How do we fund Public Health in Australia? How should we?

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Abstract

Objective: To map how public health is funded in Australia. To assess whether changes to funding methods might improve system performance.

Methods: Review of publicly accessible documents and discussions with public health key informants.

Results: Australia spent $140 per person on public health in 2019-20, (1.8% of total health spending). But there is considerable state and territory variation. This money flows through multiple channels and payment mechanisms. Responsibility for what is funded is largely delegated to authorities close to the problems. This makes it easier to choose the best mechanism for funding an activity. Much information is hidden from view, however. This makes it impossible to assess whether the potential for population benefit is fully realised.

Conclusions: Australia avoids some of the difficulties experienced elsewhere because funding is largely devolved to states in block grants; they shape their own investments. The US, by contrast, prefers categorical funds for specific purposes. Three suggestions for making the funding system here more visible, useful and accountable are canvassed, including 'satellite accounts'.

Implications for Public Health: Funding needs to be more transparent before it is possible to assess whether public health system performance could be improved through changes to the way public health is funded.

Key words: public health funding, health finance, funding model, National Health Reform Agreement 2020-25

Introduction

The current National Health Reform Agreement (2020-2025) asserts the need to increase the share of health spending going to prevention.[1] The extra spending is probably warranted given what we know about the cost-effectiveness of public health interventions.[2] Yet the evidence from the USA, which is reviewed shortly, shows their system continues to underperform despite spending more than three times as much per person as occurs in Australia.[3] This suggests that changing the total spend may not be enough. We also need to examine how public health is funded to ensure that the methods used are conducive to efficient and equitable public health practice.

Funding is one part of the wider issue of health finance. Health finance embraces three subfunctions: revenue collection; pooling of funds; and the purchasing of services.[4] The first of these subfunctions (revenue collection) considers where the money to pay for health care comes from, and how should it be collected to meet the goals of health policy. The second subfunction (pooling of funds) considers how the money that is collected is combined to best support policy objectives, particularly in relation to sharing the costs of health care fairly and promoting equity. The third subfunction (purchasing of services) considers how the providers of services are reimbursed for the work that they do.

Abbreviations

ACT, Australian Capital Territory; AIHW, Australian Institute of Health and Welfare; FFS, Fee for Service; GST, Goods and Services Tax; IoM, Institute of Medicine (USA); LHD, Local Health Districts; MBS, Medicare Benefits Scheme; NHR, National Health Reform; NHRA, National Health Reform Agreement; NPAPH, National Partnership Agreement on Preventive Health; NSW, New South Wales; OECD, Organisation of Economic Cooperation and Development; PBAC, Pharmaceutical Benefits Advisory Committee; PBS, Pharmaceutical Benefits Scheme; PIP, Practice Incentive Payments; SA, South Australia; USA, United States of America.

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Our interest is in the third of these subfunctions, specifically the purchasing of *public health* (that is, prevention, protection and health promotion).[5] We prefer the term funding rather than purchasing, however, since not all public health activities can be 'bought' in the same way that hospital admissions for hip replacement surgery or the medical treatment of cardiac arrest are purchased or bought in health care budgets. Important activities such as capacity building, community development, and policy implementation are not services as such, but actions aimed at foundational systems change. They are collaborative and cumulative, based on trust rather than transaction, and involve lengthy time periods with multiple, and often uncertain, outcomes. The necessary inputs to these foundational activities require funding, but the activities themselves cannot be bought as and when required.

Commentary on financial issues in public health tends to concentrate on *how much is spent* on public health and whether it is sufficient to promote and protect the population's health.[6,7,8] Far less attention has been paid to the way that public health is funded or the effect this has on the system's performance, though there are notable exceptions.[9,10] A full evaluation of the funding of public health must consider the *pathways* along which funds are channelled as they flow between the original funding agency and the eventual provider of public health activities and services, and the *mechanisms* that are chosen along the way to pay those who provide input. We refer to the combination of pathways and funding mechanisms, and the decision-making that guides them, as the funding model.

