

# Tuberculosis, 'Race', and Migration, 1950-70

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## *Introduction*

Tuberculosis is now acknowledged as a global health catastrophe. A third of the world's population are infected with the bacillus; eight million people develop active tuberculosis every year; and some two million die. With co-infection with HIV and the emergence of drug-resistant strains that have led in turn to the adoption of the WHO Directly Observed Therapy, Shortcourse (DOTS) strategy, tuberculosis has 'apparently made a resurgence almost everywhere in the world'.<sup>1</sup> This includes in sub-Saharan Africa; in the former Soviet Union and Eastern Europe; in South America; and in New York and London. In their recent study, Matthew Gandy and Alimuddin Zumla argue that the idea that infectious disease had been defeated, prevalent in the 1950s, has been proven to be wrong. With hindsight, it is now clear that public health professionals had too short a time horizon; looked only at people; played little attention to evolution and ecology; and were over-optimistic about development. Gandy and Zumla's overall argument is that the resurgence of tuberculosis is a telling indictment of the failure of global political and economic institutions to improve the lives of ordinary people.<sup>2</sup>

Tuberculosis is particularly interesting in relation to recent debates about disease; borders; and geographies of difference. Alison Bashford, for example, has been concerned to integrate the history of health and infectious disease control into the history of nationalism, arguing they have been part of the legal

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\* Address for correspondence: The Institute for Health Research, Bowland Tower East, Lancaster University, Lancaster LA1 4YT. The original research for this work was funded by the Wellcome Trust; more recent support has been given by the British Academy. I would like to acknowledge the comments made by the participants at the Liverpool Medical History Society at the Liverpool Medical Institution, in February 2004, where the article was originally given as a paper. I am grateful to Sally Sheard for inviting me to give the original paper, and for her comments and suggestions. A longer version of this article will appear as a chapter in *From Urban Penalty to Global Emergency: Current Issues in the History of Tuberculosis*, ed. by Flurin Condrau and Michael Worboys (McGill-Queens University Press, forthcoming 2005).

<sup>1</sup> Leopold Blanc and Mukund Uplekar, 'The present global burden of tuberculosis', in Matthew Gandy and Alimuddin Zumla (eds), *The return of the White Plague: Global poverty and the 'new' tuberculosis* (London, Verso, 2003), p. 100.

<sup>2</sup> Alimuddin Zumla and Matthew Gandy, 'Politics, science and the 'new' tuberculosis', in *The return of the White Plague*, p. 241.

and technical constitution of 'undesirable' entrants. Bashford has argued of Australia that tuberculosis changed from being a disease of civilisation in the early 1900s, to, by the 1980s, one associated particularly with migrants, asylum-seekers, and refugees. By 2001, it was the only communicable disease nominated in Australian migration regulations.<sup>3</sup> In the Gandy and Zumla collection, Nick King writes that the resurgence of tuberculosis has led to renewed concern over the borders that separate people, and created a dilemma of how to address inequalities in health while maintaining non-discriminatory policies. Tuberculosis has been a disease associated with immigration, where national and social contexts have been laden with debates about 'racial', ethnic, and national difference. Essentialist explanations have explained disease in terms of simple causes and 'natural' characteristics, while anti-essentialist approaches have looked at contingent factors. King argues that in general, tuberculosis has served to focus attention on the bodies of people crossing international frontiers, and attention has been diverted from socioeconomic and structural problems. His suggestion is that geographies of difference need to be rethought.<sup>4</sup>

Anne Hardy has recently shown how perceptions of the character of tuberculosis changed in Britain between 1940 and 1970 following the application of new medical technologies and investigative methods in the diagnosis and tracing of the disease. New techniques such as mass miniature radiography and BCG vaccination meant that the old romanticized image of tuberculosis as a disease of youth was replaced by one centred on children and older people.<sup>5</sup> Nevertheless despite the declining level of interest in the disease, there was interest in tuberculosis among migrants. It is well-known that Britain experienced successive waves of immigration in the post-war period, derived from a combination of 'push and pull' factors, and both structural and cultural imperatives. From the mid-1950s, researchers began to explore the allegedly higher incidence. While the early papers focused on Irish migrants, the later papers were concerned more with those from India and Pakistan. The location of this research also shifted, reflecting the emergence of large ethnic minority populations in many British cities. While the early research on Irish migrants was based on London, later papers were concerned more with cities such as Birmingham and Bradford, and with smaller centres including Uxbridge and Wellingborough. Chest medicine had low status in the early NHS. The interest

<sup>3</sup> Alison Bashford, 'At the border: Contagion, immigration, nation', *Australian Historical Studies* 33 (120) (2002), 351-2; Alison Bashford, 'Tuberculosis and immigration in Australia, 1901-2001: The Great White Plague turns alien', in Michael Worboys (ed.), *Tuberculosis, Culture and National Identity* (London, Routledge, 2005).

<sup>4</sup> Nicholas B. King, 'Immigration, race and geographies of difference in the tuberculosis pandemic', in *The Return of the White Plague*, pp. 39-54.

<sup>5</sup> Anne Hardy, 'Reframing disease: Changing perceptions of tuberculosis in England and Wales, 1938-70', *Historical Research*, 76 (194) (2003), 535-56.

of researchers in tuberculosis among migrants can be seen in the context of an attempt to revive their speciality.

There has been limited interest in health, 'race', and migration in post-war Britain, certainly compared to the literature on health and 'race' in the USA.<sup>6</sup> Earlier work has concentrated on the development of the research literature on tuberculosis and migration; on the policy response by central government departments and the British Medical Association; and on service delivery in the Midlands city of Leicester.<sup>7</sup> This article responds to King's analysis by examining how far his framework fits the way the debate on migration, tuberculosis, and 'race' played out in Britain, in the period from the mid-1950s to the early 1970s. These debates were complicated, but for simplicity the chapter looks at three approaches to explaining tuberculosis among migrants. First, it explores how and why some researchers focused on immigration, and argued that migrants were 'bringing in' the disease. Second, the article examines how other researchers directed attention more to contingent structural and socio-economic factors, including nutrition and overcrowding. Third, the chapter traces essentialist explanations and the influence of 'race', arguing that older ideas such as the 'virgin soil' theory persisted much longer than has previously been realised, and were revived in new ideas of 'susceptibility' in the post-war period. In each case, it tries to show how these explanations shaped the policy response on the central issue of medical examinations at the ports of entry.

