ROBERTA BIVINS

CONTAGIOUS
COMMUNITIES

MEDICINE, MIGRATION, & THE NHS IN POST WAR BRITAIN

OXFORD

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Post-War Britain*

ROBERTA BIVINS

To Lisa

Acknowledgements

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List of Abbreviations

AMC	Association of Municipal Corporations
AMO	Area Medical Officer
BAME	Black, Asian, and Minority Ethnic
BMA	British Medical Association
BMJ	*British Medical Journal*
BNF	British Nutrition Foundation
BPA	British Paediatric Association
CCA	County Councils Association
CHC	Community Health Council
CIA	Commonwealth Immigrants Act
CIB	Commonwealth Immigrants Bill
CMO	Chief Medical Officer
COMA	Committee on Medical Aspects of Food Policy
CRC	Community Relations Commission
CRE	Commission for Racial Equality
CRO	Commonwealth Relations Office
DCMO	Deputy Chief Medical Officer
DHSS	Department of Health and Social Services
FAO	United Nations Food and Agriculture Organisation
GP	General Practitioner (in the NHS)
HEC	Health Education Council
HSSJ	*Health and Social Service Journal*
ISRs	International Sanitary Regulations
JAMA	*Journal of the American Medical Association*
LCC	London County Council
LHA	Local Health Authority
LSHTM	London School of Hygiene and Tropical Medicine
MAFF	Ministry of Agriculture, Fisheries and Food
MAPG	Merseyside Area Profile Group
MOH	Medical Officer of Health (pl. MOsH)
MP	Member of Parliament
MRC	Medical Research Council
NACNE	National Advisory Committee on Nutritional Education
NBTS	National Blood Transfusion Service
NHS	National Health Service
NSCACA	National Sickle Cell Anaemia Control Act (USA)
OSCAR	Organisation for Sickle Cell Anaemia Research
PKU	Phenylketonuria
PMO	Principal Medical Officer
RDCA	Rural District Councils Association
SAMO	Senior Administrative Medical Officer
SAP	Serum alkaline phosphatase
SCA	Sickle cell anaemia

SHHD   Scottish Home and Health Department
SMAC   Standing Medical Advisory Committee
STAC   Standing Advisory Committee on Tuberculosis
UDCA   Urban District Councils Association
UKTS   United Kingdom Thalassaemia Society
UN   United Nations
WHO   World Health Organization

Introduction

Medicine, Migration, and the Afterimage of Empire

'Well it's not two countries you know, it's one country...we are part of India and part of British soil as well.' With these words, thrice-migrant Londoner Maghar Singh Hunjan neatly encapsulated a fundamental characteristic of the post-imperial period: the world that empire made persisted long after its formal demise, shaping the identities, actions, and beliefs of its subjects. Countries and cultures bound together by imperial ties of trade and migration were not readily disentangled. Moreover, the habitudes formed by empire, like its institutions, endured not only in former colonies, but in the once and future imperial metropoles. Hunjan was born into the Raj, recruited to East Africa, displaced to independent India and finally settled in East London. For him, the expansive contact zones created by empire seamlessly merged geography and culture, constituting from 'India' and 'Britain' one country—a country to which he and others like him were 'belongers' by right. Borders defined by history and community trumped those prescribed by cartography and political citizenship whether rooted in *jus soli* or *jus sanguis* (birth or blood).

Other boundaries proved less easily transcended, including those mapped on and through the body itself. Rather than language, politics, or economics, it was the limits of bodily adaptability that finally tied Hunjan to Britain rather than India: 'my body [is] used to the English weather...and my lifestyle is here. I don't think I will be going back and settle because medication there doesn't fit to the people living in this country for more than 30 years.'[1] Thus, through his years of residence, Hunjan had—perhaps inadvertently—become a brown-skinned Englishman in ways unimagined by nineteenth-century imperialists: not in his 'opinions' but in his experience of embodiment.[2] *Contagious Communities* will explore the impacts on British medicine of the 'unimagined communities' founded by Hunjan and his fellow migrants on British soil, and of a global context in which Karachi, Kingston, and New Delhi served as metropoles to an English periphery, just as much as the reverse.

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[1] Maghar Singh Hunjan, interviewed by Irna Imran on 26 March 1998 *'London Voices'* http://www.museumoflondon.org.uk/archive/londonsvoices/web/interview.asp?pid=19#i1051 (accessed 30 January 2012) and used with the permission of the Museum of London.

[2] Macaulay famously argued for the creation in India of 'a class of persons Indian in blood and colour, but English in tastes, in opinions, in morals and in intellect' as 'interpreters between us and the millions whom we govern.' Thomas Babington Macaulay, 'Minute of 2 February 1835 on Indian Education', G. M. Young, *Macaulay, Prose and Poetry* (Cambridge MA: Harvard University Press, 1957), 721–4, 729.

Physical traits and bodily practices also came to define some post-war migrants in the eyes of their British hosts. In particular, British attention focused on and often conflated the bodily signs of 'race' with those of ill health and cultural difference. The Irish, European Voluntary Workers, and especially the 'dark strangers' coming to Britain from her former tropical colonies were assumed to imperil the integrity both of individual British bodies and of Britain's body politic.[3] The latter, in particular, were suspect. In the eyes of the general public and in the rhetoric of many politicians and medical professionals, such 'New Commonwealth' migrants imported certain diseases; were especially vulnerable to others; and endangered, by their visible, ineradicable *difference* (albeit from a white British norm that was only ever imaginary), the social whole on which the post-war consensus and Welfare State alike were built. Crucially, they were perceived and represented as burdening the already-prized National Health Service (NHS) and undermining the important but fragile health gains it had generated for the majority population. Still worse, the diseases with which New Commonwealth migrants became most firmly associated—tuberculosis (TB), smallpox, rickets—threatened British claims of modernity: once eradicated or at least in steep decline, all were resurgent among Britain's newcomers (or so the papers said).

This book explores the ways in which British post-war policies on migration were (and were not) medicalized. It considers how migrants themselves were perceived through their relationships—both metaphorical and material—with British medicine, health, and disease. Finally, it assesses the impact of post-colonial migration on British medical research and culture. In short, through close analysis of political and press discourse, and medical and health policy making, *Contagious Communities* begins to integrate the history of the post-war medical state with debates on immigration and race relations, tracing the ways in which British identity and the NHS became intertwined as the British nation became 'multicultural'.

In focusing on the limits, dangers, and distinctiveness of migrants' physical bodies and cultures of embodiment—their diets, hygiene, dress, and behaviours—post-war Britain continued a pattern of responses to immigration already well-established in the immigrant-receiving nations of North America, Australia, and New Zealand. Studies of medicine and migration past and present have highlighted the deep suspicion in which migrants were held, and the extent to which this suspicion was grounded on and rationalized by fears of contagion, threats to hygienic protections, racial degeneracy, and imported 'burdens of disease'. The literature is rich in accounts of what Howard Markel and Alexandra Minna Stern have called 'the foreignness of germs'. While much of this work has explored immigration to the USA, Australia, and Canada, shorter accounts have tackled a wide range of global sites.[4] Recent work, too, has highlighted the centrality of infectious disease

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[3] I take this descriptor from Sheila Patterson, *Dark Strangers: A Sociological Study of the Absorption of a Recent West Indian Migrant Group in Brixton, South London* (London: Tavistock Publications, 1963). See also Chris Waters, ' "Dark Strangers" in Our Midst: Discourses of Race and Nation in Britain, 1947–1963', *Journal of British Studies*, 36 (1997), 207–38.

