., 2019). This is particularly key in small states, which often do not have the health systems' capacity to invest in specialised health services (Azzopardi- Muscat et al., 2014). However, this study has highlighted that the current SADC frameworks - in as much as they are aimed at fostering regional cooperation across the SADC through collaborated and coordinated efforts to tackle health challenges that transcend national boundaries (Southern African Development Community, 2009) – they have not been fully

translated into the national policies of SADC member states (specifically Eswatini) primarily due to their lack of adaptability. For example, the SADC policy frameworks, such as the 1999 SADC Protocol on Health (Southern African Development Community, 1999), have not been updated since they were ratified. This means that the evolving nature of health systems makes them hard to adopt at national levels. Outdated regional cooperation policies tend to lack the legal and regulatory provisions that address the specific changing needs in health migration (World Health Organization, 2013). This leads to inconsistencies in providing health services to mobile patients and the harmonisation of health services between and across national borderlines.

Finally, the study's findings support previous assertions about the challenges faced by small states whose health systems somewhat overlap with the health systems of larger countries to meet health needs (Azzopardi- Muscat et al., 2014). And small states are pushed to establish bilateral agreements with their larger neighbours' relatively advanced health systems so that unidirectional specialised health referrals can be made (Muscat et al., 2006). This includes establishing government-funded schemes to facilitate cross-border patient migration. However, such schemes face cross-cutting challenges that negatively impact equity, accessibility, and the quality of care that patients receive or ought to receive (Boudville et al., 2020). Given these findings, including their implications, Eswatini policymakers should recognise the significance of establishing a platform for dialogue and deliberation among the various stakeholders involved in implementing Phalala Fund's cross-border patient migration, especially where stakeholder trust has been strained. This is particularly important in managing expectations, mitigating risks, building alliances, and improving decision-making (Bernstein et al., 2020) in implementing Phalala Fund's cross-border patient migration. This would further be crucial to establishing priorities, trust, and adaptable policy frameworks, fostering consensus and mutual learning among stakeholders, and leading to informed policy formulation and implementation (Rubinelli & von Groote, 2017). This way, stakeholder pain points can be targeted to strengthen Phalala Fund's cross-border patient migration and health collaboration between Eswatini and South Africa.

The study provides an understanding and insight into how formalised cross-border migration through the Phalala Fund from Eswatini to South Africa is facilitated and the challenges faced in the process. The methods employed in this study offer several strengths, notably the comprehensive scoping review and the subsequent application of the IPA. The scoping review facilitated a robust contextual understanding of Eswatini's cross-border patient migration and the Phalala Fund, which was critical for mapping stakeholder interactions and influences (Buse et al., 2012). Additionally, the IPA approach allowed for an in-depth analysis of inter-subjective stakeholder meanings, proving valuable insights into the policy implementation process (Yanow, 2015). However, the study is not without limitations. The sole focus on documentary evidence, while thorough, may have restricted the depth of understanding regarding stakeholder characteristics and power dynamics. Direct engagement with stakeholders through interviews and focus groups could have provided richer, more nuanced insights into their perspectives and experiences (McElfish et al., 2016). Furthermore, the generalisability of the findings is limited to the specific context of Phalala Fund's cross-border patient migration from Eswatini to South Africa, and caution should be exercised when applying these findings to other settings. Although data triangulation was employed to mitigate investor bias, the absence of patient lived experiences is a notable gap. Continuous reflexivity was maintained throughout the study to enhance credibility of the findings, yet the inherent limitations of relying solely on documentary evidence should be acknowledged.

Given these limitations, further research should delve into the perspectives of patients, health workers, healthcare providers, and policymakers from both Eswatini and South Africa who are in practice to understand

the challenges and opportunities in cross-border healthcare initiatives. This would enhance our understanding of the impact of prolonged waiting times, communication gaps, and financial constraints on patients' access to care and health systems responsiveness. Furthermore, quantitative analyses of patient outcomes, utilisation patterns, and cost-effectiveness are necessary for empirical evidence, including economic evaluations of Phalala Fund's cross-border patient migration. Mixed methods comparative studies across different cross-border arrangements in the SADC region could key in shedding light on best practices, policy frameworks, and strategies for improving regional health systems overlap. Addressing these research inquiries would strengthen the evidence base for designing and implementing effective cross-border patient migration programmes in Eswatini and the broader SADC region.

Conclusion

This study has provided an interpretive analysis of the various stakeholders' perspectives in implementing Phalala Fund's cross-border patient migration, emphasising the meanings derived from each stakeholder in the policy implementation process. The meanings attached by each stakeholder are key in providing an understanding of the various challenges that are faced in implementing cross-border patient migration from Eswatini to South Africa through the Phalala Fund, thus further contributing to the ongoing debates on cross-border patient migration (Durham & Blondell, 2017; Lee et al., 2019). Interventions on Phalala Fund's cross-border patient migration should be cautious of the existing stakeholder relations as the lack of trust and engagement has strained some of these relations. It is essential to have a close look at how each stakeholder action(s) is shaped by the cross-cutting realities they each experience in the implementation of the Phalala Fund, the value that they place within each of the realities, and the responsibilities they are willing to take to ensure that the rights of all cross-border patients are protected.

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Appendices

Appendix 1. Study design phases (Source: Author)

Study phases	
Phase 1 **Scoping review of broader literature**	• Mapping of key research concepts on (i) cross-border border patient migration in LMICs, (ii) cross-border patient migration from Eswatini to South Africa, and (iii) landlocked LMICs whose health systems overlap with larger (country) health systems • Context mapping using the stakeholder mapping framework for a comprehensive understanding of the various actors involved in the implementation of the Phalala Fund
Phase 2 **Interpretive policy analysis**	• Sourced data purposefully sampled based on the research question and study objectives. This was done to have an understanding of stakeholder inter-subjective meanings in the policy process through an inductive and deductive thematic analysis of multiple literature on Phalala Fund's cross-border patient migration • Thematic analysis will be applied to allow for the development of three-level category codes: priori themes, emerging themes, and analytical themes • The use of the judgement framework will be used to characterise stakeholders' systems of meaning

