

British Colonial Health Care Development and the Persistence of Ethnic Medicine in Peninsular Malaysia and Singapore

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Abstract

Both Malaysia and Singapore share a common colonial legacy in health care development. Health care in both countries has been characterised by a plural health care system comprising Western and ethnic medicine—Chinese, Malay, Indian and aboriginal medicine. In this paper, the introduction, development and increasing dominance of Western medicine is discussed with the aim of explaining the implications for the persistence of ethnic medicine. This persistence of ethnic medicine can be traced in part to colonial health care development policies. The uneven development of health care services during the colonial period has resulted in a reliance on ethnic medicine which has persisted till today.

Introduction

The organisation of the delivery of health services is one of the major development issues facing governments in both developed and developing nations. In a discussion of the development of health care delivery, it is necessary to consider its historical context. The historical perspective contributes towards an understanding of the characteristics of a country's health care delivery system. Examining the historical development also helps in the explanation of some of the current issues in health care delivery such as the persistence of ethnic medicine.

Nations like Malaysia and Singapore

share a common colonial legacy in health care development. A plural health care system persists in both these countries. It comprises Western and varying systems of ethnic medicine such as Chinese, Malay, Indian and Orang Asli or aboriginal medicine. Ethnic medicine has persisted in spite of the introduction, development and increasing dominance of modern Western medicine during the British colonial period.

The British colonial administrators were generally disparaging of ethnic medicine but tolerated its practice because it contributed to the care of Asian ethnic communities without burdening the administration with the costs. When the bid was made to enforce the acceptance of modern, Western-style medicine during the late British colonial period, various measures were then introduced to restrict ethnic

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medical practice. By then, a Western-style health care delivery system was already in place.

Practitioners of ethnic medicine had become more organised as well and were therefore in a better position to resist the imposition of the restrictions on ethnic medical practice. In this paper, it is argued that ethnic medical practice has persisted because of the colonial government's policies on health care development. Its unevenness and problems have contributed to the establishment of ethnic medicine. The practitioners of ethnic medicine have also been able to organise themselves in varying degrees in order to cope with the growing competition from Western medicine.

This paper examines health care development during both the early and late colonial periods with a focus on late British colonial rule and also discusses the impact of such development on the persistence of the various forms of ethnic medicine in both Peninsular Malaysia and Singapore. In the discussion, focus is on first, the uneven pace in the development of modern Western health services and second, the implications for ethnic medical practice. The discussion draws mainly on the persistence of Chinese medicine and contrasts it with the continuance of other systems of ethnic medicine in terms of practitioner organisation and consumer support. It is also necessary to discuss the other forms of ethnic medicine because they contributed to colonial health care and their persistence is as much a feature of the historical development of health care in both Malaysia and Singapore

as the introduction of Chinese and Indian ethnic medicine. The persistence of these forms of ethnic medicine also reinforces the argument that the course of colonial health care development contributed to the continued use and patronage of traditional healers. These other systems of ethnic medicine like Malay and aboriginal traditional medicine were already in use among local communities when Chinese medicine was introduced by the migrant Chinese community.

It is not within the scope of the paper to delve into the nature of each ethnic medical system. Rather the aim is to illustrate that with the uneven and unequal access to colonial health care, local Asian communities in both Singapore and Malaysia had little choice but continue to rely on ethnic medical practice. The persistence of ethnic medicine is in part reflected in its organisational and institutional development and partly on the extent of patronage. Discussion is centred on the organisational and institutional development of ethnic medicine as its practitioners adjusted to new conditions imposed on ethnic medical practice with the growth and expansion of colonial health care services.

Focus has been placed on Chinese medicine for a number of reasons. Practitioners of Chinese medicine were among the first to organise medical associations and schools to ensure the propagation of ethnic Chinese medical care. They were also the first to lobby against a number of restrictions imposed on ethnic medical practice. Hence, organisationally, Chinese medicine had a headstart on other forms of

ethnic medical practice. The reasons for such organisational differences and hence, varying degree of persistence, are examined in this paper.

Development and the Persistence of Ethnic Medicine

According to modernisation theory, ethnic medicine should have fallen victim to the same socioeconomic processes that transformed Western medical science in the nineteenth and twentieth centuries, that is, urbanisation, monetisation, industrialisation, spread of literacy, mass communication and political participation by the masses [Lerner 1958]. The progress assumed by these changes implies modifications in social behaviour, re-orientation of attitudes, beliefs, motivations, aspirations and values that are expected to contribute to the preference for modern rather than traditional medicine [Redfield and Singer 1954; Hoselitz 1960; Hagen 1962]. Governments in developing nations adopt modern Western medical institutions and technology in order to encourage and hasten modernisation of health care services.

Often, ethnic medicine has drawn the scorn of Western-trained Third World medical planners because it is perceived to be pre-scientific, irrational or superstitious—which are believed to be characteristics of groups resistant to social and economic change. Ethnic medical practice is associated with simple, small-scale organisation and community-oriented and interpersonal institutions. The minimal division of labour and lack of a technology equivalent

to that of modern medicine reinforces the negative, stereotyped image.

Despite such negative characterisation of ethnic medicine, it is clear that it still persists. The total displacement of traditional by modern activities simply does not occur. There has been instead a transformation of both traditional ethnic and modern Western medicine in a process of change which has been stimulated by their having to be practised alongside each other. There has not been an unchanging ethnic form of medicine as implied in modernisation theory. Nor is modern Western medicine being practised without its traditions.

