Amplify Impact: Patient Organisation Sustainability & Health Equity

PROJECT ASSESSMENT

Introduction

Amplify Impact: Patient Organisation Sustainability & Health Equity

01

Introduction

The policy problem

Health charities, patient associations, community-controlled organisations and other nonprofit providers occupy a distinctive position within contemporary health systems. They often bridge the gap between formal clinical services and the practical, social and informational needs experienced by patients, families and communities. Their contribution may include peer support, navigation, health education, prevention, advocacy, outreach, research participation and the development of trusted relationships with populations poorly served by conventional institutions. Yet the public value of these activities is not always captured by standard measures of service throughput, clinical activity or short-term expenditure. A funding system can therefore be transparent and administratively orderly while still failing to sustain the community organisations on which equitable access depends.

This distinction provides the rationale for evaluating government support not simply in terms of the availability of grants, but in terms of the design, accessibility, flexibility and distributive effects of the funding environment.
Community participation as a substantive funding principle.

The theoretical foundations of community-first funding extend beyond consultation. Arnstein (1969) distinguishes symbolic participation from forms of citizen influence that redistribute decision-making power. Applied to grantmaking, this means that asking communities to comment on an already designed funding program is not equivalent to involving them in defining priorities, assessing applications or determining what constitutes success. Bovaird (2007) similarly conceptualises co-production as an arrangement in which public service users and communities contribute actively to the design and delivery of services. Together, these perspectives imply that a program should be evaluated by the authority communities exercise over decisions, rather than by the number of consultation events undertaken. A government agency may demonstrate extensive engagement activity without demonstrating that community preferences have changed its funding allocations.

The empirical case for meaningful engagement

Community engagement is not solely a normative commitment; it has an empirical public-health rationale. In a meta-analysis of interventions involving disadvantaged groups, O'Mara-Eves et al. (2015) reported positive pooled effects for health behaviours, health consequences, self-efficacy and social support, although the evidence did not identify one universally superior engagement model. This qualification matters: engagement is not an automatic intervention, and its value depends on design, relationships, context and implementation. Community-based participatory research also emphasises reciprocal knowledge production, with community members contributing to the formulation of questions, interpretation of evidence and development of responses (Wallerstein & Duran, 2010). A funding framework informed by this literature should examine whether lived experience is accepted as evidence, whether participation is resourced and whether community feedback can meaningfully alter decisions.

Nonprofits as health-system infrastructure

Nonprofit organisations are frequently funded as deliverers of discrete activities rather than recognised as institutions requiring continuing investment. However, service quality depends on organisational capabilities that are not always visible in project budgets: governance, workforce supervision, digital infrastructure, data protection, finance, evaluation, community representation and reserves. Lecy and Searing (2015) describe a nonprofit starvation cycle in which pressure to minimise overhead can encourage underinvestment in the infrastructure necessary for effective delivery. Their analysis is particularly relevant to government contracts that specify extensive performance obligations but provide limited support for management and indirect costs. The apparent efficiency of low overhead can be misleading when costs are shifted to unpaid volunteers, philanthropic donors or the future financial stability of the provider.

Funding quality and economic efficiency

From a health economics perspective, the relevant unit of analysis should include the total resources required to generate an outcome, not only the amount transferred by a funder. Application preparation, duplicate reporting, cash-flow financing, grant renewal and compliance all consume real resources, even when those costs are excluded from the public budget. Short funding cycles can create repeated transaction costs, inhibit workforce retention and discourage investment in evaluation or service improvement. Conversely, flexible multi-year arrangements may reduce administrative duplication and allow organisations to adapt to changing needs, although such benefits should be tested rather than presumed. The economic assessment should therefore distinguish direct program costs, indirect organisational costs, funder administration, applicant burden and the opportunity costs borne by patients and communities.

Accountability without administrative overload

Public funding requires accountability, but accountability is multidimensional. Ebrahim (2003) identifies reporting, evaluation, participation, self-regulation and social audits as different mechanisms and highlights the tendency for upward accountability to funders to overshadow accountability to communities. Ebrahim (2005) further warns that a narrow emphasis on short-term rule compliance can displace organisational learning and long-term mission. This literature supports a proportionate approach in which reporting is calibrated to funding value and risk, and in which communities have opportunities to judge whether programs meet their priorities. A larger volume of reporting should not automatically be interpreted as a higher standard of accountability. A stronger test is whether information improves decisions, protects public resources and supports meaningful learning.

Equality, equity and access to public funding

A central analytical distinction is between formal equality and substantive equity. A grant scheme may offer every eligible organisation the same form, deadline, matching requirement and reporting schedule. Nevertheless, these common rules impose different burdens on a large national charity, a volunteer-run patient group and a small community-controlled provider. Established organisations can spread administrative costs across programs and maintain professional grant-writing and evaluation teams. Emerging organisations may have strong community trust but little financial history, limited unrestricted reserves and incomplete datasets. Consequently, apparently neutral assessment criteria may favour organisational maturity rather than community need. Community engagement evidence indicates that context and participation matter in addressing disadvantage (O'Mara-Eves et al., 2015; Wallerstein & Duran, 2010). An equitable funding system should therefore test whether applicants can realistically participate, rather than treating published eligibility as sufficient proof of access.

Rare conditions and populations with small numbers

The equity question is especially acute for rare diseases, uncommon conditions and geographically dispersed patient communities. Conventional value-for-money indicators often reward the number of beneficiaries reached or the cost per participant. These measures can undervalue organisations serving small populations where the severity of need is high, specialist services are scarce, families bear substantial navigation burdens or there is no alternative source of reliable information and peer support. Such groups may also lack the epidemiological data, fundraising base and local concentration required by standard grant criteria. An equity-sensitive framework should consider the absence of substitutes, consequences of unmet need, cross-jurisdictional coordination and the fixed costs of maintaining a credible national organisation. This is not an argument for exempting rare-condition programs from evaluation, but for choosing measures that reflect their actual social and economic contribution.

Why international comparison is useful

International comparison can reveal institutional design choices that may be difficult to recognise within a single national system. The seven-country project examines Australia, New Zealand, the United States, Canada, the United Kingdom, Singapore and India across transparency, accessibility, funding quality,

timeliness and reliability, equity, proportional accountability and operational enablement. The jurisdictions differ in government structure, health financing, civil-society regulation and the relationship between public agencies and nonprofit providers. Such variation permits structured comparison of mechanisms—including grant portals, commissioning, indirect-cost rules, core funding, capability programs and differentiated reporting—without assuming that a policy can be transferred unchanged between contexts. The audit scores are provisional documentary assessments of system design, not causal estimates of program effectiveness or independently validated international rankings.

The proposed assessment framework

The project uses a seven-dimension country audit, scored from zero to three per dimension, for a maximum of 21 points. This is supplemented by a more detailed program-level self-assessment intended for government agencies, program administrators and independent funders. The two tools serve different purposes: the national audit maps the enabling environment, while the program assessment examines concrete practices within a particular funding mechanism. Both place community leadership, organisational sustainability and equity alongside conventional transparency and accountability criteria. Importantly, scores should be accompanied by narrative explanation and a documented evidence register. The numerical total is a summary of judgement, not a substitute for understanding why specific groups benefit or are excluded.

Health economics contribution and research direction

The longer-term research agenda is to determine whether alternative funding designs improve value for money when a broader societal and distributional perspective is adopted. Relevant outcomes include administrative time, staff turnover, payment delays, service continuity, community participation, access among underserved populations and organisational resilience. Evaluation could compare application and compliance costs across funding models, examine whether advance payments reduce financial stress, and test whether multi-year full-cost grants improve continuity relative to short-term restricted awards. Distributional analysis would examine whether reforms benefit small organisations and rare-condition communities rather than merely increasing aggregate grant efficiency. This work should distinguish observed associations from causal effects and seek to validate the proposed assessment scales before treating score bands as external standards.

Study rationale and significance

The underlying proposition is that health funding arrangements shape both what nonprofit organisations do and which communities can obtain representation. Funding decisions may reinforce existing capacity by rewarding established providers, or they may strengthen overlooked community infrastructure by adjusting for unequal starting conditions. A comprehensive assessment must therefore consider not only whether a funding opportunity exists, but whether communities influence its purpose, whether providers receive the full resources needed to deliver it and whether accountability supports learning as well as compliance. By combining international policy comparison, organisational analysis, community participation theory and health economic evaluation, this project seeks to develop a practical evidence base for funding systems that are efficient, sustainable and responsive to the needs of communities with the least institutional power.

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Methods

Amplify Impact: Patient Organisation Sustainability & Health Equity

02

Objective & methodology

The objective of this project is to systematically identify, verify and code publicly available evidence describing government support mechanisms for health charities and non-government organisations (NGOs) across Australia and five comparator countries.

The audit will identify both the existence of support instruments and the characteristics of those instruments using a standard taxonomy and scoring framework.

Countries

The audit will include:

- Australia
- United Kingdom
- New Zealand
- Canada
- United States
- Singapore

Together these represent a range of government support models while remaining highly feasible to audit using publicly available evidence.

Unit of analysis

The unit of analysis is an individual government support instrument.

Examples include:

- grant programs
- tax concessions
- procurement policies
- registration reforms
- infrastructure support
- data-sharing arrangements
- volunteer support
- government-backed finance
- capacity-building initiatives

Each instrument is coded individually before being aggregated to country level.

Evidence hierarchy

Evidence will be prioritised according to source authority.

Tier 1 (Primary evidence)

- Government legislation
- Government regulations
- Official government policy documents
- Government programme guidelines
- Government budget papers
- Treasury documents
- Government agency operational manuals
- Official grant programme documentation
- Tax authority guidance
- Official procurement rules
- Official charity regulator guidance

Tier 2 (Secondary official evidence)

- Auditor-General reports
- Parliamentary committee reports
- Government evaluations
- Independent statutory reviews
- National audit office reports
- Government performance reports

Tier 3 (Supporting evidence)

- OECD
- WHO
- World Bank
- Academic literature
- Published evaluations
- Major independent think tanks
- Peak charity organisations

These sources may explain or corroborate instruments but cannot replace primary government evidence where that evidence is available.

Search strategy

Searches will be conducted separately for each country using standardised search strings.
Searches will be undertaken across:

- Government websites
- Legislation databases
- Treasury
- Finance ministries
- Health ministries
- Charity regulators
- Tax authorities
- Procurement agencies
- Cabinet policy documents
- National audit offices
- Parliamentary publications

Example search terms

Each country will use combinations of terms such as:

- health charities government funding
- NGO grants
- community grants
- charity regulation
- nonprofit funding
- government contracts nonprofit
- procurement charities
- gift aid
- tax deduction charities
- charity tax concessions
- volunteer support
- capacity building nonprofit
- government partnership NGOs
- grant programme health NGOs
- charity infrastructure support
- commissioning voluntary sector
- social prescribing voluntary organisations
- emergency NGO funding
- health service commissioning charities

Country names will be substituted consistently, for example:

- Australia health NGO grants
- Canada charity tax incentives
- Singapore nonprofit capacity building

Inclusion criteria

Include instruments that:

- are government initiated or government funded
- apply nationally or are major subnational programmes
- are currently active or were active during the audit reference period
- support health charities directly or indirectly
- have publicly verifiable documentation
- materially affect NGO operations, sustainability or service delivery

Exclusion criteria

Exclude instruments that are:

- private philanthropy
- corporate donations
- purely clinical health programmes
- programmes for individuals rather than organisations
- one-off local initiatives lacking national relevance
- non-government accreditation systems
- unsupported commentary or opinion pieces
- media reports without official confirmation

Coding framework

Each identified instrument will be coded using the project taxonomy.

A. Direct financial support

- Core funding
- Project grants
- Commissioning
- Service contracts
- Block funding
- Subnational funding
- Emergency funding
- Innovation funding
- Infrastructure grants
- Capital funding
- Operational subsidies

B. Indirect financial support

- Income tax concessions
- GST/VAT concessions
- Payroll tax concessions
- Stamp duty concessions
- Property tax concessions
- Deductible gift incentives
- Matched funding
- Government-backed loans
- Loan guarantees
- Fee waivers
- Reduced regulatory charges
- Import concessions
- Customs exemptions

C. Operational support

- Registration facilitation
- Regulatory simplification
- One-stop government portals
- Capacity-building programmes
- Training
- Digital capability support
- Infrastructure access
- Shared facilities
- Government referral pathways
- Health system integration
- Data-sharing mechanisms
- Volunteer support
- Cross-sector coordination
- Procurement access measures
- Innovation programmes
- Emergency preparedness partnerships
- National advisory structures
- Consultation mechanisms

Scoring framework

Each country will be assessed across seven dimensions.

Scores range from 0–3.

Score	Interpretation
0	No meaningful evidence of the support characteristic
1	Limited or fragmented evidence; available only for some organisations or programmes
2	Well-established support with moderate coverage or some implementation limitations
3	Comprehensive, systematic and well-documented support embedded across government

Dimension 1: Transparency

Assessment considers:

- public availability
- clarity
- discoverability
- eligibility information
- published guidance
- reporting

Dimension 2: Accessibility / administrative burden

Assessment considers:

- application complexity
- reporting burden
- duplication
- proportionality
- digital accessibility

Dimension 3: Funding quality

Assessment considers:

- availability of unrestricted funding
- duration
- funding diversity
- sustainability
- infrastructure support

Dimension 4: Timeliness and reliability

Assessment considers:

- predictable funding
- payment speed
- renewal processes
- continuity

Dimension 5: Equity and inclusion

Assessment considers:

- support for rural organisations
- Indigenous organisations
- culturally diverse communities
- disability inclusion
- small organisations
- underserved populations

Dimension 6: Proportional accountability

Assessment considers:

- reporting proportionality
- risk-based oversight
- duplication
- governance expectations
- administrative efficiency

Dimension 7: Operational enablement

Assessment considers:

- procurement access
- commissioning opportunities
- health system integration
- referral pathways
- infrastructure
- data sharing
- government coordination
- capacity building

Evidence recording

Every coded instrument will include:

- country
- instrument name
- taxonomy category
- responsible government agency
- legislative or policy basis (if applicable)
- implementation level (national or subnational)
- date accessed
- URL
- evidence excerpt
- coding rationale

Each country score will include a concise narrative (approximately 100–200 words) explaining the assigned score, supported by pinpoint citations to the underlying evidence.

Quality assurance

To maximise consistency and reproducibility:

- A standardised coding manual will be developed before full data extraction.
- Pilot coding will be undertaken across all six countries to refine definitions and calibrate scoring.
- Ambiguous instruments will be discussed and documented to ensure consistent treatment.
- All scores will be traceable to coded instruments and supporting evidence.
- An audit trail will record coding decisions, assumptions, and any judgement calls.
- The final comparative dashboard will only include evidence that can be independently verified from publicly available sources, with uncertainties and evidence gaps explicitly documented.

This protocol provides a transparent, repeatable framework that supports robust international comparison while remaining feasible to implement across the selected countries.

Australia

Amplify Impact: Patient Organisation Sustainability & Health Equity

03

Australia country audit

Audit parameters

Field	Australia audit specification
Jurisdiction	Australia
Primary unit	Commonwealth government support framework
Subnational treatment	Targeted scan of material state and territory instruments
Organisations in scope	Registered health charities, health-related not-for-profit organisations, community-controlled organisations, advocacy bodies and NGOs delivering health or related community services
Evidence standard	Publicly accessible and independently verifiable sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's lived experience
Instrument status	Predominantly current instruments, with selected earlier emergency instruments used to demonstrate the existence of an emergency-support mechanism

Overall finding

Australia has a substantial but fragmented government support framework for health charities and NGOs. Its strongest features are:

- a central Commonwealth grants framework;
- public grant-opportunity and award reporting;
- a national charity regulator and searchable register;
- significant tax concessions and donor incentives;
- substantial government purchasing and commissioning of services;
- specific support for Aboriginal community-controlled health organisations; and
- several program-based mechanisms for health-sector coordination, capacity building and referral integration.

Government support is economically significant. The Productivity Commission reported that Australian, state, territory and local governments provided approximately $97 billion in direct funding to charities through grants and contracts in 2021, equivalent on average to about half of charity-sector revenue. This figure covers the whole charity sector rather than health charities alone but demonstrates the importance of government funding to the operating environment.

The framework is less strong in relation to:

- routinely available unrestricted or organisational core funding;
- consistency across portfolios and jurisdictions;
- public evidence about payment timeliness;
- explicit recognition of the full indirect costs of service delivery;
- simplified access for very small organisations;
- nationally harmonised fundraising and subnational regulatory requirements; and
- evidence that proportionality principles are consistently implemented in individual funding programs.

Instrument matrix

A. Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-01	Health Peak and Advisory Bodies Program	Commonwealth	Competitive funding for selected national peak health and advisory bodies. It is the clearest health-specific example of funding that can support representation, policy participation, information and sector leadership rather than only discrete frontline projects. The current program is described as capped and competitive.	Strong primary evidence.
DF-02	Health portfolio project grants	Commonwealth	The Department of Health, Disability and Ageing administers grants under the Commonwealth grants framework. Programs cover health promotion, disability, aged care, mental health, preventive health, research, consumer support and community services.	Strong framework evidence, but individual program conditions vary.
DF-03	Information, Linkages and Capacity Building Program	Commonwealth	Time-limited competitive grants to eligible organisations for disability inclusion, information, community participation and organisational or community capacity-building activities.	Strong evidence; principally project-based and one-off rather than recurrent core support.
DF-04	Indigenous Australians' Health Program	Commonwealth	Funds First Nations-led and culturally appropriate health initiatives, with an explicit priority for Aboriginal Community Controlled Health Services to lead program and service delivery.	Strong evidence of targeted and equity-oriented funding.
DF-05	Primary Health Network funding and commissioning	Commonwealth and regional	The Commonwealth funds 31 Primary Health Networks as regional coordinating and commissioning organisations. PHNs assess local needs and commission primary health services, creating contract and grant opportunities for NGOs and community providers.	Strong evidence of a large-scale commissioning pathway.
DF-06	Commissioned mental health, alcohol and other drug, suicide	Commonwealth-funded/regional	PHNs and other commissioning bodies contract community organisations to deliver regionally targeted services, including severe	Strong evidence that commissioning exists; access and contract conditions differ by region.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
	prevention and chronic disease services		mental illness, suicide prevention and integrated care.	
DF-07	Commonwealth Home Support and aged-care community programs	Commonwealth	Community and charitable organisations receive grants and agreements to provide home support, aged-care, disability and community services. Published departmental contract lists show both smaller community grants and multi-million-dollar agreements.	Strong evidence, although not all recipients are charities.
DF-08	Health and medical research grants	Commonwealth	Medical Research Future Fund and related programs support medical research institutes, universities, foundations and eligible not-for-profit entities. Some initiatives involve long-term mission funding and community-driven research priorities.	Strong evidence, but research funding is not generally available to all patient or service organisations.
DF-09	State and territory health NGO grants	Subnational	States and territories operate health-specific NGO grants and service agreements. NSW, for example, has a Ministry of Health NGO Grants Program and targeted palliative-care NGO grants.	Strong evidence of material subnational support, but arrangements are not nationally uniform.
DF-10	Multi-year subnational project funding	Subnational	NSW palliative-care NGO grants have included four-year funding ranges of $320,000–$800,000, while additional grants have provided up to $240,000 over specified periods.	Demonstrates that multi-year funding exists, although it remains program-specific.
DF-11	Emergency and crisis funding	Commonwealth and subnational	During COVID-19, government funded additional capacity for helplines and community mental-health services and provided preparedness, viability and workforce payments to aged-care and community providers.	Strong evidence that emergency mechanisms can be activated, but they are episodic rather than standing entitlements.
DF-12	Volunteer workforce grants	Subnational	Targeted grants can support volunteer coordination, recruitment and training. NSW's community-based palliative-care grant supported a volunteer manager position.	Verified but narrow and program-specific.

Direct financial support assessment

Australia clearly supports health charities and NGOs through a mixture of grants, commissioning, contracts and emergency assistance. The framework is broad, but most publicly documented opportunities are restricted to specified activities, populations or outputs. The Health Peak and Advisory Bodies Program is an important exception because it supports sector-level functions, although it is capped and competitive. There is no desk-verifiable evidence of a universal or broadly available Commonwealth mechanism through which health charities can routinely obtain unrestricted organisational funding. Core or infrastructure support therefore appears selective rather than systemic.

B. Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-01	Income-tax exemption	Commonwealth	Registered charities may apply to the ATO for endorsement as income-tax exempt.	Strong evidence.
IF-02	GST concessions	Commonwealth	Eligible registered charities may access concessional GST treatment, including treatment of donations and some charitable activities.	Strong evidence.
IF-03	Fringe Benefits Tax concessions	Commonwealth	Eligible charities may qualify for an FBT rebate or, for certain public benevolent institutions and health promotion charities, relevant exemptions subject to legislative conditions and caps.	Strong evidence that the concession class exists; eligibility varies by charity subtype.
IF-04	Deductible Gift Recipient endorsement	Commonwealth	Eligible organisations can obtain DGR endorsement, enabling donors to claim tax deductions for qualifying gifts.	Strong evidence, but DGR is not automatic for all registered charities.
IF-05	Donor income-tax deductions	Commonwealth	Individuals may deduct eligible gifts and donations made to DGR-endorsed organisations, subject to ATO rules and recordkeeping.	Strong evidence.
IF-06	Integrated ACNC/ATO application pathway	Commonwealth	Applicants can request relevant tax concessions through the ACNC charity-registration application, avoiding a completely separate initial ATO application process for those concessions.	Strong evidence of procedural facilitation.
IF-07	State and territory tax concessions	Subnational	Depending on jurisdiction and eligibility, charities may access payroll tax, land tax, stamp duty, rates or other concessions. The ACNC confirms that state, territory and local concessions exist but are separately administered.	Strong evidence of availability; fragmented eligibility and processes.

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-08	Regulatory and application fee relief	Commonwealth/subnational	Some charity-related processes are free or integrated, and individual grant programs may waive requirements for registered charities. However, no comprehensive national health-NGO fee-waiver framework was identified.	Partial evidence; instrument is not systematic.
IF-09	Government-backed loans or guarantees for health NGOs	Commonwealth/subnational	No broad, standing, health-charity-specific government-backed loan or guarantee mechanism was identified through this search. Organisations may access general programs where eligible.	Evidence gap/no sector-wide instrument located.
IF-10	Import and customs concessions	Commonwealth	No general import-facilitation or customs-exemption framework specifically for domestic health charities was identified. Limited concessions may exist for particular goods or circumstances but were not established as a general support instrument.	Evidence gap.

Indirect financial support assessment

Australia has a mature and valuable charity tax-concession system. The combination of charity registration, income-tax exemption, GST and FBT concessions, DGR endorsement and donor deductibility represents a substantial indirect subsidy.

However, the framework involves multiple legal classifications. A registered charity is not necessarily a DGR, and access to particular concessions depends on organisational purpose, subtype and endorsement. The system is therefore comprehensive but not uniformly accessible to every health charity.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-01	Australian Charities and Not-for-profits Commission	Commonwealth	National charity regulator providing registration, guidance, education, compliance information and a public Charity Register.	Strong national infrastructure.
OS-02	Online charity registration and integrated tax-concession request	Commonwealth	Organisations can apply for charity registration and request ATO tax concessions through the ACNC process.	Strong evidence of registration facilitation.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-03	ACNC guidance and education	Commonwealth	The ACNC publishes factsheets, guidance, webinars, reporting resources and governance information to help charities understand their obligations.	Strong and accessible operational support.
OS-04	Public Charity Register	Commonwealth	Free searchable database covering registered charities, activities, finances, responsible persons and compliance information.	Strong transparency infrastructure.
OS-05	GrantConnect	Commonwealth	Central portal for Commonwealth grant opportunities and awards. Commonwealth entities must publish relevant individual grant information within prescribed periods.	Strong transparency and discoverability mechanism.
OS-06	Commonwealth grant templates and guidance	Commonwealth	Standardised low-risk, standard and other grant templates are available. Guidance requires agreements and monitoring to be proportionate to activity risk and complexity.	Strong framework-level proportionality support.
OS-07	Health-system commissioning infrastructure	Commonwealth/regional	PHNs identify community needs, coordinate primary care and commission services, providing NGOs with pathways into publicly funded regional health delivery.	Strong operational integration, although locally variable.
OS-08	Referral and care coordination	Commonwealth-funded/regional	Integrated Team Care links clients to general practice, specialist, allied-health and medication services and supports communication between mainstream and Aboriginal health sectors.	Strong, population-specific integration.
OS-09	Organisational and community capacity building	Commonwealth	ILC and Indigenous health initiatives fund organisational capacity, community participation, culturally appropriate care and workforce capability.	Strong but program-targeted rather than universally available.
OS-10	Sector advisory and consultation structures	Commonwealth	Peak and advisory body funding and program advisory structures enable selected NGOs and community-controlled organisations to	Material but selective.

Code	Instrument	Level	Description and relevance	Evidence assessment
			contribute to policy and program governance.	
OS-11	Procurement framework	Commonwealth	Commonwealth Procurement Rules govern government purchasing. They contain general value-for-money and procurement requirements but do not establish a broad preference for ordinary health charities as a class.	Strong general infrastructure; limited charity-specific access measure.
OS-12	Indigenous procurement and community-controlled participation	Commonwealth	Procurement and program policy provides targeted opportunities for eligible First Nations organisations, although some Indigenous procurement mechanisms are business-focused and may exclude charities from particular joint-venture arrangements.	Strong equity intent but mixed applicability to charities.
OS-13	Subnational grant portals and health NGO programs	State/territory	States maintain separate portals and health funding programs. These expand available support but require organisations to navigate multiple systems.	Material support accompanied by fragmentation.
OS-14	Shared government infrastructure or facilities	Mixed	No general national entitlement for health charities to access public buildings, clinical facilities or administrative infrastructure was identified. Access appears to arise through individual partnerships and contracts.	Limited/systematic evidence not found.
OS-15	General data-sharing framework for health NGOs	Mixed	Program-specific data and referral integration exists, particularly through PHNs and coordinated-care programs, but no single cross-system mechanism giving health charities routine access to public health data or referral platforms was identified.	Moderate and fragmented.

