Section 02

Cross country evidence-barriers matrix

Cross-country barrier/constraint evidence matrix

This matrix consolidates the six-country secondary evidence review across Australia, United States, United Kingdom, India, Brazil and South Africa and aligns it with the operating domains already used in the attached Amplify Impact analysis. The original document identifies finance, IT, HR, CRM and communications as core domains and argues that the most persistent inefficiencies are concentrated in CRM, HR and IT.

The purpose here is not simply to identify whether a constraint exists, but to assess five questions systematically:

- Evidence strength: how directly and consistently the barrier is supported by existing evidence.
- Universality: how consistently the barrier appears across the six countries.
- Quantifiability: how readily it can be translated into measurable economic parameters.
- Shared-services suitability: how appropriate the function is for pooling, common infrastructure or centralised support.
- Remaining evidence gap: what still cannot be answered from secondary evidence.

Scoring framework

Score	Evidence strength	Universality	Quantifiability	Shared-services suitability
5	Multiple strong national datasets/reviews; highly consistent evidence	Appears across almost all six countries with similar underlying mechanism	Strong monetary/time/workforce parameters available	Strong economies of scale; low need for local relational delivery
4	Strong evidence but some indirectness or uneven country coverage	Common across most countries, with contextual variation	Several usable parameters but modelling assumptions required	Highly suitable, usually with some local configuration
3	Moderate or mainly sector-level evidence	Present in several countries but context matters substantially	Some measurable inputs, but important gaps	Hybrid/shared support likely preferable to full centralisation
2	Limited direct evidence	Strongly country- or organisation-dependent	Difficult to quantify reliably	Limited shared-service role

Score	Evidence strength	Universality	Quantifiability	Shared-services suitability
1	Little robust evidence	Primarily local/organisation specific	Not currently measurable	Should remain local

The scores are analytical ratings derived from the reviewed evidence, not survey-generated statistics.

1. Master cross-country constraint matrix

Domain / constraint	Evidence strength /5	Universality /5	Quantifiability /5	Shared-services suitability /5	Overall interpretation	Principal remaining gap
Financial fragility / inadequate operating margins	5	5	5	2	Fundamental structural condition affecting small organisations internationally	Patient-organisation-specific financial resilience by size
Underfunding of core / indirect costs	5	5	5	4	One of the strongest systemic drivers of underinvestment in infrastructure	Comparable indirect-cost ratios in Brazil and South Africa
Funding restrictions / short-term project funding	5	5	4	2	Repeatedly forces organisations to prioritise projects over institutional capability	Comparable grant-duration/restriction data across all countries
Small workforce / volunteer dependence	5	5	5	3	Creates limited internal specialist capacity and key-person dependency	Comparable volunteer administrative-hour data

Domain / constraint	Evidence strength /5	Universality /5	Quantifiability /5	Shared-services suitability /5	Overall interpretation	Principal remaining gap
HR administration and volunteer management	4	4	4	4	Repeated recruitment, onboarding, policies and recordkeeping create duplicate effort	Actual administrative hours and platform costs
IT infrastructure and support	5	5	4	5	One of the clearest candidates for pooled infrastructure	Market-cost modelling by country
Cybersecurity / privacy capability	4	5	3	5	Requirement increasingly exceeds what very small organisations can support independently	Comparable cyber maturity data outside Australia/UK/US
CRM / stakeholder data management	4	5	3	4	Likely major structural bottleneck, especially for patient organisations	Direct patient-organisation CRM architecture and duplication data
Data analytics / impact measurement	4	5	3	4	Skills, tools and reporting requirements repeatedly exceed internal capacity	Comparable measures of staff time and data-system expenditure
Duplicate data entry / reporting	4	5	4	5	Strong candidate for common platforms and reusable data	Current cross-country time-and-cost measures

