Invisible Healthcare Providers: Non-Profit, Non-Government Hospitals and Large Clinics in Developing Countries

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Abstract

Not-for-profit, non-government hospitals and large clinics are the only means for many communities in developing countries who have no other means of accessing emergency healthcare. They provide free, or extremely low-cost, care relying on volunteers to assist by staffing, promoting and funding their operations. This paper highlights the 'invisible' healthcare providers who work with a broad range of non-state actors to provide emergency care to those least able to access healthcare. It explores the range of providers and classifies them into a broad typology based on questions of ownership and funding. The paper explores what we do not know from existing academic literature and why these hospitals and clinics should be studied further, as an important contributor to the principle of universal healthcare for all. It argues that they should be considered an integral part of future health systems reform.

Introduction

Access to healthcare is one of the fundamental human rights; since the Alma-Ata Declaration (World Health Organization 2005) in 1978 it has been widely recognised as a priority area. Yet for millions of people in developing nations it remains inaccessible, unaffordable or simply unavailable. Despite all the gains made in global healthcare in the past three decades, access and affordability remain two of the biggest challenges. As more organisations join the push for Universal Health Care as a successor to the Millennium Development Goals, the role of providers from the informal sector needs to be better understood. Charting these 'invisible'; healthcare providers, the not-for-profit, non-government hospitals and large clinics who are often classified as being part of the informal sector - even though the boundaries between their operation and the public health sector are highly porous - will provide a greater understanding of the opportunities they present to all stakeholders involved in the supply of healthcare.

This paper will identify what we do not know from the academic literature and demonstrate the need and support for further research. Exploration of the key concepts, identification of the definitional confusion within the field, and the lack of a guiding framework for the study of this informal sector all demonstrate the need for a typology to categorise key actors into a meaningful structure which addresses the key issues of ownership, financing, governance, mode of supply etc. The first step is to identify organisations which fit under the definitions identified here and to look for key characteristics which provide useful categories. The second step is to identify key sources and review the available peer-reviewed and grey literature. The final step in this paper is to identify a typology which is supported by the evidence.

Background

The work of international humanitarian actors who provide health services during periods of emergency or crisis (including the International Committee of the Red Cross and Médecins Sans Frontières, which are highly visible) is generally well-known in the global community. However, they are but one part of a highly complex and diverse sector, whose approach, organisational structure, delivery model, funding model, geographic service and case-mix are vastly different. Their significance is difficult to quantify, given they often develop in parallel to the broader health sector (Olivier, Tsimpo & Wodon 2012, p. 3).

The overwhelming complexity and scale of the need for health services in developing countries has often overshadowed the efforts of small organisations sitting outside the public health system. For large international bureaucracies with multiple functions like the World Health Organization (WHO), the vast number of actors, both state and non-state, has in itself been a challenge. The WHO's response has been to limit those who can present their views. To achieve official status with the WHO, the not-for-profit organisation is required to be an international Non -Government Organisation (NGO), establish a joint programme of work and a three-year plan with WHO Under these rules, only 189 NGOs globally qualified as at 2002 (*WHO's Interactions with Civil Society and Nongovernmental Organizations* 2002). The result has been that smaller scale organisations servicing established needs are, in practical terms, excluded from the policymaking processes at an international level. As an article published by The Lancet in 2014 recognised "participation and representation of some actors, such as civil society, health experts, and marginalised groups, are insufficient in decision-making processes." (Ottersen et al. 2014, p. 631)

At a national level, their status is highly variable and dependent on individual relationships, governance structures and broader political concerns. Some governments, recognising their limited ability to deliver health services, have effectively contracted out their role to non-government providers. In Papua New Guinea, for example, faith-based organisations run a significant portion of all tiers of the health system under agreement with the government (Ascroft et al. 2011). In Lesotho, the government took this a step further, in a controversial decision, to engage in a public-private partnership, with a private for-profit provider, to rebuild and operate the main national hospital, the Queen Mamohato Memorial Hospital. A 2014 Oxfam International report said the new hospital now absorbs 51% of the government's total health budget for the country (Marriott 2014). Yet in other countries, organisations like Mercy Ships have been forced to withdraw or postpone visits. Mercy Ships has a well-established protocol which host governments must agree to; it includes practicalities such as government agreement to supply fresh water to the ship and garbage removal (Stephens 2005, p. 82). When the government refused to meet basic requirements to enable the visits to occur, these visits have been postponed.

