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The Political Economy of Human Development: Colonial Asia, 1900–2000

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Abstract

How did Asian states and peoples try to achieve better lives across the twentieth century, and how far did they succeed? Modern discussions of development concentrate on the importance of enhancing personal capabilities and human development, rather than on simple economic growth. The comparative history of colonial Asian countries, both before and after political independence, shows the range of economic, political, social, and environmental conditions necessary for such improvements. Increases in life expectancy across the range of countries are a useful metric to compare public health and the supply of basic needs. Countering endemic disease – especially malaria – has played an important part here. One key to success in the fight against malaria has been the ability of states, local authorities, and communities to provide support-based security to those who require it. Some colonial Asian countries have been better at this than others and have prospered accordingly.

Keywords

human development – support-based security – life expectancy – malaria – colonial Asia

1 Introduction*

The political economy of development across the globe is one of the most important topics in our shared past, present, and future. This article considers a sample of "colonial" Asian countries that were under imperial rule in 1900, achieved independence in the 1940s and 1950s, and then followed distinctive policies to secure development for the rest of the twentieth century. These are British India, British Malaya, French Indochina, the Netherlands East Indies (Indonesia), Taiwan and South Korea (annexed by Japan in 1895 and 1910), the Philippines (ceded from Spain to the United States in 1898), and China (never a formal colony, but heavily influenced by the actions of imperial powers until 1949). A comparative perspective can identify the similarities and differences between these countries' experiences of colonialism and independence, and the causes of their varying achievements in development both in the colonial and the postcolonial eras.

2 The Political Economy of Empire

The first half of the twentieth century was a period of active imperialism in Asia. Economic problems and international rivalries forced the Dutch to ask what benefits they wanted from their rule in Indonesia; the French from Indochina; the United States from the Philippines; the British from India and Malaya; the Japanese from Korea, Taiwan, and Manchukuo. Mostly this examination was characterized by what has been called "pessimistic mercantilism" (Hardy 1988, 809), or the "economics of siege" (Hancock 1940, 103–104) – new policies to make the most of Asian colonies as markets for manufactures and producers of raw materials. Japan took this furthest, developing her East Asian colonies as sources of raw materials and labor to fortify the imperial center's military capabilities. The Indo-British economic relationship was the only one that had moved beyond this simple bilateral stage by the 1920s. The major British interest in India that could now only be secured by direct rule was the use of her army for imperial defence, although with Britain paying some of the costs.

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If economic policy was the key to development, then there were initial similarities across postcolonial Asia in the second half of the twentieth century, triggered by the disruptions of wars (especially in Korea and Indochina) and the consequences of imperial collapse, the imposing of new national borders, and political fragmentation. The new states in the 1950s often followed similar policies for growth, such as import-substituting industrialization, and the use of economic systems for state-building. Development in the 1950s and 1960s was linked to the process of national state formation. From the 1970s there was much greater variance, with East Asia and Southeast Asia pursuing export-oriented industrialization; China taking a radically different path to development until the 1980s; and India not changing her basic approach to development (the "permit-license raj") until the 1990s.

The structure and activities of the state have often been seen as a critical factor in economic growth in Asian countries – from Gunnar Myrdal's "soft state" in India (Myrdal 1968), through Chalmers Johnson's "developmental state" in East Asia (Johnson 1995), to Atul Kohli's analysis of "state-directed development" (Kohli 2004), and the characterization of many Asian administrations – such as Indonesia under Sukarno and Suharto, and the Philippines under Ferdinand Marcos – as "kleptocratic states" (Halili and Arguelles, 2015). The analysis of local capitalism before and after independence has been dominated by explorations of the relations between big business and the state – with a critique of the role of indigenous businesses as "compradors," a "national bourgeoisie," or "rent-seekers"; a stress on "crony capitalism," or "pariah capitalism"; or a search for corporatism in the collaboration of business and state institutions (Walter and Zhang 2012, Lim 2021).

