

Political economy of development: colonial Asia 1900-2000

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The political economy of development across the globe is one of the most important topics in our shared past, present and future. This paper considers a sample of Asian countries that were under imperial rule in 1900, achieved independence in the 1940s and 1950s, and 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.

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 US from the Philippines; the British from India and Malaya; the Japanese from Korea, Taiwan, and Manchukuo. Mostly this was characterised by “pessimistic mercantilism”, or the “economics of siege” - new policies to make the most of Asian colonies as market for manufactures and producers of raw materials. Japan took this furthest, developing her East Asian colonies as sources of raw materials and labour to fortify the imperial centre'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 was the use of her army for imperial purposes, although with Britain paying some costs.

The charts that follow this text set out three sets of statistical indicators by which development over time has been measured. Chart 1 uses the traditional measure for development - gross national product (GNP) per capita, adjusted by a measure for purchasing power parity (PPP) across countries. If per capita GNP growth is

the best measure of development, then there is a clear contrast between first and second halves of the twentieth century: per capital GNP growth rose very little in Asian colonies before 1960, and quite 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 benefitted every country after 1960. The GNP 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 - although the activities of multinational enterprises (MNEs) and official aid programmes can blur the distinction between imperial and post-imperial economics.

Did an imperial past affect development policy in any positive way? The clearest connections have been made for South Korea and Taiwan, which have achieved remarkably high growth rates since 1960, leading to a wide-spread argument that the Japanese imperial impact uniquely facilitated rapid economic growth after decolonization. However, careful comparative studies show that Japanese rule was as 'imperial' in Korea, Taiwan, and Manchukuo as were other powers elsewhere. The East Asian colonies were bound tightly into a bilateral trade network with Japan - supplying food, raw materials, and unskilled labour, 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 USA. Chart 1 suggests that Malaya was only area in colonial Asia to show significant modest growth before 1960 - presumably linked to sustained international demand for rubber and tin.

Over the last thirty years many have questioned whether growth in per capita GNP is the most effective measure of development. Such growth can cause environmental degradation and ecological strain and has not 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 population, equating successful development with "happiness" or "freedom". In 1990 the United Nations Development Programme signalled a switch away from simple measures of economic growth to the concept of a Human Development Index (HDI), following the work

of South Asian economists such as Amartya Sen and Mahbub ul Haq. 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". [United Nations, *Human Development Report*, 1990]

From 1990 to 2009, the HDI was based on equally weighted measurements of GNP per capita at PPP, life expectancy at birth, and knowledge and education as measured by the adult literacy rate and enrolment 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. Chart 2 shows a historical series for HDI in colonial Asia. This tells the same headline stories as the GNP data, but with some significant differences. The dynamism of South Korea and Taiwan in comparison to 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 funding for education), followed by Taiwan. Of course, a rise in the HDI for 1900-1950 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 ILO (International Labour Organisation) proposed an alternative measure of development in the 1970s which measured 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 lack of adequate shelter - have been restated as key UN Millennium Development goals. One simple measurement which came out of this approach is the Human Life Indicator (HLI) based on life expectancy at birth. These data are simpler to collect and use than the HDI (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 a high proportion of annual deaths in poor countries are made up of infants and small children, changes in these rates show the effects of changes in the provision of health support. The

indicator also allows for simple comparisons between countries and for comparisons within countries - differing rates among Indian States, for example.

Chart 3 shows data for life expectancy at birth across the countries of colonial Asia. The most notable figures 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, 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 GNP and increased life expectancy lies in non-medical determinants - the spread of education and some public health interventions - which sharply reduced mortality among infants and children under 5 years. These provided what Jean Drèze and Amartya Sen have called “support-led security” [Drèze and Sen, *Hunger and Public Action*, 1991] that accompanied the fall in death rates in China, and in Kerala in India. It is worth noting that 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.

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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 1950s often followed similar policies for growth, such as import-substituting industrialisation (ISI), 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-orientated industrialisation; China on a radically different path to development until the 1980s; and India not changing her basic approach to development until the 1990s.

The structure and activities of the state has often been seen as a critical factor in economic growth in Asian countries - from Gunnar Myrdal's 'soft state' in India, through Chalmers Johnson's 'developmental state' in

East Asia, to Atul Kohli's analysis of 'state-directed development', and the widespread characterisation of Indonesia under Sukarno and Suharto, and the Philippines under Marcos, as 'kleptocratic states'. The analysis of local capitalism has been dominated by exploration of 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.

