HISTORICAL PERSPECTIVES ON ECONOMIC CRISES AND HEALTH*

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ABSTRACT. During periods of recession, both historians and policy-makers have tended to revisit the multi-faceted relationship between health and economic crisis. It seems likely that the current economic downturn will trigger a new revival of efforts to gauge its implications for people’s health around the world. This review will reflect on aspects of the relationship between health and economic crisis, exploring some of the unanswered questions within the historiography of the Great Depression and health, and suggest new directions that this work might take. Within a broadly transnational framework, I will reassess the diverse historiographies of interwar public health, in order to highlight ways in which the methodologies used could inspire future studies for neglected areas within this field, such as Southeast Asia. In doing so, I will illustrate that the effects of the interwar economic fluctuations on health status remain imprecise and difficult to define, but marked a transitional moment in the history of public health.

Academic interest in the complex relationship between economic crises and health has waxed and waned. Often neglected during periods of economic prosperity, both historians and policy-makers have tended to return to the subject during episodes of recession. Perhaps inevitably, studies have tended to look to earlier economic crises and their effects on health systems and policies. The global recessions of the twentieth century, of the 1930s, the early 1980s and 1997–8 amongst others, are frequently invoked in explorations of policy options, both for the West and particularly for developing countries.¹ It seems likely that the current economic downturn will trigger a proliferation of new scholarship on economic crises and health. Within a broadly transnational framework, this review will highlight some of the unanswered questions in the existing historiography of the Great Depression, and suggest directions that this new work might take, while also exploring the ways in which a reconsideration of the 1930s might contribute to discussions about current concerns.

The debates stimulated by the global economic depression of the 1930s framed the connection between economic crisis and health, and have been foundational to subsequent discussions of the issue. The Great Depression marked the first time that people began to analyse and theorize the specific connections between economic crises and health in global terms. For Europe’s newly established international organizations, the health effects of the depression were an issue of international concern. ‘The economic depression which has affected the whole world’, according to a report by the League of Nations Health Organization in 1933, had created ‘the gravest dangers for the health and the very existence of millions of people’. As mass unemployment eroded food consumption and household cut-backs curtailed access to health services, the League argued that it was ‘necessary to make fresh efforts to perfect the work of health protection’, but at the moment when these efforts were most desperately needed, ‘restrictions, reductions and economies’ were being imposed on existing institutions and services.\(^2\) The crisis was believed to have exacerbated social conditions which were already a cause for concern, highlighting the potentially grave costs to international health presented by mass unemployment and poverty. A new generation of public health experts believed that widespread malnutrition, increased susceptibility to disease, deteriorating mental health, and stunted growth in children would result. Many were also anxious that declining state revenues would limit investment in health services, resulting in the closure of hospitals and essential health programmes. These fears stimulated a vast number of quantitative studies in Europe and the US, under the auspices of the League, often with a markedly transnational focus.

The Great Depression was also a critical juncture within histories of public health in other parts of the world. The centrality of the depression to histories of South and Southeast Asia has long been recognized. It had profound consequences for the interconnected economies of the region, which had become increasingly enmeshed with the expansion of colonial states in the early twentieth century.\(^3\) It is central to debates about the moral economy of the peasant, as economic hardship provoked rural unrest and rebellion in the early 1930s, particularly the Saya San rebellion in Burma and the Nghe-Tinh Soviet movement in Central Vietnam, playing a key role in destabilizing entrenched political systems.\(^4\) Until recently, the depression’s impact on public health has rarely featured in these narratives, as histories of the Great Depression in Southeast Asia have tended to focus on adjacent areas, on standards of living, and peasant welfare, often omitting health altogether. Yet new work on transnational perspectives on health in Asia suggests that public health was becoming a pan-Asian, if not a


global enterprise from the 1930s.\textsuperscript{5} There is evidence to suggest that the new international community of health experts galvanized by the depression was becoming increasingly aware of the problems the crisis posed to individual health in South Asia. Studies and surveys conducted in rural and urban south India in the 1930s by the British nutritionist, W. R. Aykroyd, suggested that the nutritional status of the south Indian population had deteriorated, resulting in a range of deficiencies as highly milled, poor quality Burmese rice flooded the Indian market, due to the collapse in world commodity prices.\textsuperscript{6} The debate about economic crisis and health was not limited to Europe and the US. As this review will suggest, Asia had an important role within these larger transnational debates.