Following this analysis, the political economy of postcolonial development has often been investigated by identifying powerful national interests – such as privileged groups in the countryside or corporate actors in business and government. Some analysts have provided a historical context for such accounts by investigating the activities of these groups across the twentieth century. A more recent approach has sought to link the progress of development with the effectiveness of market mechanisms for allocating resources. In Asian postcolonial countries, economic institutions played a prominent role in coordinating activity by acting as substitutes for missing markets. Examples include the conglomerates of South Korea and Taiwan, where chaebols and LTC s, respectively, helped usher in successful corporate capitalism (Kang 1995).

Did an imperial past affect postcolonial development in any positive way? The clearest connections have been argued for South Korea and Taiwan, which have achieved remarkably high growth rates since 1960, leading to arguments that the Japanese imperial impact uniquely facilitated rapid economic growth

after decolonization (Kohli 1994, 1997). However, careful comparative studies show that Japanese rule was as "imperial" in Korea, Taiwan, and Manchukuo as the rule of other powers elsewhere, and that economic growth in the Japanese colonies was not much different to that in French, British, or Dutch possessions (Booth and Deng 2019). The East Asian colonies were bound tightly into a bilateral trade network with Japan – supplying food, raw materials, and unskilled labor, and receiving manufactured goods, military personnel, and skilled immigrants. Although the Japanese Empire ended in 1945, rapid economic growth in South Korea and Taiwan took place only in the 1960s and was heavily based on support from the United States (Haggard 1998).

3 Measuring Development

Figures 1–3 that follow this text set out three sets of statistical indicators by which development over time has been measured. Figure 1 uses the traditional measure for development – gross domestic product per capita, adjusted by a measure for purchasing power parity across countries. If per capita GDP growth is the best measure of development, then there is a clear contrast between the first and second halves of the twentieth century: per capita GDP growth rose slowly in Asian colonies before 1960, and more rapidly thereafter. But it was much easier to achieve economic growth after 1960 than it had been in the first half of the century. Two world wars and the Great Depression limited economic growth everywhere before 1945: the expansion in international trade and the stability of economic institutions benefited almost every country after 1960. The GDP growth rates for the "imperial" countries over the course of the century show a similar pattern. The economies of Britain, Japan, France, the Netherlands, and the United States were certainly not catastrophically affected in the second half of the twentieth century by the loss of their Asian colonies.[1] Malaya was perhaps the only area in colonial Asia to show significant sustained modest growth in GDP before 1960 – presumably linked to sustained international demand for the key exports of rubber and tin.

Over the past thirty years many have questioned how effective a measure of development per capita GDP can be. Rapid growth can cause environmental degradation and ecological strain and has not often led to an equal or just distribution of benefits. Broader definitions of development have stressed the importance of enhancing capabilities and life-chances for the entire

1 The activities of multinational enterprises and official aid programmes can blur the distinction between imperial, postimperial, colonial, and postcolonial economies.