The design of the funding model is important for two reasons. First, it determines where the money eventually ends up, and therefore what can and will be done with it. Changing one of the pathways will affect population health if it redirects resources from one use to another that is more (or less) cost-effective. Second, the mechanisms that are used to pay providers create incentives that encourage some forms of practice and discourage others. We know this is the case in health care because fifty years of health services research has demonstrated it to be so.[11] The way we reimburse hospitals and clinicians affects service quality, accessibility, effectiveness, and efficiency. We suspect the same holds true for public health, though the evidence is mainly anecdotal and not so extensive (see below).

Most of what is known already about the impact of funding is found in two major reviews of the public health system in the USA organised by the Institute of Medicine (IoM). These reports point to the problems caused by a poorly designed funding model.[12,13] They describe a public health system in disarray with outdated infrastructure, uneven and inequitable development of the foundational capabilities required by local public health systems, and bureaucratic inefficiencies associated with securing funds and reporting on their use. This has led to poorer than expected population health outcomes and persistent inequalities in health. Inadequate funding was seen as part of the problem, but the funding model, with its over-reliance on categorical funding rather than block grants was also implicated. Categorical funding is money that is tied to the provision of specified services, which in the USA case examined by the IoM related more to federally determined, political priorities, rather than local needs. There is no entitlement to the funds, and money is usually allocated through a competitive process. Block grants are less prescriptive and allow decision-making to be delegated to local public health units, which should, in theory, have a better grasp on what is required locally and can respond more nimbly than national agencies to changing needs or opportunities. Allocations are usually based on population numbers, perhaps adjusted for some indicator of need. The IoM found the shift towards categorical funding had created inefficiencies and inequalities. It increased the administrative load on front-line staff and led to the duplication of infrastructure spending coexisting alongside gaps in service provision since categorical funds allocated for one service cannot be deployed to support another service. Funding also tended to go to agencies that were better equipped to compete for extra resources, which were not always those with the greatest public health needs.

The public health system in Australia is different from that in the USA, both in its structure and the values that drive it. Yet commentators describe the funding of public health in Australia using the same terms as those used by the IoM in its evaluation of the system in the USA. The funding of public health in Australia is regarded as inadequate, siloed, sporadic, short-term, and piecemeal.[14,15,16]

Is the funding model for public health in use in Australia fit for purpose? To address this question, we must first understand how public health is currently funded. To do this, we set out to map the flow of funds as they move through the public health system from the original funding agencies to the eventual providers of services or activities, to identify the channels through which the funds flow, and the funding mechanisms at play along each route. Where possible, we report on the amounts of funds that flow along each channel, but, as argued previously, the amounts, while important, are not necessarily the best clue as to whether the system is working to its full benefit.

Methods

Our methods combined internet searches for relevant reference materials with emailed correspondence and telephone conversations with selected experts in the fields of public health and finance. We adopted a hermeneutic approach to our literature search, starting with very general search strategies based on broad terms such as 'population health' and 'funding model' before refining more targeted searches to fill gaps that we found in the literature and address anomalies in the information we obtained.[17] The literature we gathered included annual reports and financial accounts from health agencies, budget statements from public health funders, working papers and technical reports from regulatory and funding agencies, and online data sources. We also collected and reviewed conventional research papers. As the literature searches unfolded, we engaged with health officials in public health management and finance, academics in public health policy and practice, librarians and leaders in related organisations in local government and the voluntary sector to suggest any further sources of information and to aid with fact-checking and confirm our interpretation of the documentary material that we had reviewed.

Correspondents were chosen purposefully for their ability to contribute to our understanding of the funding model: that is, we used a key informant approach.[18] This was assisted first by policy makers at the Australian Prevention Partnership Centre (a 10-year, NHMRC and state and Commonwealth collaboration to promote better system-level thinking about prevention)[19] who offered their insights and recommended other possible informants. We also identified possible participants based on their professional positions or their contribution to the policy and practice literature. Data

collection continued until we reached saturation. That is, until no new information was revealed.

