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Refugees, Immigrants, and the Public Health

Several papers in recent issues of the Journal,[1,2] including the one by Skeels, *et al*,[3] in the current issue, bear witness to an upsurge of interest in the medical problems of recent immigrants and refugees. The Index Medicus for 1980, under the heading, emigration and immigration, lists 33 papers published in American journals on health problems of immigrants to the United States and another 18 such papers under the heading, refugees. In 1970 there was no heading "refugees", and only four comparable papers were listed under the heading emigration and immigration. The upsurge is not surprising. In 1978 (the most recent year for which figures are published) 601,442 immigrants were admitted to the United States, the largest number since 1921.[4]

Immigration has played a pivotal role in American history, but its role in the history of public health is less well recognized. One of the earliest actions of the Congress in 1796 provided for federal "cooperation" with states and localities in enforcing state and local quarantine relating to ships.[5] Although a few legislators argued as early as 1796 that the federal government should be given greater powers, the Congress avoided stepping on the toes of States for the next 82 years and even then did so very lightly: The Quarantine Act of 1878 specified that any regulations of the Surgeon General of the Marine Hospital Service to whom the federal power of quarantine was delegated "shall not conflict with or impair any sanitary or quarantine laws or regulations of any state or municipal authorities now existing or which may hereafter be enacted".[5] In spite of these limitations, the 1878 Act represented a significant broadening of the authority of the United States Public Health Service, then known as the Marine Hospital Service. The law included a charge "to investigate the origin and causes of epidemic disease and cholera," thus initiating a course of action whose ultimate product was the present Naitonal Institutes of Health.[6]

Pressures to enact the 1878 law came from many sources, all related to the rising tide of immigration.[7] The fear of imported epidemics was one of these sources, and a growing consensus favorable to the germ theory of disease kindled hopes that contagion could be easily contained by quarantine. In the forefront of such believers were members of the newly formed (1872) American Public Health Association (APHA).

The quarantine responsibilities of the Marine Hospital Service lasted but a short time, being transferred in 1879 to the ill-fated National Board of Health.[5] The 1879 law was a virtual brain child of the APHA and Association officers were prominent as members of the Board. Its passage was greatly accelerated by a severe epidemic of yellow fever in 1878, however. According to the Board's Chairman, James L. Cabell, sixth president of the APHA, the law was intended to carry a provision for funding the first state grants-in-aid program for public health work, a block grant, "to aid in the work of State Boards of Health, and of State

and municipal authorities, by such means and to such an extent as may seem to it necessary and desirable."[8] A clerk transcriber omitted to include this provision in the final draft of the law, and it was never enacted. The law, as passed, had a number of deficiencies as well as omissions; there was substantial resentment of "federal intrusion" by state officials, including the state and local health officer constituents of the APHA itself; the administrative responsibilities of the Board proved to be unworkable.[5] Since Congress was not yet prepared to create a National Department of Health, quarantine responsibilities soon drifted back on the shoulders of Marine Hospital physicians. Their authority was reaffirmed and formalized by Congress in 1893, this time with the added provision that federal regulations could supersede state and local laws if the latter were not adequate. The 1893 law also gave the Public Health Service greater power over interstate quarantine, thus opening up a long and productive relationship between federal and state health authorities.[6]

It would be comforting to believe that this latter sequence of events reflected an orderly planned process, but this is far from the case. The tide of immigrants had shifted in the late 1870s from Northern Europe and the British Isles to Southern and Eastern Europe. The immigration laws passed between 1882 and 1893 reflected a compromise between forces that sought to restrict immigration and those that wished to encourage it, the former based on ethnic and religious prejudice and fear of lost jobs, the latter on the desires of industrialists to capitalize on cheap labor.[9] The influx of immigrants had increased to such an extent that New York City had threatened to close down its immigrant depot unless it received federal aid; the Haymarket bomb set off in Chicago in 1886 by persons unknown became propaganda warning of radical infiltration; and a cholera epidemic on shipboard in 1892 sparked the law of 1893. Fortunately, public health leaders were again prepared to seize this opportunity to strengthen the public health structure of the country.

