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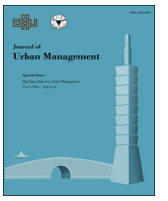

Research Article

Analysing the aid effectiveness on the living standard: A check-up on Southeast Asian countries

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ABSTRACT

The present research work aims to analyse the effect that the disaggregated developmental aid has had on the health status and the standard of living in the urban sector after the Millennium Development Goals (MDGs) were established. Infant Mortality and Improved sanitation facilities are taken as indicators for health status and urbanisation respectively; and the relationship between disaggregated health aid with Infant Mortality Rate (IMR) and disaggregated aid for water and sanitation with improved sanitation facilities was analysed for the years from 2002–2012 using data from India, Indonesia, Thailand, Malaysia, Philippines, Cambodia, Vietnam and Lao PDR of Southeast Asia through the dynamic panel data modelling using the Generalized Methods of Moments (GMMs). Findings suggest that the developmental aid has not been effective in both the health sector and urbanisation sector. Moreover, improvement in health status has been growth driven. With the advent of the Sustainable Development Goals (SDGs); the most important thing to ensure is that the disbursed aid is used effectively to achieve the very purposes it is being given for and to reduce the gaps in various classes of developing countries in the region.

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1. Introduction

With the end of the 20th century approaching; it had been realised that given the fact that most of the countries had become independent of colonisations which had given rise to emergence of various under-developed and developing economies. Hence, economists started to realise that it was the quality of life led on an average in a country which determines whether a country is developed, developing or under-developed. The view of development goals shifted from mere economic growth to improvement of living standards in a country. Stiglitz (1998) contributed to shift the development goals set by governments in developing countries to wider objectives like improvement in income distribution, health and education. “To maximise income growth, environmental consideration were left to languish on the side-lines; the standard

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of living was often allowed to slide; large inequalities between classes, regions, and genders were ignored; and poverty was tolerated more than it should have been in rush to generate maximum growth (Basu, 2000).

Hence it was at the millennium summit 2000, that a declaration concerned mainly about development was adopted which envisioned eight goals (Appendix A), called as, *Millennium development goals*. The Millennium Development Goals consisted of eight international goals with 21 measurable targets, and a series of measurable health and economic indicators for each target which were agreed upon by all member states and at least 23 international organisations to be achieved by 2015. Originally the MDGs were meant to serve two purposes: rescue millennium declaration from oblivion and broaden the development narrative beyond the growth narrative.

One of the pre-dominant characteristics of the transitioning economies (under-developed to developing and developing to developed) became rapid *urbanisation* in the wake of better employment and education opportunities. But, this did not necessarily improve the standards of living rather led to new problems of which predominant were health, sanitation and water.

Life expectancy and IMR have been generally considered the best representatives of the health status of a country (Mishra & Newhouse, 2009). Often, high life expectancy and low mortality has been linked to higher income; however, an argument is often made about the non-linear relationship between infant mortality or life expectancy with income. Further, better sanitation facilities have been often linked to lower infant and maternal mortality rates (Cheng, Wallace, Watt, Newbold, & Mente, 2012; Newell & Gazeley, 2012). Moreover, the disparities in infant mortality between different countries and within the same country have been observed as inequalities in socio-economic groups (Gray, Hollowell, Brocklehurst, Graham, & Kurinczuk, 2009; MacDorman & Mathews 2011).

The study area of the present analysis includes the developing countries of South-east Asia namely – India, Indonesia, Thailand, Malaysia, Philippines, Cambodia, Vietnam and Lao PDR. The purpose of the study is to shed some light on how far the MDGs have been able to achieve better health statuses and standard of living in these countries and whether the major driver of this achievement was – economic growth as some critiques of the MDGs point out or it has been the Official Development Assistance (ODA) or are there any other major drivers which effect the heath and standard of living in these countries. Further, with the advent of the SDGs, the paper seeks to make some suggestions for the same. The study seeks to do the same by building two econometric models so as to assess the effectiveness of health aid and aid for water and sanitation on the health and standard of living which is analysed using the generalized methods of moments as formulated by Roodman (2009).

2. Literature review

Huge disparities in terms of socio-economic conditions can be found in most of the South-east Asian countries and also between the rural and urban areas within the same country.

2.1. Status of health and sanitation in india and south-east asian economies

The WHO report (2013) mentioned that though the progress in reducing the infant mortality rates accelerated, still large gaps persisted among and within the countries. Further, the report mentioned that the South-east Asia region carried the highest burden of mortality rate due to diseases like pneumonia and diarrhoea. The report also mentioned that there was progress in access to safe drinking water facilities; however huge disparities in the access still existed. On one hand 1900 million people gained the access to sanitation facilities and on the other hand 2500 lacked these facilities.

Before 2005, Cambodia had the highest mortality rates in Southeast region only less than Lao PDR but made a significant improvement during that period and reduced the rates below India. In India, the overall mortality rates have not been very high as compared to these countries but the reduction has been very low. The main reason for the same are four states-Uttar Pradesh, Rajasthan, Bihar and Madhya Pradesh which account for half of these deaths and is a showcase for within country disparities in the socio-economic situation (Sahoo, 2011).

2.2. Demographic and epidemiological transition and its linkages with economic development

Cervellati and Sunde (2009) investigated the causal effect of life expectancy on economic growth by explicitly accounting for the demographic transition. The study observed that reductions in mortality result in high populations but only before the onset of demographic transition and turns negative for post-transitional economies. It also illustrated the smaller increase in population for the countries in post-transitional period than pre-transitional period. Life expectancy was found to be weakly associated with GDP in pre-transitional countries whereas it was positive and highly significant for countries in post-transitional period. Moreover, another study by Cervellati and Sunde (2013) argued that the economy finally converges endogenously to a sustained growth path and minimal child mortality. Mornand (2004) showed the existence of two different health regimes by an epidemiological transition and mapped the same into the standard growth neoclassical model. The paper concluded that increased longevity induces the agents to spend more on capital which acts as an accelerator to the economic growth. The paper also derived an important hypothesis that a health transition can help a country switch from a neo-classical growth regime to a modern growth regime.

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