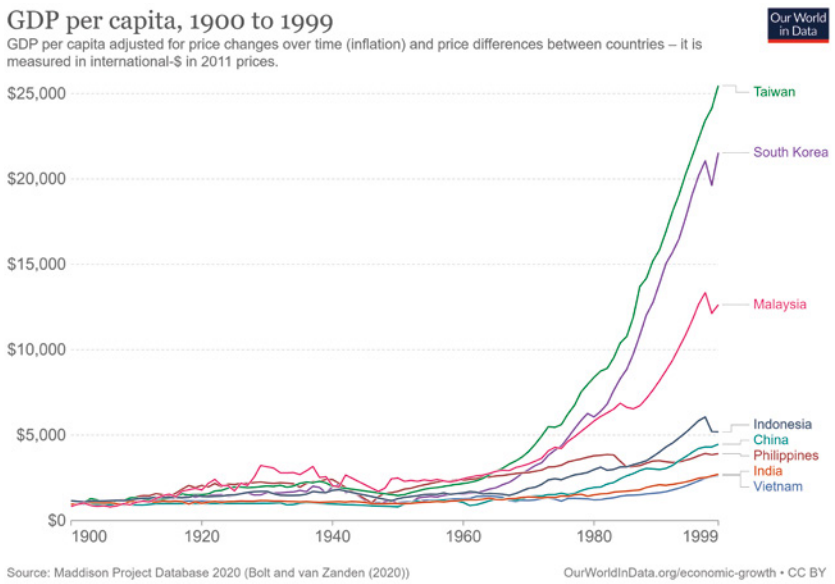

FIGURE 1 Economic growth in colonial Asia
ROSER, MAX. 2013 – "ECONOMIC GROWTH." PUBLISHED ONLINE AT OURWORLDINDATA.ORG AT HTTPS://OURWORLDINDATA.ORG/GRAPHER /MADDISON-DATA-GDP-PER-CAPITA-IN-2011US-SINGLE-BENCHMARK. RETRIEVED FROM: HTTPS://OURWORLDINDATA.ORG/ECONOMIC-GROWTH, OCTOBER 2022. DATA FROM MADDISON PROJECT DATABASE, VERSION 2020. BOLT, JUTTA AND JAN LUITEN VAN ZANDEN. 2020, "MADDISON STYLE ESTIMATES OF THE EVOLUTION OF THE WORLD ECONOMY. A NEW 2020 UPDATE" AT GRONINGEN GROWTH AND DEVELOPMENT CENTRE.HTTPS://WWW.RUG.NL/GGDC/HISTORICALDEVELOPMENT /MADDISON/RELEASES/MADDISON-PROJECT-DATABASE-2020

population, equating successful development with "happiness" or "freedom." In 1990 the United Nations Development Program signaled a switch away from simple measures of economic growth to the concept of a Human Development Index. Human development was defined as "the process of enlarging people's choices," these choices allowing them to "lead a long and healthy life, to be educated, to enjoy a decent standard of living," as well as "political freedom, other guaranteed human rights, and various ingredients of self-respect" (UNDP 1990, 1).[2]

2 The intellectual history of the HDI, and the important roles of Mahbub ul Huq and Amartya Sen in establishing it as an accepted measurement for development, are covered in Stanton 2007 and Gaspar 2011.

From 1990 to 2009, the index was based on equally weighted measurements of GDP per capita at purchasing power parity, life expectancy at birth, and knowledge and education as measured by the adult literacy rate and enrollment in educational institutions. Since then the index has been constructed from broader measures of a long and healthy life, education, and a decent standard of living. Figure 2 shows a historical series for the Human Development Index in colonial Asia. This tells the same headline stories as the GDP data, but with some significant differences. The dynamism of South Korea and Taiwan in comparison with the rest of colonial Asia after 1960 is not so pronounced; the Philippines stand out as most successful in development before 1950 (presumably because of the expansive education policy of the colonial government

