As a percent of Gross National Income Australia's contribution to international development assistance (ODA/GNI) has been declining since 1970, although this has recovered somewhat since 2005. On these OECD generosity tables Australia sits in the lower mid-zone, somewhat above Italy and Greece but far below the Scandinavian countries. Clearly it is a "bad look" for this to be greatly reduced further as the current government has done, but in my view there are areas of waste or inefficiency that could be addressed. Furthermore the model of interspersing for-profit companies between the bilateral agency and development programs is widely seen as suspect. In dollar terms, as a donor country, Australia's contribution is similar to that of Holland, Sweden, Canada and Norway. Like the countries listed we are a medium sized player at a global level, yet our role is very different from those countries.

During the 1990s Australia was seen by international diplomats in Geneva as "punching above its weight", as an influential and active member of multilateral agencies such as WHO. By the year 2000 this role had declined somewhat as Australia came to focus more on its immediate region. After the turn of the century the international aid scene changed dramatically. The Bill and Melinda Gates Foundation appeared on the scene, dwarfing other donors. The Millenium Development Goals brought health into the development spotlight, after a decade of neglect, and the appearance of new bilateral organizations directed at specific diseases (AIDS, TB, malaria, polio) or specific strategies (Global Alliance for Vaccines and Immunization or GAVI), greatly complicated the global health scene. Under a succession of poor leaders WHO went into decline, a process that was further hastened by the diversion of donor funds to Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and to GAVI. Whereas Australia had been active in the (largely unsuccessful) efforts to reform WHO in the 1990s, it played a more minor role in the early 2000s. Similarly, Australia's contribution to the troubled GFATM and to GAVI was modest during the early 2000s. Indeed GAVI's first Director once commented that Australia's important contribution to immunization was to support the small countries of its immediate region, so it did not matter so much that they were not supporting GAVI. After 2010 Australia's position changed quite quickly. Between 2006 and 2010 Australia's total contribution to GAVI was $36 million. In 2011-2013 Australia contributed about $200 million to GAVI, as well as substantial future pledges. In the same period Australia contributed $198 million to GFATM, despite the well-publicized problems of mismanagement of that agency's funds. It is unclear what was the basis for this sudden change in posture.

Australia differs from the other small-medium donors in one important respect. It is surrounded countries in need of support and assistance. In health terms Timor Leste might be the worst country in the region. Endemic malnutrition, with over 50% of children stunted (growth impairment due to chronic malnutrition), high fertility rates, high maternal mortality and poor quality health care point to a country that has yet to deliver adequate health to its people. Papua New Guinea remains a country with many problems, while growing inequity in Indonesia has left the eastern provinces of that country in something of a time-warp.

Malnutrition remains a particular problem of the Asian region, with Philippines, the Mekong countries, Burma and South Asia all affected by high stunting rates. Despite its prevalence, the answers to many fundamental nutrition questions remain unknown, creating dilemmas for policy makers. An innovative program to make the nutrition literature accessible to health officials in developing countries was developed by an Australian group with AusAID support, but funding was stopped in 2013, leaving the project only partially completed.

When addressing health problems in Africa the important issues are generally clear and the available solutions are usually supported by reasonable evidence. In contrast the situation in Asia, especially the high mortality countries of South-east Asia, is much more opaque. The reasons for this date

back to the colonial era. Almost all African countries have a credible research institute that has been undertaking research and collecting health information for decades. In most cases these were put in place by the colonial masters, and the dominant African research institutes of today have been and continue to be supported by France or the UK. In Asia this has not happened on the same scale, although important exceptions are the International Centre for Diarrhoeal Disease Research (ICDDR) in Bangladesh and the Institute for Medical Research in Goroka, Papua New Guinea, both of which have been supported by Australia for many years. The British MRC closed their Asian research institutes at the end of the colonial era, and although Wellcome Trust supported programs in Thailand, Laos and Vietnam have grown in recent years, their focus has been on clinical research, while French and Dutch institutions have focused more on laboratory research. Public health or epidemiological research has been neglected in the important region between Bangladesh and Papua New Guinea. For the high child mortality countries of the region, such as Cambodia, Laos, Burma and Timor Leste, and for the high mortality regions of Indonesia, there is rather little information on the causes of child death. As a result, when partners such as UNICEF and Australian Aid try to facilitate a more evidence based approach to priority setting and budgeting in health, they find that the available evidence is limited to computer generated models of limited value. Australia has a proud history in health research, another instance where we can be said to "punch above our weight", yet the development of health in our region of greatest influence is floundering because of unanswered questions; in part because of a lack of targeted public health research.

In 2008 AusAID began a rather belated effort to engage with the academic international health community in Australia. The community is of course small because of the absence of the sort of international health career paths one would find in the UK, US or Europe. Nevertheless the AusAID Knowledge Hubs for Health made good progress, and represented a sound first step for Australia to become a serious player in international health research. Sadly, despite a series of positive reviews, the program was dropped in 2013.

As a bilateral donor in the region, Australia's performance has been patchy. Some areas have worked well, such as their support for immunization, evidenced by the ground-breaking introduction of three new vaccines into Fiji, while others have been less impressive. What Australia does well is health research. What the region needs is well focused health research. Perhaps it is time for us to match that need and begin to take a more responsible regional and global role in international health research.