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DEVELOPMENT AND HEALTH IN SOUTHEAST ASIA FROM THE COLD WAR TO THE PRESENT

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This NTS Alert is the second of two that seek to examine the relationship between development and health. In this issue, the links between international development – in particular, the provision of aid by developed nations – and health are explored by observing trends in Western aid to Southeast Asia from the Cold War era to the present, and the ramifications of changes in why and how such aid is given. This NTS Alert will argue that these patterns invariably reflect the pursuit (and waning) of particular Western interests in each period, rather than an active interest in the health of populations in developing regions, and that this has resulted in considerable health gains, but also particular problems, such as the specific health needs of populations not being addressed in a comprehensive manner.



Maternal and child health in developing countries

Credit: UN Photo.

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Introduction

In a previous NTS Alert (February 2011, Issue 1), it was suggested that economic development has been central to improving health, with solid infrastructure, better nutrition and rising hygiene and sanitation standards forming the foundation for progress in health. This follow-up issue seeks to develop the theme further by focusing on international development, in particular, the provision of international or foreign aid. It will analyse trends in Western aid distribution in Southeast Asia during the Cold War, in its immediate aftermath, in the decades since, and through to the present. By examining these trends, this NTS Alert will demonstrate that there

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has been a shift from a focus on primary healthcare to a more selective approach centred on non-material aspects of health.

Through a broad analysis of the literature, this NTS Alert will argue that these patterns invariably reflect the pursuit (and waning) of particular Western interests in each period, rather than an active interest in the health of populations in developing regions. Thus, while foreign aid has resulted in sometimes significant improvements, the fact that Western-centric perspectives tend to prevail in why and how funding is allocated and distributed means that the specific needs of developing regions are not being addressed in a comprehensive manner. The merging of health and security in the contemporary period is simply the latest aspect of this trend.

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The Cold War: Development, Modernisation and Health

It is generally agreed that the Western foreign aid regime originated in the Cold War and the associated ideological confrontation between the US and the Soviet Union (Grant and Nijman, 1997:34). Initially, this aid was channelled, under the Marshall Plan, into the short-term economic recovery of European states in the aftermath of the Second World War. Boosting economic development was seen as the most effective method of preventing the spread of communism in Europe and elsewhere, reducing the appeal of communist parties, stabilising Germany and offering an alternative to the Eastern Bloc's socioeconomic system (Grant and Nijman, 1997:34).

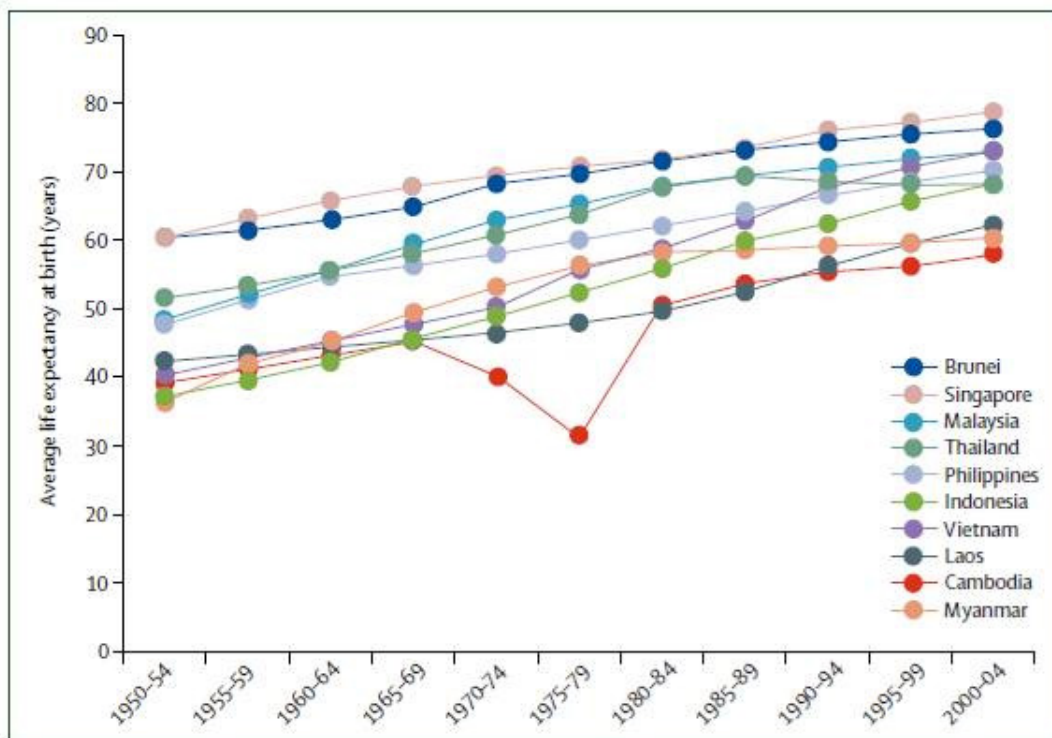
However, in the 1950s, the focus of foreign aid shifted to developing states in other regions, with the growing consciousness that if the West did not support such states, they might turn to the Soviet Union for support. At the same time the West became concerned with population growth in the developing world, informed by security concerns which equated demography with power (Furedi, 1997). It was then that the US increased investment and development aid to 'recently stirred and awakened' regions, one of which was Southeast Asia, in order to 'create a firm economic base for the democratic aspirations of their citizens' (Truman, 1949).