Appendix 2. Relevant literature from the scoping review used in Phase 1 of the study

Source	Title	Methodology/Type	Focus
Boudville et al. (2020)	Overseas medical referral: The health system challenges of Pacific Island Countries	Mixed method study analysis of quantitative and qualitative data	Small island countries with bilateral agreements with countries for unidirectional cross-border patient migration
Liverani et al. (2020)	Cross-border medical travels from Cambodia: Pathways to care, associated costs and equity implications	Qualitative study using the pathway to care model	South-south flow of patients seeking health services not available at home (unidirectional pathway)
Ormond and Lunt (2020)	Transnational medical travel: Patient mobility, shifting health system entitlements and attachments	Literature Review	The movement of patients across national borders to meet health needs unavailable at home including the drivers of such travel
Whittaker et al. (2017)	Regional circuits of international medical travel: Prescriptions of trust, cultural affinity and history	Participant observation and interviews	Unidirectional cross-border patient travel from Indonesia to Malaysia
Hunter-Adams and Rother (2017)	A qualitative study of language barriers between South African health care providers and cross-border migrants	Qualitative study - using secondary data analysis of semi-structured in-depth interviews	Challenges faced by cross-border patients when accessing the South African health system
John and Larke (2016)	An analysis of push and pull motivators investigated in medical tourism research published from 2000 to 2016	Quantitative study using content analysis of peer-reviewed articles	A classification of the motivations of people to travel outside their home countries to access health services
Bell et al. (2015)	Transnational healthcare, cross-border perspectives	Case study	Conceptual tools for transnational healthcare practices
Noree et al. (2016)	Medical tourism in Thailand: A cross-sectional study	Cross-sectional survey and patient records	Health systems overlap between neighbouring countries
Ganji (2015)	Hub healthcare: Medical travel and health equity in the United Arab Emirates	Mixed method (quantitative and qualitative)	Patients crossing international borders to access healthcare services
Guinto et al. (2015)	Universal health coverage in 'One ASEAN': Are migrants included?	Scoping review	The inclusion of mobile populations in universal health coverage at a regional scale
International Organization for Migration (2015)	2015 regional forum on HIV/AIDS, TB and non-communicable diseases among migrants and mobile population in Southern Africa region – legal and policy framework for actions towards universal health coverage	Position paper on cross-border health migration	The importance of knowledge-sharing platforms on cross-border patients in Southern Africa
Azzopardi-Muscat et al. (2014)	Challenges and policy concerns for health systems in small European states	Systematic literature review	The implications of European policies on the health systems of small states in Europe
Maung and Walsh (2014)	Decision factors in medical tourism: Evidence from Burmese visitors to a hospital in Bangkok	Quantitative research study (cross-sectional survey)	Unidirectional cross-border patient migration from Myanmar to Thailand
Memon et al. (2014)	Medical value travel in India	Mixed method (qualitative and quantitative)	Patients seeking healthcare services in the Indian health system
Ormond (2014)	Medical tourism	Document review of contexts that send and receive medical tourists	Conceptual definition and how medical tourism is framed in LMICs
Connell (2013)	Contemporary medical tourism: Conceptualisation, culture and commodification	Scoping review	The history of medical tourism from a global perspective
Mamun and Andaleeb (2013)	Prospects and problems of medical tourism in Bangladesh	A mixed-method research study (primary and secondary data)	The reasons Bangladeshi patients seek health services in neighbouring countries

Crush (2012)	No. 57: Patients without borders: Medical tourism and medical migration in Southern Africa	Review of regional and international research studies	Cross-border patient migration across and between countries in Southern Africa (both unidirectional and multidirectional)
Legido-Quigley et al. (2012)	Analysis arrangements for cross-border mobility of patients in the European Union: A proposal framework	Conceptual analysis of various case studies	A framework for understanding cross-border patient mobility in the European Union
European Parliament (2011)	Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare	Policy directive document	Establish rules for facilitating multidirectional cross-border patient migration across the European Union including addressing logistical issues
Lautier (2008)	Export of health services from developing countries: The case of Tunisia	Case study	Health service trade and bilateral agreements between Tunisia and Libya
Keckley and Underwood (2008)	Medical tourism: Consumers in search of value	Quantitative survey	The focus is on the growth of unidirectional and multidirectional cross-border patient mobility globally including associated costs
Kangas (2007)	Hope from abroad in the international medical travel of Yemeni patients	Qualitative research study drawing on interviews	Perspectives of Yemeni patients who travel to Jordan to access health services unavailable at home
Muscat et al. (2006)	Sharing capacities – Malta and the United Kingdom	Case study	Referral of Maltese patients (a small state) to access healthcare in the United Kingdom (with an advanced health system compared to Malta)
Chikanda (2005)	Medical leave: The exodus of health professionals from Zimbabwe	Mixed-method study	The migration of patients and health professionals from Zimbabwe to South Africa
Crush et al. (2005)	Degrees of uncertainty: Students and the brain drain in Southern Africa	A quantitative study using the Potential Skills Base Survey	The migration of professionals and health students from Southern Africa to work abroad
Simelane and Crush (2004)	Swaziland moves: Perceptions and patterns of modern migration	Qualitative study through interviews	Migration patterns in Eswatini and the regional approach for migration
Bicknell et al. (2002)	Economic study of referral health services in Lesotho: The future of Queen Elizabeth II Hospital	Mixed-method study, including patient surveys, and referral study	Provides a perspective on unidirectional cross-border health service referrals from Lesotho to South Africa
Eswatini Ministry of Health (2023)	Ministry of Health	Government website	The objectives of the Eswatini Ministry of Health
Eswatini Medical Christian University (2022)	Eswatini Medical Christian University 2022/2023 prospectus	University prospectus	Overview of the courses that are offered in health sciences
Hlatshwayo (2022)	Girl (6) needs E400 000 for heart treatment in South Africa	News report	Health providers' reluctance to treat patients because of outstanding debts
Gama (2022)	Woman needs E50 000 for urgent throat operation	News report	The extreme measures patients take for specialised treatment
Mohammed (2022)	Plea for child with rare disease	News report	The challenges limiting the referral of patients
Hlatshwayo (2021)	Life not easy – colon cancer patient	News report	Phalala Fund's referral waiting list