We deliberately worked within the confines of the definition of public health that is used by the Australian Institute of Health and Wellbeing (AIHW) in its health expenditure series (see appendix 1 for details), despite knowing that this draws a rather tight, and somewhat contentious, boundary around what constitutes public health.[20] Notable exclusions from the AIHW database include spending on inter-sectoral action to address the social determinants of health, the costs of local government activities beyond those funded through transfers from health agencies, and spending by individuals on activities such as gym memberships and wellness programs. We kept to the AIHW definition in the hope that we would be able to validate our depiction of the funding model by reconciling our estimates of the flow of funds with the public health spending reported by the AIHW. We return to the issue of how public health should be defined in our discussion of what can be done to make the funding model more transparent.

Results

Per capita spending on public health in Australia

In 2019-20, Australia spent $140 per person on public health, which is less than 2% of the total spent on health. The figure is inflated somewhat as this was the first year of the COVID-19 pandemic. For much of the previous decade, annual spending hovered between $100 and $110 per person. Compared with other OECD countries, Australia is ranked 'mid-table'. We spend a bit more than Belgium, Spain, or Portugal, about the same as France, Iceland and Slovenia, a bit less than Denmark, Japan and Lithuania, and considerably less than Canada, the US and the UK.[21]

Average spending varied among states and territories, from $110 per person in Victoria to $167 per person in the ACT, with the Northern Territory being something of an outlier at $527 per person. Despite the best efforts of the AIHW to standardise the accounts across jurisdictions, some of this variation is the result of differences in the way that public health services are organised and funded, and we cannot tell how much of the variation in funding is real.

More than 95% of the reported spending on public health comes from government at commonwealth or state and territory levels, though spending by individuals and local governments is largely excluded for definitional reasons. Proportionally, in 2019-20, 54% of the total spend on public health was attributed to the Australian Government and 42% to states and territories. In previous years, the difference in the shares of spending covered by each level of government was smaller.

The flow of funds

The route this money takes as it flows from the funding agency to the eventual end-user is quite convoluted (Figure 1).

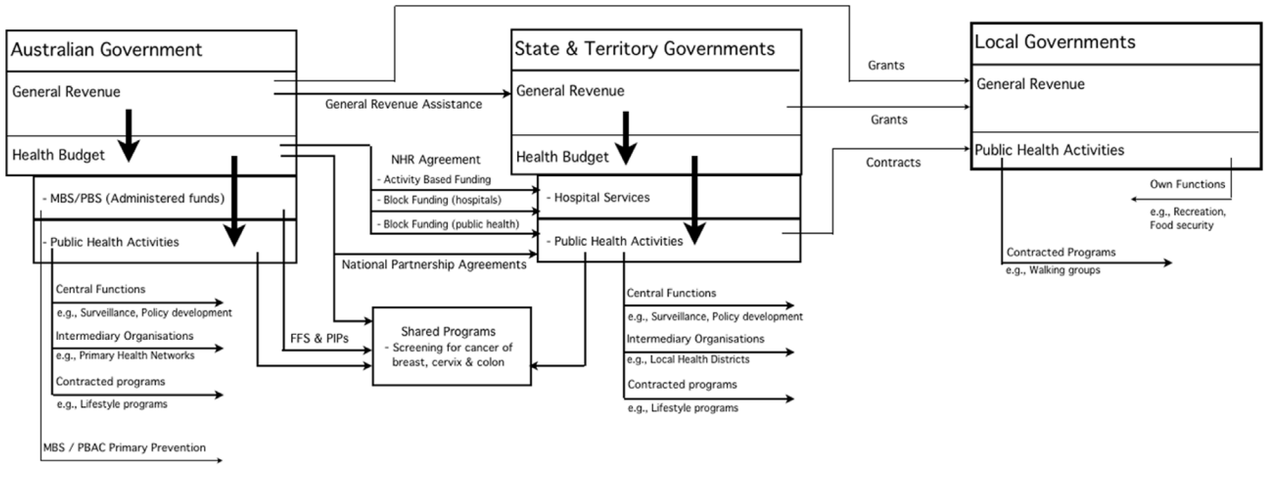
There are three areas to focus on in the figure: (a) Federal transfers from the Australian Government to the states and territories; (b) the funding of jointly managed services in cancer screening; and (c) the self-funding of public health activities within jurisdictions at both levels of government.