The wider Asia-Pacific region became the US's most important aid recipient region in the 1950s, reflecting Western concerns, as evidenced by their actions in the Korean War and the Vietnam War, over the possible spread of communism in the region (Grant and Nijman, 1997:42). The US-initiated Griffin Mission of 1950 recommended that USD60 million of economic and technical assistance be funnelled into the region, particularly to Vietnam, Lao PDR and Cambodia (US Department of State, 1950). Also, the Truman administration developed the Point Four Program, a technical assistance programme for developing countries. This programme was implemented at around the same time as the fall of nationalist China and the advancement of Chinese communism under Mao. To the Western powers, these events reflected the supposed 'susceptibilities of Asiatic peoples to the Communist appeal' (Reubens, 1949:61). The Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC), established in 1961, also responded to the political developments of the time, perceiving aid to be a significant foreign policy tool in the pursuit of capitalist development, particularly in newly independent Asian states such as Vietnam and Malaya (Grant and Nijman, 1997:34).

These security-focused concerns had a concomitant influence on the attitudes of government elites towards international health policy. Pupavac (2005:174) notes that 'international health policy in the political climate of the Cold War was planned on the assumption that non-western states should be industrialised and reach the same levels of development as western industrialised states'. Indeed, health came to be perceived as being integral to the achievement of western industrialised status. Disease eradication was thought to be vital to promoting a healthier workforce and to helping to free up disease-ridden land for cultivation, development and industrialisation purposes. Health improvements were also held to promote new Western values among developing populations (Pupavac, 2005:175). The belief that the same levels of economic development could be achieved anywhere in the world gave rise to ambitious health policies focused on the cure and eradication of diseases.

The high levels of Western aid to and investment in Southeast Asia for industrialisation and economic development resulted in various health gains across the region. Efforts towards disease eradication increased and became more ambitious, encouraged by the success of the systematic elimination of smallpox from the early 1950s to the late 1970s. The construction of advanced health infrastructure such as modern hospitals and the rise of primary healthcare also led to gains such as lower infant mortality rates and longer average life expectancies. As seen in Figure 1, life expectancy at birth in Southeast Asia rose from 1950 onwards (except for Cambodia which experienced a significant dip during the Khmer Rouge period).

Figure 1: Average life expectancy at birth in Southeast Asia, 1950–2010.



Source: Chongsuvivatwong et al. (2011:432).

However, the optimistic ambitions in relation to international health gains gradually diminished after an unsuccessful attempt at eradicating malaria. Although the World Health Organization (WHO)-led Global Malaria Eradication Program of 1955 was initially highly successful, widespread agricultural use of DDT is held by some to have led to mosquito resistance. The primary factor behind the disappointing results was, however, the withdrawal of political and financial support by major donor states, notably the US, after DDT was banned there in 1972 due to perceived environmental and human health threats (Pupavac, 2005:176). Ultimately, the programme was successful in eliminating malaria only in areas with 'high socio-economic status, well-organized healthcare systems, and relatively less intensive or seasonal malaria transmission' (Sadasivaiah et al., 2007:250). As well as the absence of political will, environmental factors (which contributed to continuous mosquito life cycles) and poor infrastructure impeded similar progress in developing countries in the tropics, including Southeast Asian states. In some of these countries, early decreases in malaria cases came to be partially or completely reversed. Transmission rates even increased in certain cases (Chapin and Wasserstrom, 1981).

Criticisms of the modernisation approach to health in developing countries emerged in the wake of this failed eradication attempt. The approach was panned as inequitable and wasteful, benefiting only a small percentage of the population in specific countries. It was also seen as encouraging rapid urbanisation in developing countries, which contributed to the spread of diseases and the creation of new health problems such as alcoholism and chronic diseases (Pupavac, 2005:176). However, it could equally be argued that modernisation simply never went far enough and that the reluctance to continue the anti-malaria programme allowed a more limited view of what was achievable to take hold.

