Tuberculosis Then and Now
Perspectives on the History of an Infectious Disease
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The Great White Plague Turns Alien: Tuberculosis and Immigration in Australia, 1901–2001

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INTRODUCTION

The historiography of modern nationalism has recently taken a distinct turn. A number of studies have shown how the public health management of populations through medico-legal border control has actively constituted national identities. And many of these studies have persuasively demonstrated the close connections between communicable-disease prevention, race-based exclusions and restrictions, and the formation of racialised nations.1 Australian history is exemplary in this respect, in large part because of the stridency and efficacy of the white Australia policy. Initially implemented in each of the Australasian colonies in the late nineteenth century, the national Immigration Restriction Act (1901) was one version of the Chinese exclusion acts then proliferating across the globe. Elsewhere I have detailed the extent to which race-based immigration restriction was technically and legally (as well as rhetorically and culturally) part of Australia’s public health policy in the early and mid-twentieth-century.2 In this chapter, and against this historical and historiographical background, I trace Australian medico-legal border control with respect to tuberculosis over the entire twentieth century: that is, from the establishment of the new Australian nation – the Commonwealth of Australia – in 1901 to the crises of border protection, nationally and internationally, at the end of 2001. In 1901 tuberculosis simply did not register as a communicable disease requiring quarantine or immigration regulation. Unlike
leprosy or smallpox, it had nothing to do with the racialised pollution anxiety that in large part rationalised the invention and implementation of the white Australia policy. In 2001, however, tuberculosis was the one and only disease for which people were denied a visa or entry into Australia.

This dramatic shift overarches complicated and intersecting lines of Australian migration and public health history, as well as the natural history of the disease. I trace the changing epidemiology of tuberculosis from endemic high morbidity in 1901 to very low morbidity in the overall national population in 2001. I am interested also in the accompanying shift in cultural comprehension of the disease from being the “the great white plague” affecting most families in the country, white as well as Indigenous, to being a disease almost exclusively associated with refugees and migrants. Finally, I map these shifts in tuberculosis epidemiology and comprehension within the changing patterns of migration in twentieth-century Australia, from predominantly British migration under the white Australia policy to the incorporation of Southern and Eastern European migrants in large numbers after the Second World War, and since the mid-1970s, people from Southeast Asia and the Middle East.

From the mid-1970s onwards, tuberculosis has been increasingly linked rhetorically, but also epidemiologically, with refugees and migrants. In more and less explicit ways, this link has been articulated with recourse to the conflation of race, disease, and “invasion,” which characterised the early white Australia policy and the Immigration Restriction Act. In the early twentieth century, the threat and prevention of tuberculosis was often conceptualised similarly to the “invading” “Chinese” diseases of nineteenth-century Australia: leprosy and smallpox.3 But tracing this resurgence of racialised discourse alone would be too easy: doing so would simultaneously reproduce the problematic image of the diseased “coloured alien” so constantly discussed in Australian history and obscure the common problematising of other groups and other factors. In particular, I pay historical attention to the ways in which British migration to Australia was also scrutinised and bureaucratised over the twentieth century. Furthermore, while offering a critique of the return of the “Asian invasion” narrative through the refugee-tuberculosis scare from the late 1990s, it would be a sleight of hand to ignore the epidemiological data. Rather than dismissing public articulations about tuberculosis and global refugee and
migrant movement as simply racist (a common but not necessarily the most thoughtful move), I incorporate into this historical and cultural analysis, data that clearly shows higher incidence amongst asylum-seekers and refugees, both from Southeast Asia and more recently from the Middle East.

Thus, in this chapter I trace the (racialised) shift from an endemic great white plague in the first half of the twentieth century to the conceptualisation of tuberculosis as a thoroughly alien disease. But I want to complicate this historical story as well. The chapter proceeds chronologically, surveying first the emergence of linked immigration and quarantine measures that were a central part of white Australia and its “coloured alien” exclusions. I then discuss the period between 1901 and 1948, when “white Australia” was thoroughly and endemically infected with tuberculosis. In this period, health screening of Britons was implemented with ever-increasing reference to tuberculosis. From 1948 until 1976 a large-scale National Prevention Campaign reduced morbidity and mortality in the white population dramatically, and this coincided with a new focus on tuberculous migrants from postwar Europe, as well as British assisted migrants. In the final section, I discuss the coincident abandonment of the National Prevention Campaign in 1976 with the sudden increase in refugees from Southeast Asia in that very year.