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 colonial countries, economic institutions played a prominent role in co-ordinating activity by acting as substitutes for missing markets. Examples of this are the accounts of the role of chaebols and LTCs (large conglomerates) in Korea and Taiwan as examples of successful corporate capitalism.

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If we look at development across Asia from an alternative perspective, we can open larger issues. What do changes in human development, especially in life expectancy across the region, tell us about the political economy of 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. The histories of anti-malarial programmes 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 'tropical malaria' caused by *Plasmodium falciparum*. Colonial and postcolonial authorities tried to limit the spread of malaria; both by

controlling the parasite (various species of *plasmodium*) through the use of quinine, synthetic quinine, and other treatments; and by controlling the vector of the disease (*anopheles* mosquitos of various sub-species) 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 so-called '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 labour, and the arrival of imperial settlers and personnel. Imperial public health initiatives sought to increase and sustain exports of crops and minerals or facilitate the migration of labour. In India early measures to control malaria focussed on the wheat-growing areas of the Punjab, which had benefitted from an extensive canal-building programme, and in tea-growing areas where there was a vocal planter lobby. The Japanese imperial state was concerned to improve the health of the labour necessary for agricultural growth and mineral exports in Taiwan, Korea, and Manchukuo. In Southeast Asia imperial priorities protected labour on plantation crops and in mining, as well as European settlers in Malaysia, Indochina, and Indonesia. Development activities and incentives had often resulted in environmental degradation. By disrupting ecological stability, such policies had inadvertently stripped the population of its most effective natural protection against lethal strains of malaria.

The focus of imperial public health policy everywhere was initially towards the parasite, rather than the vector, and concentrated on the 'human factor' in malaria transmission. There were some changes in policy over time, but providing quinine was much cheaper than undertaking public works. It was also much easier to tackle malaria in urban settings, or on plantations, than to supervise 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 re-enforced imperial attitudes to 'uncivilised' local populations. In the Philippines under 'Insular Government', as the U.S. civil administration was known up to 1935, 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.

The most successful malaria eradication programme of the colonial period was that in Taiwan. The island was only declared malaria free in the 1960s, following a large-scale programme of spraying insecticide, supported by the USA. However, the incidence of the disease had already been heavily reduced by the 1930s, following the Japanese imperial policy of requiring close supervision by local police of blood tests, quinine dosing and local environmental cleaning, supported by a local informal policing system (the *hoko* system) based on group responsibility and enforced by intrusive police supervision. 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 from Japan but concentrated on other diseases and did not initiate a dedicated anti-malaria programme until the late 1920s. This then focussed 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. Elsewhere, where there was close control and rapid reporting, as in the supervised quinine therapy run through field-based dispensary centres in India, colonial policies had some success in reducing malaria mortality, if not always morbidity. However, supplies of quinine and other febrifuges were often inadequate and adulterated, which reduced their effectiveness. This limited take-up, and prejudiced nationalists against prophylactic treatments in favour of more drastic intervention.

In the 1950s and beyond anti-malarial programmes entered a heroic phase, with newly independent governments committed to improving the health of their populations, and large-scale interventions to target *anopheles* mosquitos by spraying with insecticides available through the World Health Organization (WHO) or American agencies. However, such programmes - especially those using DDT - had other, unforeseen, effects, and were not sustained. In India the success of early eradication programmes in the 1960s gave way to complacency and a transfer of resources to other programmes which led to a resurgence of infections, especially in rural areas. In Southeast Asia, political instability and the prevalence of insurgencies and warfare limited the effectiveness of anti-malaria programmes. The South Korean Government launched a National Malaria Eradication Service in collaboration with the WHO after 1960. This programme 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 re-emerged in the 1990s, possibly because of contamination across the DMZ.

By the end of the twentieth century, effective anti-malaria programmes had come to depend, like the Taiwanese programmes 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 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. 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: the growth of chloroquine-resistant parasites, and the spread of new sub-species of mosquito, have overwhelmed weaker local reporting and response systems. 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 north-east, the disease accounted for over 20% of fever-related deaths in the 2010s, as opposed to 6% elsewhere. In Southeast Asia, malaria is most prevalent and persistent in areas separated from the programmes of national governments and settled communities by insurrection, and subject to large-scale movement of refugees and migrants.

The same lesson can be learnt by studying India's successful campaign to eradicate smallpox in the 1970s. This vaccination campaign succeeded, where earlier ones had failed, not because of technical change - new vaccines and better needles - but because of much closer monitoring, which brought about a 'surveillance-containment' strategy. In 1974 over 30,000 district health personnel and more than 100,000 additional field workers launched an intense campaign that combined village-level visitations, large-scale advertising and information distribution, and monetary rewards for reporting cases. The WHO recorded the last smallpox case in India in 1975, and declared the disease eliminated across the globe in 1977.