Mamba (2021)	The perceived needs and challenges of family caregivers in providing palliative care for relatives living with cancer in Hhohho Region, Kingdom of Eswatini	An exploratory descriptive qualitative study	The study explored the needs and challenges faced by family caregivers providing palliative care for Phalala patients living with cancer
University of Eswatini (2021)	Prospectus undergraduate programmes	University prospectus	Overview of the programmes offered in health science
World Bank (2022a)	Gross domestic product per capita – Eswatini	Economic report	Overview of Eswatini's developmental trajectory
The Global Fund (2020)	Results report	Institutional report	HIV burden in Eswatini
Eswatini Ministry of Health (2014)	First quarter performance report for 2019-20	Mixed method	Reports on quarterly Phalala's performance
Kunene (2019)	Phalala Fund in E66 million mess	New report	Outstanding bills of Phalala Fund from 2013
Mdluli (2018)	Phalala patients stranded as SA hospitals reject them	News report	Health service actors' impact on specialised health service delivery
World Health Organization (2018)	World Health Organization cooperation strategy at a glance: Swaziland	Institutional report	The health situation, health policies and systems in Eswatini
Parliament of the Kingdom of Swaziland House of Assembly (2018)	Select Committee investigating irregularities of the administration of the Phalala Fund Select Committee	Written and oral submissions	Stakeholder submissions on Phalala Fund's cross-border patient migration
Swaziland Ministry of Health (2017)	Service availability and readiness assessment	Cross-sectional survey	Service availability assessment
World Health Organization (2017)	Landlocked developing countries health and World Health Organization	report	The challenges faced by the 32 landlocked developing countries
Nxumalo (2014)	Performance audit on the utilization of Phalala Fund	Performance report	An in-depth understanding of the Fund including the challenges faced
Dlamini (2012)	Phalala E4.6m fraud	New report	Governance challenges of Phalala
World Bank (2012)	Swaziland's funding of referrals abroad: Assessment of the Phalala and civil servants' medical schemes and options for improvement	Institutional report	Phalala Fund's expenditure, the governance loopholes, and recommendations for improvement
Crush and Tawodzera (2011)	Medical xenophobia: Zimbabwean access to health services in South Africa	In-depth interviews and focus group discussions	Focused on issues affecting cross-border Zimbabwean migrants
Tsabedze (2011)	SA hospitals view Phalala as a blank cheque	News report	The importance of standard charges for Phalala patients
United Nations Office of Legal Affairs (2011)	No. 48072. South Africa and Swaziland	Bilateral agreement	This sets the tone for cross-border patient migration

Khumalo (2010)	South Africa, Swaziland sign health agreement	News report	Cross-border health interaction between the countries
Southern African Development Community (1999)	Protocol on Health in the Southern African Development Community	Multilateral regional agreement.	Raises the importance of regional health collaboration in Southern Africa

Appendix 3. Data sources used in the interpretive policy analysis used in Phase 2 of the study

Classification	Unique identifier	Reference	Relevance
Journal articles (J)	J1	Whittaker et al. (2017)	Underscores that intra-regional medical travel from Indonesia to Penang reflects not only dissatisfaction with domestic healthcare but also historical ties, cultural affinities, and regional circuits established through trade, education, and shared histories, emphasising the importance of contextualising cross-border patient migration within broader historical and social frameworks.
	J2	Liverani et al. (2020)	The study on cross-border medical travels from Cambodia reveals a complex interplay of socio-economic, cultural, and health system factors shaping patient migration to Thailand and Vietnam, emphasising the diverse pathways to care, associated costs, and equity implications, and underscoring the potential impact on both the quality of local health services and the widening disparities in access to care among different population groups.
	J3	Azzopardi-Muscat et al. (2014)	The study highlights the unique challenges faced by health systems in small European states, emphasising the importance of understanding the implications of European policy on these systems, particularly addressing common concerns such as primary care, attitudes of health professionals, workforce planning, and organisation of highly specialised care, underscoring the need for tailored European policies to meet the distinctive needs of small states in the realm of healthcare.
	J4	Legido-Quigley et al. (2012)	The authors propose a comprehensive framework for analysing arrangements facilitating cross-border mobility of patients in the European Union, encompassing actors involved, the content of arrangements, institutional frameworks, processes, and contextual factors, providing a valuable tool for researchers and policymakers engaged in cross-border collaborations within the European healthcare landscape.
	J5	Ganji (2015)	Emphasis is placed on the substantial financial investment by the government in sending citizens abroad for healthcare, highlighting the potential equity implications of this strategy, as it may inadvertently prioritise international patients over residents, particularly expatriates, underscoring the need for monitoring and planning mechanisms within medical travel initiatives to mitigate potential harms and enhance equity in healthcare provision.
	J6	Lautier (2008)	This is a study on the export of health services from Tunisia that reveals the significant potential and economic impact of this cross-border collaboration, demonstrating that health services exports, driven by Tunisia's high-quality health sector and geographic proximity to Europe, could account for a substantial portion of the country's private health sector output, generate employment, and contribute significantly to its total exports, underscoring the regional dimension and emphasising the emerging role of South-South trade in the international health services market.
	J7	Muscat et al. (2006)	This case study on patient mobility in Malta (a small state) and the United Kingdom reveals the historical context of patient movements, from the influx of overseas patients in the early 20th century to the contemporary challenges faced by Malta as a European Union (EU) member, emphasising the need for adaptation to EU regulations on patient mobility and highlighting the unique challenges and best practices in providing health care for tourists and referring Maltese patients abroad within the framework of a closely regulated mechanism.
Institutional reports (I)	I1	World Health Organization (2018)	This strategy notes progress in health outcomes, emphasising gains in life expectancy, infant mortality, and HIV/AIDS control. Challenges like maternal mortality and non-communicable diseases persist. The strategy focuses on universal health coverage, particularly maternal and child health, HIV, and TB. It outlines policy frameworks, health system features, and key partners, highlighting a collaborative