"THE VIRGIN CONTINENT": IMMIGRATION, HEALTH SCREENING, AND "WHITE AUSTRALIA"

In the late nineteenth century, the Australian colonies, like many other places in the world, hosted a virulently anti-Chinese culture. Chinese people had entered the country initially with the mid-nineteenth-century goldrushes. Even though white culture and governance itself constituted an alien invasion, having been on the continent only two or three generations, there developed a powerful colonial anti-Chinese discourse of alien-ness. By the 1880s and 1890s a strong labour movement in the Australasian colonies emerged, backed by a deeply integrated nationalism and racism, summed up in the slogan “Australia for the White Man.” This intense race-based nationalism was rhetorically driven by a conflation of Chinese culture with disease, a conflation problematically familiar not only in Australian history but in other contexts too. In
the Australian colonies this racialised pollution fear was particularly acute, and constitutive of the nation, for several geopolitical reasons. First, the British (that is, “white”) colonies of settlement were located inside the non-white Asia Pacific region. Thus the borders of the colonies, and later the nation, were often considered precarious; mythically subject to an invasion from the Asian north (sometimes Chinese people represented the particular threat, sometimes Japanese, sometimes a generic “Asia”). This anxious racial and national geopolitical identity was precisely what drove the (always too strident) idea of White Australia from the 1880s through to the Second World War. Second, the problematically common anti-Chinese sentiment of the late nineteenth century coincided with the self-conscious nation-forming around the federation of the six colonies into the Commonwealth of Australia in 1901. Third, the new nation was also an island continent. Surrounded by oceans, a popular as well as an expert culture developed whereby Australia was understood as pure but vulnerable in both health terms and race terms, vulnerable both to “aliens” and to “their” diseases. In this period, questions of race, disease, and immigration were not just incidental or coincidental to Australian nationalism but fully formative of it. One delegate at the Australasian Sanitary Conference of 1884 put it this way: “it is important to discourage as far as practicable the advent of Chinese population in Australasia, as we are of opinion that from such immigrants leprosy may become established as an endemic disease.” Early race-based immigration screening thus began: “in the opinion of this Conference, a special examination should be made of all Indian and Chinese immigrants upon their arrival in Australasia, in order to ascertain the presence or absence of leprosy among them.”

There was significant geographical distance between the island continent that was to become Australia and various endemic foci of disease around the globe. This meant that the communicable-disease profile of the population within the continent was very different indeed from that of Britain, Europe, India, or North America. Smallpox was not endemic, for example, and cholera simply never arrived on the continent. Leprosy certainly received major attention, but the morbidity rates were minimal; perhaps five or six new cases each year were documented. Nineteenth- and twentieth-century epidemiologists and public health policy-makers were geographically hyper-aware of the significance of the island status of
the continent. The long sea voyage from Europe via India was useful, rendering visible (that is, symptomatic) any diseased passenger. For these reasons, maritime quarantine regulations were held to very rigidly in nineteenth- and twentieth-century Australia and were often more comprehensive than British or most European regulations. As one expert put it during discussions on federation in 1895: “A code of sanitary regulations for Australia ... with federal quarantine, would give the colonies the best chance of still retaining the proud title of the virgin continent.”

Strict quarantine was often argued to safeguard the “purity” of the colonies-turned-nation. One manifestation of this was Australia’s Immigration Restriction Act, passed in 1901. Using various legal devices, this effectively acted as a Chinese exclusion act, the legislative base of the infamous white Australia policy. But the Immigration Restriction Act also contained public health powers—the “loathsome diseases” clause. Indeed, the Immigration Act worked in concert with the Quarantine Act (1908), jointly nominating many particular diseases as restricted, the initial list being smallpox, plague, cholera, yellow fever, typhus fever, and leprosy. Notably, tuberculosis was not on the pre-First World War list of quarantinable diseases. The racialising of smallpox and leprosy in Australia—that is, the cultural and rhetorical linking with Chinese-ness—meant that the Quarantine Act was itself understood as a mechanism of white Australia too: it was understood to keep Australia clean and pure, that is “white.”

The white Australia policy was well known internationally in the early twentieth century, partly because it was championed so vigilantly by Australian governments and partly because it was the test case for the principle of racial/national discrimination and sovereignty at the peace conference after the First World War. In fact, this kind of exclusionary immigration act was far more ordinary than extraordinary for the period. From the 1880s onwards there were many versions and manifestations of Chinese exclusion acts or restrictive immigration acts in the United States, in Canada, New Zealand, South Africa, Natal, and more, many of which had some kind of health and disease power of exclusion as well. Elsewhere I have suggested links between the earliest wave of these acts and concern about leprosy: the Australian instance is exemplary, rather than unique. For the purposes of this chapter, however, the point is the intense connection between the idea of “coloured aliens” and
“alien diseases.” The Australian director-general of health, Dr J.H.L. Cumpston, put this all very succinctly, saying that “Quarantine” guaranteed “National Cleanliness,” “the whole object of which is the keeping of our continent free from certain deadly diseases at present unknown amongst us. And secondly the strict prohibition against the entrance into our country of certain races of aliens whose uncleanly customs and absolute lack of sanitary conscience form a standing menace to the health of any community amongst which such aliens are found.”