Domain / constraint	Evidence strength /5	Universality /5	Quantifiability /5	Shared-services suitability /5	Overall interpretation	Principal remaining gap
Finance administration / bookkeeping	4	5	5	5	Highly standardisable transactional function	Legal/accounting configuration differs nationally
Grant application and acquittal administration	5	5	4	4	Large mission opportunity cost; partly shareable through systems/expertise	Direct measurement by patient organisations
Regulatory compliance	5	5	4	3	Universal burden but content is highly jurisdiction-specific	Costs by organisation size and regulatory regime
Governance support	4	4	2	3	Specialist advice/templates could be shared; governance authority should remain local	Direct evidence of governance capability in patient organisations
Communications technology/infrastructure	4	4	4	4	Technical infrastructure is shareable	Actual savings from shared platforms
Communications content / advocacy voice	4	5	2	1	Relational and cause-specific comparative advantage of patient groups	Not a priority evidence gap because centralisation is undesirable

Domain / constraint	Evidence strength /5	Universality /5	Quantifiability /5	Shared-services suitability /5	Overall interpretation	Principal remaining gap
Policy/advocacy capacity	4	4	2	1	Often crowded out by administrative burden but should remain organisation-led	Quantifying displaced advocacy activity
Knowledge management / succession	4	5	3	4	Volunteer turnover and key-person dependence create repeated loss of institutional knowledge	Comparable data on turnover and onboarding costs
Procurement / software licensing	3	5	5	5	Strong theoretical economies of scale	Actual existing licence inventories and negotiated savings
Mission opportunity cost	5	5	3	N/A	Strong evidence that administrative demands displace or constrain mission capacity	Avoid assuming 1 administrative hour = 1 patient-facing hour

This matrix strongly supports the central proposition in the attached report that high-system functions create the largest structural disadvantage for small organisations, whereas high-relational functions often represent their principal strength.

2. Country-by-country evidence-strength matrix

The next table scores the strength of the available secondary evidence, rather than the severity of the barrier itself.

Domain	Australia	US	UK	India	Brazil	South Africa
Financial fragility	5	5	5	5	4	5
Core/indirect-cost underfunding	5	5	4	5	3	4
Volunteer/workforce constraints	5	4	5	3	3	5
HR/volunteer management	4	4	4	3	2	4
IT/digital capability	5	4	5	4	3	4
Cybersecurity/privacy	5	4	4	3	2	3
CRM/data fragmentation	4	4	4	3	2	3
Data/impact capability	5	4	4	3	3	3
Reporting/compliance burden	5	5	5	5	4	5
Governance capability	4	4	4	3	3	4
Communications infrastructure	4	4	4	3	3	3
Mission opportunity cost	5	5	5	4	3	4
Shared-services precedent/evidence	4	4	5	4	3	3
Overall secondary-evidence maturity	5	5	5	4	3	4

Interpretation

The key methodological implication is that lower scores in Brazil and parts of India/South Africa should not be interpreted as evidence that the barrier is weaker. They usually indicate that the barrier is less directly measured.

3. Financial fragility and core-cost underfunding

Overall scores

Evidence strength 5 | Universality 5 | Quantifiability 5 | Shared-services relevance 4

This is probably the strongest cross-country constraint. In Australia, national charity and community-sector evidence demonstrates that a very large proportion of small organisations lack paid capacity and that administrative infrastructure cannot realistically be treated as optional expenditure. ACNC specifically notes that small charities cannot operate entirely without administration costs, while volunteer-run organisations are disproportionately exposed to regulatory burden (ACNC, 2025).

In the United States, Nonprofit Finance Fund's 2025 survey of 2,206 organisations found that 81% regarded raising funds sufficient to cover full costs as a challenge, 36% ended 2024 in deficit and 52% had no more than three months' cash available (Nonprofit Finance Fund [NFF], 2025).

The UK evidence similarly describes a "broken funding system" characterised by insufficient unrestricted and multi-year funding and disproportionate application processes affecting small organisations (National Council for Voluntary Organisations [NCVO], 2025).

India provides unusually strong quantitative evidence. Dasra's survey of 400 NGOs found that 72% reported a funding deficit, while only 22% had a corpus fund (Dasra, 2025). Bridgespan's separate survey of 388 NGOs documented chronic underfunding of organisational and indirect costs (Venkatachalam et al., 2021).