The persistence of ethnic medicine can be explained by its continued utility to the communities in which it is practiced and hence, to the administration which does not have to pay as much for health care costs [Bettelheim 1972; Meillassoux 1972; Bradby 1975]. Both political and economic factors contribute to the persistence of institutions like ethnic medicine. This persistence of ethnic medicine entails its change and the process involves not a unilateral relationship between modern Western and ethnic medicine but a reciprocal one. In the following discussion it becomes clear that ethnic medical practice is transformed even as it faces increasing competition from the development of modern Western medicine.

Colonial Health Care

The persistence of ethnic medicine in Malaysia and Singapore can partly be

attributed to the colonial administration's attitudes towards the organisation of social services such as health care. Such policies determined the course of health care development and the types of health services provided. However, as the policies were always subject to political and economic exigencies, the course of health care development was accordingly, uneven. As a result, there was a chronic shortage of medical staff and other resources which affected the development of Western-style health care delivery throughout the entire period of British colonial rule but particularly during the early days of colonial administration. Certain communities, like the Chinese, had to rely on their own resources—money, practitioners and institutions—to organise health care services. So ethnic medical practice and their practitioners remained useful throughout colonial rule and have persisted until today. The development process therefore, partly explains the persistence of the use of ethnic medicine in both Peninsular Malaysia and Singapore.

The origins of the dominance of Western medicine and the preservation of ethnic medicine in Peninsular Malaysia and Singapore are examined in the early colonial period. Then, changes in the development policy with greater British intervention in the colonies' affairs are discussed. This leads to an analysis of the impact of the colonial legacy on post-colonial health care.

Early Colonial Period (1511–1874)

Originally, Portuguese (1511–1641), Dutch (1641–1824) and the early stage of British (1824–1874) rule had little impact on the Malay Peninsula's people and their way of life because, as Jackson [1961] and Sandhu [1973] have noted, there was little resistance to colonialism. Where such opposition occurred, it was quickly crushed as when both the Portuguese and the Dutch removed the Malacca Sultans on two separate occasions.

Ethnic institutions like Malay medicine survived because it posed no immediate threat to colonial rule. Western medicine, with its rudimentary facilities, infirmaries and clinics, was the preserve of Europeans then engaged in trade and maritime activities. Early colonial medicine made no appreciable contribution to the indigenous Malay society. In an analysis of the interaction between the colonialists and the local communities during this period of colonial history, Caldwell [1970: 377] has argued that indigenous institutions and traditions survived because:

European merchants fitted themselves in to the existing pattern, as traders, plunderers, and the rulers of the ports they were able to capture and hold. Penetration into the hinterland was sporadic and temporary, contingent upon the needs of security or acquisition of local produce. The indigenous social structure remained unaffected: at the base the homeostatic, amoeboid and broadly

self-sufficient village community, growing rice and, depending upon geographical location, fishing, holding land in common . . . , and to a large extent . . . self-governing

Malay healers formed part of this subsistence-based, rural economy and their practice focussed on immediate needs, existing local resources and customary cultural beliefs about environmental conditions and their effects on health and illness. Centred on the production activities of Malay communities—rice cultivation, fishing and mining—part-time ethnic practitioners comprised: the *pawang* (priest or religious healers who mediated with the natural forces for good health, harvests, catches and tin strikes); *bomoh* (medicine men) who were mostly farmers skilled in treating common illnesses with local herbs and religious rites; *bidan kampung* (midwives); and the *mudim* (barber-surgeons) who dealt with operations required for Islamic circumcision rites.

If the Malays remained isolated from early colonial inroads in the peninsula, the aboriginal groups were further removed. By then, the aborigines had been driven inland from their riverine settlements by the Malays. There were fewer types of aboriginal 'curers' in terms of specialised skills compared to Malay communities [Newbold 1971; Werner 1979]. Drawing on their understanding of the natural environment, the *poyang* or priests, incantators and exorcists, were believed to be skilled in healing. Such skills corresponded with the needs of the hunting and

gathering activities that characterised aboriginal production activities at that time. The physical segregation of these aboriginal communities from early colonial contacts effectively preserved their traditions like ethnic medicine, at least until the first decade of the British phase of colonialism.

Early British rule, which began in 1824, saw more substantial efforts at introducing Western medicine care to combat rampant epidemics. Chroniclers of the period up to 1870, such as Cameron [1965], Begbie [1967] and Newbold [1971], have reported that death rates from endemic fevers were very high among Malay, Indian and Chinese people. The mortality from fevers was particularly high in the Straits Settlements and their immediate environs. Sandhu [1973] has recorded that up until the 1960s, mortality among Indian settlers from tropical illnesses was registered at eighty to ninety per cent. As Mills [1966] and Begbie [1967] have noted in their journalistic accounts of this period, British officials were also susceptible to tropical illnesses and were affected by the epidemics. In fact, illness almost brought the colonial administration to a standstill, as happened during the cholera outbreak in Penang in 1833.

The construction of new townships near malarial swamps brought further health problems. Conditions were worse in the Straits Settlements towns because, despite the continual influx of immigrants, there were no adequate sanitation facilities, particularly in the crowded quarters of the Asian communities. Health care facilities

provided by the colonial and immigrant ethnic sectors to curb epidemics and deterioration in health conditions were initially perfunctory. Colonial medicare then was persistently short of money, men and premises. The organisation of health services was frequently interrupted by political events in India since the Colonial Office there controlled the Straits Settlements until 1867.

