Analysis

Amplify Impact: Patient Organisation Sustainability & Health Equity

09

Comparative analysis of government support for health charities and nonprofit organisations against community-first best-practice frameworks

1. Introduction

The seven-country audit identified substantial differences in how governments support health charities, community organisations and nonprofit service providers. Australia, New Zealand, the United States, Canada, the United Kingdom, Singapore and India all provide some combination of grants, contracts, tax concessions, donor incentives, procurement opportunities and regulatory infrastructure. However, the existence of support does not establish that the funding system is community-led, equitable, accessible or organisationally sustainable.

The best-practice literature indicates that community-first funding should be assessed against several linked principles:

- communities should influence priorities before funding programs are designed;
- community members should participate in governance and resource allocation, not merely consultation;
- lived experience and community knowledge should be recognised as evidence;
- nonprofit organisations should be treated as community infrastructure;
- continuing needs should receive predictable, multi-year support;
- grants and contracts should cover the full cost of delivery;
- organisations should retain enough flexibility to respond to changing needs;
- operational capability should be funded directly;
- application and reporting requirements should be proportionate;
- accountability should flow to communities as well as upward to funders;
- funding distribution should be based on equity and unmet need rather than formal equality alone; and
- outcomes should include community influence, organisational resilience and reductions in inequity, not only service volumes.

These principles are supported by research on citizen participation, co-production, community-based participatory research, nonprofit accountability and financial resilience. Arnstein's (1969) distinction between consultation and shared power remains particularly relevant: a government may consult extensively while retaining control over the definition of need, acceptable services, eligible organisations and allocation of funds. Meaningful engagement requires some transfer of authority.

Similarly, community-based participatory research treats affected communities as contributors to problem definition, evidence generation and action, rather than merely as research subjects or consultation participants (Wallerstein & Duran, 2010). Systematic reviews indicate that well-designed community engagement can improve participation, service relevance, health behaviour, empowerment and health outcomes, especially for disadvantaged populations (Cyril et al., 2015; Haldane et al., 2019; O'Mara-Eves et al., 2015). These benefits are not automatic. They depend on institutional support, relationships, resources and actual community influence over decisions (George et al., 2015).

Against this standard, none of the seven countries represents a complete community-first funding system. The strongest countries combine more of the necessary elements, but all retain important structural gaps. Across the group, governments are generally better at funding defined services, regulating charities and incentivising donations than they are at transferring priority-setting power to communities, funding the full organisational cost of community representation, or ensuring that small and rare-condition organisations can participate on equal terms.

2. Overall comparative position

The provisional audit scores were:

Country	Score
United Kingdom	18/21
Singapore	18/21
New Zealand	17/21
Canada	16/21
United States	14/21
Australia	13/21
India	11/21

These scores assess the documented government-support environment across transparency, accessibility, funding quality, timeliness, equity, proportional accountability and operational enablement. They should not be interpreted as a direct measure of the quality of every government–nonprofit relationship within each country.

The ranking shows that the strongest systems are not necessarily those with the largest total funding pools. Rather, higher-scoring countries tend to combine funding with institutional structures that make nonprofit participation more visible, stable or operationally supported.

The United Kingdom performs strongly because voluntary, community and social enterprise organisations are recognised as health-system partners, particularly within NHS structures and local commissioning. Singapore reaches the same total through a different model: central coordination, substantial organisational-capability funding, digital systems, shared-service support and targeted integration of nonprofit providers into community care.

New Zealand scores strongly because of relational commissioning, Māori and Pacific models, streamlined social-service contracting and recognition of community and whānau-centred approaches. Canada combines relatively strong transparency, Indigenous and community funding, risk-based transfer-payment policy and published service standards. The United States offers a very large federal grant environment and formal indirect-cost protections, but administrative burden and fragmentation weaken accessibility. Australia has strong regulatory and grant transparency but weaker evidence of core funding, payment reliability and operational support. India has broad targeted funding and strong equity intent, but the cumulative burden of separate legal, tax, grant, foreign-funding and state-level systems substantially reduces practical accessibility.

3. Community priority-setting and decision-making power

3.1 Best-practice standard

A community-first system begins with communities identifying and interpreting need before funding priorities are settled. It then gives affected communities continuing influence over program design, allocation and evaluation.

This is more demanding than consultation. Arnstein (1969) argued that informing and consultation may amount to tokenism where institutions retain decision-making control. Bovaird's (2007) work on co-production similarly rejects a model in which professionals or government agencies independently design services for passive recipients. Co-production recognises that users and communities contribute knowledge, relationships, informal support and implementation capacity.