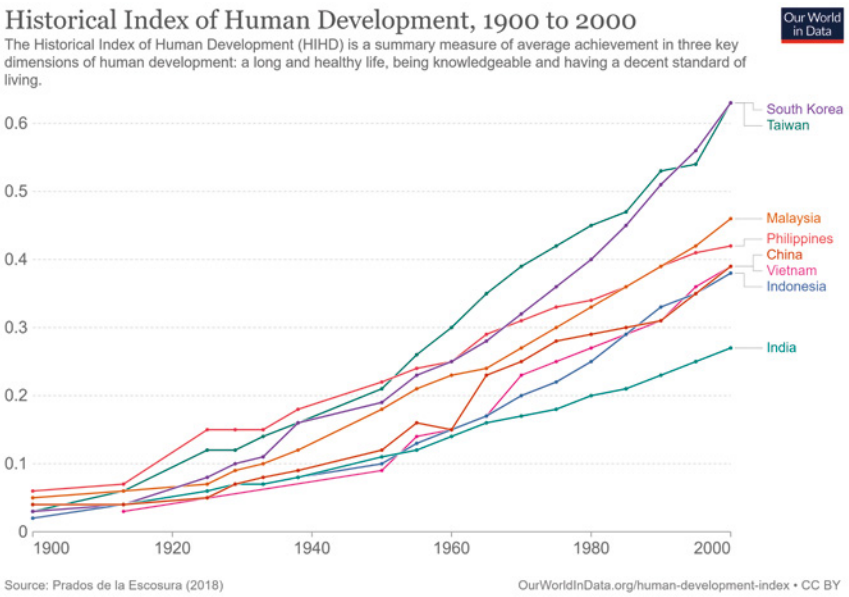

FIGURE 2 Human development in colonial Asia
ROSER, MAX. 2014 – "HUMAN DEVELOPMENT INDEX (HDI)." PUBLISHED ONLINE AT OURWORLDINDATA.ORG. RETRIEVED FROM: HTTPS://OURWORLDINDATA.ORG/HUMAN-DEVELOPMENT-INDEX, OCTOBER 2022. DATA FROM PRADOS DE LA ESCOSURA, LEANDRO. "HISTORICAL INDEX OF HUMAN DEVELOPMENT HIHD)" HTTPS://FRDELPINO.ES/INVESTIGACION/EN/CATEGORY/01_SOCIAL-SCIENCES/02_WORLD-ECONOMY/03_HUMAN-DEVELOPMENT-WORLD-ECONOMY/?LANG=EN. UNDP' 1990. *HUMAN DEVELOPMENT REPORT 1990: CONCEPT AND MEASUREMENT OF HUMAN DEVELOPMENT*. NEW YORK. HTTPS://HDR.UNDP.ORG/CONTENT/HUMAN-DEVELOPMENT-REPORT-1990

aimed at disseminating the English language and "American values"), followed by Taiwan. Of course, a rise in the index from 1900 to 1950 does not mean that colonial administrations were benign developmental states, but simply that their imperial purposes required greater investment.

The HDI has been widely criticised, particularly for weaknesses in the underlying data, and the problems of weighting its various components. The International Labour Organization proposed an alternative measure of development in the 1970s, one that would measure levels of poverty by access to "basic needs" – the provision of food, clothing, shelter, housing, water, and sanitation. Some of these criteria – reducing income poverty, hunger, disease, and the lack of adequate shelter – were restated as UN Sustainable Development Goals in 2015. One simple measurement that came out of this approach is the Human Life Indicator, which is based on life expectancy at birth. These data are simpler to collect and use than the Human Development Index – although they were not universally calculated across colonial Asia in the first half of the twentieth century. The HLI (average age of death in the year of birth) is a good proxy for a range of basic needs – including health care, maternal education, and access to clean water and food. Since infants and small children account for a high proportion of annual deaths in poor countries, changes in these rates show the effects of changes in the provision of health and other support (Ghislandi 2018). The indicator also allows for simpler comparisons between countries and for comparisons within countries – differing rates among Indian states, for example.

Figure 3 shows data for life expectancy at birth across the countries of colonial Asia. The most notable statistics are for China in the post-1950 period. Life expectancy here increased from 1949 to 1958, fell sharply during the famine caused by the Great Leap Forward, rose consistently from the early 1960s to 1980, despite the disruptions of the Cultural Revolution, and then tailed off for the last two decades of the century. As has often been noted, these fluctuations run counter to the pattern of economic growth in China, which was much slower from 1950 to 1980 than it was from 1980 to 2000. The explanation for this disconnection between growth in GDP and increased life expectancy lies in nonmedical determinants – the spread of education and some public health interventions – that sharply reduced mortality among infants and children under five years.[3]

3 One detailed study, based on a database of province-based panel data for the 1950s, 1960s, and 1970s, concluded that "increases in educational attainment and public health campaigns jointly explain 50–70 per cent of the dramatic reductions in infant and under-five mortality during our study period" (Barbiarz 2015, 39).