Even narrowing down what is meant by not-for-profit, non-government hospitals and clinics in developing countries is fraught. The literature varies considerably and most of the key terms are highly contested. For the purposes of this paper, not-for-profit excludes providers who charge a fee which is beyond the capacity of the individual to reasonably pay without going into debt. Some private providers identify as not-for-profit when they charge the cost price for surgery or when they use a hybrid model of user pays and some subsidisation; these providers are excluded from this study. It refers specifically to those facilities that either charge nothing at all, or charge a very small

co-payment which could reasonably be afforded by the poorest members of the population it is servicing. It includes faith-based organisations (also referred to in the literature as faith-inspired institutions). Essentially these are facilities that provide a public health service, without necessarily being part of the public health system.

Non-government does not exclude contractual arrangements with government; however it does delineate that the facility is operated as a non-government entity and is at least partially resourced by other sources of funding. The rationale for the inclusion of both hospitals and large clinics is the different meanings attributed to the terms hospital and clinic dependent on context. For example, Papua New Guinea has small health outposts which carry the name of hospital; yet clinics in many Asian nations that treat 150,000 patients annually with a wide case-mix, including some minor surgical interventions, do not carry the name of a hospital. Ideally, in a western context, you would use another health metric, such as bed numbers as an indicator. However facilities in developing country contexts do not have 'beds' as we recognise them; they may be as simple as blankets lining a floor which are used by patients and their families alike. At the core is an understanding that the facilities referred to in this paper have some emergency capacity, whether that emergency relates to road trauma, birthing complications, or the treatment of acute infection diseases. Similarly, while their mode of delivery differs and may be transient, the facilities included in this paper have existed for at least five years, with most having existed for decades.

In respect of the definition of a developing country, a deliberate decision was made to keep this to a common understanding of the simple divide between developed and developing nations. One measure used in academic literature is the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) list of Overseas Development Aid (ODA) recipients ((OECD) 2012). However many countries listed in the lower-middle income and upper-middle income brackets on the OECD DAC ODA list still have vast inequity in service provision and struggle to provide essential services to large swathes of their population. Similarly, there has been significant criticism of the Human Development Index as a measure of development (Sagar & Najam 1998). The purpose of this research is to illuminate an area of health provision that is under-recognised and it is in that spirit, the decision to avoid contested terminologies and instead use a readily understood division between developed nations and developing.

Many academics have argued that social service provision is integral to the development of functioning governments, in that the social compact of service provision in return for elected status and community buy-in is essential to build trust in government. Be that as it may, in practical terms, the reality is that not-for-profit providers play an important role in service provision (Jütting 1999, p. 4) particularly in circumstances where governments cannot or will not provide basic services. Bloom et al note that "since the 1980s, economic and structural crises have exposed the weak institutional capacity of the public sector in many countries", the result being "the rapid growth of non-state provision to fill gaps in supply." (Bloom, Standing & Lloyd 2008, p. 2079)

Stepping back from the specificities, the rationale for broadening understanding of not-for-profit, non-government hospitals and large clinics is clear. If, as is advocated by organisations including the WHO and the World Bank, we are to achieve Universal Health Care (UHC) given the scale of the challenge there is no option but to include these facilities as tools in the armoury.

