Public health funding mechanisms in New Zealand

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Abstract

The funding of population-based public health services (health protection, health promotion and disease prevention) has received little attention in the international literature on health reforms, and yet these services are of fundamental importance to the health of populations and to the economy. This article provides justification for health policy-makers placing more emphasis on the level of public health funding compared with funding on personal health services, and accountability arrangements for its expenditure, when considering options to improve the performance of their health sectors. The New Zealand experience of funding public health services is described within the context of the health reforms. The strengths and weaknesses of the adopted approach are analysed.

Why worry about public health funding?

Public health is defined in New Zealand legislation as the health of all of the people of New Zealand or a community or section of such people (*Health and Disability Services Act 1993*). Public health services are the only health services in developed countries that all of the population access many times a day, usually unknowingly. These services contribute to the quality of the air we breathe, to the safety of the water we drink and the food we eat, and the safe disposal of our waste. There is a strong regulatory component to public health services that protect health, but disease prevention (for example, population-based screening programs or immunisation) and health promotion usually rely on mobilising communities and the health sector to achieve population health outcomes. Public health services are largely invisible until something goes wrong (for example, an outbreak of food-borne disease), a new risk emerges (for example, the debate about the safety of foods derived from gene

technology), a disgruntled risk generator objects publicly to the regulations with which they have to comply (for example, advertisers' requirement to comply with a ban on the advertising of tobacco products in smoke-free legislation), or a multimedia campaign is used to promote particular health messages.

According to traditional economic theory, public health services, such as clean water and sanitation, are public goods. It is impossible, or prohibitively costly, to make consumption of public goods exclusive to those who would demand and pay to consume them. Other public health services, such as immunisation and control of sexually transmitted diseases, are merit goods in that they produce externalities. It is socially optimal for government to finance most of these types of services (Hsiao 1995).

The health system is shaped by the way the funds to maintain the system are collected, allocated and distributed (Vienonen & Wlodarczyk 1993). Public health funding accounts for a fraction of total health funding – 1.7% (NZ$101.2 million) in New Zealand in 1997–98 (Ministry of Health 1999a). This compares with the United States where, in 1993, different methods have estimated that public health accounted for between 1% and 3% of the nation's total health spending (Lee & Paxman 1997; Wall 1998) and with Australia where, in 1995–96, public health expenditure was probably around 2–3% of total health expenditure (Deeble 1999). International comparisons are compromised by different definitions of 'public health'. For example, in the Australian context, some clinic services are included.

Government funding for public health services in many countries is constrained by the demands of personal health (treatment) services within the health sector and caps on public sector funding because funding of health services, including public health services, competes for funding with other sectors in the budget process. Within the health sector, only in controlled socialised countries such as China has public health been considered the most important activity of the health sector (Pickett & Hanlon 1990). Some countries, such as the United States and Canada, have decentralised public health programs to more local levels of government usually on a cost-sharing basis. The United States experience is that high dependency on local revenue in some states makes the public health services vulnerable to changes in local priorities and shifting economic fortunes (Wall 1998).

The province of Ontario in Canada enacted legislation in 1983 for the provision of mandatory and priority public health programs by boards of health. Under the legislation, the provincial government provides to the 42 boards of health 75% of funding for mandatory public health programs (such as food and water safety, immunisation, communicable disease control) and 100% of funding for priority programs such as AIDS prevention. In this province, funding for public health services are prioritised against funding of other sectoral activities. As a result, prior to the legislation, many municipalities were known to put roads ahead of public health services. Even after the legislation, many local health boards have been unable to spend their full allocation for public health services from the provincial government because

local politicians would not approve their share of 25%. Nevertheless, the legislation was considered an improvement on the previous arrangement (Chambers 1997).

The invisibility of public health services militates against injections of funding, even though there is high-quality evidence of the effectiveness of public health programs, and of the importance of their contribution to the economy. For example, it has been estimated that New Zealand's tobacco control program has been associated with a gain of 140 000 years of life for New Zealanders between 1975 and 1995 (Cancer Society & Ministry of Health 1996). Lack of access to public health services, such as a public awareness program to encourage smoking cessation, does not have the same emotional impact on the public as a lung cancer sufferer who may have to wait for an oncology appointment. The media, lobbyists and advocates are more likely to use the example of the lung cancer sufferer to achieve enhanced funding for oncology services in the short term, rather than focus on the lack of promotion of smoking cessation which, by reducing the need for oncology services by preventing lung cancer, will benefit more New Zealanders in the medium and long term.