The Malay Peninsula was forced to accept the lower priority given to its needs. Following the Indian mutiny in India in 1857, development programmes in the Malay Peninsula were affected. The Straits colonial authorities were ordered, according to Turnbull [1972], to halt all public works programmes in the Straits Settlements. Nevertheless, despite the difficulties, a rudimentary health care infrastructure was set up in the major Straits Towns of Penang, Malacca and Singapore—general hospitals, district, prison and pauper medical facilities. Most of the hospitals that also accommodated the Asian ethnic communities such as those in Penang were paid for by wealthy Chinese merchants. Taxes on Chinese religious ceremonies and the sale of pork funded whatever sanitation facilities were provided at the time as well as the maintenance of some of the hospitals. Each of the major Straits towns had a medical department but these were understaffed and the personnel paid such low salaries that most of them were also engaged in other part-time employment.

In the Singapore settlements, the local populace was left very much to its own

devices when it came to caring for the sick. There were initially no hospitals, only one or two government doctors and few private practitioners. The effort made to train Eurasian medical support staff in 1823 met with few takers because of the low pay and poor prospects. There was a token provision of health care facilities like the atap shed built and maintained to house sick paupers with funds raised from the taxes on the sale of pork [Turnbull 1977].

Most of the earnings of transitory Indian and Chinese immigrants were remitted to their home countries and little was invested in the colonies. These immigrants were also largely labourers who, at best could only afford processions and other religious ceremonies to fight off epidemics so common during this phase of British colonial rule. Low [1972: 317], a British resident in the peninsula during the 1820s, has written of his surprise at the ability of the Asians to survive the poor conditions despite their reliance on ethnic medicine:

The chief diseases which prevail amongst the natives throughout the population . . . , are fevers, remittent and intermittent; the fever often proving fatal. It is only surprising how any of them do recover from acute illnesses, when the low state of native medicine is considered.

For the Asian communities, there was often little choice in health care but to rely on their ethnic medical practitioners. On several occasions, Low [*ibid.*] has noted that the poor performance of colonial facilities and services was generally suf-

ficient deterrent to its sustained use by both the Malay and immigrant Indians and Chinese. Conditions were so bad at the medical institutions provided, people had to be forced to use them. Indeed, Turnbull [1977: 64] has noted that patronage of the hospitals had to be forced, noting that 'No one will enter who can crawl and beg, unless compelled by the police'. The situation was such that people entered the hospitals to die rather than to be treated or cured.

In the settlement of Singapore, a pauper's hospital was the most prominent feature during the period spanning the earlier days of British colonial rule up to the 1840s. This was built facing a swamp which was also the town's main rubbish dump, with a donation from Tan Tock Seng and when finally instituted, services were so poor, the use of the hospital was only as a last resort. Between 1852 to 1853, one third of its patients died.

Until the 1870s, therefore, the organisation of health care delivery made little progress beyond the establishment of rudimentary facilities and concomitantly, made little impact on ethnic medical practice. It was only with increased British economic and political commitment to the Malay Peninsula and Singapore after 1874, that there was a shift in colonial policies towards the development of improved health care services.

Late Colonial Period (1874–1957)

Changes in colonial political and economic interests during the late nineteenth

century and the first four decades of the twentieth, saw the transformation of the western area of Peninsular Malaysia into one of the most intensively exploited regions in Southeast Asia. Colonial entrepreneurs—Europeans and Chinese—and the local Malay elite directed profits from tin mining activities into rubber plantations along the western coast of Peninsular Malaysia.

These massive investments had to be safeguarded against two threats—faction fighting among Malay leaders (aided by Chinese secret societies) and malaria. Death tolls from malaria among imported Indian labour communities in newly opened rubber estates within the jungles of interior Peninsular Malaysia jeopardised productivity and the entrepreneurs' profits. Indeed, *the Institute of Medical Research Reports* [1923; 1924; 1925] have noted that death rate on rubber plantations in the early 1900s was 62 per 1,000 from fevers alone. Ooi, J. B. [1963] confirmed that individual estates such as Highland Para Limited, lost 20 per cent of its labourers during the first few years of its establishment. Even in the Straits towns like Singapore, the mortality rate was higher than in colonies elsewhere—Hong Kong or India—ranging from 44 to 51 per 1,000 [Turnbull 1977].

There was, therefore, continual agitation among the merchants for British intervention in Perak, Selangor, Pahang and Negri Sembilan where their vested interests and indentured labourers were under the greatest threat from political infighting and the lack of medical facilities. Responding

Table 1 Health Care Expenditure during the Late British Colonial Period (1874–1957)

Year	Health Care Expenditure* SS\$	Annual Rate of Increase Per Cent
1877	77,412	—
1883	93,911	3.5
1900	193,551	6.2
1901	195,422	1.0
1911	4,178,742	203.8
1921	8,747,969	10.9
1931	11,755,555	3.4

* Includes Singapore.

Source: *Straits Settlements Blue Book* [1877; 1883; 1900; 1901; 1911; 1921; 1931].

to these demands, British protection was imposed on these four states which later became known as the Federated Malay States.

The remaining Sultanates were also coerced into accepting British advisors, whose recommendations in all matters including health care, had, according to Loh [1969] and Khoo [1972], to be implemented. In the process, more financial resources were allocated to the development of Western health services. According to reports in the *Straits Settlements Blue Books*, expenditure on health care soared by 152 per cent in fiscal terms between 1877 and 1901 (see Table 1). As a result, hospitals which had previously been concentrated in the Straits towns, were built in the inland state capitals. Urban sanitary boards were established, medical departments increased their staff and the Institute of Medical Research was up in Kuala Lumpur in 1900 to supervise quarantine procedures and investigate tropical diseases which had undermined British colonial administration and economic activities.