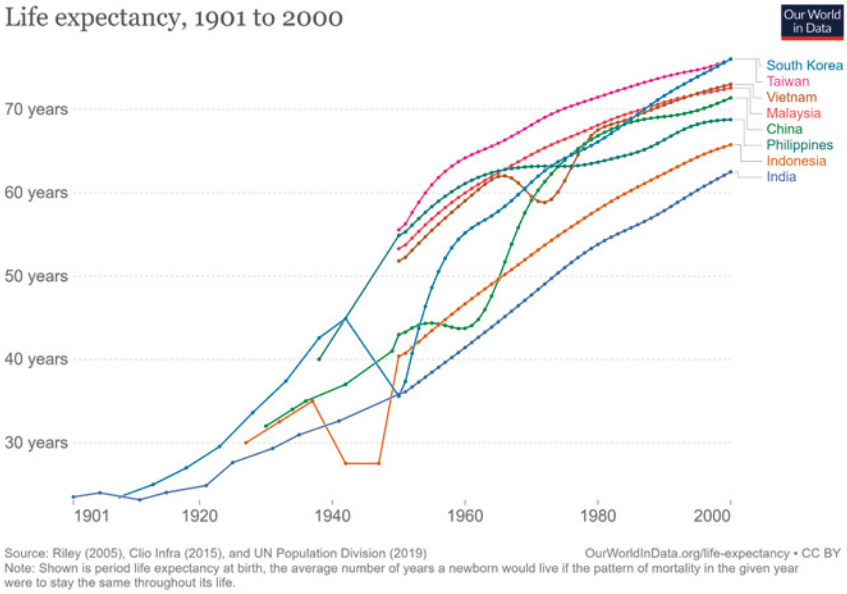

FIGURE 3 Life expectancy in colonial Asia
ROSER, MAX, ESTEBAN ORTIZ-OSPINA, AND HANNAH RITCHIE. 2013. "LIFE EXPECTANCY." PUBLISHED ONLINE AT OURWORLDINDATA.ORG. RETRIEVED FROM: HTTPS://OURWORLDINDATA.ORG/LIFE-EXPECTANCY, OCTOBER 2022. DATA FROM JAMES C. RILEY. 2005. "ESTIMATES OF REGIONAL AND GLOBAL LIFE EXPECTANCY, 1800–2001. ISSUE POPULATION AND DEVELOPMENT REVIEW" *POPULATION AND DEVELOPMENT REVIEW*, (313):537–43. CLIO INFRA PROJECT DATABASE OF LIFE EXPECTANCY AT BIRTH, AT HTTPS://CLIO-INFRA.EU/INDICATORS/LIFEEXPECTANCYATBIRTHTOTAL.HTML. UNITED NATIONS, DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *WORLD POPULATION 2019 HIGHLIGHTS* (UNITED NATIONS, NEW YORK, 2019) AT HTTPS://WWW.UN.ORG/DEVELOPMENT/DESA/PUBLICATIONS/WORLD-POPULATION-PROSPECTS-2019-HIGHLIGHTS.HTML

Amartya Sen has stressed the importance of mortality information as an indicator of the effectiveness of health care and a wide range of other basic social services in poor countries. He used the Chinese example to show that rising life-expectancy accompanied increased well-being, breaking any simple link between rates of GDP growth and human development (Sen 1998). Sen has also argued that the concept of "support-led security" was a key component of successful development policy in the 1960s and 1970s: "the contrast between China and India in public distribution systems and in social security programmes is certainly very striking, and it is plausible to see China's success

story as one of support-led security."[4] In India life expectancy at birth also increased faster between 1960 and 1980 than between 1980 and 2000, although not at the same rate as in China.[5]

4 Disease and Human Development

What do changes in human development, especially in life expectancy, tell us about the relationship between political economy and development in colonial Asia in the twentieth century? Let us approach this question through a comparative history of endemic disease – especially malaria – across the region. Malaria was a major cause of death (mortality) in twentieth-century Asia; infection (morbidity) also caused considerable weakening of human potential.[6] The histories of antimalarial programs have several features in common. Many members of local indigenous populations had some immunity to established strains of the *plasmodium* parasite because of contacts with the disease in childhood. Different species of malaria parasite caused different intensities of disease, relatively mild in the case of *Plasmodium vivax*; more severe with the "tropical malaria" caused by *Plasmodium falciparum.* Colonial and postcolonial authorities tried to limit the spread of malaria; both by controlling the parasite through the use of quinine, synthetic quinine, and other treatments; and by controlling the vector of the disease (*anopheles* mosquitoes of various subspecies) though insecticide spraying and drainage, and the use of local deterrent devices such as specialised bedding.