Framework

Given the paucity of research data and the complexity of working in developing countries, as well as all the barriers identified above, this research references the conceptual frameworks outlined in *Health Policy and Systems Research: A methodology reader* by Gilson et al to provide the core framework, as well as work by Walt, Shiffman et al (Walt et al. 2008) to guide its overall design. These are not a perfect alignment to the research; but given they are focussed on health policy in low and middle income countries they provide the most solid framework for the genuinely exploratory work being undertaken. As Gilson et al outline, health policy and systems research seeks to show what health systems are and how they operate (Gilson 2012, p. 31). One of the priorities identified in 2009 by the Alliance for Health Policy and Systems Research was the coverage of healthcare services provided by the non-state sector for the poor (Gilson 2012, p. 44). This research sets out to do that and the final work will be part of a broader PhD.

A study which most closely approximates the intent of this work is the efforts of Wright et al to map the levels of palliative care on a global basis. Their journey has been similar in that there was little collated, verified data to work from. Their work involved classification into categories as well as more specific data gathering in low-resource contexts.(Wright et al. 2006; Wright et al. 2008).

As recommended by Gilson (2012) the research by Bloom et al (Bloom, Standing & Lloyd 2008) on health system frameworks has influenced this research, specifically in affirming the underlying assumptions regarding the overall complexity of healthcare in developing nations and the porous "boundaries between public and private healthcare sectors and lack of state regulatory capacity" (Bloom, Standing & Lloyd 2008, p. 2076).

Methodology

Over a 12-month-period, an array of peer-reviewed and grey literature was consulted from sources as varied as *Social Science and Medicine* and *The Lancet*, to *IRIN* (Integrated Regional Information Networks). Desktop research of this nature was combined with informal meetings with key stakeholders, including academics, practitioners and providers. More than 60 individuals were consulted and initial discussions were held with service providers about the potential for further access. Those individuals consulted were primarily (although not exclusively) based in Australia. They included: representatives from peak bodies including the Australian Council for International Development (ACFID); government representatives from AusAID (now the Department of Foreign Affairs and Trade (DFAT)); academics; practitioners from Mae Tao Clinic, Bairo Pite Clinic, the Hamlin Fistula Foundation, Mercy Ships, Médecins Sans Frontières; journalists from ReliefWeb; mining company foundations such as the Oil Search Foundation; and religious organisations.

During this time, the rationale for this research was presented to 55 practitioners and aid policy representatives at the 2014 Australasian Aid and International Development Policy Workshop, allowing further engagement with policymakers to determine the usefulness of this research for their work. Grey literature experts were consulted about ways to validate work including reports published by non-government organisations.

In addition, an exploratory survey was undertaken. This survey, which utilised Survey Monkey, was distributed online using social media networks and websites. A total of 416 respondents had

completed the four-question survey as at May 10, 2014. A deliberate choice was made not to provide definitions within the survey questions, even though that left the question open to broader interpretation by the person completing the survey. Given this research is genuinely exploratory, this decision was made to guard against bias and to mitigate the possibility that other types of health facilities that may not have been considered at this point could be excluded on the basis of question wording. The word 'large' was omitted and just clinics included, as the size of an operation is not always clear to a lay person and is value-laden. It was kept very short and simple to encourage responses from a wide variety of people in the community. The fourth question was simply asking for a contact email address for those people who wish to be kept informed of the research progress.

Findings

Peer-review and grey literature

One of the barriers to the understanding of this area of the health sector in developing countries is the dearth of research specifically looking at not-for-profit, non-government hospitals and large clinics. This absence of solid research is a common issue with health in developing countries; as Evans, Shim and Ioannidis' work regarding the health burden and global research recently found, "the global burden of health disease accounts for *none* of the distribution of total health research or controlled trials" (Evans JA 2014, p. 3). Similarly, Pang et al have been vocal about the need for more health systems research as "health research is too often a fragmented, competitive, highly specialized, sectoral activity where researchers within scientific disciplines often work in isolation from other disciplines" (Pang et al. 2003, p. 815). Even research in the broader area of health policy and systems has been described by Gilson as the 'Cinderella' area of health research (Gilson 2012, p. 13) – that is, it is ignored even though it deserves attention. As noted by Groen et al, in a 2012 article for *The Lancet,* there is more a general lack of data.