### *Importation, Immigration, and Medical Examination*

Nick King has noted that immigration has often been identified as the 'cause' of tuberculosis. However while focusing on borders has been politically useful, it has also led to the scapegoating of migrants for social problems. Moreover he points out that blaming immigration for tuberculosis obscures complexities in the dynamics of the transmission of tuberculosis between individuals and populations. King writes that 'focusing too closely on immigrants as vectors of disease conceals the causal roles played by inadequate health care and social

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<sup>6</sup> On the USA see Deborah Dwork, 'Health conditions of immigrant Jews on the Lower East Side of New York: 1880-1914', *Med Hist*, 25 (1981), 1-40; Alan M. Kraut, *Silent travelers: Germs, genes and the 'immigrant menace'* (New York, BasicBooks, 1994); Howard Markel, "'Knocking out the cholera": Cholera, class and quarantines in New York City, 1892', *Bull Hist Med*, 69 (1995), 420-57; Alan M. Kraut, 'Southern Italian immigration to the United States at the turn of the century and the perennial problem of medicalised prejudice', in Lara Marks and Michael Worboys (eds), *Migrants, Minorities and Health: Historical and Contemporary Studies* (London, Routledge, 1997), pp. 228-49.

<sup>7</sup> John Welshman, 'Tuberculosis and ethnicity in England and Wales, 1950-70', *Sociology of Health & Illness*, 6 (2000), 858-82.

and economic injustice in their destination country'.<sup>8</sup> There certainly has been much recent concern about the number of reported cases of tuberculosis in foreign-born persons in the United States; the worldwide spread of drug-resistant tuberculosis; the spread of tuberculosis in central and eastern Europe; and tuberculosis in prisons in countries with high prevalence.<sup>9</sup> In the United Kingdom, the outbreak in a Leicester school in April 2001 focused attention on the relationship between a local experience and a global problem.<sup>10</sup> Together these debates have tended to focus attention on the merits of a screening system at the ports of entry.

In tracing the historical background to these contemporary concerns, the sociological literature has tended to stress the usefulness of a 'port health' interpretation, where the emphasis was allegedly on the 'exotic' nature of infectious diseases; the construction of a pathological view of the migrant; and the prevention of the spread of disease to the 'native' population.<sup>11</sup> In the early 1900s, public health doctors had been concerned with the health of Irish and Jewish migrants, but in general there was much less interest in this field, certainly compared to the USA.<sup>12</sup> When they did turn belatedly to health, 'race', and migration, it is certainly the case that many of these early researchers argued that tuberculosis was imported by migrants, and that its rising incidence could best be tackled by medical examinations at the Ports of Entry. This was certainly true of work by V.H. Springett and colleagues based at the Birmingham Chest Clinic, comparing the incidence of tuberculosis among Irish,

<sup>8</sup> King, 'Immigration, race and geographies of difference', pp. 44-6, 48.

<sup>9</sup> See for example, Janice Hopkins Tanne, 'Drug resistant TB is spreading worldwide', *BMJ*, 319 (1999), 1220; Marta Balinska, 'Tuberculosis is spreading in central and Eastern Europe', *BMJ*, 320 (2000), 959; Rudi Coninx, Dermot Maher, Hernán Reyes, and Malgosia Grzemska, 'Tuberculosis in prisons in countries with high prevalence', *BMJ*, 320 (2000), 440-2; Fred Charatan, 'US alarmed over rise in tuberculosis among immigrants', *BMJ*, 320 (2000), 140.

<sup>10</sup> John M. Watson and Fiona Moss, 'TB in Leicester: Out of control, or just one of those things?', *BMJ*, 322 (2001), 1133-4.

<sup>11</sup> See for example, Jenny L. Donovan, 'Ethnicity and health: A research review', *Soc Sci Med*, 19 (7) (1984), 663-70; W.I.U. Ahmad, E.E.M Kernohan, and M.R. Baker, 'Health of British Asians: A research review', *Comm Med*, 11 (1) (1989), 49-56; W.I.U. Ahmad, 'Making black people sick: 'Race', ideology and health research', in Waqar I.U. Ahmad (ed.), *Race and health in contemporary Britain* (Buckingham, Open University Press, 1993), pp. 11-33; Liam Donaldson and Luise Parsons, 'Asians in Britain: The population and its characteristics', in Brian R. McAvoy and Liam J. Donaldson (eds), *Health care for Asians* (Oxford, Oxford University Press, 1990), pp. 72-89; Chris Smaje, *Health, 'race' and ethnicity: Making sense of the evidence* (London, King's Fund Institute, 1995); Chris Smaje, 'The ethnic patterning of health: New directions for theory and research', *Sociology of Health & Illness*, 18 (2) (1996), 139-71.

<sup>12</sup> On children, see for example, Bernard Harris, 'Anti-alienism, health and social reform in late Victorian and Edwardian Britain', *Patterns of Prejudice*, 31 (4) (1997), 3-34.

Asian, West Indian, and other migrants.<sup>13</sup> Thus it followed from this analysis that the recommended measures were BCG vaccination before departure for Irish migrants, and X-ray examinations before entry to Britain for those from India and Pakistan.

This analysis was made more explicit in some of Springett's other early writing. In an article published in the *Lancet* in 1964, Springett argued that those going from an area of very low incidence to one with a higher level of incidence would be likely to undergo primary infections in the new environment. On the other hand, groups moving from an area of high incidence to one with lower levels might include a number of cases of tuberculosis. Springett conceded that the high incidence among migrants was exacerbated by poor living conditions, but argued that among 'Asian' migrants was due 'mainly to their bringing with them the high rates they would experience in their own country'.<sup>14</sup> It was only through procedures such as chest X-rays at entry that there was any prospect of controlling and eradicating the disease. But again concern was mitigated by relief that migrants had little contact with the native population. Springett wrote of Birmingham that 'it is in some ways fortunate that the immigrant groups with the higher tuberculosis-rates – that is, those from Asia – have in general shown little tendency to integrate fully with other groups resident in the city'.<sup>15</sup> He maintained his belief in chest examinations at the ports of entry, which would 'protect' those already in Britain. For Springett, this was the only satisfactory method of control.<sup>16</sup> As late as 1971, in a review of tuberculosis control in Britain between 1945 and 1970, Springett continued to emphasise the importance of facilities for diagnosis and examination of contacts, and appeared to place little stress on prevention through improving housing and working conditions.<sup>17</sup>

Other early studies were concerned with particular occupational groups, such as workers in the catering trade. A study of tuberculosis in the catering trade in Soho, London, published in 1961, was carried out by researchers based at a London hospital chest clinic and mass radiography service, and was based on pubs, restaurants, cafes, and coffee bars. Peter Emerson, Gillian Beath, and John Tomkins found from X-rays of 2,611 employees that there was a much higher incidence of 'active' cases of tuberculosis per 1,000 workers, compared to the general population. Tuberculosis was four times more common,

<sup>13</sup> V.H. Springett, J.C.S. Adams, T.B. D'Costa, and M. Hemming, 'Tuberculosis in immigrants in Birmingham, 1956-1957', *Brit J Prevent Soc Med*, 12 (1958), 135-40.