The country audits provide stronger evidence of community participation in service systems than of community control over funding priorities. In most jurisdictions, governments establish funding programs and invite organisations to apply. Communities may influence policy consultations or individual service design, but there is limited evidence that they systematically control:

- the initial definition of unmet need;
- the proportion of resources directed to different communities;
- grant eligibility requirements;
- application assessment;
- renewal decisions; or
- national health-charity funding priorities.

3.2 United Kingdom

The United Kingdom shows comparatively strong alignment through formal recognition of the voluntary, community and social enterprise sector within health-policy and NHS partnership structures. NHS England's policy on working in partnership with people and communities establishes an expectation that communities should influence service planning and delivery, while the VCSE Health and Wellbeing Alliance provides a continuing relationship between government, NHS institutions and civil society organisations (Department of Health and Social Care, n.d.; NHS England, n.d.-a).

This represents greater alignment with co-production than a purely competitive grant system. It acknowledges that voluntary and community organisations contribute knowledge and reach that statutory services may not possess. Integrated care systems and local commissioning also create opportunities for place-based priorities to influence resource decisions.

However, the evidence is stronger for partnership and consultation than for delegated resource control. Community organisations may inform strategy, participate in alliances and deliver commissioned programs, but statutory bodies generally retain authority over budgets, provider selection and performance requirements. Consequently, the system sits closer to partnership than community control in Arnstein's (1969) terms.

Smaller organisations may also experience the partnership framework differently from large national charities. Larger organisations are more likely to have policy staff, commissioning expertise, quality systems and the capacity to attend sustained governance meetings. A formally open partnership structure can therefore reproduce unequal influence if participation depends on organisational resources.

3.3 New Zealand

New Zealand demonstrates some of the strongest substantive alignment with community-defined priorities, particularly through Māori and whānau-centred models. Whānau Ora is based on collective family or whānau aspirations rather than narrowly defined service outputs and uses commissioning arrangements intended to support locally responsive solutions (Te Puni Kōkiri, n.d.). Māori and Pacific commissioning structures provide a stronger basis for culturally grounded priority-setting than mainstream consultation models.

This alignment is important because equity requires more than inviting Māori communities to participate in institutions whose priorities and evidence rules are already fixed. Community-led commissioning can shift authority over service design and implementation closer to affected populations.

Nevertheless, New Zealand's alignment is not universal across all health charities. Organisations outside established commissioning pathways may still depend on conventional contracts and grants. Small disease-specific organisations, rare-condition groups and national patient organisations may not benefit from the same degree of devolved or culturally specific commissioning. The strongest community-first arrangements are therefore concentrated in particular policy domains rather than embedded across all nonprofit health funding.

3.4 Canada

Canada has substantial structures for consultation, Indigenous partnership and community-based funding. Federal health departments fund community organisations, and Indigenous Services Canada operates targeted programs designed around First Nations, Inuit and Métis health and wellbeing (Indigenous Services Canada, n.d.). Public Health Agency of Canada funding programs also frequently include community-based prevention, mental health and health-promotion activities (Public Health Agency of Canada, n.d.-a).

The strongest potential for community-defined priorities lies in Indigenous-led and distinctions-based funding. Where Indigenous governments and organisations possess authority over program design and implementation, this may move beyond consultation toward shared or delegated control.

However, Canadian federalism fragments authority across federal, provincial, territorial and local systems. Communities may be consulted by multiple institutions without having a single route for influencing the overall distribution of resources. Patient organisations addressing rare or cross-jurisdictional conditions may

struggle because need is nationally distributed but service authority is provincial.

3.5 Singapore

Singapore's framework is highly coordinated and operationally strong, but it is more state-directed than community-directed. Government bodies define many service, capability and fundraising priorities, then support eligible organisations to deliver them. The National Council of Social Service and Agency for Integrated Care provide structured development and partnership pathways, while the Charities Capability Fund strengthens governance, digital systems, training and collaboration (Agency for Integrated Care, n.d.-a; Commissioner of Charities, n.d.-a; National Council of Social Service, n.d.-a).

This model can produce responsive and effective services, particularly where government has strong population data and established relationships with providers. However, central coordination should not be equated with community control. The audit identified limited evidence that affected communities directly allocate funds or independently determine national nonprofit priorities.

Singapore therefore aligns strongly with organisational enablement but less clearly with participatory grantmaking or delegated community authority. Smaller organisations may be disadvantaged if they do not fit recognised service, social service agency, community-care or Institution of a Public Character categories.

3.6 Australia

Australia has extensive consultation structures across health policy, Primary Health Networks and government grant programs, but the audit identified limited evidence of a systematic community-first allocation model. GrantConnect makes opportunities visible, and Primary Health Networks conduct regional needs assessments and commission local services (Australian Government, n.d.; Australian Government Department of Health, Disability and Ageing, n.d.).