Holland and Stewart have stressed the importance of public health practitioners influencing funding if public health is to be improved:

> *They have to be able to influence the budget for public health activities in order that the longer term issues are not omitted in favour of the clamant short-term demands. This is crucial as public health resource needs are always in competition with the needs of clinical services. The latter nearly always take precedence – treatment of individual patients seems far more immediate a priority than changes in health status for the future. (Holland & Stewart 1998)*

Influencing the budget cycle is critically important to ensure that public health funding is not eroded. A decline in funding may be associated with a decline in public health expertise, which can increase the likelihood of public health becoming visible because something goes wrong. Such events can be associated with an inquiry. For example, in the United Kingdom in the 1980s two major outbreaks of communicable disease, both of which were investigated in public inquiries led, in 1998, to the Acheson Inquiry into Public Health in England. This inquiry resulted in a significant reinvestment in the public health function (Acheson 1988).

To date, New Zealand has been fortunate. In the 1990s, successive New Zealand Ministers of Health have emphasised the importance of public health (Upton 1991), improvements in health status (Shipley 1996), achieving action on health and independence (English 1998) and a greater emphasis on population health approaches (Creech 1999). This article considers the New Zealand experience of funding public health services. The article starts to fill a gap in the international literature on health reforms and funding of health services, which is dominated by seeking to improve the effectiveness and quality of expenditure on personal health services and neglects the important area of public health.

The impact of the health reforms on public health in New Zealand

The configuration of public health policy advice, funding and service delivery in New Zealand has undergone many changes in the last decade. Earlier changes resulted in the establishment of area health boards with elected board members. The first boards were formed in 1985 and combined the areas and roles of former hospital boards with district health offices or health development units of the Department of Health. The establishment of area health boards continued until June 1989 (National Interim Provider Board 1992). The objectives of area health boards were:

- to promote, protect and conserve the public health
- to provide for the effective coordination of the planning, provision and evaluation of health services, and
- to establish and maintain an appropriate balance in the use of resources for health protection, health promotion, health education and treatment services (*Area Health Boards Act 1983*).

It is important to note that area health boards did not have responsibility for general practitioner services, which continued to be centrally-funded.

In 1991 the New Zealand Government commenced reform of the health sector. At that time it was noted that the structure of New Zealand's health system dated back to the 1930s and the changes in the intervening period, including those described above, were ad hoc (Upton 1991). Given the changes in population, expectations and technology, the system was considered unsustainable. The politicisation associated with elected area health boards was thought to hamper the strategic decision-making process. Hospital buildings were viewed as monolithic structures deteriorating from neglected maintenance. Public health activities had fared poorly even though they were considered essential for the long-term health of the population. The Government's statement of health policy, *Your Health & the Public Health,* recognised that:

> *…much lip-service is paid to the importance of public health functions, but when money gets tight, disease prevention and health promotion programs frequently fall victim to area health board cost-saving drives. (Upton 1991)*

As part of its reforms the Government decided to separate the funding and management of population-based health strategies from personal health services, separate the purchaser and provider roles in public health services and establish contestable contracting arrangements (Upton 1991). The Public Health Commission, established in 1993, was directed to monitor the state of the public health and to identify public health needs; advise the Minister on matters related to public health, including personal health matters relating to public health and regulatory matters relating to public health; and to purchase (or arrange for the purchase of) public health services (Public Health Commission 1994).

This arrangement raised the profile of public health in New Zealand but proved complex with five purchasers (the Public Health Commission and four regional health

authorities) of publicly-funded health services (public health services, personal health services and disability support services) for a population of 3.7 million people. Under this arrangement, public health policy advice was isolated from the mainstream of health policy advice, from the public sector and thus from the flow of information within Government. This information is essential to set public health policy advice within an appropriate context so that it is timely, relevant, analytically robust and thus can have impact.

As a result, the Public Health Commission was disestablished in 1995. Its monitoring and policy advice functions returned to the Ministry of Health, which was required by statute to establish a Public Health Group to undertake these functions. The purchasing functions were mainstreamed with the other health purchasers, which have subsequently been merged into a single Health Funding Authority. The current configuration is shown in Figure 1.