<sup>14</sup> V.H. Springett, 'Tuberculosis in immigrants: An analysis of notification rates in Birmingham, 1960-62', *Lancet* (1964), 1, 1091-5.

<sup>15</sup> *Ibid.*

<sup>16</sup> V.H. Springett, 'Tuberculosis', in *Immigration: Medical and Social Aspects* ed. by G.E.N. Wolstenholme and Maeve O'Connor (London, J & A Churchill, 1966), pp. 6-63.

<sup>17</sup> V.H. Springett, 'Tuberculosis control in Britain 1945-1970-1995', *Tubercle*, 52 (1971), 136-47.

especially among those serving alcohol, preparing food, and working in kitchens, and the 'Chinese' (mainly from Hong Kong) had the highest prevalence. Emerson, Beath, and Tomkins argued from cases with past or present tuberculosis that half had the disease before joining the catering trade (those from Hong Kong, Italy, and Ireland), while others joined healthy and then developed it (those from Britain and Cyprus). They recommended that all new entrants to the trade should be X-rayed and tuberculin-tested, with BCG vaccination where necessary. Emerson, Beath, and Tomkins therefore endorsed the value of routine radiographic examinations, especially for those they deemed the 'Chinese'.<sup>18</sup>

Work based on Bradford considered the case of arrivals from Pakistan. Here D.K. Stevenson, a Consultant Chest Physician, noted that 'Asians' with tuberculosis were first seen at the local Chest Clinic in 1954, and by 1961, many of the new notified cases of tuberculosis were from this ethnic group. Overall, he endorsed the recommendation of the British Medical Association (BMA) that migrants should have X-ray examinations of the chest at the Ports of Entry.<sup>19</sup> Later work by his colleague Dr William Edgar noted that control measures had included attempts to reduce overcrowding, selective use of mass miniature radiography, and comprehensive tuberculin testing.<sup>20</sup> The annual reports of the Medical Officer of Health (MOH) for Bradford echoed Springett's concern about protecting the native population from the spread of exotic diseases. He noted with relief in 1970 that 'no case has yet come to light where a locally born resident acquired tuberculosis from an immigrant'.<sup>21</sup> Similarly it is clear that the health of migrants was interpreted solely in terms of the risk posed by infectious disease. The MOH admitted in 1971 that 'the detection, or better, the prevention of tuberculosis occupies perhaps 99 per cent of the time devoted, in general, to the health of immigrants'.<sup>22</sup>

With hindsight, it can be seen that many of these research studies did not have sufficient data to draw sensible conclusions about the relative influences of importation and social deprivation. Nonetheless what is more important in terms of the development of health policy is not the scientific accuracy of the conclusions drawn, but the judgements made on the basis of this admittedly flawed evidence. In particular, much of the research published in the 1960s reflected pressure on the part of the BMA that all migrants should have medical examinations at the Ports of Entry. Contemporary newspapers indicate that

<sup>18</sup> Peter A. Emerson, Gillian Beath, and John G. Tomkins, 'Tuberculosis in Soho', *BMJ* (1961), 2, 148-52.

<sup>19</sup> D.K. Stevenson, 'Tuberculosis in Pakistanis in Bradford', *BMJ* (1962), 2, 1382-6.

<sup>20</sup> W. Edgar, 'Control of tuberculosis in Pakistani immigrants', *BMJ* (1964), 2, 1565-8.

<sup>21</sup> Bradford Health Committee, *Annual report of the MOH, 1970* (Bradford: Bradford Corporation, 1971), p. 57.

<sup>22</sup> Bradford Health Committee, *Annual report of the MOH, 1971* (Bradford: Bradford Corporation, 1972), p. 59.

there certainly was evidence of a 'moral panic' on the question of migration and tuberculosis.<sup>23</sup> Certainly the perceived need for medical examinations was the subject of consecutive recommendations by the BMA and other pressure groups.<sup>24</sup> Exactly why the BMA took the line, and whether it was a question of personalities or professional interests, is not clear. Probably it perceived that in the absence of an efficient screening system it was general practitioners who would be left to pick up the pieces. But the emphasis on medical examinations at the Ports of Entry must also be seen in terms of its wider symbolic value, the limited (and acknowledged) effectiveness of the measure notwithstanding. The extent to which the BMA colluded with this moral panic in the early 1960s can be seen in leader articles and correspondence in the *British Medical Journal* (*BMJ*).<sup>25</sup> The *BMJ* clearly felt that the system announced by the Ministry in January 1965, that relied on notifying addresses to local MOsH, did not go far enough. Contrasting the UK and Canada, the journal compared the failure to take action on medical examinations in the early 1960s to the delay in taking up diphtheria immunisation in the 1930s. The BMA set up a small working party to investigate the health 'problems' of migrants. The Working Party's main recommendation was that all migrants should have medical examinations in their country of origin, with further examinations and follow-up measures after entry, 'in view of the low natural immunity to disease of many immigrants and the social conditions under which they live'.<sup>26</sup>

The 1962 Commonwealth Immigrants Act gave powers to Port Health Authorities to require those entering as voucher holders (long-stay migrants) to submit to a medical examination, including a chest X-ray. The Act stated that refusal of entry could be on grounds of health, criminal record, security, or previous deportation. In the case of health, this was if it appeared to Immigration or Medical Officers the settler was 'a person suffering from mental disorder, or that it is otherwise undesirable for medical reasons that he should be admitted'.<sup>27</sup> Some measures were taken, including the introduction in February 1965 of chest X-rays on an experimental basis at London's Heathrow Airport. Furthermore under the 1968 Commonwealth Immigrants Act the provisions for medical examinations and chest X-rays were extended to the families and dependents of long-stay migrants. Whether an X-ray was taken or not, the name and intended address of the migrant, his family, and dependents were forwarded

<sup>23</sup> National Archives, Kew, London (hereafter NA) MH 55/2275: cutting from the *Daily Herald*, 10 February 1953; NA MH/2277: cutting from the *News Chronicle*, 5 August 1960.

