Chapter Eight

Conclusion

The economic transition in Myanmar since 1988 has been more than an exercise in regime maintenance for the military rulers. Certainly, that was a significant factor in motivating the change from a bankrupt, socialist economy towards a more market-oriented economy. However, to achieve the transition, major structural and ideological components of the Myanmar state had to be adjusted. Fourteen years on, the long-term effect of these adjustments is not yet apparent. But the momentum of transition, and the corresponding changes in foreign policy, methods of achieving internal security, and the place of social sectors in state priorities have generated changes in the role and nature of the Myanmar state.

Less prone to change has been the pattern of state-society relations. Fundamentally, the state is elite-driven, repressive and underdeveloped. Although the methods of the successive military rulers have changed, their underlying goal of maintaining military dominance and preserving the vision of a unitary state remains the main determinant of policy decisions. This vision is a key cause of the legitimacy crisis under military, which has meant the attempts of successive governments to consolidate the state have been unsuccessful. In response to opposition to its rule, a security agenda has dominated governance since military rule began in 1962, causing resource-deprivation and mismanagement, as well as the crushing of dissent, diversity and intellectual inquiry. Governance is further restricted by a lack of state embeddedness in society; as in all repressive and inefficient states, citizens who are unable to exploit the state do their best to avoid contact with authority as much as possible.

These two factors, the changing role of the state and the unchanging nature of state-society relations, have been examined in this thesis through the
analysis of the functions and structure of the state, and how these affect its relations with society. Specifically, a case study of the health sector has offered an understanding of how the state system works, and, being shaped by state ideology, how it is changing over the course of economic transition. This concluding chapter reviews what the study of the health system has revealed about the Myanmar state, partly confirming, and partly tentatively challenging, the established interpretations of Myanmar politics.

**State Consolidation and the Legitimacy Crisis**

Anthropologist, Monique Skidmore, has described urban Myanmar as having ‘a pervasive sense of “wrongness”’ (Skidmore 1998: 7). This reflects the atmosphere of fear in which people live, through living in a state that relies on coercion to enforce its will, and malfunctions in most areas of policy. Unable to establish its right to rule, the SPDC’s capacity to carry out changes to state and society is limited by its need to place regime maintenance before all other concerns.

The SLORC/SPDC bases its claim to legitimacy on its role as the guardian and developer of the state. Yet the constant feature of military rule in Myanmar has been the inability of the military elite to convince the rest of society that its security agenda provides the basis for a national ideology that could finally consolidate the nation-state. Instead, the military’s insistence that a unitary state is the only model appropriate for Myanmar perpetuates the distrust by many ethnic minorities of central state authority.

The power of the regime rests on a narrow base, dominated by military interests. The result is a highly militarised state, where the regime can exert its will over society, but its autonomy to prioritise goals outside its immediate security agenda is limited. This military support is backed up by limited support from the elites, many of whom have benefited from the economic transition, but would welcome a political change as much as the rest of the population. Moreover, the status quo is ensured by the passive acceptance from the majority of the population, who recognise the relative immutability of the political situation, or at least their inability to influence it. This passive
acceptance amounts to support without legitimacy, which contributes to the
durability of military rule. However, it is far from the strong autonomy that is
characterised by the embeddedness of the state in society that would give the
regime the type of legitimacy it needs to truly shape the state in its vision.

The cumulative legacy of a state that is preoccupied with security and
regime maintenance is institutional weakness in the state, which significantly
reduces its capacity to implement policy goals. Societal resistance to state
authority also limits state capacity; this is usually carried out in a covert and
uncoordinated manner, but on such a scale that the power of the state is
weakened. Other factors that detract from the strength of the state are the
personalisation of authority within the military, ‘everyday resistance’ within the
bureaucracy, and societal tendencies to disassociate from authority. These
factors continually undermine the regime’s attempts to centralise power within
itself, leading to a constant struggle against forces that would undermine the
autonomy of the centralising state.

With the development of the state subordinated to social control, the
regime is unable to implement the necessary reforms to generate performance
legitimacy. Essentially, the lack of social development in Myanmar results from
the dominance of unresolved issues of state consolidation.

State and Regime in Transition

The return to direct military rule in 1988 marked an epoch in Myanmar
politics, and in the political, economic and social development of the country.
While the security agenda still dominates, the secondary ideology of socialism
was replaced with a focus on economic development – ostensibly with the goal
of creating a ‘developmentalist state’, but in reality being a narrow
development focus on economic growth, which has no room for the promotion
of social development. The economic transition has been a change in style and
processes, marked by policy experimentation, which is gradually producing
within-regime change.