Funding of public health services

The definition of public health services, for the purposes of identifying and managing the funding, covers environmental health, food, nutrition and physical activity, the prevention and control of communicable diseases, and the health of Maori, children, young people, adults and older people. For each area, tasks include:

- assessment of health status, analysis of risks to the public health and preparation of district health strategies
- routine surveillance, investigation and intervention

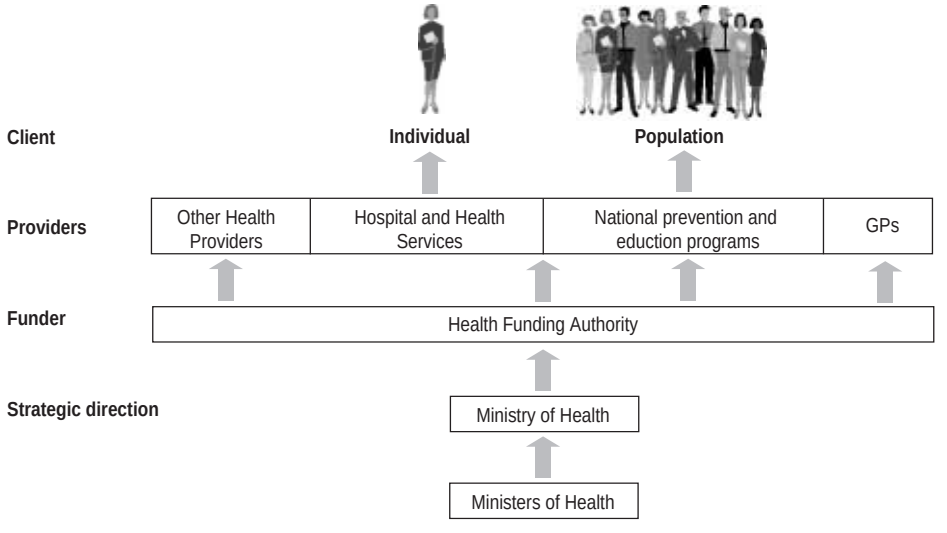

Figure 1: The structure of the publicly-funded health sector

- coordination of public health programs (including, where appropriate, the coordination of activities delivered by personal health services)
- health promotion and health protection services including advice to local policy-makers, enforcement, community development, public education/social marketing, and advice to personal health and disability services (Shipley 1995).

The concerns expressed by the Government in relation to funding of public health services (Upton 1991) were borne out by subsequent analysis of the funding of public health activities by area health boards. By 1989, when area health boards had been established throughout the country, a total of NZ$107.6 million per annum (in 1991 $) had been added to the area health board allocation. This transfer was mainly for the devolution of district office functions to area health boards, which occurred between 1985 and 1989. Funding for one psychiatric secure unit was included in this transfer but it has not been possible to identify the specific amount. The monies were not tagged or designated for any express purpose. Boards were under no obligation to continue to spend that money in part or in full on public health services.

By the 1990–91 financial year, expenditure on health promotion and health protection by area health boards was NZ$66.7 million (GST exclusive) and this reduced to NZ$57.2 million (GST exclusive) in 1991–92. It is possible that the reduction in funding from the time of transfer until 1990–91 was due to changes in the definition of activities and staff groups used as the basis for the transfer to area health boards. However, definitions for the two service categories (health promotion and health protection) for area health boards were not changed between 1990–91 and 1991–92, and the reduction in reported expenditure is considered to represent a true reduction in expenditure.

At that time there were 11 national service categories and only the intellectual handicap service experienced a comparable percentage fall in reported expenditure (National Interim Provider Board 1992). The experience of integrated funding in area health boards was therefore detrimental to public health. The associated diversion of resources from public health services within area health boards has been linked with adverse health outcomes, inadequate monitoring of health outcomes, and a lack of central planning and coordination. Skegg (1994) argued that '…even more than in earlier decades, public health became the Cinderella of New Zealand's health services'.

With the establishment of the Public Health Commission, funding for public health functions was unbundled from the Health Vote (National Interim Provider Board 1992). The unbundling was associated with the establishment of three main ring fences pursuant to the *Public Finance Act 1989* in the health appropriation by parliament: public health, personal health and disability support. A ring fence is a legal mechanism to protect funding for the reasons specified. These are two-way ring fences – the funding in each ring fence can only be spent on services specified for that ring fence. That means, for example, that funding in the personal health ring fence cannot be spent on services specified for the public health ring fence.