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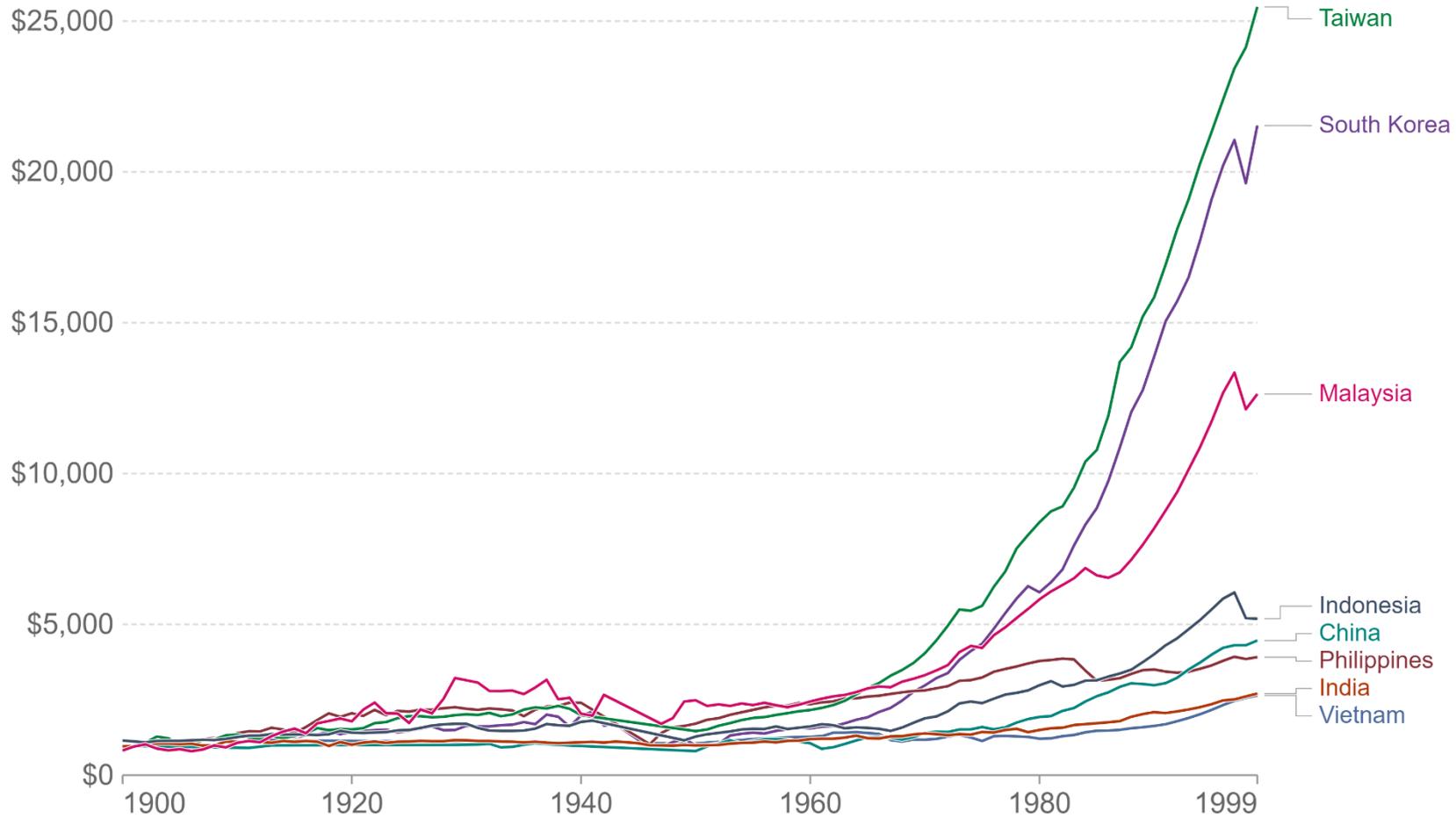
Human Development - especially increased life expectancy - occurred fastest in Asia after 1950, in the period of national, not colonial, government. In basic disease control, significant achievements reflected the ability of national states to harness a sense of solidarity and/or a willingness and ability to impose much closer supervision and control over the rural population. This last was the secret to the eradication of malaria, smallpox 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 needs and social security for all their members. As the data presented here in Charts 1-3 make clear, some postcolonial Asian countries have been more successful than others at providing such security-based development. This is an on-going 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.