> We identified no countrywide surveys of the prevalence of surgical conditions or surgical causes of death in low-income countries. Most existing data from low-income countries documenting the burden of surgical conditions are based on hospital assessments or extrapolations from high-income countries. In countries where medical records are often incomplete or absent, these data probably underestimate the true prevalence of surgical disease and surgically related deaths. Extrapolations based on high-income country data might lead to overestimations of need. (Groen et al. 2012)

A series of papers based on research conducted for the World Bank by Olivier and Wodon in 2012, note the absence of research:

> One would ideally like to have a comprehensive assessment of the scope and scale of all health-related services provided not only by government facilities and faith-inspired providers, but also by private for-profit providers and other non-religious, not-for-profits (NGOs), community-based organizations and initiatives - including diversion into engagement in particular responses such as HIV/AIDs. (Olivier, Shojo & Wodon 2012, p. 2)

Further complicating this area of research is the sheer number of academic disciplines which overlap without any discipline being the custodian of a specific body of literature on this specific area of the

health sector. Development studies, health administration, public policy, organisational theory, governance, global health, biomedical research, health financing, and religious studies all encompass some aspects which are useful for conceptualising and investigating this area. These health facilities also suffer from the fact they are largely disorganised; while some of the religious groups have organised themselves within countries or on a limited regional basis, there is no over-arching body advocating for them at a national, regional or international level.

While an argument can be made for each and every one of the health-related neglected areas of research in developing countries, the reason not-for-profit, non-government hospitals and large clinics are particularly important is because of the sheer number of people that seem to be reached by their services annually and especially because we have no reliable data to quantify this. There is no official data for this sub-sector of health service provision. Individual clinics, including Mae Tao and Bairo Pite, report treating up to 150,000 patients per year. There are a few smaller scale surveys looking at individual countries, but these do not use the same parameters so they cannot be validly combined. Even the then World Bank President James Wolfensohn was forced to rely on anecdotal evidence, using the common wisdom that the church does half the work in healthcare and education in Africa in the absence of substantiated research data(Olivier & Wodon 2012).

Beyond a further understanding of the scale of the population they serve, there is also a broader health systems imperative for this research. “Problems of coordination, duplication, and lack of integration between state and non-state services underline the need for an effective working arrangement as a basis for a more comprehensive and integrated system of health provisioning at the national and district levels.” (Robinson & White 1997, p. 30)

One of the other barriers to understanding the impact of the sector is the absence of any list of not-for-profit, non-government hospitals and large clinics. With a list, perhaps data could be extracted for individual health facilities and some indicative data could be compiled. However with the absence of organising structures and representative bodies, comes the issue of the quality, comprehensiveness and reliability of data collection. Without achieving standard reporting guidelines and training across facilities, there is no way of knowing how close to reality the statistics are. Many institutions have reasons for either inflating or deflating the patient numbers. For those appealing for outside funding, inflating the figures may help them achieve greater funding to manage their patient load; for those operating in areas of conflict, there may be strategic or safety implications which the organisation is seeking to avoid. As has been widely documented, volunteers, aid workers and health facilities have all become targets in periods of conflict. As recently as May 2014, reports from a not-for-profit, faith-based hospital, Mother of Mercy Catholic Hospital, in Nuba, Sudan suggested it had been deliberately targeted in bombing attacks by its own government (‘Bishop appeals to Bashir to stop bombing Nuba hospital’ 2014). For obvious reasons, the facility may not wish to alert the government to patient numbers under those circumstances.