Immigration had another profound effect on the growth of the public health movement in the United States. The deplorable housing and sanitary conditions to which immigrants were exposed were directly responsible for the establishment of strong local health departments.[10] Indeed, Stephen Smith, New York City's first health commissioner, and the APHA's first president, was recruited as a young surgeon to the public health field by his experience in a typhus epidemic which raged among New York's Irish immigrants.[11] On investigating the address given by 100 cases in his charge, he found it to be a deteriorating tenement, abandoned by its landlord, but crowded with immigrant families who could find no other lodging. Smith's efforts to correct this situation, together with a group of public-spirited citizens, led to a careful sanitary survey of the city and culminated in the establishment of the first stable administrative structure for the execution of public health work in the United States. The successful pursuit and achievement of this goal by the Citizen's Association is a model of how a combination of public education, and the efforts of a dedicated constituency can overcome even the most powerful political oppositions.[12]

Unlike the Irish, Italians, Swedes, Russians, and Poles of the 1880s, today's Cubans, Cambodians, Haitians, Mexicans, and Vietnamese pose no real or imagined threats of uncontrollable contagion; nor are they likely to act as a spur to legislation or administrative change specific to the field of public health. Nevertheless, there are other aspects of the political scene facing the nation and the public health community that are not unlike those of a century ago. Arguments continue to rage concerning federal regulatory authority vis-a-vis that of the sovereign states and concerning the nature of federal grants for public health activities. The basic administrative structure of the health system has not changed in the past century, but its responsibilities have grown and become dispersed among a variety of agencies at federal, state, and local levels, resulting in chaos at least as great as that faced by Stephen Smith and his colleagues in New York City. Whether or not we are able to assimilate our most recent immigrants, we have not been able to assimilate the involuntary immigrants who arrived more than a century ago as slaves; ethnic frictions are as rife as ever. Now as then we tend to blame immigrants for our own deficiencies.

If there are any lessons to be learned from the past, they are that health issues are rarely predominant instigators of change in themselves. Changes in the health system within the past two centuries have followed in the wake of or been appended to changes that derive from crises or larger social issues (the New Deal, the Great Society). To most observers of the public health scene today, the federal administration seems bent on ignoring the need for constructive changes in our health and social systems and moving the clock backward into the last century. Such actions can only hasten the advent of a crisis which has been building slowly in the present century.

This is a time, then, for public health leaders to prepare themselves, as did the founders of the APHA, to take advantage of the larger social changes which are bound to come as backlash to current reactionary policies so that long overdue reforms of the health system can be enacted into law. The speech Dr. Cabell delivered to the 8th annual meeting of the APHA in 1879 was flowery and long-winded, but its message is relevant again today:[8]

> "While it is undeniable that we are mainly indebted to the profound impression produced by these events (the yellow fever epidemic) for the readiness with which the two houses of Congress entered upon measures of sanitary legislation, we may yet, without unbecoming self-laudation, claim for this body the sagacity to perceive and the energy to utilize the opportunity thus offered for initiating measures which looked to the probable consummation of its hopes in the inauguration of a system of sanitary legislation, which should thereafter become a permanent feature in the civil administration of government, State and national, aiming thereby to make the epidemic of 1878 achieve for the cause of State medicine in the United States what the cholera epidemic in England had done for that country not many years ago."

It may be well to remember two other lessons from the previous century. The changes proposed should not be patchworks of the past like most of our legislation in the

twentieth century. New laws should chart directions as bold and new as those of a century ago. The ability to preserve our environment for future generations, the need for a National Department of Health, and a rational and equitable health care system serving all citizens are challenges we have yet to meet. On the other side of the coin is the fact that there are no quick cures for chronic problems whose causes are multiple or remain to be discovered. Although they set a course for the future, the New York Metropolitan Board of Health in 1866 and the National Board of Health in 1879 foundered because they tried to do too much too soon with too little and failed to respond to the political realities of the day.[10] We will need a firm hand and a solid consensus to avoid the extremes of Scylla and Charybdis. Two hundred years is a short time in the life of a nation, and we are still a nation of immigrants and refugees:

It is a strange thing—to be an American. . . .
America is neither a land nor a people,
A word's shape it is, a wind's sweep—
America is alone: many together,
Many of one mouth, of one breath,
Dressed as one—and none brothers among them;
Only the taught speech and the aped tongue.[13]

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Symposium on Fundamental Cancer Research Announced

"Perspectives on Genes and the Molecular Biology of Cancer" is the topic of the 35th annual Symposium on Fundamental Cancer Research to be held at the Shamrock Hilton Hotel, March 2–5, 1982. The symposium, sponsored by the University of Texas M. D. Anderson Hospital and Tumor Institute, will focus on the molecular biology of cancer and explore in depth the metabolism involved in cellular cancer growth. Topics include gene organization and evolution, gene transfer, regulation of gene expression, and novel applications of recombinant DNA technology to human cancer. Co-chairpersons: Drs. Grady F. Saunders and Donald L. Robberson.

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