			approach to address ongoing health challenges and achieve the Sustainable Development Goals (SDGs).
	I2	World Health Organization (2017)	This underscores the challenges landlocked developing countries (LLDCs) face, comprising 32 nations across Africa, Asia, Europe, and South America. Among the poorest and least developed, LLDCs encounter economic hurdles due to their lack of direct sea access, necessitating costly land transport and infrastructure investment. Dependency on neighbouring transit countries amplifies vulnerabilities, hindering economic development and impeding effective responses to health needs.
	I3	Boudville et al. (2020)	This policy brief highlights the health system challenges in Pacific Island Countries (PICs), where the small and dispersed population creates difficulties in providing specialised clinical services. Overseas Medical Referral (OMR) is a solution to address this gap but presents challenges in cost, quality, equity, and integration with the broader health system. Despite government support through OMR schemes, there are issues with awareness, policy implementation, and financial protection.
	I4	United Nations Office of Legal Affairs (2011)	The document outlines an agreement between the Governments of the Republic of South Africa and the Kingdom of Eswatini regarding cooperation in health.
	I5	The Global Fund (2020)	The report highlights a nearly 50% reduction in HIV/AIDS deaths in countries it supports. Nine nations, including Eswatini, achieved UNAIDS's 90-90-90 targets by 2019. Notably, Eswatini, in partnership with Switzerland, reached the '95-95-95' HIV target a decade early, which was attributed to targeted investments in prevention and treatment interventions. The Global Fund's HER initiative focuses on reducing HIV infections among adolescent girls and young women in 13 sub-Saharan African countries, with specific programmes like "Girl Champ" in Eswatini promoting health awareness and empowerment.
	I6	World Bank (2012)	The World Bank's assessment of Phalala Fund's cross-border patient migration reveals weaknesses, including limited coverage, lack of cost-effectiveness guidelines, and financial non-transparency. Recommendations include creating a managed care system and making the Phalala Fund autonomous. Immediate actions involve defining referral criteria, setting up preferred provider arrangements, and enhancing administration.
	I7	European Parliament (2011)	Directive 2011/24/EU emphasises cooperation on health technology assessment (HTA) within a voluntary network connecting national authorities or bodies designated by member states. The objectives include supporting collaboration, providing objective information on health technologies, avoiding duplication, and receiving EU aid for administrative, technical support, and cooperation between member states. The Commission is tasked with adopting measures for the network's establishment and functioning. Aid arrangements, conditions, and amounts are subject to regulatory procedures.
	I8	Southern African Development Community (1999)	The Protocol on Health highlights the collaborative effort among SADC member states to address health issues, including infectious diseases such as HIV, TB, and malaria, emphasising the importance of harmonised standards to ensure standardised prevention and treatment services for children and adolescents, including migrants and vulnerable populations, with potential implications for cross-border health initiatives.
	I9	Southern African Development Community (2009)	This is a draft framework that recognises the impact of population mobility on the spread of infectious diseases. It seeks to guide on protecting the health of cross-border mobile populations, including migrants, while simultaneously addressing the control of infectious diseases in the SADC region, emphasising the importance of harmonising health and movement objectives.

Government documents (G)	G1	Nxumalo (2014)	The performance audit provides insight into a health fund's efficiency and goal achievement. Highlighting challenges and successes in delivering specialist medical care can potentially inform discussions on cross-border patient migration.
	G2	Parliament of the Kingdom of Swaziland House of Assembly (2018)	The report on irregularities in the administration of the Phalala Fund underscores challenges such as delayed payments, immigration issues, and service provider disputes, which are pertinent to understanding the complexities of cross-border patient migration.
	G3	Eswatini Ministry of Health (2014)	The first-quarter performance report emphasises challenges in patient transfers to South Africa, such as delayed referrals and outstanding payments, shedding light on operational issues that impact Phalala Fund's cross-border patient migration dynamics.
	G4	Ministry of Health (2006)	The document recognises the impact of the HIV/AIDS pandemic on health services. It aims to guide the Eswatini MoH in developing strategies to address current challenges, emphasising the need for efficient and effective utilisation of limited resources to improve the quality, safety, and cost-effectiveness of health service delivery, which is pertinent to understanding the healthcare landscape for potential cross-border patient migration considerations.
	G5	Ministry of Health (2009)	The Plan outlines Eswatini's MoH's commitment to addressing current and emerging health challenges, emphasising an integrated approach, health systems, and universal access to quality health services, contributing to understanding the country's healthcare goals and strategies.
	G6	Ministry of Finance (2001)	This regulation outlines the establishment and objectives of the Phalala Fund, emphasising its role in providing specialist medical care to deserving citizens of Eswatini, both within and outside the Kingdom. It also details the administrative procedures, financial aspects, and composition and functions of the Specialist Care Medical Aid Committee, which is crucial for understanding the framework governing access to specialised healthcare.
	G7	Swaziland Ministry of Health (2017)	The assessment aims to comprehensively evaluate the availability, readiness, and quality of health services in all public and private facilities, aligning with the Essential Health Care Package (EHCP) and supporting evidence-based health sector planning, which is essential for understanding the healthcare infrastructure.
	G8	Eswatini Ministry of Health (2014)	This underscores the importance of the National Health Sector Strategic Plan (NHSSP II) in addressing health-seeking behaviours, promoting client-focused services, and ensuring equity of access to health services, providing a comprehensive and rationalised investment focus crucial for understanding the strategic direction of the health sector.
Books (B)	B1	Crush (2012)	The publication examines the dual issues of health worker migration and medical tourism, focusing on South Africa. It explores the impact of the global migration of health professionals on South Africa and analyses the phenomenon of medical tourism, both from the Global North and within Africa. The study challenges traditional perceptions of medical tourism, emphasising the significant flow of patients within Africa.
	B2	Simelane and Crush (2004)	The focus is on migration within the SADC region. The paper emphasises the need for accurate information in policymaking, human rights considerations, and regional cooperation. It examines Eswatini's migration history and challenges in monitoring migration and presents findings from national surveys conducted in 2001 and 2002. It aims to contribute to Eswatini's understanding of migration trends and advocates for a cooperative, regional, and harmonised approach to migration management within SADC.
News publications (N)	N1	Hlatshwayo (2022)	A six-year-old patient urgently required R400,000 for heart treatment in South Africa. Referred under the Phalala Fund, which aims to assist citizens in need of specialist medical care, the child's