The public health ring fence was established because of the problems described above and also because, under previous arrangements, there had been an apparent reluctance to spend money on less visible activities such as public health and on activities where the benefits occur in the medium to long term. The ring fence has been retained through the various institutional changes, but growth in public health funding may have been disadvantaged under the Public Health Commission which was excluded from central government processes. The average percentage annual growth of the public health ring fence for the two years the Public Health Commission could influence the Budget from outside the Government was 4% compared with 11% average annual growth for the Vote. This increased to an average 10% annual growth of the public health ring fence in the first four years that the Public Health Group (inside Government) was able to influence the Budget. This is in excess of the 6% average annual growth for the rest of the Vote in the same time period. Figure 2 shows the cumulative percentage growth of the public funding in the three ring fences.

The increases in the level of funding in the public health ring fence have resulted from four main factors. First, there are adjustments to funding to compensate for population growth. These adjustments are small and amount to an annual increase of about 0.007% or approximately NZ$0.75 million. Second, there are emerging issues which necessitate a public health response. Examples include the appearance of toxic algal blooms in New Zealand waters and epidemics of meningococcal disease and measles. Third, there are increases in tobacco taxation. There have been two recent increases above the regular adjustments as a result of changes in the consumer price index. Whereas the majority

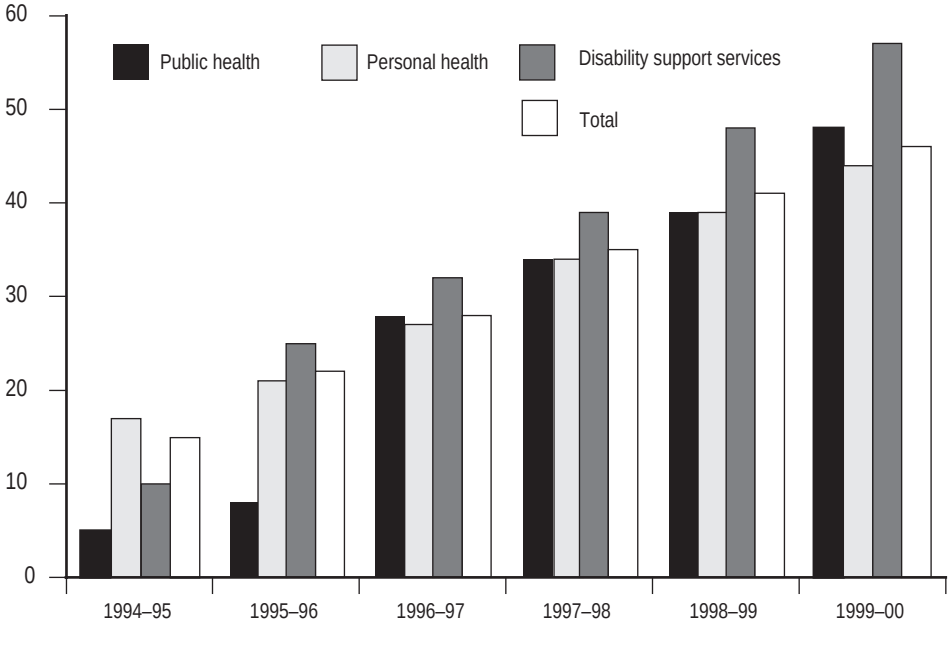

Figure 2: Cumulative percentage growth within the public health, personal health and disability support funding ring fences for publicly provided services.

of the tax revenue is returned to the consolidated fund, some funding has been allocated to tobacco control programs. Finally, there are new or augmented public health programs. These programs have included the population component of breast cancer screening programs, immunisation and the promotion of sexual and reproductive health.

Accountability arrangements for public health expenditure

Public health policy framework

New Zealand has taken a strategic approach to public health in the last decade. The current policy framework, developed after reviews of the health of the nation and widespread consultation, focuses on strengthening public health action to achieve progress on seven goals and 41 objectives. The goals focus on the health of populations. The objectives relate to environmental determinants, behavioural risk or protective factors, or specific diseases or injuries. A set of criteria enable priorities to be set within the overall framework which are appropriate to the needs of local communities and the available resources. These criteria include current and future health impact, effectiveness of available interventions, potential to reduce inequalities in health status, value for money, sustainability and public and inter-sectoral support (Ministry of Health 1997a, 1997b; Durham 1999).

