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"Loathsome and Dangerous": Health Screening in a Globalized World

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As the world has become steadily more interdependent over the last century, disease has been able to spread with increasing ease. As a consequence of this new danger, the international community has changed the way that it understands contagion, and public health has taken on new roles and new meanings around the world. I argue that the globalization of public health and the relatively new perception of diseases as "global" threats have dramatically altered practices of health screening, both at the border and beyond. Above all, these changes also reveal the importance of public health systems in supporting the nation-state system as a whole. Using a brief history of the WHO, Part I discusses how globalization has facilitated a shift in thinking about disease as a "global" threat rather than as an "international" problem. Part II examines the historical significance of public health policies in defining national identities, as well as the extent to which globalization has made this difficult. Finally, Part III uses three case studies to suggest that the new "global health" paradigm has provided nation-states with the tools to reassert claims to national sovereignty and identity-building in an increasingly globalized world.

Part I: From "International Health" to "Global Health"

The term "international health" was used a great deal in the late nineteenth and early twentieth century, and "referred primarily to a focus on the control of epidemics across the borders or boundaries between nations[1]." International health uses nations as the primary unit of analysis. By contrast, "global health" "implies the consideration of the health needs of the people of the whole planet as an agenda above the concerns of particular nations[2]." Global health "makes no distinction among nation-states and other social constituents of society," and is

[1] T. Brown et. al, "The World Health Organization and the Transition from 'International' to 'Global' Health." *Medicine at the Border*, (Basingstoke: Palgrave Macmillan, 2007): 77
[2] *Ibid.,* 77

instead concerned with actors beyond governmental or intergovernmental organizations and agencies, such as the press, various international foundations, and transnational corporations.[3] Over the course of the twentieth century, "global health" gradually became the new paradigm for thinking about, and implementing, international health programs. In order to examine this shift more closely, it is useful to trace the history of the WHO from its conception as the hegemonic leader of "international health" in the mid twentieth century to its place in the contested realm of "global health" in the 1990s.

After the first World Health Assembly ratified its constitution in 1948, the WHO began tackling international health issues with a focus on intergovernmental strategies. A number of its initiatives over the next two decades illustrate this tactic. During the Cold War, for example, most of the WHO's policies focused on national development. In 1955, it began a global malaria eradication program that aimed primarily at improving the economic structures of endemic countries. Since the Soviet Union had left the UN in 1949, the United States was able to exert a great deal of control over the WHO's policies until the USSR returned in 1956. The US supported the malaria eradication program with the intent to foster economic growth in developing countries and create international markets for US technologies.[4] At the same time, the program would increase support for local governments and their US supporters, creating a barrier against Communism. The WHO also mounted immunization campaigns aimed at eradicating certain diseases around the world. In 1974, it selected six illnesses that had "effective and inexpensive" vaccines[5] (tuberculosis, diphtheria, neonatal tetanus, whooping cough, poliomyelitis, and measles) and carried out immunization programs in various nations. Although

[3] *Ibid.,* 77
[4] *Ibid.,* 81
[5] *Ibid.,* 84

it did not work closely with national populations, or with even national governments for the most part, its top-down implementation of immunizations was contained within national borders.

In the 1980s the World Bank began to threaten the WHO's primacy in the realm of international health management, a development that contributed a great deal to the rise of the "global health" paradigm. The World Bank argued, in its 1980 *World Development Report*, that "both malnutrition and ill-health could be addressed by direct government action-with Bank assistance[6]," and began awarding loans and grants for "food and nutrition, family planning, maternal and child health, and basic health services[7]." While the World Bank's influence grew steadily over the next decade, the WHO's legitimacy was rapidly diminishing due to internal inefficiencies and budgetary problems. Underlying this shift in power was an even more important ideological transformation. The World Bank, an avid proponent of neoliberalism, contributed to the "globalization" of public health, and to the rise of "global health", in several ways. First, it argued in favor of increased private-sector involvement in public health programs. This would open up national health organizations to foreign investment, thereby facilitating interconnectedness on a global scale. Second, it opened the door for other multinational organizations to become involved in public health initiatives, creating an arena for global competition. In the early-1990s, for example, UNICEF, the World Bank, the UN Development Program, the Rockefeller Foundation, and several other organizations all sought to gain control of vaccine development for the Children's Vaccine Initiative.[8] The World Bank had created a space in which the free market could dictate international health programs. This removed the incentive for individual governments to pursue national initiatives, and turned public health (at