However, regional needs assessment does not necessarily mean that communities control priority-setting. PHNs remain accountable within government-defined objectives and contract structures. National patient organisations and rare-condition groups may also fall between local commissioning and national program structures because their communities are geographically dispersed.

Australia therefore has mechanisms for listening to communities but weaker evidence that communities routinely participate in setting grant categories, reviewing applications or controlling funds. This reflects a broader gap between consultation and power identified by Arnstein (1969).

3.7 United States

The United States has a vast grant ecosystem and substantial community-based health funding through agencies such as the Health Resources and Services Administration, the Centers for Medicare & Medicaid Services and federal disease programs. Community health centres and other nonprofit providers may have strong local governance and community representation requirements (Health Resources and Services Administration, n.d.-a).

This can create meaningful community influence at the provider level. However, the federal grant system remains highly programmatic. Federal agencies define notices of funding opportunity, eligibility rules, performance measures and allowable costs. Community influence over national funding architecture is therefore limited.

The system's complexity also privileges organisations capable of interpreting federal rules and managing grants. Formal equality exists because eligible organisations can apply through common portals, but practical equity is weaker because technical capacity is highly unequal.

3.8 India

India's National Health Mission and targeted social-sector programs explicitly use NGOs to reach underserved and remote communities. This aligns with the principle that local organisations possess knowledge and relationships needed for last-mile delivery (National Health Systems Resource Centre, n.d.).

However, the system generally engages NGOs as implementers of government-defined schemes rather than as equal partners in allocating resources. District and state involvement may bring decisions closer to communities, but it can also add administrative stages without transferring authority to community members.

India therefore demonstrates strong recognition of local delivery capacity but less consistent recognition of local decision-making power. Grassroots organisations may have the closest relationships with marginalised communities yet the weakest capacity to satisfy experience, audit, registration and digital requirements.

4. Recognition of community knowledge as evidence

Best practice requires lived experience, qualitative evidence and community-generated data to be treated as legitimate sources of knowledge alongside epidemiological and administrative data. Wallerstein and Duran (2010) argue that community-based participatory research improves relevance by integrating community experience with formal research. Brunton et al. (2017) similarly show that engagement processes and contextual relationships influence whether community participation produces useful outcomes.

Across the audited countries, community knowledge is acknowledged most visibly in:

- UK people-and-community partnership policies;
- New Zealand whānau-centred and Indigenous commissioning;
- Canadian community and Indigenous programs;
- Australian PHN needs assessments;
- US community health-centre governance;
- Indian NGO outreach in underserved areas; and
- Singaporean community-care partnerships.

However, the audits provide much less evidence that community-generated evidence has equal standing in national funding decisions. Governments generally privilege:

- disease prevalence;
- service utilisation;
- clinical evidence;
- economic modelling;
- administrative datasets;
- formal organisational track records; and
- measurable output commitments.

This can disadvantage small and rare-condition communities. Rare conditions may have low population prevalence but severe individual, family and system burdens. Administrative data may underestimate need because diagnosis is delayed, coding is inconsistent, services are fragmented and people are dispersed across jurisdictions. If funding formulas prioritise total numbers reached, common conditions and large service systems will usually outperform rare-condition proposals.

Equality-based assessment may ask every organisation to demonstrate the same volume of need. Equity-based assessment would instead consider:

- severity;
- absence of alternative services;
- geographic dispersion;
- diagnostic delay;
- specialist scarcity;
- carer burden;
- information gaps;
- the cost of serving a small population;
- the consequences of having no dedicated organisation; and
- the extent to which mainstream systems fail to respond.

None of the country audits identified a comprehensive mechanism ensuring that rare-condition burden and community evidence are consistently weighted in general nonprofit funding decisions.

5. Funding quality: project funding, core funding and full costs

5.1 Best-practice standard

A community-first system must fund both community priorities and the organisational infrastructure required to respond. Necessary costs include leadership, finance, human resources, digital systems, governance, evaluation, safeguarding, volunteer coordination and community engagement.

Research on the nonprofit starvation cycle shows how unrealistic expectations of low overhead can lead organisations to understate costs, underinvest in infrastructure and become less effective over time (Lecy & Searing, 2012). Administrative-cost ratios are poor proxies for effectiveness and may create incentives to avoid necessary investments (Burkart et al., 2018).

Financial resilience also depends on the flexibility and diversity of revenue, not merely its total value. Restricted funding may leave an organisation with significant nominal income but insufficient resources to pay for leadership, technology, service adaptation or reserves (Green et al., 2021).

5.2 Singapore

Singapore demonstrates the strongest alignment with direct organisational-capability funding. The Charities Capability Fund explicitly supports training, consultancy, shared services, information technology and collaboration, while NCSS schemes support organisational development, workforce and digital transformation (Commissioner of Charities, n.d.-a; National Council of Social Service, n.d.-a, n.d.-b).