The colonial health care policy was therefore moving from coercion and the imposition of the use of Western-style medical services to the establishment of an institutional and ideological base for the propagation of Western-type medical services. The process, was however, uneven and the emphasis was on curative care with medical facilities concentrated in the towns. In 1905, the Singapore Medical College was set up to train local people in Western medicine. The trainees were then sent to staff medical institutions in the Malay Peninsula.

A Health Branch and Malaria Advisory Board were added to this curative structure in 1911—the addition of the preventive aspects of health services laying the groundwork for a more comprehensive system of health care delivery. The Malaria Advisory Board was, in essence, the first attempt by the colonial government to provide for rural people and areas. Allocations for anti-mosquito work only assumed significant proportions in the early 1920s—SS \$88,936 in Penang and SS \$32,957 in Malacca. This was in contrast to SS \$46 which was allocated for vaccinating the whole population of the Malay Peninsula in 1883 [*Straits Settlements Blue Book* 1883]. The increased commitment to preventive health care programmes was therefore part of the shift in colonial health care policies.

Infant welfare clinics were also set although the first unit was established in Kuala Lumpur in 1922. In the town of Singapore, local girls were trained to be midwives by 1910 so that they could visit

homes to provide maternity services since women were refusing to go to hospital for deliveries [Lee 1987]. This together with the provision of more maternal and child welfare services resulted in improvements in maternal and infant health, with a decline in the 1910 peak in infant mortality of 345 per thousand. In the peninsula, health workers were appointed to attend to women and children brought in from their villages. Travelling dispensaries using buses and boats were used for more remote areas in Pahang and Kedah.

Despite the efforts at extending the coverage of Western-style health services, there was never at any time a full substitution of these services for traditional indigenous medicine. As earlier mentioned, the curative facilities like the hospitals built by 1900 were all located either in the Straits towns like Kuala Lumpur or the smaller district hospitals [*Straits Settlements Blue Book* 1900]. In Singapore, 'specialised' hospitals were built. The Middleton Isolation Hospital was opened in 1913 for the treatment of infectious diseases. Others followed in the 1920s. These included the Outram General Hospital and the Trafalgar Home for lepers in 1926, with the Woodbridge Hospital in 1927 and the Kandang Kerbau Maternity Hospital in 1928.

The impressive range of physical infrastructure was not however, matched by the quality of the personnel staffing it. Health conditions remained poor right up to the early 1900s, especially among the low-income people. Until the 1930s, the hospitals were staffed by part-time para-

medical workers. Even with the training of these paramedical workers—beginning in the late 1870s—there was a chronic shortage of medical staff. In 1877, for example, there were only two part-time non-nursing staff in the Penang General Hospital despite an intake of 687 patients [*Straits Settlements Blue Book* 1877]. Furthermore, the medical staff were either Indian or British rather than Malay and Chinese although these two ethnic groups comprised the majority of the population in both the Straits Settlements and the Federated Malay States. The persistent problem of labour shortage in the government-sponsored health sector meant that ethnic medical practitioners remained useful in the provision of health care services.

The medical services provided by the colonial government carried a stigma because of their pauper and charity emphasis. This stigma was also aggravated by the segregation of institutions and facilities catering to the Europeans and the Asians. A large proportion of hospital beds provided for Asian people was located in pauper institutions and those hospitals set up to accommodate the decrepit, destitute, lepers and lunatics. Where Europeans were cared for at these hospitals and institutions, there was a segregation of the wards meant for the European and those for Asian patients. If such treatment was insufficient deterrent to the Asian people, then the persistently high death rate among hospital patients may have been further disincentive. Seven per cent of the admissions to the Penang General Hospital died in 1877

and the proportion increased to 10 per cent in 1931.

There was notwithstanding, a steady increase in the number of patients shown in hospital registers, especially among the women. Outpatients also increased and the Federated Malay States Government Gazette [1925] had recorded that travelling dispensary boats on the Pahang River doubled the number of patients treated from 9,817 in 1924 to 16,931 in 1925. The increase in the use of the medical facilities is illustrated in Table 2. Such an increase in the acceptance of colonial health services among the Asian people would have been due to the efforts made to gain their acceptance. Apart from the provision of mobile dispensaries to reach the more remote areas, local Malay girls were trained in midwifery and incentives were given in the form of salary bonuses to the non-Malay midwives when they passed Malay language examinations. Both the measures would have

contributed substantially to the success of the efforts being made to increase the acceptability of Western-style medical care within the Malay community and especially among the women. Malay rulers were also coerced into persuading their subjects to cooperate with the colonial health authorities [Kennedy 1970]. The other Asian communities were obviously considered by the colonial health authorities as too transient to warrant the effort which they had devoted to health services for the Malays. They were moreover at the time, the most stable ethnic group. Both Western and Chinese medical services were supplied by members of the Chinese community.