[4] For instance, Howard Markel and Alexandra Minna Stern, 'The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society', *The Milbank Quarterly*, 80 (2002),

to the histories of nationalism, colonialism, internationalism, and development—as well as contemporary ideas of globalism.[5] Most of this research has focused on the first modern era of mass migration (by sea), beginning in the wake of the Irish famine and ending as the traditional immigrant-receiving nations adopted restrictive legislation, exclusionary or assimilative border controls, and quarantine regimes in the early decades of the twentieth century. Across nations and migrant groups, this literature demonstrates the ways in which portrayals of migrants as vectors of disease (and madness) provided a 'scientific alibi' for discrimination and anti-immigrationism.[6] A handful of studies, including Markel and Stern's essay, Alison Bashford's work on Australia, and Nayan Shah's influential study of San Francisco's Chinese community have confirmed the persistence of such links between migration and contamination up to the mid-century. Historians have written far less about the relationship between health, disease, and perceptions of migration and migrants in the second half of the twentieth century, especially in the UK.[7] While some British scholars (particularly of empire) examining the

757–88. For a small sample of case studies and examples: Emily Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (London: Rutgers University Press, 2007); Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Basingstoke: Palgrave Macmillan, 2003); Amy Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: Johns Hopkins University Press, 2003); Alan Kraut, *Silent Travelers: Germs, Genes and the Immigrant Menace* (London: Johns Hopkins University Press, 1994); Eithne Luibheid, *Entry Denied: Controlling Sexuality at the Border* (London: University of Minnesota Press, 2002); Laura Madokoro, '"Slotting" Chinese Families and Refugees, 1947–1967', *Canadian Historical Review*, 93 (2011), 25–56; Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (London: Johns Hopkins University Press, 1997); Lara Marks and Michael Worboys (eds), *Migrants, Minorities and Health: Historical and Contemporary Studies* (London: Routledge, 1997); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); Barrington Walker (ed.), *The History of Immigration and Racism in Canada* (Toronto: Canadian Scholar's Press, 2008). For reflections in relation to contemporary concerns: Charles T. Adeyanju and Nicole Neverson, '"There Will Be a Next Time": Media Discourse about an "Apocalyptic" Vision of Immigration, Racial Diversity, and Health Risks', *Canadian Ethnic Studies*, 39 (2007), 79–105; Nick King, 'Security, Disease, Commerce: Ideologies of Post-Colonial Global Health', *Social Studies of Science* 32 (2002), 763–89; Nancy Tomes, 'Public Health Then and Now: The Making of a Germ Panic, Then and Now', *American Journal of Public Health*, 90 (2000), 191–8.

[5] Alison Bashford, '"The Age of Universal Contagion": History, Disease and Globalization', in Alison Bashford (ed.), *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* (Basingstoke: Palgrave, 2006), 1–17 at 1. Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–65* (Basingstoke: Palgrave Macmillan, 2006).

[6] Shah, *Contagious Divides*, 161; see also Krista Maglen, 'Importing Trachoma: The Introduction into Britain of American Ideas of an "Immigrant Disease", 1892–1906', *Immigrants & Minorities*, 23 (2005), 80–99; on migrant mental health, see Alison Bashford, 'Insanity and Immigration Restriction', in Catherine Cox and Hilary Marland (eds), *Migration, Health and Ethnicity in the Modern World* (Basingstoke: Palgrave Macmillan, 2013), 14–35; Catherine Cox, Hilary Marland, and Sarah York, 'Itineraries and Experiences of Insanity: Irish Migration and the Management of Mental Illness in Nineteenth Century Lancashire', in Cox and Marland, *Migration, Health and Ethnicity*, 36–60; Angela McCarthy and Catherine Coleborne (eds), *Migration, Ethnicity and Mental Health, International Perspectives, 1840–2012* (London: Routledge, 2012).

[7] Note, however, David Feldman, 'Migrants, Immigrants and Welfare from the Old Poor Law to the Welfare State', *Transactions of the Royal Historical Society*, Sixth Series, 13 (2003), 79–104 at 96–104; Joanna Herbert, *Negotiating Boundaries in the City: Migration, Ethnicity and Gender in Britain* (Aldershot: Ashgate, 2008); Anne MacClellan, 'Victim or Vector? Tubercular Irish Nurses in England 1930–1960,' in Cox and Marland, *Migration, Health and Ethnicity*, 104–25; and John Welshman (see n. 8). See also

post-war period have noted the rhetorical fusion of race with abiding anxieties about degeneracy, dirt, and disease, only John Welshman has focused on race and immigration through a medical lens.[8] *Contagious Communities* will bridge this gap, asking how the ideas and ideals of the post-war Welfare State have played out in terms of political and practical responses to the key challenges of racialized migration and medicalized embodiment.

In some cases, mass migration had direct and immediate implications for British public health and medical research. As subsequent chapters will illustrate, many migrant groups, both 'white' and 'black', experienced higher rates of tuberculosis than the majority population. Some were also strongly associated with the importation of smallpox—one of the few 'imported' illnesses that produced any direct impact on the health of the indigenous British public. Other migrant groups and their descendants experienced distinctive patterns of nutritional deficit; and only with the settlement of certain communities did once-rare genetic conditions become relevant and accessible to UK-based practitioners and researchers. However, the challenges faced by migrants and the society into which they entered were also often described and configured in medical terms, the presence of obvious social and economic roots notwithstanding. Consequently, efforts to restrict immigration were often rhetorically linked to claims about migrant pathogenicity, despite considerable evidence that most immigrants were hale and that enclavism limited the circulation of any 'imported' disease. Similarly, responses to tuberculosis among migrants focused on screening, surveillance, and medical interventions, rather than improving appalling living conditions and low socioeconomic status. Nutritional disorders, too, might be linked to poverty or inadequate access to necessary amenities—but were consistently investigated in relation to biological differences or distinctive cultural practices.

Responses to the association between migrants and infectious diseases were also shaped by another crucial problem: national responses to migration and to the migrants themselves took place in an intensely international context, shaped both by Cold War politics and by increasingly global scrutiny of what the British termed 'race relations'. Yet as Alison Bashford has pointed out, persistent conflations of 'race' and 'contagion' notwithstanding, epidemiological data throughout the post-war period also confirmed marked differences in health between the populations of the

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John Eade, 'The Power of the Experts: the Plurality of Beliefs and Practices Concerning Health and Illness among Bangladeshis in Contemporary Tower Hamlets, London', in Marks and Worboys, *Migrants, Minorities and Health*, 250–71.

