

From beneficial exploitation to well meant dependency (and back?).

European-Asian health care cooperation in the 20th century.

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First of all I want to thank the organisation and especially Tim Goudriaan for giving me the honour to deliver the opening speech of this interesting and important conference, which I sadly enough will only be able to attend this first day.

Secondly, I want to warn you. This is going to be an of course scientifically nuanced, but nevertheless bluntly left-wing talk, on the importance of selfless, humanistic, in short, good intentions, in delivering aid, medical or otherwise.

In this lecture in a bird's eye view I want to give European involvement in Asian healthcare a thought, from the times of economic gain, political reign and military violence (from the end of the 19th century up until the Vietnam War) to the end of the 20th century, the times of international healthcare dictated and influenced by the right to health. Or better: I want to give the way this aid is reflected upon a thought. For some time the years of colonial submission were all but entirely criticized, and it is strange to see that in the last years these times are viewed 'more nuanced', so to speak, whereas the times of selfless aid are criticized. Dutch developmental aid for instance is now focused on self interest. In fact, Indonesia is said to be not a developmental country

anymore and still it receives ministerial money but only if Dutch companies are allowed to do the work involved. And of the old days of Dutch or British colonial reign it is said that maybe the motives behind healthcare were not very medical-humanitarian, but undeniably the health of the indigenous people had improved. Although this revisionism of as well colonialism as modern developmental aid often go together, in fact to a certain degree they contrast. For modern criticism on developmental cooperation, medical or otherwise, is that it would only lead to dependence and dependence is seen as a hindrance of development and therefore of health. Dependence however was also the key word of colonialism, but was in those days not considered to have been a hindrance of development and therefore health. One exception is made nowadays. Emergency aid of course should always be given. A sarcastic Dutch columnist even said that 'to make an exception for emergency aid' is the modern Dutch definition of decency. He too will have asked the question if a decline of developmental aid will in time not lead to more and more emergency aid. Emergency aid is not, at least not all the time, the result of inescapable natural disasters, but of poverty, violence, dictatorship. Emergency aid cannot solve this, and sometimes even strengthens it. This shows that emergency aid has its problems as well, such as fierce competition between the myriad organisations or the question where the line with long time aid, flowing into developmental aid, is crossed.

The days of colonization were characterized by what is called imperial medicine, to be defined by the sentence: by the white, for the white. Medicine served military-economical interests of the colonizing power. In the Dutch East Indies for instance healthcare for a long time was military healthcare; taking first and foremost care of the health and fighting strength of the Dutch

army, and within that army taking better care of white soldiers and officers, than of the majority of indigenous soldiers. Healthcare at the plantations did look after its servants and workers, but the reason behind the care these indigenous servants and workers received (which already proves Western medicine did anything but benefit all) was not humanitarian but economic. Sick servants were a health threat to the Europeans plantation owners and their families and sick workers were lousy workers, costing instead of earning money. Looking after their health was simply sound business.

Medical views were partly racial, social-Darwinistic in nature, and the so called scientific proof they gave of supremacy was used to justify the colonial system. Furthermore they proved the supremacy of the motherland in question. As likewise organizations in for instance Britain, the erection of the Dutch Society for Tropical Medicine in 1907, was not so much a translation of a medical-humanitarian, international longing, but of a clear view of national interest. 'Our' illnesses, had to be solved by 'our' doctors. This was not a Dutch phenomenon. Champion of tropical medicine Ronald Ross for instance stated that clearly the British were superior to the people they had militarily defeated. For they had introduced 'honesty, law, justice, order, roads, posts, railways, irrigation, hospitals' and, also 'necessary for civilisation, a final superior authority'. This shows that medicine not only proved physical and mental supremacy, but also that healthcare was a sign of civilisation and with that another argument in favour of colonialism. The scientific as well as humanitarian healthcare proved that Europeans were civilized and civilisation gave the right to submission up until the moment the colonised peoples were civilised as well. By the way, there also was a clear similarity between military power and

civilization. Japan was gained access to the up until then all white ring of civilized nations after it had defeated China at the end of the 19th century.