<sup>24</sup> J.F. Skone, 'The health and social welfare of immigrants in Britain', *Public Health*, 76 (1962), 132-48.

<sup>25</sup> Editorial, 'The tuberculous immigrant', *BMJ* (1961), 2, 1624-5; Editorial, 'Tuberculosis in immigrants', *BMJ* (1962), 1, 1397-8.

<sup>26</sup> 'Report of the BMA Working Party on the medical examination of immigrants', *BMJ* (1965), 2, 1423-4.

<sup>27</sup> *BMJ* (1961), 2, 1297.

to the MOH in the area where he was planning to settle. Overall, much of the discussion about tuberculosis and migrants was bound up with concerns with 'race', immigration, and the maintenance of national boundaries.

There are intriguing parallels here with contemporary debates about screening systems. Professional bodies have continued to be active in calling for tuberculosis screening. The British Thoracic Society's Code of Practice recommends that all immigrants or other entrants from Asia, Africa, South and Central America, and other countries where tuberculosis is common, should be screened, suggesting that an incidence of 40 per 100,000 population per year is a reasonable level above which tuberculosis might be considered common.<sup>28</sup> There are currently ten Port Health Control Units in the United Kingdom, based at major ports and airports. Since the 1971 Immigration Act, officials have had the right to refer to 'medical inspectors' people who are seeking to enter the country, and can take into account the results of a medical examination when deciding to admit a passenger.<sup>29</sup> Finally the stance adopted by political parties, both Conservative and Labour, on tuberculosis and migration, along with interest in the screening systems adopted by other countries including Australia, indicates that screening continues to have a symbolic and metaphorical value, over and above any claims to clinical effectiveness.<sup>30</sup>

#### ***'Anti-Essentialist' Narratives: Socio-Economic and Other Contingent Factors***

Thus contemporary debates about the need for screening systems; the way in which the Port Health Unit system operates; and the wider political context all have striking resonances with those in the postwar period. Much of the debate about tuberculosis and 'race' in the postwar period focused on immigration as the cause, and the necessity of establishing medical examinations at the Ports of Entry. Nevertheless Nick King also notes that many public health researchers have adopted 'anti-essentialist' methods of explaining health disparities, emphasising the contingent and multi-factorial causes of tuberculosis. Rather than focusing on the tuberculosis bacillus as the single cause, the anti-essentialist viewpoint argues that multiple factors – poverty; nutrition; homelessness; residential overcrowding; drug and alcohol abuse; institutionalisation; and access to health care – contribute to the spread of infection and incidence of active cases. These factors are not natural, but are

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<sup>28</sup> Joint Tuberculosis Committee of the British Thoracic Society, 'Control and prevention of tuberculosis in the United Kingdom: Code of practice 2000', *Thorax*, 55 (2000), 887-901.

<sup>29</sup> 'Spot check', *Guardian Society*, 6 November 2002, p. 6.

<sup>30</sup> 'Test migrants for HIV and TB, say Tories', *Independent*, 15 February 2005, p. 18.

contingent on social conditions.<sup>31</sup> Again this emphasis on structural factors is borne out in a survey of recent research.<sup>32</sup>

It is interesting to look at this recent research in historical perspective. In cities such as Liverpool, where the population was predominantly white, discussions of tuberculosis in the 1950-70 period focused on deprivation in the inner-city areas. In showing how concern about tuberculosis centred on older men this bears out Hardy's depiction of debates about tuberculosis in the postwar period, but in illustrating that tuberculosis remained of major concern, local evidence also challenges her interpretation.<sup>33</sup> In the mid-1950s, Liverpool was aware that it had a higher mortality from tuberculosis than any city apart from Glasgow and Sheffield. Writing at the end of that decade, Dr Andrew Semple, the city's MOH, noted that the problem was one of the many people still living in deprivation and overcrowding, especially in the central wards, and the vagrants occupying the common lodging houses. Seamen were occasionally seen at the city's clinics, and the quick turnaround of their ships meant that rapid diagnosis and treatment was essential, requiring co-operation with the Medical Officers employed by the Shipping Federation and National Dock Labour Board. In 1961, for example, the MOH noted that the 1959 mass miniature radiography campaign had indicated 'that there was in the central Liverpool area a considerable residual body of unknown tuberculosis infection'.<sup>34</sup> Moreover as late as 1970 the MOH was writing that 'the eradication of this disease remains a difficult problem which has lost none of its urgency in recent years despite the development of effective anti-tuberculosis drugs and surgical techniques'.<sup>35</sup> Overall there was surprisingly little discussion, in Liverpool in the 1950s and 1960s, of tuberculosis as a disease of migrants, despite the existence of the local Chinese community, and much more about its being associated with deprivation and overcrowding.

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<sup>31</sup> King, 'Immigration, race and geographies of difference', p. 43.

<sup>32</sup> D.P.S. Spence, J. Hotchkiss, C.S.D. Williams, and P.D.O. Davies, 'Tuberculosis and poverty', *BMJ*, 307 (1993), 759-61; N. Bhatti, M.R. Law, J.K. Morris, R. Halliday, and J. Moore-Gillon, 'Increasing incidence of tuberculosis in England and Wales: A study of likely causes', *BMJ*, 310 (1995), 967-9; Kenneth M. Citron, Anna Southern, and Michelle Dixon, *Out of the shadow: Detecting and treating tuberculosis amongst single homeless people* (London: Crisis, 1995); A. Story and K. Citron, 'Private wealth and public squalor: The resurgence of tuberculosis in London', in *The Return of the White Plague*, pp. 47-62; Janet H. Darbyshire, 'Tuberculosis: Old reasons for a new increase?' *BMJ*, 310 (1995), 954-5; Punam Mangtani, Damien J. Jolley, John M. Watson, and Laura C. Rodrigues, 'Socioeconomic deprivation and notification rates for tuberculosis in London during 1982-91', *BMJ*, 310 (1995), 963-6.

<sup>33</sup> Hardy, 'Reframing disease'.

<sup>34</sup> Liverpool Health Committee, *Annual report of the MOH, 1961* (Liverpool: Liverpool Corporation, 1962), p. 85.

<sup>35</sup> Liverpool Health Committee, *Annual report of the MOH, 1970* (Liverpool: Liverpool Corporation, 1971), pp. 88-9.