Impact of Colonial Health Care Development Policies on Ethnic Medical Practice

Apart from the extension of the coverage of health services and the training of local people as medical personnel, the colonial government also took steps to displace traditional medical practitioners like the midwives. In 1924, legislation was passed which restricted the activities of these midwives but as Chen [1975] has observed, the implementation was lax and appeared to apply only in the vicinity of the urban centres. The concentration of medical facilities in the towns has been mentioned. This together with problems of chronic shortage of medical staff implied that traditional ethnic medicine continued to be useful in meeting the shortfalls of the colonial health care complex. Research

Table 2 Use of 'Late Colonial' Medical Facilities (1924-1925)

Place	Patients	
	1924 number	1925 number
<i>Hospitals and dispensaries:</i>		
Perak	221,096	216,282
Selangor	177,896	219,739
Negri Sembilan	96,432	99,047
Pahang	88,837	86,725
<i>Infant welfare clinics:</i>		
Kuala Lumpur	16,238	23,134
Ipoh	10,257	15,523
Taiping	7,342	18,259

Source: *Supplement to Federated Malay States Government Gazette* [1926].

among the South Indian plantation labourers [Jain 1973: 157–158] has shown that they preferred indigenous health care to subsidised colonial medical services despite the fact that:

... the cost of [ethnic] medical consultations and medicine is another drain on the labourer's earnings. This is somewhat paradoxical, considering that [Western] medical services are provided free to all estate workers and their dependents The paradox is resolved, however, when it is realised that estate workers have a deep-seated mistrust of Western medicine and an equally strong faith in the efficacy of the indigenous pharmacopoeia.

Indian medicine has continued to be patronised and Indian medical practice persists within the Indian community. Yet several factors have contributed to the greater undermining of the position of Indian ethnic medicine compared to Chinese and Malay medicine. The Indian caste system has meant that the Indian community is relatively more fragmented than either the Chinese or Malay communities. In addition, the plantation owners who employed the Indian labourers wielded absolute control over them. All of these factors have combined and mitigated against the comprehensive and collective organisation of ethnic Indian medical practice.

While the majority of the Chinese showed no parallel prejudice against Western medicine, they continued to rely on ethnic

Chinese medicine as well. This reliance and support of the institutions of ethnic Chinese medical care is evident in the level of patronage of free clinics which has persisted, the increase in the numbers of registered *chung-i* and medicine retailers as well as the continued operation of medical organisations supplying ethnic medicare.

Right from the beginning, both Western and traditional Chinese medical services were provided by members of the Chinese community. Wealthy Chinese merchants, especially those given the office of *Kapitan Cina* by the colonial government and recognised as the leaders of the Chinese community, built Western-style hospitals for paupers and lepers and also established maternity services in the major Straits Settlements towns. Simultaneously, hospitals operating free clinics and offering classical Chinese medical care were also organised. The first such free clinic was established in Penang in 1884. This was the Lam Wah Ee. As recently as 1978, the clinic had annual outpatient attendance totalling more than 20,000. It was among the many free clinics initiated by the *kapitan* group while the Tung Shin Hospital in Kuala Lumpur, established in 1892, owed its origin to Kapitan Yap Ah Loy who like the other *kapitan*, had funded health care institutions to provide medical care to his Chinese wage-workers and their dependents. Similarly, in 1977, its annual total number of patients totalled 24,000. Both the Lam Wah Ee and Tung Shin hospitals engaged *chung-i* from mainland China and thereby promoted the transfer of Chinese classical medical practice to

Peninsular Malaysia and Singapore. The free clinics run by the Singapore Chinese Physicians' Association had a total of 663,165 patients in 1978 [Ooi, G. L. 1982].

Originally, the hospitals established by the Chinese community employed traditional medical practitioners, the *chung-i*, from mainland China. The onus of the upkeep of health care facilities established by the Chinese community was solely the responsibility of the Chinese public. Initially, the British colonial authorities assumed responsibility only for the health establishments they had instituted, such as leper and pauper institutions. The Tung Shin Hospital records have shown that a sum of S\$ 5,000 was donated by the Selangor British health authorities to its operations initially but even this money was raised through tariffs placed on the tin produced and sold by Chinese miners. The ethnic Chinese medical institutions have relied on community or public funding for its establishment and maintenance. Since the late British colonial period, medical schools and free clinics have been financed, almost uninterrupted, by practitioners, business and public donations. Hospitals like the Tung Shin and free clinics operated by Lam Wah Ee, which were still operating well into the 1970s, incurred annual expenditures totalling some M \$46,000 in 1977 and M \$50,000 in 1978 respectively [*ibid.*; Tung Shin Hospital 1977].

The upkeep of the health care facilities provided for the Chinese community and the propagation of ethnic Chinese medical

care remained entirely the responsibility of the Chinese people themselves. Being viewed as self-sufficient from the beginning of their immigration to the Malay Peninsula, the Chinese people were incidental beneficiaries of colonial health care programmes. In Singapore, well into the early 1900s, the majority of the population relied on charitable organisations like the Thong Chai Medical Association which was financed by Chinese merchants. Originally, this organisation supplied services by Chinese physicians from China who practised ethnic Chinese medicine and provided free care for the poor, regardless of race [Turnbull 1977].

The Persistence of Ethnic Medicine

Although the community made use of the colonial medical services provided, the Chinese were also given the opportunity to preserve its own ethnic medical tradition through the establishment of an institutional network of medical organisations comprising free clinics for the Chinese people, schools and associations for its practitioners.

By the time the colonial government had moved to impose various restrictions on the practice of Chinese ethnic medicine, the collective strength of the *chung-i* was sufficient to counter them. Similar institutional and organisational developments among practitioners of other ethnic forms of medicine have not been recorded mainly because of the very nature of the ethnic medical systems themselves. Local medical systems, as conceptualised by Dunn [1976] have been characterised as

involving self-designation or inheritance as a mode of entry into 'practice'. In addition, the practitioners of Malay and aboriginal medicine and other forms of folk medicine have been portrayed as spirit intermediators often 'self-trained following inspiration'. This is in contrast with regional medical systems such as Ayurvedic, Unani and Chinese medicine which today emphasise scholarly master-pupil relationship or scholarly education at a school. These differences in the propagation of ethnic medicine partly accounted for the varying degrees to which the various forms of ethnic medicine have persisted.