**Tuberculosis, 1901–48**

Australian policy-makers who imagined and created the 1901 white Australia policy, including the Immigration Restriction Act, seamlessly conflated disease with racial otherness. Tuberculosis, however, was entirely outside this equation, for it was simply not problematised as a racialised alien or an invading disease. Rather, in 1901 tuberculosis was a disease endemically disabling white working- and middle-class families in Australia, in the middle years of life. With respect to tuberculosis, Australia was not a virgin continent at all.

Tuberculosis was only just being conceptualised as communicable at the beginning of the twentieth century. An emerging sense of tuberculosis as a dangerous disease because it was infectious had several implications. First, this characterisation became one of the rationales for its spatial management in the new sanatoria, both private and public. New kinds of healthy and responsible citizens were to be produced by these institutions. For Indigenous communities in Australia, tuberculosis was certainly a major, if not the major, cause of death, but various manifestations of informal and formal racial segregation meant that the sanatoria were generally not utilised by, or open to, Aboriginal people in the early to mid-twentieth century. Rather, the system of missions and then reserves already worked to keep the Indigenous community and the white community apart, to some degree. Often in this period of Australian history, racial segregation and health segregation dovetailed.

The second significant shift resulting from the “new” infectiousness of tuberculosis in the early twentieth century was that its management became a duty of the state. As a communicable disease, rather than an individual condition, tuberculosis came to be under-
stood within a discourse of “dangerousness,” and government responsibilities for population health and containing epidemic disease were mobilised. Within the tri-level system of government of the new Commonwealth of Australia (local, state, and commonwealth, or federal, levels), many health and welfare responsibilities remained with the middle level, with the “states.” Deeply linked to questions of economy and labour, government involvement in managing tuberculosis was an important part of burgeoning systems of welfare, largely promoted under new Labour governments. As in Britain and Germany, this involved crucial innovations in health and invalidity insurance schemes and pensions. Third, the conceptualisation of tuberculosis as a communicable disease in the early twentieth century implicated the new first level of government, the commonwealth, or federal, government, and its powers over migration and entry. Pulmonary tuberculosis was specifically named in the Immigration Act, first in 1912, and in the Quarantine Act in 1917.

In the nineteenth century, the climate of the Australian and New Zealand colonies and the long sea voyage to them had been seen as therapeutic for British consumptives. Many people made the voyage, and even settled, for this reason. With the reimagining of tuberculosis as communicable and with new commonwealth powers over entry into the nation, the twentieth century was characterised by an increasingly intense government effort to keep consumptives out of the country. Rather than providing an open air haven for consumptives from the Old World, quarantine and immigration regulations served increasingly to exclude consumptive Britons on the grounds of their infection. British authorities and individuals began to realise this only gradually. For example, the 1919 British Interdepartmental Committee on Tuberculosis received numerous proposals for the settlement of tuberculous former servicemen “in those Dominions in which the climatic conditions are such as to be likely to aid in the cure of the disease.” They found, however, that by 1919 not only Australia but also Canada and South Africa had clauses in their various immigration acts specifically prohibiting people with any form of tuberculosis. Indeed, as the interwar decades progressed, tuberculosis prevention became one of the foremost reasons for increasingly complex and thorough health screening of immigrants. At the same time, because the disease was so endemic with the white population already in the country, at this point in the century the immi-
igration screening mechanism for prevention was by no means the main focus of tuberculosis management.

How, then, did this fit with the race-based rationales of the quarantine and immigration regulations discussed above? Quite simply, the early to mid-twentieth-century Australian focus on Britons and their health was precisely a result of the exclusionary acts. Because of the working of the Immigration Act, so-called coloured aliens were barred from entry into the country or were deported: the vast majority of migrants to Australia for the first half of the century were British and white.\(^9\) The “loathsome diseases” clause, written with Chinese and their “alien” disease in mind, in fact was used primarily to screen intending British migrants. Thus, precisely because of the exclusion act, the entire mechanism of health screening was built around monitoring, inspecting, and screening Britons, either at point of departure or at port of entry, or more commonly both. Before x-rays, this mechanism involved varying levels of clinical examination and certification. One confused and concerned British traveller detailed the procedures in place around 1920:

[In England] we must get a certificate from a doctor that we are in good health; any doctor will do so long as we produce the certificate ... Then there are in London two doctors who gaze at us as we go up the gangway onto the ship just before we sail ... We have no care until we anchor ... and are boarded by the doctor. This doctor stands on the deck and every passenger is made to pass slowly in front of him. At first this process strikes us as farcical ... but our respect for it deepens when we find that the doctor has picked out every person we know of on board who has been at all in ill health ... The doctor made us undress and examined us very minutely. He told that I had a “click,” whatever that might be, and that I was not to leave the ship till the Customs officers had seen me ... I then learned that I was reported to be suffering from tuberculosis, that I had been made a prohibited immigrant, and that I must go back to England.\(^20\)