The economic crisis sparked an international dialogue about the effects of poverty on health, promoting a flow of ideas and knowledge beyond national borders and academic disciplines. During the interwar period, the boundaries of international health work were expanding. International organizations and philanthropic institutions such as the League of Nations Health Organization and the Rockefeller Foundation initially focused their attentions on Europe and the US, but public health campaigns were quickly expanded into Latin America, South Asia, and China.\textsuperscript{7} As well as becoming a site for transnational exchange, research into health and the economic depression formed an integral base for a new move towards broader social welfare concerns within public health systems.\textsuperscript{8} The depression thrust poverty, unemployment, and sickness on to the agenda of international organizations, leading to an expansion of the field of social medicine. The interwar period was crucially important in establishing welfare states, as pioneering schemes were launched in Weimar Germany, Sweden, the Soviet Union, and the US under Roosevelt’s New Deal. Ideas within this new, flourishing field of social medicine extended well beyond the boundaries of Europe and America, reaching colonial officials, scientists, and nationalists in the Asian colonies too.\textsuperscript{9} Evidently, the interwar economic crisis was a significant moment, stimulating the internationalization of public health, the expanding horizons of social medicine, and the connections between them.

\textsuperscript{5} Sunil Amrith, \textit{Decolonizing international health: India and Southeast Asia, 1930–1965} (Basingstoke, 2006).
\textsuperscript{6} Ibid., p. 34.
\textsuperscript{8} Soma Hewa, \textit{Colonialism, tropical disease and imperial medicine: Rockefeller philanthropy in Sri Lanka} (Lanham, MD, 1995).
\textsuperscript{11} Amrith, \textit{Decolonizing international health}, pp. 21–46.
The historiography of the Great Depression is beginning to reflect the transnational elements of interwar public health, particularly the role of the depression in stimulating international dialogue on health issues. This new focus has reminded us of the global nature of interwar debates on economic crisis and health, which were explicitly comparative in reference. This is in sharp contrast with the very national or even local approaches which have most frequently been taken in much of the historical writing on the subject since the 1930s. In this review, I will take a comparative and connective approach, in order to reflect more broadly on the relationship between health and economic crises. I will discuss the national and local literature from Europe and the US, where it is most abundant, juxtaposing studies from these developed countries with work from other parts of the world, and highlighting ways in which the methodologies used could inspire future studies for neglected areas within the scholarship on economic crisis and health, such as Southeast Asia.

I

The critical question of whether economic crises adversely affect public health has been a battleground within different national historiographical debates since the 1930s. Similar sorts of questions have been debated in scholarship on Europe, particularly Britain, and the US, and as I will discuss later, elements of this debate can also be found within work on Southeast Asia. The sub-strata of questions within this larger one have focused primarily on mortality rates and demographic trends as a reflection of a population’s health, and closely connected to this, the capacity of health systems to protect the most vulnerable from the dangers to health presented by the economic crisis. These two elements are evident both in the debates of the 1930s by health experts, and the debates about the 1930s by historians. Yet the evidence is often contradictory, and historians often too preoccupied by the internal historiographical debates of their field to place these developments in a global perspective. But there have been parallel historiographical debates across the world, both in terms of what historians in different fields were talking about, and the way that they were talking about them. At the same time, it is important to look beyond the narrow confines of these debates. There has been an innovative movement in recent years towards broadening histories of health and economic crisis. I will explore three of the most fruitful: the growing field of transnational histories of public health, the explorations of how the economic crisis affected discourses on health as well as actual well-being, and broader social histories of interwar health.

The vast majority of the numerous reports and studies commissioned on the subject in Europe and the US during the early years of the Great Depression came to the unexpected conclusion that mortality rates had failed to deteriorate as many had ominously predicted. In a report on ‘The economic depression and public health’ conducted by the League of Nations Health Organization in 1932, it was concluded that the crisis had no appreciable effect on the aggregate
mortality rates of the countries included in the study, namely Germany, the United States, France, Hungary, Italy, the Netherlands, Poland, the United Kingdom, and Czechoslovakia.\textsuperscript{12} In Asia too, local studies and surveys revealed that the general pattern of declining mortality was not significantly affected by the depression. Despite this general agreement within debates of the 1930s, more recent debates about the 1930s have found these mortality statistics to be central to reinterpretations of the effects of the crisis on health. Within British historiography of the Great Depression, since the 1980s a critical assessment of public health during the interwar period has dominated the field, with key arguments based on a detailed re-examination of mortality statistics at the local level. Charles Webster, one of the main proponents of this ‘pessimistic’ view, has argued that public health policies failed to address the impact of unemployment on child and maternal health during the 1930s. Webster argued that falling infant mortality rates obscured major regional and small area variations, emphasizing that the disparity between social classes remained significant and that unemployment had an adverse effect on nutrition.\textsuperscript{13} At the same time, Webster argued that welfare provision aimed specifically at pregnant and nursing mothers was not effectively counteracting the adverse consequences of the economic depression, illustrated by a notable rise in maternal mortality.\textsuperscript{14} A proliferation of national, regional, and local studies of mortality rates followed these inquiries, and many confirmed Webster’s account of unevenness and inequity.