			heart condition was discovered in December. Delays in Phalala Fund payments have hindered the process, and the patient's health has deteriorated.
	N2	Gama (2022)	This is a 45-year-old patient who urgently requires R50,000 for a throat operation in South Africa. She was diagnosed with a rare throat disease five years ago, and her condition worsened a year ago, preventing her from eating or swallowing liquids. Currently relying on a feeding tube, the patient's family seeks public assistance for the operation. Despite approaching the Phalala Fund, delays and uncertainty persist. The family is appealing for financial support to address the patient's deteriorating health.
	N3	Mohammed (2022)	This is a case of an 11-month-old baby with a rare head-swelling disease called 'Cerebral Edema,' who urgently needed medical assistance. Born with the condition, the head swelling worsened at four months old. The family, facing financial constraints, sought help from the Phalala Fund, but government assistance was unavailable due to a lack of funds.
	N4	Hlatshwayo (2021)	This is a case of a patient diagnosed with colon cancer, struggling with unbearable pain since 2018. The patient faced financial hardships, unable to work or provide for his family. Despite being on the Phalala Fund waiting list for specialist care, he has not received treatment. The patient appealed to the public for R60,000 to undergo an operation, emphasising the dire need for financial assistance.
	N5	Mdluli (2018)	South African hospitals have reportedly ceased treatment for Eswatini citizens transferred through the Phalala Fund due to outstanding debts owed by the Eswatini government. The situation, affecting over 100 individuals, has forced some patients to return home (Eswatini) without medical care.
	N6	Dlamini (2012)	A South African nurse and a relative were accused of defrauding the Eswatini government of R4.6 million through the Phalala Fund. The frozen assets, including a R1.6 million townhouse, were allegedly purchased with proceeds from the fraudulent claims. The nurse is accused of submitting false medical claims, resulting in R4.6 million.
	N7	Kunene (2019)	The Phalala Fund, grappling with a surge in cancer cases, reportedly owes South African hospitals approximately R66 million in medical bills dating back to 2013. Economic challenges in Eswatini have hindered the fund's transfer of patients, particularly those with cancer, to South African referral hospitals. Phalala's debt situation affects various hospitals, impacting cancer patients' treatment options and specialists' availability.
	N8	Khumalo (2010)	The Health Departments of South Africa and the Kingdom of Eswatini entered a cooperation agreement to enhance healthcare services in the SADC region. The agreement, signed by Health Ministers Dr Aaron Motsoaledi and Benedict Xaba, encompasses technical, professional education and training of health professionals, experience sharing in research and development, twinning of public hospitals, and special medical care and health services, including patient referrals. The collaboration supports SADC's health initiatives, including alleviating the financial burden on Eswatini citizens when seeking specialised medical treatment in South Africa and fostering cooperation to address common health challenges in the two countries.
	N9	Tsabedze (2011)	The Phalala Fund encounters issues such as being perceived as a 'blank cheque.' Minister of Health Benedict Xaba highlights concerns about excessive payments.
Theses (T)	T1	Mamba (2021)	This qualitative study explores the unmet needs and challenges faced by ten family caregivers offering palliative care to cancer patients. Challenges included uncertainty about the future, time constraints, financial difficulties, and limited engagement with healthcare workers. The study emphasises the essential support required for family caregivers and recommends their integration into the healthcare system for enhanced patient care.

Appendix 4. Stakeholder quotes on dominant meanings in the implementation of Phalala

Stakeholder 1. Government of Eswatini

Eswatini Ministry of Health		
System of meaning	**Quote**	**Explanation**
Actions	*"The Phalala Fund is a special fund financed through an annual budget allocation of R60 million appropriated by Parliament to the MoH from the consolidated fund" (G1).* *"In the first quarter of FY [financial year) 2019/2020, a total of 58 patients were referred to RSA [Republic of South Africa]. This quarter has been the most quiet period for patient transfer, due to the fact that Phalala Office was prevented from sending patients due to outstanding payments to service providers" (G3).* *"The main areas of focus for most (government) partners are HIV/AIDS, TB, malaria, and health systems strengthening" (I1).*	The MoH's main priorities have been addressing the national disease burdens: HIV/AIDS, TB, and malaria. Although financial resources have been poured into Phalala Fund's cross-border patient migration, gaps have resulted in outstanding payments to South African health providers taking Phalala patients.
Value judgements	*"Although the Fund has managed to pay down arrears from previous financial years, payments for the current financial year have been slow and this is tied to the limited staffing of the Accounts team for the Fund. The team has been working hard to process payments timeously however there is still a backlog of invoices that are yet to be logged into the system; additional staff is required to ensure that invoices are processed for payments timeously" (G3).* *"A questionnaire was sent to the Minister of Health, Lizzie Nkosi asking if Phalala Fund's list was categorised or was just one long list...Nkosi said 'We do have waiting lists on certain conditions, but every attempt is made for emergency and urgent interventions" (N2).*	**Service efficiency:** The Ministry has attempted to ensure that Phalala payments are processed efficiently. However, limited staffing continues to delay payment processing. Furthermore, the Ministry is trying to sort out Phalala backlogs and ensure patients can access the required treatment (s).
Reality judgement	*"The sad part of the story is that government's Phalala Fund, which was established to meet medical needs of Eswatini who cannot afford the costs of external specialist treatment, is currently unable to assist - due to lack of funds" (N3).* *"An 11-month-old baby girl suffering from a rare head-swelling disease, whose mother is a high school pupil, while the father dropped out, is battling for her life at the Mbabane Government Hospital. The sad part of the story is that government's Phalala Fund, which was established to meet medical needs of emaSwatini who cannot afford the costs of external specialist treatment, is currently unable to assist - due to lack of funds…Director of Health Services, Dr Vusi Magagula, in an interview yesterday, described this particular case as 'one of those that government was unable to fund at the moment due to the fiscal financial position it is faced with" (N3).* *"Landlocked developing countries have not made improvements in increasing life expectancy… Swaziland saw dramatic decreases between 1985 and the early 2000s" (I3).*	**Financial barriers:** The perception of the Phalala Fund is that it was established through the Eswatini Ministry of Health to meet the medical needs of EmaSwati, who cannot afford specialised treatment. The most essential "reality" of the Eswatini MoH is that the Fund does not have the financial capacity to meet the needs. **Priorities:** Although life expectancy in Eswatini has increased, patients requiring specialist treatments through Phalala are not adequately assisted.