However: this critical view on tropical medicine is quite recent. Before 1970 medicine, also by medical historians, was described as a history of doctors all taking small steps for man but together making one continuous giant step for mankind. And now, a mere thirty to forty years later, already this critical view is under attack again. Up until the nineteen seventies the dominant view within the historical world was that, no matter how one feels about colonisation itself, medicine and healthcare served as proof that the ruling powers were not all bad. Whatever crimes they, in hindsight, had committed as well, the colonizing powers could be proud on the way they had introduced, implemented and practised medicine in the colonies; giving birth to a lot of highly important and influential discoveries by men of international stature that have saved lots of lives, also in the colonies themselves. No matter how destructive colonialism has been in many ways, it was medicine that saved its day. So colonial medicine was seen as one of the good things of imperialist oppression. Maybe one of the few, or even the only one, but good it was. But even more it was seen as a justification of colonialism for western medicine had brought health and longer life to the indigenous people. Medicine was seen as an objective science instead of a political and cultural construction, giving the historians – and the doctors themselves - the chance to portray it as a means of liberation from illness and backwardness, instead of as a means of regulation, control and/or repression which in any case it was as well.

So no wonder around 1970 this view began to shift into a tradition of context and critique, focusing on the role medicine played in installing and continuing colonialism, instead of seeing it as an act happening in fact outside colonial

context. Physicians were 'as much agents of imperial enterprise as were foot-soldiers and missionaries' as one historian put it. Not seldom almost all Western physicians in the colonies were military doctors who naturally focused on the interest of state and army. So historians began to focus, to quote another one, 'on the control of tropical-parasitic diseases that most affected European health, or on the major campaigns against diseases that were politically, economically or socially important', showing for instance that – although the strengthening influence of medicine on colonialism should also not be overstated - the burden of disease was not lifted by colonialism but shifted from the colonising to the colonized inhabitants. Actually, without that shift, without mastering tropical diseases, colonialism would have been impossible. Some even say that European colonialism has been a “health hazard”, unleashing a crisis of mortality', because relatively spoken there by far were not enough doctors and nurses to really make the shift from autochthonous to Western healthcare a medical success.

In a way the old view is now making a come-back, not restrained to medicine, but medicine surely playing a big part in it. In spite of the arguments behind it, some historians begin to argue that, although as said this surely has been done, one cannot dispute that the health of the indigenous people, be it in the Dutch East Indies, be it in British India, has made giant steps forward in the days of colonization. This not only is an unscientific utterance because one can never say how health and healthcare in the colonized countries would have developed without colonialism. It also it is a view with a huge hindsight-character. It looks at history from the angle of what afterwards can be said is achieved, instead of looking at it as much as possible out of the perspective of the time and place itself, looking at what one was hoping to achieve. Further-

more it is an ideological struggle: the new historians claim to be neutral, because it is not the task of a historian to judge, but only to describe and explain. Problem however is that by doing so they come dangerously close to legitimizing a system that in the eyes of others (and mostly by the people directly involved), cannot and may not be legitimized: the reign of one nation, of one group of human beings over another, out of military and/or supposed cultural, ideological or racial superiority. Compare it with the abolition of slavery. Undoubtedly some former slaves were worse off after abolition, an act set in by people of good will. But can this ever be a reason for saying 'maybe abolition came too soon?' 'Maybe slavery was not all bad?'

The more critical view on imperial medicine was accompanied by a medical care not anymore dominated by doctors working at one place in the colonies for years at a stretch, in service of plantation or army, but by doctors flying out to several places for a short period of time, at least in theory not posing themselves as the all-knowing physicians, but trying to set up local healthcare. The so called third world not any more was home, but hotel. This was a direct result of the end of colonialism and it was theoretically fed by men like Ivan Illich who criticized expensive Western healthcare only benefitting the happy few. It had its peek at the Alma Ata conference in 1978. Doctors subscribing these views not focused anymore on a specific disease, in which also the West was interested, but on trying to raise general health and general healthcare. Colonial medicine had been replaced by international healthcare, leading to and influenced by terminology like *right to health* or *health for all by the year 2000*. Mutual medical development cooperation had replaced top-bottom medical aid. A first breach in this approach was made in the nineteen nineties when the in itself to be welcomed concept of Disability-Adjusted Life Years

was introduced, more focusing on a handful of diseases such as psychiatric illness or malaria, which eradication would do more for expanding life expectancy, than a focus on general health would ever be able to.