The Health Funding Authority has a reasonable amount of freedom to set priorities for public health expenditure, providing basic regulatory public health services are funded as specified by the Ministry of Health (1999b) and providing it meets the Crown's Statement of Objectives which are tabled in parliament annually. The key priorities and expectations are incorporated in the funding agreement between the Minister of Health and the Health Funding Authority. The Health Funding Authority is supported by:

- 31 issue-based policy advice papers, each reviewing the evidence for progress in relation to one or more objectives in the strategic framework
- guidelines produced by the Ministry of Health (reference to all of these publications can be found at <http://www.moh.govt.nz>), and
- its own work on reviewing the evidence to support the public health function.

The Health Funding Authority seeks to achieve equitable distribution of funding according to population density and distribution in New Zealand and to set priorities between public health programs within the overall strategic framework.

Allocation mechanisms

In addition to ring fences, successive governments have approved the use of population-based funding formulae. The Ministry of Health developed population-based funding formulae as a mechanism of identifying 'fair shares' of health funding for the regions in the 1980s and 1990s.

Initially, the population-based funding formula was applied to the personal health ring fenced funding. The Ministry of Health developed a separate public health funding formula for public health services in 1996 in recognition that funding issues in public health are substantially different from personal health (Ministry of Health 1996). This formula is applied to public health ring fence funds. It provides for significant weighting for Maori and changes in relative population size for each of four regions. The formula can be applied to smaller units, such as the 11 localities of the Health Funding Authority or the 23 Hospital and Health Services units. Although the Hospital and Health Services do not have a defined population to whom personal health services are provided, they are contracted to provide public health services to gazetted health districts.

As a result, public health funding is distributed after two funding divisions occur, where the ring fences and the population-based funding formulae are applied. The result is a 'fair and accepted' approach to identification of the gross amount of public health funding which can be applied to each of four regions.

The Health Funding Authority has moved towards equitable distribution of public health ring fence funding according to the population-based funding formula. For the 1999–2000 year, regional equity is achieved and locality equity is substantially achieved for the public health ring fence. Equitable funding is defined on a per capita basis, adjusted for age and to allow for the greater need for public health services by Maori.

A different process exists for the personal health ring fence funds applied to public health services (for example, control of communicable diseases and tobacco cessation services). Historical funding is used and an internally contestable Health Funding Authority prioritisation process is applied to funding growth, as detailed below. Funding for tobacco cessation services is regarded as a personal health service and as such has not benefited from increased funding allocated to public health services as a result of changes in tobacco taxation.

Prioritisation of public health spend by the Health Funding Authority

In 1998–99 the Health Funding Authority was required by Government to develop an organisation-wide process for making explicit rationing decisions. Initially it was proposed that any new services, including population-based public health services, should be subject to a cost utility analysis. It was argued, however, that such analyses are inappropriate for services which are directed at populations rather than individuals. This is primarily because of the 'public good' nature of these services. Also the manner in which diverse interrelated programs combine to produce an effect makes it difficult to link a defined activity to a specific health outcome.

Services like disease screening and immunisation, which are delivered to individuals but which have a population perspective, are amenable to economic analysis with quantification of cost-benefit. For example, a cost utility analysis has been used to assess enhanced funding for smoking cessation services. As these services are directed at individuals, they are funded out of the personal health ring fence.

The Public Health Operating Group of the Health Funding Authority funds services from both the public health and the personal health ring fences. Accordingly, in addition to using the cost utility analysis for the personal health ring fence funding, the Public Health Operating Group uses a principles-based, qualitative decision-making tool, known as program budgeting and marginal analysis, in the public health ring fence funding. This tool and its application to public health have been described by Deeble (1999). The use of program budgeting and marginal analysis is based on the Health Funding Authority's principles for decision-making which are effectiveness, cost, equity, Maori health and acceptability.