Brazilian evidence is less directly quantified but demonstrates longstanding difficulties financing institutional development and core capability rather than designated projects. GIFE data have similarly documented barriers to funding organisational development (GIFE, 2016).

Shared-services implication: This barrier does not itself become a shared service. Rather, it creates the economic rationale for shared services: if each organisation cannot adequately finance a complete administrative infrastructure, collective purchasing and infrastructure can lower the minimum cost of capability.

4. Workforce and volunteer dependence

Overall scores

Evidence strength 5 | Universality 5 | Quantifiability 5 | Shared-services suitability 3–4

The constraint is not volunteering itself. The issue is the mismatch between limited workforce depth and increasingly specialist organisational requirements. Australia provides the clearest measurement: 43% of charities are entirely volunteer-run, and these organisations disproportionately report regulatory and funding disadvantages (ACNC, 2025). UK research reaches essentially the same structural conclusion. Small organisations frequently rely on small teams or volunteers in which individuals simultaneously undertake fundraising, governance, compliance and operational functions (NCVO, 2025). Comparable mechanisms are evident in the US national nonprofit datasets, which explicitly measure staff, volunteers and organisational financial health across organisation size (Urban Institute, 2026).

Shared-services implication: Do not centralise volunteer relationships themselves. Share onboarding infrastructure, HR templates, training systems, policies, recordkeeping, checks and potentially payroll. Retain locally recruitment relationships, culture, volunteer leadership and community engagement.

Suitability score: 4 for HR infrastructure; 1–2 for relational volunteer management.

5. IT and digital infrastructure

Overall scores

Evidence strength 5 | Universality 5 | Quantifiability 4 | Shared-services suitability 5

This is one of the strongest candidates for shared services.

Australian Infoxchange evidence is particularly important because its 2025 survey included 824 NFPs and identifies persistent gaps in data, cyber, digital transformation and organisational digital foundations (Infoxchange, 2025). The problem is also evolving. Infoxchange reports that although technology adoption is expanding, capability and governance are not keeping pace; only 14% of surveyed organisations had an AI governance framework, while 25% identified insufficient data/analytics skills as their main data-capability barrier (Infoxchange, 2025).

The Australian sector is consequently now moving toward collective digital infrastructure, including the NFP Digital Futures initiative, whose stated objective is to build sector-wide digital capability and reduce administrative burden rather than requiring every organisation to develop capability independently.

The UK evidence reaches a similar conclusion, while NCVO identifies digital tools and practical operational support as areas that small organisations struggle to navigate independently (NCVO, 2025).

Shared-services rating: 5/5

Candidates include: cloud infrastructure; software procurement; technical support; cybersecurity; identity/access management; backup; standard integrations; website hosting; training; and common system configuration. These have relatively low relational dependence and strong economies of scale—precisely the profile predicted by the Operating Model Tension model in the attached report.

6. CRM and stakeholder data management

Overall scores

Evidence strength 4 | Universality 5 | Quantifiability 3 | Shared-services suitability 4

This requires a more careful conclusion than other domains.

Across patient organisations, CRM sits at the intersection of: patients and carers; donors; clinicians; researchers; policymakers; industry; volunteers; advocates; events; communications; and service delivery.

The independent literature strongly validates the component problems—data capability, technical skills, fragmented systems and reporting requirements—but national nonprofit datasets rarely ask specifically: "Do you operate a fragmented CRM?"

Australian evidence, for example, shows that data and reporting capability has become a leading priority while many organisations lack the systems, skills and resources needed to use data effectively (Infoxchange, 2026).

Consequently, the evidence rating should be 4 rather than 5. This is the single domain in which the project's existing 60-organisation desk analysis may provide genuinely useful additional empirical evidence rather than merely reproducing known sector findings.

Shared-services rating: 4/5

A shared CRM platform is highly plausible, but relationship ownership must remain local.

That implies: shared platform and standard data architecture and common security and local datasets/permissions and local stakeholder management.