[6] *Ibid.,* 85
[7] *Ibid.,* 85
[8] *Ibid.,* 87

least on the economic side) into a borderless zone of competition. Finally, it caused the WHO to refashion itself as an organization aimed at solving "global" health issues, rather than "international" ones. In 1992, the Executive Board of the WHO appointed a working group to "recommend how WHO could be most effective in international health work in the light of the 'global change' rapidly overtaking the world[9]." This "global change" refers, of course, to globalization's effect on international health programs. The next year, the working group recommended that "if [WHO] were to maintain leadership of the health sector," it must, above all, "increase the emphasis...on global health issues and WHO's coordinating role in that domain[10]." Over the next few years, a substantial body of literature emerged that painted disease as a global threat[11]: "Bestselling books and news magazines were full of stories about Ebola and West Nile Virus, resurgent tuberculosis, and the threat of bioterrorism[12]." Individual nations were no longer the focus. Disease had become a borderless problem in the eyes of the key players.

This shift in thinking about health as an "international" problem to a "global" one is important for several reasons. First, the WHO's adoption of global health initiatives demonstrates the effects that globalization had on theories, policies, and practices. Before the 1990s, the WHO's actions had been targeted primarily at national development in order to eradicate disease through structural changes. With the rise of neoliberalism as the dominant force in international relations, however, national economies became increasingly interconnected during the late twentieth century, and the economy of international/intergovernmental health was handed over to multinational institutions and foundations. Finding its old role usurped, the WHO

[9] *Ibid.,* 87
[10] *Ibid.,* 87
[11] *Ibid.,* 88
[12] *Ibid.,* 88

created a new role for itself as a "global" health leader in order to survive.[13] This is not to suggest that neoliberalism is the sole cause of globalization, or that the WHO invented "global health". It is important, however, to acknowledge how privatization and free market rule contributed to the rise of a "global health" economy, as well as how the WHO helped shape the new paradigm. Second, in embracing the terminology and the policies of "global health," the WHO helped solidify and legitimate this change in thinking with respect to policy making. While it did not invent "global health," the WHO did help "promote interest in the field and contributed significantly to the dissemination of new concepts and a new vocabulary[14]." This will be discussed further in Part III. Finally, "global" health's status as the new paradigm suggests that public health has indeed been "globalized." Globalization has so drastically changed the ways that modern nation-states perceive disease that a new terminology was needed- one that has been used to inform and legitimate policy ever since.

Part II: Public Health, National Sovereignty, and Identity-Building

One of the most important ideological underpinnings of the nation-state is the concept of (usually ethnic) homogeneity. Various forms of nationalism played a vital role in producing the nation-state as the dominant social and political unit in the early nineteenth century. These nationalisms were largely predicated on the belief that certain ethnic populations had legitimate claims to various geographic locations. They successfully created histories, policies, and modes of thinking that solidified the concept of "national identities" contained within arbitrary borders. These national borders have historically been important spaces where governments have been able to effectively define the national identities of their states. One of the ways they have done