[8] John Welshman, 'Importation, Deprivation, and Susceptibility: Tuberculosis Narratives in Post-war Britain', in Flurin Condrau and Michael Worboys (eds), *Tuberculosis Then and Now: Perspectives on the History of an Infectious Disease* (London: McGill-Queen's University Press, 2010), 123–47; John Welshman, 'Compulsion, Localism, and Pragmatism: The Micro-Politics of Tuberculosis Screening in the United Kingdom, 1950–1965', *Social History of Medicine*, 19 (2006), 295–312; John Welshman, 'Tuberculosis, "Race", and Migration, 1950–70', *Medical Historian: Bulletin of Liverpool Medical History Society*, 15 (2003–04), 36–53; John Welshman, 'Tuberculosis and Ethnicity in England and Wales, 1950–70', *Sociology of Health & Illness*, 26 (2000), 858–82; Ian Convery, John Welshman, and Alison Bashford, 'Where is the Border? Screening for Tuberculosis in the United Kingdom and Australia, 1950–2000', in Bashford, *Medicine at the Border*, 97–115.

global South, and those of the global North.[9] Contagion followed the perceived global 'colour line': rates of infectious disease were (and remain) markedly higher in the regions from which racialized migrants came than in the areas to which they migrated. In political terms, this fact was sometimes convenient, but it was also awkward. As this volume will argue, the prominence of race discourse in the Cold War struggle for 'hearts and minds' in the non-aligned developing world made even epidemiologically-based port and public health measures politically sensitive if they affected solely or even predominantly non-white populations. In the specifically British context of decolonization, they were also perceived as threatening to the Commonwealth on which many of Britain's post-war claims to international influence were based.[10] Such concerns have implications, too, for the writing of history; while it is imperative to recognize the material, epidemiological, and environmental constraints and conditions under which all parties operated, it is equally essential to avoid reinforcing the abiding association between immigration and infection, and to recognize the generally good health in which most migrants arrive at their destinations.

'COLOUR', 'RACE', AND 'ETHNICITY': TERMS AND TERRAINS

Conceptions of race as biological have been central to models of identity and belonging throughout the western world in the twentieth century, as in the nineteenth. They played a very visible role in shaping immigration policy in the USA and in Britain's colonies (and later, dominions).[11] The intentional or accidental conflation of race and health in the construction and application of border medical controls was (and remains) common among migrant-selecting nations.[12] In Britain,

[9] Alison Bashford, 'The Great White Plague Turns Alien: Tuberculosis and Immigration in Australia, 1901–2001', in Condrau and Worboys, *Tuberculosis Then and Now*, 100–22 at 115–17.

[10] See also Nick King, 'Immigration, Race and Geographies of Difference in the Tuberculosis Pandemic', in Matthew Gandy and Alimuddin Zumla (eds), *Return of the White Plague: Global Poverty and the New Tuberculosis* (London: Verso Press, 2003), 39–54. On Britain and the Commonwealth, see Chapters 1–2, and Jim Tomlinson, 'The Empire/Commonwealth in British Economic Thinking and Policy', in Andrew Thompson (ed.), *Britain's Experience of Empire in the Twentieth Century* (Oxford: Oxford University Press, 2011), 211–50 at 220–33.

[11] In addition to the studies of migration already listed, see Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (Durham, NC: Duke University Press, 2006); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006); Natalia Molina '"In a Race All Their Own": The Quest to Make Mexicans Ineligible for U.S. Citizenship', *Pacific Historical Review*, 79 (2010), 167–201; Alexandra Minna Stern, 'Buildings, Boundaries, and Blood: Medicalization and Nation-Building on the U.S.–Mexico Border, 1910–1930', *The Hispanic American Historical Review*, 79 (1999), 41–81.

[12] See nn. 6–9, and Renisa Mawani, 'Screening out Diseased Bodies: Immigration, Mandatory HIV Testing and the Making of a Healthy Canada' in Bashford, *Medicine at the Border*, 136–58; Renisa Mawani, '"The Island of the Unclean": Race, Colonialism and "Chinese Leprosy" in British Columbia, 1891–1924', *Journal of Law, Social Justice and Global Development*, 1 (2003), 1–21.

both Jewish and Irish migrants were at times racialized and medicalized, alongside more obvious (to us) targets including the Chinese and the many ethnic groups together designated 'lascar seamen'.[13]

Here, I argue that in mid- and late twentieth-century Britain, too, interactions between health status and racial identity have influenced debates about in-migration. Eventually, a stable dichotomy became established, associating health with European or 'Old Commonwealth' origins, and illness and contagion with origins in the tropical world. However, this binarism emerged only gradually from a far less distinct picture in which class, occupation, and gender played equally important roles in shaping perceptions of migrants' place in the hierarchies of health and risk.[14] Professional and policy responses to New Commonwealth immigrants and Hungarian refugees in the 1950s, and to British Cypriot and Black British communities in the 1970s and early 1980s reveal the changing perceptions and effects of such intersectionality over time, and in relation to international developments including the Cold War and the US civil rights movement.

As immigrants marked out by 'racial' characteristics became residents, then citizens, and finally the pioneering settlers of established multi-generational communities, simple elisions of race and disease were further complicated by questions of acculturation and 'assimilability'.[15] In this context, the emergence of 'ethnicity' as the language of choice for health professionals and policy makers from the late 1960s to the present was not just a reflection of inter- and post-war anxieties about racism and the appearance of racism—although it was certainly boosted by them.[16] It also reflected emerging doubts about the plasticity of 'culture' and in particular the cultural practices that shape and constrain embodiment: matters of diet, dress, hygiene, physical activity, reproductivity. Thus, following the lines that Megan Vaughan and Peter Wade have delineated for colonial South Africa and colonial and contemporary Latin America respectively, post-war British descriptions and assumptions about 'race' were tied to and infused with conceptions

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[13] See for a masterful but concise summary of a rapidly expanding literature, Laura Tabili, 'A Homogenous Society: Britain's Internal "Others", 1800–Present', in Catherine Hall and Sonya Rose (eds), *At Home with the Empire: Metropolitan Culture and the Imperial World* (Cambridge: Cambridge University Press, 2006), 53–76; also Feldman, 'Migrants, Immigrants and Welfare'; Marjory Harper and Stephen Constantine, *Migration and Empire* (Oxford: Oxford University Press, 2010), especially Chapter 7; Colin Holmes, *John Bull's Island: Immigration and British Society* (Basingstoke: Macmillan, 1988); Andrew Thompson, 'Afterword: The Imprint of Empire' in Thompson, *Britain's Experience of Empire*, 330–45; Rozina Visram, *Asians in Britain: 400 Year of History* (London: Pluto Press, 2002), especially Chapters 7–9; Waters, ' "Dark Strangers" in Our Midst'.

[14] See Lousie Ryan and Wendy Webster (eds), *Gendering Migration: Masculinity, Femininity and Ethnicity in Post-war Britain* (Aldershot: Ashgate, 2008); Wendy Webster, *Imagining Home: Gender, 'Race' and National Identity* (London: UCL Press, 1998).

[15] Gavin Schaffer, *Racial Science and British Society, 1930–62* (Basingstoke: Palgrave Macmillan, 2008). Schaffer has recently argued that models and understandings of 'race' became increasingly the domain of the social rather than the biological science in the years after 1950—a flow which Lundy Braun argues is now, once again, reversing as molecular genetics becomes a dominant explanatory mode. See Lundy Braun, 'Race, Ethnicity, and Health: Can Genetics Explain Disparities?', *Perspectives in Biology and Medicine*, 45 (Spring 2002), 159–74.

[16] David Kelleher, 'A Defence of the Uses of the Terms "Ethnicity" and "Culture" ', in David Kelleher and S. M. Hillier, *Researching Cultural Differences in Health* (Abingdon: Taylor & Francis Routledge, 2002), 69–90.

of 'culture' and 'civilisation'.[17] In this, they followed the established precedents of colonial medicine.