The restrictions on ethnic medical practice were not imposed until the 1920s chiefly because the Chinese community had generally been left on its own by the British colonial authorities. In the 1920s, the British colonial government had imposed import tariffs on medical supplies from mainland China, ostensibly to recover deficits in public funds which had been exhausted during the First World War. Associations of Chinese physicians emerged throughout Peninsular Malaysia and Singapore to lobby against import levies.

On another occasion, there was a similar consolidated move to protest the threat to withdraw official recognition of the *chung-i*'s right to practise in mainland China. The success of these efforts are triumphantly chronicled in the historical records covering the formation of medical associations that had emerged to represent the interests of the traditional Chinese medical practitioners. The threat of the mainland Chinese government to dissolve classical Chinese

medical practice in favour of Western health care was a major force in galvanising the ethnic Chinese medical practitioners into consolidated action.

The onset of the Japanese Occupation of Peninsular Malaysia in the 1940s forced this 'resistance' movement among Chinese physicians into quiescence. However, it stressed the need for associations to maintain the continuity of Chinese medical practice. The Japanese rulers permitted Chinese medical businesses to continue but required that regular reports of their activities be furnished by chosen representatives. For such tasks, the Chinese practitioners could rely on their associations. Other forms of ethnic medical practice were not apparently subjected to such attention during the Japanese occupation of Peninsular Malaysia and Singapore.

Among the earliest of the Chinese medical practitioners' associations to be established was Perak Chinese Physicians' and Druggists' Association which was set up in 1925. The initial aim of the association was to protest the proposal to prohibit the practice of ethnic Chinese medicine by the government of mainland China. The association has been among the first to set up a medical school to train *chung-i* or Chinese medical practitioners to counter stricter immigration laws imposed on movements between mainland China and Peninsular Malaysia and Singapore during the period following the Second World War. The first Chinese medical institute was established by the Central Malayan Physicians' and Druggists' Association in Kuala Lumpur in 1955.

By 1960, there were nineteen Chinese medical associations throughout Peninsular Malaysia. These had all been loosely organised into a Federation of Chinese Physicians and Druggists in 1960. Although the presence of so many associations reflect the disparate state of ethnic Chinese medical organisation at the time, the constitutions of the associations shared similar objectives. These recognised the need to standardise ethnic medical practice and training, introduce innovations and improve and propagate the use of Chinese medicine.

Together, the associations were also able to wage a successful campaign to be allowed to provide medical care in 'new villages' established during the Emergency period in Peninsular Malaysia in the early 1950s. These 'new villages' had been established during the Emergency period for resettling rural Chinese people to prevent them from aiding Communist insurgents. In the beginning, only 'western' health services were provided and ethnic medical care disallowed. The *chung-i* in the town of Ipoh lobbied successfully to remove the prohibition and organised visits by these Chinese physicians to the villages to deliver health services.

The numbers of *chung-i* and medical retailers of ethnic Chinese medicines had increased meanwhile. In 1883, a census taken by the British authorities recorded a total of 139 Chinese chemists and druggists in the Straits Settlements. By 1960, the *chung-i* and proprietors of Chinese medicine shops who were known and registered with the Federation of Chinese

Physicians and Medicine Dealers of Malaysia had increased to 619 and 1474 respectively. The number of Chinese physicians practising in Singapore in the same year was 369 and there were 579 Chinese medicine retailers. Where before 1950 there had been one distributor of Chinese medicines to 200 retailers, in the post-1950s period, the number of distributors or wholesalers had increased to an estimated five or six international firms. Some like Eu Yan Sang, had an estimated trade turnover of some M \$11 million in 1979 [Ooi, G. L. 1982].

Compared with the number of practitioners registered with the Federation in 1960, the number of physicians in Peninsular Malaysia had increased only slightly by 1976, to a total of 695 practitioners. There had however, been a greater increase in the number of Chinese medicine shop proprietorships, the total being 1942 compared to 1474 in 1960 [*ibid.*]. However, the ratios of the *chung-i* to population compared quite favourably with those for Western-trained medical doctors as evident from the following figures.

Country	<i>Chung-i</i>	Western-trained Doctors	Comments
Malaysia	1:3, 122	1:4, 347	Both concentrated in urban areas [Chen 1975].
Singapore	1:2, 500	1:1, 536	Quah[1977]

The clash that had taken place between the colonial authorities and *chung-i* was not characteristic of other forms of ethnic medical practice still persisting in Malaysia and Singapore. Malay people had been the target mostly of the colonial effort at

introducing Western medicine to the Malay Peninsula. Official coercion and legal measures, as will be discussed later, would be employed to ensure the acceptance of Western-style health care delivery within the Malay community. Equal persistence in the form of public and market support of ethnic medicine has not been reported among the Malay people. As Rudner [1977] has documented, the village chiefs of Malay *kampung* near urban centres, were demanding Western-style dispensaries and doctors trained in Western medicine.

Malay, aboriginal and Indian traditional medical practitioners did not organise a well-integrated response to colonial health care policies. They lacked the cohesiveness and some of the internal characteristics—chiefly a written body of medical knowledge, network of personnel and community support—typifying Chinese medicine. Malay healers and their Indian counterparts were also disadvantaged from the point of view of organisation. Malay and Indian traditional healers were highly fragmented as they were located in widely-dispersed communities, being largely rural-based. Among the Indians, the physical distance was compounded by social segregation between Indian merchants, labourers and convicts. As a result, the development of Indian medical practice was jettisoned. The further evolution of the Malay system was also blocked.