This is highly consistent with the proposition that operational capacity is part of impact rather than an illegitimate overhead. Shared-services funding is particularly valuable for smaller organisations because it can reduce the need for each charity to maintain independent finance, legal, digital and human-resource functions.

However, capability grants are not the same as unrestricted core funding. They are generally tied to approved organisational-development activities. An organisation may be able to obtain a new system or consultancy but still lack flexible funding for senior leadership, advocacy, rent, reserves or unexpected demand.

The framework may also favour established organisations that satisfy government-recognised categories and can manage formal improvement projects. Very small patient groups may need basic survival funding rather than transformation funding.

5.3 United Kingdom

The United Kingdom shows moderate alignment through core-grant examples, local commissioning and recognition of voluntary-sector infrastructure. Northern Ireland's health core-grant programs are explicit examples of support that is not limited to individual service transactions (Department of Health, Northern Ireland, 2026). Scottish Government fair-funding commitments also recognise the importance of longer-term and sustainable arrangements (Scottish Government, 2025).

However, practice varies among the four nations and across local commissioners. Many voluntary organisations still depend on restricted contracts, short-term grants and local budget decisions. Full-cost recovery is not uniformly guaranteed.

Large charities may manage this variation through diversified income and professional contracting teams. Smaller organisations often have less capacity to absorb underfunded overheads or delayed decisions. A grant that covers 90% of a project may be formally generous but structurally inaccessible to an organisation without unrestricted funds to supply the balance.

5.4 New Zealand

New Zealand's outcome-agreement and social-sector commissioning reforms show greater recognition of relational funding and streamlined contracts than traditional transactional procurement (New Zealand Government Procurement, 2016a, 2016b). Whānau Ora also provides a stronger basis for flexible, family-centred responses than narrow output purchasing.

Nevertheless, multi-year and full-cost funding are not universal. Smaller organisations may still encounter short contract cycles, workforce insecurity and government purchasing that does not fully cover organisational costs.

The strongest New Zealand approaches are conceptually aligned with best practice, but the audit does not establish that all health charities can access comparable funding quality.

5.5 Canada

Canada's transfer-payment policy and directive incorporate risk-based administration and formal service standards, which create a stronger basis for predictable grants than systems lacking government-wide guidance (Treasury Board of Canada Secretariat, n.d.-a, n.d.-b).

Health Canada and the Public Health Agency of Canada publish service standards for funding processes, and Indigenous funding can include longer-term relationships (Health Canada, n.d.; Public Health Agency of Canada, n.d.-b). However, funding remains fragmented across federal, provincial and territorial systems, and indirect-cost treatment varies.

Canada's larger national organisations may be able to combine federal and provincial funding. Smaller and rare-condition groups may face a mismatch: their population is too dispersed for a single province to regard them as a priority, but they may lack the national scale expected for federal investment.

5.6 United States

The United States aligns strongly with full-cost principles through the federal Uniform Guidance, including formal indirect-cost mechanisms for eligible recipients (Office of Management and Budget, 2024). This is an important comparative strength because it recognises that federal awards carry legitimate shared organisational costs.

However, the administrative burden required to obtain and manage federal funding is substantial. The benefit of formal indirect-cost recovery is therefore more accessible to organisations with sophisticated accounting, audit and grants-management systems.

Small community organisations may have a legally available right to indirect costs but still be unable to compete for an award. The framework therefore aligns with funding quality after entry but is misaligned with accessibility before entry.

5.7 Australia

Australia's principal misalignment is the limited availability of unrestricted, multi-year and full-cost organisational funding. Commonwealth grants are transparent and governed by formal rules, but many health charities rely on short-term project grants, commissioning arrangements, philanthropy and volunteer labour (Australian Government Department of Finance, 2024, 2025).

The audit did not identify a national health-charity capability fund, a universal indirect-cost standard or a broad core-funding mechanism. This means organisations may be funded to deliver activities while remaining responsible for financing governance, systems, fundraising and community engagement.

This model is particularly difficult for rare-condition organisations. Their small donor base, dispersed membership and limited access to corporate sponsorship make it harder to cross-subsidise underfunded government projects.

5.8 India

India's funding is predominantly scheme-specific and restricted to defined beneficiaries, staff, services and approved expenditure. Although the number of available programs is large, the audit identified weak evidence of unrestricted funding, standard overhead recovery, indexation or stable multi-year arrangements.

This creates a significant risk of organisational fragility. Grassroots organisations may be expected to maintain registrations, audited accounts, staff, premises, digital reporting and local relationships without consistent funding for these functions.