In recent years, reinterpretations of this mortality data have led to a more generous evaluation of public health in interwar local government. Analysing infant mortality rates by county, Clive Lee has argued that the period of the slump was actually characterized by convergence towards equality rather than divergence of the depressed areas, and attributes this to growing prosperity and improved housing during the 1920s.\textsuperscript{15} However, recent regional studies still support elements of the ‘pessimist’ case. A recent study of South Wales by Steven Thompson compared regional age and sex specific mortality with that for England and Wales, and discovered that for most age groups they did deteriorate during the early 1930s, but this was not due entirely to the economic crisis. Thompson argues that these patterns of mortality were the product of a specific ‘social, economic and ecological environment as much as of the economic depression of the period’.\textsuperscript{16}

This emphasis on the more subtle, insidious effects on public health was evident within the interwar period. The marked inequalities in the health of the


\textsuperscript{16} Steven Thompson, \textit{Unemployment, poverty and health in interwar South Wales} (Cardiff, 2006).
British population were revealed by regional and local studies conducted during the interwar period. Numerous other studies stimulated by the depression, particularly in the US, found evidence of malnutrition, increasing frequency of illness, deteriorating mental health, and stunted height and weight of children. Research into the incidence of sickness among 12,000 wage-earning families in ten US cities between 1929 and 1932 concluded that the rate of disabling illness was 56 per cent higher for those who had suffered the greatest loss of income during the depression than that of those whose economic circumstances were not materially reduced. In Europe, too, there was evidence that the economic crisis had affected the health of the unemployed and their families. In a study of Vienna conducted for the League of Nations Health Organization, marked differences were found between the children of the unemployed and the employed with regard to both height and weight.

The role of public health infrastructures in combating the effects of the depression on health has been another key area for debate, both among public health experts in the 1930s, and within later historiography. During the interwar period, the Rockefeller Foundation supported innovative research and public health schemes through its International Health Board, with programmes in Europe, South Asia, China and Latin America. Many of the Rockefeller Foundation’s philanthropic programmes were reviewed, curtailed, or deferred due to the fall in income from its financial empire during the depression. In Colombia, where Rockefeller Foundation officials had been active in health care and medicine since the 1920s, this led to the paralysis of anti-mosquito measures as well as other public health activities. Evidently, in some areas public health programmes were the victims of economic austerity, but in other parts of the world historians have argued that the situation was less severe. In the US, the federal government expanded its social welfare spending during the depression in a dramatic and unprecedented fashion, arguably resulting in a lower infant mortality rate whilst also boosting the fertility rate.

In Britain, too, as part of the shift towards a more positive reassessment of the effects of the depression on health, it has been argued that a significant increase in spending could be observed at the local level. A recent quantitative analysis of the level of expenditure on health care provision in England and Wales county boroughs during the interwar period concludes that aggregate expenditure on

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health rose sharply from 1930, driven by general hospitals and supported by rises in other services, such as maternal and child welfare, and the treatment of TB. Despite the lack of uniformity across services, boroughs, and over time, the authors argue that the rise in real spending on health indicated a qualitative improvement.  

This collection of national and regional debates on mortality statistics, on the structures of health care provision, and the effectiveness of alleviation programmes have formed partial answers to the larger question of how public health was affected by the Great Depression. These debates have added a great deal to our understanding of the complex and subtle effects of economic austerity on morbidity and mortality, and on health systems. Through quantitative analysis of unemployment rates, mortality, food expenditure and consumption, housing, hospital funding, and innumerable other determinants of the standards of living, it is now possible to build up a detailed picture of public health in interwar Britain. However, these studies often remain isolated from the wider literature on the depression and health. Looking again at this local and national literature from a more comparative and connective perspective, one of the most striking features of this work on Britain is its similarity to other, separate, historiographies of interwar public health. In the US, comparable debates centre on mortality rates during the Great Depression. One recent analysis of demographic statistics during the 1930s reveals that the New Deal relief spending was associated with lower infant mortality, lower suicide rates, fewer deaths from infectious diseases, and higher birth rates, thereby averting a demographic disaster.  

Placing these histories in a global perspective can reveal interesting and unexpected international connections, and enable us to think more broadly about international histories of public health during periods of economic crisis.