The sheer number of actors involved in health development is also an impediment for scoping this area of health provision. While the faith-based organisations have some level of cooperation, many of the other facilities work independently, with little if any collaboration with other similar organisations. Given the complexity of development as a whole, and that the complexity is growing over time, rather than declining this makes mapping this are a complex task. As Ottersen et al wrote: “New modes of economic, political, educational, and development cooperation between developing

countries are also emerging, challenging traditional dynamics of development aid." (Ottersen et al. 2014, p. 635)

Geographically, the not-for-profit, non-government hospitals and large clinics are spread across developing nations, with the exception of a significant portion of the Pacific. Whether that is because of the comparatively small sizes of populations in that region, the proximity to Australia for emergency healthcare, or other factors is unknown. Not-for-profit, non-government hospitals and large clinics are particularly prevalent in Africa and Asia. In Africa these are largely as faith-based organisations and in Asia, more predominantly as independent organisations. Working on the hypothesis that these hospitals and clinics arise out of an evident and pressing need, these would seem to make sense. Again however, there is no definitive research to support or refute these claims.

In the past, there have been some limited attempts to develop a typological framework, which have been too context specific, or too simplistic. Magezi had a four-level typology of church involvement in healthcare in Africa which included 'refusal – not here!' (Magezi 2012). Green and Matthias looked at NGOs more broadly and proposed six different types of NGOs: grassroots; development; welfare; advocacy; support and financing (Green & Matthias 1995, p. 318). In a brief report, as part of their working paper series, the Nossal Institute provided a typology of non-state providers of healthcare which consisted of: for-profit informal; for-profit formal; not-for-profit informal; not-for-profit formal (Ahmed, Bloom & Sweeney 2011, p. 7). Robinson and White offer a broad summary of the main types of non-state health providers (Robinson & White 1997, p. 8). However the most comprehensive typology dates back to 1987, when Green documented seven main types of non-state organizations being: religious organizations; international (social welfare) NGOs; locally based (social welfare) NGOs; union and trade and professional organizations; other not-for-profit (but pre-paid) healthcare; and private sector (Green 1987, p. 42). While this is a useful base, the changes in the sector in the intervening 27 years means some of the categorisation now is unrepresentative of the operational reality in situ.

Informal discussions

Informal discussions were an important part of the groundwork for this research. They have proven to be a cost-effective and time-efficient way of driving the research forward. Given the paucity of data in peer-reviewed literature and the difficulty in identifying and accessing relevant unpublished or otherwise 'hidden' material held by individuals and organisations, meeting practitioners and academics has been an important strategy. Conferences have proven to be a particularly productive means of reaching people who may hold source material or can offer connection to those who do. The conferences attended have broadened contact with NGOs, civil society practitioners, health specialists, governance specialists, and development experts from a range of organisations. The intent is that the final research will be useful to academics and practitioners alike; identifying not only the knowledge they hold, but also the gaps they perceive exist and their information needs has been useful for building the research design for the research still to be undertaken. Building awareness of this research will assist with snowball sampling expansion further into the study. At this stage, formal interviews in these settings have not been feasible. Each of the individuals concerned has significant demands on their time; informal discussions have allowed access to difficult-to-reach individuals and established first contact so as to make future structured and semi-

structured phone and email interviews viable. This strategy has also proven to be a valuable source of information; confident in the confidentiality of the discussions, much useful information has been disclosed that possibly would not have been if the setting had been a formal interview. Some of the individuals have indicated a reticence to disclose information in a ‘cold’ interview scenario, where there has been limited prior contact. It has also allowed for the triangulation of source material. Because of the range of disciplines engaged in this area of research, different specialist groupings attended each of the conferences. With sources unknown to each other, it has been possible to test the information gathered and gain confidence in the reliability of each source. Some actors have freely offered additional contacts that may be of assistance in the future, allowing the building of a rich array of sources for future research.