Evidence and instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct financial support	Broad	Multiple grant, contract and commissioning pathways; predominantly restricted and program-specific
Indirect financial support	Broad	Strong tax-concession and donor-incentive framework, but eligibility categories are complex
Registration facilitation	Strong	National regulator, online registration and extensive guidance
Capacity building	Moderate–strong	Significant targeted programs, but no universal support platform
Procurement access	Moderate	General procurement access plus targeted First Nations measures; few charity-specific preferences
Health-system integration	Moderate–strong	Strong through PHNs and particular care programs; uneven across conditions and regions
Infrastructure access	Limited	Mostly dependent on individual contracts and partnerships
Emergency support	Demonstrated	Government can activate emergency funding, but support is episodic
Government-backed finance	Limited/not identified	No broad health-charity-specific mechanism found
Import facilitation	Limited/not identified	No broad instrument found

Australia scorecard

Scoring table

Dimension	Score	Summary
1. Transparency	3 – Comprehensive	Central grant and charity information systems are established and extensively documented
2. Accessibility/admin burden	2 – Established but uneven	Centralised systems and simplified processes exist, but complexity and jurisdictional fragmentation remain
3. Funding quality	1 – Limited/fragmented	Funding is substantial but generally restricted, competitive and program-specific; broad core funding is uncommon
4. Timeliness and reliability	1 – Limited evidence	Publication deadlines exist, but there is insufficient consistent public evidence on payment timeliness and renewal reliability
5. Equity and inclusion	2 – Established but uneven	Strong targeted First Nations and underserved-population mechanisms, but access is not uniformly embedded across all instruments
6. Proportional accountability	2 – Established but uneven	Formal proportionality principles and tiered charity reporting exist; implementation across funders and jurisdictions varies
7. Operational enablement	2 – Established but uneven	Strong regulator, commissioning and selected integration mechanisms, but infrastructure, procurement and data access remain fragmented
Total	13/21	A developed but fragmented framework
Mean	1.86/3	—

1. Transparency — Score: 3/3

Australia has a highly developed formal transparency architecture. GrantConnect centralises Commonwealth grant opportunities and award information, and non-corporate Commonwealth entities must publish individual grant information no later than 21 calendar days after the grant agreement takes effect. The ACNC provides a free searchable register containing information on registered charities, their programs, finances and responsible people. The Department of Health also publishes grant information, program pages, guidelines and some departmental grant-contract listings.

The score does not imply that every program is equally easy to find. State and territory instruments remain dispersed, and contract-performance, payment and renewal information is less consistently visible than award information. Nevertheless, the core national framework is systematic, public and desk-verifiable.

Score rationale: Comprehensive national systems exist for charity registration, grant opportunities and grant-award disclosure.

2. Accessibility and administrative burden — Score: 2/3

Australia has introduced several accessibility measures. The ACNC offers online registration, extensive guidance and an integrated pathway through which applicants can request relevant ATO tax concessions. GrantConnect provides a central Commonwealth opportunity portal, and standard grant documents are available for different levels of risk and complexity.

However, organisations may still need to navigate the ACNC, ATO, Commonwealth departments, PHNs, state and territory regulators, separate grant portals and differing fundraising or incorporation requirements. DGR endorsement is not automatic for all charities. Smaller organisations must also develop the governance, financial and technical capacity required for competitive grants and service contracts. Evidence submitted to public inquiries has continued to identify cross-jurisdictional regulation and administrative burden as material concerns.

Score rationale: Entry points and guidance are well developed, but access is not sufficiently simple or harmonised for a score of 3.

3. Funding quality — Score: 1/3

The volume and range of government funding is substantial. Health organisations can receive project grants, peak-body funding, research grants, commissioned-service contracts and emergency assistance. Some programs provide multi-year support.

The principal weakness is the nature of that funding. Much of the publicly documented support is competitive, capped, activity-specific or tied to commissioned outputs. The ILC program, for example, is expressly described as time-limited and one-off, while the Health Peak and Advisory Bodies Program is capped and competitive. There is no broadly available mechanism guaranteeing that health charities can recover governance, evaluation, information technology, workforce development, advocacy and other organisational overhead costs.

Score rationale: Funding is extensive in aggregate but does not consistently exhibit the unrestricted, long-term and full-cost characteristics required for a higher funding-quality score.

4. Timeliness and reliability — Score: 1/3

The Commonwealth framework imposes a clear deadline for publishing grant awards and encourages entities to track payments and progress. Standard grant agreements can specify payment schedules and performance milestones.

However, publication timeliness is not the same as payment timeliness. The desk search did not locate a government-wide, publicly reported standard showing:

- average time from application closure to decision;
- average time from approval to contract execution;
- the percentage of NGO payments made on schedule;
- treatment of late government payments;
- minimum notice periods for non-renewal; or
- funding-continuity performance.

There are examples of multi-year agreements, but continuation and renewal remain program-dependent. The available evidence therefore supports the existence of administrative processes, not consistently timely or predictable funding from the recipient's perspective.

Score rationale: Insufficient nationally consistent evidence is available to demonstrate reliable decision, contracting, payment and renewal performance.

5. Equity and inclusion — Score: 2/3

Australia has strong targeted instruments for Aboriginal and Torres Strait Islander organisations and communities. The Indigenous Australians' Health Program prioritises Aboriginal Community Controlled Health Services and aims to increase access to First Nations-led, culturally appropriate and self-determined health care. Integrated Team Care supports culturally appropriate referral, coordination and access to specialist and allied-health services.

Other programs target disability, rural and remote communities, culturally diverse populations and specific underserved groups. PHNs are intended to commission services in response to regional need.

The limitations are that equity measures are frequently confined to designated programs, eligibility streams or priority populations. The framework does not establish that all mainstream grants provide adjustments, application support or proportionate requirements for small, rural, culturally specific or lived-experience-led organisations.

Score rationale: Equity is a significant and visible feature of several major programs, but it is not consistently demonstrated across the entire support framework.

6. Proportional accountability — Score: 2/3

The Commonwealth grants framework explicitly states that grant agreements, monitoring and reporting should be proportionate to the risk and complexity of the activity. Standard templates are available for different risk levels.

ACNC reporting is also graduated by organisational size. Small charities with annual revenue below $500,000 generally submit an Annual Information Statement without a mandatory financial report; medium charities must submit a reviewed or audited financial report; and large charities must provide an audited report.

These are significant proportionality measures. Nevertheless, charities funded by several departments or governments may face overlapping regulatory, contractual, acquittal and evaluation requirements. The available desk evidence establishes good framework principles but does not demonstrate uniform implementation by every funding body.

Score rationale: Proportionality is formally embedded and visible in regulatory thresholds, but duplication and inconsistent application prevent the highest score.

7. Operational enablement — Score: 2/3

Australia provides substantial operational infrastructure. The ACNC supports registration, education and compliance; GrantConnect supports opportunity discovery; PHNs create regional commissioning and coordination structures; and programs such as Integrated Team Care build referral pathways and cross-sector communication. Capacity-building grants and peak-body funding support selected organisations' capability and policy participation.

Operational enablement is nevertheless program-dependent. There is no general entitlement to public infrastructure, shared administrative services, health-data access or government referral systems. General Commonwealth procurement rules do not create a comprehensive access pathway specifically for health charities, although First Nations procurement and community-controlled policies create important targeted opportunities.

Score rationale: Strong enabling institutions and selected integration mechanisms exist, but they do not form a comprehensive, universally accessible NGO-support system.

Evidence gaps

The following matters could not be scored confidently from public desk evidence alone:

Evidence gap	Why it matters
Average grant decision time	Determines whether organisations can plan staffing and service continuity
Contract execution time	Delays can require charities to carry unfunded costs
Payment-on-time performance	Essential to assessing cash-flow risk
Renewal notice periods	Determines workforce and program stability
Percentage of grants permitting full indirect-cost recovery	Central measure of funding quality
Prevalence of indexation	Determines whether funding retains real value
Prevalence of unrestricted/core funding	Distinguishes organisational support from purchase of activities
Application completion time and cost	Needed for a robust administrative-burden comparison
Success rates by organisation size and community type	Needed to test equitable access
Duplication across Commonwealth and state reporting	Needed to assess actual proportionality
NGO access to health data and referral systems	Needed to distinguish isolated examples from system-wide integration
Availability of government-backed finance	No clear health-charity-specific mechanism was identified
Outcome reporting	There is no systematic access to reports on outcomes of funded projects

Policy interpretation

Australia's system is best characterised as a well-regulated, tax-supported and heavily commissioned model, rather than a comprehensive civil-society operating-support model.

The principal policy strengths are:

1. national charity regulation and disclosure;
2. central Commonwealth grant publication;
3. substantial tax concessions;
4. high aggregate levels of grants and contracts;
5. established health-service commissioning;
6. targeted First Nations community-controlled funding; and
7. formal risk-proportional grant principles.

The main policy vulnerabilities are:

1. limited broadly accessible core funding;
2. uncertain full-cost and overhead recovery;
3. fragmentation across Commonwealth, states, territories and regional commissioners;
4. limited public reporting of payment and renewal performance;
5. uneven access for small organisations;
6. program-specific rather than system-wide operational integration; and
7. no clearly identified government-backed finance or shared-infrastructure framework for health charities.

Country fiche conclusion

Australia has a mature and economically significant framework for supporting charities and NGOs. Health organisations can access direct funding, commissioned service delivery, tax concessions, donor incentives, registration assistance, capacity building and health-system partnerships. Transparency at the Commonwealth framework level is particularly strong.

The framework is not, however, equivalent to a coherent whole-of-government strategy for sustaining health charities as institutions. Support is spread across grants, contracts, tax rules, regulators, regional commissioners and state or territory programs. Most funding is attached to specified activities, populations or services, while evidence about payment reliability, indirect-cost recovery and organisational sustainability is limited.

Desk score: 13/21, or 1.86/3. This places Australia in the category of a developed but fragmented support framework, subject to recalibration after the same protocol is applied to the five comparator countries.

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United Kingdom

Amplify Impact: Patient Organisation Sustainability & Health Equity

04

United Kingdom country audit

Audit parameters

Field	United Kingdom audit specification
Jurisdiction	United Kingdom
Primary unit	UK central government support framework
Devolved treatment	Separate consideration of England, Scotland, Wales and Northern Ireland where health, charity regulation and third-sector funding are devolved
Organisations in scope	Registered health charities, voluntary and community organisations, social enterprises, patient organisations, community health providers, hospices, advocacy bodies and other not-for-profit health and care organisations
Evidence standard	Publicly accessible and independently verifiable sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's experience
Regulatory context	England and Wales share the Charity Commission; Scotland is regulated by OSCR; Northern Ireland is regulated by the Charity Commission for Northern Ireland
Health-system context	NHS structures and commissioning arrangements differ across England, Scotland, Wales and Northern Ireland

Overall finding

The United Kingdom has a developed and comparatively enabling framework for health charities and voluntary, community and social enterprise organisations.

Government support is delivered through:

- health and social-care service contracts;
- central and local grants;
- targeted health inequality and community funds;
- some core-cost funding;
- national charity tax reliefs;
- Gift Aid;
- mandatory business-rates relief;
- health-system partnership and advisory structures;
- social-prescribing and community-referral arrangements;
- dedicated grant and procurement portals;
- proportionate grant standards;
- flexible health-service procurement rules; and
- devolved-government third-sector programs.

A distinctive feature is the formal recognition of the VCSE sector as a health-system partner, rather than only a recipient of grants. NHS England describes VCSE organisations as contributing to service delivery, service design, advocacy, community voice and action on health inequalities. Its VCSE Health and Wellbeing Programme combines a national alliance with funded project mechanisms.

The framework is especially strong in:

- charity and award transparency;
- tax and donor support;
- national health–VCSE partnership infrastructure;
- social-prescribing and community integration;
- flexible procurement for health and social services;
- explicit equity and health-inequality objectives;
- proportional grant and charity-reporting requirements; and

- the existence of genuine core-cost funding in Northern Ireland.

Its principal weaknesses are:

- major variation among the four nations and local commissioning systems;
- widespread reliance on restricted grants and service contracts;
- limited consistent full-cost recovery;
- short funding cycles in many programs;
- uncertain inflation and wage indexation;
- fragmented local access;
- limited published evidence about payment and renewal performance; and
- significant cumulative regulatory and procurement requirements for organisations working across the UK.

Instrument matrix

Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-UK-01	NHS health and care service contracts	National systems/local	Health charities and VCSE organisations deliver commissioned health, public-health, mental-health, social-care, hospice and community services under NHS and local-government agreements.	Strong and structurally embedded, although commissioning differs by nation and locality.
DF-UK-02	NHS England VCSE Health and Wellbeing Fund	England	Provides funding for bespoke VCSE projects intended to improve health, address inequalities and test community-based approaches.	Strong health-specific project mechanism.
DF-UK-03	VCSE Health and Wellbeing Alliance funding	England	National partnership mechanism through which funded VCSE representatives contribute expertise, lived experience and community perspectives to health policy and service design.	Strong example of funding sector participation, not only frontline delivery.
DF-UK-04	Integrated Care Board grants and contracts	England/local	ICBs can commission and fund VCSE organisations for population health, prevention, employment support, community care and health-inequality initiatives. NHS England's 2024–25 performance	Strong but locally variable.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			assessment records ICB funding committed through VCSE partners.	
DF-UK-05	Social-prescribing and community-support commissioning	England/local	NHS and local systems fund or contract VCSE organisations to provide community activities, link-worker destinations, peer support and non-clinical services.	Strong integration pathway, although funding may be indirect or short term.
DF-UK-06	Better Care Fund expenditure	England/local	The Better Care Fund pools NHS and local-government resources for integrated health and social care. Local plans can include VCSE grants and commissioned community services.	Major financial framework, but local allocations to charities are not consistently separable nationally.
DF-UK-07	Local-authority public-health grants and subgrants	England/local	Councils use public-health and other funds to commission or grant-fund community organisations for prevention, wellbeing and health inequalities.	Strong but highly decentralised.
DF-UK-08	Healthy Communities and local VCSE grant programs	Local	Councils operate targeted health and wellbeing grants. Coventry's Healthy Communities program, for example, supports locally led VCSE work focused on prevention and cardiovascular health.	Verified but local and program-specific.
DF-UK-09	Men's Health Community Fund	England	A £6.3 million community fund announced in 2026 supports community-led projects addressing men's health and unequal engagement with traditional services.	Strong current targeted mechanism, but time-limited.
DF-UK-10	Strategic health-program grants	England	DHSC and NHS bodies may fund disease-specific, prevention, women's health, mental-health, carer and community initiatives through grants or intermediary funders.	Broad but dispersed.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-UK-11	NHS engagement and co-production contracts	England	NHS England may commission VCSE organisations to conduct engagement where they have necessary community relationships, knowledge or skills.	Strong recognition of community expertise as a purchased capability.
DF-UK-12	Scottish Government third-sector funding	Scotland	Scotland funds charities and third-sector organisations across health, poverty, equality, care and community priorities. Funding announced for 2025–26 and 2026–27 included multi-year support across several portfolios.	Strong devolved-government support.
DF-UK-13	Scotland Fairer Funding approach	Scotland	The Scottish Government has committed to improving funding security and has moved selected third-sector programs toward multi-year arrangements.	Strong policy direction, although not yet universal.
DF-UK-14	Communities Mental Health and Wellbeing Fund for Adults	Scotland/local	Community mental-health funding distributed through local partnerships has supported thousands of grassroots projects; £15 million was committed for 2026–27 as part of a Fairer Funding pilot.	Strong community-level mechanism.
DF-UK-15	Welsh Government third-sector grants	Wales	Wales provides grants through health, social services, children, communities and other portfolios and operates a statutory Third Sector Scheme governing government–sector relationships.	Strong strategic framework, with program-specific funding.
DF-UK-16	Welsh social-services and third-sector support	Wales	Welsh Government funds key third-sector and social-service organisations and has reviewed arrangements for sustaining these grants from April 2026.	Strong recognition of sector sustainability, though current models remain under development.
DF-UK-17	Welsh stabilisation funding	Wales	Additional one-off stabilisation funding has been used for	Demonstrates emergency or stability support, but it is episodic.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			health and social-care pressures, including a £4.3 million allocation approved for 2025–26.	
DF-UK-18	Northern Ireland Department of Health Core Grant	Northern Ireland	Supports voluntary and community-sector organisations with fixed and core operating costs rather than direct service delivery. More than 70 organisations were anticipated to receive funding in 2026–27.	Exceptionally relevant core-funding instrument.
DF-UK-19	Northern Ireland health service-delivery contracts	Northern Ireland	Core Grant recipients may also hold substantial Health and Social Care service contracts. In 2023–24, 84% of Core Grant recipients reportedly also received service-delivery contracts worth £53 million.	Strong evidence of combined core and service funding.
DF-UK-20	Northern Ireland Support While Waiting grants	Northern Ireland	Voluntary and community organisations could apply for grants of £5,000–£30,000 to support people on health-service waiting lists; the 2025–26 funding pot was £0.5 million.	Strong targeted community-health mechanism.
DF-UK-21	Northern Ireland cancer-charity support	Northern Ireland	A 2025–26 scheme provided £2 million for cancer charities.	Strong condition-specific example.
DF-UK-22	Research and innovation grants	UK-wide/devolved	UK Research and Innovation and health-research bodies fund universities, medical charities, research institutes and eligible nonprofits.	Strong but generally research-focused and capacity-intensive.
DF-UK-23	Local community grants	UK/local	Councils throughout the UK provide grants for voluntary organisations, community wellbeing, carers, disability, prevention and social inclusion.	Extensive but fragmented.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-UK-24	Capital and infrastructure grants	UK/devolved/local	Selected government programs fund buildings, equipment, accessibility, digital infrastructure and community facilities.	Material but not a general entitlement.
DF-UK-25	Emergency and humanitarian funding	UK/devolved	Governments may establish emergency funds, rapid-response grants and continuity mechanisms during crises.	Demonstrated but event-specific.
DF-UK-26	Social-investment and blended-finance programs	Devolved/program-specific	Some public programs use loans, grants or blended finance through intermediaries. Scotland's Social Enterprise Just Transition Fund used a part-loan, part-grant model.	Useful but not health-charity-wide.

Direct financial support assessment

The UK provides broad direct financial support through a combination of:

- NHS and social-care commissioning;
- central-government grants;
- devolved-government third-sector programs;
- local-authority grants;
- research funding;
- community-health initiatives; and
- targeted core support.

The Northern Ireland Department of Health Core Grant is particularly important for this audit because it explicitly supports fixed operating costs. Contributions have covered costs such as premises, management and organisational infrastructure rather than simply purchasing service outputs.

Scotland's Fairer Funding direction and multi-year commitments also represent stronger recognition of sector sustainability than a purely annual project model.

Nevertheless, core funding is not available consistently across the UK. Much health-charity funding remains:

- restricted to specified services or projects;
- competitively allocated;
- tied to government priorities;
- locally determined;
- time-limited; or
- dependent on annual public budgets.

Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-UK-01	Charitable income and gains tax relief	UK	Charities generally receive tax relief on income and gains used for charitable purposes, subject to HMRC rules.	Strong national fiscal instrument.
IF-UK-02	Gift Aid	UK	Charities can claim basic-rate income tax on qualifying individual donations, increasing the value of the gift.	Strong and high-value donor incentive.
IF-UK-03	Higher-rate donor tax relief	UK	Eligible higher- and additional-rate taxpayers may claim further tax relief on Gift Aid donations.	Strong additional donor incentive.
IF-UK-04	Mandatory charitable business-rates relief	UK/devolved/local	Charities occupying non-domestic property generally receive an 80% business-rates discount, with local discretion potentially providing additional relief.	Major operating-cost concession.
IF-UK-05	Inheritance Tax relief	UK	Gifts to charities are generally exempt from Inheritance Tax and may reduce the tax rate applied to the remainder of an estate where statutory conditions are met.	Strong philanthropic incentive.
IF-UK-06	Relief on donated shares and property	UK	Donors may receive relief for qualifying gifts of shares, securities, land or buildings.	Strong but more specialised donor mechanism.
IF-UK-07	Stamp Duty Land Tax and related reliefs	UK/devolved	Charities may receive relief on qualifying property transactions, subject to relevant rules and devolved tax arrangements.	Material but transaction-specific.
IF-UK-08	VAT reliefs for specified charitable goods and activities	UK	Certain goods and services supplied to charities may be zero-rated or reduced-rated, and particular charity activities receive special VAT treatment.	Useful but complex and incomplete.
IF-UK-09	VAT relief on business donations of goods	UK	A measure introduced from 2025 removes the requirement for businesses to account for VAT on eligible goods donated for charitable distribution or service use.	Strong new in-kind donation incentive.
IF-UK-10	Gift Aid Small Donations Scheme	UK	Eligible charities can claim a Gift Aid-style payment on certain small cash or contactless donations without obtaining an individual declaration for every gift.	Material small-donation facilitation mechanism.
IF-UK-11	Corporation Tax relief for charitable companies	UK	Charitable companies may receive relief on income and gains applied to charitable purposes.	Strong but dependent on organisational structure and activity.
IF-UK-12	Free charity registration	UK/devolved	Charity-regulator registration services generally do not charge an application fee.	Useful facilitation, though professional

Code	Instrument	Level	Description and relevance	Evidence assessment
				advice may still be costly.
IF-UK-13	Free grant-search service	UK	Find a Grant allows organisations to search government grants and assess eligibility without a subscription fee.	Strong access mechanism.
IF-UK-14	Government-backed social investment	Program-specific	Publicly supported social-investment and blended-finance mechanisms can provide repayable funding to charities and social enterprises.	Available selectively rather than as a universal health-charity facility.
IF-UK-15	Indirect-cost and overhead recovery	Mixed	Central grant rules permit eligible expenditure to be defined in agreements, but no mandatory UK-wide minimum overhead rate for health charities was identified.	Major gap compared with the US federal de minimis model.
IF-UK-16	Import and customs concessions	UK	Certain donated or medical goods may qualify for relief under specific customs rules, but no broad general import-facilitation framework for ordinary domestic health charities was identified.	Limited/systematic evidence not found.

Indirect financial support assessment

The UK charity tax-relief framework is substantial. HMRC's 2026 statistics estimated:

- £2.87 billion in non-domestic rates relief;
- £1.88 billion in Gift Aid paid to charities;
- £1.28 billion in Inheritance Tax relief associated with charitable giving; and
- £920 million in higher-rate donor relief.

Gift Aid is particularly valuable because a charity can normally reclaim 25 pence for every £1 donated where the qualifying conditions are met.

Business-rates relief is another major strength. Registered charities generally receive an 80% discount on qualifying non-domestic property, meaning the concession directly reduces premises costs.

VAT treatment is less favourable and more complex. Charities often pay VAT on purchased goods and services and cannot necessarily recover it unless they undertake VAT-taxable business activities. Specific zero-rating and relief provisions exist, but there is no general charity VAT rebate comparable to Canada's Public Service Bodies' Rebate.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-UK-01	Charity Commission for England and Wales	England and Wales	Registers and regulates charities, publishes guidance and maintains the public register.	Strong national-level infrastructure for England and Wales.
OS-UK-02	Office of the Scottish	Scotland	Registers and regulates Scottish	Strong devolved infrastructure.

Code	Instrument	Level	Description and relevance	Evidence assessment
	Charity Regulator		charities and maintains a downloadable public register.	
OS-UK-03	Charity Commission for Northern Ireland	Northern Ireland	Registers and regulates charities and publishes annual monitoring information and guidance.	Strong devolved infrastructure.
OS-UK-04	Online charity registration	UK/devolved	Regulators provide online registration and reporting systems. In England and Wales, non-CIO charities generally register once annual income reaches £5,000; CIOs register regardless of income.	Strong facilitation, but requirements differ across jurisdictions.
OS-UK-05	Public charity registers	UK/devolved	Public registers disclose organisational details, trustees and increasingly annual accounts and reports. Scotland began publishing submitted annual reports and accounts in full from March 2026.	Strong transparency.
OS-UK-06	Tiered annual reporting	England and Wales	Reporting requirements increase with income. Charities below £10,000 provide limited income and expenditure information, while higher-income organisations submit fuller returns and	Strong proportionality mechanism.

Code	Instrument	Level	Description and relevance	Evidence assessment
			supporting documents.	
OS-UK-07	Tiered reporting in Northern Ireland	Northern Ireland	Annual Monitoring Return requirements vary according to income; smaller charities complete fewer sections than organisations above £250,000.	Strong proportionality mechanism.
OS-UK-08	Scottish annual reporting	Scotland	Every registered Scottish charity submits an annual return, accounts, trustees' report and external scrutiny report within nine months; scrutiny requirements vary with size and structure.	Strong accountability, although requirements may be comparatively demanding for very small organisations.
OS-UK-09	Find a Grant	UK central government	Central service enables users to search, filter and assess eligibility for government grant opportunities.	Strong grant discoverability.
OS-UK-10	Government Grants Functional Standard	UK central government	Establishes minimum requirements for grant design, award, agreements, risk management, monitoring and evaluation.	Strong standardisation framework.
OS-UK-11	Proportionate grant agreements	UK central government	General grant agreements must be proportionate to the value and characteristics of the grant.	Strong formal proportionality principle.
OS-UK-12	Model Grant Funding	UK central government	Provides standard clauses for government grants, including	Strong standardisation and timeliness mechanism, though it excludes liability for loss caused by delay.

Code	Instrument	Level	Description and relevance	Evidence assessment
	Agreement		a default expectation that approved grant claims are paid within 30 days unless otherwise stated.	
OS-UK-13	Risk-based grant management	UK central government	Grant risk management is required throughout design, award and delivery, allowing controls to reflect assessed risk.	Strong formal proportionality framework.
OS-UK-14	Procurement Act 2023	England, Wales and Northern Ireland for covered procurement	The Act came into force on 24 February 2025 and aims to simplify procurement and improve access for smaller suppliers and social enterprises.	Strong general access reform.
OS-UK-15	Light-touch contracting regime	Covered jurisdictions	Health, social, education and certain person-centred services can be procured under more flexible light-touch rules.	Strong flexibility relevant to VCSE providers.
OS-UK-16	NHS Provider Selection Regime	England	Allows greater flexibility when arranging healthcare services and reduces the presumption that every service must be competitively retendered.	Strong potential for stable and collaborative VCSE relationships.
OS-UK-17	VCSE Health and Wellbeing	England	Formal joint program of DHSC, NHS England and UKHSA that supports co-	Strong health-specific operating partnership.

Code	Instrument	Level	Description and relevance	Evidence assessment
	Programme		production, community voice, health equality and scalable community solutions.	
OS-UK-18	VCSE Health and Wellbeing Alliance	England	National advisory and partnership structure allowing VCSE organisations to shape policy and system design.	Strong sector-coordination infrastructure.
OS-UK-19	VCSE engagement principles	England	NHS England has published principles for more inclusive and systematic VCSE involvement.	Strong framework-level support.
OS-UK-20	Integrated Care System VCSE partnership	England/local	Integrated care systems are expected to engage VCSE partners in planning, population health, community engagement and service delivery.	Strong in policy design, with variable local implementation.
OS-UK-21	Strategic Commissioning Framework	England	NHS England's framework states that commissioning should support ongoing collaboration with the VCSE sector and people with lived experience.	Strong current policy direction.
OS-UK-22	Neighbourhood health partnerships	England/local	The 10 Year Health Plan and related neighbourhood models envisage the NHS working as an equal partner	Strong strategic intention; implementation is developing.