[13] *Ibid.,* 90
[14] *Ibid.,* 90

this is through the implementation of mandatory health screening laws for immigrants. These laws typically reflected deeply rooted nativist sentiments that came as a direct result of nation-building by nationalist groups. A good example of these policies and attitudes is the United States' use of disease in crafting new immigration laws in the late nineteenth and early twentieth centuries. The Immigration of Act of 1891 mandated the exclusion of anyone suffering from a "loathsome or dangerous contagious disease[15]." This was the first time that American immigration policy had incorporated medical terminology and used it as a basis for exclusion. More importantly, it allowed the US government to paint outsiders as carriers of infectious disease, thereby defining them in medical terms against the purportedly pure, healthy American public. It also lead to the broad adoption of disease metaphors by nativist groups who sought to exclude immigrants for other reasons. For example, many Americans at the turn of the century feared that eastern European Jews would disrupt the labor force by forming unions and espousing socialist beliefs, and thus alleged that they would bring about the "disease and ruination" of the country.[16] By excluding immigrants based on the risk of contagion, states ensured the "safety" of their national populations against the spread of disease, cemented the importance of national borders as sites of identification and security, and created a new way for populations to define themselves.

Mandatory health screenings have not been aimed solely at exclusion, however. They have also been important modes of identity-building and assimilation through the imposition of national norms upon outsiders. Amy Fairchild suggests, for example, that health screening at

[15] Howard Markel & Alexandra Minna Stern, "Which Face? Whose Nation?: Immigration, Public Health, and the Construction of Disease at America's Ports and Borders, 1891-1928," *American Behavioral Scientist*, Vol. 42, No. 9 (June, 1999): 93
[16] *Ibid*., 108

Ellis Island before 1924 "was shaped by an industrial imperative to discipline the laboring force in accordance with industrial expectations[17]." Likewise, Alison Bashford points out how exclusionary policies that targeted Chinese immigrants on the west coast "became a provisional incorporation of Chinese communities into the US civic body by the 1920s and 30s," albeit one that depended on "standardizing Chinese conduct and living spaces according to American hygienic norms[18]." She writes that "through the implementation of these powers, national populations were literally shaped, territories were marked, and inclusions and exclusions on all kinds of bodily criteria were implemented[19]." Health screening at the border has thus played a dual role in defining citizenship after the invention of the nation-state: On the one hand, states have employed them in order to exclude individuals that represent a threat to national populations. On the other, they have been used to strengthen national identities by forcing outsiders to conform to certain norms about health and hygiene in order to gain entry or citizenship.

Globalization has complicated this picture significantly by making it increasingly difficult for states to police their national boundaries. More specifically, the rapid increase in human mobility during the latter half of the twentieth century has hindered national governments' ability to define their national identities as they had done before: New economic systems have led to massive migrant worker populations, tourism is now the world's largest industry, and global conflicts have forced millions to seek refuge in foreign countries. Many scholars in recent years have even argued that globalization has all but completely eroded the

[17] A. L. Fairchild: *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore, Johns Hopkins University Press, 2003), 16
[18] A. Bashford, "'The Age of Universal Contagion': History, Disease, and Globalization." *Medicine at the Border*, (Basingstoke: Palgrave Macmillan, 2007): 8
[19] *Ibid.,* 8

nation-state as the primary unit of political, economic, and social analysis. They suggest that state autonomy is virtually nonexistent in a post-globalized world, and that we must instead step back and view the international community as one interconnected entity.[20] While the rise of "global health" would seem to support this position, the term does not actually extend that far outwards. It simply refers to disease as an increasingly borderless concept. The lack of distinction between nations is limited purely to the realm of disease, and although this is certainly a byproduct of other kinds of interconnectedness, "global health" does not provide for the complete annihilation of the nation-state system.

While it is true that national borders have become increasingly porous, nation-states are still important entities and borders remain critical sites of security. However, globalization has severely limited the ways in which states can define and maintain national identities. This is why the narrative of "global health" is so important. Now that disease is understood as a borderless danger, states have begun reasserting the importance of national borders in containing the spread of infections. Under the auspices of "global health," national governments can implement increasingly harsh mandatory health screening laws that allow them to regain one of the nation-state's essential prerogatives: The ability to define and protect a homogenous national culture.