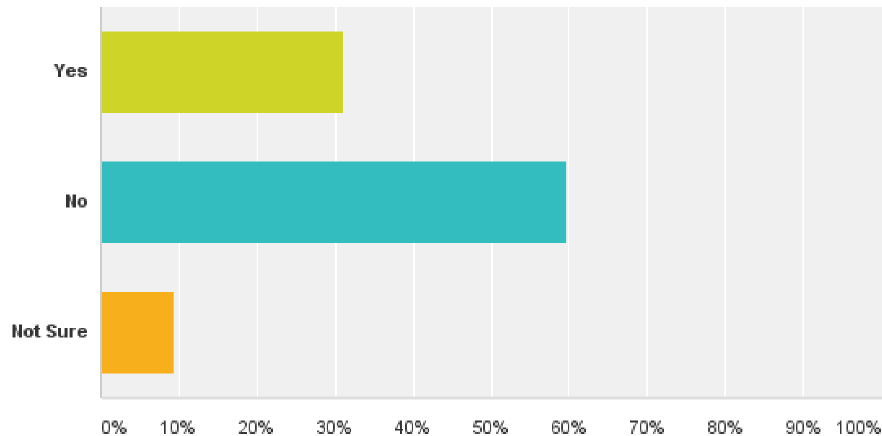
Given the exploratory nature of the work, journalistic techniques were used to probe further into whether the actors could see value in the work, what information they felt was missing and whether they felt further research would make a contribution to the literature. All bar one academic were supportive of the work and gave suggestions for further reading; and without exception the practitioners’ stated they felt that further research was needed and that these facilities held some importance in the broader health and development framework.

Similarly, presentations at these conferences have proven rich sources of information which could not be accessed by other means. Negative data is rarely published; yet in conference arenas with PowerPoint presentations, sources have shared some of the trial-and-error of their work and the realities of working in low-resource contexts where developed nation strategies are not always successful.

Key sources included attendees at: the 2nd International Emergency Care Symposium "Global access to emergency care: priorities and strategies" held in Melbourne, Australia; the Mining for Development Conference 2013, held in Sydney, Australia; the Future of International Development in Asia and the Pacific conference held in Melbourne, Australia; and the 2014 Australasian Aid and International Development Workshop. In all these interactions with contacts developed at large scale specialist events, no-one contradicted the view that there was very little academic literature available.

Survey

The survey design was very simple and was designed with two goals in mind: to test the theory that there was little awareness of these facilities and to provide data that could be followed up on individual not-for-profit, non-government hospitals and large clinics. Of the 416 people who completed the survey, almost 60% had never heard of this type of hospital or clinic and almost 10% did not know whether they had.



A total of 138 respondents answered the second question asking them to name a facility if they could recall one. This was around 2% higher than the number of people who answered 'yes' to the question regarding awareness of any not-for-profit, non-government hospitals and large clinics; in other words, more people had answered the question regarding specific names and locations of hospitals and clinics than had said they were aware of one of these facilities However analysis of the individual responses to question 2 showed some of those had simply said 'no, sorry' or similar. Interestingly, some respondents had identified clinics that were adjunct to orphanages or other development projects.

Of the 98 respondents to question3, regarding the provision of contact details for facilities listed in question 2, most provided website details or offered to be contacted direct should there be a problem with tracking information on the organisation. At the final question, 119 people left their email contact details so they could be kept informed about the research.

Typology

Based on all three elements of the methodology, a basic typology was assembled. Using the previous typologies detailed above as a basis and incorporating the feedback provided through informal discussions and the survey responses, the typology seeks to capture the key differentiating factors identified. It is supplied in table format below. The six key types identified are Mining companies; Faith-based; Humanitarian; Specialist; Personality-based; and Delivery innovators. Eight categories that identify areas of difference and areas of similarity are specified: ownership; location; staffing (local or international); origins; duration of service; mode of supply; volunteers (Y/N); funding. Examples of facilities for each type are cited in the final row of the table.