It was consumer rather than practitioner resistance which had sustained ethnic medical practice like Chinese medicine against the onslaught of colonial health care programmes. Yet, towards the end

of colonial rule, even consumer support for Malay and Indian ethnic medical services appeared to be on the wane. Village chiefs had started to ask for Western-style health care delivery. Consumption of ethnic Indian medicine remained restricted to Tamil and small urban communities. It failed to expand before the incorporation of ethnic Indians into the Western medical sector, as both professional and paramedical workers.

The Indian and Malay healers failed to organise institutional means through which their Chinese counterparts had contested the more restrictive policies of the colonial health authorities. If the Indian healers had lacked the 'market' support, the Malay and aboriginal practitioners probably were disadvantaged from the absence of a written tradition in ethnic healing. Yet they were gradually integrated into the new socio-economic structure that evolved under late British colonial rule as a complementary and subordinate form of health care. The number of personnel which has persisted remain largely undocumented. Similarly, the *chung-i* had established a strong commercial network which became closely linked with the colonial complex. Their institutions vied side by side with those established to deliver Western-style health care services. Hence the various ethnic medical traditions were preserved to varying extent with the advent of modern Western medicine.

Post-Colonial Health Care Development Policies and Ethnic Medicine

Following Independence for both Malaysia and Singapore, the two countries embarked on their own programmes of health care development. The Malaysian government sought to extend health services to the poor areas and rural villages. A World Health Organisation assessment team, which put up a report by Roemer and Manning [1969: 14] had suggested that:

... the continued use of traditional

healing can be taken as a barometer of the effectiveness of the RHSS [Rural Health Service Scheme] or vice-versa . . .

Effectively therefore, the suggestion was that the success of the rural health scheme would be reflected in the displacement of traditional medicine. The strategy was therefore essentially to render ethnic medical care superfluous by extending Western-style health services to what was then believed to be the last repositories of tradition—the poor and rural areas.

There is however, evidence to show that traditional medicine like Chinese medicine continues to be practised mainly in urban

Table 3 Distribution of Ethnically-Trained Chinese Practitioners and Medical Druggists

State Chief City	1960				1976			
	Chinese Medicine Shops		Chinese Physicians		Chinese Medicine Shops		Chinese Physicians	
	number	per cent	number	per cent	number	per cent	number	per cent
Perlis	8	0.5	3	0.5	14	0.8	3	0.5
Kangar	3		3		5		3	
Kedah	67	4.5	19	3.1	99	5.4	19	3.2
Alor Setar	12		7		23		5	
Penang	176	11.9	67	10.8	348	18.9	69	11.8
Georgetown	126		50		162		55	
Perak	358	24.3	116	18.7	367	20.0	106	18.2
Ipoh	89		58		92		71	
Selangor	391	26.5	197	31.8	435	23.7	153	26.2
Kuala Lumpur	270		128		294		117	
Negri Sembilan	69	4.7	52	8.4	81	4.4	53	9.1
Seremban	17		19		35		29	
Malacca	78	5.3	43	6.9	84	4.8	38	6.5
Malacca	46		36		39		23	
Johor	227	15.4	74	11.9	296	16.1	119	20.4
Johore Bharu	21		3		47		21	
Pahang	82	5.6	16	2.6	76	4.1	19	3.3
Kuantan	—		—		11		6	
Trengganu	10	0.7	17	2.7	12	0.7	n.a.	—
Kuala Trengganu	10		17		6		—	—
Kelantan	8	0.5	15	2.4	25	1.4	4	0.7
Kota Bharu	8		15		20		4	
Peninsular Malaysia	1,474	100.0	619	100.0	1,837	100.0	583	100.0

Soucre: Federation of Chinese Physicians and Druggists of Malaysia [1960; 1976].

centres. In Table 3, it is seen that in 1960, the highest concentrations of Chinese physicians were in the more urbanised and affluent states of Peninsular Malaysia. In the state of Selangor for example, 65 per cent of the *chung-i* were practising in the capital city of Kuala Lumpur. Some 75 per cent of the *chung-i* in the state of Pulau Pinang had located their practices in Georgetown. The practice of Chinese traditional healing has furthermore, been urban-based and such a characteristic has persisted if not become more pronounced in certain areas by 1976, despite the gradual growth and development of Western-style health care services. So the persistence of ethnic medicine is not merely a rural phenomenon but a consequence of colonial policies towards health care development.

The momentous growth in the development of Western-style health care delivery prompted ethnic medical practitioners like the *chung-i* to re-organise themselves with the aim of consolidating their stake in health care. Family-based and highly individualistic forms of organisation were eventually integrated into local and then nation-wide associations—the successors to local associations of Chinese physicians which had emerged during the late British colonial period. Most of the associations were urban-based and it was easier for the *chung-i* to organise their resistance during conflicts with the authorities than rural-based Malay healers.

Chinese physicians had business interests to protect—concerns which did not apply to other ethnic variants. In fact, profit-

ability of their practices had become more important to Chinese physicians than in other ethnic forms of medical practice where practitioners did not depend on their practices for a livelihood. Chinese medicine depended in part on the trade in herbal supplies for survival and many *chung-i* engaged in retailing and wholesaling of medicines to supplement income from their medical care activities.