All the imperial powers in Asia saw combatting malaria as part of their "civilizing mission." They were also aware that outbreaks of the disease in their colonies were associated with attempts at economic development through irrigation schemes, transport infrastructure, the movement of migrant labor, and the arrival of imperial settlers and personnel.[7] Imperial public health

4 Drèze and Sen 1990: 210.

5 Some Indian states – notably Kerala – managed to provide a range of effective social services, and were rewarded by increased life expectancy, but most did not (Drèze and Sen 1990, 221–22). Other studies of India in the 1990s using HDI data also show Kerala as the best-performing state, ahead of much richer states such as Punjab, Maharashtra, and Haryana (Shiva Kumar 1991).

6 Colonial malaria outbreaks were most deadly where they combined with widespread poverty and famine to form "epidemic malaria" (Wakimura 2004).

7 For a strong statement of this argument, and its impact on malaria-control policy in India, see Watts 1999.

initiatives sought to increase and sustain exports of crops and minerals or facilitate the migration of labor. Development activities and incentives often resulted in environmental degradation and, by disrupting ecological stability, such policies "inadvertently stripped the population of its most effective natural protection against lethal strains of malaria" (Klein 2001, 169). Therefore, in India early measures to control malaria focused on the wheat-growing areas of the Punjab, which had benefited from an extensive canal-building program, and on tea-growing areas where there was a vocal planter lobby (Zurbrigg 2019, Bhattacharya 2012). The Japanese imperial state was chiefly concerned with protecting the health of the labor necessary for agricultural growth and mineral exports in Taiwan, Korea, and Manchukuo (Liang 1991; Kim 2015, 2018). In Southeast Asia imperial priorities protected labor on plantation crops and in mining, as well as European settlers in Malaysia, Indochina, and Indonesia (Guénel 2004, Verhave 2011).

The focus of imperial public health policy everywhere was initially toward the parasite, rather than the vector, and concentrated on the "human factor" in malaria transmission. There were changes in policy over time, but providing quinine was much cheaper than undertaking extensive public works. It was also much easier to tackle malaria in urban settings, or on plantations, than to effect eradication in rural areas without close supervision. Stressing the "human factor" also encouraged colonial health services to try to regulate and control the hygiene habits of their subjects and reenforced imperial attitudes to "uncivilized" local populations. In the Philippines under the United States, the colonial government's malaria policy initially identified "dirty natives" as the cause of the disease; then, as Filipino officials took over local administration, policy switched to a class-based explanation of disease prevalence (Anderson 2006).

The most successful malaria-eradication program of the colonial period was that in Taiwan. The island was not declared malaria-free until the 1960s, following a large-scale program of spraying insecticide, supported by the United States. However, the incidence of the disease had already been heavily reduced by the 1930s, following the Japanese imperial policy of blood tests, quinine dosing, and local environmental cleaning, closely supervised by local police supported by a local informal enforcement system (the *hoko* system) based on group responsibility (Liang 1991).[8]

The malaria problem in colonial Korea was less virulent than that in Taiwan. The imperial government was concerned by its effects on soldiers and settlers

8 The number of malaria deaths in Taiwan was reduced from 36 per 10,000 population in 1910 to less than 8 in the 1930s.

from Japan but concentrated on other diseases and did not initiate a dedicated antimalaria program until the late 1920s. This then focused on the "human factor" and was based on the use of quinine: this approach worked better for the Japanese expatriate population than for the Koreans – especially those locals affected by economic hardship (Kim 2015). Elsewhere, where there was close control and rapid reporting, as in the supervised quinine therapy run through field-based dispensary centers in India, colonial policies had some success in reducing malaria mortality, if not always morbidity (Klein 2001). However, supplies of quinine and other febrifuges were often inadequate and adulterated, which reduced their effectiveness (Barton 2007). This limited take-up, and caused nationalists in many Asian countries to discount prophylactic treatments in favour of more drastic intervention.