Another intending British migrant from Pembrokeshire, managed to arrive in Fremantle, Western Australia, in 1928. He was also diagnosed with tuberculosis and deported, but the case raised a significant amount of controversy: “how [did] this migrant come to be passed by the Medical Officer in England?” The case elicited
concern at the highest bureaucratic level. Director-General of Health Cumpston, for example, wrote personally to the man’s mother to determine whether or not he had actually been placed in a sanatorium in England, suggesting not only the rarity with which infected people slipped through the immigration/quarantine line (or more likely were picked up) but also the seriousness with which the screening process was taken. His certificate of medical examination itself suggests the prominence of tuberculosis in the migrant-screening processes by 1928. The first question was, “Have you ever been in a Sanatorium or other institution or attended thereat for the treatment of Tuberculosis?”

The health screening of Britons was not undertaken on the basis of racial difference (the Immigration Act had “solved” that). Nonetheless, this kind of health screening was still squarely about the ambition of white Australia. Now understood much more in eugenic terms, screening came to be explicitly about purifying white Australia – segregating externally as well as internally those individuals likely to tarnish, in the language of the time, the whiteness of the nation. In the curious interwar conflation of infection and heredity, people with tuberculosis were seen to be undesirable in terms of the “race” (however configured), and in various ways they were discouraged from reproducing. Not only Australian governments but groups like the Racial Hygiene Association of New South Wales saw immigration as a health issue in terms of excluding “tarnished” whites, consumptives among them.

While the distinction between “native-born” and “alien” is usually a strongly “raced” distinction in Australian history, the history of tuberculosis epidemiology shows how this was not always the case. When it came to (white) British migrants, they were sometimes alien too. As we shall see, under visa regulations from the 1990s, country of origin currently situates people as low, medium, high or very high risk, determining the extent of health screening to be undertaken. This rationality of risk groups began to be honed with respect to British migrants in the first half of the century. While in this period white Australians usually identified themselves as thoroughly British, with respect to tuberculosis distinctions were constantly drawn between Australians and others. In some studies, the categories were “Australian,” “British-born,” and “foreigners.” In others, British and foreign were categorised together: the categories would be more strongly put as “Australians” and
"non-Australians," the latter meaning those born in "England, Scotland, Ireland, Wales, or Foreign Countries." Throughout the period between 1901 and 1948, then, tuberculosis was certainly problematised in terms of migration and health screening, amongst other things. But the problem population was the intending British migrant, not the coloured alien. The rationale was not the need to protect a pure Australian community from infection but rather the need to minimise what was already a high prevalence. After the Second World War, this story of tuberculosis, migration, race, and health screening began to change.

THE NATIONAL PREVENTION CAMPAIGN, 1948–76

In the immediate postwar years, tuberculosis was squarely a disease of both the white and the Indigenous populations in Australia. As one senator put it at the debate on what was to be the Tuberculosis Act, 1948: "Tuberculosis strikes at men and women in their most virile years – their most productive and reproductive years. It causes far more deaths among women of child-bearing age than are caused by all the risks of pregnancy combined. The incidence of the disease is greatest amongst the young and active with their most useful years in front of them."

From 1948 until 1976 Australian commonwealth and state governments backed a large-scale intensive anti-tuberculosis campaign that radically altered the incidence of the disease in the country. Morbidity fell from 49.5 per 100,000 in 1949 to 9.9 per 100,000 in 1975. The precursors of this successful campaign were innovations in miniature mass radiography undertaken by the Australian Army in the Second World War. As elsewhere, the reduction largely resulted from effective chemotherapies: streptomycin, first used in a 1947 trial, and isoniazid and PAS (para-amino salicylic acid) in 1953; rifampicin was trialled in 1969. But it also resulted from an intensive and large-scale preventive effort, nationally funded and state-implemented, in particular from the program of active case finding. The 1948 Tuberculosis Act (Cth) made MMR screening compulsory for every person over sixteen years and ensured ongoing commonwealth funding for it. Powers were granted to examine any contact. The act also granted an allowance to people suffering from tuberculosis, in order that they might stop working and undergo treatment at any stage of the disease, which made it differ-
ent from the older pension requirement for "total and permanent incapacity." In administering the distribution of this allow-
ance, Aboriginal people were specifically excluded until 1965.\textsuperscript{39}
A National Tuberculosis Advisory Council reporting to state and
commonwealth ministers of health oversaw this multi-directional
campaign: active case finding, a network of chest clinics, national
mass chest x-ray surveys (eventually compulsory in all states), and a
standardised case register.\textsuperscript{50} BCG vaccination of all white school
leavers was introduced in the late 1940s, and with varying consist-
tency through the states, and continued until the mid-1980s.\textsuperscript{31} Vac-
cination programs were intermittently introduced into Aboriginal
communities – in Western Australia from 1950 and New South
Wales from 1951.\textsuperscript{32}