Discussion

The approaches to prioritisation and the distribution of health funding are controversial. For example, the ring fences have been criticised as restricting innovation and holistic health care by creating artificial barriers to fully integrated care. Anecdotal evidence suggests that there has been seepage out of the public health ring fence in providers that are funded from within more than one ring fence (that is, personal health and/or disability support ring fences). This seepage is possible through the calculation of overhead costs allocated to different services and also by inadequate definition of public health services within each ring fence when these are funded from two ring fences, such as communicable disease control. In addition, Maori have a commitment to personal and public health and have in the past experienced difficulty getting purchasers to recognise the need for Maori providers to deliver services funded from two ring fences (Public Health Commission 1995).

On the other hand, supporters of ring fences argue that public health funding fell significantly (possibly up to 40% over four years, although the information is incomplete) in the unprotected integrated environment of area health boards, whereas public health funding has grown measurably in a ring fenced environment. From the New Zealand experience, it appears that public health funding is vulnerable when managed by organisations whose core business is the delivery of personal health services.

The personal health funding formula is criticised for being too blunt and not recognising unique factors facing local communities, but the public health funding formula appears to be well supported. For example, the move of the Health Funding Authority to formally apply the Maori weightings to public health funding (and as a result, increase the overall funding applied to Maori health) has been well received by mainstream and Maori providers and community groups alike.

The National Health Committee has reviewed the Health Funding Authority prioritisation principles, processes and problems (Ashton et al. 1999). The National Health Committee is a statutory body providing advice to the Minister of Health. The general principles-based approach to using program budgeting and marginal analysis and, where appropriate, cost utility analysis was endorsed but the Committee concluded

that any prioritisation process should always be guided by informed judgement. They further concluded that it is essential that the Health Funding Authority:

- proceed carefully and, if necessary, undertake pilot studies
- document information used for prioritisation and the reasons why particular decisions are taken
- consider further how to open all aspects of the decision-making process to scrutiny and discussion with the public, providers and other key stakeholders
- continually update information on costs and effectiveness of services
- evaluate the prioritisation process as it develops.

Ring fencing has been positive for public health in terms of the level of funding particularly when public health policy advice is able to closely influence the budget cycle. The challenge for the future is to develop an effective set of incentives which allow input controls to be relaxed, while providing for an integrated approach to improving the health of New Zealanders. Health policy-makers should place more emphasis on public health funding when considering options to improve the performance of their health sectors.

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Commentary

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Public health funding mechanisms in New Zealand

Gillian Durham and Bette Kill have written an important review and commentary of public finance and public health in New Zealand. I would have liked to say how stimulating and interesting most readers would find their work. However, this would not be true, as consideration of public policy in the field of public health is perhaps one of the least sexy and most boring of all topics.

The lack of passion and interest has always been a serious problem in this vital area. It has made investment in public health unattractive to governments and careers unattractive to health professionals – at least, until things go wrong. Public health can become front-page news within minutes if water supplies are contaminated or if baby food and oysters become poisoned. Recent such events in Sydney caused premature ageing of our public health colleagues despite the lack of a single death!

The support of public health is a given in all societies. Indeed, such support is literally a matter of life and death for public health professionals with their special knowledge of the dangers to society of a run-down public health service, or of the inevitable complacency that followed the virtual disappearance of infectious diseases in the post-antibiotic and vaccination era.

Durham and Kill correctly observe that public health funding in New Zealand is vulnerable when managed by organisations whose core business is the delivery of personal health services. There is considerable anecdotal evidence from many countries including the United Kingdom, Australia and (perhaps of most interest) China that the experiences of New Zealand are shared by others.

The lesson is simple. Public health is so vital that financing levels and specialist expertise need to be very carefully protected by governments, and by health professionals who work in both the public and personal health fields. Delegation to any authority with dual responsibilities for public and personal health services should be avoided – dare I say it – like the plague!

Privatisation is an issue not canvassed in detail by Durham and Kill. The recent enthusiasm for privatisation in health appears to have originated in the sophisticated writings of Drucker, followed by the London and Chicago Schools of Economics, and was first put into practice on a grand scale by Keith Joseph and Margaret Thatcher in

the United Kingdom. Unthinking followers have not, however, realised that Drucker and others were mainly concerned about the value of competition, and specifically argued for the retention of the regulatory role of governments and indeed for retention of public ownership in non-competitive situations.

Competition does not provide value in public health in most circumstances and, as the Chinese have found, services may simply collapse if privatised. Where the responsibility for public health services is delegated to organisations that are also in the business of personal health care provision, it may be that each public health activity needs to be clearly defined and a rational decision made for the management of each separate activity on the grounds of public interest.