Note on Charts: These charts have been created and downloaded from the open access and open-source website [Our World in Data](#) (a project of the Global Change Data Lab), based on the sources listed below each. *Our World in Data* allows the user to identify individual countries against several variables.

GDP per capita, 1900 to 1999



GDP per capita adjusted for price changes over time (inflation) and price differences between countries – it is measured in international-\$ in 2011 prices.



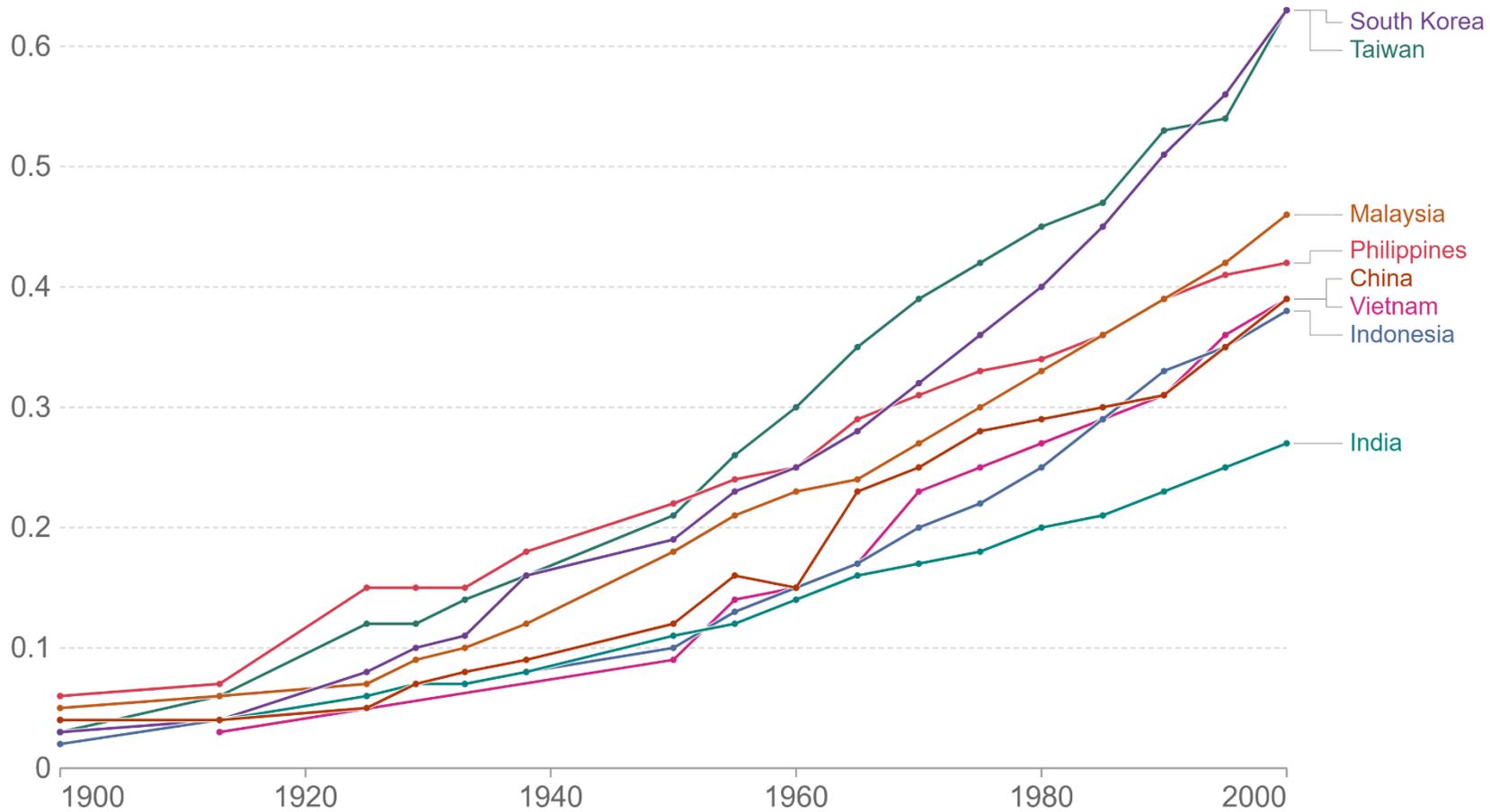
Source: Maddison Project Database 2020 (Bolt and van Zanden (2020))