Part III: Hidden Realities: Case Studies in Health Screening and Immigration Law

In a 1998 article entitled "The Globalization of Public Health, I: Threats and Opportunities," Derek Yach and Douglas Bettcher wrote that the "new paradigm" of globalization could be defined as "the process of increasing economic, political, and social interdependence and integration as capital, goods, persons, concepts, images, ideas and values

[20] See M. Hardt and A. Negri, *Empire* (Cambridge: Harvard University Press, 2000). See also Z. Bauman, *Society Under Siege* (Cambridge: Polity Press, 2002)

cross state boundaries[21].” They argued that the globalization of public health had a dual aspect, one positive and one negative. On the positive side, globalization has made it easier to diffuse beneficial technologies and values, such as human rights, across national borders. On the negative side, however, it can lead to environmental degradation, the increased marketing of illegal drugs, and, most importantly, the inevitable spread of infectious diseases across borders[22].” Countries have certainly realized this risk, and mandatory health screenings for immigrants have once again become a prevalent international norm. But viewing these screenings simply as safeguards against disease contagion risks missing the larger picture. Several examples suggest that nation-states are more concerned with reasserting claims to national sovereignty and identity-building than with preventing public health risks, although they all tend to work together. It is to these case studies that I now turn.

A. HIV/AIDS in Canada

Mandatory HIV/AIDS testing for prospective immigrants to Canada reveals the different ways that sick bodies are portrayed as threats to national interests, and are used as mechanisms of nation-building in a post-globalized world. In 1994, the then Reform Party’s Immigration critic introduced a bill to Federal Parliament that demanded mandatory HIV testing for all immigrants applying for Canadian citizenship.[23] Citizenship and Immigration Canada had already been active in trying to amend Canada’s old immigration law, and were consulting with a company called Health Canada about the need for more aggressive health screening procedures. Health Canada initially recommended that blanket-testing all immigrants for HIV/AIDS and

[21] D. Yach & D. Bettcher, “The Globalization of Public Health, I: Threats and Opportunities,” *American Journal of Public Health,* Vol. 88 No. 5 (1998): 737
[22] *Ibid.,* 737
[23] R. Mawani, “Screening out Diseased Bodies: Immigration, Mandatory HIV Testing, and the Making of a Healthy Canada,” *Medicine at the Border,* (Basingstoke: Palgrave Macmillan, 2007): 137

denying entry to those who tested positive would be the safest public health strategy. But this drew a great deal of criticism from various immigrant/refugee and HIV/AIDS advocacy groups, and they later revised their recommendation. In April 2001, Canada's Minister of Health sent a newly drafted statement to the Minister of Citizenship and Immigration, writing: "mandatory testing for HIV is necessary, but prospective immigrants, after receiving counselling need not be excluded from immigrating to Canada on public health grounds[24]." However, in 2002, Canada's federal government mandated HIV/AIDS testing as part of its new *Immigration and Refugee Protection Act.*

Since HIV/AIDS was no longer seen as a public health risk, the government had to find a new way to exert control over infected immigrants. Under the new law, people with chronic illnesses can be denied Canadian citizenship if they are expected to "place an excessive demand on health and/or social services compared to the average Canadian[25]." In theory, then, immigrants with HIV/AIDS cannot be excluded solely for being sick. However, most chronic illnesses are assessed by their projected costs over a ten year period. Many critics have pointed out that this is an "inappropriately long" window, especially in the case of HIV/AIDS where the costs are highly variable over time.[26]

Globalization, along with the emergence of the "global health" paradigm, has allowed states like Canada to use health screenings to protect their national interests and to determine the ethnic makeup of their populations. In this instance, the increased migration of sick people is presented as an economic burden. In the most positive sense, this does actually defend Canada's economy against a detrimental effect of globalization. Canada's free universal healthcare system