'Race' in the wake of the Second World War and during the Cold War was a hotly contested and politically sensitive term and concept, indelibly marked by the horrors of the Holocaust. A previous generation of scholarship, both in the sciences and the humanities, argued that the notion of fixed biological race was, if not eliminated, at least in sharp decline in the post-war period.[18] However, more recent work in the history and social studies of science, medicine, and technology has explored the degree to which 'race' persisted as a valued category in biomedical research (and indeed the wider culture).[19] Certainly 'race'—or 'colour', as it was also commonly termed between 1948 and the mid-1960s—remained (and remains) a key variable and interpretive category in medical research, practice, and public health. In the medical and scientific literature analysed here, explicitly racial terminology was often replaced by the language of 'populations' and 'ethnic groups'. Nonetheless, the presumed existence of distinctive and identifiable biological groups broadly recognizable by the old racialized traits of skin colour, hair colour and texture, and a shifting but familiar palette of other biological and temperamental characteristics survived. And as a plethora of scholars have argued, they are once again in the ascendant as markers of identity and as viable biomedical categories, particularly through the new discourses of genomics on one hand and 'personalised medicine' on the other.[20] Thus professional and political responses to the racialized genetic conditions sickle cell anaemia and thalassaemia from the late 1960s onwards prefigure and resonate strongly with David Skinner's cautionary assessment of contemporary 'biologism' in contemporary discussions of race.[21]

Forging a language through which to discuss different concepts of race, and the different groups to whom those concepts were applied is a significant challenge for any scholar writing about the late twentieth century. Like 'race' itself, and like the terminology used to designate particular human populations, the terms with which communities and individuals choose to identify are fluid and highly emotive. They

[17] Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, (Palo Alto, CA: Stanford University Press, 1991), especially Chapter Two; Peter Wade, 'The Presence and Absence of Race', *Patterns of Prejudice*, 44 (2010), 43–60.

[18] See Elazar Barkan, *The Retreat of Scientific Racism: Changing Concepts of Race in Britain and the United States Between the World Wars* (Cambridge: Cambridge University Press, 1992); Richard King, *Race, Culture and the Intellectuals, 1940–1970* (Baltimore: Johns Hopkins University Press, 2004); Nancy Stepan, *The Idea of Race in Science: Great Britain 1800–1960*, (London: Macmillan, 1982).

[19] E.g. Braun, 'Race, Ethnicity and Health'; Marek Kohn, *The Race Gallery: the Return of Racial Science* (London: Jonathan Cape, 1995); Jennifer Reardon, *Race to the Finish: Identity and Governance in an Age of Genomics* (Princeton: Princeton University Press, 2004); Shaffer, *Racial Science and British Society*; William Tucker, *The Funding of Scientific Racism: Wickliffe Draper and the Pioneer Fund* (Urbana: University of Illinois Press, 2002).

[20] Brian Beaton has usefully reviewed a growing literature in 'Racial Science Now: Histories of Race and Science in the Age of Personalised Medicine', *Public Historian*, 29 (2007), 157–62; see also Troy Duster, 'The Medicalisation of Race', *Lancet* (2007), 702–4; Elizabeth Phillips, Adebola Odunlami, and Vence Bonham, 'Mixed Race: Understanding Difference in the Genome Era', *Social Forces*, 86 (2007), 795–820.

[21] David Skinner, 'Racialized Futures: Biologism and the Changing Politics of Identity', *Social Studies of Science*, 36 (2006), 459–88.

vary in different national and regional cultures, and particularly over time. Thus in a volume like this one, traversing decades punctuated by the landmarks of significant change in attitudes towards personal, group, and national identity, a wide variety of terms necessarily appear. At different moments between the late 1940s and the early 1990s, racialized migrants were homogenized as 'coloured', 'Negro', and 'black'. They and their descendants were called 'immigrants', 'New Commonwealth immigrants', and later 'Black British'. Less generically, from the late 1950s, many migrant groups were differentiated by their (assumed) global regions of origin. At this point, categories like 'West Indian', 'Asian', 'African', and less commonly 'Mediterranean' were seen by the naming classes—politicians, policy makers, media commentators, and medical professionals—as more accurately representative of the differences between such large and internally fragmented groups. This approach ignored the extent to which intra-imperial labour (free, indentured, and forced) mobility had already dispersed and intermingled its subject populations.[22] National origins too came into use, as the evident importance of differentiating between Indians and Pakistanis (in particular, due to the political and nationalist sensitivities of both nations), or for example, Jamaicans and Bajans became better known. The major immigration crises triggered in the late 1960s and early 1970s by the 'Africanization' policies of the newly established states of Kenya and Uganda also introduced the term 'East African Asians' or simply 'African Asians' to describe these exiled communities. Today, abbreviations like BAME (Black, Asian, and minority ethnic) attempt to acknowledge the diversity of these populations while capturing certain shared aspects of their experiences in the UK. All of these actors' terms will appear here. All were deeply imbued with assumptions about the race of the groups so identified, and thus represent to a greater or lesser degree the twinned phenomena of racialization and 'othering'. None can be accepted as neutral or merely factual. My goal here is to recognize and assess attitudes towards populations and individuals who were considered, between 1948 and 1991, to be physically, medically or culturally distinctive migrants to Britain, without reifying the assumptions which underpinned them. On the other hand, to avoid a distracting blizzard of punctuation, I will only set off such contemporary designations—like the term 'race' itself—where necessary for clarity, rather than to indicate at each occasion that the categories and relationships they denote remain are contested, contingent, and far from transparent. In particular, while I will use the terms 'South Asian' and West Indian' where my sources do not allow greater precision, I recognize that these are artificial categories, and do not necessarily reflect the self-defined or experienced identities of the diverse populations subsumed under them for the sake of administrative convenience.[23]

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[22] See Harper and Constantine, *Migration and Empire*, Chapter 6 for an introduction to this topic; Clare Anderson, *Biographies of Colonialism in the Indian Ocean, 1790–1920* (Cambridge: Cambridge University Press, 2012) offers a more detailed perspective, often through the eyes of those subject to penal transportation.

[23] Indeed many migrants have described their 'discovery' of a shared West Indian or 'Asian' identity only after arriving in the UK. See Webster, 'The Empire Comes Home', 149–50; David Ellis, '"The Produce of More than One Country": Race, Identity and Discourse in Post-Windrush Britain', *Journal of Narrative Theory* (*JNT*), 31 (2001), 214–32.

The ways in which three other migrant groups were identified is also worth brief consideration under this heading. European migrants and refugees, who play only a small part in my story despite their prominence in the immediate post-war period, were commonly labelled 'European Voluntary Workers' (EVWs). Alternatively, they were identified by their nationalities, and occasionally as 'refugees', a term which was also favoured in relation to Hungarians fleeing from the collapse of the Revolution of 1956. Nationals of Eire, like the residents of the UK 'Home Nation' Northern Ireland, were usually identified simply as 'Irish'. When a distinction between these two populations was required, formal documents and those produced by the state for public consumption might use the term 'nationals of Eire'; more casually, 'Southern Irish' was the norm. Finally, in the 1960s and 1970s, migrants from Britain's Mediterranean territories Malta and Cyprus presented a particular linguistic challenge: sometimes they were classed as 'white', sometimes as 'Mediterranean' and sometimes as 'coloured'. In recognition of their ambivalent racial status, they too were usually identified by their nationalities.