If discussion of tuberculosis in Liverpool remained bound up with poverty, researchers in those cities that experienced the emergence of large ethnic minority populations did also stress the role played by structural factors. While the research carried out by V.H. Springett and others based on Birmingham had largely endorsed the concern with 'port health' measures, this emphasis was contested by other researchers in the West Midlands. Some of this work was not conducted by the personnel of chest clinics, but by the staff of local public health departments, and their methods and findings reflected their different professional perspective. One survey, carried out in July 1956 by the MOH and Chief Public Health Inspector for West Bromwich, confirmed that West Indian, Indian, and Pakistani migrants tended to live in overcrowded conditions. Communal living was a financial necessity - language, 'custom', and circumstances had brought them together initially, and poverty meant they could not move. The authors suggested that their findings did not support the allegation that migrants arrived in Britain suffering from tuberculosis - instead the results indicated 'that they contract the disease readily when they work in heavy industry and live in overcrowded conditions'.<sup>36</sup>

Evidence that migrants developed tuberculosis post-entry pointed to public health interventions other than medical examinations at the Ports of Entry. One study based on Uxbridge, in the London suburb of Southall, linked the high incidence of pulmonary tuberculosis among Indian migrants to their having developed the disease after arrival, and stressed the need for co-operation between general practitioners, public health departments, factory medical officers, and chest clinics.<sup>37</sup> As the pace of immigration increased, the experience of other provincial towns and cities began to attract attention. In Wolverhampton for example, a study found from new cases notified in 1960 that there were four times as many among Indian migrants as might be expected in a similar number of local inhabitants. It claimed that of new cases notified in Wolverhampton since 1954, only 19 per cent would have been picked up by chest radiography at the time of entry. It was suggested the remainder had developed the disease in England, even though their housing and living conditions, though poorer than those of the host community, were not much worse than in their countries of origin. The study recommended that all Indians should have X-rays after entry and before being accepted on general practitioner lists, and all adults should have annual check-ups.<sup>38</sup> These findings were supported by those of John Corbett, a general practitioner in Wellingborough, who observed the high incidence of tuberculosis among a small group of

<sup>36</sup> J.F. Skone and S. Cayton, 'An inquiry into the housing, health, and welfare of immigrant coloured persons in a midland County Borough', *Medical Officer*, 97 (1957), 121-6.

<sup>37</sup> J.T. Nicol Roe, 'Tuberculosis in Indian immigrants', *Tubercle*, 40 (1959), 387-8.

<sup>38</sup> J. Aspin, 'Tuberculosis among Indian immigrants to a midland industrial area', *BMJ* (1962), 1, 1386-8.

Indians who had migrated there from the state of Bombay. He concluded that while climate, working conditions, and poor diet were all factors in the high incidence of tuberculosis, 'overcrowded living conditions, with consequent possibilities for infection' was probably the most important cause.<sup>39</sup>

Moreover even those researchers whose studies had endorsed the emphasis on medical examinations at the Ports of Entry appreciated the links between tuberculosis and socio-economic deprivation. Although Stevenson in Bradford had stressed the value of 'port health' measures, he observed that the migrants from Pakistan worked in the textile trade, engineering industry, and public transport, and noted that they lived in the older, central wards of the city, which tended to be overcrowded. He claimed from an in-patient survey of hospital cases that while 40 to 50 per cent of the cases would have had an abnormal X-ray picture at the time of entry, over 50 per cent of those eventually developing a pulmonary infection 'probably' acquired it in Britain. Thus he argued there were two sides to the issue - it was both a question of 'the tuberculous immigrant' and the 'susceptible Pakistani'.<sup>40</sup> His colleague Dr William Edgar agreed that the arrivals in Bradford from Pakistan worked in the local textile trade, foundry work, public transport, and unskilled engineering, and he not only advocated the selective use of mass miniature radiography, and tuberculin-testing, but also supported attempts to reduce overcrowding.<sup>41</sup>

It seems that the complex nature of tuberculosis itself created the space in which these debates about the relative importance of importation and subsequent development of the disease could occur. Recent clinical studies have shown that the relative influences of importation and social deprivation are very difficult to untangle. The natural history of the disease (potentially very long incubation periods, subclinical infection that is difficult to identify except through tuberculin testing, and difficulty in distinguishing primary disease from post primary or reactivated disease) complicates such research.<sup>42</sup> The close correlation between social deprivation and the area of residence of migrants makes it difficult to assess the relative contribution of each factor. An analysis of tuberculosis transmission between nationalities in the Netherlands suggests

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<sup>39</sup> John T. Corbett, 'Tuberculosis amongst a small group of Indian immigrants', *J Coll Gen Practit*, 4 (31) (1961), 332-7.

<sup>40</sup> Stevenson, 'Tuberculosis in Pakistanis in Bradford', p. 1385. On work in Bradford in the early 1980s see, for example, Katherine Froggatt, 'Tuberculosis: Spatial and demographic incidence in Bradford, 1980-2', *J Epid Comm Health*, 39 (1985), 20-6.

<sup>41</sup> Edgar, 'Control of tuberculosis in Pakistani immigrants', p. 1568.

<sup>42</sup> K. Tocque, M.J. Doherty, M.A. Bellis, D.P. Spence, C.S. Williams, and P.D.O. Davies, 'Tuberculosis notifications in England: The relative effects of deprivation and immigration', *Int J Tuberc Lung Dis*, 2 (3) (1998), 213-8.

that DNA fingerprinting techniques may offer one way forward.<sup>43</sup> However even this method is not without its problems. A cautious interpretation would be to suggest that it is artificial to draw a distinction between importation and socio-economic effects. It is more likely that they both operate, and do so synergistically.