[24] Alana Klein qtd. in *ibid.,* 137
[25] "Immigrants, Refugees and Non-Status People with HIV," *Canada's Source for HIV and Hepatitis C Information*

[26] Klein qtd. in *ibid.,* 148

is particularly vulnerable to influxes of sick immigrants, whose movement is facilitated by increasingly interconnected regions and transportation systems. However, it also allows the state to reassert its national identity against the rest of the world. Critics have shown that this law is unnecessarily harsh and unrealistic in its cost projections for certain chronically ill patients, especially those with HIV/AIDS. And since the disease is no longer considered a danger to public health, the state most likely had other motivations for crafting the law. One explanation that is consistent with fears about globalization[27], is that the Canadian government has imposed overly-strict regulations upon sick immigrants in an effort to prevent the potential dilution of its national population by outsiders.

` B. Tuberculosis in Australia

Australia has a long history of defining its national identity through the exclusion of diseased immigrants. Its status as an island-nation is important in understanding this picture: "A British (that is white) settlement in the Asia-Pacific region felt the need to assert its racial difference stridently, and constantly felt that its borders were under threat[28]." Strict "maritime quarantine practice" aimed at keeping diseases out of a continent where many of them were not endemic. Thus Australia's burgeoning national identity came to be defined in part by the absence of diseases that were common throughout the rest of the world.

Globalization has made this method even more attractive in recent years. Under the Commonwealth Migration Act (1958) Australia requires all immigrants, international students, and long-term residents to undergo screenings for several diseases, the most important of which

[27] Elinor Caplan, the Minister of Citizenship and Immigration when the law was passed, explained that globalization and access to travel would make it impossible to test everyone that passed through Canada's borders for HIV/AIDS, saying, "[w]e know that it is impossible to shrink wrap our borders." This obviously factored into the decision to only test those applying for citizenship. (Caplan qtd. In *ibid.,* 137)

[28] I. Convery et. al., "Where is the Border?: Screening for Tuberculosis in the United Kingdom and Australia, 1950–2000," *Medicine at the Border,* (Basingstoke: Palgrave Macmillan, 2007): 99

is tuberculosis.[29] Interestingly, the Australian government demands that applicants undergo the screenings in their home countries, creating another barrier to entry that extends beyond national borders. In the contemporary era, risk has begun to feature prominently in amendments to the 1958 Act: "Very high risk countries (defined by their incidence of tuberculosis) are currently (2005) listed as Algeria, Argentina, Bangladesh, Brazil, and Chile, among others.[30] Convery et. al point out that immigrants from these countries have an incredibly difficult time gaining entry, even if they are not infected. They observe that "[i]n practice...this directly affects the national (and therefore the ethnic) composition of entrants to Australia[31]."

Australia has been able to use TB to stabilize its national identity during a time when populations are constantly in flux. By categorizing over 20 countries as "very high risk," health screening procedures have become a vital way for the state to curate its ethnic makeup. Additionally, by co-opting the narrative of disease as a "global" threat, it has legitimated its legal right to enact these exclusionary policies. Although it is an island-nation, it is included under the umbrella of "global health," and is thus vulnerable to infection from other parts of the world. It is easy to argue that the Australian government, like so many others, is simply trying to protect its citizens from disease contagion. But by observing the ways in which health screenings helped produce its national identity early on, and keeping in mind how globalization has threatened this identity in the contemporary era, one can begin to see how these screenings have taken on new meaning.