Phalala Fund's committee		
System of meaning	**Quote**	**Explanation**
Actions	*"The Director or Chairperson of Phalala Fund Committee as per the Administration of the Specialists Care Medical Aid Fund Regulations, 2001, must issue a guarantee letter to pay the service provider who has been quoted as the physician who will provide the service… It was observed that the patients' files were not updated with all the necessary documents that had to be in the file. Furthermore, when reviewing the patients' files, some did not have proof of nationality (copy of national identity document or travel document)" (G1).*	**Administrative obstacles:** Patients' files are outdated, and some lack the necessary paperwork. This makes it hard to process payments to providers in South Africa.

Value judgements	*"We (Phalala) live on negotiations and begging doctors and hospitals to accept cancer patients because of the bad records we have in terms of paying outstanding debts…" (N7).* *"The Phalala Fund administrator, manages all cases indeed they work with Healthshare, she is the only one if a client is critical it depends on the level of the client's condition, as clients' condition is always treated in confidentiality… patients should be told the honest truth about the level of their disease especially the cancer patients, the need to assist patients holistically, not to be lied at that he is cured yet still ailing" (G2).* *"The Phalala fund personnel and the MGH try to assist the patients with some social support activities such as contacting families, arranging temporary accommodation in MGH" (I8).*	**Patient support:** Relevant Phalala staff offer social support. This includes ensuring that the patient has the correct diagnosis and is aware of the diagnosis, including further steps to be taken. **Negotiations:** Due to the poor payments, Phalala goes outside its scope of work and negotiates, to some extent, begging health providers in South Africa to treat patients who require care.
Reality judgement	*"Due to the increasing number of cancer cases in the country, Phalala Fund is said to be owing South African hospitals medical bills estimated to be in the region of E66 million… it is stated that some of the outstanding bills date back to the year 2013" (N7).* *"There is a standing Board which conducts referral cases and they do not receive any seating allowances. The Board and Phalala Fund meet fortnight to leverage work with the other countries" (G2).*	**Debt accumulation:** Phalala continues to accumulate debt. This is mainly due to the increasing number of cases that require specialist care outside the country.

Referring hospital (Mbabane Government Hospital)		
System of meaning	**Quote**	**Explanation**
Actions	*"Also, patients have to fund themselves to get to MGH or from MGH back to their homes. The application for travel documents has to be done by the patient or family members with various fees being charged" (I8).*	**Costing:** Patients referred from any of the regional hospitals in Eswatini are responsible for the financial costs (such as transport) associated with the referral to the MGH.
Value judgements	*"The reduction in the oncology treatments could be attributed to the increasing availability of cancer medicines at the chemotherapy unit in Mbabane and an increasing number of patients being treated at the unit since the Oncologist was recruited earlier this year. Almost all of the referred patients were sent for chemotherapy and/or radiation therapy… There are still some patients being referred to South Africa as they need a combination of radiotherapy & chemotherapy" (G3).*	**Investment in local specialist treatment:** MGH, the hub for all Phalala referrals, has bolstered its local treatment systems, making oncology treatments available, thus reducing most cancer referrals to South Africa.
Reality judgement	*"…the referral process starts with patients referred to Mbabane Government Hospital…there is no system of feedback whenever patients have been referred… irregularities in its [Phalala] administration dates back as far back as 2006, such that an inquiry was conducted by Parliament to investigate all operations, but this time it was more in operations of Mbabane Government Hospital which acts as a referral centre" (G2).*	**Referral chain:** The Mbabane Government Hospital (MGH) is the main point for national referrals. MGH is where all Phalala cases are assessed and referred to South African health providers. However, the referral chain is not linked, as there is no communication between health providers and the MGH. This interrupts follow-up treatments.

Treasury Department		
System of meaning	**Quote**	**Explanation**
Actions	*"Significant progress in paying Phalala arrears – As indicated in the Financial Management section, with assistance from the Treasury, the Fund has been able to pay a significant amount (approximately 57%) of its old debts (pre-current financial year) to South African providers" (G3).* *"The accounting officers in the Phalala office and Accountant General's office diligently review invoices and facilitate the*	**Debt clearing: The Treasury has helped clear** some of Phalala's main debts. However, this manual process is daunting and vulnerable to corruption.

	payment process. Much of this is a manual process with numerous forms to be filled…" (I8).	
Value judgements	*"A South African nurse and her relative have had their assets frozen after allegedly defrauding the Swaziland Government an amount of E4.6 million. The money was paid by the Ministry of Health under the Phalala Fund Scheme" (N6).*	**Support anticorruption:** The department acting against those defrauding the Fund.
Reality judgement	*"…the country [Eswatini] committed to making payments 45 to 60 days from receipt of invoices. Due to the limited staffing in the Account's Office, the Fund hasn't performed too well in processing payments in the 45-to-60-day payment terms" (G3).*	**Staffing:** The Treasury finds it challenging to make Phalala payments within the stipulated timeframe due to insufficient staffing.