It was the post-war disciplines of sociology and anthropology that pioneered, tested, (and usually discarded) these terms first. In *The Afterlife of Empire*, Jordanna Bailkin has ably explored the '"birth" of the immigrant in social science' and the 'psy' disciplines.[24] As Bailkin has shown, this 'migrant', perhaps especially in Britain, was forged in the embers of imperial and pre-war (often eugenically influenced) physical anthropology, and then defined and captured by psychiatry, psychology, psychoanalysis, sociology, and social anthropology. The state and the media alike recirculated what became increasingly doom-laden visions of post-war migration; so too did the general medical profession. Medical experts, in contrast, often refined or rejected some aspects of social scientific research, while embedding others in the many assumptions which all too often served to replace consultation with migrants themselves.

ASSIMILATION, INTEGRATION, AND 'HYGIENIC CITIZENSHIP'

Soon after their arrival in Britain's cities, many migrants encountered another facet of responses to their presence: efforts aimed at their assimilation, integration, and later, under the remit of 'multiculturalism' a more limited—but still normative— agenda of incorporation into a fluid but supposedly singular 'national culture'.[25]

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[24] Jordanna Bailkin, *The Afterlife of Empire* (Berkeley: University of California Press, 2012), 18. See Chapter 1; 'psy' is defined at 33.

[25] On 'multiculturalism' in Europe, see Riva Kastoryano, 'Negotiations beyond Borders: States and Immigrants in Postcolonial Europe', *Journal of Interdisciplinary History*, 41 (2010), 79–95. Kastoryano also explores the emerging phenomenon of 'transnationalism': 'A transnational organization allows immigrant populations to escape national policies. But transnational networks linking the country of origin to the country of residence and promoting participation in both locations also challenge the single allegiance required by membership in a nation's political community. Transnationalism has led to an institutional expression of multiple belonging, in which a country of origin becomes a source of identity; a country of residence, a source of right; and the transnational space, a site of political action'

Underpinning each of these responsive modes were prescriptive models of British embodiment. Just as Shah has illustrated in relation to mid-century San Francisco's Chinese Americans, in Britain under the Welfare State, medical and public health services were recruited as primary mediators, interpreters, and indeed potential levellers of bodily difference.[26] Linking these medicalized responses to immigrant bodies and practices of embodiment is the idea of 'hygienic citizenship', carefully explored by Warwick Anderson, Alison Bashford, and others.[27] Much of this work has been situated in colonial contexts rather than in the metropoles; however, as Fairchild, Shah, and Stern have documented, migrants too have been expected to earn their places through conformity to the dominant culture's hygienic expectations. Such expectations and pressures intensified in Britain, where the migrants themselves were identified with an unwelcome domestication of colonialism's 'civilizing mission', just as empire itself was receding. For (New) Commonwealth migrants to Britain in the second half of the twentieth century, compliance with medical surveillance measures and the adoption of certain practices of self- or family surveillance were added to earlier models of hygiene that incorporated everything from toilet habits to compliance with domestic standards not just of cleanliness but of 'tidiness'—the maintenance of the cosmetic appearance of shared and even private amenities. Untoward sights, unwanted sounds, and unfamiliar smells—repeatedly, the smell of curry—could trump even the most meticulous conformity to community ideals (certainly not norms) of personal hygiene, as illustrated for example, by a noisy discourse of complaint about cooking odours, loud parties, and backyard litter.[28]

In interpreting British responses to the medical impacts of postcolonial immigration, gender and age, as well as race and ethnicity, are important variables. Thus while both male and female migrants from the New Commonwealth were construed as posing threats both to individual British bodies, and to the body politic, the nature of those threats was very different. Male South Asian and especially Pakistani migrants were closely associated with infection—single male workers were blamed both for spreading TB within their own, and smallpox to the majority community. On the other hand, as migrants became settlers, public and policy responses positioned female migrants as threatening the body politic through their uncontrolled fertility and their failed maternity, as represented both by genetic and nutritional disorders among their children. Female Pakistani and Indian migrants were also seen as a vector of incomplete modernity, and blamed for reproducing foreign and anti-modern behaviours among their children.

(at 95). On 'national culture' see David A. Hollinger, 'National Culture and Communities of Descent', *Reviews in American History*, 26 (1998), 312–28; Tariq Modood, *Multicultural Politics: Racism, Ethnicity and Muslims in Britain* (Minneapolis: University of Minnesota Press, 2005).

[26] Shah, *Contagious Divides*, Chapters 4, 8, and 9. See also Bailkin, *Afterlife of Empire*, on the Welfare State itself.

[27] See Anderson, *Colonial Pathologies* 180–207; Bashford, *Imperial Hygiene*, 79–80.

[28] Shah shows the deep history of this trope of disgust at the unfamiliar smells of 'exotic' foodstuffs, which was expressed just as explicitly by those missionizing Chinatown in the early twentieth century. Shah, *Contagious Divides*, 116–18. On curry see Elizabeth Buettner, ' "Going for an Indian": South Asian Restaurants and the Limits of Multiculturalism in Britain', *Journal of Modern History*, 80 (2008), 865–901.

Geography too played a role: the story of postcolonial migration and medicine in this period is principally English and urban, since it was to London and England's largest industrial conurbations that most migrants moved. Scottish responses to immigration, building on a different tradition of public health as well as the smaller scale of the inward movement, leaned towards active intervention, a difference that would eventually produce professional tensions and policy differences within the wider British response.[29] Wales and Northern Ireland attracted comparatively small numbers of New Commonwealth migrants from the 1950s through the early 1990s. The migrants themselves came from a wide range of backgrounds, climates, and settings; their (often presumed) urban or rural origins in particular affected how they were perceived, and the type of threats attributed to their presence.

MEDICINE AND MIGRATION IN THE POST-COLONIAL ERA

For post-imperial Britain, migration became empire's enduring afterimage, simultaneously inverting and perpetuating the assumptions of colonialism, and in the process destabilizing understandings of Britishness itself.[30] This was no less true for medicine than for other hegemonic cultural endeavours—indeed, it may have been even more true: parts of the medical civil service in particular were awash with a returning professional diaspora, dislodged by the end of empire.[31] Yet the post-colonial history of migration to the UK is still a minor, if a growing literature, in the wider fields both of late twentieth-century history, and of migration and ethnicity studies. It is overshadowed by the expansive body of scholarship addressing the USA on one hand and nineteenth-century immigration, on the other. Those histories which do consider post-war migration to Britain have until recently largely ignored the period's rich discourse linking migration and disease, dismissing

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[29] On the distinctive and often more interventionist approach in Scotland, see Roger Davidson, 'A Scourge to be Firmly Gripped': The Campaign for VD Controls in Interwar Scotland', *Social History of Medicine*, 6 (1993), 213–35; Martin Gorsky, ' "Threshold of a New Era": The Development of an Integrated Hospital System in Northeast Scotland, 1900–39', *Social History of Medicine*, 17 (2004), 247–67; Morrice McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900–1950* (East Linton: Tuckwell Press, 2003); David F. Smith and Malcolm Nicholson, 'Chemical Physiology Versus Biochemistry, the Clinic Versus the Laboratory: The Glaswegian Opposition to Edward Mellanby's Theory of Rickets', *Proceedings of the Royal College of Physicians of Edinburgh*, 19 (1989), 51–60; Charles Webster, *The Health Services Since the War*, Vols I and II (HMSO, London, 1988–96).