	Mining	Faith-based	Humanitarian	Specialist	Personality	Delivery Innovators
Ownership	Mining companies	Religious organisations	A handful of key organisations - MSF / ICRC	Internationally-based	Mix of local and international	International
Location	Centred on mining locations only	Worldwide; but most prevalent in Africa	Conflict / emergency zones	Worldwide	More predominant in post-conflict areas	Mobile
Staffing (Local or Internat?)	Mixed	Mixed	Mixed	Mixed	Mixed	Mixed
Origins	CSR Push	Missionaries	Originated in 1863	Volunteering of specialists led to more coordinated efforts	Individually-led	Vary
Duration of service	Life of mine site	Indefinite	Usually limited term	Indefinite yet sporadic in many cases	Permanent - most have exited for decades	Indefinite yet sporadic
Mode of supply	Fixed location	Fixed locations	Fixed locations	Mixed - fixed and travelling	Fixed	Mobile
Volunteers	No	Yes	Yes	Yes	Yes	Yes
Funding	Corporate	Religious community	Public and Govt	Public and Govt	Public and Govt	Public, corporate and Govt
Examples	PNG - Lihir Medical Centre(funded by Newcrest)	Mother of Mercy Catholic Hospital	ICRC & MSF	Hamlin Fistula Hospital, Fred Hollows, Operation Smile, Operation Rainbow	Mae Tao Clinic, Bairo Pite, Friends Without A Border	Mercy Ships, Partners in Health, Lifebuoy Friendship Hospitals

NB: This instrument will be refined as further data is gathered.

Discussion

As an exploratory area of research, there are many counterfactuals and unknowns that need to be explored. The primary purpose of the work to date was to verify that there was a genuine absence in the literature which needed to be addressed; and that the work would be useful and relevant to academics and practitioners alike. Both of those questions were resolved in the affirmative through the literature review, the informal interviews and the survey. This academic gap cannot be justified on the grounds of not-for-profit, non-government hospitals and clinics being too small, or too insignificant. On the contrary, the initial evidence suggests these organisations fill a significant and otherwise unmet need. However like many other informal sectors, there are barriers to mapping this area of global health. This is compounded by the general weaknesses in governance and service provision in many developing countries, the disparity in each organisation's structures and services, the geographic spread of these organisations and the complexity of health provision in low-resource contexts.

It was surprising that all three methodologies employed for this paper came up with a similar result. While it was expected that this research would attract some support from practitioners, it was by no means assumed that there would be such an overwhelming level of support across the different stakeholders. Testing this work with different audiences has provided some reassurance that the research is relevant. This work forms the basis of a broader PhD study. But even once the PhD is produced, the author makes no claims about the generalisability of the work. The intention is that this will provide a baseline from which other researchers will be able to test and refine in different contexts.

The typology is designed as a global tool, however in future work (including three case studies) the focus will be on Asia and the Pacific because of the array of organisations and the vast development challenges and inequities within communities across Asia. The three focus countries / regions for further work are: Timor-Leste; Thai-Burma border area; and Cambodia. All have emerged from periods of conflict and have acute health needs which have been well-established in the academic literature.

Conclusion

Providing healthcare in developing countries remains a very significant challenge. Despite all of the advances made in global health, including the eradication and near-eradication of diseases including smallpox and polio, making healthcare accessible, affordable, and appropriate to the context is a barrier which has yet to be achieved. With the World Health Organization and the World Bank advocating for the concept of Universal Health Care as the health goal to succeed the Millennium Development Goals, every potential source of medical care must be optimised and used wisely. Charting these 'invisible'; healthcare providers, the not-for-profit, non-government hospitals and large clinics who are often classified as being part of the informal sector - even though the boundaries between their operation and the public health sector are highly porous - will provide a greater understanding of the opportunities they present to all stakeholders involved in the supply of healthcare. This paper has articulated what we do not know from the academic literature and demonstrated the need and support for further research. The health imperative is clear: to give

people access to emergency healthcare we need to expand our understanding of the resources available, look to improve their scalability and examine whether they can be replicated in other locations. But before any of that can be achieved we first need to develop our understanding through rigorous research of the not-for-profit, non-government hospitals and large clinics in developing countries. These hospitals and clinics should be studied further, as they are important potential contributor to the principle of universal healthcare for all.

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