Stakeholder 2. South African providers

System of meaning	**Quote**	**Explanation**
Actions	*"…Some specialists have cited that the history of poor payment is a challenge, and they would rather not engage with the Fund for referrals…Baragwanath Hospital is the service provider the Fund engages for chemotherapy of children. The hospital is seeing a few patients at the moment but is refusing to see new patients until they can meet with the Phalala team and iron out challenges they have seen in the referral & logistics process" (G3).* *"Netcare is a major share player in Radiation and Chemotherapy (oncology) and has stopped receiving patients… Those who are hospitalised are treated, but those treated on outpatient basis and who might have travelled back to Swaziland are not received back (by providers)…" (G2).*	Reluctance to treat Phalala patients: Due to the Phalala Fund's payment record, South African health providers have been reluctant to admit and treat Phalala patients. Some providers have initiated conditional treatment arrangements with the Eswatini MoH, which include settling the minimum debt before a certain number of patients can be admitted to their facilities. Other providers have wholly stopped accepting Phalala patients.
Value judgements	*"...a specialist doctor may be willing to operate or attend to a patient's case, but if the hospital does not allow Emaswati patients then their efforts become in vain" (N7).*	**Willingness to treat patients:** Some doctors are willing to 'help' patients by providing treatment. However, the hospitals they work for may decline.
Reality judgement	*"…there are definitely hidden and huge costs which are incurred by our Government as some doctors use South African tariffs, particularly on consultations" (G2).* *"The Phalala Fund is viewed as a 'blank cheque' by South African private doctors and hospitals. This was said by the Minister of Health, Benedict Xaba, who said a lack of negotiating tactics, exposed the Phalala Fund to exorbitant charges, which only served to limit the effectiveness of the fund in the long run…Fees and other prices are not negotiated beforehand and are completely supplier-determined. Enquiries about fees are made at the point of need when government is at its weakest negotiating position" (N9).*	**Hidden costs:** Some providers charge the Government of Eswatini additional 'hidden' costs. This is mainly because the Fund has been viewed as a blank cheque, and the Government of Eswatini has no negotiating power with the South African service providers.

Stakeholder 3. Healthshare Integrated Solutions

System of meaning	**Quote**	**Explanation**
Actions	*"Invoices amounting to E37 million for the financial years 2012/13, 2011/1, and 2011/2010 were submitted to Healthshare Integrated Solutions (PTY) LTD in November 2012 were for amongst other things; multiple payments, authenticity verification, overcharges, which further delays the payments" (G1).*	**Tracking of payments:** Working with Healthshare Integrated has improved the monitoring of Phalala's untraceable payment discrepancies.
Value judgements	*"Patients referred to the Republic of South Africa by the Kingdom of Swaziland shall be treated in public hospitals" (I6).*	All Healthshare referrals should be made to South African private-sector health providers. However, referrals have been made to both public and private health providers.

Reality judgement	*"There has been delay in the signing of the contract of the intermediary body (Healthshare), this delay was caused by the need for cabinet approval and a Task Team, of doctors (Doctor's Council) report of this team was delayed to adoption due to problems which emanated on the issue of doctors' overtime. Thus, the was a need to standardise the on-call requests of huge overtime claims. Government wanted to leverage this, and the contract has only been signed end of March 2018, practically Healthshare has been operating for fourteen months without pay and unceasingly" (G2).* *"Swaziland owes 12.7 million rands to Healthshare - Phalala Fund Administrator… Healthshare has not been paid since early 2017…the Ministry is not responsible for making payments, rather it is the Ministry of Finance" (G2).*	**Debt:** Healthshare is owned by the Eswatini MoH, and the Ministry of Finance has not made the payments. This is after Healthshare worked on Phalala Fund's cross-border patient migration without the contract for 14 months.

Stakeholder 4. Southern African Development Community (SADC)[1]

System of meaning	Quote	Explanation
Actions	*"State Parties shall co-operate in addressing health problems and challenges facing them through effective regional collaboration and mutual support…In order to ensure access to good quality data and its use in planning and managing health system, State Parties shall develop and formulate coherent, comparable, harmonised, and standardised policies…" (I8).*	**Focus on health system cooperation:** The regional focus is on enabling collaboration between and across SADC countries to ensure a shared understanding of health system issues in the region.
Value judgements	*"…patients can be referred to the country's public hospitals with a minimum payment for health services rendered… The agreement supports activities and obligations under the Protocol on Health in the SADC region, which among others entails the poaching of health workers from countries in the region and inter-country initiatives to combat diseases such as malaria and tuberculosis (TB)" (N8).* *"…progressively building capacity in State Parties to provide appropriate high-quality specialised care through the exchange and attachment of specialists in the Region" (I8).*	**Access:** The SADC Protocol on Health prioritises accessible health services across the region. This has influenced the bilateral health agreements between Eswatini and South Africa, as access has been at the forefront. **Capacity:** There is a commitment to ensure that the health system in the region can handle patient mobility.
Reality judgement	*"Collaboration among health institutions such as universities, research institutions, manufacturers and supplies of drugs and equipment in the two countries remain very strong…He added that Swaziland does not have adequate capacity to provide specialised health care and has benefited immensely from its partnership with South Africa…Xaba said the two countries face similar health challenges including HIV and AIDS, TB, H1N1 and other chronic diseases" (N8).*	**Shared health challenges:** SADC has a shared regional health profile. Health system collaboration between Eswatini and South has largely benefitted both countries.

[1] SADC as a stakeholder refers to the intergovernmental organisation headquartered in Botswana of which Eswatini and South Africa are members states. SADC is also used interchangeably to refer to the SADC region.