[30] For wider discussion, see Bill Schwarz, *The White Man's World* (Oxford: Oxford University Press, 2011); Thompson, *Britain's Experience of Empire*; Webster, *Englishness and Empire*; Webster, *Imagining Home*.

[31] Little has been written on the effects of this returning group in medicine or in other fields; Anthony Kirk-Greene, 'Decolonization: The Ultimate Diaspora', *Journal of Contemporary History*, 36 (2001), 131–51, has done important preliminary work documenting the postcolonial second careers of returning civil servants. Bill Schwarz hints at the political impacts of such returnees in *White Man's World*. I have also written briefly about this subject in Roberta Bivins, 'Coming "Home" to (Post)Colonial Medicine: Treating Tropical Bodies in Post-War Britain', *Social History of Medicine*, 26 (2013), 1–20.

the widely expressed contemporary concerns with these topics as mainly rhetorical. Instead, authors have focused intently on expressions and experiences of racism; changing models of citizenship in the wake of imperial decline and decolonization; and cultural responses to the migrants and the emergence of a 'multiracial' Britain.[32] In contrast, *Contagious Communities* focuses specifically on discourse, policies, and practices that represented and responded to migrant bodies as pathological, pathogenic, or vulnerable.

I argue that the history of postcolonial migration in Britain—the inward movement of population from Britain's colonies, former colonies, and New Commonwealth—is intricately intertwined with ideas and experiences of health and disease, and with the history of the NHS and public health in the post-war Welfare State. Medical and political responses to the migrants reflected the deeply embedded traditions and attitudes—about race, 'civilization', and health—of colonial medicine. At the same time, they were shaped by a vision of national modernity expressed through a medical state, which was both universally accessible and universally participatory. In other words, the post-war consensus predicated health(care) as both the marker and the earned reward of active citizenship.

It is only a striking coincidence that the arrival of the Empire Windrush and its 492 Jamaican passengers—popularly construed as launching the era of mass Commonwealth in-migration and multicultural Britain—preceded the NHS Appointed Day by less than a month. Yet, taken together, these events neatly bring into conjunction the 'push' and 'pull' factors of the era's mass migrations, its key actors, and a crucial site both of their agency and their disempowerment, the NHS. Certainly, there was nothing coincidental at all in a pattern of immigration legislation tailored around, among other economic factors, the Service's manifest dependency on colonial and post-colonial labour recruitment. The advent of the NHS, with its promise of free access to a complete medical service, released a tidal wave of pent-up medical need, and shone a spotlight on the complete inadequacy of existing systems to meet that need. By the early 1950s, it was clear that the NHS was stretched to the limit under its formidable burden of antiquated and bombed-out hospital stock, and inadequate supplies of increasingly high-tech professional equipment. But the greatest challenge lay in Britain's limited facilities for training

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[32] As well as historical depictions of British racism and racialism, both popular and political, there are many first-hand accounts. Colin Holmes, *John Bull's Island: Immigration and British Society, 1871–1971* (London: Macmillan, 1988) is a strong general introduction. Herbert, *Negotiating Boundaries in the City* offers an accessible entry point and extensive bibliography of the growing literature exploring the Asian experience in Britain, as well as an innovative attempt to assess the origins of white working class racism. Mary Chamberlain, *Family Love in the Caribbean: Migration and the Anglo Caribbean Experience* (New Brunswick: Transaction Publishers, 2006) and Karen Fog Olwig, *Caribbean Journeys: An Ethnography of Migration and Home in Three Family Networks* (Durham, NC: Duke University Press, 2007) do similar work with Caribbean examples. On race and citizenship, see the sharply contrasting accounts of Kathleen Paul, *Whitewashing Britain: Race and Citizenship in the Postwar Era* (Ithaca: Cornell University Press, 1997); and Randall Hansen, *Citizenship and Immigration in Post-War Britain: The Institutional Origins of a Multicultural Nation* (Oxford: Oxford University Press, 2000). Hall and Rose, *At Home with Empire*; Thompson, *Britain's Experience of Empire*; and Webster, *Englishness and Empire* all present valuable starting points for examining the impact of immigration on British culture.

healthcare staff of all descriptions, from specialist consultants to general practitioners to nurses, medical social workers and health visitors. As all sides recognized, Aneurin Bevan's promises could be redeemed only if NHS access to professional and skilled migrant labour continued unimpeded. Moreover, in a period of near-full employment, the intimate, dirty, and low-paid work supporting the edifice and practices of modern medicine—cleaners, carers, and manual workers—could not attract indigenous British labour. Unskilled, or de-skilled labour too was essential.[33]

Paradoxically, however, migration was simultaneously imagined as a threat to the very institutions in which so many migrants provided essential services. I will argue here that in the minds of many Britons, the NHS represented more than a national commitment to health equity, more than a safety net against the bitterly remembered unfairness of the pre-war period. Its success, and the parallel achievements of public health services and campaigns, in reducing unnecessary and premature mortality and alleviating morbidity across the entire British population was a prized symbol of Britain's national status and modernity. The decline of tuberculosis among the indigenous British population was an especially cherished sign of progress—and one seen as particularly threatened by immigration. Local, regional, and national governments in Britain and global bodies like the United Nations (UN) and the World Health Organisation (WHO) were united in assuming that migrants from the less developed nations of the New Commonwealth would impose greater health costs and risks, particularly of infectious disease on developed host nations. Moreover, they expected the migrants to be less willing or able to comply with the demands of modern public health. Politicians, the public, and many in the medical profession volubly attributed a range of imported infections, bodily vulnerabilities, and moral or hygienic failures to the migrants. Thus pathologized,

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[33] As well as Charles Webster's magisterial (political) *History of the Health Services since the War*, the history of the NHS has been detailed in numerous accounts. The three most widely available are Rudolph Klein, *The New Politics of the NHS*, 6th edn (Milton Keynes: Radcliffe Publishing, 2010); Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London: Kings Fund Publishing, 1998) (and his regularly updated website http://www.nhshistory.net) and Charles Webster, *The National Health Service: A Political History*, 2nd rev edn (Oxford: Oxford University Press, 2002). Both Rosemary Stevens and Martin Gorsky have reviewed this expansive and disputatious literature, with slightly different results: see Rosemary Stevens, 'Fifty Years of the British National Health Service: Mixed Messages, Diverse Interpretations', *Bulletin of the History of Medicine*, 74 (2000), 806–11; Martin Gorsky, 'The British National Health Service 1948–2008: A Review of the Historiography', *Social History of Medicine*, 21 (2008), 437–60 Although richly attested in the pages of Hansards, and in the records of the Ministry of Health, accounts of migrants' contributions to the NHS are thinner on the ground; for doctors, see Aneez Esmail, 'Asian Doctors in the NHS: Service and Betrayal', *British Journal of General Practice*, 57 (2007), 827–31; Christopher Kyriakides and Satnam Virdee, 'Migrant Labour, Racism and the British National Health Service', *Ethnicity and Health*, 8 (2003), 283–305; Parvati Raghuram, Joanna Bornat, and Leroi Henry, 'The Co-marking of Aged Bodies and Migrant Bodies: Migrant Workers' Contributions to Geriatric Medicine' in Julia Twigg, Carol Wolkowitz, Rachel Cohen, and Sarah Nettleton (eds), *Body Work in Health and Social Care: Critical Themes New Agendas* (Oxford: Blackwell, 2011), 147–61; David Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980). For nurses, see Louise Ryan, 'Who do you Think you are? Irish Nurses Encountering Ethnicity and Constructing Identity in Britain', *Ethnic and Racial Studies*, 30 (2007), 416–38; Linda Ali, *West Indian Nurses and the National Health Service in Britain 1950–1968* (PhD thesis, University of York, 2001) In contrast, see Jessica Howell, 'Nursing Empire: Travel Letters from Africa and the Caribbean', *Studies in Travel Writing*, 17 (2013), 62–77.

their presence was constructed as endangering both the health improvements British 'natives' had earned through their wartime efforts, and Britain's already fragile standing among the world's leading nations.