There has been an explosion of interest in recent years in the internationalization of public health during the interwar period. The importance of the League of Nations, in particular, has received much attention, carving out a firm position within the field of transnational history. Scholars have traced the role of international organizations, particularly the League of Nations Health Organization, in developing international social medicine during the depression. The depression led to a collaborative exploration of the effects of the crisis on public health in Europe, focusing on nutrition, internal migration, and public health systems. Nutrition, in particular, emerged as an experimental scientific research field during the 1930s, and it became central to the new

23 Fishback, Haines, and Kantor, ‘Births, deaths and New Deal relief during the Great Depression’, p. 2.
international landscape. Many of the studies of nutrition during the 1920s and 1930s focused on European countries, including Czechoslovakia, Denmark, France, Great Britain, Hungary, The Netherlands, Romania, Spain, Portugal, and Sweden. However, a significant number also covered South Africa, Chile, China, India, Japan, and the Philippines. The work of the League of Nations Health Organization evidently extended the international boundaries of health work. Closely connected was the work of the Rockefeller Foundation, which provided much of the funding for the League’s Health Organization, in addition to supporting innovative research and public health schemes through its International Health Board. It expanded its work in international health during the interwar period, initiating research-driven health campaigns in Europe, Latin America, South Asia, and China, targeting hookworm, yellow fever, malaria, and tuberculosis, as well as funding medical education.

As Sunil Amrith has compellingly argued, the depression played a catalytic role in launching rural public health on to the global agenda. In Indonesia, partially under the auspices of the League of Nations Health Organization, attempts were made to transform rural society through village-level campaigns to educate the population in hygiene and nutrition, culminating in the League’s conference on rural hygiene in Bandung in 1937. The rural health experiments of Dr J. L. Hydrick, a Rockefeller Foundation officer, at Poerwokerto in Java illustrate attempts to transform local expertise into a global discourse on health. Hydrick relied on mantris, or local hygiene nurses, to teach Javanese peasants hygienic practices, including handwashing, toothbrushing, boiling water, sweeping yards, and whitewashing homes as well as maintaining water sources to prevent communicable diseases. This expansion of the global horizons of international organizations into rural health programmes during the interwar period is only just beginning to be explored.

Whilst at an international level, it is possible to see a greater degree of expansion and, in some cases, co-operation over issues of health, in other areas the new shared language of international health was used to justify division and exclusion. Public health played a role in shaping shifting attitudes towards immigrant populations during periods of economic turmoil. In interwar Paris, North African migrants were alleged to be infected with congenital syphilis and predisposed to catch tuberculosis, as public health officials portrayed them as biological threats to the health of French citizens. A similar use of rhetoric can be found elsewhere. Natalia Molina’s fascinating study of public health and race in Los Angeles constructs the depression as a major turning point for the city’s

27 Amrith, Decolonizing international health, p. 26.
marginalized immigrant communities.\textsuperscript{30} By 1930, Mexicans were the largest immigrant group in Los Angeles. Constructions of the Mexican as culturally, and later genetically, inferior long preceded the interwar period, but when the US economy collapsed, these attitudes were strongly reinforced. In Los Angeles, as jobs were scarce, white residents and government agencies increasingly regarded Mexicans as an economic burden, and the idea that Mexicans’ social inferiority arose from their biological inferiority returned with force. Public health discourses were mobilized in order to legitimate the removal of the same population that only a few years earlier had been deemed a key source of cheap labour. Public health officials constructed the image of the Mexican as diseased, afflicted in particular by tuberculosis, overly fecund, and charity-seeking; a drain on the city’s dwindling resources. As a result, assimilation programmes were replaced with repatriation programmes. According to one estimate, one third of Mexicans living in Los Angeles had been repatriated by 1935.\textsuperscript{31}

In fact, as Molina illustrates, the Mexican community was one of the most vulnerable during the economic depression. Mexicans endured unemployment rates that were consistently higher than those of other ethnic groups in the city; in 1932 it was estimated that of the 2.5 million Mexicans in the United States, 2 million were unemployed.\textsuperscript{32} The economic crisis also had a direct effect on Mexican health. Studies revealed that children’s health had significantly worsened; birth rates in the Mexican community decreased dramatically during the 1930s; and Mexican tuberculosis rates were also alarmingly high. Yet in Los Angeles County, for example, strategies to combat these widespread problems generally tended to exclude the Mexican community: Mexican, Asian and African American children received only a fraction of the resources allocated for tuberculosis detection as compared to white children.\textsuperscript{33} Evidently, in some cases, health systems failed to accommodate those who were most in need. As this case illustrates, the language of public health could be used to determine social membership; just one of its multiple, complex and subtle uses.