Under this scheme of prevention and treatment, migrant screen-
ing continued to be a focus, but a minor one. Government records
and Cabinet submissions regarding the Tuberculosis Act commonly
made no mention of migration and health screening at all.\textsuperscript{33}
At other moments, migration entered the debate marginally, with
respect to the intake of postwar refugees and migrants from
Europe. For example, the Anti-Tuberculosis Association of Western
Australia managed to drag a series of ministers for immigration
into detailed discussions about the minutiae of the screening pro-
cess in Europe. "If he or she cannot come here with a certificate of
freedom from Tuberculosis, then he or she is not a welcome addi-
tion to our population. No migrants at all would be better than
migrants bringing Tubercular trouble."\textsuperscript{34} It is worth noting that this
Western Australian group (Fremantle, near Perth, being the first
point of contact for ships from Britain and Europe) were as con-
cerned with British migrants, who were not necessarily x-rayed, as
they were with "alien migrants and displaced persons."\textsuperscript{35} In other
words, while the discussion of migration was changing to some
extent, problematising Southern and Eastern Europeans, British
people were still considered the major high-risk group. In 1965, for
example, 6,597 people applying for migration from Britain, or 38
percent of all British applicants, were rejected on "medical and
radiological grounds."\textsuperscript{36} Epidemiologists and immigration bureaus
crats also argued over the categorisation of "migrant" with respect
to tuberculosis as a chronic disease. In 1963, for example, the Med-
cal Journal of Australia's editor wrote: "[T]he Department of
Immigration does not regard as a 'migrant' anyone who has been in
Australia for 10 years or more. This may well be logical from their point of view ... But from a medical point of view the origin of people must be kept in mind. To neglect it in the present instance is to ignore the natural history of pulmonary tuberculosis and the fact that endogenous reinfection may occur many years after the initial seeding of tuberculosis. 37

Historically, medico-legal border control often distils all kinds of social divisions and relations, where distinctions are made between categories of people on grounds of social privilege rather than on epidemiological grounds. In the postwar period strange but perhaps unsurprising delineations were made. For example, until 1968 chest x-rays were required of all British migrants whose passages were financially assisted. But any non-assisted (that is full-fare paying) British migrant did not require a chest x-ray. 38 Under a new section of the Quarantine Act, full-fare British migrants had to produce evidence that they were free from tuberculosis before embarking, and airline and shipping companies were required to see that all migrants produced a certificate declaring that they were free from tuberculosis. 39 But there still remained a real discrepancy between what was required of different people. As A.J. Proust of the Commonwealth Department of Health explained it in 1974: “assisted-passage migrants from the United Kingdom ... are required to undergo the full medical and radiological examination. Full-fare British migrants, on the other hand, are required to furnish evidence that in the twelve months before their arrival in Australia they have had a chest x-ray examination which showed no evidence of active tuberculosis ... All applicants from Europe and the Middle East are required to undergo the complete medical and X-ray examination.” 40 This was so despite epidemiological argument that incidence amongst full-fare paying British migrants would be least twice that amongst “native born Australians.” 41

The low rate of tuberculosis toward the end of this postwar period encouraged the gradual re-emergence of the discourse of Australia as pure. Sometimes this discourse created a reactionary politics, where the low incidence meant vulnerability and therefore the need for tight border protection: “With the continued influx of potentially tuberculous people into a very vulnerable country where the tuberculosis incidence was now the lowest in the world, Australia would be wise to continue a policy of vigilance, and to consider measures designed to protect its native-born population.” 42
other times, Australian “healthiness” gave rise to a distinct generosity, now rare in Australian public discussion on migration. The editor of Medical Journal Australia wrote in 1963, for example: “It is only fair that amongst the newcomers we should take aboard a percentage of tuberculous subjects, and there is good reason to believe that a healthy country such as ours can do this safely.” Indeed in 1960 the Commonwealth government accepted a group of refugees from Austria, Germany, and Italy “whose applications have previously been rejected because of Tuberculosis.” They were identified as “World Refugee Project Special Tuberculosis Cases.”

The postwar change in the nationality of migrants to Australia led to the repeal of the Immigration Act and its replacement with a new Migration Act in 1958. The notorious “dictation test” – the legal device by which “coloured aliens” had been excluded – was abandoned. However, the public health power of the old act remained, and the current Migration Act (1958), its amendments and regulations, contain complicated and ever-changing health criteria. But first in public health significance came tuberculosis. And significantly, while many prohibited diseases and conditions were added to the regulations governing the Quarantine Act in these years, it was tuberculosis alone that remained specified in the statute itself.