It is not clear whether it was this emphasis on the role of structural factors in the transmission of tuberculosis that shaped the policy response on the central question of medical examinations at the Ports of Entry. Certainly, it is clear that the pressure from the BMA and other groups in favour of medical examinations met continued resistance from the Ministry of Health and its successor the Department of Health and Social Security (DHSS) over our entire period, from the mid-1950s to the early 1970s. As early as July 1955, for example, Iain Macleod, Minister for Health, had stated that tuberculosis among Irish migrants was not sufficiently serious to justify health checks at the Ports of Entry.<sup>44</sup> The Ministry clearly viewed the proposals to, first X-ray migrants on arrival, and second forward the addresses of migrants to MOsH in the intended areas of residence, as alternative policy responses. This was even though George Godber, then Deputy Chief Medical Officer (CMO) had observed migrant workers being processed quickly in Geneva.<sup>45</sup> There is evidence that the Home Office and Colonial Office opposed the BMA proposals. One civil servant at the Ministry observed wryly in March 1963 that 'whatever scheme we propose short of their original somewhat unrealistic campaign in favour of X-raying compulsorily every immigrant before he was admitted, is likely to give us a certain amount of trouble with the BMA'.<sup>46</sup>

It may be that the socio-economic evidence provided convenient support for the scheme favoured by the Ministry and its CMO.<sup>47</sup> However despite this recognition that socio-economic issues were important in the transmission of the disease, the policy response centred on increased surveillance at the local level. In face of the arguments about importation, central government opted for a policy that was still essentially concerned with surveillance, but which moved its site from the Ports of Entry to those local authorities that received large numbers of migrants. As was shown earlier, it was not based primarily on medical examinations, but on the system whereby Port Medical Officers

<sup>43</sup> M.W. Borgdorff, N. Nagelkerke, D. van Soolingen, P.E. de Haas, J. Veen, and J.D. Embden, 'Analysis of tuberculosis transmission between nationalities in the Netherlands in the period 1993-1995 using DNA fingerprinting', *Am J Epid*, 147 (2) (1998), 187-95.

<sup>44</sup> NA MH 55/2275: adjournment debate on 'Tuberculosis in Immigrants', 27 July 1955.

<sup>45</sup> NA MH 55/2632: J.E. Pater to Secretary, 26 October 1962; NA MH 55/2277: G.E. Godber to J.E. Pater, 31 May 1962.

<sup>46</sup> NA MH 55/2634: H.N. Roffey to J.E. Pater, 29 March 1963.

<sup>47</sup> NA MH 55/2632: Secretary to the Minister, 14 March 1962; Ministry of Health, *On the state of the public health, 1969* (London: HMSO, 1970), p. 70; Department of Health and Social Security, *On the state of the public health, 1967* (London: HMSO, 1968), p. 54.

forwarded the addresses of recently-arrived people to local MOsH in the cities where they were planning to settle. The MOsH were expected to advise the migrants to register with a family doctor, and to provide other services for both children and adults including tuberculin testing and BCG vaccination.<sup>48</sup> Health visitors were employed for some of this work, and tracing migrants was laborious and time-consuming, since the addresses given were often incorrect or temporary.<sup>49</sup> In Bradford, the main elements of local activity were mass miniature radiography surveys in residential areas favoured by migrants; tuberculin testing in particular workplaces, such as textile mills; surveys of houses in 'multi-occupation', in an attempt to relieve overcrowding; and BCG vaccination for children and adults.

It was clear from national evidence that this system did not operate effectively. Figures for the year 1967, for example, revealed that while addresses for migrants were sent to local authorities, only two-thirds were visited by the staff of local public health departments.<sup>50</sup> Yet despite this evidence, the principle that migrants were allowed to enter the country as long as they reported to a MOH was reaffirmed in the 1968 Commonwealth Immigrants Act. A range of factors were involved in the adoption of this policy. One was the advantages of relatively open borders to a government concerned about a growing economy in which the demand for labour outstripped supply. A second was wider political sensitivity by the Conservative and Labour governments to the whole issue of immigration. A third was the practical difficulties involved in attempting to X-ray large numbers of people, and the linguistic and other administrative problems that this would have created. Thus it was ultimately administrative and political pragmatism that led to a policy stance on the issue of medical examinations that appeared to reflect an interpretation of tuberculosis that emphasised socio-economic factors in transmission rather than importation. This is essentially the same system that exists in the United Kingdom today, the alleged inadequacies of which have been widely discussed in recent years.<sup>51</sup> Despite political pressure, the report by the CMO, *Getting Ahead of the Curve* (2002) was notable for the balanced

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<sup>48</sup> Ministry of Health, *Annual report of the Ministry of Health, 1965* (London: HMSO, 1966), p. 27.

<sup>49</sup> Liverpool Health Committee, *Annual report of the MOH, 1965* (Liverpool: Liverpool Corporation, 1966), p. 46; Blackburn Health Committee, *Annual report of the MOH, 1967* (Blackburn, Blackburn Corporation, 1968), p. 11.

<sup>50</sup> DHSS, *On the state of the public health, 1967* (London: HMSO, 1968), pp. 79-80.

<sup>51</sup> M. Lavender, 'Screening immigrants for tuberculosis in Newcastle Upon Tyne', *J Pub Health Med*, 19 (3) (1997), 320-3; Sally Hargreaves, 'System to detect tuberculosis in new arrivals to UK must be improved', *BMJ*, 320 (2000), 870; Surinder Bakhshi, 'Screening is of doubtful value', *BMJ*, 321 (2000), 569; C.A. Van den Bosch and J.A. Roberts, 'Tuberculosis screening of new entrants: How can it be made more effective?', *J Pub Health Med*, 22 (2) (2000), 220-3.

approach it took to tuberculosis control, and other researchers have warned that a policy of compulsory chest X-rays at the Ports of Entry is not based on adequate evidence, and has practical and moral problems.<sup>52</sup>

### 'Race' and Susceptibility

The third approach to explaining the allegedly higher incidence of tuberculosis among migrants was in terms of racial 'susceptibility'. Nick King has written that essentialist explanations assume intrinsic differences between people. Biological, physiological, genetic or cultural differences are seen as causing certain people to be more or less susceptible to tuberculosis. A group of people disproportionately affected by a disease is identified as the cause or the source of that disease and a threat to the public's health. In this way, a disease is identified as coming from outside.<sup>53</sup> The connections observers made between tuberculosis and 'race' have been explored by earlier writers on the USA and other countries. Randall Packard has previously shown how these ideas influenced the way that tuberculosis was conceptualised in South Africa.<sup>54</sup> The links between tuberculosis and 'race' in Britain have largely been neglected, although there has been some work on constructions of tuberculosis in the colonies in the interwar period. Michael Worboys and Mark Harrison have examined the constructions of 'tropical', 'primitive', and 'colonial' tuberculosis in Africa and India before the Second World War, suggesting that tuberculosis was constructed and acted upon as a 'disease of civilisation', and showing how the work of Louis Cobbett and Lyle Cummins, on the 'virgin soil' theory, and on 'primitive tuberculosis', was influential in Britain and its Empire.<sup>55</sup>

Nevertheless while it has generally been argued that the 'virgin soil' theory of tuberculosis had receded by the 1940s, debates about tuberculosis, 'race', and migration in Britain in the 1950s indicated that these earlier ideas remained influential, and were incorporated in new ideas of 'susceptibility'. One of the first reports on tuberculosis and migrants was produced by Evelyn

<sup>52</sup> Department of Health, *Getting ahead of the curve: A strategy for combating infectious diseases (including other aspects of health protection): A report by the Chief Medical Officer* (London, Department of Health, 2002); Richard Coker, 'Compulsory screening of immigrants for tuberculosis and HIV', *BMJ*, 328 (2004), 298-300.