The Great Depression’s impact on public health subtly shaped the social histories of many different communities, in different parts of the world. Yet the narrow focus that has characterized studies of health and mortality during the interwar period has often missed these more insidious consequences. To return to a volume mentioned earlier, Steven Thompson’s study of interwar South Wales has attempted to move towards a more holistic viewpoint, integrating biological events with social, economic, and cultural determinants.\textsuperscript{34} Thompson conceives of his study as ‘a social history of health and medicine ‘‘from below’’, aiming to encompass not just official and professional views, but also lay attitudes and popular perceptions, setting individual behaviour in the specific context

\footnotesize{\textsuperscript{30} Natalia Molina, \textit{Fit to be Citizens? Public health and race in Los Angeles, 1879–1939} (Berkeley and Los Angeles, 2006).  
\textsuperscript{31} Ibid., p. 159.  
\textsuperscript{32} Ibid., p. 126.  
\textsuperscript{33} Ibid., p. 161.  
\textsuperscript{34} Thompson, \textit{Unemployment, poverty and health}, p. 4.}
of working-class life. The resonance with Molina’s study is clear. By closely examining the everyday realities of people’s lives alongside quantitative analysis of demographic data, this micro-level analysis of two Welsh counties gives an alternative insight into the ways in which social factors determined patterns of mortality during the depression.

Although in general mortality rates improved, Thompson argues that the more depressed areas of South Wales did not share the same high rate of decrease in mortality experienced in England and Wales as a whole. There were notable increases in mortality from tuberculosis, neonatal mortality and stillbirth mortality during the peak of the depression, indicating that women’s health suffered disproportionately from the effects of the economic crisis. Existing cultural, economic, and environmental conditions were important factors in the intensification of regional and class inequalities, but the unemployment and poverty caused by the economic crisis also had an undeniable role in holding back improvements in mortality rates in economically depressed regions. Alongside this quantitative analysis, Thompson also considers the dynamics of domestic life, the choices and decisions that were made by individuals and families. Each week, families were forced to make decisions as to the most efficient way of dividing up their income to meet the various costs they faced. Thompson also discusses the ‘mixed economy of medical services’, which included not just the delivery of medical services by local and central government, but also ‘domestic’ medicine, and ‘folk’ medicine whose practitioners included herbalists and spiritualists. This study provides a fresh perspective on what people actually did when they became ill, and the services they utilized when deciding that medical aid was necessary.

As Thompson’s study illustrates, it is possible for the ‘healthy or hungry thirties’ debate, which has dominated British historiography of public health in the interwar period, to move forward in a new and interesting direction. Micro-level social histories ‘from below’, studies of shifting ideas of race and migration and processes of internationalization during the Great Depression have all made a much-needed contribution to the field in recent years. Such diverse studies point the way towards a broader social history of interwar health, and the possibilities suggested by a comparative framework for analysis.

II

Such a comparative framework is not new to Southeast Asia. The slump of the 1930s has long been viewed as the entry point into the interconnected histories of the region. This field has been enriched by important debates about the impact of the Great Depression on welfare and standards of living in Southeast Asia. The long accepted assessment, from the 1930s until the late 1970s, was that the crisis

35 Ibid.
37 Ibid., p. 75.
38 Ibid., p. 155.
had a devastating effect on standards of living for the indigenous peoples of Southeast Asia. According to this argument, the depression exacerbated the plight of the rural poor, leading them to resist payment of taxes to landowners and debts to moneylenders, resulting in peasant uprisings and a heightened level of political radicalization that preceded later calls for independence. However, since the early 1980s, a number of historians have argued convincingly that the depression in Southeast Asia did not have a devastating impact in all areas, for all social strata, and in all branches of the economy. In this reassessment, historians have argued that the burden of taxation was not as universal or as heavy as had been accepted; that income levels for many cultivators were successfully protected by shifting their labour from export crops to subsistence food crops or diversification into other economic spheres; and that a reduction in household expenditure alleviated the most severe effects of the crisis. Mirroring the more optimistic assessments of the depression’s impact on health and welfare in Britain and the US, these debates within Southeast Asian historiography have suggested that standards of living and individual welfare were not as profoundly affected by the economic crisis as was previously believed.

Based on an examination of surveys of peasant welfare conducted in the 1930s, Ian Brown has found rural economic distress to be less severe than anticipated, both within and outside the European colonies. Analysing household expenditure in Siam, Brown found no evidence of a shift towards increasing the proportion of cash expenditure on essential items of domestic consumption such as food and clothing, as would be expected if there had been a severe reduction in real income. This reassessment of the economic crisis was not restricted to rural areas. In urban Java, for example, where the depression had a devastating impact on export crop earnings, the depression was ‘a time of difficulty but not a disaster’. The real income of urban workers who retained their jobs, in some cases actually increased during the depression. Similarly, in metropolitan Manila the highly differentiated economy mitigated the impact of the depression. For the urban manufacturing workers in the cigar industry, for example, the greatest decline in both real wages and opportunity actually came during the decade before the depression. During the mid-1930s, there was a temporary increase in cigar piecework employment due to the comparatively low cost of Philippine labour.