In the 1950s and beyond, antimalarial programs entered a heroic phase: newly independent governments were committed to improving the health of their populations and mounted large-scale interventions to target *anopheles* mosquitos by spraying with insecticides available through the World Health Organization or American agencies. However, such programs – especially those using DDT – had other, unforeseen, effects, and were not sustained. In India the success of early eradication programs in the 1960s gave way to complacency and a transfer of resources to other programs, which led to a resurgence of infections, especially in rural areas (Anvikar 2014). Malaria returned most seriously in the areas of India where health-care provision was most inadequate.[9] In Southeast Asia, political instability and the prevalence of insurgencies and warfare limited the effectiveness of antimalaria programmes (Bharati and Ganguly 2013). The South Korean government launched a National Malaria Eradication Service in collaboration with the WHO after 1960. This program was more successful, as it was based on close and effective monitoring of blood tests at a local level, and treatment of the parasite. Malaria was eliminated in South Korea by the 1980s by these methods, helped by rising standards of living. This caused a sharp decline in infant mortality, and a rise in average life expectancy, in the 1980s and 1990s. The disease reemerged in the 1990s, possibly because of contamination across the demilitarized zone (Chai, 2020).

By the end of the twentieth century, effective antimalaria programs had come to depend, like the Taiwanese programs of the 1930s, on close integration of local with national initiatives. Quick and targeted responses depended on close surveillance and effective reporting by health-care staff, supported

9 India has consistently suffered from very low levels of rural health services. States that had better health services, such as Kerala and Mysore (now Karnataka), saw lower rates of malaria reversion in the late twentieth century (Amrith 2007).

by government investment in laboratory facilities to speed up diagnosis. The activities in China that have resulted in the WHO declaring the country malaria-free in 2021 followed drastic interventions that targeted local transmission, rather than just controlling morbidity and mortality. Elimination was not just a health issue, but one that influenced, and was influenced by, local social, political, and economic conditions (Cao, 2021). In India, by contrast, malaria infections have become entrenched in forest areas near the international borders with Myanmar and Bangladesh, inhabited by "aboriginal" populations, and subject to high rates of internal migration. Resources have not been adequate for effective monitoring or treatment. Family planning was a higher priority for local health workers, leaving local reporting and response systems to be overwhelmed by the spread of chloroquine-resistant parasites and of new subspecies of mosquito. In the 2000s, one-fifth of the Indian population contributed four-fifths of the recorded malaria cases. In the malaria-prone states of Odisha, Chhattisgarh, Jharkhand, Assam, and the small states of the northeast, the disease accounted for over 20 percent of fever-related deaths in the 2010s, as opposed to 6 percent elsewhere (Gellband et al. 2020, 43). In Southeast Asia, malaria is most prevalent and persistent in areas separated from the programs of national governments and settled communities by insurrection, and subject to large-scale movement of refugees and migrants.

In its spread, persistence, and eventual decline, across colonial Asia in the twentieth century, malaria was a disease of one stage of development, associated with poorly managed environmental and social change, political weakness, and unplanned population movement. It was also a disease that prospered when crucial conditions for human development were absent – security-based networks and institutions to meet the basic needs and enhance the essential capabilities of the rural poor.

5 Conclusion

Human development – especially increased life expectancy – occurred fastest in Asia after 1950, in the period of national, not colonial, government. In basic disease control, significant achievements reflected the ability of national states to harness a sense of solidarity and/or a willingness and ability to impose much closer supervision and control over the rural population. This tighter rein was the secret to the eradication of malaria and other endemic diseases in at least some parts of the region. This leads on to the larger conclusion that the key to unlocking human development in colonial and postcolonial Asia was not simply the ideology of the nation-state, or the application of technological or

managerial solutions to endemic problems, but the recruitment and commitment of local societies and agencies to provide basic welfare needs and social security for all their members. As the data presented here in Figures 1–3 make clear, some postcolonial Asian countries have been more successful than others at providing such security-based development. This is an ongoing process: in India, perhaps initiatives such as the Rural Employment Guarantee Scheme introduced in 2006 will make a significant difference. My hope is that asking why differential rates of human development have happened in colonial Asia, and how this relates to the history of the transition from colonialism to independence, will stimulate further discussion and research.

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