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The End of the Cold War: A 'Lost Decade' for Development and Health?

The 1980s saw a shift away from the primary healthcare ideals of prior decades, and is often referred to as a 'lost decade' in terms of development (Pupavac, 2005:182). Recalls of western loans led to cutbacks in public services and the loss of vital food subsidies in developing countries – both of which had consequences for the health of those living in the developing world (Pupavac, 2005:183).

During the Cold War, Southeast Asia had been viewed through 'the strategic lens of geopolitical significance' by the West, and aid flows to the region reflected this (Grant and Nijman, 1997:43). US economic aid to Southeast Asia underwent a slow decline after the 1950s, rose in the lead-up to the Vietnam War, peaked during the war, and fell after 1973. In the early 1980s, aid rebounded once more but dwindled to a bare minimum as the Cold War drew to a close (Grant and Nijman, 1997:43). These fluctuations and the eventual decrease in aid caused a developmental slowdown in the region. This slowdown adversely impacted the health of populations across Southeast Asia. This was further exacerbated by uneven development, rural-urban disparities, and inequalities within and between countries in the region.

In this climate, the primary healthcare approach of previous decades evolved into a selective primary healthcare approach. The focus

moved from the more ambitious disease eradication, cure and elimination strategies of the past, to centre instead on health management, prevention and adjustment processes. This approach was pioneered by the United Nations Children's Fund (UNICEF) through its growth monitoring, oral rehydration, breastfeeding and immunisation (GOBI) strategy for child health. This strategy aimed to 'allow for the scarcity of resources available to achieve health for all ... using interventions that were feasible to implement, of low cost, and with proven efficacy' (WHO, 2002). The successes of this strategy then inspired other international organisations to follow suit. However, Pupavac (2005:183) notes that this realignment towards ensuring basic needs for survival is far from the WHO's (1978, 2006) stated objective of 'the attainment by all peoples of the highest possible level of health'. It was, in effect, an attempt to make the best of a bad job.

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The 1990s: The 'Sustainable Development' Approach to Health

Ensuring and codifying basic health needs as rights emerged in the 1990s with the rise of the sustainable development approach. This approach emphasised the social empowerment of vulnerable sections of society, bottom-up development and the importance of non-material aspects of well-being. It was rationalised as 'material well-being, physical well-being, social well-being, security, and freedom of choice and action' in the World Bank's *Voices of the Poor* report (Narayan et al., 2000:22). The report 'downplays the significance of material prosperity' (Pupavac 2005:185). This increased rhetoric about rights appears to be in direct contrast to the reality of reduced development.

This era also witnessed self-help attitudes rooted in 'power, ownership, equity and dignity' rise to prominence as the primary focus of discourse on international health policy (Newell, 1988). This is evidenced by the *1994 Human Development Report* which argued that there was no clearly established link between the health status of a population and rising economic development in any given country (UNDP, 1994, cited in Phillips and Verhasselt, 1994:xiv).

Some have argued that the self-reliance rhetoric was not a step forward for international health. Pupavac (2005:184) contends that such a discourse is founded on low expectations. She also criticises it on the grounds that it shifted the initiative for development – from governments or international organisations to the individual. This led to and legitimised similarly minimalist development goals on the part of governments and international organisations themselves, seen in a general retreat from state health services (Pupavac, 2005; Abrahamsen, 2000).

During this period, Southeast Asia's strategic and security significance to the West waned (due to the end of the Cold War). Improving economic and political trends contributed to a perception by the West that the region required less economic assistance, which led to a decline in US aid (Lum, 2008:2). However, although the 1990s began with rapid growth among market economies in the region such as Singapore, Malaysia, Indonesia and Thailand, it was followed by the Asian financial crisis of 1997–1998. The crisis resulted in increases in the cost of imported drugs and other supplies, and reduced healthcare access for large segments of society (Chongsuvivatwong et al., 2011:434).

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International Health: Where Do We Stand Today?

Entering the 21st century, some have noted the increasing securitisation of international politics (Buzan et al., 1998:25). Accordingly, the new international health rhetoric emphasises how health threats transcend borders – a classic security concern. International health today appears to stress the potential risks posed by, one, diseases originating in developing countries (such as pandemic viruses and communicable tropical diseases) to countries in the West, and two, chronic diseases of the developed world (such as cardiovascular diseases) as opposed to the daily experiences of disease and ill health in developing countries (Pupavac, 2005:187).