40 Peter Boomgaard and Ian Brown, eds., Weathering the storm: the economies of Southeast Asia in the 1930s depression (Singapore, 2000), p. 7.
A central prop to this reassessment of the impact of the Great Depression in Southeast Asia has been the relative stability of mortality rates, which many have taken to indicate that there was no drastic deterioration of economic welfare. In the Philippines, for example, Norman Owen has argued that there was a continuing long-term decline in infant mortality in the Bikol region of south-eastern Luzon, which fell from roughly 130 per thousand births in the 1920s, to around 105 in the 1930s. Owen argues that this was due to long-term improvements in medicine and public health since the beginning of the twentieth century, in addition to the absence of famine and epidemics. Assessment of health in terms of mortality statistics alone has been a common feature within the historiography of the Great Depression in Southeast Asia. One historian has argued that, after worsening somewhat between 1929 and 1930, health in Singapore, measured as deaths per thousand of the population, sharply improved due to emigration. Although a thorough analysis of the impact of the depression on public health in interwar Southeast Asia has yet to be written, these debates have added much to our knowledge about standards of living in Southeast Asia during the 1930s. Any assessment of the state of public health must now take into account the vast differences in economic structures and circumstances across the region, and the sharply differentiated experiences of different socio-economic groups.

Still, many unanswered questions remain. What exactly was the impact of the Great Depression on individual health and on public health services in Asia? The brief summary of literature that follows reveals that the infrastructure of public health services in Asia appears to have borne the brunt of the interwar economic crisis. In Nationalist China, the chaotic organization of public health in the early years of the depression reflected the wider problem of ineffectual administration of the state during the Nanjing decade. The impact of the depression in China has been much debated, but it is evident that in some areas the government found it necessary to retrench. In 1931, the Central Political Council decided to change the status of the health ministry from an independent body to a semi-autonomous service within the Ministry of the Interior and change its name to the National Health Administration. The Depression also affected municipal health organizations. In 1930, the Peiping Health Department was incorporated into the Police Department, while those at Tianjian and Nanjing were abolished outright.

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(in 1931 and 1932 respectively). The latter two cities maintained only a health sub-bureau within the municipal government.\textsuperscript{48}

In Burma, a widespread peasant rebellion in the rice-growing areas had already dramatically illustrated the unrest caused by the Great Depression. The economic crisis also affected public health administration at the highest level, as the role of hygiene publicity officer was taken over by a sub-assistant surgeon (who had taken the shorter medical course in Burma and was a licentiate, not a graduate) in 1932 when the post was abolished due to financial stringency.\textsuperscript{49} This financial stringency was also felt locally. By the early twentieth century, midwifery services had been developed through both charitable and official resources. Hospitals, hospital wards, and maternity shelters were built from subscriptions raised by the public, although they were often maintained by local authority funding. In 1931, there was a marked slump in local subscriptions due to the economic depression. Three local societies – Mandalay, Prome and Pegu – were forced to dismiss midwives that year as an economic measure. At the same time, a training centre for health visitors, originally planned for 1929, was delayed due to financial restrictions, until it was rescued by the Red Cross in 1935.\textsuperscript{50}

There is evidence that the economic crisis also affected the lives of health professionals outside the European empires, as economic austerity infiltrated debates over medical training in Siam. In the early 1930s, as the Great Depression bit deeper into the economy, voices of criticism were raised against the expense of training at the Bangkok medical school. Carl Zimmerman, an associate professor of sociology at Harvard, had been commissioned by the Siamese government to conduct its first economic survey in 1930. Zimmerman argued that, in line with the needs of a poor country, ‘junior doctors’ with lower qualifications should also be trained. The ensuing controversy, which involved the medical school itself, became a political issue. Zimmerman was opposed by Ellis, the director of the Medical School in Bangkok, who argued that the proposed scheme for ‘junior doctors’ was impracticable and undesirable since it would endanger existing standards. The controversy ended in 1935 with the government adopting Zimmerman’s scheme on a modified basis, as a school of junior doctors was opened at Chiangmai in 1935, offering a six-month course. ‘Graduates’ of the course could later continue their training at Chulalongkorn University.\textsuperscript{51} Evidently the economic crisis invigorated debates about the financial costs of medical training, a debate which resonates with more recent policy discussions.\textsuperscript{52}


\textsuperscript{49} Judith L. Richell, \textit{Disease and demography in colonial Burma} (Singapore, 2006), p. 188.