The 1950s and 1960s saw marked changes in migration regulations. These decades also saw a rapid decrease in the domestic incidence of tuberculosis, in both the white Australian population and in the British population, which was still by far the dominant source for Australian immigration. Deemed successful by any standard, the internationally renowned Australian National Prevention Campaign ceased at the end of 1976. Its abandonment coincided with the sudden reception of new refugees from Southeast Asia. Again and again in medical and popular commentary, the great gains of the preventive campaign that ran from 1948 to 1976 were presented as threatened by the changing migration patterns. From the late 1970s, the idea of the “alien” and of alien diseases – the (barely) repressed of Australian history – returned.45


From 1975 increasing numbers of Laotians, Cambodians, and Vietnamese sought refuge and/or migration to Australia, many arriving
on the northern borders of the nation by boat; as onshore asylum seekers, in Australian public culture they are “the boat people.” In 1976–77, 7,135 refugees entered Australia. The following year it was 7,077 and the number remained around 10,000 each year until 1984.\(^4\) Initially, there was nothing like the tight border restrictions or the popular resistance to asylum claimants from Southeast Asia that characterised Australian policy in the early twenty-first century. But the question of tuberculosis arose almost immediately: questions were asked and answered in parliamentary debate, driven by media reports of tuberculosis amongst Vietnamese refugees.\(^4\) The particular threat of multi-drug resistant tuberculosis focussed concern, even though its incidence has been low in Australia.\(^4\)

In the early 1990s the tuberculosis “problem” was intensified in both the media and the medical domains. This was partly created by World Health Organization’s (WHO) declaration of a global emergency for the disease and by the U.S. and New York City episodes, which received a great deal of medical attention in Australia. In November 1994 Australia’s Public Health Association organized the first national conference on tuberculosis in twenty-five years. The connection between tuberculosis and immigration was compounded by, and coincident with, a new shift in policy to mandatory detention for all onshore refugee claimants (those who arrived “unauthorised” in the country by air or by boat, seeking asylum). Amongst the most rigid in the democratic world, this extremely controversial mandatory detention policy was in place from 1992, and diminished significantly, though not abandoned in 2008: detention was rationalised, amongst other ways, by the need for health screening.\(^4\) Speaking at the debate on the Migration Amendment Bill, for example, one senator invoked the threatened virgin continent idea: “we are sitting in the middle of an area that is rife with TB, and we are taking a large number of migrants from that area.”\(^5\)

At one level, the threat of disease has come to stand for the threat of race: the issue of higher tuberculosis morbidity becomes an acceptable and seemingly neutral way either to object to or limit migration, and especially the granting of asylum status. As the world’s nations tightened their borders after the terrorist attacks in the United States in 2001, questions about Australian border security were compounded by the so-called Tampa crisis, which also took place in that month: a Swedish ship rescued an overturned boat filled with hundreds of people aiming to seek asylum in Australia.
The Australian government refused entry either to the ship or to the asylum seekers, shunning any international obligation. A host of new measures were rushed through parliament, known as the Border Protection Legislation. The system of detention was reinforced and defended by the Australian government at the end of 2001 with specific reference to disease; a new information paper released in October 2001 announced that the detention centres were places where “former terrorists” might be incarcerated and where “tuberculosis, typhoid and Hansen’s Disease” were being diagnosed.\footnote{51}

In the last quarter of the twentieth century, then, tuberculosis in Australia became a thoroughly “alien” disease and was often discussed within a discourse both drawn from and similar to that which drove aspects of the white Australia policy. Southeast Asian people have been figured as pathologically suspicious because of their race, in the way that Chinese-ness and leprosy were conflated by the dominant culture in the late nineteenth century: immigration, race, and disease have again become rhetorically and culturally figured as a tripartite threat to Australian national and racial “security.” Sometimes this characterisation has been astonishingly explicit. For example, Senator Pauline Hanson of the then new right-wing One Nation party summarised the threat of “Asian invasion” in her 1996 maiden speech as “tuberculosis, crime and civil war.” Queensland senator Bill O’Chee called up the white Australia legacy in response: “Last century it was believed that Asians were responsible for leprosy. That was false, just as it is false to say that Asians are responsible for tuberculosis ...[If] we are to close our borders to these people, then it also follows that we must close our borders and stop Australians going overseas.”\footnote{52} But as cultural anthropologist Ghassan Hage has argued in his book White Nation, the issue of real concern is less the easily identified maverick racism of Pauline Hanson than the more subtle and careful dynamics driving liberal “multicultural” advocacy and policy: the desire for a white (controlled) nation, he argues, is not limited to “racists.”\footnote{53}

What needs full admission into this debate is that there were, and are, far higher rates of tuberculosis amongst asylum seekers in detention centres than in the Australian population as a whole or in the population of migrants who are subject to screening before arrival. At one level, Pauline Hanson is correct. A study undertaken in 2000–1 in three Australian detention centres for asylum seekers shows an incidence of active tuberculosis at 157 per 100,000. Of
5,742 adults and 1,258 children tested, 7 people were diagnosed bacteriologically, and 2 radiologically and clinically. This compares to the Australian incidence (in 1998) of 4.93 cases per 100,000.\textsuperscript{54} Even allowing for the results of a 1999 study that suggests an over-estimation, with a significant number of false-positive results,\textsuperscript{55} the higher incidence amongst asylum seekers requires recognition.