CSR funding expands the pool of resources but is usually project-based and shaped by company priorities. It may support visible activities while leaving local organisations responsible for the institutional costs of delivery.

6. Timeliness, reliability and the hidden equity effect of cash flow

Funding timeliness is often treated as an administrative issue, but it is an equity issue.

A delayed payment affects organisations differently. A large charity may use reserves, credit facilities or other grants to continue paying staff. A small organisation may have to:

- delay wages;
- reduce service hours;
- use personal funds;
- suspend activities;
- lose experienced staff;
- decline the grant; or
- close.

Therefore, equal payment terms do not create equal effects. Organisations with fewer reserves experience greater harm from the same delay.

Canada has the strongest documented service standards among the audited countries, while the United States has formal federal payment rules and established grant administration (Health Canada, n.d.; Public Health Agency of Canada, n.d.-b; U.S. Department of the Treasury, n.d.). Singapore's centralised systems and stable agencies support institutional reliability, but the audit found limited published payment-performance data.

The United Kingdom, New Zealand, Australia and India all showed gaps in consolidated evidence on:

- decision times;
- agreement execution;
- claim-to-payment performance;
- renewal notice;
- late-payment consequences; and
- funding gaps between grant periods.

India's multi-stage district, state and Union approvals create particularly significant potential cash-flow risk. Australia's annual and competitive grant cycles also create uncertainty, while the UK's local funding environment can vary substantially by commissioner.

Rare-condition and small patient organisations are especially vulnerable because they usually lack unrestricted reserves. A payment-delay standard should therefore not merely require equal treatment. Equity-sensitive funding should provide:

- advance payments;
- higher upfront instalments;
- rapid payment for small organisations;
- automatic continuation while renewal is pending;
- late-payment interest;
- transition funding;
- and risk-based rather than universal reimbursement models.

7. Administrative burden and proportional accountability

7.1 Best-practice standard

Accountability should be proportionate to grant value, service risk, organisational size and previous performance. Ebrahim (2003) distinguishes among reports, evaluations, participation, self-regulation and social audits, emphasising that accountability mechanisms serve different purposes. Adding more mechanisms does not necessarily create better accountability.

Ebrahim's (2005) concept of accountability myopia is especially relevant. Organisations may become so focused on short-term upward reporting that they lose capacity for learning, mission and long-term change.

7.2 Stronger alignment

Singapore and the United Kingdom show the strongest formal proportionality. Singapore uses tiered governance expectations, differentiated audit requirements and exemptions for very small non-IPC charities (Charity Council, n.d.; Commissioner of Charities, n.d.-b). The UK also differentiates charity reporting and procurement routes and has formal grant standards and model agreements (Charity Commission for England and Wales, n.d.; UK Cabinet Office, n.d.-a).

Canada's risk-based transfer-payment policy similarly supports proportional administration in principle (Treasury Board of Canada Secretariat, n.d.-a).

7.3 Mixed alignment

Australia's ACNC reporting categories scale some obligations by charity size, which is an important equity mechanism (Australian Charities and Not-for-profits Commission, n.d.-a). However, proportional charity regulation does not necessarily translate into proportionate grant applications and contract reporting.

New Zealand has simplified contracting tools for social services, but administrative experience still varies across agencies and programs. The United States has common federal rules, yet the cumulative complexity of federal grants remains a major barrier for small organisations.

7.4 Strongest misalignment

India shows the clearest cumulative burden. An organisation may need separate legal registration, tax approval, Darpan identification, grant-portal registration, CSR registration, FCRA permission, state or district review, utilisation certificates and program reporting. Each requirement may have a legitimate purpose, but their combined effect is not proportionate for smaller organisations.

Formal equality is evident because all applicants may be asked for the same documents. Equity is weak because the time and expertise needed to produce them represent a much larger share of a small organisation's resources.

Across all countries, administrative burden can also disadvantage rare conditions. A funding body may require extensive prevalence estimates, service-volume forecasts and economic modelling. Large disease organisations can commission this work; small patient groups may rely on volunteers and incomplete data. The apparently neutral evidence requirement therefore favours conditions with established research and administrative datasets.

8. Operational enablement

Operational enablement concerns whether governments help organisations function effectively, not only whether they fund outputs.

Singapore is the strongest example. Its capability funds, shared services, digital-transformation support, training and organisational-development programs directly address nonprofit operations (Commissioner of Charities, n.d.-a; National Council of Social Service, n.d.-a).

The United Kingdom also performs strongly through charity infrastructure, NHS partnership arrangements, grant standards and procurement reforms. New Zealand's social-sector contracting infrastructure and relational commissioning provide meaningful support.