\textsuperscript{50} Ibid., p. 124.

\textsuperscript{51} D. J. M. Tate, \textit{The making of modern South-East Asia, II: The western impact, economic and social change} (Oxford, 1979), p. 559.

In British Malaya, tensions over the administration of public health simmered beneath the surface. In the Federated Malay States, the establishment of the Malaria Advisory Board in 1911 had served to concentrate government interest on environmental control as a means of preventing malaria on rubber and tin estates, and much of the work of the board was to promote the maintenance of these measures and to remind estates periodically to undertake them. In conducting this task there was a degree of jurisdictional tension between the board and other government authorities – the town sanitary boards, the Mosquito Destruction Board, individual estates, and health officers. Tensions became more marked in the early 1930s as budgets were cut to save costs. In the Federated Malay States, state revenues were roughly halved between 1929 and 1932. The chief health officer of the Federated Malay States wrote to the chief of the Malaria Advisory Board in April 1930 stating that sanitary boards (at local government level) were not willing to be responsible for anti-malarial measures on government reserves and state land, and had no funds to do so, as a consequence of which, board advice to continue selective clearance of the jungle was being ‘universally disregarded’. A notice in the press, placed by the board, stressed the importance of maintaining these measures, as ‘loss of labour from sickness and death will inevitably result in estates where anti-malarial works are neglected’. At the same time, for economic reasons, the measures themselves were modified: for instance, oiling was reduced from once every seven days to once every ten days.

As this case illustrates, funding for a number of projects intended to expand medical and public health services during the 1930s, many of which emphasized the benefits of disease prevention – vaccination, hygiene, and sanitation – was reduced. In Indonesia, international interest in rural health was increasing during the interwar period, as illustrated by Hydrick’s work in Java, but alongside this, the effects of the depression were still being felt. In a discussion of the high level of infant mortality in Batavia, J. H. de Haas, a pioneer of infant nutrition, observed that ‘local authorities thus far have not allowed health officials to establish this alliance (of hygiene and paediatrics) on a broader basis. Evidently the authorities are more concerned with the slight financial consequences of such improvements than with the judgment of future historians’.

As in Malaya, state revenues to the Dutch East Indies were drastically reduced during the early 1930s. More generally, it has been observed that, although in some local areas in Java, government expenditure on public health programmes was high, particularly on programmes dealing with malaria, there was an apparent lack of financial concern for programmes aimed more specifically at improving personal hygiene standards among the mass of the population.

Though this was perhaps a consequence of longer-term neglect of public health, elsewhere, well-established health care schemes were suddenly left without funds when the economic crisis diverted money away from public health. In Burma, a scheme of health inspections of Burmese school children had begun in 1913. Initially they were confined to the Anglo-vernacular and European schools, and were carried out by the local civil surgeon or doctor, and paid for by the government. The number of schools examined rose rapidly as the scheme expanded, and by 1931, a total of 301 schools had joined the scheme. However, in the same year, the government withdrew all grants as part of the general financial retrenchment, and the number of schools declined rapidly.\(^{56}\)

In other cases, budget cuts had a direct effect on the spread of diseases. At the time of the most serious outbreak of plague in Java between 1930 and 1934, the main method of reducing the incidence of the disease, a programme of house improvements—including replacing thatched roofing with tiles or corrugated iron and replacing hollow bamboo, which encouraged the breeding of rats, with wood—was being cut back. Over 15,000 people died in 1933 alone. The budget of 1,650,000 guilders in 1932 fell to 844,000 in 1933, but in terms of realized expenditures the position was even worse. From a peak in 1929 of 1.8 million guilders, the economic depression pressed government expenditures on house improvement down to 1.5 in 1930, then to 1.4, 1.0, 0.8, and finally to 0.65 million guilders in 1934.\(^{57}\)

In Malaya, and elsewhere in Southeast Asia, the structural financial retrenchments were most deeply felt by migrant workers, where financial and administrative factors constrained the development of sanitary and public health services on estates. In the early 1920s, it was proposed to introduce rules for estate sanitation to ensure the provision of clean water, dwellings, and surroundings, to prevent cholera, typhoid, and plague as well as malaria. In 1926, a new health initiative, the Health Boards Enactment, had been brought into force, with the aim of protecting estate workers from malaria. It was intended to give practical effect to the policy of landowner responsibility for anti-malarial work. The Health Boards Enactment was amended many times and implemented very slowly to allow time, so it was said, to gather data for specific anti-malarial and other projects and in order to avoid disturbing existing estate practices of private doctors. However, most European and Chinese estate employers opposed the scheme. They objected to the costs and to the assumption by the government of additional powers. Little had been accomplished by 1930 when employers successfully lobbied for its termination, pleading financial hardship arising from the severe slump in rubber and tin prices accompanying the worldwide depression.\(^{58}\)

\(^{56}\) Richell, Disease and demography in colonial Burma, p. 147.