In many ways, the policies of the SLORC and SPDC governments
reversed the major ideological orientation that had dominated government
since independence, and encouraged a return to the elitist, growth-oriented, and economically divided society that had characterised the colonial order. Although the generals would never admit a similarity between their regime and the colonial regime, and indeed share their predecessors’ aversion to anything associated with colonialism, the SLORC/SPDC has consciously linked its legitimacy and style of rule to that of the pre-colonial kings, while unconsciously reshaping the state with goals and priorities that happened to dominate the colonial state.

For example, like that of the colonial rulers, the policy of the regime is based on the premise that the development and welfare of the country will be furthered by a concentration on economic growth. The growing stake of the regime and its supporters in business interests, which has disproportionately benefited the elite of the society, perpetuates a narrow economic concept of development in favour of other forms of development. In addition, the business environment does not provide a level playing field. The economic transition has been only a quasi-transition, because the structure of the economy is subordinated to the political priorities of the regime. The economy remains centrally-controlled, with government monopolies on key export items and direct, high-level government patronage necessary to succeed in medium to large-scale business. Some of the most significant business organisations in the country belong to the leaders of former and current narcotics trafficking organisations, which the regime must keep on side.

Inevitably, the end of the socialist experiment in Myanmar has also seen a return to the Furnivallian plural society. The government has welcomed foreign investors back into the country. Small-scale investors have been deterred by the lack of economic reform, but companies that are accustomed to working in high-risk environments, such as oil and mining companies, have formed partnerships with the government to exploit the rich natural resources of the country. Other sources of capital to develop the economy have come from the ethnic Chinese (including the Wa and Kokang, which are considered by Burmans to be Chinese), who have come to dominate small and large-scale
business enterprise. Most Burmans have been excluded from sharing in the economic potential of their country.

From the beginning of the transition, the economy has been distorted to benefit the elite. In the face of strong opposition to its vision of the nation, the SLORC/SPDC’s nation-building strategy has relied on alliances with powerful ethnic groups such as the Wa and Kokang, and an unacknowledged policy of homogenisation for less powerful ethnic communities. Ultimately, the regime is relying on coopting the power-holders in society into accepting the status quo through economic rewards.

Less successful has been the regime’s attempts to create a controllable and loyal support base in society by manipulating community activities into the institutional structure of GONGOs, which has merely increased the negative connotations of state authority and encouraged avoidance.

Meanwhile, the orientation of government policies towards promoting private provision of collective goods such as health care, disadvantages and further impoverishes the large proportion of the population living in poverty.

The elite-oriented nature of the colonial health system was one of the factors that spurred the post-colonial focus on social equity. Now, the state leadership associates the pursuit of social equity with the bankruptcy of the socialist state that almost ended military dominance of the Myanmar state. The transition has resulted in less ability, and less inclination, of the regime to play a major role in health promotion. Consequently, in the regime’s construction of a new political economy to replace the failed socialist ideology, social equity is no longer a priority of the state, and the promotion of health and education is not politically feasible.

However, the parallel between the colonial regime and the current regime should not be taken too far. The forty years of insurgency, experimentation with democratic rule, and socialism has left a legacy just as great as that of colonialism. Other core features that have characterised the state under every form of post-independence government still apply to the rule of SLORC/SPDC. They include excessive centralisation of decision-making and
administration, and the continuing pursuit of political and economic self-sufficiency at the expense of rational economic policy.

The combination of, and conflict between, new values taken on by the regime over the last decade, and the values derived from an institutional legacy, produce a somewhat schizophrenic policy atmosphere in which policies seem to go either too far, or not far enough.

**Nuances of Policy Change in an Authoritarian State**

The analysis of the health system has revealed the pattern of state-society relations that results from the unconsolidated nature of the state, and how it impacts on the functioning of state institutions. The process of policy formulation and implementation is affected by the political bottlenecks common in authoritarian systems. The highly centralised and hierarchical nature of bureaucracy creates a system where initiative is stifled, management rather than implementation dominates the work of civil servants, and the low rungs of the bureaucracy are overburdened and undersupported.