C. Chagas in Europe

[29] *Ibid.,* 103
[30] The list also includes China, India, Indonesia, Korea, Malaysia, Pakistan, Papua New Guinea, the Philippines, Portugal, Russia, Serbia and Montenegro, Singapore, Sri Lanka, South Africa, Vietnam, and Zimbabwe
[31] *Ibid.,* 100

The case of Chagas in Europe reveals the vast influence that national sovereignty concerns in the era of "global health" have had upon disease perception and attitudes toward immigrants. Chagas is a parasitic disease endemic in 17 countries across Latin America.[32] It is a disease of poverty, caused by the *triatomine* insects that "live in crevices of the walls and roofs of very poor homes[33]." Since it thrives almost exclusively within poor communities, it has received very little medical or scholarly attention, and can thus be classified as a Neglected Tropical Disease (NTD). However, Chagas has been thrown into the spotlight in the last decade. In the early 2000s, political repression and economic stagnation stimulated mass migrations from endemic countries to Europe and North America.[34] Over the next few years, a substantial body of literature emerged that warned of the danger that Chagas presented to these industrialized regions. One piece that received a great deal of attention labelled Chagas as the "new HIV/AIDS of the Americas[35]." De Maio et. al point out that the spread of this kind of idea is "indicative of securitization, with Chagas coming to matter only when it was rebranded as a threat to populations in industrialized countries[36]."

One could argue that globalization and mass movement have been actually beneficial in this respect, increasing awareness of NTDs that might not have received attention otherwise. However, there are negative sides to this as well. First, there is the question that De Maio et al. have already raised: Do NTDs and other diseases of poverty only matter when they affect industrialized communities? Globalization has undoubtedly drawn attention to these kinds of

[32] G. A. Schmunis & Z. E. Yadon, "Chagas disease: A Latin American Health Problem Becoming a World Health Problem. *Acta Tropica,* Vol. 115 Ser. 1-2 (2010): 14
[33] F. G. De Maio et. al, "Chagas disease in Non-Endemic Countries: 'Sick Immigrant' Phobia or a Public Health Concern?" *Critical Public Health,* Vol. 24, No. 3, (2013): 373
[34] Schmunis & Yadon, "Chagas Disease," 14
[35] P. J. Hotez et. al, "Chagas Disease: 'The New HIV/AIDS of the Americas'," *PLoS Neglected Tropical Diseases* Vol. 6, No. 5 (2012)
[36] De Maio et. al, "Chagas Disease in Non-Endemic Countries," 376

illnesses by moving people across borders and natural boundaries. But by focusing solely on the threat that they pose to certain regions, it also risks diverting attention away from the endemic countries themselves, and the problem then becomes one of immigration. Second, this kind of attention can contribute to the "sick immigrant" phobia that has plagued the international community since the nineteenth century. In his article on Chagas in Europe, Gabriel Schmunis advocates for public health policies that will halt the spread of the disease by screening immigrants from endemic countries.[37] Alongside these policies, however, he also recommends that immigrants from endemic countries should be legally protected against discrimination based on "potential" infection.[38] Despite the public health benefits, screening immigrants from *all* endemic countries can lead to cultural perceptions of certain people as synonymous with disease and contagion. Instead of simply representing public health risks, immigrants become existential threats to entire national communities. This has already happened to a degree: Literature talks about Chagas menacing *Europe*, threatening *America*. It refers to each national community as a whole, which are defined and homogenized in this instance by their lack of the disease.

Part IV: Conclusion

While certainly not a new phenomenon, globalization has had important effects on how nations perceive and treat disease. Most significantly, it has contributed to the acceptance of "global health" as the new paradigm in international health regulation. The case studies I have discussed in this paper outline the different ways in which national governments have used this shift to reclaim their "rights" to national sovereignty and identity-building in an increasingly globalized world. In other words, globalization has produced both a problem and a solution:

[37] Schmunis & Yadon, "Chagas Disease," 13
[38] De Maio et. al, "Chagas Disease in Non-Endemic Countries," 376

Increased interconnectedness has diminished national autonomy and made it difficult for national borders to act as sites of identity-building as they had done in the past. But this same interconnectedness has led to the perception of disease as a "global" threat, arming nation-states with new medical terminology that they can use to craft new health screening laws. These laws in turn bolster autonomy by reconstituting the border's role in defining national identity.

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