A loosely-organised federation of nineteen local *chung-i* associations that had emerged during and after the late British colonial period in Peninsular Malaysia and Singapore was formed in 1960. Membership of the federation, aimed at protecting trading interests of the Chinese physicians and traders of Chinese medicines, had increased to twenty-four organisations in 1976—by then the Malaysian group had become independent of Singapore. In contrast, the first Indian association of practitioners did not emerge until 1976 and the Malay parallel was not formed until 1979. There is still no association of aboriginal *poyang* which has been reported.

In the late 1970s, Werner [1979] had shown that the aboriginal system had undergone little change—the same apprenticeship arrangement had been retained. Similarly, the organisation of association of Malay healers had been motivated not by the practitioners themselves but the United Malay National Organisation, the 'Malay' arm of the ruling political party, Barisan Nasionalis, with the aim of preserving the cultural heritage of the country's people. The decision to support the Malay ethnic medical tradition was in

part, motivated by the practitioners' success in treating cases of drug addiction among Malay youths. Colson [1971] has also noted that the specialist *bomoh* have been able to draw their clientele from surrounding villages or urban residents unlike the old-style *bomoh* whose patrons had come mainly from their immediate villages. Studies of Malay ethnic medical practice by [*ibid.*] and Chen [1971; 1975a; 1975b; 1978] have however, generally shown that changes initiated by the practitioners have been rare.

Under the Rural Health Service Scheme that had been launched by the post-Independence government, a programme was introduced to coopt the *bidan kampung* or traditional Malay midwives, into the Western health care delivery system. The aim was to facilitate the acceptance of Western medicine in rural areas. During the early 1970s, the *bidan kampung* was given a six-month course equivalent to that of a dresser or medical auxiliary. However, this has been a stop-gap measure which would be dispensed with after the establishment of rural health clinics and their full complement of staff and services. The *bidan kampung* continue to persist but in a diminished role largely within the rural areas. Such a diminished role for ethnic Malay healers even in the rural areas, was exemplified in the findings from a study by Chen [1969]. This study revealed that 92 per cent of Malay household heads interviewed in rural areas used a combination of Chinese medicine retailers, Western-trained personnel in government health centres as well as the *bomoh*.

Indian practitioners, like Malay healers, have taken steps individually, to counter competition from the increasingly more established Western-style health delivery system. In their study of Kuala Lumpur Indian healers, Meade and Wegelin [1975] have found that the healers have concentrated in predominantly Indian neighbourhoods. Nevertheless, the 100-strong Association of Homeo, Ayurvedic and Siddha healers is dominated by urban-based members who continue to remain separate organisationally from temple-based Indian curers and rural practitioners. From the studies by Dunn [1975], Meade and Wegelin [1975] and Colley [1978], it is evident that the Indian healers have not organised the infrastructure which the Chinese physicians have done—schools, medicine trade, control of medical supplies by entrepreneurs and political networks. The studies further show that the Indian healers were being relegated to the treatment of illnesses in which Western medicine was found to be less effective such as common cold, indigestion, fever and headaches.

The practitioners and traders in Chinese medicine along have been most vigorous in organising the checks to counter competition from Western medicine. Through petitions and lobbies organised by medical associations and their national federation, practitioners of Chinese medicine have among other things—removed colonial and post-colonial import taxes on Chinese medicines; secured a reduction in duties on ginseng (from 25 per cent of its prevailing value to a fixed M \$7.50 per pound);

obtained a revision of import formalities related to medical supplies from mainland China; and resisted the threat of the national trading agency, PERNAS (Perbadanan Nasional Berhad) to take over the import trade in Chinese medical stocks. Obstructive delays because of the customs office's inefficient procedures of evaluating imported medical commodities for taxation were resolved via further association lobbies. Hence, a levy system based on the weights of herbal imports rather than their prevailing value was introduced in 1979 to overcome a recurrent cause of contention between the Chinese medical practitioners and government officials.

Conclusion

The uneven course of health care development during the British colonial period has encouraged the continued reliance on ethnic medicine and this has contributed in part to its persistence in health care in both Peninsular Malaysia and Singapore. Since its dismal start, the introduction of Western-style colonial health services to the Malay peninsula and Singapore has been marred by such factors as, its initial poor performance, the charity and pauper emphasis of the medical institutions, segregation in the accommodation of Asians and Europeans, persistent problems of staff and money and the neglect of various Asian communities like the Chinese. The Chinese community has therefore had to rely on its own resources. It did this by bringing ethnic medical practitioners from mainland China and the provision of

medical care through free clinics financed by the Chinese merchants and such public donors.

In the late colonial period, the effort made to redress the inadequacies of colonial health care saw the rapid expansion of infrastructure and establishment of training facilities for local personnel. Such effort resulted in an increase in the use of colonial health services and steady growth in its acceptance among the Asian community. However, the institutional network established by ethnic medical practitioners like the *chung-i* involving professional associations, medical schools and free clinics, made them particularly difficult to dislodge. The characteristics of the health care development process during the colonial period, like their continued concentration in urban areas, neglect of certain segments of the population and the shortfalls in the provision of services also meant that the introduction and the ultimate dominance of Western medicine could not entirely displace the public support of ethnic medical practice. Thus, ethnic medical practice has persisted till today. The degree of persistence varies from one form of ethnic medical practice to the next depending on their organisational abilities and internal characteristics. Both consumer and practitioner resistance have contributed to the persistence of ethnic Chinese medical practice in the face of conflict and competition from Western medicine. In other ethnic medical traditions, either consumer or practitioner resistance or both proved to be too weak to counter the advent of Western medicine.

Ethnic medical practice like Malay healing, has actually been given a boost by the official support it received in the late 1970s. The official tolerance of ethnic forms of healing has also contributed to their persistence albeit, in varying extent.

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