Code	Instrument	Level	Description and relevance	Evidence assessment
			with local VCSE organisations.	
OS-UK-23	Social-prescribing infrastructure	England/devolved/local	Primary care and community systems refer patients to VCSE activities and supports through link workers and community networks.	Strong referral integration, but organisational funding is not always stable.
OS-UK-24	Better Care Fund integration	England/local	Pooled health and local-government funding supports integrated care and can involve community and VCSE partners.	Strong operational mechanism, locally variable.
OS-UK-25	Welsh Third Sector Scheme	Wales	Statutory framework structures Welsh Government engagement, consultation and partnership with the third sector.	Strong distinctive coordination instrument.
OS-UK-26	Scottish third-sector infrastructure partnerships	Scotland	Scottish Government works with national and local third-sector infrastructure organisations and funds volunteering, community development and sector coordination.	Strong operational support.
OS-UK-27	Northern Ireland core-cost recognition	Northern Ireland	The Department of Health distinguishes core organisational support from separately commissioned service delivery.	Strong recognition of institutional infrastructure.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-UK-28	Prompt Payment Code expectations	UK	Government grant terms and procurement policy may require or encourage recipients and contractors to pay supply-chain partners within agreed periods or 30 days.	Strong policy expectation, but coverage and enforcement vary.
OS-UK-29	Local-sector support and grant-search services	Local/devolved	Councils and third-sector interfaces provide funding searches, application advice, governance assistance and volunteer support.	Broad but uneven.
OS-UK-30	Shared infrastructure and facilities	Local/program-specific	Some health charities gain access to NHS or council premises, referral platforms or co-location through partnerships, but no universal right exists.	Moderate and locally dependent.
OS-UK-31	Health-data integration	Local/program-specific	VCSE providers may participate in integrated-care data and referral arrangements, subject to contracts, information governance and local technical capacity.	Moderate and fragmented.
OS-UK-32	Import facilitation	UK	No standing expedited import system specifically for ordinary domestic health charities was identified.	Evidence gap.

Instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct grants	Broad	Extensive central, devolved and local opportunities
Commissioning and service contracts	Very broad	VCSE providers are integrated into NHS and social-care delivery
Core funding	Moderate	Strong specific example in Northern Ireland; less systematic elsewhere
Multi-year funding	Moderate	Emerging strongly in Scotland and selected programs, but not universal
Emergency and stabilisation funding	Demonstrated	Governments can activate targeted crisis or continuity support
Tax concessions	Very strong	Gift Aid, tax exemption and business-rates relief are substantial
VAT relief	Moderate	Several reliefs exist, but no general rebate
Indirect-cost recovery	Limited–moderate	Program-dependent; no mandatory minimum overhead rate
Registration facilitation	Strong	Online regulators and extensive guidance
Grant transparency	Strong	Find a Grant and published program guidance provide central access
Procurement access	Strong	Procurement Act, light-touch services and NHS Provider Selection Regime
Capacity building	Strong but uneven	National VCSE structures and local infrastructure exist
Health-system integration	Strong	Formal NHS partnership, social prescribing and integrated-care structures
Equity and inclusion	Strong	Health inequalities and community voice are embedded in major frameworks
Government-backed finance	Limited–moderate	Social-investment instruments exist but are selective
Infrastructure access	Moderate	Available through local arrangements, not a universal entitlement
Import facilitation	Limited/not identified	No broad sector-specific system located

United Kingdom scorecard

Dimension	Score	Summary
1. Transparency	**3 – Comprehensive**	Strong charity registers, central grant discovery and public procurement information
2. Accessibility/admin burden	**2 – Established but uneven**	Central systems and flexible procurement exist, but national, devolved and local fragmentation remains
3. Funding quality	**2 – Established but uneven**	Core and multi-year funding exist in parts of the UK, but restricted and short-term funding remains common
4. Timeliness and reliability	**2 – Established but uneven**	Model grant terms use a 30-day payment expectation, but renewal and payment performance are not consistently reported
5. Equity and inclusion	**3 – Comprehensive in framework design**	Health inequalities, community voice and targeted population support are embedded across health–VCSE frameworks
6. Proportional accountability	**3 – Comprehensive in framework design**	Tiered charity reporting, proportionate grant agreements and risk-based assurance are formally established
7. Operational enablement	**3 – Comprehensive in framework design**	Dedicated health–VCSE partnerships, flexible procurement, integrated-care structures and social prescribing provide substantial enablement
Total	**18/21**	**A developed, partnership-oriented and operationally enabling framework**
Mean	**2.57/3**	—

1. Transparency — Score: 3/3

The UK has extensive transparency infrastructure.

Find a Grant allows organisations to:

- search government grants;
- filter opportunities;
- assess eligibility; and
- identify application routes.

Charity information is publicly available through separate registers for England and Wales, Scotland and Northern Ireland. Regulators publish organisational details, trustees, filings and annual accounts according to each jurisdiction's reporting rules. Scotland expanded transparency in March 2026 by publishing newly submitted annual reports and accounts in full.

Procurement notices and awards are also published through government tender systems, while the Procurement Act reforms place increased emphasis on transparent public purchasing.

The main limitation is fragmentation. Users may need to consult:

- Find a Grant;
- NHS or ICB websites;
- local-authority portals;
- devolved-government sites;
- tender systems; and
- separate charity regulators.

Score rationale: Despite fragmented entry points, the existence, eligibility and administration of major instruments are comprehensively documented and desk-verifiable.

2. Accessibility and administrative burden — Score: 2/3

The UK has introduced meaningful accessibility measures:

- a central grant-search service;
- online charity registration and reporting;
- standard grant agreements;
- proportionate grant requirements;
- the Procurement Act's simplified supplier framework;
- light-touch procurement for person-centred services;
- the NHS Provider Selection Regime; and
- local VCSE infrastructure organisations.

The NHS Provider Selection Regime is particularly relevant because it moves England away from an expectation that healthcare services must always be competitively tendered. This may reduce repeated tender costs and allow commissioners to preserve effective provider relationships.

However, charities operating across the UK may need to navigate:

- different charity regulators;
- separate NHS systems;
- central and devolved-government funding portals;
- ICBs or health boards;
- local authorities;
- procurement systems;

- tax registration;
- safeguarding and service regulations; and
- program-specific reporting.

Smaller charities may still lack procurement, contract-management and bid-writing capacity.

Score rationale: Access architecture is comparatively strong, but decentralisation and cumulative compliance prevent a score of 3.

3. Funding quality — Score: 2/3

There is clear evidence of higher-quality funding in parts of the UK.

Northern Ireland's Core Grant explicitly supports fixed organisational costs and is additional to service-delivery contracts.

Scotland has made explicit commitments to fairer and more predictable third-sector funding, including funding allocations extending across 2025–26 and 2026–27.

The NHS Provider Selection Regime also has the potential to support more stable provider relationships by reducing unnecessary retendering.

Nevertheless, many opportunities remain:

- one-year or short-term;
- project-restricted;
- competitively allocated;
- linked to service outputs;
- locally variable; or
- vulnerable to annual budget decisions.

There is no UK-wide requirement that every public funder:

- covers full indirect costs;
- applies inflation or wage indexation;
- offers multi-year agreements;
- provides adequate exit notice; or
- funds organisational reserves and development.

Score rationale: The UK contains credible core and multi-year funding models, but these are not consistently available across health charities and jurisdictions.

4. Timeliness and reliability — Score: 2/3

The UK Model Grant Funding Agreement states that, unless otherwise specified, an authority will make payment within 30 days of approving a grant recipient's claim.

Prompt-payment expectations also appear in government grant terms and procurement policy, including expectations that grant recipients pay contractors by the agreed date or within 30 days where no date is specified.

Multi-year funding in Scotland and recurrent health service contracts provide some organisations with improved continuity. Northern Ireland's recurring Core Grant also demonstrates an ongoing institutional-support mechanism.

However, the model grant agreement also states that the authority has no liability for losses caused by delayed grant payment.

The audit did not identify consistent UK-wide reporting of:

- grant-payment compliance;
- time from application to decision;
- contract-signing delays;
- renewal notice periods;
- late-payment compensation for grants;
- funding gaps between contracts; or
- inflation adjustments.

Score rationale: Clear payment expectations and some multi-year mechanisms exist, but system-wide performance and continuity are insufficiently demonstrated for a score of 3.

5. Equity and inclusion — Score: 3/3

Equity and community voice are embedded in major UK health–VCSE frameworks.

NHS England's VCSE Health and Wellbeing Programme aims to:

- promote equality;
- address health inequalities;
- support co-production;
- incorporate lived experience into national policymaking; and
- develop scalable community-based solutions.

The emerging neighbourhood-health approach also states that the NHS should work as an equal partner with local VCSE organisations to remove barriers and improve access.

Dedicated mechanisms target:

- men's health;
- mental health;
- carers;
- disability;
- waiting-list support;
- cancer;
- linguistic and cultural communities;
- rural and island communities;
- poverty and social exclusion; and
- groups experiencing unequal access.

Northern Ireland's Support While Waiting scheme and Scotland's community mental-health fund illustrate community delivery targeted at access gaps and population need.

The score reflects formal framework design. It does not imply that health inequalities have been resolved or that all grassroots organisations receive equitable funding.

Score rationale: Equity, lived experience, community voice and health inequalities are explicit and recurring features of national and devolved support frameworks.

6. Proportional accountability — Score: 3/3

The UK has several mutually reinforcing proportionality mechanisms.

For central-government grants, agreements must be proportionate to the value and nature of the award. Risk management is required across the grant lifecycle, allowing assurance and monitoring to reflect assessed risk.

Charity reporting is also scaled according to organisational income and structure.

In England and Wales:

- charities below £10,000 provide basic income and spending information;
- charities between £10,000 and £25,000 answer an annual return;
- organisations above £25,000 provide fuller documentation and scrutiny;
- larger organisations face more extensive audit and reporting requirements.

Northern Ireland's Annual Monitoring Return similarly varies according to income bands, with smaller charities completing fewer sections.

Although Scotland requires annual returns and supporting reports from all registered charities, scrutiny and accounting obligations vary according to size and legal form.

Cumulative requirements can still be burdensome, especially for charities funded by several commissioners. However, the formal framework contains clear, desk-verifiable proportionality at both regulatory and grant-management levels.

Score rationale: Proportionality is explicitly embedded in charity reporting, grant agreements and risk-based assurance.

7. Operational enablement — Score: 3/3

The UK has a broad set of operational-support instruments extending beyond financial awards.

These include:

- separate public charity regulators and registers;
- Find a Grant;
- government grant standards;
- standard funding agreements;
- flexible person-centred procurement;
- the NHS Provider Selection Regime;
- the VCSE Health and Wellbeing Programme;
- the VCSE Health and Wellbeing Alliance;
- ICB and integrated-care partnerships;
- social-prescribing infrastructure;
- devolved third-sector schemes;
- local infrastructure bodies; and
- community grant-distribution partnerships.

NHS England explicitly describes VCSE organisations as essential to health-system design, community representation, service delivery and action on inequality.

The Strategic Commissioning Framework states that health commissioning should support continuing collaboration with the VCSE sector and people with lived experience.

The Provider Selection Regime provides flexibility to continue suitable provider arrangements without defaulting to repeated competitive tendering, supporting integration and potentially reducing disruption.

There are still gaps in:

- universal shared infrastructure;
- standard data access;
- consistent local VCSE representation;
- stable funding for social-prescribing providers; and
- uniform implementation among health systems.

Score rationale: Dedicated health–VCSE partnership, commissioning, procurement and referral structures are sufficiently extensive to support the highest desk-based score.

Evidence gaps

Evidence gap	Why it matters
Total UK government funding paid specifically to health charities and VCSE organisations	No single dataset combines grants, NHS contracts, local authorities and devolved administrations
Distribution of funding by UK nation	Needed to assess territorial equity
Percentage of health-charity funding that is core or unrestricted	Core funding is visible in Northern Ireland but not quantified UK-wide
Percentage of contracts lasting three years or more	Indicates continuity and workforce stability
Full-cost recovery rates	Needed to assess whether overheads and infrastructure are adequately funded
Inflation and wage indexation	Particularly important for labour-intensive health and social-care services
Payment performance against the 30-day model term	Policy expectations do not demonstrate actual compliance
Contract-renewal notice periods	Determines whether charities can retain staff and services
Frequency of gaps between contracts	Important for cash flow and service continuity
Grant success rates by organisation size	Would test practical accessibility
Access for grassroots and lived-experience-led organisations	Formal eligibility may not translate into competitive capacity
Variation in ICB use of VCSE grants and contracts	Central to assessing England's actual implementation
Stability of social-prescribing funding	Referral integration is weakened if destination organisations are underfunded
Cross-border regulatory burden	Organisations operating in several UK nations may face duplicate registration and reporting
Data-sharing access	No national measure of VCSE participation in integrated records or referral systems
Government-backed finance specifically for health charities	Social-investment schemes exist, but no comprehensive health-sector facility was identified
Import facilitation	No broad health-charity-specific pathway was identified

Preliminary policy interpretation

The UK framework is best characterised as a tax-supported and publicly commissioned charity system with formal health–VCSE partnership structures**.**

Its principal strengths are:

1. formal recognition of the VCSE sector as a health-system partner;
2. strong Gift Aid and business-rates relief;
3. central grant-search infrastructure;
4. proportionate government grant standards;
5. tiered charity reporting;
6. flexible procurement for health and social services;
7. the NHS Provider Selection Regime;
8. health-system engagement and advisory structures;
9. social-prescribing and integrated-care pathways;
10. targeted core-cost support in Northern Ireland;
11. emerging multi-year and fair-funding approaches in Scotland; and
12. statutory third-sector partnership arrangements in Wales.

Its principal vulnerabilities are:

1. uneven funding and implementation between UK nations;
2. local variation among commissioners;
3. limited universal core funding;
4. no mandatory full-cost-recovery rate;
5. uncertainty about indexation and renewal;
6. fragmented data and referral access;
7. limited published payment-performance data;
8. potentially unstable community-provider funding;
9. cumulative compliance for cross-border organisations; and
10. dependence on public-sector priorities and annual budgets.

Country fiche conclusion

The United Kingdom provides a mature government-support environment for health charities and VCSE organisations. These organisations receive grants, health and social-care contracts, tax concessions, Gift Aid, business-rates relief, community funding and operational support.

The UK's most distinctive strength is its recognition of health charities and community organisations as partners in health-system planning, engagement and delivery. NHS England's VCSE structures, integrated-care arrangements, social prescribing and flexible provider-selection rules collectively support a more embedded role than simple project grant eligibility.

The framework is nevertheless uneven. Funding quality and access differ between England, Scotland, Wales and Northern Ireland and among local commissioners. Core funding is not universally available, and public evidence remains limited on full-cost recovery, indexation, payment performance and renewal stability.

Desk score: 18/21, or 2.57/3. The United Kingdom is therefore classified as having a developed, partnership-oriented and operationally enabling government-support framework**,** with fragmented implementation and inconsistent funding sustainability as its principal limitations.

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United States

Amplify Impact: Patient Organisation Sustainability & Health Equity

05

United States country audit

Audit parameters

Field	United States audit specification
Jurisdiction	United States
Primary unit	Federal government support framework
Subnational treatment	Targeted scan of material state mechanisms, particularly Medicaid commissioning, charity registration and state/local tax treatment
Organisations in scope	Section 501(c)(3) health charities, nonprofit health providers, community-based organisations, federally qualified health centres, public-health organisations, patient organisations, faith-based organisations and tribal organisations
Evidence standard	Publicly accessible and independently verifiable sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's experience
Federalism note	States administer major health programs, regulate charitable solicitation and determine many state tax concessions, producing substantial variation

Overall finding

The United States has an exceptionally large, diverse and financially significant nonprofit health-support system, but it is also highly decentralised and administratively demanding.

Government support reaches health charities and nonprofit providers through:

- federal project and program grants;
- formula and block grants channelled through states;
- large-scale Medicare and Medicaid purchasing;
- grants and operational funding for nonprofit community health centres;
- public-health, mental-health, substance-use, ageing, disability and HIV programs;
- federal research grants;
- emergency and disaster assistance;
- federal income-tax exemption;
- tax deductibility of charitable contributions;
- federal cost-recovery rules, including indirect costs;
- central grant, procurement and spending databases; and
- technical-assistance and community-integration initiatives.

The US framework is especially strong in the scale and diversity of available instruments**.** Grants.gov publishes federal organisational funding opportunities, while SAM.gov supports federal registration, assistance listings and contracting. USAspending.gov provides searchable data on federal grants, contracts and loans.

The framework's main weaknesses are:

- multiple federal registration systems and compliance stages;
- complex program-specific applications;
- substantial reporting and audit obligations;
- major variation between states;
- competitive and highly restricted funding;
- limited general organisational core funding;
- fragmented contracting and referral arrangements;
- inconsistent applicability of federal prompt-payment protections to grants, subawards and state-funded services; and
- inequitable access for small or low-capacity community organisations.

The United States therefore offers substantial support, but ability to access it often depends heavily on institutional capacity, specialist grant knowledge, established financial systems and state location**.**

Instrument matrix

Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-US-01	Federal discretionary health grants	Federal	Federal agencies publish competitive grants for public health, community health, mental health, substance use, maternal and child health, disability, ageing, prevention, advocacy-related education and service delivery. Nonprofit organisations are a recognised applicant category on Grants.gov.	Strong, broad primary evidence.
DF-US-02	HHS grant programs	Federal	The Department of Health and Human Services and its operating divisions award grants and cooperative agreements to public and nonprofit entities. Relevant agencies include CDC, HRSA, SAMHSA, NIH, ACF and the Administration for Community Living.	Strong evidence; eligibility varies by program.
DF-US-03	HRSA Health Center Program operational funding	Federal	Public or private nonprofit, community-based organisations can receive operational funding to provide comprehensive primary care to medically underserved populations.	Strong example of continuing operational support rather than a small project grant.
DF-US-04	Federally Qualified Health Center payments	Federal and state	Eligible nonprofit community health centres can receive HRSA support and reimbursement through Medicare, Medicaid and other public programs. CMS maintains dedicated payment and policy infrastructure for FQHCs.	Strong, embedded financing mechanism.
DF-US-05	Ryan White HIV/AIDS Program	Federal/local	Federal grants support states, metropolitan areas, community organisations and nonprofit providers delivering HIV treatment and support services. Eligibility varies by program component.	Strong health-specific support; administratively segmented.
DF-US-06	CDC grants and cooperative agreements	Federal	CDC funds state, local, tribal, academic and nonprofit partners for public-health programs, surveillance, prevention, workforce and emergency preparedness. CDC's grants and procurement office undertakes a large volume of assistance and acquisition actions annually.	Strong evidence of substantial public-health grant infrastructure.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-US-07	HRSA community and workforce grants	Federal	Public, private and nonprofit organisations, including community and faith-based groups, can apply for many HRSA opportunities covering health workforce, rural health, maternal and child health and community services.	Strong evidence; eligibility remains opportunity-specific.
DF-US-08	NIH and federal health-research grants	Federal	Nonprofit research institutes, health foundations, universities and eligible patient-linked organisations may participate in federally funded health and medical research.	Strong but predominantly research-focused rather than operating support for general patient organisations.
DF-US-09	Medicaid service purchasing	Federal/state	Medicaid is jointly funded by federal and state governments and administered by states. Nonprofit providers and community organisations can receive payment directly or through managed-care arrangements for covered health and community-based services.	Very substantial but highly state-dependent.
DF-US-10	Medicaid home- and community-based services	Federal/state	States fund home- and community-based services for people with disability, ageing-related needs and functional limitations. Nonprofit organisations frequently deliver these services under state contracts or provider agreements.	Strong operational and financial pathway; state rules differ.
DF-US-11	Medicaid health-related social-needs initiatives	Federal/state	CMS permits and encourages state Medicaid approaches addressing housing instability, food insecurity and other health-related social needs, potentially creating funding opportunities for community-based organisations.	Strong policy potential; implementation varies greatly by state.
DF-US-12	Medicare and value-based purchasing	Federal	Nonprofit hospitals, community health centres and other eligible health providers may receive Medicare payments and participate in value-based arrangements.	Major financing mechanism, but most ordinary patient charities are not eligible clinical providers.
DF-US-13	Accountable-care community partnerships	Federal/private-plan implementation	CMS models have encouraged clinical-community linkages and referrals to social-service organisations to address health-related social needs.	Strong demonstration and integration mechanism, but not a universal NGO funding entitlement.
DF-US-14	Community Services Block Grant	Federal/state/local	Federal block-grant funding passes through states to local community-action agencies and other eligible entities addressing poverty and associated health and social needs.	Strong indirect route to community organisations; not specifically a health-charity program.
DF-US-15	Social Services Block Grant	Federal/state	States and territories use capped federal funds to provide services for children, older adults, people with	Material but state-directed and not

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			disability and low-income populations, often through nonprofit providers.	exclusively health-related.
DF-US-16	State and local health grants	State/local	State health departments, Medicaid agencies, counties and cities award grants and contracts for public health, behavioural health, disability, ageing, prevention and community care.	Material but too fragmented for a single national description.
DF-US-17	Tribal health and tribal-organisation funding	Federal/tribal	Tribal governments and tribal organisations are eligible for numerous health and community-service grants. Many federal health opportunities explicitly recognise tribes and tribal organisations.	Strong equity-oriented funding pathway.
DF-US-18	Rural health funding	Federal/state	HRSA and other agencies provide dedicated rural-health grants, technical assistance and service-delivery funding, including opioid-response and workforce initiatives.	Strong targeted support; usually competitive and restricted.
DF-US-19	Infrastructure and capital grants	Federal/state	Selected programs fund health-centre construction, renovation, equipment, emergency preparedness or digital infrastructure.	Verified, but generally limited to eligible provider classes or existing award recipients.
DF-US-20	FEMA Public Assistance for eligible nonprofits	Federal/state	Following qualifying disasters, FEMA can provide supplemental grants to certain private nonprofit organisations for emergency work and restoration of eligible facilities.	Strong standing emergency-support mechanism, subject to disaster declarations and eligibility rules.
DF-US-21	Other FEMA nonprofit grants	Federal/state	FEMA administers programs under which eligible nonprofits can receive preparedness, security or disaster-related funding.	Strong but specialised.
DF-US-22	Emergency continuity and public-health response funding	Federal/state	Federal emergency appropriations may support nonprofit health providers, community health centres, behavioural-health services and emergency response.	Demonstrated capacity, although mechanisms depend on legislation and emergency conditions.
DF-US-23	Cooperative agreements	Federal	Federal agencies use cooperative agreements when substantial government involvement is expected, including technical assistance, shared implementation and monitoring.	Important funding form for national and community health organisations.
DF-US-24	Formula funding passed through states	Federal/state	Federal health and social-service funds are frequently awarded first to states, which then operate procurements, subgrants or provider-payment systems.	Major route of support but adds another administrative layer.

Direct financial support assessment

The United States offers one of the broadest ranges of direct government funding instruments in the comparison.

Particularly significant are:

- federal health grants;
- nonprofit community health-centre operational support;
- Medicaid and Medicare purchasing;
- state and local service contracts;
- block-grant pass-through funding;
- tribal and rural-health programs; and
- standing disaster assistance for eligible nonprofits.

Unlike systems where NGOs are primarily funded through one health ministry, the US distributes support through many federal departments, agencies, states, managed-care organisations and local governments.

This diversity creates opportunities, but it also creates fragmentation. Eligibility may be limited to:

- established healthcare providers;
- entities serving specified geographic areas;
- current grant recipients;
- particular professional or organisational types;
- organisations with formal 501(c)(3) status;
- organisations registered in SAM.gov;
- entities with clinical billing capability; or
- state-approved Medicaid providers.

The Health Center Program is a notable example of comparatively high-quality operational funding. It supports nonprofit, community-based and patient-directed organisations providing comprehensive primary healthcare in underserved areas. Bureau of Primary Health Care

However, general patient organisations and advocacy charities do not have equivalent automatic access to continuing operating support.

Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-US-01	Federal income-tax exemption under section 501(c)(3)	Federal	Eligible organisations organised and operated for recognised charitable purposes are exempt from federal income tax, subject to restrictions on private benefit, political campaigning and substantial lobbying.	Strong evidence.
IF-US-02	Federal charitable-contribution deduction	Federal	Qualifying donations to eligible charitable organisations may be deductible by individual and corporate donors, subject to tax rules and limits.	Strong evidence.
IF-US-03	Public charity classification	Federal	Qualifying 501(c)(3) organisations may be classified as public charities rather than private foundations where they meet statutory criteria, affecting fundraising, tax treatment and compliance.	Strong but legally complex.
IF-US-04	Tax-exempt organisation search and donor verification	Federal	The IRS maintains a searchable tool showing tax-exempt status, filings and eligibility to receive tax-deductible contributions.	Strong transparency and donor-enablement instrument.
IF-US-05	State corporate	State	Many states provide income or franchise-tax exemptions for qualifying	Material but not nationally uniform.

Code	Instrument	Level	Description and relevance	Evidence assessment
	income-tax exemption		charities, but recognition may require separate applications or documentation.	
IF-US-06	State sales and use-tax exemptions	State/local	Eligible charitable organisations may receive exemptions from sales or use taxes in some states, often subject to purpose and transaction restrictions.	Highly variable by state.
IF-US-07	State and local property-tax exemptions	State/local	Property used for charitable or health purposes may qualify for local property-tax relief, subject to state constitutions, statutes and local assessment rules.	Potentially valuable but fragmented and contested in some jurisdictions.
IF-US-08	Postal concessions	Federal	Eligible nonprofit organisations may qualify for reduced nonprofit postal rates for approved mailings.	Established indirect operating concession, but not specific to health charities.
IF-US-09	Federal indirect-cost recovery	Federal	Federal award recipients may recover allowable indirect costs through a negotiated rate or elect a de minimis rate of up to 15% of modified total direct costs if they do not have a negotiated rate.	Important full-cost funding instrument.
IF-US-10	Protection of negotiated indirect-cost rates	Federal/pass-through	Federal agencies and pass-through entities generally may not require a recipient or subrecipient to accept a lower indirect-cost rate than its approved rate or elected de minimis rate unless authorised by law or regulation.	Strong formal protection, though implementation may remain complex.
IF-US-11	Multi-year indirect-rate extension	Federal	A recipient with an approved negotiated indirect-cost rate may apply for a one-time extension of up to four years.	Helpful administrative stability mechanism.
IF-US-12	Federal grant and registration fees	Federal	Grants.gov and SAM.gov registration and opportunity searching are free.	Strong direct fee-access feature.
IF-US-13	Government-backed loans	Federal/state	Federal assistance listings include loans and loan guarantees, and nonprofit health facilities may be eligible under some capital or rural-development programs. No universal health-charity finance facility was identified.	Partial, program-specific evidence.
IF-US-14	Fee waivers	Federal/state	Individual agencies and states may waive filing, licensing or service fees for charities, but no comprehensive national health-charity fee-waiver framework was identified.	Fragmented.
IF-US-15	Import and customs concessions	Federal	No broad standing customs exemption for ordinary domestic health charities was identified. Special rules may apply to donated goods, humanitarian relief or specific imports.	Limited/systematic evidence not identified.