Commentary

Rosalie Viney

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Public health funding mechanisms in New Zealand

Gillian Durham and Bette Kill's article raises many interesting issues about funding arrangements for public health services. The term 'public health services' covers a fairly diverse set of services. Some can be thought of as classic public goods (clean water, sanitation, shade structures in public areas). Others are private goods having external benefits which may be subject to other market failures and which may warrant public provision (such as screening services and immunisation).

Somewhere between these two endpoints the line is blurred and much of health promotion falls in this area. Thus, although the actual screening service provided to an individual is a private good with a private benefit, we know that screening services are likely to be under-provided without an infrastructure to promote the idea of screening. This infrastructure again includes a diverse range of services: media campaigns, community development programs, public health advocacy and public health information provision. Other public health services such as nutrition and drug and alcohol harm minimisation further complicate the picture. The issue that arises here is that across this range of services different market failures exist, different incentives operate and very different funding and provision solutions are likely to be optimal. This is one of the lessons that has been learnt in New Zealand's attempt to devolve provision and to separate funding and provision of services. Public (preventive) health services are much more complex and therefore perhaps much more vulnerable to changes in funding than personal (curative) health services.

The story told by Durham and Kill is about what happens to public health services when government devolves funding and delivery responsibility. The clear message is that these services are vulnerable. New Zealand's experience was that funding to public health services reduced under an area health board structure. There may be a number of reasons for this. The pay-offs from investment in public health services lie well in the future and, by their nature, are uncertain. Public health services do not fare well in a world of evidence-based health care: the link between intervention and outcome is harder to demonstrate. The combination of sceptical clinicians, disinterested consumers and managers with politically imposed time horizons (much shorter than those for public

health services) means that it is almost inevitable that when public health competes directly with curative services it will be the loser.

It is interesting to ask why this matters more if responsibility is further devolved. National governments have short time-horizons too, but seem to have a better history of maintaining investment in public health infrastructure. It is possible that the greater distance from direct service delivery provides a buffer from public pressure to increase funding for curative services.

New Zealand has addressed this issue in two ways:

- by devolving service delivery responsibility but centralising funding responsibility through a purchasing role, and
- by setting up explicit funding arrangements through the use of ring fences and frameworks for priority-setting.

This raises an interesting contrast in funding approaches. At the highest levels of funding distribution the relative balance between public health services and curative services, and between traditional public health services and personal preventive services, is decided in advance and fixed by the ring fencing. The factors which determine the amount and distribution of funding appear to be a mix of historical funding levels, application of equity principles and the outcome of particular policy initiatives.

However within programs there is a requirement to engage in priority-setting processes, using cost-utility analysis or program budgeting and marginal analysis. Underlying both these approaches is the principle of assessing costs and benefits at the margin. There is no barrier in theory to the same principles being used at all levels of the system to determine funding between interventions, between sub-programs, between different public health programs and, ultimately, between public health programs and health care programs. The fact that no health system has done this successfully is perhaps indicative of three ongoing problems:

- the lack of evidence available to make valid comparisons of marginal cost and marginal benefit across programs
- the reluctance of all players in the health system to embrace explicit priority-setting using these principles, and
- the persistent role that health and health care politics plays in driving implicit priority-setting.

The approach that New Zealand has taken in public health is a promising start to addressing these problems.

Perhaps the most interesting lesson for Australia is that the various reforms in funding and delivery arrangements in New Zealand seem to have led to a relatively explicit, centralised and structured approach to resource allocation of public health services. This has almost certainly been facilitated by the political structure in New Zealand where

there is not the issue of different levels of government being involved in funding and delivery of services. In Australia the National Public Health Partnership and the Public Health Outcomes Funding Agreements are major steps towards an organised approach to funding, delivery and priority-setting in public health. The National Public Health Partnership has already devoted considerable attention to issues of resource allocation across public health services. The Public Health Outcomes Funding Agreements have created greater scope for priority-setting at the State/Territory level, while maintaining national objectives and outcome monitoring for the specified programs. But even within national programs there is considerable variation in how public health services are funded and delivered. These variations deliver the flexibility to target local priorities and to benefit from innovation, but also come at the expense of differences in the efficiency and equity of access to services.