As a result of these changes, and the generally lax surveillance of estate living conditions and public health measures, there is evidence to suggest that the health of estate workers did suffer. In Kedah, it has been suggested that this resulted in increases in the incidence of malaria in both central and southern areas of the state. Contemporaries were evidently worried. There was renewed concern by officials that estate owners and managers should ‘fully appreciate the economic advantages of the measures recommended for the improvement of health conditions’. ‘While it is impossible to expect estates to continue to carry out major sanitary improvements (unless a very vital sanitary service is involved) with the present prices of rubber and copra, nevertheless careful supervision is exercised to ensure that the present sanitary conditions are maintained.’ At the same time, there was a steady decline in the number of estate hospitals in Malaya through the early 1930s: in 1924 there were 167 plantation hospitals in the Federated Malay States (estate and group hospitals), but the number had fallen to less than 125 in 1939. Although many migrant workers were repatriated (in 1932, numbers were reduced from 216,303 to 170,285), the health of those estate workers who remained in Malaya was evidently at increased risk during the depression.

It was not just the presence of migrant workers in the countries of Southeast Asia during the Great Depression which affected public health, but also their absence. In Rangoon, the sanitation industry was dominated by Indian sweepers, scavengers, and night-soil removers, and many of the city’s doctors were also Indian migrants. As the depression destroyed the livelihoods of many Burmese peasants, artisans, and small traders, there was an increasing degree of competition with low-paid immigrant Indian labourers for scarce jobs. The outbreak of communal violence in 1930 involved fierce anti-Indian riots, and resulted in a significant outflow of Indians – both unskilled sanitary workers and doctors – with a consequent deterioration in Rangoon’s public health infrastructure. The evidence suggests that economic crisis, health, and migration were intimately connected.

The precise nature of these connections, along with many other key aspects of the subject, remain unexplored. But the innovative studies of interwar public health from other parts of the world can provide a methodology for future work. Can parallels be drawn between the ways in which the depression affected the health of the immigrant Mexican community in Los Angeles, and the South Asian migrant labourers in Southeast Asia? How were economic crisis, health, and migration connected? Existing research has built up a detailed picture of the large-scale effects of the Great Depression on Southeast Asia’s demographic record, but the health effects of the economic crisis at micro-level, on domestic life, have yet to be explored. As Thompson illustrates for Wales, this focus might...
also provide an alternative picture of the infrastructure of interwar medicine, particularly as it was experienced beyond the realm of the state. A broader social history of economic crisis and health in interwar Southeast Asia would create a new way of addressing these issues and constitute a valuable addition to the debate.

III

The relationship between economic depression and health has continued to engage historians, health experts, and policy-makers, as more recent crises have presented major challenges to health systems, particularly in the developing world. The 1997–8 East Asian economic crisis, for example, has generated a number of important studies on its consequences for health care. Studies have revealed that in Indonesia, the devaluation of the Indonesian currency led to inflation and reduced real public expenditures on health. Household expenditures on health decreased, as did self-reported morbidity in both rural and urban areas. The crisis also led to a substantial reduction in health service utilization. Studies of other developing countries found a comparable deterioration in health. In Cuba, the combined effects of a severe economic decline from late 1989 and a tightening of the US embargo in 1992 resulted in a significant deterioration in public health. Declining nutritional levels, rising rates of infectious diseases and violent death, and a deteriorating public health infrastructure were the direct results.

Yet just as during the Great Depression, many of the trends are contradictory. Mortality rates increase in some countries, but not in others. Research into the financial crises of the 1980s and 1990s and health outcomes in Mexico found that mortality rates for the very young and the elderly increased or declined less rapidly in crisis years as compared with non-crisis years. The authors tentatively suggest that this was due to reduced incomes and the increased burden on the medical sector. However, in the US and western Europe, there is evidence that mortality tends to fall during recessions with the decreased use of alcohol, reduced pollution due to lower industrial output, and fewer road collisions due to less traffic.

The effects of economic fluctuations on health status remain imprecise and difficult to define, as the historiography of public health during the Great Depression clearly illustrates. Connecting and comparing histories of public health in interwar Europe and the US with Southeast Asia reveal the


66 Parry and Humphreys, ‘Health amid a financial crisis’, p. 5.
potential of this field of research, contributing to social histories of medicine, and also touching on wider transnational historical debates in innovative ways. Whilst relatively little has been written directly on the subject for Southeast Asia, this brief survey has offered a glimpse of the possibilities for future work in this field.