Indirect financial support assessment

The United States has a powerful indirect-support framework built around section 501(c)(3).

Qualifying organisations benefit from:

- federal income-tax exemption;
- tax-deductible donations;
- access to public-charity status;
- searchable IRS recognition;
- state and local tax concessions in many jurisdictions; and
- nonprofit postal rates.

The federal charitable deduction is particularly significant because it supports a large private-philanthropy market alongside direct government funding. However, its practical value depends on donor tax circumstances and the organisation's recognised status.

The federal indirect-cost framework is also a major strength. Recipients without a negotiated rate may elect a de minimis rate of up to 15% of modified total direct costs. Pass-through entities are generally required to recognise an appropriate indirect-cost rate rather than simply refusing overhead recovery.

This provides stronger formal protection for overhead recovery than was clearly identified in the Australian and New Zealand audits.

The weakness is complexity. Federal tax exemption does not automatically resolve:

- state charity registration;
- state fundraising registration;
- state income-tax treatment;
- sales-tax exemption;
- property-tax exemption;
- local licensing; or
- eligibility for particular federal grants.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-US-01	IRS tax-exempt recognition system	Federal	Provides formal recognition of federal tax-exempt charitable status and associated guidance.	Strong national infrastructure, although legally demanding.
OS-US-02	IRS Tax Exempt Organization Search	Federal	Public database verifies tax-exempt status, contribution eligibility and filings.	Strong transparency tool.
OS-US-03	Grants.gov	Federal	Central portal for federal grant opportunities directed to organisations and other eligible entities.	Strong opportunity-discovery infrastructure.
OS-US-04	SAM.gov entity registration	Federal	Organisations register for a Unique Entity ID to apply for federal financial assistance or bid for contracts.	Essential federal access mechanism, but adds administrative requirements.
OS-US-05	SAM.gov assistance listings	Federal	Authoritative catalogue of federal assistance programs, including grants, loans, insurance and other assistance.	Strong program-transparency infrastructure.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-US-06	USAspending.gov	Federal	Official open-data source for federal contracts, grants, loans and recipient profiles.	Very strong expenditure-transparency mechanism.
OS-US-07	Uniform Guidance under 2 CFR Part 200	Federal/pass-through	Provides government-wide administrative, cost and audit rules for federal awards and subawards.	Strong standardisation mechanism, but extensive and complex.
OS-US-08	Risk-based subrecipient monitoring	Federal/pass-through	Pass-through entities must evaluate subrecipient risk and tailor monitoring to factors such as experience, audit findings, systems and prior performance.	Formal proportionality instrument.
OS-US-09	Single Audit threshold	Federal	Entities expending at least US$1 million in federal awards in a fiscal year must undergo a Single Audit or program-specific audit where applicable. Those below the threshold are exempt from that federal audit requirement, although records remain reviewable.	Strong threshold-based accountability mechanism.
OS-US-10	Federal Prompt Payment Act	Federal contracting	Federal agencies must generally pay valid vendor invoices on time and pay interest when covered payments are late.	Strong contractor protection, but does not uniformly protect grant reimbursement or downstream subcontracts.
OS-US-11	Invoice Processing Platform	Federal	Centralised, no-cost invoicing platform used by participating federal agencies and vendors for invoice submission and payment notification.	Strong transactional infrastructure.
OS-US-12	HRSA technical assistance	Federal	HRSA provides application guidance, compliance manuals, program support and technical assistance to health-centre and health-workforce applicants and recipients.	Strong health-specific operational support.
OS-US-13	Health Center Program governance requirements	Federal	Funded health centres must be community-based and patient-directed and comply with detailed governance, service and accountability standards.	Strong community-governance model, although compliance burden is substantial.
OS-US-14	Clinical-community referral integration	Federal/state/local	CMS models support screening for health-related social needs and referrals between clinical providers and community organisations.	Strong demonstration framework; not universally implemented.
OS-US-15	Accountable-care integration	Federal/provider systems	Accountable-care models allow health providers to coordinate care and connect patients to social services.	Material operational pathway but primarily provider-led.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-US-16	Medicaid community integration	Federal/state	States may integrate community-based and social-service organisations into Medicaid managed-care, home-care and health-related social-needs arrangements.	Potentially substantial, but state variation is extreme.
OS-US-17	Community health-centre designation	Federal	Nonprofit entities can apply for Health Center Program funding or “look-alike” designation, which confers selected program benefits without the operational grant.	Strong structured entry route for qualified providers.
OS-US-18	Federal grant learning resources	Federal	Grants.gov provides applicant guides, eligibility information and step-by-step application instructions.	Strong public capacity-building resource.
OS-US-19	State charity regulators	State	State attorneys-general, secretaries of state and charity offices regulate incorporation, solicitation and reporting.	Necessary public oversight but highly fragmented.
OS-US-20	State Medicaid provider-registration systems	State	Nonprofit providers must often enrol separately as Medicaid providers or contract with managed-care organisations.	Major operational gateway and burden.
OS-US-21	State and local referral and data systems	State/local	Health information exchanges, 211 systems, managed-care referral platforms and local care networks may include nonprofit organisations.	Potentially valuable but inconsistent and often not universally accessible.
OS-US-22	Small and community organisation participation	Federal	Many funding opportunities expressly permit community-based, faith-based and nonprofit organisations to apply.	Strong formal eligibility, but eligibility does not ensure practical accessibility.
OS-US-23	Tribal organisation participation	Federal	Federal health opportunities routinely recognise tribes and tribal organisations as eligible applicants or partners.	Strong formal inclusion mechanism.
OS-US-24	Disaster grant portal and process	Federal/state	FEMA provides a formal application and delivery process for eligible nonprofit disaster assistance.	Strong standing emergency infrastructure.
OS-US-25	Public award and recipient data	Federal	Grant and contract award amounts, recipients and program information can be reviewed through USAspending and agency databases.	Exceptional formal transparency, although data interpretation can be difficult.
OS-US-26	Shared government infrastructure	Mixed	No general entitlement gives health charities access to government buildings, clinical facilities, equipment or back-office services. Access usually arises through contracts or local partnerships.	Limited system-wide support.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-US-27	Import facilitation	Federal	No general expedited import pathway for domestic health charities was identified.	Evidence gap.

Instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct grants	Very broad	Numerous federal and state opportunities across almost every health domain
Core or operational funding	Moderate	Strong for designated provider classes such as health centres, but limited for ordinary patient and advocacy charities
Commissioning and contracts	Very broad	Medicare, Medicaid, public-health and social-service purchasing create substantial opportunities
State and local support	Very broad but fragmented	Material programs exist, but access and requirements vary significantly
Emergency support	Strong	FEMA provides a standing framework for eligible nonprofits
Indirect tax support	Very strong	Federal exemption and donation deductibility, supplemented by state and local concessions
Full-cost recovery rules	Strong federally	Negotiated and 15% de minimis indirect-cost mechanisms are formally protected
Registration facilitation	Moderate	Strong digital infrastructure, but multiple registrations and renewals are required
Procurement access	Strong	SAM.gov and federal procurement infrastructure are comprehensive
Capacity building	Moderate–strong	Extensive guidance and technical assistance, especially for established program applicants
Data and referral integration	Moderate	Advanced models exist, but access is inconsistent and locally dependent
Government-backed finance	Limited–moderate	Program-specific finance exists, but no general health-charity facility
Infrastructure access	Limited	Generally tied to provider or capital programs
Import facilitation	Limited/not identified	No broad health-charity mechanism found

United States scorecard

Scoring table

Dimension	Score	Summary
1. Transparency	**3 – Comprehensive**	Extensive national grant, contract, expenditure and tax-exempt databases
2. Accessibility/admin burden	**1 – Limited/fragmented**	Opportunities are extensive, but access requires complex federal and state registrations and substantial technical capacity
3. Funding quality	**2 – Established but uneven**	Strong program funding and indirect-cost rules, but ordinary charities face restricted and competitive funding
4. Timeliness and reliability	**2 – Established but uneven**	Federal contractor protections are strong, but grant, state and downstream payment reliability is less consistent
5. Equity and inclusion	**2 – Established but uneven**	Extensive targeted programs exist for underserved populations, tribes and rural communities, but practical access remains unequal
6. Proportional accountability	**2 – Established but uneven**	Risk-based monitoring and audit thresholds exist, but cumulative compliance is substantial
7. Operational enablement	**2 – Established but uneven**	Strong digital, contracting and technical-assistance infrastructure, but fragmented health-system integration

Dimension	Score	Summary
Total	**14/21**	**A high-resource but administratively complex and fragmented framework**
Mean	**2.00/3**	—

1. Transparency — Score: 3/3

The United States has an exceptionally developed federal transparency infrastructure.

Grants.gov provides a central portal for organisational funding opportunities. SAM.gov provides federal entity registration, assistance listings, contract opportunities and award-related information. USAspending.gov is the official open-data source for federal grants, contracts and loans and provides recipient-level profiles and award histories.

The IRS Tax Exempt Organization Search tool allows users and donors to verify:

- tax-exempt status;
- eligibility to receive deductible contributions; and
- available organisation filings.

The principal limitation is not lack of information but information overload and fragmentation. A user may need to consult:

- Grants.gov;
- SAM.gov;
- USAspending.gov;
- an agency-specific portal;
- an agency grants-management system;
- IRS databases;
- state charity systems;
- state Medicaid portals; and
- local procurement sites.

Nevertheless, the underlying federal evidence is sufficiently comprehensive and publicly accessible to warrant the highest score.

Score rationale: Federal opportunities, awards, recipients and charity status are extensively documented through central public databases.

2. Accessibility and administrative burden — Score: 1/3

Federal systems provide detailed guidance and are generally free to use. Nonprofit organisations are expressly eligible for many opportunities, and Grants.gov provides application and eligibility guides.

However, accessing federal support may require organisations to:

1. incorporate under state law;
2. obtain an Employer Identification Number;
3. apply for federal tax-exempt recognition;
4. comply with state charity or fundraising registration;
5. obtain a Unique Entity ID;
6. register and renew in SAM.gov;
7. create Grants.gov accounts and roles;
8. use an agency-specific grant-management portal;
9. maintain federal financial-management systems;
10. comply with 2 CFR Part 200;
11. satisfy program-specific eligibility and evidence requirements; and

12. meet state or local provider-enrolment rules.

Federal service grants may also require sophisticated budgets, needs assessments, outcome measures, evaluation plans, clinical compliance, data systems and sustainability strategies.

SAM.gov registration enables organisations to apply for federal assistance and contracts, but its existence illustrates that charity registration alone is not sufficient for government funding access.

The federal-state structure adds substantial burden. An organisation working in several states may face different:

- charitable-solicitation rules;
- Medicaid contracts;
- licensing systems;
- tax exemptions;
- reporting requirements; and
- procurement procedures.

Score rationale: Formal access is broad, but the level of legal, financial and technical capacity required creates substantial barriers for smaller organisations.

3. Funding quality — Score: 2/3

The United States provides substantial and sometimes durable funding.

Examples include:

- continuing Health Center Program operational awards;
- Medicare and Medicaid reimbursements;
- multi-year cooperative agreements;
- community-service contracts;
- infrastructure grants; and
- formula funding passed through states.

The Health Center Program is particularly significant because it supports nonprofit, community-based and patient-directed organisations to provide continuing comprehensive care in underserved communities.

Federal cost rules also support funding quality. Recipients without a negotiated indirect-cost rate may elect a de minimis rate of up to 15% of modified total direct costs. Recipients with negotiated rates have stronger cost-recovery protection.

These rules are a major comparative strength.

However, funding quality is uneven because many programs are:

- restricted;
- competitive;
- appropriation-dependent;
- time-limited;
- reimbursement-based;
- subject to annual continuation decisions;
- contingent on measurable outputs; or
- available only to established provider classes.

Ordinary health charities, support groups and advocacy organisations have no general entitlement to core funding. Medicaid and Medicare payments are also payment for eligible services, not general subsidy for the organisation’s broader mission.

Score rationale: Durable program funding and formal indirect-cost recovery exist, but support remains highly restricted and unevenly accessible.

4. Timeliness and reliability — Score: 2/3

The federal Prompt Payment Act requires covered federal vendor invoices to be paid on time and generally requires interest when payment is late. Payment is generally due within 30 days of a proper invoice unless another rule or accelerated arrangement applies.

The federal Invoice Processing Platform provides participating agencies and vendors with a central mechanism for invoice submission, status tracking and payment notification.

These are significant reliability protections for direct federal contractors.

However, the protections do not translate uniformly across all forms of support:

- grant drawdowns may follow different rules;
- state and local payment standards vary;
- Medicaid managed-care payment practices vary;
- nonprofit subrecipients may depend on state or prime-recipient processing;
- the Prompt Payment Act does not generally require prime contractors to pay ordinary subcontractors interest;
- reimbursement models may require organisations to carry costs before payment; and
- federal shutdowns, continuing resolutions or delayed appropriations can affect award administration.

The federal government no longer has a general annual Prompt Payment reporting requirement, limiting desk-verifiable performance assessment.

Score rationale: Strong federal contractor rules exist, but system-wide timeliness cannot be demonstrated across grants, states and subcontracting chains.

5. Equity and inclusion — Score: 2/3

The US framework contains many targeted mechanisms for underserved populations.

Examples include:

- Health Center Program support for medically underserved areas and populations;
- rural-health grants;
- migrant health centres;
- healthcare for people experiencing homelessness;
- public-housing health centres;
- tribal and tribal-organisation eligibility;
- Medicaid coverage and home- and community-based services;
- HIV programs;
- maternal and child health programs; and
- health-related social-needs initiatives. HRSA

Federal health-grant notices frequently recognise:

- community-based organisations;
- faith-based organisations;
- tribes;
- tribal organisations;
- minority-serving institutions; and
- nonprofit providers. HRSA

However, targeted eligibility does not ensure equitable access. Smaller, rural, tribal, culturally specific or lived-experience-led organisations may lack:

- grant-writing staff;
- cash reserves;
- audit capability;
- clinical billing systems;
- evaluation capacity;
- required partnerships; or
- prior federal-award experience.

State variation also creates geographic inequity. Medicaid service coverage, provider participation and community-service contracting differ materially between jurisdictions.

Score rationale: Equity is strongly represented in program targeting, but administrative and geographic disparities limit equitable participation in practice.

6. Proportional accountability — Score: 2/3

The federal Uniform Guidance contains several proportionality mechanisms.

Pass-through entities must evaluate subrecipient risk using factors such as:

- prior experience;
- audit results;
- personnel or systems changes; and
- previous federal monitoring.

Monitoring should respond to the assessed risk.

The Single Audit threshold also provides proportionality. A non-federal entity must generally undergo a Single Audit when it expends at least US$1 million in federal awards during its fiscal year. Entities below the threshold are exempt from that specific federal audit requirement, although their records remain subject to review. ecfr.gov

Indirect-cost provisions also prevent pass-through entities from simply imposing lower overhead rates without authority.

Nevertheless, even below the Single Audit threshold, organisations may face:

- detailed financial reporting;
- program outcome reporting;
- procurement standards;
- subrecipient monitoring;
- record-retention requirements;
- civil-rights compliance;
- lobbying and political-activity restrictions;
- state charity reporting;
- state licensing;
- Medicaid audits; and
- multiple funder-specific evaluations.

The framework is therefore formally risk-based but operationally demanding.

Score rationale: Meaningful proportionality rules exist, but cumulative federal and state compliance remains substantial.

7. Operational enablement — Score: 2/3

The United States provides extensive operational infrastructure:

- Grants.gov;
- SAM.gov;
- USAspending.gov;
- IRS registration and verification;
- federal assistance listings;
- Uniform Guidance;
- agency technical assistance;
- health-centre designation;
- FEMA disaster processes;
- invoicing infrastructure; and
- clinical-community integration models.

Grants.gov and SAM.gov provide national entry points into federal assistance and contracting, while USA spending enables award and recipient analysis.

The Health Center Program provides a particularly structured operating environment, including community governance, underserved-population requirements and technical assistance.

CMS models also support referrals between clinical systems and community organisations for health-related social needs.

However, operational enablement is not coherent across the entire nonprofit health sector. There is no universal system for:

- shared health-data access;
- standard NGO referral integration;
- common service agreements;
- shared public infrastructure;
- national nonprofit commissioning;
- state registration harmonisation; or
- centralised Medicaid contracting.

Many organisations must build separate relationships with health systems, managed-care plans, counties and state agencies.

Score rationale: The federal infrastructure is extensive, but health-system integration and state-level operating conditions remain highly fragmented.

Evidence gaps

Evidence gap	Why it matters
Total annual federal and state funding specifically paid to health charities	Federal spending databases do not provide a simple, definitive health-charity total
Share of health nonprofit revenue from government	Needed to assess overall dependency and system importance
Percentage of awards providing true core funding	Distinguishes organisational support from payment for specified activity
Average federal grant decision time	Indicates application burden and planning uncertainty
Average time between award and accessible funding	Important for recruitment and program commencement
Payment performance for grants and cooperative agreements	Prompt Payment evidence primarily covers vendor payments

Evidence gap	Why it matters
State Medicaid payment timeliness	Major source of nonprofit-provider cash-flow risk
Percentage of awards using negotiated or de minimis indirect-cost rates	Needed to assess actual full-cost recovery
Treatment of costs above the 15% de minimis rate	Important for organisations without negotiated rates
Multi-year funding prevalence	Needed to determine continuity across agencies
Grant success rates by organisation size	Would test practical accessibility
Grant success rates for tribal and community-led applicants	Would test equity beyond formal eligibility
Cost of SAM.gov, Grants.gov and agency compliance	Systems are free, but internal staff costs may be substantial
State charity-registration duplication	Important for national organisations fundraising across states
Access to Medicaid and health-system referral platforms	Highly variable and not captured by one national source
Public infrastructure access	No national inventory exists
Government-backed finance for general health charities	No comprehensive federal mechanism was identified
Import concessions	No general health-charity framework was identified

Policy interpretation

The US framework is best characterised as a large-scale, tax-supported and programmatically funded nonprofit health market**,** rather than a unified government–NGO partnership system.

Its principal strengths are:

1. a very large and diverse federal grant environment;
2. extensive nonprofit participation in healthcare delivery;
3. continuing operational funding for community health centres;
4. substantial Medicaid and Medicare purchasing;
5. a strong charitable tax framework;
6. strong federal indirect-cost protections;
7. standing disaster support for eligible nonprofits;
8. highly developed spending and award transparency;
9. targeted rural, tribal and underserved-community programs; and
10. extensive agency-specific technical assistance.

Its principal vulnerabilities are:

1. high entry and compliance burdens;
2. separate federal and state registration systems;
3. state-by-state variation;
4. limited general core funding;
5. dependence on restricted service or project funding;
6. variable payment reliability outside direct federal contracts;
7. unequal organisational capacity to compete;
8. fragmented data and referral integration;
9. complex auditing and subrecipient oversight; and
10. limited shared infrastructure for ordinary health charities.

Country fiche conclusion

The United States has a vast and sophisticated support environment for health charities and nonprofit providers. Federal and state governments fund these organisations through grants, service contracts, Medicaid and Medicare payments, community-health programs, public-health initiatives, research funding, block grants and disaster assistance.

The strongest components are:

- federal award transparency;
- extensive tax support;
- community health-centre operational funding;
- formal indirect-cost recovery;
- risk-based federal grant rules; and
- targeted support for underserved populations.

Its central weakness is not scarcity of instruments but fragmentation. Organisations must navigate different federal agencies, state charity systems, Medicaid authorities, managed-care organisations and local procurement processes. This particularly disadvantages smaller patient organisations and community groups without specialist grants, finance and compliance staff.

Desk score: 14/21, or 2.00/3. The United States is therefore classified as having a high-resource but administratively complex and fragmented government-support framework**.** Its strongest policy lesson for Australia is the explicit recognition and protection of nonprofit indirect costs; its clearest warning is the access burden created when support mechanisms are spread across too many disconnected systems.

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India

Amplify Impact: Patient Organisation Sustainability & Health Equity

06

India country audit

Audit parameters

Field	India audit specification
Jurisdiction	Republic of India
Primary unit	Union-government support framework
Subnational treatment	Targeted consideration of states, Union Territories, district administrations and State Health Societies because health delivery and many NGO partnerships are implemented subnationally
Organisations in scope	Charitable trusts, registered societies, Section 8 companies, voluntary organisations, community-based organisations, nonprofit hospitals, patient organisations, disability organisations, public-health NGOs, research institutions and other not-for-profit health and social-care providers
Evidence standard	Publicly accessible and independently verifiable government or government-agency sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's experience
Federalism note	Public health and hospitals are substantially administered through states, while Union ministries provide national schemes, centrally sponsored funding, regulation and program guidance
Legal-form note	India does not have one single national "charity" legal form. Nonprofits may be constituted as public charitable trusts, societies or nonprofit companies under section 8 of the Companies Act
Foreign-funding note	Receipt of foreign contributions is separately regulated under the Foreign Contribution (Regulation) Act through the Ministry of Home Affairs' FCRA system

Overall finding

India has a large, highly targeted but administratively fragmented government-support framework for health NGOs and nonprofit service providers.

Government support is delivered through:

- National Health Mission partnerships;
- state and district health contracts;
- HIV-prevention programs implemented through NGOs and community-based organisations;
- disability-service grants;
- drug-demand-reduction programs;
- older-person and marginalised-community grants;
- tribal-area health and welfare grants;
- health-research grants;
- grants-in-aid from multiple Union ministries;
- public procurement and service agreements;
- income-tax exemption for eligible charitable institutions;
- donor deductions under section 80G;
- mandatory corporate social responsibility expenditure;
- digital NGO registration and grant portals;
- the Public Financial Management System;
- state-level health societies; and
- foreign-contribution registration or prior permission.

The National Health Mission formally recognises NGO participation in health-service delivery, community mobilisation, innovation and reaching underserved populations. Its published NGO guidelines describe decentralised involvement through State Health Societies and district or state processes rather than one nationally uniform grant mechanism.

India also has several substantial online systems. NGO Darpan provides a national identity and information platform for nonprofits and reported more than 582,000 active Darpan IDs in April 2026. Ministry-specific systems such as e-Anudaan and the Ministry of Tribal Affairs NGO Grants Portal then use the Darpan ID as a gateway to grant applications.

The framework's principal strengths are:

- very broad sectoral coverage;
- explicit focus on underserved communities;
- strong use of NGOs in last-mile service delivery;
- national nonprofit-identification infrastructure;
- multiple online grant-management systems;
- targeted disability, tribal, HIV, substance-use and ageing programs;
- income-tax and donor incentives;
- access to corporate social responsibility funding;
- public health-research grants; and
- a large potential funding base across Union, state and district levels.

Its principal weaknesses are:

- no single charity regulator or unified grant system;
- overlapping registrations and approvals;
- major state-by-state variation;
- program-specific and restricted funding;
- limited unrestricted organisational support;
- weak public evidence on full-cost recovery;
- extensive inspection, utilisation and reporting requirements;
- limited published payment-performance data;
- uncertain renewal and indexation practices;
- separate foreign-funding controls;
- limited consolidated award transparency; and
- substantial practical barriers for small or newly established organisations.

India is therefore best characterised as having a broad but compliance-intensive and unevenly accessible framework**,** with extensive targeted opportunities but limited system-wide funding security.