Federal transfers from the commonwealth to states and territories

Formal responsibility for public health rests largely with the states and territories, but most resources accrue to the national government primarily through personal income and company taxes. Thus, much of the funding journey depicted in Figure 1 involves the transfer of money from commonwealth to state and territory governments rather than the direct funding of public health services and related activities. These financial transfers travel along one of three channels. The first channel is general revenue assistance, which covers the distribution of revenues raised by the goods and services tax (GST). This tax is collected by the Australian Government, but the revenue is transferred in its entirety to the states and territories except for some administrative costs. It is transferred unconditionally as a financial pass-through, and states and territories can use the money as they see fit. This money is blended with the lower jurisdictions' own revenues (from sources such as stamp duty) and from this single pool, funds are allocated to social and economic programs according to each state and territory's usual budgetary processes.

The second flow between commonwealth and state and territory governments is through the National Health Reform Agreement

Figure 1: Funding Model for Public Health in Australia.



(NHRA). In 2019-20, $22.6 billion was transferred to states and territories via this route. Most of this money was earmarked for hospital services. This was paid, primarily in the form of activity-based funding, where the amount of money a hospital ultimately receives is determined largely by the number and type of patients it treats each year. A small share of the NHRA money (1.9% of the total or $16.50 per person) was earmarked for public health. This money was transferred to states and territories in the form of a block grant with no requirement to report back on its use.[22] The only restriction placed on the use of these funds is that they be allocated to prevention.

The third and final channel is through national partnership agreements. These are bilateral agreements between the Australian Government and one, some, or all states and territories. Of past partnership agreements, perhaps the best known in public health is the National Partnership Agreement on Preventive Health (NPAPH), which made $800 million available for initiatives to prevent lifestyle-related chronic disease, with a further $800 million promised should specified public health targets be met. Current partnership agreements with a preventive focus include vaccine procurement, suicide prevention and the country's response to COVID-19.

Though the GST is collected by the Australian Government, the spending it supports is attributed to the states and territories in the AIHW health expenditure database. In contrast, the money that comes to the states and territories through the National Health Reform Agreement is netted out of the spending that those jurisdictions report to the AIHW and attributed instead to the commonwealth, even though the states and territories determine what that money is spent on. The same is true of all partnership money. These practices prevent double-counting the spending, once when it leaves the coffers of the Commonwealth, and again when it is spent by the recipient state or territory.

If we assume that state and territory spending on public health draws on the jurisdiction's own revenues and its share of GST income in proportion to their total amounts, then 41% of state and territory spending on public health that is reported by the AIHW comes through the GST, and 59% comes through local sources.

These financial transfers are made in a way that delegates decision-making largely to the state or territory level. There are no restrictions placed on how states and territories can use their GST revenues, and practically no restrictions (beyond spending it on prevention) associated with how they can use the funds they receive for public health through the NHRA. Combined, these two sources of funds (GST revenues and the NHRA) account for 95% of the value of the financial transfers from the Australian Government. The money that comes through the third source, the national partnership agreements, is tied to some extent, but is only a small percentage of the total amount transferred to states and territories. Delegating responsibility for spending to decision makers who are close to the problem at hand is one of several principles that guide all federal funding arrangements in Australia.[23] The situation in Australia is therefore markedly different from the one we saw in the USA, where the US federal government ensures that 90% of the funds it transfers to lower jurisdictions come in the form of categorical grants that are tied to federally determined priorities and programs.

Funding of jointly managed services in cancer screening

The second area of interest in Figure 1 relates to the joint funding of Australia's three national cancer screening programs. In 2017-18 (the most recent year for which data were available), Australia spent close to $435 million, or $17.50 per person, on screening for early detection of cancers of the breast, cervix and bowel (a fourth program, screening for lung cancer, will commence in July 2025). Close to one-third of the total spend (32%) came directly from the Australian Government including all the costs of the National Bowel Cancer Screening Program. The states and territories contributed 53% of the funding for these programs from their own revenues, including their share of the GST revenue, and the remaining 15% came through the income the states and territories had received from the Australian Government through the National Health Reform Agreement.