Moreover, the nature of the state system, and the way society reacts to it, means that the process of policy change is reactive, *ad hoc*, and beyond the long-term planning of the regime. Pressures from above, as well as subtle forms of societal resistance, affect the administration of the state on a daily basis. Indeed, administration under military rule has not been as monotonous as is sometimes assumed. Although, on the surface, the regime’s control of the government appears absolute, close examination of the health system has revealed two things. First, government policy and practice has not been uniform, either over time or across the institutions of the state. This reveals a space in which administrators and health practitioners can move (recognising, of course, that the will of the SPDC is dominant). One result of the *ad hoc*ism of policy, and the sometimes conflicting power structures in the country, is that loopholes can be found, goals can be pursued indirectly, and the boundaries of high-level policy can be nudged outward. In particular, variations in the implementation of policy, either through liberal interpretations or direct contradictions, can be found on regional and local levels where the reach of the
central state is weaker. Secondly, the power of various actors varies between sectors. The regime focuses resources into the areas of the state it considers most important to maintaining its goals. This selectivity produces an unevenness of state capacity, because in the areas that receive less attention and resources, the regime is unable to implement its goals as successfully. In these areas, weak state capacity corresponds to the capacity of non-state actors to surreptitiously fill the space left over. For example, where quality health services are not available, a community organisation, a local village healer, or a vendor with drugs imported from China moves to fill the gap. However, for the most part, this would not be described as civil society, which, in the absence of public space, consists more of informal associational life.

Even within the health system, there are variations, as some programs – like EPI or border areas development – suit the regime’s political goals, and are given extra support, while other areas, such as HIV/AIDS, are more difficult to implement. However, while extra political capacity exists in some areas of health, weak state capacity applies across the sector, as it does throughout the state system.

Further, the influence of international actors is greater in the areas that are lower on the regime’s priorities. The dependence of the health sector on support by international agencies, and SLORC/SPDC’s attempts to play the part of a good international citizen, means that policy is strongly shaped by the norms of the international community (although bureaucrats also anticipate the unspoken directives of the generals). It seems that the SLORC/SPDC has been influenced by strong international pressure since the late-1990s to pay more attention in fields such as HIV/AIDS prevention and education reform. Of course, even if this pressure is reflected in policy, it is rarely backed up by an increase in government funding. Rather, the maldistribution of resources in the state, and the nature of policy making within a top-heavy state, leaves the health sector dysfunctional and ineffective.
Implications of Health Crisis and Underdevelopment for State Consolidation

The subtle influences of non-state and international actors on policy are significant, but the fact remains that the Myanmar state as a whole is under-resourced. Even high-priority projects, such as infrastructure development, must be financed through foreign loans and grants, and private business. However, within the state budget, the health sector is allocated one of the lowest shares of public expenditure. Very low levels of overseas development aid exacerbate this.

Myanmar’s public health sector struggles to deal with a population suffering from high mortality and morbidity rates from preventable diseases and a rapidly growing HIV/AIDS epidemic. The Ministry of Health is not given enough resources to implement the government’s policy. As the public health system becomes increasingly user-pay, the low health status of the population is exacerbated by widespread poverty.

These problems stem partly from the problem of maintaining government commitment to social services in an economic transition. A commitment to the improvement of public health services would entail the diversion of resources from the defence and security sectors and the development of economic infrastructure. That would challenge the primacy of the regime’s security agenda: diverting resources away from defence and security would threaten the interests of the regime’s narrow support base, and potentially destabilise its hold on state power.

More fundamentally, the capacity of the public health sector, and of the state to respond to a health crisis, is considerably degraded. Reform of the public health sector would require transformation of the state system as a whole in order to rebuild the institutions, knowledge, and social institutions that are essential to state capacity. As has been argued throughout the study, it has been the suppression of challenges to military rule in the bureaucracy and society that has destroyed state capacity in most areas and perpetuated the underdevelopment of the state. The long-term dominance of the security agenda, now combined with the impact of economic transition, and the use of
health as political tool by the regime and its opposition, creates political incapacity for the regime to achieve policy goals in the health sector. The regime’s support base – the military – is compensated through a separate health system that spares them from experiencing the worst of the public health system.

Thus, due to the political and economic incapacity of the military rulers since 1962 to maintain a strong health system, and SLORC/SPDC’s declining commitment to social equity as an ideological goal, the public health system is characterised by low quality and inefficient services that are too expensive for much of the population, and of great detriment to the health status of the population. To relieve the state of the burden of providing social services, government policy has encouraged the development of a private sector. However, the state does not have the capacity to regulate the inequitable tendencies of the private sector, and its drain on human resources from the public sector, further reducing state capacity in this area.

Meanwhile, with the poor quality of the services, people choose not to utilise public health facilities, instead seeking care in the private and informal health sectors. The reach of the state is reduced, and the regime’s claim to legitimacy is even further discredited, though, paradoxically, these cultural factors of avoidance and of making do contribute towards the durability of the mismanaged system.

The military regime has chosen political survival over long-term development, by orientating the state to maintain its power instead of implementing policies. Consequently, economic and social development within the unconsolidated state has proven ineffective and unsustainable.