<sup>53</sup> King, 'Immigration, race and geographies of difference', p. 41.

<sup>54</sup> Randall M. Packard, *White plague, black labor: Tuberculosis and the political economy of health and disease in South Africa* (Pietermaritzburg: University of Natal Press, 1989), pp. 5, 201, 207, 210, 235, 241-2.

<sup>55</sup> Mark Harrison and Michael Worboys, 'A disease of civilisation: Tuberculosis in Britain, Africa and India, 1900-39', in Marks and Worboys, *Migrants, Minorities and Health*, pp. 93-124; Michael Worboys, 'Tuberculosis and race in Britain and its Empire, 1900-50', in Waltraud Ernst and Bernard Harris (eds), *Race, Science and Medicine, 1700-1960* (London, Routledge, 1999), pp. 144-66.

Hess and Norman Macdonald in 1954, based on their experiences in hospitals in Hertfordshire and North London. They noted there was a belief that the Irish migrant was particularly 'susceptible' to tuberculosis, and this appeared to be supported by statistical evidence.<sup>56</sup> In attempting to explain these figures, Hess and Macdonald turned to the ideas of Louis Cobbett and Lyle Cummins. As Worboys has shown, Cobbett in the 1920s had attempted to explore whether the resistance of 'civilised man' to tuberculosis was 'racial' or individual.<sup>57</sup> By the late 1920s, Cummins had modified his theory of 'virgin soil' to describe the unprotected state of people living in isolated areas who had escaped contact with the tuberculosis bacillus.<sup>58</sup> Hess and Macdonald argued that the Irish-born patients had much less exposure to human-type bacilli in childhood and adolescence than experienced by those who lived in English cities. Some patients 'broke down' due to reactivation of earlier infections, and this was accelerated by the 'altered environment' and 'additional strain' of living in the poor districts of a big city.<sup>59</sup> But what was more important was the low level of natural resistance. Therefore Hess and Macdonald claimed to reject a theory of 'racial weakness' in favour of one related to epidemiological phase. What they emphasised was the importance of the degree of exposure experienced by earlier generations, and the epidemiological phase in the tuberculosis cycle reached by the community concerned. Together these created the 'susceptible country-dweller'.<sup>60</sup> Hess and Macdonald argued there was little evidence to support hereditary susceptibility on a racial basis, but there was some 'transmissible' factor that influenced the resistance of later generations.

Hess and Macdonald provide a striking illustration of how a modified version of the 'virgin soil' theory persisted in the early 1950s. Ideas of susceptibility were also apparent in research on 'Asian' migrants. C.P. Silver and S.J. Steel, based at the London Chest Hospital, argued from chest radiographs of seven patients from India and the West Indies that some migrants 'fail to develop the same degree of acquired resistance as the European at the time of primary infection, so that the subsequent clinical picture may present

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<sup>56</sup> Evelyn V. Hess and Norman Macdonald, 'Pulmonary tuberculosis in Irish immigrants and in Londoners: Comparison of hospital patients', *Lancet* (1954), 2, 132-7. On the health of Irish migrants, see for example Liam Greenslade, Moss Madden, and Maggie Pearson, 'From visible to invisible: The 'problem' of the health of Irish people in Britain', in Marks and Worboys, *Migrants, Minorities and Health*, pp. 147-78.

<sup>57</sup> L. Cobbett, 'The resistance of civilised man to tuberculosis: Is it racial or individual in origin?', *Tubercle*, 6 (1925), 577-90.

<sup>58</sup> S. Lyle Cummins, "'Virgin soil' and after: A working conception of tuberculosis in children, adolescents and aborigines", *BMJ* (1929), 2, 39-41; S. Lyle Cummins, *Primitive tuberculosis* (London, John Bale Medical Publications 1939).

<sup>59</sup> Hess and Macdonald, 'Pulmonary tuberculosis in Irish immigrants and in Londoners', p. 135.

<sup>60</sup> *Ibid.*, p. 136.

features of both primary and chronic pulmonary tuberculosis simultaneously'.<sup>61</sup> In interpreting tuberculosis among migrants in Wolverhampton, the author of one study drew on the work of Silver and Steel. He wrote that when 'young people from stocks susceptible to tuberculosis' moved from isolated rural communities in an underdeveloped country to a crowded industrial environment they would suffer an excessive development of tuberculosis, including unusual forms. He noted that 'urban dwellers whose earlier equally susceptible neighbours have long since succumbed to infection before reproducing their genetic inheritance now tend to develop much more chronic disease'.<sup>62</sup>

Packard has argued of the South African experience that the 'myth of the healthy reserve', and the tendency to blame the victim, became entwined with the language of environmental reform, but led to inaction.<sup>63</sup> This point about the 'susceptibility' of both Irish and Asian migrants was reiterated where action was most important - at the local level.<sup>64</sup> Contemporary textbooks provide one way of exploring how these ideas may have been spread among the public health workforce. One of the most interesting was published in 1969 by J.S. Dodge, Senior Medical Officer in Bradford. Dodge's own background is revealing. Trained at Barts, Dodge spent two years of his National Service in West Africa, seconded to the Royal West African Frontier Force, serving in Freetown and northern Nigeria. Later he joined the Colonial Medical Service, and the Northern Nigeria Public Service. During his ten years in Nigeria he worked with Medical Field Units, leaving Nigeria in 1966, and taking up his Bradford post in 1967, where much of his time was spent on issues of the health of migrants. In terms of tuberculosis control, Dodge argued that one factor was the 'innate resistance' of the individual, a quality lacking in races in Asia and Africa where tuberculosis was a relatively new disease. Arriving migrants might include those suffering from the disease, but also might be more 'susceptible'. He wrote that 'the immigrant may by virtue of his race be more susceptible to tuberculosis infection than the indigenous population even when he has acquired a degree of resistance either naturally or by BCG infection'.<sup>65</sup> More generally, the Dodge

<sup>61</sup> C.P. Silver and S.J. Steel, 'Mediastinal gland tuberculosis in Asian and coloured immigrants', *Lancet* (1961), 1, 1254-6.