These funds find their way into the hands of service providers through a variety of routes and funding mechanisms. The fit between the type of service and its funding mechanism appears good, suggesting that the mechanisms were chosen with consideration paid to the purpose and characteristics of the specific activity being supported. The mechanisms include block funding, which was used to cover infrastructure, fee for service payments for readily standardised clinical services, price and volume contracting for clinical activities that are not so easily standardised, and performance-based funding to provide an incentive to improve quality and promote access for hard-to-reach population sub-groups. However, we were unable to deduce the share of funding distributed via each of these mechanisms from the information that was publicly available.

Two further aspects of the funding of the national cancer screening effort are worth noting.

The first is the role played by economic evidence in the decisions to introduce, and later expand, each of the three programs. Economic evaluations of screening for breast cancer and cervical cancer were commissioned by the Australian Government to help decide whether to implement the programs,[24,25] and a pre-existing, independent evaluation of cost-effectiveness was influential in relation to the decision to introduce screening for cancer of the bowel.[26] Second, once the decision was made to implement these programs, each was funded at scale. Age restrictions, informed by the cost-effectiveness evidence, were placed on access but otherwise, coverage was universal.[27] This is not the case with other health-promoting interventions, where the availability of economic evidence is more *ad hoc*, and cost-effective programs are rarely implemented at scale or sustained over time.

Funding of public health spending within jurisdictions

The third area of interest in Figure 1 relates to public health activities that are funded and managed within each jurisdiction, either at the national level or by states and territories. There are differences among the jurisdictions in the way that public health is organised and funded, but broad similarities, also. Each jurisdiction manages some public health activities in-house and contracts directly with third-party providers for the provision of other services. In-house activities usually relate to policy development, strategic planning, implementation, and health surveillance. Here, salaries are likely to be the primary payment mechanism. Contracts involving some form of price and volume

agreement are typically used for the provision of services that can be readily standardised and where need is predictable: for example, third-party provision of lifestyle education or group exercise programs.

Some jurisdictions also channel funds through third-party intermediary organisations. The Australian Government provides funding to primary health networks and Aboriginal and Torres Strait Islander community-controlled health organisations. States and territories support both state-wide organisations, examples being the Victorian Health Promotion Foundation (VicHealth), the WA Health Promotion Foundation (Healthway), Queensland Health and Wellbeing, and Wellbeing SA in South Australia, and/or regionalised organisations, such as local health districts in NSW, hospital, local hospital and health services in Queensland, and the women's health networks and recently established public health units in Victoria.

Unlike the transparency seen with transfers between the levels of governments and the funding of jointly managed services, information on the financial amounts channelled through each of the pathways within jurisdictions, and the mechanisms used to fund activities, is largely hidden from view. Accounting data cannot always be found, at least not easily, and when it is published it sometimes appears in a piecemeal fashion across multiple sources. It may also be compiled in idiosyncratic ways, with activities that would not normally be considered public health grouped together with those that clearly are public health in ways that do not allow the funding to be disaggregated. This makes it difficult to interpret the available data, compare public health spending across jurisdictions or reconcile state and territory reports of their own spending with the data that is put out by the AIHW.

A wide range of funding mechanisms are employed to support intra-jurisdictional activities, and, within states and territories, a degree of spending power is further delegated to sub-regions. What we cannot say reliably or comprehensively from the data that are publicly available is which mechanisms are used in what circumstances, or what proportion of the public health spend is covered by each mechanism.

Discussion

Our primary aims in this work were to describe how public health is funded in Australia and to consider whether changes in the funding model might lead to service improvements such as increased efficiency, improved quality or reduced inequalities.

Three substantial insights can be drawn from our efforts to describe the system for funding public health in Australia. The first is the degree of decision latitude provided to state and territory jurisdictions in Australia in relation to their use of public health funds, which is far higher than that offered to their counterparts in the USA. This should make it easier to avoid some of the problems experienced by the public health system in the USA that we documented earlier, which, according to the IoM, were caused at least in part by over-reliance on categorical (that is tied) funding.