Approaches to the intersections of medicine and migration in the context of mid- and late twentieth-century Britain have largely focused either on imported, often exotic, 'burdens of disease' or on racially-linked domestic (or border-crossing) 'health inequalities'.[34] While these dominant tropes remain central to this volume as well, it also highlights the much greater diversity of lenses through which the medical impacts of migration were interpreted by medical professionals, politicians, civil servants, the press, and the general public. Migrants and the multi-generational communities they nucleated in Britain were understood as cancers, as 'colonies'— both political and bacterial—and as resources, particularly for leading-edge medical research and the mundane servicing of the NHS. At the same time, they were, as one medical author put it in 1965, the 'intravenous radioactive isotope, showing up blockages and points of strain in our society'—a role which they certainly serve in this volume.[35]

In no small part, this diversity of conceptions reflects the increasing variety of medical models through which migrants' bodies, capacities, and needs could be read. The 'medical gaze', eugenics, and microbiology—the biomedical tools which dominated efforts to identify, contain, and control the 'immigrant menace' from the late nineteenth through the early twentieth centuries—remained important. But these approaches were joined by epidemiology, biochemistry, and molecular genetics. To capture this shift, and the ways in which new and established modes of interpreting immigrant embodiment interacted in late twentieth-century Britain, *Contagious Communities* explores reactions to post-war immigration through a series of different diseases and conditions, all associated closely with particular migrant and ethnic groups.

Two of these are classic 'port health' diseases, contagious and readily communicable. Once the archetypal 'disease of civilization', devastatingly exported from industrial cities to tropical colonies, tuberculosis became the model 'immigrant' illness in this period.[36] Familiar enough to be fearsome, tuberculosis was—after massive wartime public health efforts and with the discovery of antibiotics— seemingly on the verge of eradication among the majority community. Yet this

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[34] See Waquar I. U. Ahmad (ed.), *'Race' and Health in Contemporary Britain* (Buckingham: Open University Press, 1993); Raj Bhopal, 'Research Agenda for Tackling Inequalities Related to Migration and Ethnicity in Europe', *Journal of Public Health*, 34 (2012), 167–73; Hannah Bradby and James Nazroo, 'Health, Ethnicity and Race', in William Cockerham (ed.), *The New Blackwell Companion to Medical Sociology* (Malden, Oxford: Wiley-Blackwell, 2010), 113–29; Convery, Welshman, and Bashford, 'Where is the Border?'; Jenny Donovan, 'Ethnicity and Health: A Research Review', *Social Science & Medicine*, 19 (1984), 663–70; Jenny Donovan, *We Don't Buy Sickness, It Just Comes: Health, Illness and Health Care in the Lives of Black People in England* (Aldershot: Gower, 1986); Chris Smaje, *Health, 'Race' and Ethnicity: Making Sense of the Evidence* (London: King's Fund, 1995); Evan Smith and Marinella Marmo, *Race, Gender and the Body in British Immigration Control: Subject to Examination* (Basingstoke: Palgrave Macmillan, 2014).

[35] 'Immigration', *Lancet* (18 December 1965), 1286.

[36] Mark Harrison, Michael Worboys, 'A Disease of Civilisation: Tuberculosis in Britain, Africa and India, 1900–1939', in Marks and Worboys, *Migrants, Minorities and Health*, 93–124.

highly transmissible disease was undeniably common among Britain's migrants. As the sole public health threat which could convincingly be attributed to immigration, tuberculosis attracted the lion's share of medical, political, and public attention from 1948 through to the end of the 1960s. Smallpox, meanwhile, was already officially extinct in Britain despite regular importations from empire throughout the inter-war and war years. Nonetheless, it too came to have particular resonance in relation to the immigration debates, demonstrating the dangerously permeable boundaries between national policy and geopolitics, as well as between endemic and disease-free territories.

While tuberculosis and smallpox posed real, if often exaggerated risks to the British public, other diseases commonly linked to immigration physically affected only the migrants themselves. The bone-softening disorder rickets (in adults, osteomalacia) was, like tuberculosis and smallpox, once common in Britain—so common that it was long called the 'English disease'. Eliminated among the indigenous poor by direct and forceful state intervention during the Second World War, rickets was transmuted, by politics and by science, from a marker of poverty into an imported 'tropical' disease in the 1960s and '70s. If introduced infections seemed to threaten individual British bodies, the return of rickets among South Asian immigrants and their children endangered the body politic, signifying failed assimilation and imperilled national modernity. It therefore drew unprecedented medical attention to the newcomers' diets, dress, and daily lives. Yet responses to rickets also demonstrate the impact of wider societal shifts as 'migrants' became 'ethnic minorities', and as 'race relations' gradually reshaped official attitudes towards both racial discrimination and health disparities. Policy responses were profoundly influenced by the nutritional expertise of returning colonial medical workers. At the same time, this non-contagious chronic condition provided research opportunities on biochemistry's leading edge, thus creating links between elite biomedicine and the under-served poor of Britain's inner cities.

Finally, the volume closes with the racialized 'immigrant' body on the cusp of the genomic revolution, when the presence in domestic populations of sickle cell anaemia and thalassaemia—genetic disorders of the blood—became a vital resource in Britain's battle for international scientific standing. The final case study explores the impact of molecular genetics on medical responses to migrant and ethnic minority groups who were assumed to be genetically distinctive, and on medical policy making in the shadow of 'race'. The 1949 discovery that sickle cell anaemia could be directly linked to a specific genetic miscoding put an under-studied, under-funded, and, in the UK, initially uncommon genetic disease at the forefront of biomedical science. Researchers rapidly discovered that the deadly heritable condition thalassaemia also resulted from genetic coding errors affecting the manufacture of the haemoglobin molecule. Like rickets, the haemoglobinopathies sickle cell and thalassaemia suddenly attracted intense clinical and scientific attention. And like rickets, this medical attention brought media and political scrutiny in its wake. Crucially, Britain's 'immigrant' communities were again positioned as a valuable resource in the battle to maintain the nation's biomedical leadership.

In Part One of *Contagious Communities*, responses to TB among migrants to the UK offer a window on understandings of immigration in the last years of imperial identity and 'open door' migration policies. In the nineteenth and early twentieth-century metropolitan centres of empire, TB was a disease of poverty, and particularly of the industrial and urban poor. Hard to diagnose in port health settings, and endemic across Europe and North America, TB (like venereal disease) was specifically excluded from control under the International Sanitary Regulations. In the settler-colony nations (for example, Canada, Australia, New Zealand, and the USA), separate legislation brought it under remit of border health controls and rendered it an excludable disease by the first decade of the twentieth century, despite difficulties in obtaining a swift and reliable diagnosis.[37] However, in Edwardian Britain, with less immigration and a more laissez-faire attitude towards border control (driven by a commitment to the free movement of trade), migrants were only one more vulnerable population at great risk of tuberculosis. Moreover, it was well-recognized that many contracted tuberculosis only after arrival in the urban slums of their host countries. Representations of TB as a specific 'disease of immigration' thus only began to appear after the Second World War.