Stakeholder 5. Phalala patients

System of meaning	Quote	Explanation
Actions	*"Due to her depreciating condition, her family is now seeking assistance of the public in order for her to undergo an operation in South Africa" (N2).* *"…they were informed that the operation would cost between E50 000 to E70 000…He said that the quotations they made amounted to approximately E100 000, but some people had already promised them E20 000… We will also host an event Hospital Bill Fundraising, where we invite everyone to participate at Dvokolwako Hall" (N2).* *"Masilela is appealing to members of the public to help him raise E60 000 for undergoing an operation as he had failed to go to South Africa through the Phalala Fund" (N4).*	**Flexibility:** Relatives of patients who qualify for Phalala's care are acting and taking matters into their own hands by being flexible in raising funds to access specialist health services in South Africa.
Value judgements	*"…in Swaziland, patients' rights are not respected, and there is no legislation to safeguard this. Swazis are easily turned into guinea pigs there is no law to safeguard them, they are charged exorbitant fees…" (G2).* *"Even the little money that I used for bus fare from home (KaNkonjwa) to Mbabane, I was given by Thandiswa's father which was a wage he got from doing odd jobs around our area…" (N3).* *"…Masilela stated that life had not been easy such that he had wished for death since 2018 as he said that the pain had been unbearable and the fact that he could not provide for his family made it worse…Masilela has been under the Hospice at Home palliative programme (Eswatini Hospice Life) … Masilela said there was a doctor around Manzini who had promised to [financially] assist him" (N4).* *"My daughter went once to South Africa and stayed for 2 months. When it was time for her to go back, she was told that Phalala Fund does not have money and if she wishes to return, then she can pay for herself" (T1).*	**Protection of patients' rights and well-being:** There is a perception that the citizenry's rights are not protected, and human life is not valued in Phalala Fund's cross-border patient migration as the wellbeing of patients is not considered.
Reality judgement	*"Magaula (45) was diagnosed with a rare throat disease about 5 years ago, but the situation became worse a year ago as she could not take anything down her throat anymore… We tried to approach Phalala Fund, but the challenge is that we were put on the waiting list..." (N2).* *"…he stated that when he enquired why he was not being attended to [by doctors at Mbabane Government Hospital], he was told that his condition required specialist care and the hospital did not have a doctor, hence he needed to be transferred to South Africa through the Phalala Fund" (N4).* *Among family members who were initiated on cancer treatment in South Africa [some] never completed their treatment as they were told that funds from the Government owned Phalala Fund were insufficient to send people for treatment to South Africa" (T1).*	**Waiting list:** In reality, most patients with rare and complex medical conditions who need specialist interventions unavailable in the Eswatini are placed on the Phalala waiting list. **Poor communication mechanisms: S**ome patients who need to be transferred through the Phalala Fund do not receive proper communication from health workers such as doctors and nurses. Some do not even know that they require a Phalala transfer, while others' treatment in South Africa is abruptly stopped without any form of communication.

Appendix 5. Stakeholder analysis (Brugha & Varvasovszky, 2000)

Stakeholder analysis stage	Explanation of the stage
Identifying stakeholders	• All relevant stakeholders who are involved or affected by the Phalala Fund's cross-border patient migration were identified from the rapid scoping review • Identified stakeholders were the Government of Eswatini, South African health providers, Healthshare Integrated Solutions, SADC, and Phalala patients
Understanding stakeholder interests	• The document analysis during the scoping review allowed for an understanding of each stakeholder's interests and priorities regarding Phalala Fund's cross-border patient migration. This further allowed for the understanding of the points of conflict and opportunities for collaboration • This also included the mapping of the relationships and interactions between and across stakeholders to identify key actors and networks that could influence policy outcomes
Assessing stakeholder power and influence	• Each identified stakeholder's power and influence on Phalala Fund's cross-border patient migration was assessed. This was determined by the level of authority, decision-making, and resources as far as the research phenomenon is concerned • This was assessed as (i) high power, (ii) medium power, (iii) low-medium power, and (iv) low power. High power signifies significant influence in decision-making, and low power means no influence in decision-making as far as Phalala Fund's cross-border patient migration is concerned

Appendix 6. Steps followed in the IPA thematic analysis (Braun & Clarke, 2006)

Step in IPA thematic analysis	Explanation
Familiarising with the contents of the publication document(s)	• This started with selecting relevant publications (some identified in the literature review), categorised as journal articles, institutional reports, government reports, books, news publications, and academic theses, which were included in the analysis. The research question and study objectives guided the selection of publications for analysis. The initial assessment comprised the overview of the title and abstract of each publication • In no order, each publication deemed fit as per the research question and study objectives was read in full to gain familiarity
Coding	• Priori themes relevant to the IPA approach based on the literature review (Phase 1), the research question, and study objectives were identified • The order of analysis: each publication was analysed sequentially, starting with journal articles, institutional reports, government reports, books, news publications, and academic theses. The researcher ensured a thorough analysis of each publication before moving to the next • Guided by the research question and study objectives, all selected publications (journal articles, institutional reports, government reports, books, news publications, and academic theses) were assigned codes (visible by different colours) directly related to the predetermined priori themes, and new themes emerged. The emerging themes were captured into a Microsoft Excel sheet and categorised into broader categories based on similarities. Some categories aligned with the priori themes, while others represented newly emerging patterns • An in-depth analysis within each category was conducted. This allowed the researcher to explore relationships, patterns, and connections between and across codes as guided by the research question and study objectives. After that, from the categories, overarching analytical themes of high-level, in-depth interpretations were done
Identification of common themes	• Patterns from the data captured on Excel, including recurrent ideas, were identified to create and categorise as per the priori themes that rightly reflect the meaning of the data • Coded data was organised from one theme to the next to have a systematically organised flow
In-depth analysis	• This included the cross-comparison of the various themes from the data to explore relationships, including conflicts across the data set, to have a better understanding of the meanings
Developing a coherent narration of the themes	• This was a storytelling of the themes and the overlapping relationships between and across the themes, including explaining the information in a systematic and organised manner. Themes were continuously reviewed and refined, ensuring that they accurately represented the data and aligned with the research objectives while addressing the research question
Validation	• The analysis was an iterative process that was reviewed and discussed with the researcher's primary supervisor to ensure consistency and validity of the analysis. The research also returned to the data and codes to check interpretations and refine the themes where necessary

Appendix 7. Journal of Public Policy (JPP) submission guidelines

The manuscript should be submitted in Word. Each table and figure should be on a separate page at the end of the file and not embedded in the text.

Use endnotes, not footnotes, at the bottom of the page. End notes should be kept to a minimum for points that are relevant but distracting if included in the text. Simple citations of literature should be included in the text in the standard citation format.

The abstract should be approximately 150 words.

Keywords: four to six.

Title page: Include the date of the current version at the top and a word count. Also, give the author(s) email and other relevant contact points.

The title should come next, with the author's departmental and institutional affiliation and names.

Acknowledgements at the bottom of the title page.

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Professor Richard Rose 28.9.09

Prof_r_rose@yahoo.co.uk

Editor, Journal of Public Policy

Preparing your materials preparing your materials (cambridge.org)

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