Second, a wide array of funding mechanisms is employed across the broad scope of public health practice. This includes block grants that allow the greatest degree of discretion, contract funding specifying differing degrees of price and/or quantity of the services being procured, and incentivised payment schemes to improve quality and access. The funding of the jointly managed national screening programs illustrates how a sophisticated funding model for public health more generally could work. Funds flow through multiple channels, via an array of funding mechanisms chosen to match the characteristics and purposes of the specific activities they are designed to support. The one gap is any formal mechanism for tying the funding of health-promoting interventions to evaluations of their cost-effectiveness (and impacts on inequalities), such as we have with the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medicare Services Advisory Committee (MSAC). Such a mechanism has been considered; first by the Australian Government in 1999[28] and later in an options paper written for the National Health and Hospitals Reform Committee by economists Tony Harris and Duncan Mortimer,[10] but neither proposal gained traction. It would be timely now to reconsider such a mechanism as there have been substantial improvements in health economics methods in relation to equity,[29] health outcomes and population values,[30,31] as well as the guidance issued by NICE in the UK[32] and the experience that they have gained since their remit was extended to include public health.[32]

The third insight is that much of the funding model for public health in Australia remains hidden from easy view; not just from outside researchers and the public, but also from many in the public health system. Thus, we cannot say comprehensively or with any degree of certainty, how much is spent on what sorts of public health activity, what mechanisms are used to get the funds into the hands of the service providers, whether those mechanisms are fit for purpose or could be improved upon, or what percentage of the population has access to preventive programs of proven cost-effectiveness. Notwithstanding any parallel discussion on how much is spent on public health in Australia, the country is well placed to operationalise a funding model for public health that is suited for purpose. However, from the data that is publicly available, it is not possible to assess whether that potential is being realised. We suspect that it is not, at least not fully.

There have been changes announced in public health funding since 2019-20 (the most recent year for which expenditure data were available when we first set out on this project). Nationally, the Australian Centre for Disease Control has been established with an allocation of $91.1 million over two years to set up the centre reported in the 2024-25 budget papers, and the age restrictions on eligibility for bowel cancer screening have been relaxed to include people aged 45 to 49 years. Western Australia has also publicly declared its commitment to increase prevention spending to 5% of total health spending and has started to examine what is included in its current funding envelope for prevention to see where improvements can be made. However, it will be some time before we see whether the national changes lead to a net increase in spending, rather than simply a redistribution of existing budgets, and whether the Western Australian government succeeds in its aim. It takes time for health agencies to produce the data and for the AIHW to ratify the information it receives.

The lack of transparency makes it very difficult to hold jurisdictions to account for the things they choose to fund, and, as importantly, for the things they choose not to fund. This makes it hard to assess whether the system's performance could be enhanced by reallocating resources within the current funding envelope, or whether increased spending will generate benefits that outweigh costs. It has also made it impossible to describe the funding model comprehensively and so

has hampered our efforts to determine whether the current model could be improved upon.

To set the foundations for this rigorous examination of whether the system's performance can be improved by changes to the funding model and/or the country's investment in prevention, we have three suggestions to improve the transparency of public health funding decisions in Australia.

Resurrect the annual reporting of public health spending

The first suggestion is for the AIHW to resurrect its detailed reporting of annual public health spending. The last such report (in what was an annual series) reported spending for 2008-2009 and appeared in 2011.[33] The series covered both levels of government and provided a breakdown of expenditure over time, and against each of eight 'core public health activities': communicable disease control; selected health promotion programs; organised immunisation; environmental health; food standards and hygiene; screening programs; prevention of hazardous and harmful drug use; and public health research. Trends and significant changes in the share of spending going to different activities were noted, as were some of the reasons for taking care when comparing spending across jurisdictions.

Resurrecting the series would signal the important and distinct role played by public health in the wider health system despite its small share of resources. It would add fuel to the commitment to reconsider the share of total health spending going to public health, and, if done well, that is in following the other suggestions we make here, it would aid and encourage deliberations about priority setting and resource allocation.