A major question, then, is how the issue of disease, race, and geography can be articulated without calling up the discourses of white Australia and the accompanying racialised pollution anxiety that so haunts Australian culture. The difficulty lies in gathering and discussing epidemiological data without re-circulating old and deep ideas about the whiteness of a pure but vulnerable Australia in a “dark and diseased” region. These ideas do reappear, however unwittingly: “It is only by constant vigilance that we can hope to maintain our current state of ‘paradise,’ as we continue to be surrounded on many sides by countries in which tuberculosis and other communicable diseases are recognized by world authorities as being out of control, and with no useful likelihood of control being achieved by Year 2000.”\textsuperscript{56} Both articulating and not articulating the issue of tuberculosis and migration have been understood as problematic. For example, in 1992 a Labor MP “called for stricter health screening procedures, which he thought had not been enforced for fears of (the enforcers) being branded racist.”\textsuperscript{57} Simply denying or reversing the epidemiological connection, as Senator O’Chee did in response to Pauline Hanson, is not a subtle enough response.

In looking for and decoding the racism that lingers in Australian migration policy, or, as Hage puts it, the internal managing of national otherness,\textsuperscript{58} one approach is to think critically about which population is problematised, why, and how. More to the point, it is to think about which populations are not problematised, either epidemiologically or in terms of screening policy. O’Chee’s reversal of the problematised population – suggesting restrictions on Australian’s travel – is more useful. There is clearly a higher incidence of tuberculosis in some Southeast Asian countries. The current rigid screening procedures may therefore be justified. Yet left unexamined in this geopolitical and epidemiological picture are the thousands of (entirely traceable) eighteen- to twenty-five-year-old Australians who travel through Southeast Asia each year, with no previous exposure to tuberculosis and usually without BCG. Should they also be routinely screened on or before return?\textsuperscript{59} Why is
this not considered an option? In a globalised world – and SARS and swine flu excepted – it is often the case that migrants are problematised, while travellers are not.

Since 1992 the regulations for entry into the nation have proliferated in complexity, through ever-refining systems of visas (the classes of visa now runs into the hundreds). As in the late nineteenth century, the “virgin continent” is guarded by extremely strict quarantine procedures (incidentally under the original Quarantine Act of 1908). And as in earlier periods, quarantine and health-screening procedures are constantly working bureaucratically in concert with immigration regulation. There are several axes on which this works: period of stay, class of visa, country of origin. Each visa for entry into Australia has a different health criterion attached to it. For example, a tourist visa (normally) requires no clinical examination (or chest x-ray). A temporary resident visa does. But this can change according to the country from which the intending entrant applies. If in the interwar period risk was crudely determined by categories such as “alien,” “British,” or “native-born,” in the 1990s and currently, each nation is grouped within a risk category: different health criteria apply to applicants from each category. In 2002, low-risk countries were Iceland, Monaco, Norway, San Marino, Sweden, and Australia. Medium-risk included Canada, Germany, New Zealand, the United Kingdom, the United States, and Puerto Rico. High-risk included Algeria, Egypt, Fiji, Lebanon, Saudi Arabia, Spain, Turkey, and the United Arab Emirates. And finally, very high risk included Bangladesh, Chile, China, Hong Kong, Indonesia, Korea, Malaysia, Pakistan, Papua New Guinea, Philippines, Portugal, Russia, Singapore, Sri Lanka, South Africa, Vietnam, and Zimbabwe.60

Tuberculosis is the prime element in this system of risk assessment. While there was a flurry of bureaucratic concern about HIV and migration in the mid-1980s, positive status does not automatically mean visa rejection. Positive tuberculosis status does, however. The Procedures Advice Manual for 2002 states, “In Australia HIV/AIDS is not regarded as a public health risk and it is not on the basis of fears of transmission to members of the public that diagnosis of disease might render someone unable to satisfy health criteria (unlike TB, which is a public health risk).”64 Tuberculosis, then, is the only disease for which a discretionary waiver of the health criteria for any visa cannot be made. The manual for clinicians is quite
clear, indeed emphatic: "TB is the only health condition prescribed in migration law as precluding the grant of a visa ... There are no exceptions." WHO's declaration of a global epidemic and emergency "with its epicentre in Asia" authorises this emphasis. The manual also refers non-specifically but tellingly to the "public interest" in tuberculosis: "The subject of TB is one that readily achieves a high profile in public interest and comment, given Australia's achievement as a low risk country."62

CONCLUSION

The management of tuberculosis in Australian policy and epidemiology has always problematised the place of origin of the infected person: broadly, whether they were native-born to Australia or came from elsewhere. One of the telling aspects of examining tuberculosis epidemiology historically in a country of migration such as Australia is the changing nomenclature through which "those from elsewhere" were categorised. "Immigrant," "alien," "British," "coloured alien," "foreigner," "outside the Commonwealth," the significant marker has sometimes been nationality, sometimes place of birth, sometimes place of residence, race, or region. And for the hyper-scrutinised British migrant, the crucial distinction for health screening was one's "assisted" or "unassisted" passage, broadly, one's class. At times in the twentieth century, the native-born/immigrant distinction has been the central and crucial question in managing tuberculosis in Australia, while at other moments it has been a secondary or tertiary question, falling short of other issues in the minds of those charged with understanding the disease at population level.