7. Finance administration

Overall scores

Evidence strength 4 | Universality 5 | Quantifiability 5 | Shared-services suitability 5

Accounting itself is governed nationally, but much transactional finance activity is highly standardised: bookkeeping; expense processing; invoice management; payroll; reconciliations; budgeting templates; financial dashboards; grant-cost coding. Each small organisation independently procuring software, bookkeeping assistance and specialist advice creates a classic fixed-cost duplication problem.

The current report's economic model already identifies finance systems as low-relational/high-system functions particularly suited to sharing.

An important boundary is that financial governance cannot be outsourced. Boards remain responsible for their organisations. The service that can be shared is the infrastructure and processing capability, not organisational accountability.

8. Reporting, grant administration and regulatory compliance

Overall scores

Evidence strength 5 | Universality 5 | Quantifiability 4 | Shared-services suitability 3–5 depending on function

This is a universal burden but a good example of why "shared" does not always mean "global." NCVO describes funding applications and reporting as disproportionately burdensome for smaller organisations because of limited administrative capacity (NCVO, 2025). In the UK, government is actively increasing charity accounting thresholds in 2026 specifically to reduce costs and administrative effort for smaller charities (Department for Culture, Media and Sport, 2025).

Australia similarly identifies cumulative regulatory burden as disproportionately affecting small volunteer-run charities (ACNC, 2025). The US has responded to parallel problems through federal grant reforms and indirect-cost rules. India, Brazil and South Africa each have substantially different regulatory architectures, meaning the burden is universal but its content is not. Therefore, a way forward is to split the function.

Function	Shared-services suitability
Reporting platform/data reuse	5
Common templates	5
Grant opportunity tracking	5
Application/project-management tools	5
Grant-writing technical support	4
Regulatory alerts	4
Compliance interpretation	3
Legal accountability	1

9. Governance

Overall scores

Evidence strength 4 | Universality 4 | Quantifiability 2 | Shared-services suitability 3

Governance constraints are recurrent but should be framed carefully. There is a risk of incorrectly concluding that small organisation equal poor governance.

The evidence does not support that.

Smaller patient groups can have highly mission-aligned boards with strong lived-experience representation and rapid decision-making. The attached report explicitly recognises these advantages. The constraint arises in access to specialist capability, such as: finance; cybersecurity; data governance; legal interpretation; HR; risk management.

An appropriate shared model includes shared board templates; governance training; policy library; expert helpline; induction; risk tools; legal updates. What needs to remain local is board membership; fiduciary decisions; strategy; mission; community accountability.

Shared-services suitability: 3/5.

10. Communications

This domain needs to be split.

Communications infrastructure

Evidence strength 4 | Universality 4 | Quantifiability 4 | Shared-services suitability 4

Potential shared components include: web hosting; mailing technology; design templates; media monitoring; accessibility tools; analytics; platform support.

Communications content and advocacy voice

Evidence strength 4 | Universality 5 | Shared-services suitability 1

This is one of the clearest examples of something that should not be centralised.

Small patient organisations' local or condition-specific knowledge, trust and community credibility are precisely the capabilities that shared services should protect. The exception is where advocacy platforms are shared around common issues, however the identification of issues needs to be generated in the first instance, locally.

11. Mission opportunity cost

Scores

Evidence strength 5 | Universality 5 | Quantifiability 3

This is the conceptual endpoint of the matrix. The constraint is not that "administration is bad." Every organisation requires administration. The problem is avoidable duplication or excessive administrative demands consume financial and human resources that cannot then be allocated elsewhere.

NCVO's small-charity research explicitly observes that funding-search and application activity requires time and resources that could otherwise support service delivery (NCVO, 2025). US evidence demonstrates a comparable pressure: 81% of surveyed organisations report difficulty raising funds that meet full costs, while demand continues to rise (NFF, 2025).

India's funding evidence provides the same mechanism from another institutional context: programme funding that fails to support organisational infrastructure contributes to chronic financial stress (Venkatachalam et al., 2021).

The important measurement rule

Do not calculate: administration saved × patient-hours = patient impact.