Use AIHW definitions of public health when reporting public health spending

To be effective the annual reporting series would need the buy-in of the jurisdictions to ensure the accuracy and comparability of the spending data. Our second suggestion supports this aim by requesting that the jurisdictions in both levels of government be more assiduous in their use of the AIHW definitions of public health when classifying their spending and reporting the budgets associated with public health activities. Current practice, which occasionally looks rather idiosyncratic in the way it aggregates and sometimes misclassifies spending, may be expedient but it hides how much is really being spent on public health and undermines efforts to hold jurisdictions accountable for what they do and do not do to support public health. For the original AIHW series, a financial carrot was provided to the states and territories in the Special Purpose Payments (the forerunner of the current NHRA). Something similar needs to be considered with the next NHRA.

Use satellite accounts to expand reporting of public health spending

The third suggestion addresses the boundary issues relating to what counts as public health, which were outlined briefly in the methods section. The AIHW approach to compiling the health expenditure database fulfils many functions, not least in allowing comparisons of spending to be made consistently among jurisdictions within Australia, within jurisdictions over time, and internationally between Australia and other OECD countries. Their approach draws a boundary around public health that is logical, principled and, largely, replicable, but it is quite tight. The resulting financial accounts are neither comprehensive nor entirely in keeping with contemporary interest in addressing the social determinants of health.

Changing the definition of public health that is used by the AIHW to be more embracing of contemporary practice has its attractions. It would legitimise and signify the value of many public health practices that are not currently included in the accounts (action to tackle the social determinants of health for example), and it would help to maintain a degree of accountability regarding inter-sectoral action. But this would also undo the extensive efforts that the AIHW, along with state and territory health bureaucrats and their international peer agencies, have made to standardise accounting approaches. The benefits of widening the definition of public health can instead be achieved in a less disruptive way. The AIHW's processes, and those followed internationally in the OECD, allow for the periodic compilation of 'satellite accounts', which supplement the main expenditure statements.[34] Satellite accounts widen the scope of the published expenditure data without requiring permanent changes in definition. This facility can be applied in two ways: first to allow expenditure items that are already counted as health expenditures to be regrouped in ways that are relevant for different purposes, and second to draw into the health accounts spending that is not currently defined as health expenditure but which contributes to public health. The first of these would allow health system spending that is already defined as 'public health' by the AIHW, but which cannot be counted as such because of data collection issues, to be included in the annual reporting of public health spending. This would ensure that clinical prevention, especially in primary care, could be counted in public health expenditure as an occasional special exercise. The second would enable local government spending (which supports about half of all childhood vaccinations in Victoria but is not included in the AIHW's statements), and national, state and territory government action on the social determinants of health to be drawn into the public health accounts on a one-off basis.

Both exercises would require special surveys to aid data collection and additional data analysis, but the result would be a more comprehensive understanding of the actions being taken in Australia to promote public health, including the level of investment made by each level of government and their commitment to tackling the social determinants. The results would provide a firmer basis for discussions about broad public health policy and priority setting. The use of satellite accounts in this way will not get around the immense challenges of delineating public health from clinical practice at one end of the scale, and social and economic interventions at the other end, but it will allow the consequences of different ways of operationalising the definition of public health to be explored without cementing those changes permanently into practice.

Conclusion

We have reported the results of an extensive examination of available data on how public health is funded in Australia. To our knowledge, this is the first time that this task has been attempted. The current funding model has two major strengths: a commitment to delegate authority for deciding how funds should be spent to decision makers who are closer to the problems; and the use of an array of funding mechanisms, which, in theory, allows the choice of funding method to be determined by the characteristics of the specific activity being

supported. There is evidence of this level of deliberation, especially in the way that national screening programs are funded. Much of the funding model is obscure, however; hidden from view behind piecemeal or absent reporting and occasionally idiosyncratic categorisation of what counts as public health. Three suggestions are made to improve the transparency of the system, which would set the foundations for an evaluation of the effectiveness of the funding model.

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Conflicts of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A Supplementary data

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