OurWorldInData.org/economic-growth • CC BY

Historical Index of Human Development, 1900 to 2000



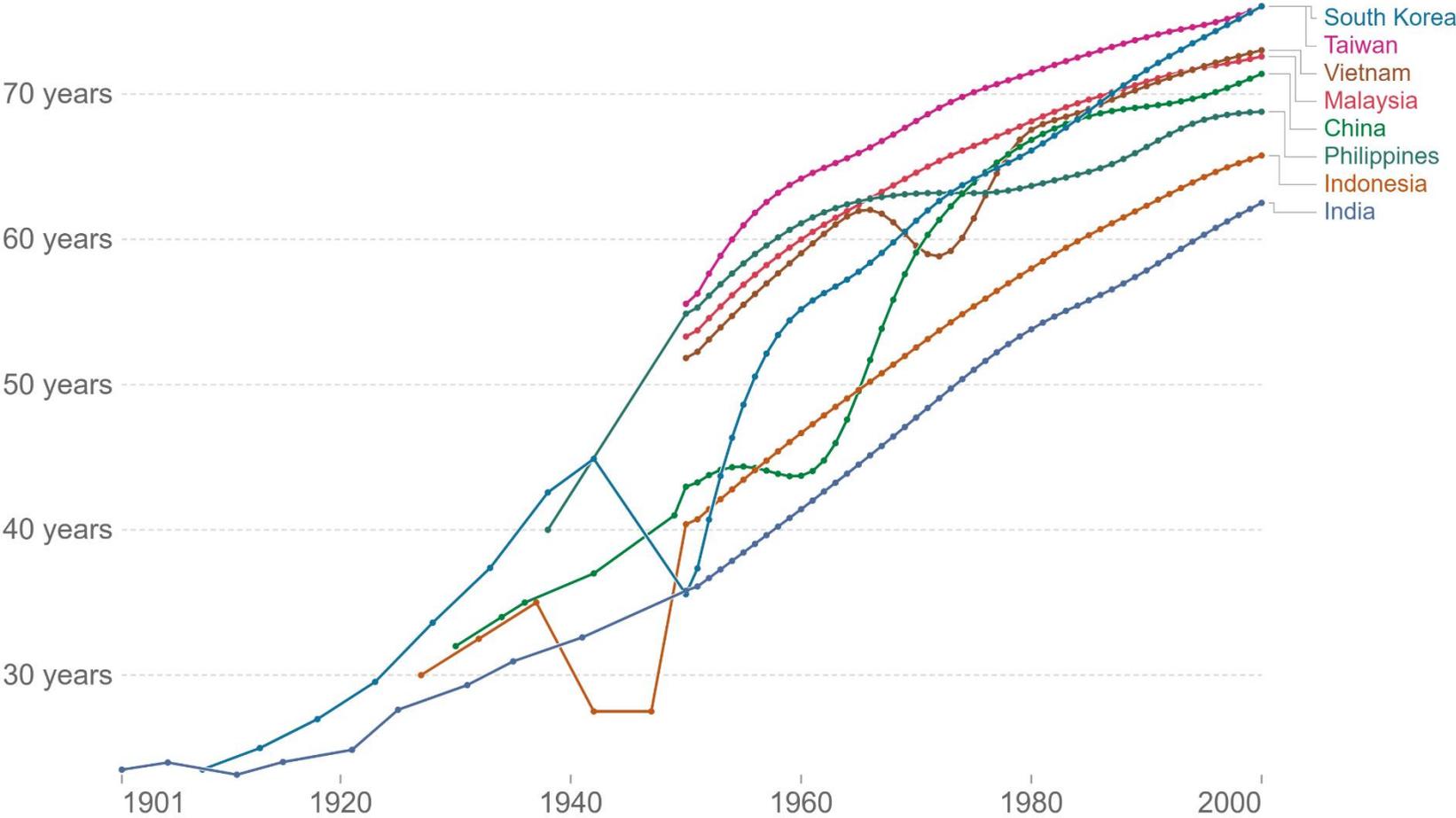
The Historical Index of Human Development (HIHD) is a summary measure of average achievement in three key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living.



Source: Prados de la Escosura (2018)

OurWorldInData.org/human-development-index • CC BY

Life expectancy, 1901 to 2000



Source: Riley (2005), Clio Infra (2015), and UN Population Division (2019)

OurWorldInData.org/life-expectancy • CC BY

Note: Shown is period life expectancy at birth, the average number of years a newborn would live if the pattern of mortality in the given year were to stay the same throughout its life.