Trends in Western aid to Southeast Asia have also reflected this shift towards securitisation. Since 2001, the 'war on terror' has re-oriented foreign assistance priorities in Asia and accelerated a trend towards increased security-focused aid to the region. Within this new aid distribution scheme, Southeast Asian countries, particularly the Philippines and Indonesia, 'due to their strategic importance, large Muslim populations, and insurgency movements with links to terrorist groups', have been prioritised (Lum, 2008:2–3). This aid is being directed specifically into education and livelihood skills development for impoverished and conflict-ridden areas (Lum, 2008:3).

Meanwhile, the health systems of other low- and lower-middle-income Southeast Asian nations remain dependent on external aid, but from more limited sources. For instance, external aid is one of Myanmar's major sources of healthcare financing (Ministry of Health Myanmar, 2010:9). Also, one-third of public health expenditure in Lao PDR, and 70 per cent of such expenditure in Cambodia, is donor-driven (Chongsuvivatwong et al., 2011:web appendix 7–9). However, unlike during the Cold War period, the funding comes from a vast array of disparate charitable efforts, rather than a concerted strategic push.

Within a security-focused framework of analysis, a number of health issues have been neglected. Chronic non-communicable diseases remain responsible for 50 per cent of the disease burden in low- and middle-income countries (Nugent, 2008:17). Affordability of medical

care and availability of cheap generic medicines and vaccines in developing countries have become causes championed primarily by non-governmental organisations such as Médecins Sans Frontières and Oxfam, not by state governments. This reflects the shift from aid as a strategy to aid as charity.

Most crucially, the Cold War era aspiration that developing countries should attain the same standard of health as their developed counterparts has disappeared (Pupavac, 2005:187). This lack of commitment to achieving health equality can be observed in many of the WHO's recently released reports. For instance, its first report on neglected tropical diseases (NTDs) indicates that while NTDs continue to affect millions in the developing world, there remains little incentive for pharmaceutical industries to invest in developing new or better drugs for markets that cannot afford them. According to the report, one of the goals of the Global Plan to Combat NTDs 2008–2015 is the *elimination and eradication* of selected NTDs. However, somewhat contradictorily, the report also states that the Plan's overarching vision is to 'achieve cost-effective, ethical and sustainable *control* of NTDs' (emphasis added) (WHO, 2010:31).

Today, the legitimisation of unequal health outcomes occurs based on cultural relativist arguments: international advocacy in health remains informed by different health and development outcomes for different countries. This approach may do more harm than good in the long term. For example, the UN's Millennium Development Goals on health – reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases – appear innovative and inclusive, but they effectively constitute a selective healthcare strategy reminiscent of the prevalent approach in the 1980s (Pupavac, 2005:184). This approach may be preventing further, faster and more efficient development in the health sectors of developing countries by continually inculcating low expectations for change and development.

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Conclusion

Development trends from the Cold War to the present, as reflected by aid flows and their political underpinnings, underwent a gradual shift of focus from material to non-material perceptions of health.

During the Cold War, the desire of the market economies of the West to keep newly independent developing countries from turning to the Soviet Union for support led them to increase aid to those regions; the wider Asia-Pacific region in particular benefited from this. Initially, Western attitudes towards development were founded on the assumption that non-western countries were quite capable of reaching levels of development similar to the industrialised states of the West. Such a standpoint gave rise to ambitious health policies focused on the cure and eradication of diseases such as smallpox and malaria. The influx of developmental aid to the Asia-Pacific region led to improvements in the overall health of populations.

However, with the end of the Cold War, many developing countries lost their strategic significance to the West. This was exacerbated by specific problems, such as the failure to eradicate malaria, a failure which was itself the result of diminishing aspirations and confidence. The broader strategy of providing material aid to developing countries gave way to a more piecemeal approach which emphasised selective primary healthcare.

These shifts both reflected and further influenced Western development priorities. This was seen in a change in attitudes towards and perceptions of health, from a focus on ambitious large-scale material change to a more limited one centred on non-material aspects of well-being. The focus thus becomes teaching developing populations to merely survive in the absence of welfare systems, modern infrastructure and facilities. In other words, this system promotes a self-managing and self-reliant third world able to survive within existing developing world conditions without causing security problems for its developed counterparts (McCormack, 2011:7).

Today, material aid for state development has been replaced with a large number of smaller development projects. While each project may be beneficial to the individuals involved (both recipients and donors), their sum does not add up to a cohesive development strategy. To what extent these small projects are practical and workable in developing world conditions also merits further discussion. It remains to be seen whether the health of developing populations will truly benefit from a Western perspective which posits that 'post-industrial social relations can be created in a pre-industrial society, bypassing the question of material development altogether' (McCormack, 2011:16).

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