Instrument matrix

A. Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-IN-01	National Health Mission NGO partnerships	Union/state/district	NHM permits states to involve NGOs in service delivery, community processes, innovation, outreach and work in underserved areas.	Strong policy evidence, but implementation varies materially by state.
DF-IN-02	State Health Society grants and contracts	State	State Health Societies can engage NGOs and voluntary organisations to implement NHM activities and other public-health programs.	Major practical pathway, but no uniform national contracting model.
DF-IN-03	District-level NGO health agreements	State/district	District health administrations may recommend, supervise or contract NGOs for outreach, community mobilisation and service-delivery activities.	Strong within decentralised program design; highly variable locally.
DF-IN-04	National health-program	Union/state	NGOs participate in disease-control, maternal and child health, immunisation, blood	Broad framework, with program-specific eligibility.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
	implementation partnerships		donation, reproductive health and other national health activities.	
DF-IN-05	HIV targeted-intervention funding	Union/state	State AIDS Control Societies and related bodies use NGO and community-based organisation partnerships for targeted HIV prevention and support.	Established health-specific NGO-delivery model; award arrangements are decentralised.
DF-IN-06	Community-based HIV services	Union/state	Community organisations may deliver prevention, testing linkage, adherence, harm-reduction and population-specific interventions under national and state AIDS programs.	Strong inclusion model but contract-dependent.
DF-IN-07	Tuberculosis community partnerships	Union/state	NGOs and community groups can support tuberculosis case finding, treatment adherence, awareness, patient support and community engagement.	Strong program relevance, though funding instruments vary.
DF-IN-08	Maternal and child health partnerships	State/district	NGOs may deliver outreach, referral, behaviour-change, reproductive-health and community-mobilisation activities under state health plans.	Broad but locally variable.
DF-IN-09	Department of Health Research grants-in-aid	Union	The Department of Health Research provides grants-in-aid for research addressing knowledge gaps and translating health research into deliverable products.	Strong research-funding mechanism.
DF-IN-10	Indian Council of Medical Research grants	Union	Eligible nonprofit research bodies, institutions and investigators may participate in medical and public-health research grants.	Strong but research-focused and capacity-intensive.
DF-IN-11	Rare-disease voluntary-donation platform	Union	The Ministry of Health and Family Welfare operates a platform facilitating voluntary donations toward treatment of patients with notified rare diseases.	Strong condition-specific fundraising facilitation, but not general NGO operating support.
DF-IN-12	Deendayal Disabled Rehabilitation Scheme	Union/state	Grants-in-aid support voluntary organisations providing rehabilitation and disability services.	Strong targeted service-delivery mechanism.
DF-IN-13	Assistance to Disabled	Union/state	Eligible organisations participate in provision and	Strong targeted instrument; primarily

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
	Persons scheme implementation		fitting of aids and appliances for people with disability.	beneficiary or service specific.
DF-IN-14	National Action Plan for Drug Demand Reduction	Union/state/district	Grants support Integrated Rehabilitation Centres for Addicts, outreach and drop-in centres, community peer-led interventions, district de-addiction centres and related services.	Strong health and social-care NGO funding stream.
DF-IN-15	District De-Addiction Centres	Union/district	Eligible organisations can apply to establish district-level de-addiction centres through e-Anudaan.	Strong current, targeted service grant.
DF-IN-16	Community peer-led substance-use interventions	Union/state	NGOs may operate community-based peer-led prevention and outreach interventions under drug-demand-reduction programs.	Strong community-delivery mechanism
DF-IN-17	Older-person service grants	Union/state	Grant programs support organisations providing care, shelter, health-related support and services for older persons.	Strong targeted support; administered through ministry-specific systems.
DF-IN-18	Support for Marginalised Individuals for Livelihood and Enterprise	Union/state	The SMILE program funds eligible organisations, including for shelters and services for marginalised populations with associated health and social-care needs.	Strong equity-targeted mechanism.
DF-IN-19	Garima Greh grants	Union/state	Eligible community-based organisations, NGOs, trusts and charitable institutions may receive grants to operate shelters for transgender beneficiaries.	Strong current targeted example with defined experience requirements.
DF-IN-20	Tribal-area health grants	Union/state/district	The Ministry of Tribal Affairs funds voluntary organisations to extend services and fill gaps in remote and underserved tribal areas, including health projects.	Strong equity and geographic-targeting mechanism.
DF-IN-21	Tribal health projects	Union/state	The Ministry of Tribal Affairs portal includes inspection and proposal structures specifically for health projects implemented by NGOs.	Strong explicit health-NGO mechanism.
DF-IN-22	Scheduled Caste welfare grants	Union/state	Voluntary organisations may receive grants supporting welfare and services for Scheduled Caste	Broad equity instrument rather than a dedicated health fund.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			communities, including health-related components.	
DF-IN-23	State disability and rehabilitation grants	State	State governments fund disability, rehabilitation, shelter, assistive-device and community-service organisations.	Material but jurisdiction-specific.
DF-IN-24	State mental-health and de-addiction contracts	State/district	States can commission NGO-run rehabilitation, helpline, community mental-health and substance-use services.	Strong potential but uneven implementation.
DF-IN-25	State public-health grants	State/local	State health departments, missions and municipal bodies fund outreach, disease prevention, primary care and community-health activities.	Broad but fragmented.
DF-IN-26	Nonprofit hospital participation in public schemes	Union/state	Charitable and nonprofit hospitals may participate in publicly financed insurance or health-assurance schemes where empanelled.	Potentially substantial service revenue, but dependent on eligibility, tariffs and claims systems.
DF-IN-27	Ayushman Bharat empanelment	Union/state	Eligible nonprofit hospitals may receive reimbursement for covered services delivered to beneficiaries through state implementing agencies and insurers.	Major provider-financing pathway, but not accessible to ordinary patient charities.
DF-IN-28	Government health-service procurement	Union/state	Ministries, states and public bodies procure health, training, outreach, research and community services from eligible organisations.	Broad but dispersed across procurement systems.
DF-IN-29	Ministry of Social Justice e-Anudaan grants	Union/state	e-Anudaan supports online applications and administration for multiple grants-in-aid schemes involving health, disability, addiction, ageing and marginalised populations.	Strong multi-program grant infrastructure.
DF-IN-30	Ministry of Tribal Affairs NGO Grants Portal	Union/state/district	The portal supports applications, state and district review, sanction, monitoring, completion certificates and grievances.	Strong targeted grant-management mechanism.
DF-IN-31	Grants to nonprofit organisations under other Union ministries	Union	Multiple ministries fund nonprofit organisations for nutrition, women and children, rural development, sanitation, livelihoods and social protection with health relevance.	Broad but highly fragmented.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-IN-32	Emergency and disaster-response grants	Union/state	Governments may partner with NGOs during disasters, epidemics and humanitarian emergencies through relief, health and social-protection arrangements.	Demonstrated capacity but event-specific.
DF-IN-33	COVID-19 NGO service partnerships	Union/state/local	NGOs were used in relief, public-health communication, food support and community assistance during the pandemic.	Demonstrates emergency mobilisation, but not a standing unified grant mechanism.
DF-IN-34	Grants for health innovation and pilots	Union/state	Departments and health missions may fund pilot projects, innovation and new care models through grants, expressions of interest or research schemes.	Available but episodic.
DF-IN-35	Public-private and public–not-for-profit partnerships	State	States may contract nonprofit organisations to manage facilities, mobile services, diagnostics, primary care or specialist programs.	Significant in selected states but not nationally standardised.
DF-IN-36	Grant-in-aid to established institutions	Union/state	Established voluntary organisations and institutions may receive continuing grants under sector-specific schemes, generally linked to approved services and beneficiary targets.	Moderate operating support but usually restricted.
DF-IN-37	Corporate social responsibility implementation funding	Corporate/regulator-enabled	Eligible nonprofit entities can act as implementing agencies for mandatory corporate social responsibility projects, including health, sanitation and preventive healthcare.	Large quasi-public policy-enabled funding stream, though money originates from companies rather than government budgets.
DF-IN-38	Government company CSR funding	Public-enterprise/corporate	Central and state public-sector enterprises may fund eligible NGO health projects through their CSR obligations.	Material hybrid public–corporate support, but competitive and project-specific.
DF-IN-39	Capacity-building expenditure under CSR	Corporate/regulator-enabled	Corporate CSR frameworks may fund monitoring, evaluation and implementation-related capacity subject to statutory rules.	Potentially useful but not a general entitlement.
DF-IN-40	Local government and	Local/district	District administrations, urban local bodies and local missions may provide grants	Important last-mile mechanism but poorly consolidated nationally.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
	district society funding		or contracts for health, sanitation, disability and community services.	

Direct financial support assessment

India has one of the broadest potential direct-support environments in the comparison because NGOs may receive funding through:

- Union ministries;
- state departments;
- State Health Societies;
- district administrations;
- statutory missions;
- public insurance schemes;
- research agencies;
- disability and social-justice schemes;
- tribal welfare programs; and
- government-enabled corporate social responsibility.

The National Health Mission framework is particularly important. It formally identifies NGOs as partners capable of extending services, supporting innovation and reaching populations not adequately served through conventional government facilities. However, the NHM approach is deliberately decentralised: states determine the nature, scale and selection of NGO partnerships within approved health plans.

This decentralisation has benefits:

- services can reflect local need;
- states can select appropriate organisations;
- district authorities can supervise delivery; and
- community organisations can be used in remote areas.

It also generates substantial inconsistency. The availability, size and quality of NGO funding may depend on:

- the state or Union Territory;
- the district;
- the specific health mission;
- annual state program implementation plans;
- local administrative capacity;
- state procurement rules;
- whether a scheme accepts new proposals;
- the organisation's prior experience; and
- its capacity to pre-finance or document expenditure.

The e-Anudaan system illustrates both opportunity and burden. It brings multiple social-sector schemes onto one digital platform and permits organisations to submit proposals and track applications, but applications pass through verification, inspection, screening, recommendation, financial approval and sanction stages.

Most funding is restricted to:

- specified beneficiaries;
- approved staff positions;
- sanctioned service models;

- geographic priority areas;
- defined project periods;
- utilisation certificates;
- performance targets; and
- approved budget heads.

The audit did not identify a broad Union-government program providing unrestricted institutional funding to independent health charities or patient organisations.

Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-IN-01	Income-tax exemption under section 12AB	Union	Eligible charitable trusts and institutions can obtain tax registration supporting exemption of qualifying charitable income, subject to statutory conditions and continuing compliance.	Strong national fiscal mechanism.
IF-IN-02	Donor deduction under section 80G	Union	Donations to approved charitable institutions and specified funds may qualify for deduction in calculating the donor's taxable income.	Strong donor incentive, subject to approval and statutory limits.
IF-IN-03	Electronic donation reporting	Union	Approved organisations must comply with prescribed reporting and donor-certificate processes to support section 80G deductions.	Strong verification mechanism but adds administrative work.
IF-IN-04	Charitable-purpose tax treatment	Union	Health and medical relief fall within recognised charitable purposes under income-tax law, subject to registration and application-of-income rules.	Strong legal basis for health charities.
IF-IN-05	Accumulation and application rules	Union	Charities may retain or apply income under statutory conditions, but generally must comply with rules governing the use of charitable income.	Supports mission activity while imposing detailed compliance.
IF-IN-06	Exemption for qualifying nonprofit hospitals and institutions	Union	Certain hospitals and medical institutions may receive tax exemption under specific provisions, depending on legal status and approval.	Strong provider-specific fiscal support.
IF-IN-07	Goods and Services Tax exemptions for specified health services	Union/state	Healthcare services by clinical establishments, authorised medical practitioners and paramedics generally receive GST exemptions under specified conditions.	Significant for nonprofit health providers, but not a comprehensive charity-wide GST exemption.
IF-IN-08	GST exemptions for selected charitable activities	Union/state	Certain charitable, religious, training or welfare activities may receive exemptions	Useful but technically complex and activity-specific.

Code	Instrument	Level	Description and relevance	Evidence assessment
			where statutory definitions are met.	
IF-IN-09	Customs relief for specified donated or medical goods	Union	Certain imports for charitable or medical purposes may qualify for concession under specific notifications and institutional conditions.	Selective rather than a broad NGO entitlement.
IF-IN-10	Property and local-tax relief	State/local	Charitable institutions may obtain property-tax or local-fee concessions under state and municipal law.	Potentially valuable but highly variable.
IF-IN-11	Mandatory corporate social responsibility market	Union/corporate	Companies meeting statutory thresholds must spend on eligible CSR activities, creating a large funding market for health, sanitation and community projects.	Strong policy-enabled funding incentive, though not a direct tax concession to NGOs.
IF-IN-12	CSR eligibility for implementing agencies	Union/corporate	Eligible Section 8 companies, registered public trusts and registered societies can implement CSR projects if statutory registration and other conditions are met.	Strong access pathway with significant compliance requirements.
IF-IN-13	CSR-1 registration	Union	Eligible implementing agencies register through the prescribed CSR system before undertaking CSR activities for companies.	Improves verification but adds another registration layer.
IF-IN-14	Government-company CSR	Union/state public enterprises	Public-sector companies allocate CSR funds to eligible social and health initiatives.	Material hybrid funding pathway.
IF-IN-15	NGO Darpan identification	Union	NGO Darpan provides a national unique ID used as a prerequisite for numerous government grant portals.	Strong standardisation mechanism but not legal incorporation or tax exemption.
IF-IN-16	Free digital grant-portal access	Union	NGO Darpan, e-Anudaan and ministry portals allow organisations to register, apply and track proposals online without commercial portal subscriptions.	Strong transaction-cost reduction.
IF-IN-17	Foreign contribution registration	Union	Eligible organisations may obtain FCRA registration to receive foreign contributions, subject to Ministry of Home Affairs approval and continuing compliance.	Enables international philanthropy but is regulatory rather than concessional.
IF-IN-18	FCRA prior permission	Union	Organisations without continuing FCRA registration may seek prior permission for a specified donor, amount and project.	Provides a limited foreign-funding route but is administratively restrictive.
IF-IN-19	Public FCRA certificate verification	Union	The FCRA portal permits validation of registration certificates and publication of	Strong transparency tool.

Code	Instrument	Level	Description and relevance	Evidence assessment
			registered-association information.	
IF-IN-20	Government-backed loans or guarantees	Union/state	No broad loan, guarantee or working-capital facility specifically for health charities was identified.	Important gap.
IF-IN-21	Indirect-cost recovery	Union/state/program-specific	Some schemes permit administrative or institutional expenses within approved budgets, but no universal minimum overhead rate was identified.	Major comparative weakness.
IF-IN-22	Fee waivers	Union/state	Some online government registrations are available without commercial access fees, but legal, accounting, audit and application costs remain.	Partial.
IF-IN-23	Concessional land or premises	State/local/program-specific	Charitable hospitals or institutions may receive concessional land, leases or facility support under particular state policies.	Potentially significant but selective and not nationally uniform.
IF-IN-24	Government donation platform for rare diseases	Union	Government infrastructure reduces transaction and trust barriers for donors supporting eligible rare-disease treatment.	Strong condition-specific fundraising facilitation.

Indirect financial support assessment

India's indirect-support system has three major pillars:

1. income-tax exemption for approved charitable institutions;
2. tax deductions for eligible donors; and
3. the policy-created CSR funding market.

Section 12AB registration is central to the tax status of many charitable trusts and institutions, while section 80G approval enables qualifying donors to claim deductions. These are separate approvals and are accompanied by return, audit and donation-reporting requirements.

Mandatory CSR is a distinctive comparative feature. It can mobilise substantial private and public-enterprise resources for:

- healthcare;
- preventive healthcare;
- sanitation;
- nutrition;
- disability;
- disaster relief;
- rural development; and
- other public-benefit activities.

However, CSR should not be treated as equivalent to government core funding. It is ordinarily:

- corporate money;
- project specific;
- time limited;
- competitively allocated;
- shaped by company priorities;
- dependent on implementing-agency eligibility; and
- subject to separate statutory reporting.

The most significant indirect-support weakness is the absence of a general full-cost-recovery framework. India does not appear to require Union ministries, states or pass-through bodies to recognise an organisation's actual indirect-cost rate or provide a standard overhead allowance.

Foreign funding also differs from domestic philanthropy. Organisations must use the FCRA framework, either through continuing registration or prior permission, and submit annual information through the Ministry of Home Affairs portal.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-IN-01	NGO Darpan	Union	NITI Aayog's national portal provides unique identification and a searchable registry of trusts, societies and Section 8 companies.	Strong central nonprofit-identification infrastructure.
OS-IN-02	NGO Darpan public statistics	Union	The portal publishes aggregate organisation numbers, legal-form distribution and blacklisting information.	Strong sector-level transparency.
OS-IN-03	NGO Darpan as grant gateway	Union	Multiple ministry portals require organisations to obtain a Darpan ID before applying for grants.	Strong standardisation but adds a mandatory registration stage.
OS-IN-04	e-Anudaan	Union/state/district	Provides online NGO registration, proposal submission, verification, inspection, screening, sanction and application tracking for several social-sector grants.	Strong digital grant administration.
OS-IN-05	e-Anudaan status tracking	Union	Organisations can track office-level application pendency and access sanction information.	Strong applicant transparency, though not proof of timely decisions.
OS-IN-06	Ministry of Tribal Affairs NGO Grants Portal	Union/state/district	Provides registration, proposal submission, state screening, district review, sanction, completion certificates and grievance processes.	Strong targeted grant infrastructure.
OS-IN-07	Ministry-specific grant portals	Union	Several departments operate separate digital systems for NGO	Strong program administration but contributes to fragmentation.

Code	Instrument	Level	Description and relevance	Evidence assessment
			applications and monitoring.	
OS-IN-08	Public Financial Management System	Union/state	Government grants and payments are increasingly linked to central financial-management, bank-validation and expenditure-monitoring systems.	Strong accountability and payment infrastructure; NGO-specific performance data are limited.
OS-IN-09	Health Management Information System	Union/state	Public-health programs use digital reporting systems that may include data supplied by contracted NGO providers.	Strong program monitoring, but data access for NGOs is usually limited to their operational role.
OS-IN-10	National Health Mission NGO guidelines	Union/state	Published guidelines describe selection, appraisal, funding, monitoring and decentralised NGO participation.	Strong policy guidance but based on an older planning framework and unevenly implemented.
OS-IN-11	State Health Societies	State	Provide a legal and administrative vehicle for NHM funding, contracts, partnerships and program oversight.	Core health-system integration mechanism.
OS-IN-12	District Health Societies	State/district	Coordinate district-level health planning, implementation and partnerships.	Important for local NGO access but variable in capability.
OS-IN-13	Government e-Marketplace	Union/state	National e-procurement infrastructure allows eligible entities to participate in public purchasing, subject to registration and tender requirements.	Strong general procurement platform, though not designed specifically for charities.
OS-IN-14	Central Public Procurement Portal	Union	Publishes tenders and procurement information from Union-government entities.	Strong formal transparency for contracts.
OS-IN-15	State e-procurement systems	State	States operate separate tender portals and procurement rules.	Broad access but significant duplication for multi-state organisations.
OS-IN-16	FCRA Online Services	Union	Provides digital applications for registration, prior permission, renewal and annual returns.	Strong e-governance infrastructure within a demanding regulatory regime.
OS-IN-17	Public FCRA association lists	Union	Registered associations can be searched by year, state, district and keyword.	Strong formal transparency.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-IN-18	Income Tax e-filing portal	Union	Charitable institutions file tax returns, audit reports, registration applications and donation-related information online.	Strong digital infrastructure, though technically demanding.
OS-IN-19	Form 10B and 10BB audit system	Union	Prescribed audit reporting applies to eligible charitable or religious institutions depending on statutory conditions.	Strong accountability but substantial compliance.
OS-IN-20	ITR-7 charity return	Union	Charitable institutions use a specialised return containing detailed income, application and compliance information.	Strong transparency to government; operationally complex.
OS-IN-21	Corporate CSR implementing-agency registration	Union	Provides a formal verification gateway for organisations delivering corporate social responsibility projects.	Strong trust and accountability mechanism but another registration layer.
OS-IN-22	Ministry inspections	Union/state/district	Grant schemes may require institutional inspection and verification before sanction or continuation.	Strong control but burdensome and potentially slow.
OS-IN-23	Utilisation certificates	Union/state	Recipients generally document that grants were spent for sanctioned purposes before subsequent instalments or renewals.	Strong financial control; potential cash-flow burden.
OS-IN-24	Beneficiary-level reporting	Union/state/program	Some schemes require beneficiary details and link further grants to achievement of target numbers.	Strong output accountability but can be administratively intensive.
OS-IN-25	Application experience requirements	Union/state/program	Schemes may require two or more years of registration and prior sector experience.	Protects quality but excludes new and emerging organisations.
OS-IN-26	State and district recommendation process	State/district	Applications may require district review, state screening or recommendation before Union sanction.	Supports local verification but creates multiple decision stages.
OS-IN-27	Grant grievance mechanisms	Union/program	Some grant portals allow NGOs to register grievances and track applications.	Positive operational support.
OS-IN-28	Online sanction generation	Union	Ministry portals can generate and publish sanction documentation electronically.	Strong administrative infrastructure.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-IN-29	Health research electronic project systems	Union	Department of Health Research grant applications and project administration are managed through an electronic project-management system.	Strong research-grant infrastructure.
OS-IN-30	Rare-disease donation portal	Union	Provides a verified interface linking donors and designated treatment needs.	Strong specialised operational infrastructure.
OS-IN-31	Community and civil-society participation in NHM	Union/state/local	Health missions can use community organisations for mobilisation, monitoring and service delivery.	Strong policy inclusion but uneven practical influence.
OS-IN-32	Tribal NGO application support	Union	Portal guidance, timelines, contact points, forms and application tracking are publicly available.	Strong targeted accessibility.
OS-IN-33	Disability grant digital systems	Union/state	Disability-grant proposals are processed through dedicated or shared online grant systems.	Strong digital administration.
OS-IN-34	Government data and referral integration	Union/state/program	Contracted NGOs may participate in disease registries, patient-referral systems and program reporting, but no universal health-data access right exists.	Moderate and program-specific.
OS-IN-35	Shared infrastructure	State/local/program	Some NGOs receive government premises, equipment or facilities through particular schemes, but there is no general entitlement.	Limited and selective.
OS-IN-36	Capacity-building support	Union/state/program	Training and technical support may be provided within NHM, HIV, disability, tribal and social-sector programs.	Moderate but fragmented.
OS-IN-37	Standard contracting	Union/state	No single standard health-NGO grant or service agreement applying across India was identified.	Major fragmentation gap.
OS-IN-38	Prompt-payment standards	Union/state	No comprehensive publicly reported payment standard specifically covering health-NGO grants and contracts was identified.	Significant evidence gap.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-IN-39	Import facilitation	Union	Selected medical or charitable imports may receive concessions, but no unified expedited route for health NGOs was identified.	Limited.
OS-IN-40	Cross-state portability	State	Registrations, procurement access, local approvals and service requirements may need to be addressed separately in each state.	Significant operational burden.

Instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct grants	Very broad	Numerous Union and state schemes, but highly fragmented
Health-service commissioning	Broad	NHM, state missions, disease programs and public insurance use nonprofit providers
Core or unrestricted funding	Limited	Most support is tied to services, beneficiaries, schemes or approved projects
Operating subsidies	Moderate	Available to selected institutions and providers, not general health charities
Multi-year funding	Limited–moderate	Continuing schemes and renewals exist, but agreement duration is not consistently transparent
Emergency support	Demonstrated	NGOs are mobilised during epidemics and disasters
Tax concessions	Strong	Section 12AB and related charitable tax treatment
Donor incentives	Strong	Section 80G deductions for approved organisations
Corporate-giving support	Very strong	Mandatory CSR creates a large project-funding market
Foreign-funding access	Regulated	FCRA registration or prior permission is required
Indirect-cost recovery	Limited	No universal overhead rate or full-cost requirement identified
Registration facilitation	Moderate	NGO Darpan standardises identification, but does not replace other registrations
Grant discoverability	Limited–moderate	Multiple portals exist; there is no comprehensive whole-of-government grant finder
Procurement access	Moderate	National and state tender systems exist but are technically demanding
Award transparency	Limited–moderate	Portals provide sanctions and status information, but no consolidated recipient-level database exists
Capacity building	Moderate	Available within programs but not as comprehensive as Singapore
Health-system integration	Strong for contracted providers	Weak or inconsistent for independent patient and advocacy organisations
Equity and inclusion	Strong in program targeting	Extensive schemes for tribal, disability, marginalised and remote communities
Proportional accountability	Limited–moderate	Some scheme differentiation exists, but cumulative compliance is heavy
Payment reliability evidence	Limited	No comprehensive public performance framework identified
Government-backed finance	Limited/not identified	No broad health-charity loan or guarantee mechanism found
Shared infrastructure	Limited	Selective and program specific
Import facilitation	Limited	No general health-NGO framework identified

India scorecard

Scoring table

Dimension	Score	Summary
1. Transparency	**2 – Established but uneven**	Major portals and guidelines exist, but grants, sanctions and contracts are not consolidated nationally
2. Accessibility/administrative burden	**1 – Limited/fragmented**	Multiple legal, tax, grant, procurement and foreign-funding registrations create substantial burden
3. Funding quality	**1 – Limited/fragmented**	Funding is broad but predominantly restricted, scheme-based and weak on core funding and indirect costs
4. Timeliness and reliability	**1 – Limited/not demonstrated**	Multi-stage approvals and instalment controls are visible, but payment and renewal performance are not
5. Equity and inclusion	**3 – Comprehensive in framework design**	Numerous programs explicitly target tribal, disability, rural, marginalised and underserved populations
6. Proportional accountability	**1 – Limited/fragmented**	Accountability is extensive, but cumulative and not consistently scaled to organisation or award size
7. Operational enablement	**2 – Established but uneven**	Digital portals and program partnerships are extensive, but highly fragmented and status dependent
Total	**11/21**	**A broad, equity-oriented but administratively fragmented support framework**
Mean	**1.57/3**	—

1. Transparency — Score: 2/3

India has significant transparency infrastructure.

NGO Darpan provides:

- a national NGO identity;
- public organisation statistics;
- legal-form information;
- ministry links; and
- blacklisting information.

As of April 2026, the portal reported more than 582,000 active Darpan IDs, including trusts, societies and Section 8 companies.

Ministry-specific systems provide further information:

- e-Anudaan publishes schemes, notices and application processes;
- the Ministry of Tribal Affairs portal publishes timelines, application stages and sanction-related information;
- the FCRA portal publishes association data and registration-verification tools; and
- NHM publishes NGO involvement guidelines.

However, there is no single national system equivalent to USA spending or Canada's grants database that consolidates:

- Union grants;
- state grants;
- district contracts;
- NHM agreements;
- public-insurance payments;
- ministry sanctions;
- recipient histories;
- agreement duration; and
- payment status.

The existence of a Darpan ID also does not mean that an organisation is:

- tax exempt;
- eligible for donor deductions;
- approved for CSR implementation;
- registered for foreign contributions;
- licensed to deliver healthcare; or
- eligible for a particular grant.

Score rationale: India has extensive public portals and program information, but award and performance transparency remain dispersed and incomplete.

2. Accessibility and administrative burden — Score: 1/3

India provides meaningful digital access:

- NGO Darpan;
- e-Anudaan;
- ministry-specific grant portals;
- FCRA Online;
- income-tax e-filing;
- procurement systems;

- PFMS; and
- electronic research-grant systems.

These reduce the need for exclusively paper-based administration and allow application tracking in some programs.

However, organisations may need to navigate several distinct requirements:

1. legal formation as a trust, society or Section 8 company;
2. PAN and banking arrangements;
3. NGO Darpan registration;
4. section 12AB tax registration;
5. section 80G approval;
6. CSR-1 registration for corporate projects;
7. FCRA registration or prior permission for foreign funding;
8. ministry-specific grant registration;
9. state or district approval;
10. health-facility or service licensing;
11. PFMS-linked bank validation;
12. public procurement registration;
13. project inspection;
14. utilisation certificates;
15. annual tax and audit reporting; and
16. beneficiary-level or output reporting.

The e-Anudaan manual illustrates the layered process: Darpan registration precedes e-Anudaan registration, after which organisations add schemes, enter bank details, create projects, submit proposals and track applications through administrative stages.

Ministry of Tribal Affairs grants can require:

- NGO registration;
- proposal submission;
- state screening;
- district review;
- state approval; and
- Union sanction.

Some calls require an organisation to have at least two years of registration and social-sector experience, excluding newer organisations regardless of community legitimacy.

Score rationale: Digitalisation improves formal access, but cumulative registrations, inspections and multi-level approvals create a high barrier, especially for small and emerging organisations.

3. Funding quality — Score: 1/3

India’s framework offers a very large number of possible funding routes, but the quality of funding is uneven.

Positive features include:

- continuing national schemes;
- service-delivery agreements;
- public health-insurance reimbursements;
- grants for established disability and addiction services;
- research grants;
- tribal-area projects; and
- CSR funding.

Some organisations may receive renewed or continuing support over several years. However, continuation normally depends on:

- annual budget availability;
- satisfactory performance;
- inspections;
- utilisation certificates;
- beneficiary targets;
- renewed proposals;
- state recommendations; and
- sanction of subsequent instalments.

The audit did not identify a government-wide requirement for:

- unrestricted funding;
- full-cost recovery;
- minimum overhead allowances;
- inflation or wage indexation;
- multi-year agreements;
- renewal notice periods;
- transition funding; or
- reserve-building support.

A ministry may fund administrative items inside a sanctioned project, but this is not equivalent to a protected indirect-cost rate.

CSR expands the funding pool but does not necessarily improve stability. Corporate projects may be annual, branded, geographically selective and based on company strategy rather than community continuity.