Instead, quantify: released organisational capacity and separately describe how organisations could deploy that capacity. This will make the economic model much more defensible.

12. Shared-services priority matrix

Combining universality + evidence + quantifiability + shareability produces a practical prioritisation.

Function	Priority for shared-services model	Recommended model
IT infrastructure	Very high	Shared
Cybersecurity	Very high	Shared
Technical support	Very high	Shared
Software procurement/licensing	Very high	Shared
Finance transaction systems	Very high	Shared
CRM platform	Very high	Shared infrastructure/local relationships
Data infrastructure	Very high	Shared infrastructure/local ownership
Reporting/data reuse	Very high	Shared
HR administration	High	Shared
Volunteer onboarding systems	High	Shared tools/local management
Grant administration	High	Shared capability
Evaluation/impact infrastructure	High	Shared tools/expertise
Knowledge management	High	Shared platform
Governance support	Moderate	Shared advisory infrastructure
Compliance support	Moderate–high	Shared nationally/localised
Communications technology	Moderate–high	Shared
Communications content	Low	Local

Function	Priority for shared-services model	Recommended model
Patient support	Very low	Local
Advocacy voice	Very low	Local
Community relationships	Very low	Local
Strategic priorities	Very low	Local

13. Global versus nationally localisable architecture

The matrix suggests three rather than two levels.

Level 1 globally shareable infrastructure

These have strong commonality across all six countries: CRM technology; cybersecurity tools; cloud infrastructure; data architecture; knowledge-management tools; learning systems; procurement expertise; software frameworks; impact-measurement tools; and technical standards.

Level 2 nationally shared capability

These depend sufficiently on local regulation that they should be pooled within countries rather than globally: finance/accounting support; payroll; HR compliance; charity regulation; grant compliance; privacy interpretation; fundraising regulation; taxation; and legal support.

Level 3 organisation-owned capability

These should stay with patient organisations: patient relationships; condition expertise; advocacy priorities; peer support; community engagement; lived-experience leadership; communications voice; strategy; and board decision-making.

That three-tier architecture is more precise than simply distinguishing "shared" and "local" and will be used going forward.

14. Remaining evidence-gap matrix

Gap	Importance	Does it require patient-group engagement?	Alternative first
Patient-group CRM system prevalence	High	Possibly	Continue public organisational/system analysis
Exact administrative hours by function	High for economic model	Possibly	Scenario modelling using labour benchmarks
Existing software/licence expenditure	High	Not initially	Market/invoice benchmark modelling
Cost of proposed shared platform	Very high	No	Supplier/market analysis
Country-level accounting/HR costs	High	No	Market rates
Regulatory compliance costs	Medium–high	Usually no	Published burden studies + professional cost benchmarks
Volunteer administrative hours	Medium	Possibly	Sensitivity analysis
Patient impact of released capacity	Medium	Not for initial model	Model as mission opportunity cost
Organisations' willingness to share	Very high	Yes	Cannot be resolved secondarily
Data-governance expectations	Very high	Yes, eventually	Draft model first
Trust in host/provider	Very high	Yes	Test after host options developed
Functions organisations refuse to share	Very high	Yes	Co-design rather than problem audit

The striking conclusion is that most remaining quantitative gaps do not require patient-group research. The principal questions that genuinely require patient organisations are about acceptability and governance, not problem identification.

15. Overall evidence judgement

Highly supported

Small organisations face structural financial, workforce, digital and administrative constraints that recur across very different national nonprofit environments.

Highly supported

Restricted/core-cost funding contributes to underinvestment in the organisational infrastructure required to sustain mission delivery.

Highly supported

Regulatory, funding and reporting requirements impose proportionally greater burdens on organisations with limited administrative capacity.

Strongly supported

IT, finance, data and specialist administrative functions contain significant potential economies of scale.

Strongly supported but less directly measured

CRM/data fragmentation is a major operational constraint for small patient organisations.

Strongly supported

Relational functions—including advocacy, patient support and community engagement—should not be assumed inefficient simply because the organisation's internal infrastructure is weak.

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