<sup>62</sup> Aspin, 'Tuberculosis among Indian immigrants to a Midland industrial area', p. 1387.

<sup>63</sup> Packard, *White plague, black labor*, p. 243.

<sup>64</sup> Liverpool Health Committee, *Annual report of the MOH, 1956* (Liverpool, Liverpool Corporation, 1957), p. 75; Bradford Health Committee, *Annual report of the MOH, 1965* (Bradford, Bradford Corporation, 1966), p. 69; Bradford Health Committee, *Annual report of the MOH, 1966* (Bradford, Bradford Corporation, 1967), p. 60; Bradford Health Committee, *Annual report of the MOH, 1967* (Bradford, Bradford Corporation, 1968), p. 59; Leicester Health Committee, *Annual report of the MOH, 1962* (Leicester, Leicester Corporation, 1963), p. 75.

<sup>65</sup> J.S. Dodge, *The field worker in immigrant health* (London, Staples Press, 1969), p. 138.

textbook suggests that in interpreting issues of health among migrants, some public health doctors relied on frameworks drawn from colonial medicine.

As with the Irish migrants, ideas of 'susceptibility' were used to back up the positions that bodies such as the Ministry of Health had adopted. Indeed the concept of susceptibility was attractive precisely on account of its ambiguity. Because they opposed compulsory medical examinations at the ports of entry, civil servants drew on the well-worn theme of the 'susceptible' migrant to argue against the idea that migrants were 'importing' tuberculosis into the country. In January 1956 for example, the Ministry of Health's Parliamentary Secretary, Patricia Hornsby-Smith, wrote that the real problem was 'the susceptible people who come for the first time in contact with the stresses and risks of town life here rather than those entering the country in an infectious condition'.<sup>66</sup> Much later, in 1964, the Standing Medical Advisory Council noted that some cases among migrants could be missed by X-ray examinations at the ports, and other 'susceptible groups' might acquire the disease after entry.<sup>67</sup> Associating tuberculosis with racial difference reduced a complex problem to a single cause. Nevertheless the relative importance of genetic, cultural, and socio-economic vulnerabilities remain important questions in explaining ethnic inequalities in health, unravelling the influences of ethnicity and deprivation remains an important strand in tuberculosis research, and at a popular level, discussion of tuberculosis continues to be bound up with questions of racial difference.<sup>68</sup>

### *Conclusion*

This article has been concerned with exploring three different approaches - essentialist; structural; and 'racial' - to explaining the allegedly higher incidence of tuberculosis among migrants in the early postwar period. In reality it is artificial to separate the explanations since early researchers drew on all three. The evidence presented here suggests that in the immediate postwar period,

<sup>66</sup> NA MH 55/2275: P. Hornsby-Smith to E. Burton, MP, 13 January 1956.

<sup>67</sup> Standing Medical Advisory Committee, *Tuberculosis: The changing epidemiological pattern and its implications* (London, Ministry of Health, 1964), p. 1.

<sup>68</sup> James Y. Nazroo, 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', *Sociology of Health & Illness*, 20 (5) (1998), 710-30; J.H. Schoeman, Margaret S. Westaway, and Ariane Neethling, 'The relationship between socioeconomic factors and pulmonary tuberculosis', *Int J Epid*, 20 (1991), 435-40; P.D.O. Davies, D.J. Girling, and J.M. Grange, 'Tuberculosis', in D.J. Weatherall, J.G.G. Ledingham, and D.A. Warrell (eds), *Oxford textbook of medicine* (Oxford, Oxford University Press third edn., 1996), pp. 638-64; Surinder S. Bakhshi, Jeremy Hawker, and Shaukat Ali, 'The epidemiology of tuberculosis by ethnic group in Birmingham and its implications for future trends in tuberculosis in the UK', *Ethnicity & Health*, 2 (3) (1997), 147-53; Jeremy I. Hawker, Surinder S. Bakhshi, Shaukat Ali, and C.Paddy Farrington, 'Ecological analysis of ethnic differences in relation between tuberculosis and poverty', *BMJ*, 319 (1999), 1031-4; 'A healthy colour', *Guardian Society*, 25 April 2001, p. 6.

debates about tuberculosis in migrant groups remained highly racialised. In the case of Irish migrants, the disease was presented as one of 'susceptible' migrants from rural areas, who had had little previous exposure to tuberculosis, and who therefore ran the risks of contracting the disease when they moved to English cities. This was presented as in part due to overcrowded living conditions that facilitated the spread of infection; inadequate nutrition that lowered resistance; and an interpretation that emphasised the increased stress of living in an unfamiliar urban environment. But although it was suggested that the 'racial' factor had been disproved, in fact this analysis can be seen to have incorporated elements of the older 'virgin soil' interpretation. Like Cummins, Hess and Macdonald combined the 'virgin soil' theory with one where socio-cultural conditions shaped the development of acquired and inherited immunity. What is striking is how these ideas persisted into the early postwar period. The idea that the Irish were inherently susceptible to tuberculosis because of their lack of contact with the disease deflected attention away from environmental conditions in English cities. The idea of racial susceptibility ran alongside environmental explanations, but ultimately served to reduce the impact of structural arguments.

In the case of the migrants from India and Pakistan, on the other hand, the 'problem' was represented as being one of migrants from areas with a high incidence of tuberculosis moving to areas where there was a low incidence. It was more often asserted that migrants had brought the disease with them, rather than contracted it in Britain. This provided crucial support for the BMA's campaign in favour of a system of medical examinations at the Ports of Entry. This interpretation was resisted, to an extent, by other writers, many of them from the public health community. Instead they stressed the importance of the work environment, housing, and nutrition. Again ideas of racial weakness co-existed with a structural interpretation where the argument was that the 'susceptibility' of migrants to the disease was aggravated by poor diet and overcrowding. Nevertheless the blame for Asian susceptibility to tuberculosis continued to be placed largely on the victim, and actual attempts to tackle the environmental factors in the disease remained extremely limited. Focusing on surveillance and biomedical factors meant it was possible to avoid confronting more radical political and environmental change. What this article has attempted to show are the long shadows that historical perspectives throw on contemporary debates. As we noted at the outset, it is compulsory HIV and tuberculosis screening tests for asylum seekers and migrants that are once again on the political agenda. For political parties if not for the medical profession, the importance of medical examinations remains as much symbolical as practical.