Score rationale: The quantity and diversity of funding are substantial, but most support is restricted and lacks consistent protections for organisational sustainability.

4. Timeliness and reliability — Score: 1/3

Digital systems allow organisations to track some applications and identify where proposals are pending. The Ministry of Tribal Affairs portal publishes annual timelines, while e-Anudaan automates proposal processing and sanction generation.

However, the visible process contains numerous stages:

- document verification;
- inspection;
- district review;
- state screening;
- recommendation;
- financial approval;
- sanction;
- instalment release;
- utilisation certification; and
- continuation approval.

The audit did not identify a comprehensive health-NGO payment framework specifying:

- maximum application-assessment periods;
- agreement-execution deadlines;
- claim-to-payment standards;

- late-payment interest;
- percentage of grants paid on time;
- annual renewal notice periods;
- compensation for delayed sanctions; or
- continuity funding between financial years.

Where organisations receive payments in instalments linked to utilisation or target reporting, they may need sufficient cash reserves to bridge delays.

Published portal notices extending application deadlines or reopening systems show active administration but do not establish timely award or payment performance.

Score rationale: Formal processes exist, but desk evidence does not demonstrate reliable and timely payment across Union, state and district funding systems.

5. Equity and inclusion — Score: 3/3

Equity is a major strength of India's framework design.

Programs explicitly support:

- Scheduled Tribes;
- Scheduled Castes;
- people with disability;
- older people;
- transgender people;
- people affected by substance dependence;
- people living with or at risk of HIV;
- remote rural communities;
- underserved districts;
- people requiring rehabilitation;
- rare-disease patients; and
- populations beyond the effective reach of conventional services.

The Ministry of Tribal Affairs states that NGOs are used to supplement government efforts and fill critical service gaps in remote and unreached tribal areas. Its portal includes a dedicated health-project inspection format and district and state review processes.

The Deendayal Disabled Rehabilitation Scheme and aids-and-appliances program support disability organisations, while drug-demand-reduction grants fund rehabilitation, outreach, peer intervention and district de-addiction services.

Garima Greh grants explicitly target shelters and services for transgender beneficiaries.

The NHM framework also positions NGOs as mechanisms for reaching underserved populations and filling service gaps.

The score reflects formal targeting rather than a conclusion that access is equitable in practice. Small community-led organisations may still be excluded by:

- registration age;
- prior-experience rules;
- audited-account requirements;
- digital access;
- pre-financing capacity; or
- inability to navigate district and state processes.

Score rationale: Equity and last-mile inclusion are embedded across numerous major Union and state program structures.

6. Proportional accountability — Score: 1/3

India has extensive accountability mechanisms:

- tax returns;
- prescribed audits;
- Darpan information;
- FCRA returns;
- CSR registration;
- utilisation certificates;
- beneficiary reporting;
- bank validation;
- inspections;
- district verification;
- state recommendations; and
- program monitoring.

Some variation exists according to legal form, income, funding source or scheme. For example, different prescribed audit forms apply to charitable institutions depending on statutory conditions. Income Tax India

However, the framework is not consistently proportionate across the full NGO lifecycle. A relatively small organisation may still face several parallel reporting systems because:

- tax status;
- government grants;
- corporate funding;
- foreign funding;
- service licensing; and
- state operations

are regulated separately.

The same organisation may report to:

- the Income Tax Department;
- NITI Aayog;
- a Union ministry;
- a state department;
- a district administration;
- the Ministry of Home Affairs;
- a corporate funder; and
- an independent auditor.

Grant systems may require inspection and multi-stage approval even for modest awards. The publicly available evidence does not establish a government-wide principle that reporting, audit and monitoring must be scaled to grant value and organisational risk.

Score rationale: Accountability is strong in intensity but weak in harmonisation and proportionality.

7. Operational enablement — Score: 2/3

India provides substantial operational infrastructure:

- NGO Darpan;
- e-Anudaan;
- ministry grant portals;
- PFMS;
- FCRA Online;
- income-tax e-filing;
- state health societies;
- district health societies;
- public procurement portals;
- health research systems; and
- disease-program partnerships.

NGO Darpan creates a common identity that can be reused across grant portals. e-Anudaan automatically draws registration information from Darpan and permits proposal submission and tracking.

The Ministry of Tribal Affairs portal includes:

- online applications;
- state and district review;
- application tracking;
- sanction processes;
- completion certificates; and
- grievance registration.

NHM provides a formal route for NGO participation in health delivery and community engagement.

However, operational support remains fragmented. India does not have:

- one charity regulator;
- one grant finder;
- one common health-NGO agreement;
- one consolidated award database;
- one standard payment rule;
- one national system for NGO access to health data;
- one shared-services capability fund; or
- one uniform state commissioning system.

Operational systems are primarily designed to regulate and process specific funding streams rather than to provide continuing sector development comparable to Singapore's capability architecture or the UK's health–VCSE partnership framework.

Score rationale: The digital and program infrastructure is extensive, but fragmented, compliance-heavy and unevenly accessible.

Evidence gaps

Evidence gap	Why it matters
Total annual Union and state funding paid to health NGOs	No consolidated figure was identified
Total public contracts with nonprofit health providers	Needed to assess the scale of commissioning
Funding by state and Union Territory	Essential because implementation varies geographically
Number of active NHM NGO agreements	Would show actual use of the national partnership policy
Percentage of funding that is unrestricted	Needed to distinguish institutional support from service purchasing
Percentage of grants lasting three years or more	Indicates stability and workforce security
Standard treatment of overheads	No universal indirect-cost policy was identified
Inflation and wage indexation	Important for labour-intensive health and social services
Grant success rates	Needed to assess practical accessibility
Success rates by organisation size and legal form	Would identify structural disadvantage
Average application-decision time	Multi-stage processes may create substantial delays
Average sanction-to-payment time	Needed to assess liquidity risk
Percentage of payments made on schedule	No consolidated performance reporting was found
Late-payment compensation	No general NGO protection was identified
Renewal notice periods	Important for staff and service continuity
Frequency of financial-year funding gaps	A major potential risk in annual grants
State-level payment performance	Likely to vary materially
PFMS payment data specifically for health NGOs	Would provide stronger reliability evidence
Full cost of grant administration	Needed to measure burden
Number of separate registrations commonly required	Would support international accessibility comparisons
Access for emerging community-led organisations	Experience requirements may exclude new groups
Patient-organisation access	Major funding systems favour service delivery over representation and advocacy
Health-data access	No national NGO entitlement was identified
Shared infrastructure and premises	No consolidated program was identified
Government-backed working-capital finance	No broad facility was identified
Import concessions used by health charities	Available evidence is scheme and notification specific
Effect of foreign-contribution regulation on health NGOs	Important but not measurable from portal information alone
CSR funding received by health NGOs	Needed to assess the scale and reliability of the CSR pathway
Proportion of CSR funding from public-sector enterprises	Would clarify the quasi-public funding contribution

Policy interpretation

India's framework is best characterised as a large, targeted and decentralised NGO implementation system.

Government frequently uses NGOs to:

- extend reach;
- fill service gaps;
- operate specialist programs;
- reach marginalised populations;
- deliver rehabilitation;
- support prevention;
- implement research;
- mobilise communities; and
- respond in remote areas.

Its principal strengths are:

1. very broad program coverage;
2. explicit use of NGOs under the National Health Mission;
3. extensive focus on marginalised populations;
4. strong disability and rehabilitation funding;
5. structured substance-use service grants;
6. tribal-area health and welfare partnerships;
7. income-tax exemption;
8. donor tax deductions;
9. the mandatory CSR funding market;
10. national NGO identification through Darpan;
11. multiple digital grant portals; and
12. state and district implementation pathways.

Its principal vulnerabilities are:

1. overlapping registrations;
2. fragmented Union and state administration;
3. limited unrestricted funding;
4. no universal indirect-cost rate;
5. weak payment-performance evidence;
6. annual sanction and instalment risk;
7. intensive inspection and reporting;
8. dependence on prior experience and institutional capacity;
9. strong geographic variation;
10. separate foreign-funding regulation;
11. limited consolidated award transparency; and
12. weak formal support for independent patient advocacy.

Country fiche conclusion

India has an extensive and socially targeted government-support environment for health NGOs, voluntary organisations and nonprofit providers.

The framework includes:

- National Health Mission partnerships;
- state and district health agreements;
- disease-control programs;
- disability and rehabilitation grants;
- substance-use services;
- older-person programs;
- tribal-area grants;
- health-research funding;
- charitable tax exemptions;
- donor tax deductions;
- corporate social responsibility funding;
- NGO Darpan;
- ministry grant portals;
- FCRA Online; and
- digital financial-management systems.

Its strongest distinguishing feature is the explicit use of NGOs to reach marginalised, remote and underserved communities. Its principal weakness is cumulative fragmentation. An organisation may need to navigate legal registration, tax approval, Darpan, ministry portals, state and district review, CSR registration, procurement systems, utilisation reporting and foreign-funding regulation.

The system provides many funding opportunities, but it does not consistently provide:

- unrestricted funding;
- full-cost recovery;
- multi-year security;
- indexation;
- prompt-payment guarantees; or
- proportionate cross-government reporting.

Desk score: 11/21, or 1.57/3. India is therefore classified as having a broad, equity-oriented but administratively fragmented government-support framework**,** with substantial targeted funding opportunities offset by weak funding security, heavy cumulative compliance and uneven state-level implementation.

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Canada

Amplify Impact: Patient Organisation Sustainability & Health Equity

07

Canada country audit

Audit parameters

Field	Canada audit specification
Jurisdiction	Canada
Primary unit	Federal government support framework
Subnational treatment	Targeted scan of provincial and territorial mechanisms, with Ontario used as an illustrative provincial case
Organisations in scope	Registered health charities, nonprofit organisations, community health providers, patient organisations, Indigenous organisations, disability organisations, public-health organisations and community-based service providers
Evidence standard	Publicly accessible and independently verifiable sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's experience
Federalism note	Provinces and territories are primarily responsible for organising and delivering healthcare, while the federal government uses grants, contributions, transfers, tax policy and targeted health programs

Overall finding

Canada has a substantial, transparent and relatively structured government-support framework, but support is divided across federal departments, provinces, territories, regional health systems and tax authorities.

Health charities and NGOs can receive support through:

- federal grants and contributions;
- provincial grants and transfer-payment agreements;
- commissioned health and social services;
- Indigenous health and community funding;
- mental-health, substance-use and public-health programs;
- research and partnership grants;
- emergency funding;
- federal and provincial tax incentives for donors;
- income-tax exemption for registered charities;
- GST/HST rebates;
- national grant and contract disclosure;
- risk-based transfer-payment administration; and
- procurement and applicant-assistance systems.

The federal government maintains a central grants and funding finder, while Health Canada and the Public Health Agency of Canada publish health-specific funding opportunities. Federal grants and contributions awards are searchable through the Open Government Portal, and federal contracts over CAD$10,000 are separately disclosed.

Canada's framework is strongest in:

- public disclosure of grants and contracts;
- donor tax incentives;
- GST/HST relief;
- formal risk-based transfer-payment rules;
- health-specific payment service standards;
- targeted Indigenous and equity-oriented funding; and
- extensive provincial and community-sector participation in health delivery.

Its main weaknesses are:

- fragmented federal and provincial access points;
- limited broadly available unrestricted funding;
- inconsistent treatment of indirect costs;
- complex charity and funding compliance;
- varying provincial commissioning arrangements;
- limited nationwide evidence on funding renewal and indexation;
- potentially long and resource-intensive application processes; and
- incomplete system-wide integration of community organisations into health-data and referral infrastructure.

Instrument matrix

A. Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-CA-01	Health Canada grants and contributions	Federal	Health Canada funds projects intended to maintain and improve the health system, including health policy, substance use, official-language health services and other priority areas.	Strong national evidence.
DF-CA-02	Public Health Agency of Canada grants and contributions	Federal	PHAC publishes grant and contribution opportunities for public-health promotion, prevention, mental health, chronic disease, infectious disease and population-health initiatives.	Strong health-specific funding infrastructure.
DF-CA-03	Health Care Policy and Strategies Program	Federal	Provides contribution funding for policy, innovation and strategic health-system initiatives involving governments, institutions and eligible organisations.	Strong program evidence; funding is purpose-restricted.
DF-CA-04	Official Languages Health Program	Federal	Funds organisations and initiatives intended to improve health access for official-language minority communities.	Strong equity-oriented program evidence.
DF-CA-05	Substance Use and Addictions Program	Federal	Funds community-led and evidence-informed initiatives addressing substance use, harm reduction, treatment and related public-health priorities.	Strong and significant current health-NGO mechanism.
DF-CA-06	Emergency Treatment Fund	Federal/provincial/community	Provides targeted support responding to the toxic-drug and overdose crisis, including funding	Strong emergency and priority-response mechanism.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			channelled to community-led projects.	
DF-CA-07	Mental Health Promotion Innovation Fund	Federal	Supports innovative, community-based mental-health promotion programs, including projects serving children, young people, caregivers and groups experiencing inequity.	Strong community-project mechanism; generally restricted and time-limited.
DF-CA-08	Youth Mental Health Fund	Federal/community	Provides strategic investment intended to improve community mental-health services and supports for young people and families.	Strong current evidence, but program implementation and recipient arrangements require instrument-level coding.
DF-CA-09	Indigenous Services Canada health funding	Federal/Indigenous	Indigenous Services Canada funds health, wellness, mental-health, assisted-living and community programs delivered by Indigenous governments and organisations.	Strong, large-scale equity-oriented support.
DF-CA-10	Indigenous mental-health and trauma supports	Federal/Indigenous	Dedicated funding supports Indigenous mental-health, trauma-informed services, community wellness and culturally grounded responses.	Strong targeted support, including substantial recent investment.
DF-CA-11	Federal social-development grants and contributions	Federal	Employment and Social Development Canada funds nonprofit organisations for disability, inclusion, ageing, community development, skills and social-service initiatives that may have direct health relevance.	Broad and material, though not exclusively health-focused.
DF-CA-12	New Horizons and seniors-related community funding	Federal/provincial	Community organisations may access funding for social participation, ageing, inclusion and related health or wellbeing activities.	Material complementary support; individual schemes vary.
DF-CA-13	Health and medical research funding	Federal	CIHR and other federal research programs fund universities, institutes, partnerships and eligible nonprofit organisations	Strong evidence; direct access may favour established research institutions.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
			for health research and knowledge translation.	
DF-CA-14	Community-linked research partnerships	Federal	Programs such as the College and Community Social Innovation Fund connect colleges with community organisations to address challenges including health and social innovation.	Strong capacity and partnership instrument rather than general operating funding.
DF-CA-15	Federal grants to named nonprofit and charitable recipients	Federal	The Open Government Portal records grants and contributions to charities and nonprofit organisations, including recipient, amount, program, purpose and agreement duration.	Strong evidence of widespread use across departments.
DF-CA-16	Provincial health service agreements	Provincial/territorial	Provinces and territories fund nonprofits to provide community health, mental-health, disability, home-care, palliative-care, public-health and social-support services.	Highly material but jurisdiction-specific.
DF-CA-17	Transfer Payment Ontario	Provincial	Ontario operates a central system through which organisations can identify, apply for and manage provincial transfer-payment opportunities.	Strong example of provincial grant infrastructure.
DF-CA-18	Ontario nonprofit community grants	Provincial	Ontario provides project, operational, capital and resilience funding through programs including the Ontario Trillium Foundation and other ministries.	Strong subnational support; not limited to health.
DF-CA-19	Ontario community and seniors grants	Provincial	Not-for-profit organisations can receive funding for programs supporting older adults, accessibility, social participation and healthy communities.	Strong targeted community support.
DF-CA-20	Provincial health authority and regional contracts	Provincial/regional	Regional health authorities and provincial ministries commission nonprofit providers for clinical, home, community, mental-health and addiction services.	Major support route, but no uniform national contracting model.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-CA-21	Federal emergency and crisis funding	Federal/provincial	Governments can establish targeted emergency funds and adapt contribution agreements during public-health or disaster events. The overdose Emergency Treatment Fund is a current example.	Demonstrated capacity but generally event-specific.
DF-CA-22	Capital and accessibility grants	Federal/provincial/local	Nonprofits can access selected capital, renovation, accessibility, technology or community-infrastructure funds.	Material but dispersed across portfolios and jurisdictions.
DF-CA-23	Regional development agency funding	Federal/regional	Federal regional development agencies support nonprofits through project funding, repayable contributions and capacity-building initiatives.	Broad support but not primarily designed for health charities.
DF-CA-24	Multi-year contribution agreements	Federal/provincial	Federal contribution agreements may cover multiple fiscal years, and published award data include agreement start and end dates.	Strong evidence that multi-year funding is available, but its prevalence in health NGOs is not readily quantified.

Direct financial support assessment

Canada has an extensive direct-support environment, especially for organisations working in:

- public health;
- mental health;
- substance use;
- Indigenous health;
- disability;
- ageing;
- health-system policy;
- research; and
- community services.

Health Canada and PHAC maintain dedicated funding pages, while federal awards are publicly disclosed. Provinces and territories add a second major funding layer through community-health contracts, transfer-payment programs and regional service commissioning.

The principal limitation is that most support is attached to:

- specified projects;
- eligible expenditures;
- government-defined outcomes;
- particular populations;
- contribution agreements; or
- purchased health and social services.

A contribution differs from a grant because it is subject to performance conditions and reporting requirements. The federal framework recognises both instruments, but does not create a general entitlement to unrestricted institutional support for health charities.

Broad core funding appears available mainly where an organisation is an established service provider, strategic intermediary or designated program partner.

Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-CA-01	Federal income-tax exemption for registered charities	Federal	Registered charities are generally exempt from income tax under the Income Tax Act, subject to continuing compliance.	Strong national instrument.
IF-CA-02	Official donation receipts	Federal	Registered charities and other qualified donees can issue official donation receipts for eligible gifts.	Strong donor-enablement mechanism.
IF-CA-03	Federal individual charitable donation tax credit	Federal	Individuals may claim a federal non-refundable tax credit for eligible donations.	Strong national donor incentive.
IF-CA-04	Provincial and territorial donation tax credits	Provincial/territorial	Individuals may claim provincial or territorial donation tax credits in addition to the federal credit.	Strong additional incentive, although value varies by jurisdiction.
IF-CA-05	Corporate charitable donation deduction	Federal/provincial	Corporations may generally deduct eligible charitable gifts, subject to Income Tax Act conditions and limits.	Established indirect support.
IF-CA-06	Donation carry-forward	Federal	Unclaimed eligible donations may generally be carried forward for up to five years.	Strong flexibility for donors.
IF-CA-07	GST/HST Public Service Bodies' Rebate	Federal/provincial	Registered charities, qualifying nonprofits and selected public-service bodies may recover a portion of GST or the federal part of HST paid on eligible purchases.	Significant operating-cost concession.
IF-CA-08	Enhanced GST/HST treatment for health bodies	Federal/provincial	Hospital authorities and eligible facility operators may qualify for higher rebate percentages for qualifying health-related activities.	Strong but limited to defined provider classifications.
IF-CA-09	Provincial HST rebate component	Provincial	Charities resident in participating provinces may qualify for rebates of part of the provincial HST component, with percentages varying by province.	Material but jurisdictionally variable.
IF-CA-10	GST/HST small-supplier treatment	Federal	Smaller nonprofits may fall below registration thresholds, while qualifying organisations may still claim certain public-service-body rebates.	Useful for small entities, but technically complex.
IF-CA-11	Provincial property-tax relief	Provincial/local	Charitable or nonprofit properties may qualify for exemptions, rebates or	Potentially material but not nationally uniform.

Code	Instrument	Level	Description and relevance	Evidence assessment
			relief depending on provincial legislation and municipal policy.	
IF-CA-12	Provincial sales-tax concessions	Provincial	In non-harmonised tax jurisdictions, separate provincial sales-tax treatment may apply to charities and nonprofits.	Fragmented and province-specific.
IF-CA-13	Federal registration and filing access	Federal	CRA charity-registration and annual-return services are available online, with no separate commercial access fee.	Administrative facilitation rather than a major fiscal subsidy.
IF-CA-14	Government-backed loans and repayable contributions	Federal/provincial	Regional development and infrastructure programs may provide repayable contributions or finance to eligible nonprofits, but no universal health-charity loan or guarantee program was identified.	Partial and program-specific.
IF-CA-15	Regulatory or application fee waivers	Mixed	Some charity and grant processes are free, but no comprehensive health-charity fee-waiver framework was located.	Fragmented.
IF-CA-16	Import and customs concessions	Federal	No broad standing customs or import exemption for ordinary domestic health charities was identified.	Evidence gap.
IF-CA-17	Indirect-cost allowance in contribution agreements	Federal	Indirect and administrative costs may be eligible where expressly permitted by program terms and the funding agreement.	Weaker and less automatic than the US federal de minimis approach.

Indirect financial support assessment

Canada provides a strong tax-support framework for registered charities through:

- income-tax exemption;
- official donation receipting;
- federal donor tax credits;
- provincial and territorial donor credits;
- corporate donation deductions; and
- GST/HST rebates.

Only registered charities and other qualified donees can issue official receipts that enable individual credits or corporate deductions. The CRA maintains a searchable list that includes registration status, contact information, activities and financial information.

The GST/HST Public Service Bodies' Rebate is a particularly relevant indirect instrument because it reduces unrecoverable consumption-tax costs for charities and qualifying nonprofits. Enhanced treatment may apply to recognised hospital authorities and qualifying healthcare facilities.

Canada is less strong on indirect-cost recovery. Federal program funds may cover indirect costs when the specific opportunity and agreement permit them, but the audit did not identify a universal minimum overhead rate comparable to the United States' federal de minimis mechanism.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-CA-01	Canada Revenue Agency Charities Directorate	Federal	Registers and regulates charities, publishes guidance and administers annual charity reporting.	Strong national infrastructure.
OS-CA-02	Online charity registration and administration	Federal	Organisations can apply, maintain information and increasingly file charity returns through CRA online services.	Strong digital access, although the application remains legally detailed.
OS-CA-03	CRA List of Charities	Federal	Publicly searchable register provides charity status, activities, contact details and financial information.	Strong transparency and donor-verification mechanism.
OS-CA-04	Annual T3010 return	Federal	All registered charities must file an annual information return within six months of the fiscal year end.	Strong accountability mechanism.
OS-CA-05	Rapid publication of online T3010 data	Federal	Online returns are processed immediately, with public financial information generally appearing on the List of Charities the following day.	Strong reporting transparency.
OS-CA-06	Open Government grants and contributions portal	Federal	Searchable records disclose federal grants and contributions, including recipient, purpose, amount and duration.	Strong award transparency.
OS-CA-07	Proactive disclosure requirements	Federal	Treasury Board guidelines require proactive reporting of federal grant and contribution awards.	Strong central transparency rule.
OS-CA-08	Federal grants and funding finder	Federal	Canada.ca provides a central entry point directing applicants to government funding opportunities.	Useful navigation tool, though not a single application portal.
OS-CA-09	Health Canada and PHAC funding portals	Federal	Dedicated pages identify health-specific grant and contribution opportunities and program status.	Strong sector-specific discoverability.
OS-CA-10	Departmental online grant systems	Federal	Departments operate systems such as Grants and Contributions Online Services for applications and agreement administration.	Strong digital capability, but separate departmental systems create duplication.
OS-CA-11	Policy on Transfer Payments	Federal	Establishes government-wide roles, responsibilities and accountability for grants, contributions and other transfer-payment programs.	Strong common governance framework.
OS-CA-12	Directive on Transfer Payments	Federal	Requires departments to tailor transfer-payment administration and oversight using measured responses to risk.	Strong proportionality principle.
OS-CA-13	Risk-based recipient monitoring and audits	Federal	Federal guidance provides for risk-informed monitoring and recipient audits rather than identical controls for every recipient.	Strong formal proportionality instrument.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-CA-14	Funding agreement before payment	Federal	A contribution funding agreement must generally be executed before payment is made, supporting clarity but potentially delaying commencement.	Clear control mechanism with possible accessibility implications.
OS-CA-15	Health Canada payment service standards	Federal	Health Canada publishes standards for acknowledging applications and issuing grant or contribution payments after required documentation is approved.	Strong, measurable timeliness instrument.
OS-CA-16	PHAC payment service standard	Federal	PHAC commits to issuing grant and contribution payments within 30 business days after receiving and approving required documentation, with an 85% performance target.	Strong published standard.
OS-CA-17	CanadaBuys	Federal	National federal procurement platform provides tender opportunities, registration information and contracting guidance.	Strong procurement infrastructure.
OS-CA-18	Federal procurement data	Federal	CanadaBuys provides downloadable tender and contract-award datasets, while the Open Government Portal publishes contracts above disclosure thresholds.	Strong transparency infrastructure.
OS-CA-19	Procurement Assistance Canada	Federal	Offers tools and assistance to help suppliers navigate federal procurement, registration and opportunity identification.	Strong supplier capacity-building measure.
OS-CA-20	Provincial funding portals	Provincial	Provinces operate separate opportunity and transfer-payment systems, including Transfer Payment Ontario.	Strong local access but adds fragmentation.
OS-CA-21	Indigenous funding portal and program navigation	Federal	Canada.ca maintains consolidated information on funding programs for First Nations, Inuit, Métis and Indigenous organisations.	Strong targeted discoverability.
OS-CA-22	Indigenous organisational and community capacity support	Federal	Funding supports Indigenous community leadership, health services, research capacity and self-determined initiatives.	Strong equity-oriented operational support.
OS-CA-23	Community and research partnership infrastructure	Federal	Research programs connect academic institutions and community organisations, giving NGOs access to facilities, expertise and evaluation capacity.	Strong but program-specific.
OS-CA-24	Provincial health-system integration	Provincial/regional	Nonprofit providers participate in regional health, mental-health, home-care and public-health delivery and referral pathways.	Material but highly variable by province and service.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-CA-25	Health data and referral integration	Mixed	Community organisations may participate in provincial health information, referral and coordinated-care arrangements, but no universal Canada-wide NGO integration mechanism was identified.	Moderate and fragmented.
OS-CA-26	Shared infrastructure and capital support	Federal/provincial	Selected programs fund accessibility, facilities, equipment and community infrastructure, but access is tied to particular schemes rather than a general entitlement.	Moderate.
OS-CA-27	Fund-holder or intermediary access	Mixed	Some programs allow partnerships or intermediaries to hold and administer funds, but no uniform national fiscal-sponsorship mechanism was identified.	Partial evidence.
OS-CA-28	Import facilitation	Federal	No broad operational mechanism for expedited imports by domestic health charities was identified.	Evidence gap.

Instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct grants and contributions	Broad	Extensive federal and provincial programs across health and social priorities
Commissioning and service contracts	Broad	Especially important at provincial, territorial and regional levels
Core or unrestricted funding	Limited–moderate	Available selectively, but most support is program- or service-specific
Multi-year funding	Moderate	Multi-year agreements exist, but prevalence is not transparent
Emergency support	Demonstrated	Targeted emergency and crisis mechanisms can be established
Tax concessions	Strong	Income-tax exemption, donation receipting and multiple donor credits
GST/HST relief	Strong	Public-service-body rebates reduce eligible operating costs
Indirect-cost recovery	Limited–moderate	Permitted by some programs but not protected through a universal rate
Registration facilitation	Strong	Central CRA regulation and increasingly digital administration
Grant transparency	Strong	Federal award disclosure is comprehensive and searchable
Procurement access	Strong	CanadaBuys, contract disclosure and supplier assistance
Capacity building	Moderate–strong	Particularly through Indigenous, research and community programs
Health-system integration	Moderate	Significant provincial involvement but no uniform national framework
Government-backed finance	Limited	Program-specific repayable contributions exist
Infrastructure access	Moderate	Capital and accessibility grants exist but are fragmented
Import facilitation	Limited/not identified	No general health-charity mechanism found

Canada scorecard

Scoring table

Dimension	Score	Summary
1. Transparency	**3 – Comprehensive**	Strong charity, grant, contribution, contract and program disclosure systems
2. Accessibility/admin burden	**2 – Established but uneven**	Extensive guidance and online systems exist, but federal-provincial fragmentation and contribution requirements create burden
3. Funding quality	**2 – Established but uneven**	Broad and sometimes multi-year funding, but most support is restricted and indirect-cost recovery is inconsistent
4. Timeliness and reliability	**2 – Established but uneven**	Health Canada and PHAC publish measurable payment standards, but performance and renewal evidence are incomplete across the wider system
5. Equity and inclusion	**3 – Comprehensive in framework design**	Strong Indigenous, linguistic, disability, rural and priority-population instruments
6. Proportional accountability	**2 – Established but uneven**	Federal transfer-payment policy is explicitly risk-based, but cumulative federal and provincial compliance remains significant
7. Operational enablement	**2 – Established but uneven**	Strong federal portals and assistance, but health-system integration and provincial access remain fragmented
Total	**16/21**	**A developed, transparent but federally fragmented framework**
Mean	**2.29/3**	—

1. Transparency — Score: 3/3

Canada has a strong federal transparency architecture.

The Open Government Portal provides searchable federal grants and contributions data showing:

- recipient;
- program;
- agreement amount;
- start date;
- end date; and
- purpose.

Treasury Board guidelines require proactive disclosure of grant and contribution awards. Federal contracts are separately searchable, and CanadaBuys makes procurement and contracting datasets available for download.

The CRA List of Charities gives the public access to registration status, organisational activities and financial information. Online T3010 returns are processed immediately, with the public financial component generally appearing the next day.

Funding opportunities remain dispersed across Canada.ca, Health Canada, PHAC, departmental portals and provincial systems. This affects ease of navigation but does not outweigh the quality of the underlying disclosure.

Score rationale: Canada provides comprehensive, searchable public evidence on charity status, federal grants, contribution agreements and contracts.

2. Accessibility and administrative burden — Score: 2/3

Canada provides:

- a federal funding finder;
- health-specific funding pages;
- online application systems;
- CRA digital charity services;
- CanadaBuys;
- Procurement Assistance Canada;
- provincial grant portals; and
- targeted Indigenous funding navigation.

The federal transfer-payment framework also encourages administration proportionate to recipient and program risk.

Nevertheless, organisations may need to navigate:

1. federal or provincial incorporation;
2. CRA charity registration;
3. annual T3010 reporting;
4. separate departmental funding portals;
5. program-specific applications;
6. contribution agreements;
7. provincial transfer-payment systems;
8. regional health authority contracting;
9. provincial tax rules; and
10. procurement registration.

Contribution applications may require detailed budgets, outcomes, performance measures, risk controls, partnerships and evaluation plans. A funding agreement must generally be completed before payment, which protects accountability but can delay mobilisation.

Score rationale: The systems are well documented and increasingly digital, but accessing support requires substantial administrative capacity and navigation across multiple levels of government.

3. Funding quality — Score: 2/3

Canada provides broad and sometimes substantial support through federal health grants, provincial service agreements, Indigenous health funding and community programs. Published grant data show that agreements may cover more than one fiscal year, and some funding supports organisational capability, infrastructure and community-sector development.

There are also fiscal measures that improve funding quality, particularly GST/HST rebates for charities, qualifying nonprofits and eligible healthcare bodies.

However, most direct funding remains:

- restricted;
- competitive;
- output-linked;
- project-specific;
- population-specific; or
- governed through contribution conditions.

Indirect costs are eligible only where permitted by the program and agreement. Canada does not appear to provide a universal minimum indirect-cost rate for federal health-charity awards.

The desk search also did not establish consistent:

- inflation indexation;
- full-cost recovery;
- renewal rights;
- minimum contract duration; or
- organisational core funding.

Score rationale: The scale and variety of funding warrant a score of 2, but unrestricted and full-cost funding are not sufficiently systematic for a score of 3.

4. Timeliness and reliability — Score: 2/3

Canada performs relatively strongly in publishing health-specific payment standards.

PHAC commits to issuing grant and contribution payments within 30 business days after receipt and approval of required documentation, with a target of meeting the standard in 85% of cases. Health Canada publishes similar standards and historical performance results for relevant programs.

This is stronger desk evidence than was identified for Australia and provides a concrete performance benchmark. However, the standard begins only after the required documentation is received and approved. It does not establish:

- how long assessment and approval take;
- how quickly agreements are executed;
- whether provincial agencies meet comparable standards;
- whether renewal decisions are issued early enough;
- how often recipients experience funding gaps; or
- whether late payments trigger compensation.

The 85% target also means the standard is not expected to be achieved universally.

Score rationale: Published payment standards and performance reporting support a score of 2, but system-wide reliability across federal, provincial and regional funding is not demonstrated.

5. Equity and inclusion — Score: 3/3

Canada's framework contains extensive targeted support for:

- First Nations;
- Inuit;
- Métis communities;
- official-language minority communities;
- people with disability;
- rural and remote populations;
- people affected by substance-use harms;
- young people;
- older adults; and
- communities experiencing health inequities.

Indigenous Services Canada operates dedicated funding programs for Indigenous and northern communities and organisations. Recent federal investment included nearly CAD$1.4 billion for urban Indigenous services, mental-health and trauma supports, and assisted living on reserve.

The Official Languages Health Program provides a separate mechanism addressing access for official-language minority communities. Mental-health promotion programs explicitly prioritise groups susceptible to inequity.

The score reflects formal framework design, not a finding that inequities have been eliminated or that Indigenous and rural organisations experience equal administrative access.

Score rationale: Equity-oriented funding is broad, visible and embedded across multiple major federal portfolios and population-specific programs.

6. Proportional accountability — Score: 2/3

The federal Policy and Directive on Transfer Payments provide a formal framework for grants and contributions. The directive expressly permits a measured response to risk throughout the transfer-payment lifecycle. Federal recipient-audit guidance similarly supports risk-informed oversight.

This is an important strength because it allows departments to adjust:

- monitoring;
- reporting;
- payment arrangements;
- audit activity; and
- control requirements according to recipient and program risk.

The annual T3010 creates a consistent charity-reporting mechanism, and online filing improves efficiency. However, Canada does not appear to use a simple charity-size reporting tier system equivalent to New Zealand's four financial-reporting tiers. CRA guidance recommends professionally audited financial statements for charities with income over CAD$250,000, but this is not the same as a comprehensive risk-tiered statutory framework.

Recipients may also face cumulative reporting to:

- the CRA;
- a federal department;
- a provincial ministry;
- a regional health authority;
- an evaluator; and
- additional project funders.

Score rationale: Risk-based federal principles are strong, but cumulative reporting and jurisdictional duplication prevent the highest score.

7. Operational enablement — Score: 2/3

Canada has significant enabling infrastructure:

- the CRA Charities Directorate;
- a searchable charity register;
- federal funding portals;
- Health Canada and PHAC opportunity pages;
- the Open Government grants database;
- Grants and Contributions Online Services;
- CanadaBuys;
- Procurement Assistance Canada;
- provincial transfer-payment portals;
- Indigenous funding navigation; and
- community-research partnership programs.

The framework supports organisations to identify funding, apply, manage agreements, bid for contracts and verify public awards.

The system is less comprehensive in relation to:

- common NGO service agreements;
- integrated national referral pathways;
- routine access to health data;
- shared back-office infrastructure;
- standardised provincial commissioning;
- broad fiscal-host arrangements; and
- health-charity-specific procurement preferences.

Health services are largely administered provincially, meaning integration opportunities depend heavily on location and program type.

Score rationale: Strong federal and provincial enabling tools exist, but they do not form a single coherent national NGO-support system.

Evidence gaps

Evidence gap	Why it matters
Total government funding received specifically by health charities	Federal disclosure cannot easily isolate the complete health-charity sector
Provincial and territorial health-NGO spending	Needed to assess the largest service-delivery funding layer
Percentage of agreements that provide core funding	Distinguishes organisational support from activity purchasing
Percentage of health agreements lasting three or more years	Indicates continuity and workforce stability
Treatment of inflation and wage increases	Determines whether agreement value is maintained
Standard approach to indirect costs	Needed to assess true full-cost recovery
Average application assessment time	Published payment standards start after approval
Average contract execution time	Important for service commencement
Percentage of payments meeting standards	Some program performance is reported, but not comprehensively across government
Provincial payment standards	Needed for a fair federal-system comparison
Frequency of renewal gaps	Indicates reliability and cash-flow exposure
Application success rates by organisation size	Needed to test practical accessibility
Funding access for Indigenous organisations compared with mainstream organisations	Needed to assess implementation of equity mechanisms
Administrative cost of federal and provincial compliance	Needed for an objective burden measure
Access to provincial health-data systems	Determines real operational integration
Use of common service agreements	Could reduce duplication across departments and health authorities
Government-backed finance for general health charities	No broad national facility was located
Import concessions	No broad health-charity instrument was identified

Policy interpretation

Canada's framework is best characterised as a federally regulated and tax-supported charity system combined with provincially delivered health-service commissioning**.**

Its principal strengths are:

1. comprehensive federal grant and contract disclosure;
2. central charity regulation and public financial reporting;
3. strong federal and provincial donor tax credits;
4. GST/HST rebates for charities and health bodies;
5. health-specific grant and contribution programs;
6. published Health Canada and PHAC payment standards;
7. formal risk-based transfer-payment rules;
8. substantial Indigenous health and community funding;
9. federal procurement assistance; and
10. provincial transfer-payment infrastructure.

Its principal vulnerabilities are:

1. fragmented federal and provincial access;
2. restricted rather than unrestricted funding;
3. inconsistent indirect-cost recovery;
4. limited evidence on indexation and renewals;
5. substantial application and reporting requirements;
6. variable provincial health-system integration;
7. no single national NGO commissioning framework;
8. limited common infrastructure or data access; and
9. weak nationwide evidence on actual payment performance.

Country fiche conclusion

Canada provides an extensive government-support environment for health charities and NGOs through federal grants, provincial service agreements, Indigenous health funding, tax concessions, donor credits, GST/HST rebates, procurement access and community-sector programs.

Its strongest features are transparency, targeted equity mechanisms, published health-funding payment standards and formal risk-based transfer-payment administration.

Its central weakness is fragmentation. Health charities may need to navigate the CRA, several federal departments, provincial ministries, regional health systems and different grant or procurement portals. Most support remains tied to projects, services and government-defined outcomes, while core funding, indirect-cost recovery and renewal reliability are not consistently guaranteed.

Desk score: 16/21, or 2.29/3. Canada is therefore classified as having a developed, transparent and equity-oriented but federally fragmented government-support framework**.** Its most transferable lesson is the use of published payment service standards and performance targets for health grants and contributions.

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Singapore

Amplify Impact: Patient Organisation Sustainability & Health Equity

08

Singapore country audit

Audit parameters

Field	Singapore audit specification
Jurisdiction	Singapore
Primary unit	National government support framework
Subnational treatment	Not applicable in the same form as Australia, Canada, the United States or the UK; Singapore is a city-state without state or provincial governments
Organisations in scope	Registered health charities, Institutions of a Public Character, social service agencies, community-care organisations, patient organisations, disability organisations, hospices, voluntary welfare organisations and other nonprofit health and social-care providers
Evidence standard	Publicly accessible and independently verifiable government or government-agency sources
Scoring basis	Desk evidence only; scores assess the documented framework rather than every organisation's experience
Health-system context	National policy and funding are administered through bodies including the Ministry of Health, Ministry of Social and Family Development, Ministry of Culture, Community and Youth, Agency for Integrated Care, National Council of Social Service, Health Promotion Board and Tote Board
Terminology note	"Social service agency" is now commonly used in government programs where "voluntary welfare organisation" was used historically

Overall finding

Singapore has a highly coordinated, capability-focused and operationally enabling support framework for health charities, community-care organisations and social service agencies.

Government support is delivered through:

- health and community-care service funding;
- operating subsidies for eligible care providers;
- government matching of charitable donations;
- fundraising matching programs;
- organisational-development grants;
- workforce and training subsidies;
- digital-transformation funding;
- governance and consultancy grants;
- shared-services and collaboration grants;
- charity tax exemptions;
- enhanced donor tax deductions;
- central charity and grant portals;
- public procurement infrastructure; and
- structured support for community-care integration.

Singapore's most distinctive feature is the extent to which government funds institutional capability, rather than limiting support to individual service projects. The Charities Capability Fund supports training, consultancy, shared services, information and communications technology, and collaboration. NCSS separately supports organisational development, digitalisation, volunteer management, strategic planning and workforce development.

The health and community-care system also has mature funding relationships with nonprofit providers. The Ministry of Health and Agency for Integrated Care work with community-care organisations delivering nursing-home, home-care, hospice, rehabilitation and other intermediate and long-term care services. Government mechanisms include operating subsidies, training grants, digital-transformation support and donation matching through the Community Silver Trust.

The framework's principal strengths are:

- central coordination;
- substantial capability-building support;
- strong digital infrastructure;
- significant donor incentives;
- health-sector integration;
- structured governance guidance;
- proportionate elements in charity reporting; and
- low fragmentation compared with federal systems.

Its principal limitations are:

- limited evidence of broadly available unrestricted funding;
- funding concentrated among registered, eligible and government-aligned providers;
- stronger support for service delivery than independent advocacy;
- no universal indirect-cost or overhead rate;
- limited public evidence on payment timeliness;
- incomplete evidence on contract duration, renewal and indexation;
- substantial governance requirements for IPCs;
- different eligibility pathways for charities, IPCs, NCSS members and licensed community-care providers; and
- comparatively limited public recipient-level data linking all grants, contracts and service subsidies.

Singapore should therefore be characterised as coherent and enabling, but selective and strongly structured around government-recognised service and capability priorities**.**

Instrument matrix

A. Direct financial support

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-SG-01	Ministry of Health community-care operating subsidies	National	Government funds or subsidises eligible nonprofit and other approved providers delivering nursing-home, community-hospital, rehabilitation, home-care, hospice and related services.	Strong evidence of embedded service financing, though current provider-level terms are not consolidated publicly.
DF-SG-02	ElderCare Fund	National	Endowment income was established to finance operating subsidies for nursing homes run by voluntary welfare organisations.	Strong standing example of operating support for nonprofit health providers.
DF-SG-03	Agency for Integrated Care grant administration	National	AIC administers grants and financial-support mechanisms for the community-care sector and maintains a Grants Division responsible for grant management and disbursement.	Strong institutional evidence.
DF-SG-04	Community Silver Trust	National	Government provides dollar-for-dollar matching for eligible donations to social service agencies in the community-care sector to enhance services and capability. It is managed by MOH and administered by AIC.	Strong health-specific fundraising and capability mechanism.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-SG-05	Community Care Training Grant	National	Provides training subsidies to eligible community-care organisations for relevant courses, seminars, workshops and professional development not otherwise offered through appointed training providers.	Strong workforce-development instrument.
DF-SG-06	Community Care Digital Transformation Plan support	National	Supports eligible Singapore-based community-care providers undertaking qualifying digital-transformation projects in line with MOH licensing or service requirements.	Strong sector-specific digital-capability instrument.
DF-SG-07	AIC FUN! Fund	National/partner-administered	Supports initiatives improving the wellbeing of older people receiving community-care services and builds organisational capability to design effective programs.	Strong targeted innovation and capability funding.
DF-SG-08	Government-funded home and community medical services	National	Government funding has historically been extended to approved nonprofit home-medical and home-nursing providers.	Strong evidence of service commissioning, although some available public documentation is historical.
DF-SG-09	Government-funded palliative and long-term care partnerships	National	MOH works with voluntary welfare organisation operators in aged care and palliative care and provides patient subsidies through participating services.	Strong but program-specific.
DF-SG-10	NCSS organisation-development grants	National	NCSS provides grants and schemes for capability building, digitalisation, volunteer management and strategic planning among eligible social service agencies.	Strong institutional-capacity support.
DF-SG-11	Transformation Sustainability Scheme	National	Supports social service agencies to strengthen organisational capabilities and improve service delivery, with published eligibility, grant quantum and performance requirements.	Strong current organisational-development instrument.
DF-SG-12	NCSS people-development schemes	National	Supports skills, professional capability and workforce development within social service agencies.	Strong workforce support.
DF-SG-13	Social Service Institute training subsidies	National	Eligible participants can receive substantial subsidies for short courses and academic programs relevant to the social service sector.	Strong professional-development mechanism.
DF-SG-14	Charities Capability Fund Training Grant	National	Subsidises training that strengthens charity governance and management capability.	Strong general capability mechanism.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-SG-15	Charities Capability Fund Consultancy Grant	National	Supports eligible consultancy engagements intended to improve governance, management or organisational systems.	Strong direct organisational-support instrument.
DF-SG-16	Charities Capability Fund Shared Services Grant	National	Supports shared services intended to improve productivity and reduce duplicated administrative costs.	Strong infrastructure and efficiency mechanism.
DF-SG-17	Charities Capability Fund ICT Grant	National	Supports information and communications technology adoption and improvement by charities and IPCs.	Strong digital-capability mechanism.
DF-SG-18	Charities Capability Fund Collaboration Grant	National	Supports collaboration between charities to reduce duplication and strengthen collective capability. The grant was extended through the end of FY2026.	Strong collaborative-support mechanism.
DF-SG-19	Tote Board Enhanced Fundraising Programme	National	Provides matching support for eligible fundraising projects serving underserved communities.	Strong fundraising-leverage mechanism.
DF-SG-20	Enhanced Fundraising Programme 2025–2027 extension	National	A S$270 million top-up supported a three-year extension, with dollar-for-dollar matching in FY2025 and adjusted matching ratios thereafter.	Strong current evidence of large-scale fundraising support, although access is conditional.
DF-SG-21	Tote Board grants	National	Tote Board provides grants across social, community and other public-benefit priorities, with applications submitted through the national grants infrastructure.	Broad and material, although not limited to health charities.
DF-SG-22	OurSG Grants-listed social-good funds	National	Government and public-sector grants for social-good activities are brought together on a central portal.	Strong opportunity infrastructure; program coverage varies.
DF-SG-23	Health Promotion Board partnership grants	National	Health-promotion grants support eligible organisations and partners delivering prevention and health-promotion activities.	Material health-specific funding route; instrument details vary by call.
DF-SG-24	Community Chest funding	National/sector intermediary	Community Chest raises and allocates funds to social service programs and agencies, complementing direct government support.	Material sector funding pathway; not wholly government-originated funding.
DF-SG-25	Disability-sector service and capability funding	National	Eligible disability organisations and social service agencies receive program, service and capability support through government-linked bodies including NCSS and SG Enable.	Material but distributed across programs.

Code	Instrument	Level	Description and health-sector relevance	Evidence assessment
DF-SG-26	Research and innovation funding	National	Health charities, community-care providers and partner institutions may participate in health, ageing, social-service and care-model research or innovation grants.	Strong for eligible partnerships; not general operating support.
DF-SG-27	COVID-19 charity and self-help-group support	National	Government provided additional funding support to charities and self-help groups during the COVID-19 pandemic.	Demonstrates emergency support capacity.
DF-SG-28	Matching support introduced during COVID-19	National	Tote Board established enhanced fundraising support during the pandemic, including digital fundraising and increased matching contributions.	Strong historical emergency-resilience instrument.
DF-SG-29	Direct funding through government service agreements	National	Ministries and statutory boards can fund eligible charities and social service agencies to deliver defined health, disability, ageing and community services.	Strong in practice, but public agreement-level data are fragmented.
DF-SG-30	Capital and facility support	National/program-specific	Selected care providers may receive capital, equipment or facility-related assistance through health and social-service development schemes.	Material, but no general entitlement for all health charities was identified.

Direct financial support assessment

Singapore has a broad and unusually structured direct-support environment. It combines:

- purchased health and community-care services;
- operating subsidies;
- donation matching;
- fundraising matching;
- organisational-development grants;
- workforce funding;
- digital-transformation support;
- collaborative grants; and
- targeted innovation funding.

The strongest evidence of continuing operational support is concentrated in organisations that are already part of recognised care-delivery systems. MOH and AIC work with community-care and voluntary welfare organisation providers operating nursing homes, community hospitals, home care, rehabilitation and palliative-care services. Government subsidies support service affordability, while separate grants improve workforce and digital capability.

Singapore also differs from the other countries in the degree to which organisational development is broken into specific, fundable components. The Charities Capability Fund separately recognises training, consultancy, shared services, technology and collaboration. NCSS maintains additional organisation- and people-development schemes.

However, most support is still conditional on one or more of the following:

- charity or IPC status;
- NCSS membership or social service agency status;
- community-care provider eligibility;
- service licensing or recognition;
- alignment with government priorities;

- approved project expenditure;
- matching fundraising;
- achievement of key performance indicators; or
- participation in designated service systems.

The audit did not identify a general right for an independent patient or advocacy charity to receive unrestricted institutional funding. Core support exists indirectly through capability and shared-service grants, and through operating subsidies for recognised service providers, but it is not universally available.

Indirect financial support

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-SG-01	Automatic income-tax exemption for registered charities	National	Registered charities receive automatic income-tax exemption and generally do not need to file income-tax returns.	Strong national fiscal instrument.
IF-SG-02	Property-tax exemption for charitable premises	National	Registered charities can receive property-tax exemption for premises used exclusively for charitable purposes.	Strong operating-cost concession.
IF-SG-03	IPC donor tax deduction	National	Cash donations to approved Institutions of a Public Character for local community causes are tax deductible for individual and corporate donors.	Strong donor incentive; not available for donations to every registered charity.
IF-SG-04	250% donation tax deduction	National	Qualifying donations to approved IPCs and qualifying grant makers attract a 250% tax deduction under the applicable scheme period.	Exceptionally strong donor incentive.
IF-SG-05	Qualifying Grantmaker tax-deduction scheme	National	Donors to registered qualifying grant makers can receive the enhanced deduction where donations are intended for IPCs.	Strong philanthropic intermediary mechanism.
IF-SG-06	Stamp-duty remission for property or share donations	National	Donations of eligible property or shares to an IPC may qualify for stamp-duty remission.	Strong but specialised support for non-cash giving.
IF-SG-07	GST treatment of pure donations	National	Certain donations to registered charities or IPCs are treated as pure donations and do not require the recipient to account for GST, even where a qualifying benefit is provided.	Useful concession, subject to conditions.
IF-SG-08	Matching of private donations through Community Silver Trust	National	Government matches eligible donations to community-care social service agencies, increasing the value of private giving.	Strong blended public–philanthropic instrument.

Code	Instrument	Level	Description and relevance	Evidence assessment
IF-SG-09	Enhanced Fundraising Programme matching	National	Tote Board adds public matching support to qualifying fundraising campaigns.	Strong donor-leverage mechanism.
IF-SG-10	Free access to OurSG Grants	National	Organisations can search and apply for listed government grants through a central public portal.	Strong administrative facilitation.
IF-SG-11	Free access to Charity Portal	National	Charity registration, annual submissions, governance information and public charity searches are administered digitally through the Charity Portal.	Strong administrative infrastructure.
IF-SG-12	Training subsidies	National	Eligible social-service professionals can receive subsidies of up to 90% for specified training and academic programs.	Strong indirect workforce subsidy.
IF-SG-13	Shared-services subsidies	National	Charities can obtain support to share administrative or specialist services, reducing duplicated operating costs.	Strong operating-cost support.
IF-SG-14	ICT adoption subsidies	National	Technology and digital-transformation grants reduce the cost of adopting eligible systems.	Strong operational subsidy.
IF-SG-15	Consultancy subsidies	National	Eligible charities can receive funding toward professional consultancy intended to improve governance or management.	Strong capability subsidy.
IF-SG-16	Government-backed social finance	National/program-specific	Social enterprises and selected nonprofit initiatives may access blended or enterprise-oriented funds, but no universal loan or guarantee facility specifically for health charities was identified.	Partial and selective.
IF-SG-17	Indirect-cost recovery	National/program-specific	Administrative and capability costs can be funded under particular grants, but no universal minimum overhead rate applying across government health and charity funding was identified.	Important evidence gap.
IF-SG-18	Import and customs concessions	National	No broad, standing customs or import-concession system specifically for ordinary domestic health charities was identified.	Evidence gap.
IF-SG-19	Fee waivers	National	Digital government registration and grant systems reduce transaction costs, but no comprehensive health-charity fee-waiver framework was identified.	Partial.
IF-SG-20	Public procurement opportunity access	National	Registered local organisations can participate in government procurement through GeBIZ using their Unique Entity Number and Corppass access.	Strong formal access, though not charity-specific.

Indirect financial support assessment

Singapore provides a strong indirect-support package centred on:

- automatic charity income-tax exemption;
- charitable property-tax exemption;
- enhanced donation deductions for IPCs;
- GST treatment of qualifying donations;
- donation matching;
- fundraising matching;
- workforce subsidies;
- shared-services support; and
- technology and consultancy grants.

The 250% tax deduction for qualifying donations to IPCs and qualifying grant makers is a particularly strong incentive. However, the benefit is linked to IPC status: donations to a registered charity that is not an approved IPC are not automatically tax deductible.

This creates a two-level charity environment:

1. registered charities receive tax exemption and regulatory recognition; and
2. approved IPCs receive additional fundraising advantages but are subject to stronger governance and public-benefit requirements.

Singapore is also unusual because capability grants operate as indirect financial relief. A charity that receives support for shared services, technology, consultancy or staff training avoids costs that would otherwise need to be covered from unrestricted revenue.

The main comparative weakness is the absence of a general full-cost-recovery rule. The United States has a formal federal indirect-cost mechanism, while Singapore appears to deal with organisational costs through targeted capability schemes and program-specific budgets rather than a government-wide overhead entitlement.