Canada, Australia and the United States have strong regulatory and grant portals but less comprehensive government-funded organisational-development architecture. They generally make funding opportunities and rules visible but leave organisations to build the capacity required to compete.

India has extensive digital grant and regulatory systems, but these systems are primarily designed to administer compliance rather than develop the sector as a whole.

This distinction is important. A digital portal may reduce paper processing without reducing substantive burden. Operational enablement requires:

- shared services;
- technical assistance;
- application support;
- governance development;
- digital grants;
- workforce investment;
- accessible data;
- standard agreements;
- and practical support for collaboration.

Small organisations benefit disproportionately from these mechanisms because they cannot achieve the same economies of scale as large charities.

9. Equity, equality and the position of small organisations

9.1 Equality versus equity

Equality provides the same opportunity, rules or funding amount to all eligible organisations. Equity adjusts support according to need, disadvantage, capacity and structural barriers.

An equality-based funding system may:

- publish one open call;
- apply one application form;
- use the same assessment criteria;
- require the same reporting;
- and offer the same payment schedule.

An equity-based system asks whether organisations can realistically participate on those terms. It may provide:

- simpler applications;
- technical assistance;

- community-language support;
- oral applications;
- advance payments;
- lower co-contributions;
- reserved funding;
- longer timelines;
- full-cost support;
- and additional capability funding.

Across all seven countries, equity is more visible in the populations targeted by funding than in the methods through which organisations obtain funding. Governments frequently prioritise disadvantaged populations but still require the organisations serving those populations to compete through complex systems.

This can produce an equity paradox: programs are designed to help marginalised communities, yet the organisations closest to those communities may be least able to access the funds.

9.2 Structural disadvantages experienced by small organisations

Small organisations are commonly disadvantaged by:

- limited staff time;
- volunteer governance;
- low reserves;
- lack of audited historical data;
- limited evaluation capacity;
- no specialist grant writers;
- weak access to policymakers;
- inability to pre-finance services;
- fewer opportunities to diversify revenue;
- and higher per-beneficiary operating costs.

Large organisations can spread compliance and infrastructure costs across multiple programs. A small rare-condition organisation may need the same essential functions—insurance, audit, data protection, governance and digital systems—but must fund them across a very small revenue base.

Competitive funding that rewards organisational scale may therefore create cumulative concentration. Organisations with previous grants acquire staff, data and delivery records that improve future applications. Organisations without initial funding remain unable to build those assets.

The United States and India show this problem most clearly through technical complexity. Australia and Canada also risk favouring established national charities and major service providers. Singapore's capability funding partially offsets the disadvantage, but eligibility categories may still exclude small informal or emerging groups. The UK and New Zealand provide stronger partnership pathways, though smaller organisations can still be overshadowed in local commissioning and alliance structures.

10. Rare conditions and small patient populations

Rare-condition organisations face a distinctive set of disadvantages not fully addressed by conventional equity frameworks.

10.1 Low prevalence can conceal high need

Funding systems often use:

- population size;
- number of beneficiaries;
- cost per person;
- service volume;
- and broad public-health impact.

These measures favour common conditions. Rare conditions may affect fewer people but involve:

- severe disability;
- delayed diagnosis;
- multiple specialists;
- high family burden;
- limited evidence;
- no standard care pathway;
- geographic dispersion;
- and very few alternative information or support services.

Equality-based value-for-money analysis may classify a rare-condition program as expensive per participant. Equity-based analysis would consider the absence of substitutes and the consequences of providing no support.

10.2 Geographic fragmentation

Rare-condition communities are often national or international rather than local. This creates problems in federal and devolved systems.

In Australia, PHN or state-based funding may not recognise a nationally dispersed population as a local commissioning priority. In Canada, provincial responsibility may leave national organisations without a clear funding home. In the United States, state and federal programs may divide responsibility. In the UK, four-nation differences can fragment services and eligibility.

Singapore's unitary structure avoids this particular jurisdictional barrier, but small populations may still receive less attention where programs are organised around larger service sectors. India's state variation creates substantial difficulty for conditions requiring nationally consistent specialist pathways.

10.3 Evidence disadvantage

Rare conditions frequently have:

- incomplete prevalence data;
- small research samples;
- limited health-economic evidence;
- inconsistent coding;
- and no large service datasets.

A conventional evidence hierarchy can therefore disadvantage rare communities. Community testimony, patient registries and qualitative evidence should receive greater weight where conventional data cannot reasonably be produced.

Wallerstein and Duran's (2010) community-partnership approach is especially relevant because it treats community knowledge as a legitimate form of evidence. Rare-condition organisations often possess the most complete practical knowledge available, even where formal evidence remains limited.