The structures for screening were developed almost entirely with respect to the British consumptive, in the decades when eugenic nationalist rationales governed so much social and health policy. In the last few decades, however, tuberculosis management has been almost exclusively concerned with trajectories of global movement other than that between Britain and Australia. Between 1901 and 2001 tuberculosis has shifted from being outside the screening process altogether to being the one disease for which entry into Australia is always denied. Seen another way, and from the viewpoint of the problematically dominant culture in Australia, tuberculosis has moved over the century from being "our" domestic disease to
“their” exotic disease. In many ways this aligns with the histories of comparable nations, but not every national history has such a deep and explicit connection between racial exclusion, communicable disease, and medico-legal border control.

NOTES

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4 Shah, Contagious Divides; Mawani, “The Island of the Unclean.”


6 For a full discussion of these ideas, see Bashford, Imperial Hygiene, chaps. 5 and 6.

7 Dr Bancroft, The Australasian Sanitary Conference of Sydney, Report (Sydney: Government Printer 1884), 33.

8 Ibid., 33.
11 Bashford, Imperial Hygiene, chaps. 4, 6.
13 Bashford, Imperial Hygiene, chap. 3.
14 See Suzanne Saunders, “Isolation: The Development of Leprosy Prophylaxis in Australia,” Aboriginal History 14 (1990): 168–81; Bashford, Imperial Hygiene. Indeed, in the Northern Territory, when the reserve system began to relax even a little in the 1950s and Aboriginal people were permitted less intensely surveilled movement, the idea of a sanatorium specifically for them was mooted as a new way of limiting contact and/or movement. By the 1950s of course, sanatorium treatment for the white population was thoroughly outmoded.
16 These diseases and conditions are summarised and tabled in Alison Bashford and Sarah Howard, “Immigration and Health: Law and Regulation in Australia, 1901–1958,” Health and History 6 (2004): 97–112.
20 This was in fact never implemented comprehensively: numbers of Chinese, Indian, and Islander families, sometimes in the country for generations at the time of the new act, remained; other individuals were granted entry and exemption from the act from time to time.
21 “Prohibited Immigrants. By One of Them,” typescript in JHL Cumpston Papers, National Library of Australia, Ms613 Box 7, c. 1920.

22. In Australia, as in Britain, there was never any legislation that made sterilisation compulsory or health certification for marriage compulsory. There were, however, many attempts to enact such legislation.

23. See Bashford, _Imperial Hygiene_, 153–5.


26. Tuberculosis Bill 1948, Second Reading Speech by Senator N.E. McKenna, National Archives of Australia A1658/1 1182/2/1/PART I.


31. The evidence of increasing infection in the workforce was the rationale for vaccinating at the end of school. Porter and Boag, _The Australian Tuberculosis Campaign_, 71.

32. Ibid., 85–6.

33. See, for example, “Tuberculosis Legislation Policy – Cabinet Submissions and Decisions by Cabinet,” National Archives of Australia A1658/1 1182/2/1 PART I. These documents do not mention migration, but detail “case-finding, medical care and isolation, after-care and rehabilitation and the economic security of tuberculosis patients and their dependents ... case-recording, training of personnel, pilot X-ray plants, epidemiological surveys.”

34. A.J. Bishop, Secretary, Anti-Tuberculosis Association of Western Australia to Mr N. Lemon, MHR, 1 August 1947. National Archives of Australia A436/1 1950/5/2814.
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35 See, for example, letters between Mr A.H. Bishop, on behalf of the association, and Minister for Immigration Arthur Calwell. A436/1 1950/5/2814.


38 Minister for Health, House of Representatives, Parliamentary Debates, 26 October 1960.


42 “A Review of Immigrants with Tuberculosis Treated at the Randwick Chest Hospital,” Medical Journal of Australia, 10 July 1971, 111.


44 Memo from Secretary of Department of Immigration, Canberra, to CMO’s in Sydney, Melbourne, Brisbane, and Adelaide, 1960. “Acceptance of Refugees with Tuberculosis – Bonegilla Migrant Reception and Training Centre,” National Archives of Australia, A2567/1 1960/96C.


47 See, for example, debate on 7 October 1975, 6 April 1978 House of Representatives, Commonwealth of Australia. 16 February 1977, Senate.


59 Streeton, “Paradise Lost?” 2.