Operational support

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-SG-01	Commissioner of Charities	National	Provides national charity oversight, registration and regulatory administration.	Strong central regulatory infrastructure.
OS-SG-02	Sector administrators	National	Charity oversight is distributed by charitable sector, with health and social-service organisations supported or supervised through relevant sector-administration structures.	Strong specialised structure, although applicants must identify the correct pathway.
OS-SG-03	Charity Portal	National	Provides registration, annual submissions, governance resources, public searches and fundraising information.	Strong single-sector portal.
OS-SG-04	Public charity and IPC search	National	The Charity Portal allows the public to search registered charities, IPCs and fundraising information, including by health and social-welfare sector.	Strong transparency infrastructure.
OS-SG-05	Registration criteria and guidance	National	Detailed public criteria cover charitable purpose, legal structure, governing board	Strong procedural transparency.

Code	Instrument	Level	Description and relevance	Evidence assessment
			members and registration conditions.	
OS-SG-06	Starter kit and guidance templates	National	The regulator publishes starter materials, annual-report templates, accounting guidance and other operational resources.	Strong capacity-building support.
OS-SG-07	Annual submission framework	National	Charities submit annual reports and financial statements according to statutory requirements, with revised audit thresholds intended to provide greater flexibility.	Strong accountability framework.
OS-SG-08	Scaled audit requirements	National	External scrutiny requirements vary according to charity size and structure; lower-income non-IPC charities may use independent examination rather than a full public-accountant audit.	Strong proportionality mechanism.
OS-SG-09	Governance Evaluation Checklist exemption for very small charities	National	Non-IPC charities below S$50,000 in gross annual receipts or total expenditure are excluded from mandatory checklist submission.	Strong small-charity proportionality measure.
OS-SG-10	Tiered Code of Governance	National	Governance requirements are divided into tiers according to IPC status and organisational size, with Tier 2 applying to all IPCs and large non-IPC charities.	Strong formal proportionality in design.
OS-SG-11	Public Governance Evaluation Checklist	National	Required charities submit a governance self-evaluation online and the checklist is made publicly available.	Strong transparency and self-assessment mechanism.
OS-SG-12	Simplified annual-submission exceptions	National	Certain smaller non-IPC charities are exempt from additional online financial-summary and governance-checklist requirements.	Strong targeted simplification.
OS-SG-13	Charity governance and transparency awards	National	Awards recognise charities demonstrating high standards of governance and transparency and promote sector-wide good practice.	Strong developmental rather than solely punitive regulatory approach.
OS-SG-14	Charities Capability Fund	National	Provides a dedicated operational-development architecture covering training, consultancy, shared services, ICT and collaboration.	Exceptional operational support.
OS-SG-15	NCSS sector-development role	National	NCSS operates as a sector developer, not only a membership body, supporting collaboration and stronger organisational capability.	Strong sector-development structure.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-SG-16	NCSS organisation-development suite	National	Provides structured support in digitalisation, strategic planning, volunteer management and organisational capability.	Exceptional operational enablement.
OS-SG-17	NCSS people-development suite	National	Supports professional skills and workforce development within eligible social service agencies.	Strong workforce infrastructure.
OS-SG-18	Social Service Institute	National	Provides professional education, sector knowledge and subsidised training.	Strong capacity-building infrastructure.
OS-SG-19	OurSG Grants	National	Consolidates government grants for social good, community, arts, heritage, sports and youth into one portal.	Strong whole-of-government grant-discovery and application mechanism, although it does not necessarily contain every health service contract.
OS-SG-20	GeBIZ	National	One-stop national e-procurement platform through which suppliers can identify and bid for government opportunities.	Strong procurement infrastructure.
OS-SG-21	Government procurement guidance	National	MOF publishes supplier guidance on procurement rules, participation and bidding. Procurement is decentralised to agencies but governed by central guidelines.	Strong formal access and consistency mechanism.
OS-SG-22	AIC partner portal and sector systems	National	AIC provides provider portals, training, partner resources and sector-specific systems for community-care organisations.	Strong health-operational infrastructure.
OS-SG-23	Community-care digital transformation framework	National	AIC supports qualifying care organisations in digital adoption and specifies project-evaluation and application processes.	Strong health-sector digital enablement.
OS-SG-24	Community-care workforce development	National	AIC and NCSS provide training grants and sector-development mechanisms for staff working in care and social services.	Strong workforce enablement.
OS-SG-25	Health and community-care partnership	National	MOH and AIC integrate nonprofit providers into aged care, long-term care, rehabilitation, palliative care and home-based services.	Strong service-system integration.
OS-SG-26	Fundraising disclosure regime	National	Public fundraising appeals are subject to disclosure and recordkeeping requirements through the Charity Portal, while a separate audited statement for each appeal is no longer required under the newer disclosure regime.	Strong transparency with some streamlining.

Code	Instrument	Level	Description and relevance	Evidence assessment
OS-SG-27	IPC donation-data submission	National	IPCs submit tax-deductible donation records annually through a digital government service.	Strong donor-tax integration but additional IPC compliance.
OS-SG-28	Public trust and safer-giving infrastructure	National	The Charity Portal provides public verification and safer-giving guidance.	Strong trust infrastructure.
OS-SG-29	Collaboration funding	National	Charities can obtain grants to collaborate, reduce duplication and share capability.	Strong sector coordination.
OS-SG-30	Shared-services infrastructure	National	Government support can fund shared administrative and specialist services among charities.	Strong operational-cost and efficiency support.
OS-SG-31	Volunteer-development support	National	NCSS organisational-development schemes include volunteer-management capability.	Strong support for a core nonprofit resource.
OS-SG-32	Health-data and referral integration	National/program-specific	Community-care providers participate in AIC and health-system referral and provider systems, but no universal data-access entitlement for all health charities was identified.	Strong for recognised providers; limited for independent patient organisations.
OS-SG-33	Shared public facilities	National/program-specific	Some contracted community-care organisations operate in government-supported or purpose-developed facilities, but no universal entitlement for health charities to government premises was identified.	Partial.
OS-SG-34	Payment and invoicing infrastructure	National	Government suppliers use digital procurement and invoicing arrangements, but a publicly documented health-charity-specific payment standard was not identified.	Infrastructure present; performance evidence limited.
OS-SG-35	Import facilitation	National	No dedicated expedited-import system for ordinary health charities was identified.	Evidence gap.

Instrument coverage summary

Taxonomy group	Coverage	Overall assessment
Direct grants	Broad	Numerous capability, fundraising, workforce and project mechanisms
Health-service commissioning	Strong	Nonprofit providers are integrated into community and long-term care
Operating subsidies	Strong for eligible providers	Particularly visible in nursing-home and community-care systems
Core or unrestricted funding	Limited–moderate	Capability and shared-service grants support core functions, but unrestricted institutional funding is not universal
Multi-year funding	Moderate	Some ongoing and extended schemes exist, but contract-duration data are limited

Taxonomy group	Coverage	Overall assessment
Emergency support	Demonstrated	Government and Tote Board expanded support during COVID-19
Tax concessions	Strong	Automatic income-tax exemption and charitable property relief
Donor incentives	Very strong	250% deduction for eligible donations to IPCs and qualifying grant makers
Donation matching	Very strong	Community Silver Trust and Enhanced Fundraising Programme
Indirect-cost recovery	Limited–moderate	Organisational costs are fundable in specific schemes; no universal rate
Registration facilitation	Strong	Central Charity Portal and detailed guidance
Grant discoverability	Strong	OurSG Grants provides a central government portal
Procurement access	Strong	GeBIZ is a national e-procurement platform
Governance support	Very strong	Tiered code, templates, checklists, awards and consultancy grants
Workforce development	Very strong	AIC, NCSS and Social Service Institute schemes
Digital transformation	Very strong	Charity and community-care-specific ICT support
Collaboration and shared services	Very strong	Explicit grants support collaboration and shared infrastructure
Health-system integration	Strong for recognised providers	Less clear for independent advocacy and patient organisations
Equity and inclusion	Strong	Funding is targeted to disability, ageing, vulnerable and underserved communities
Government-backed finance	Limited	No broad health-charity loan or guarantee facility identified
Import facilitation	Limited/not identified	No general health-charity mechanism identified

Singapore scorecard

Scoring table

Dimension	Score	Summary
1. Transparency	**3 – Comprehensive**	Central charity, grant and procurement portals provide strong public information
2. Accessibility/administrative burden	**2 – Established but uneven**	Systems are centralised and digital, but eligibility layers and IPC/provider requirements remain material
3. Funding quality	**2 – Established but uneven**	Strong operating and capability support exists, but unrestricted funding and universal full-cost recovery do not
4. Timeliness and reliability	**2 – Established but uneven**	Funding institutions are stable and digitally administered, but public payment and renewal performance data are limited
5. Equity and inclusion	**3 – Comprehensive in framework design**	Extensive mechanisms support ageing, disability, community care and underserved populations
6. Proportional accountability	**3 – Comprehensive in framework design**	Tiered governance, scaled audit requirements and small-charity exemptions are clearly established
7. Operational enablement	**3 – Comprehensive**	Capability, digital, workforce, collaboration and community-care infrastructure are exceptionally strong
Total	**18/21**	**A highly coordinated, capability-focused and operationally enabling framework**
Mean	**2.57/3**	—

1. Transparency — Score: 3/3

Singapore has strong national transparency infrastructure.

The Charity Portal combines:

- charity and IPC searches;
- registration information;
- annual-submission requirements;
- governance guidance;
- fundraising disclosures;
- publications; and
- public governance information.

Users can search organisations by sector, including health and social and welfare, and can verify charity or IPC status.

OurSG Grants consolidates government grant opportunities across several public-benefit sectors, while GeBIZ provides a one-stop government procurement portal.

The Code of Governance requires applicable charities to submit a Governance Evaluation Checklist, which is available for public viewing. Public fundraising appeals are also subject to disclosure requirements.

The principal transparency limitation is the absence of a single recipient-level database equivalent to Canada's federal grants portal or USA spending that consolidates:

- all charity grants;
- health-service contracts;
- provider subsidies;
- agreement duration;
- award amounts;
- recipient history; and
- payment status.

Nevertheless, the regulatory, opportunity and governance environment is sufficiently visible and desk-verifiable to support the highest score.

Score rationale: Public charity, governance, grant and procurement systems are comprehensive, centralised and searchable.

2. Accessibility and administrative burden — Score: 2/3

Singapore's unitary structure significantly reduces geographic and jurisdictional fragmentation.

Key access supports include:

- one national Charity Portal;
- one national procurement platform;
- the OurSG Grants portal;
- online donation reporting;
- detailed charity-registration guidance;
- sector-specific AIC and NCSS support; and
- subsidised training and consultancy. oursggrants.gov.sg

The system also funds organisations to build the very capabilities needed to apply for and manage public support. Training, consultancy, shared-service and ICT grants can reduce the disadvantage faced by organisations lacking specialist internal resources.

However, access is not uniform.

An organisation may need to establish or maintain:

- an eligible legal entity;
- registered charity status;
- IPC status for donor tax deductibility;
- NCSS eligibility or membership;
- community-care organisation status;
- relevant MOH licensing or service compliance;
- Corppass and a Unique Entity Number;
- program-specific key performance indicators;
- approved expenditure categories; and
- matching funds or fundraising performance.

For example, the community-care digital program requires a Singapore-based legal entity providing community-care services in line with MOH licensing or service requirements.

IPCs also face additional donation-reporting and governance requirements because of their tax-deductible fundraising privileges.

Independent patient organisations that do not deliver commissioned services, are not IPCs or do not qualify as NCSS-linked social service agencies may have access to fewer instruments.

Score rationale: Singapore offers unusually centralised and well-supported access, but status-based eligibility and program conditions remain substantial enough to prevent a score of 3.

3. Funding quality — Score: 2/3

Singapore has several strong funding-quality features.

First, eligible community-care organisations receive operating subsidies and continuing service support, rather than relying solely on small project grants.

Second, the government explicitly funds institutional capability through:

- training;
- consultancy;
- shared services;
- ICT;
- collaboration;
- workforce development; and
- digital transformation. Charity Portal

Third, donation-matching mechanisms can diversify organisational income and help providers build additional resources. The Community Silver Trust offers dollar-for-dollar matching to eligible community-care social service agencies, while the Enhanced Fundraising Programme provides matching support to eligible fundraising projects.

Fourth, some programs have multi-year continuity. The Enhanced Fundraising Programme received a planned three-year extension for 2025–2027, and the Charities Capability Fund Collaboration Grant was extended through FY2026.

However, the audit did not establish a universal policy requiring:

- unrestricted funding;
- full-cost recovery;
- a standard overhead percentage;
- automatic wage or inflation indexation;
- minimum contract duration;
- renewal notice periods;
- compensation for contract changes; or
- funding of organisational reserves.

Capability funding can cover important institutional costs, but it is generally tied to approved improvement activities rather than being fully discretionary operating income.

Score rationale: Singapore provides unusually strong capability and provider support, but the absence of universal unrestricted and full-cost funding prevents a score of 3.

4. Timeliness and reliability — Score: 2/3

Singapore's support system has several structural characteristics that promote reliability:

- stable national agencies;
- digital application systems;
- centralised grant portals;
- established health-provider relationships;
- ongoing community-care subsidies;
- formal grant-administration divisions; and
- multi-year extensions of major schemes.

AIC has a dedicated Grants Division responsible for grant management and disbursement, and Tote Board publishes application and claim processes for the Enhanced Fundraising Programme.

However, the audit did not identify a comprehensive public standard showing:

- maximum grant-assessment time;
- time from approval to agreement;
- time from claim to payment;
- percentage of payments made on time;
- late-payment interest;
- renewal-notice periods;
- frequency of delayed disbursement;
- contract-gap frequency; or
- provider-level continuity performance.

Digital administration and centralisation should not be treated as proof of timely payment.

Score rationale: Institutional continuity and clear administration support a score of 2, but the lack of published payment-performance evidence prevents a score of 3.

5. Equity and inclusion — Score: 3/3

Singapore's funding architecture is strongly focused on populations with defined health, care and social needs.

Government-supported agencies and providers serve:

- older people;
- people with disability;
- people requiring long-term or community care;
- family caregivers;
- people requiring palliative care;
- people with financial need;
- underserved communities; and
- individuals requiring integrated health and social support.

The Community Silver Trust supports agencies serving the community-care sector. AIC provides training and digital-transformation support to community-care organisations, while the Enhanced Fundraising Programme targets projects helping underserved communities.

MOH works with voluntary welfare organisation providers in aged care, nursing homes and palliative services, with public subsidies supporting affordability.

NCSS organisation- and people-development schemes strengthen agencies supporting groups with social and care needs.

The score reflects formal program design. It does not mean:

- all patient organisations have equal access;
- all population groups receive equivalent support;
- smaller advocacy organisations have equal influence; or
- government-defined priorities fully reflect every community's preferences.

Score rationale: Inclusion of ageing, disability, care dependency and underserved communities is embedded throughout major funding and capability systems.

6. Proportional accountability — Score: 3/3

Singapore has strong formal proportionality in charity governance and reporting.

Non-IPC charities below S$50,000 in gross annual receipts or total expenditure are excluded from mandatory Governance Evaluation Checklist submission.

The revised Code of Governance divides organisations into two principal tiers:

- Tier 1 for small and medium non-IPC charities; and
- Tier 2 for all IPCs and large non-IPC charities.

This scales governance expectations according to size and public-fundraising status.

Audit and examination requirements are also scaled. Smaller non-IPC charities may use independent examination, while larger charities and IPCs face stronger audit requirements.

Additional submission exceptions apply to certain smaller non-IPC organisations, including exemptions from the online financial summary and governance checklist.

The system's proportionality is not purely deregulatory. IPCs face higher expectations because they can issue tax-deductible receipts and receive enhanced public benefits. This is a defensible risk-and-privilege-based distinction, although it creates substantial compliance for organisations seeking IPC status.

Score rationale: Size thresholds, IPC distinctions, audit scaling and small-charity exemptions establish a clear and comprehensive proportional-accountability framework.

7. Operational enablement — Score: 3/3

Operational enablement is Singapore's strongest dimension.

The framework includes:

- a national charity regulator;
- a central Charity Portal;
- a central grants portal;
- national procurement infrastructure;
- governance templates;
- annual-report guidance;
- consultancy subsidies;
- training subsidies;
- shared-services funding;
- ICT grants;
- collaboration grants;
- digital-transformation support;
- workforce development;
- donation matching;
- fundraising matching;
- health-provider portals; and
- community-care integration.

The Charities Capability Fund is especially notable because it funds five distinct forms of organisational infrastructure rather than treating overhead as inherently non-charitable:

1. training;
2. consultancy;
3. shared services;
4. ICT; and
5. collaboration.

NCSS adds organisational development, strategic planning, digitalisation, volunteer management and people-development support.

AIC provides a parallel health-specific layer through community-care training, digital transformation, partner systems and grants administration.

The limitations are that these supports are not equally available to every health charity, and independent advocacy organisations may be less integrated into government systems than commissioned service providers.

Score rationale: Singapore provides one of the most comprehensive and explicit organisational-capability systems in the comparator group.

Evidence gaps

Evidence gap	Why it matters
Total annual government funding paid specifically to health charities and nonprofit providers	Needed to quantify sector scale and compare with other countries
Consolidated list of all health-charity grants and contracts	Existing portals do not fully combine service subsidies, grants and procurement
Percentage of funding that is unrestricted	Needed to distinguish organisational support from approved capability projects
Percentage of agreements lasting three years or more	Indicates stability and workforce security
Standard treatment of indirect costs	No universal overhead or full-cost-recovery rule was identified
Inflation and wage indexation	Important for labour-intensive community-care services
Grant decision times	Needed to assess actual access burden
Time from approval to agreement execution	Indicates mobilisation risk
Claim-to-payment performance	Digital systems do not establish actual payment speed
Late-payment protection	No health-charity-specific standard or compensation rule was identified
Renewal notice periods	Determines whether providers can plan staffing and service continuation
Application success rates	Needed to assess competitiveness and accessibility
Success rates by organisation size	Would show whether smaller organisations are disadvantaged
Access for non-IPC charities	Needed to assess the practical effect of the IPC distinction
Access for independent patient and advocacy organisations	Most visible support favours service and social-care providers
Full financial value of capability grants	Needed for comparison with service and project funding
Evaluation of shared-services savings	Would show whether collaboration support reduces overhead in practice
Access to health data and referral platforms	Appears strong for recognised providers but not universal
Public procurement participation by charities	Needed to determine whether formal GeBIZ access translates to awards
Government-backed finance	No comprehensive health-charity loan or guarantee scheme was identified
Infrastructure access	No national entitlement to facilities or shared premises was identified
Import and customs concessions	No general health-charity mechanism was identified

Policy interpretation

Singapore's framework is best characterised as a centrally coordinated service-and-capability partnership system.

It does not rely only on conventional competitive project grants. Instead, it combines:

- government-funded service delivery;
- operating subsidies;
- donation matching;
- tax-assisted fundraising;
- governance development;
- workforce training;
- digitalisation;
- shared services;
- collaboration support; and
- structured integration into community care.

Its principal strengths are:

1. a centralised national structure;
2. extensive organisational-capability funding;
3. explicit support for shared services;
4. strong digital-transformation support;
5. workforce and professional-development subsidies;
6. government donation matching;
7. enhanced donor tax deductions;
8. integrated community-care funding;
9. tiered governance and audit requirements;
10. national grant and procurement portals;
11. strong public-trust infrastructure; and
12. low intergovernmental fragmentation.

Its principal vulnerabilities are:

1. selective eligibility;
2. a strong distinction between ordinary charities and IPCs;
3. stronger support for providers than advocacy bodies;
4. limited broadly unrestricted funding;
5. no universal indirect-cost rate;
6. limited public payment-performance evidence;
7. limited data on contract length and renewal;
8. government-defined priorities shaping available support;
9. limited public recipient-level award consolidation; and
10. incomplete access to shared health systems for independent organisations.

Country fiche conclusion

Singapore provides a mature and highly coordinated support environment for health charities, social service agencies and community-care organisations.

Its framework combines:

- government-funded health and care delivery;
- operating subsidies;
- tax exemption;
- donor tax incentives;
- donation matching;
- fundraising matching;
- capability grants;
- workforce development;
- shared services;
- digital transformation;
- tiered governance; and
- national grant and procurement infrastructure.

The most distinctive feature is the explicit recognition that charities require institutional capability to deliver sustainable services. Government-linked schemes fund functions that are often treated elsewhere as unfundable overhead, including consultancy, technology, training, collaboration and shared administration.

Desk score: 18/21, or 2.57/3. The system is not universally accessible. The strongest support is generally available to organisations with recognised charity, IPC, social service agency or community-care provider status. Independent patient and advocacy organisations may not have access to the same service and capability pathways. Unrestricted funding, full-cost recovery, payment performance and renewal stability are also insufficiently documented.

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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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Self assessment

Amplify Impact: Patient Organisation Sustainability & Health Equity

10

Community-First Funding Self-Assessment Tool

A Best-Practice Assessment for Government Agencies, Program Administrators and Independent Funders

Purpose

This tool provides a rapid self-assessment of funding programs against international best practice in community-centred funding. It is designed for:

- Government departments
- Funding agencies
- Pharmaceutical companies
- Health departments
- Grant program managers
- Commissioning bodies
- Statutory authorities
- Foundations
- Philanthropic organisations
- Peak bodies
- Independent funding organisations

It can be completed for an individual funding program, a portfolio of programs or an entire organisation.

Estimated completion time: 20–30 minutes

How to score

For each statement, score:

Score	Description
0	No evidence or not in place
1	Limited evidence / applied inconsistently
2	Mostly in place
3	Fully embedded and routinely demonstrated

Domain 1. Community Leadership (Maximum = 18)

Statement	Score (0–3)
Communities are involved before funding priorities are determined.	
People with lived experience help design funding programs.	
Communities participate in funding allocation or assessment.	
Community members are represented in governance structures.	
Community feedback demonstrably changes funding decisions.	
Communities help evaluate funded programs.	

Subtotal: ____ /18

Domain 2. Equity (Maximum = 21)

Statement	Score (0–3)
Funding is allocated according to need rather than equal distribution.	
Small organisations have realistic opportunities to obtain funding.	
Grassroots organisations are actively supported.	
Rare diseases or small patient populations are recognised.	
Rural and remote communities are considered.	
Indigenous or First Nations organisations are appropriately supported.	
Culturally diverse communities are appropriately supported.	

Subtotal: ____ /21

Domain 3. Funding Quality (Maximum = 24)

Statement	Score (0–3)
Multi-year funding is available.	
Core operational funding is available where appropriate.	
Funding covers full costs of delivery.	
Reasonable indirect costs are funded.	
Organisations can adapt activities if community needs change.	
Funding supports innovation and service improvement.	
Funding agreements provide financial certainty.	
Payments occur on time.	

Subtotal: ____ /24

Domain 4. Organisational Sustainability (Maximum = 21)

Statement	Score (0–3)
Funding supports leadership development.	
Governance capability is supported.	
Workforce development is funded.	
Digital capability is supported.	
Evaluation capability is supported.	
Collaboration and partnerships are encouraged.	
Organisational resilience is recognised as an outcome.	

Subtotal: ____ /21

Domain 5. Accessibility (Maximum = 21)

Statement	Score
Application processes are easy to understand.	
Application requirements are proportionate to grant size.	
Technical support is available to applicants.	
Small grants have simplified application processes.	
Reporting requirements are proportionate.	
Existing information is reused rather than repeatedly requested.	
Decisions are communicated within published timeframes.	

Subtotal: ____ /21

Domain 6. Transparency & Accountability (Maximum = 21)

Statement	Score
Funding criteria are publicly available.	
Funding decisions are transparent.	
Reasons for decisions are provided where appropriate.	
Payment and decision timeframes are published.	
Outcomes are publicly reported.	
Community members can provide feedback or appeal decisions.	
The organisation evaluates its own funding processes.	

Subtotal: ____ /21

Domain 7. Community Impact (Maximum = 24)

Statement	Score
Funding addresses community-defined priorities.	
Community wellbeing is measured.	
Equity outcomes are measured.	
Organisational sustainability is measured.	
Community participation is measured.	
Partnerships are strengthened through funding.	
Funding reduces service gaps.	
Communities report that funding has improved outcomes.	

Subtotal: ____ /24

Total Score

Domain	Maximum	Score
Community Leadership	18	
Equity	21	
Funding Quality	24	
Organisational Sustainability	21	
Accessibility	21	
Transparency & Accountability	21	
Community Impact	24	

Overall Total: ____ /150

Interpretation

Score	Interpretation
135–150 (90–100%)	International leading practice. Community-centred funding is embedded across the program.
120–134 (80–89%)	Strong alignment with best practice, with relatively minor opportunities for improvement.
105–119 (70–79%)	Good program, although several areas would benefit from strengthening.
90–104 (60–69%)	Moderate alignment. Important reforms are likely to improve effectiveness and equity.
75–89 (50–59%)	Significant improvement required to better support community organisations.
Below 75 (<50%)	Major redesign recommended. The program is unlikely to meet contemporary best-practice standards for community-centred funding.

Quick Equity Check

Answer **Yes**, **Partly** or **No**.

Question	Response
Would a volunteer-run organisation have a realistic chance of obtaining funding?	
Could a newly established organisation compete successfully?	
Would an organisation supporting fewer than 500 people be competitive?	
Would a rare disease organisation be disadvantaged because of population size?	
Would an Indigenous community organisation have culturally appropriate access?	
Could an organisation without a professional grant writer apply successfully?	
Can organisations survive if grant payments are delayed?	
Does funding cover the real cost of delivering services?	
Are communities involved in deciding what gets funded?	
Does the program strengthen organisations rather than simply purchase services?	

If three or more answers are "No"**,** the program should undertake a detailed equity review

Reflection Questions

1. If this funding disappeared tomorrow, would the community infrastructure remain?
2. Are we funding projects, or are we investing in organisations that communities rely on?
3. Which organisations are least likely to receive funding under the current model?
4. Which communities are least likely to have their needs recognised?
5. Does our definition of "value for money" unintentionally disadvantage smaller or rare-condition organisations?
6. Are we measuring what matters to communities, or only what is easiest to count?

Priority Improvement Planner

After completing the assessment, identify the three highest-priority actions.

Priority	Action	Lead	Timeframe
1			
2			
3			

Guiding Principle

A community-first funding program does more than distribute money. It builds and sustains the organisations, relationships and capabilities that enable communities to identify their own priorities, participate in decisions and improve health and wellbeing over the long term. Programs should therefore be judged not only by the services they purchase, but also by whether they strengthen the community infrastructure on which equitable and effective health systems depend.