10.4 Corporate and philanthropic disadvantage

Common conditions may attract larger public campaigns, commercial partnerships and donor bases. Rare-condition organisations have fewer potential donors and less public visibility. Expecting them to match government grants or demonstrate substantial private fundraising therefore compounds inequity.

Matching-fund programs, such as those used in Singapore, can be valuable but should be modified for small or rare-condition groups. A uniform one-to-one match rewards organisations that already have fundraising capacity. An equitable model might provide:

- higher government matching ratios for small organisations;
- lower minimum fundraising thresholds;
- non-financial recognition of volunteer contributions;
- or full funding where no realistic donor market exists.

11. Accountability to communities

All audited countries have substantial upward accountability to regulators and funders. There is weaker evidence of systematic downward accountability to affected communities.

Community-first accountability should require funders and funded organisations to report:

- how communities influenced priorities;
- which recommendations were accepted;
- which were rejected and why;
- how funding was distributed by need and geography;
- whether smaller organisations were successful;
- whether lived-experience participants were paid;
- and whether funded programs strengthened community control.

The UK and New Zealand provide the strongest foundations for this through partnership and co-production structures. Indigenous and community programs in Canada may also create stronger

downward accountability where communities possess governance authority.

Singapore has strong public governance and transparency but a more state-directed priority structure. Australia and the United States provide extensive award and regulatory transparency but less evidence that funders must show how community input changed decisions. India has strong beneficiary reporting, but beneficiary counts are not equivalent to community accountability.

This distinction reflects Ebrahim's (2003, 2005) argument that financial reporting and performance measurement are only part of accountability. Participation, learning and mission accountability are also necessary.

12. Country-by-country alignment summary

Country	Strongest alignment	Principal misalignment	Main equity concern
Australia	Transparency, charity regulation, regional needs assessment	Limited core funding, weak full-cost policy, limited community authority	Small and nationally dispersed patient groups fall between funding levels
New Zealand	Whānau-centred commissioning, Māori and Pacific approaches, relational contracting	Strong approaches are not universal across all health charities	Organisations outside established commissioning streams may be excluded
United States	Large funding ecosystem, community health infrastructure, indirect-cost rules	Severe application and compliance burden, fragmented programs	Technical requirements favour large and experienced organisations
Canada	Community and Indigenous funding, transfer-payment standards, public transparency	Federal–provincial fragmentation, inconsistent overhead recovery	Rare-condition groups lack a natural jurisdictional funding home
United Kingdom	Formal health–VCSE partnership, community engagement policy, some core funding	Local variability, statutory control over budgets remains	Small groups may be overshadowed by large charities and established providers
Singapore	Capability funding, shared services, digital support, central coordination	Limited community allocation authority, selective eligibility	Emerging and independent advocacy organisations may sit outside recognised categories
India	Extensive targeted programs and underserved-population focus	Heavy cumulative compliance, weak core funding and payment evidence	Grassroots groups may be least able to access programs designed for their communities

13. Recommendations applying across all countries

13.1 Establish community-led priority-setting before funding design

Governments should create standing community priority-setting structures rather than relying on episodic consultation. These bodies should include patients, carers, community-controlled organisations, small nonprofits, rural communities and rare-condition groups.

Their role should include:

- identifying unmet need;
- determining priority populations;
- reviewing funding gaps;
- recommending allocation proportions;
- and approving outcome frameworks.

13.2 Reserve part of funding for participatory allocation

A defined proportion of health-charity funding should be allocated through community-led or joint decision panels. Community participants should receive remuneration, training and accessible information.

Participatory allocation would move engagement from consultation toward partnership and delegated power, consistent with Arnstein's (1969) higher levels of participation.

13.3 Create dedicated core-funding streams

Governments should fund organisations that provide continuing community infrastructure, including:

- patient navigation;
- peer support;

- community education;
- lived-experience evidence;
- advocacy;
- information;
- and service coordination.

Core funding should not be restricted to organisations that deliver clinical or commissioned services.

13.4 Require full-cost funding

Every grant and contract should include:

- direct delivery costs;
- indirect organisational costs;
- community-engagement costs;
- data and evaluation;
- governance and safeguarding;
- staff supervision;
- and a reasonable contribution to reserves.

This would reduce the starvation cycle described by Lecy and Searing (2012) and avoid treating operational weakness as evidence of efficiency.

13.5 Make multi-year funding the default for continuing need

Three- to five-year agreements should be standard where community needs and provider roles are continuing. Agreements should include:

- inflation and wage indexation;
- renewal notice periods;
- transition arrangements;
- and protection against service gaps.

13.6 Introduce a small-organisation and rare-condition adjustment

Funding formulas should explicitly account for:

- small population size;
- high severity;
- absence of substitute services;
- geographic dispersion;
- limited donor markets;
- higher per-person operating costs;
- and weak administrative datasets.