More and more developmental aid was attacked, because of its assumed inefficiency, because of the ways development agencies competed with one another, and because of corruption leading to enriching regimes instead of aiding the sick and starving population. As said, only emergency aid, although not without criticism either, remained OK, a fact of which critics said that this is only so because emergency aid is flashy, easy, works good on tv and gives the public in general and politicians especially a chance to show their benevolence. Emergency aid is feel good-aid. In practice however it often is a drop on a hot plate. What's the use, as one of these critics a bit bluntly once stated, to feed a hungry child, if some years later it will die of AIDS. As is the case with debunking developmental cooperation, there is some truth in it, but this too is an exaggerated picture, if only because in reality the line between short time emergency aid and long time developmental aid is difficult if not impossible to draw. Giving aid, no matter if it is labelled emergency aid or developmental aid, gives responsibility. Doctors without Borders Netherlands decided to start an AIDS-program in Burma, because it was considered a great, severe and immediate problem. But AIDS is a chronic disease, not to be cured with one shot of drugs. So by starting this emergency program it became its duty to stay in Burma spending lots of money every year on a fairly restricted amount of patients, making it vulnerable to the same critique developmental aid gets: it makes dependent, instead of independent, a critique by the way also applicable to short-term emergency aid. The praise colonial medicine got and now again gets - that it took care of the ill health of indigenous peoples - is in mod-

ern economic-political circumstances a point of critique. Long time aid is out of date. Direct Western aid should be short, as in the days of international healthcare, but it should focus on severe and immediate problems, and if possible it should not be free of self-interest as in the days of colonialism. So the conclusion can only be that in modern political circumstances medical responsibility is threatened.

Of course: critics are right when they say that developmental aid has its flaws. And yes, it should always be viewed critically, as everything should be viewed critically and with a healthy amount of scepticism. But that is not to say one should get rid of it, replacing it by a combination of emergency aid and self interest. This can only take us back to the days when eminent men like the Dutch physician N.H. Swellengrebel in his Eijkman Institute in Batavia worked seamlessly together with men like Wolfgang Weck or Ernst Rodenwaldt, members of the German Nazi party and responsible for at least a part of Nazi medical theory and therefore practice. It takes us back to the days of the wars of decolonization when in for instance Indonesia and Vietnam medical aid to civilians was a tool of military-political strategy. The aid coming from that has been hailed, but severe criticism is more justified. Not only because it was lousy healthcare, but also because it was given out of political, none medical intentions and baring the marks of this everywhere. For instance the aid the doctors and nurses of the American Medical Civic Action program gave was cheap, superficial and without any aftercare.

And if medical intentions had played a bigger role Dutch health workers would not have been ordered to finish their meal first after they had heard some Indonesian wounded were in the vicinity. An American doctor would not have stated, after having being asked why he refused to admit a wounded

Vietnamese into his hospital, that the Hippocratic oath was only valid in America. And another American doctor would not have been sentenced to one year of hard labour for criticizing the failing medical program in Vietnam which in his eyes, and rightly so, was of more military-political than medical importance.

So closing and as a kind of kick off for this conference I want to hold a plea for a resurrection and revaluation of good, selfless, medical-humanitarian intentions in international health care as a leading factor of policy, although the diversion between good or bad intentions can never be the only argument to validate medical activity, or the outcome of it. Good intentions can pave the road to hell, as we gloomy Dutch say. But that is not to say that bad intentions, national, non-medical, non-humanitarian, selfish intentions, lead up to heaven. If good intentions pave the road to hell, bad intentions are the red carpet upon that road.

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