This adjustment could include minimum institutional grants, higher government contribution rates and exemption from matching requirements.

13.7 Use tiered applications and reporting

Requirements should be scaled according to:

- award value;
- organisational size;
- prior performance;
- service risk;
- and funding duration.

Small grants should not require the same application architecture as large service contracts.

13.8 Provide advance payment and working-capital protection

Small organisations should receive higher upfront payments. Reimbursement-only models should be avoided where they require nonprofits to finance government services from reserves.

Governments should publish and report against:

- decision-time standards;
- agreement-execution standards;
- payment-time standards;
- and renewal-notice standards.

13.9 Fund organisational capability

Every jurisdiction should provide a dedicated capability program covering:

- leadership;
- governance;
- finance;
- digital systems;
- cybersecurity;
- evaluation;

- volunteer management;
- workforce development;
- collaboration;
- and shared services.

Singapore provides the strongest model for this recommendation.

13.10 Recognise community-generated evidence

Funding criteria should explicitly accept:

- qualitative research;
- lived-experience evidence;
- patient registries;
- community surveys;
- service-navigation data;
- peer-led research;
- and evidence of unmet need.

This is particularly important for rare conditions and populations poorly captured in administrative data.

13.11 Protect advocacy independence

Government funding agreements should state that organisations may continue good-faith advocacy, policy criticism and community representation. Service funding should not silence organisations or create mission drift.

13.12 Publish equity and accessibility data

Funders should publish:

- applications and approvals by organisation size;
- approvals by geography and community-controlled status;
- funding to rare-condition groups;
- average applicant hours;
- decision and payment times;
- proportion of multi-year funding;
- proportion covering full costs;
- and proportion allocated through community decision-making.

14. Recommended country-specific priorities

Australia

Australia should prioritise a national health-charity capability and core-funding program, a standard indirect-cost policy, multi-year funding and a specific pathway for nationally dispersed rare-condition organisations. PHN community needs assessments should be connected to transparent community allocation mechanisms rather than consultation alone.

New Zealand

New Zealand should extend the strengths of whānau-centred and relational commissioning to a broader range of patient and condition-specific organisations. Funding-quality and community-authority standards should apply outside Māori and Pacific commissioning streams as well.

United States

The United States should preserve formal indirect-cost protections while radically simplifying access for small community organisations. Federal agencies should expand intermediary, consortium and microgrant models so technical capacity is not a prerequisite for serving high-need communities.

Canada

Canada should establish a clearer national pathway for conditions and communities whose needs cross provincial boundaries. Federal and provincial funders should harmonise applications, indirect-cost treatment, reporting and renewal standards.

United Kingdom

The United Kingdom should reduce local variation in full-cost recovery and core funding, protect small organisations within integrated care partnerships and publish commissioning outcomes by organisation size. Community partnership policies should be tied to demonstrable influence over resource allocation.

Singapore

Singapore should build on its strong capability system by expanding community-led priority-setting, participatory grantmaking and flexible core support for independent patient and advocacy organisations. Eligibility should not depend primarily on incorporation into recognised service-delivery systems.

India

India should reduce cumulative registration and reporting, harmonise nonprofit due diligence, introduce standard overhead allowances, provide advance payment and protect grassroots organisations from multi-stage administrative exclusion. Equity-targeted programs should include capacity funding for the organisations expected to deliver them.

15. Conclusion

The audits show that government support for health charities is generally more developed than government recognition of community power.

All seven countries fund nonprofit activities, provide regulatory structures and use community organisations to extend the reach of health and social systems. The strongest jurisdictions also invest in organisational capability, relational commissioning, Indigenous or community-led models, or formal partnership structures.

However, common misalignments remain:

- communities are more often consulted than given allocation authority;
- funding frequently prioritises projects over organisations;
- full-cost recovery is inconsistent;
- multi-year support is not the norm;
- administrative burden disproportionately affects small groups;
- payment risk is shifted onto organisations with the least financial capacity;
- community-generated evidence remains secondary to conventional data;
- and rare-condition organisations are disadvantaged by scale-based assessment.

The central equity finding is that formally equal funding systems can produce unequal outcomes. The same application, evidence threshold, payment schedule or matching requirement has very different effects depending on organisational size, reserves, data availability, donor base and population prevalence.

A genuinely community-first framework must therefore do more than make opportunities universally available. It must redistribute decision-making power, differentiate support according to need, fund the institutional conditions required for participation and explicitly protect communities that are too small, dispersed or under-recognised to succeed through conventional competition.

The appropriate policy objective is not equal competition among unequally resourced organisations. It is equitable investment in the community infrastructure required to meet needs that markets, mainstream services and conventional funding formulas would otherwise leave unmet.

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