Chapter 1 covers the period from the 1948 British Nationality Act—which explicitly defined a shared Citizenship of the United Kingdom and Colonies, enveloping equally the populations of the British archipelago, the established nations that emerged from Britain's white settler colonies, and the new and aspiring nations of the tropical empire—to the mid-1950s. It explores the medicalization of migration in the absence of race, through a close examination of medical and political responses to tuberculous European and Irish migrants. The high incidence of tuberculosis among these populations provoked public and professional calls for health checks and a variety of interventions. However, the emergence of a specialist discourse of 'susceptibility' rendered their illness innocent; moreover, their labour was essential to reconstructing Britain—and in the case of the infectious Irish, they were 'kith and kin'. In the absence of either medical or bureaucratic consensus, this combination was sufficient to short-circuit demands for immigration controls.

Chapter 2 tracks the shift from a weakly medicalized to an increasingly racialized—and politicized—response as rising numbers of West Indian and South Asian economic migrants attracted public, political, and medical attention from which European Cold War refugees were tellingly exempt. By the end of the decade, momentum was building for a post-imperial and more exclusive British identity, and with it a far more rigorous regime of entry controls. Lay, professional, and political interest in the 'susceptible migrant' was replaced by moral panic about

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[37] While it was possible to identity tubercule bacilli in sputum, not all clinically diagnosed individuals produced sputum samples containing the bacilli; tuberculin testing, by contrast, might identify as tubercular individuals with no clinical signs (those who had been exposed to TB but had successfully resisted infection were just as liable to a positive result as those in whom early or latent disease persisted). See Fairchild, *Science at the Borders*, 161–72 for an interesting analysis of the US case, in which the role of medical debates foreshadows their importance in post-war Britain. Barron Lerner, among others has discussed the difficulty of establishing a TB diagnosis (even after radiographic analysis became possible). See Barron Lerner, 'The Perils of "X-Ray Vision": How Radiographic Images have Historically Influenced Perception', *Perspectives in Biology and Medicine* 36, (1992), 382–97 at 389.

'suspect' disease carriers exploiting 'loop-holes' in Britain's epidemiological de-
fences. In a foretaste of things to come, public attention was tightly focused
on 'coloured' migrants as vectors of tuberculosis contagion, despite considerable
evidence that such populations contributed a negligible volume of new infec-
tion. Yet in terms of immigration policy and public health practice, the decade
was a stable one. Tuberculosis provided a node at which expert and popular anx-
ieties converged. While this intersection of interests attracted growing political
and medial traffic, Whitehall resistance both to medicalization and to control
remained intact.

In Part Two, *Contagious Communities* moves into the era both of immigration
control—the closing of Britain's 'open door'—and the implementation of 'race
relations' legislation. Chapter 3 captures the moment when Britain definitively
ceased to be 'home' for its extended imperial family. It sifts the circumstances
under which Britain passed the 1962 Commonwealth Immigrants Act, and delin-
eates an unexpected role for smallpox in lowering bureaucratic and expert resistance
to politicizing migrant health or medicalizing calls for immigration restriction.
Late in 1961, the Conservative government introduced legislation to restrict
immigration from the Commonwealth. Weeks later, amongst a flood of migrants
anxious to forestall their exclusion, five Pakistani migrants brought smallpox to
Britain. The disease outbreaks which followed smouldered through the spring
of 1962, as the Commonwealth Immigrants Act was debated and finally enacted
in Parliament. These imported smallpox outbreaks renewed by far the oldest
and institutionally most established medical vision of immigration, one which
portrayed migrants as vectors of epidemic disease. This is the model of population
movement which had initially terrified Europe (and the nations which received
her migrants), and against which the International Sanitary Regulations stood
as a bulwark.

Smallpox itself, like tuberculosis, was a familiar if frightening presence on
Britain's medical stage. Although the disease was no longer endemic, the UK had
experienced numerous outbreaks in interwar period and in the aftermath of the
Second World War. Tourists, businessmen, service personnel, colonial officers, and
foreign students had all imported smallpox, inadvertently spreading it among
family members and strangers alike, often along the corridors of Britain's dense
transport network. For half a century, the close net of British public health surveil-
lance had reliably ensured the rapid identification of smallpox cases, and ring-fence
vaccination of their contacts. Thus although Britain was especially vulnerable to
such recurrences because of its colonial ties and poor rates of smallpox vaccination,
its population had every reason to remain calm in the face of the 1961–62 recur-
rence. However, despite the many similarities between the 1961–62 outbreak and
those which had immediately preceded it, the British media and politicians por-
trayed the event as novel and unprecedented. It is no coincidence that this 'smallpox
invasion', occurring at a crucial junction in Britain's post-colonial history, provoked
media frenzy unmatched by responses to similar outbreaks in the immediately
post-war era. Chapter 3 will explore this concatenation, and its enduring effects on the
immigration debates, public perceptions, and the medical surveillance of migrants.

Through the same lens, it exposes the impact of an increasingly global media on discourses of race, disease and 'belonging'.

After this epidemic interlude, Chapter 4 returns to the tubercular migrant, now strongly racialized and subject to potentially exclusionary border health controls. How did the new vistas of surveillance and control created by the 1962 Commonwealth Immigrants Act affect medical and political responses to immigration from the postcolonial world? In fact, despite empowering legislation and heightened attention to migrants as vectors of infection, Britain's apparently medicalized borders remained stubbornly porous to migrants and mycobacteria alike. While the nation's immigration policy was increasingly restrictive, its immigration practices were another matter. Constrained by economics and hamstrung by resistance elsewhere in Whitehall, the Ministry of Health remained focused on internal and integrative, rather than external and exclusionary health surveillance of the newcomers. Here too, I will begin to address the political twinning of immigration restriction and 'race relations' legislation. What effects did laws against racial discrimination have on the provision of health and social services to migrants and ethnic minority communities, and how did an increasingly restrictive immigration regime affect social and political responses to the medical needs of these groups? Despite the rising incidence of tuberculosis among settled migrants, rates among the majority population continued to plummet (simultaneously revealing the limitations of 1965's toothless Race Relations Act). By 1968, when Britain shockingly excluded Kenyan Asian passport holders, popular racism had replaced tuberculosis as the iconic imported 'disease' of immigration.

The examples of smallpox and tuberculosis illustrate the persistence of the traditional association between immigration and communicable disease, and the durability of medical responses focused on the surveillance, identification, and control of potentially contagious individuals. The significant role played by these diseases in debates over immigration control and the nature of 'belonging' in Britain indicates their impact on post-war responses to migrants and the communities they established. However, the years between 1948 and 1991 also saw significant changes both in patterns of immigration, and in dominant medical paradigms of disease causation. The ongoing epidemiological transition—the decline of acute infectious diseases, and the corresponding emergence of chronic, inherited or lifestyle-linked morbidity and mortality—brought into prominence a new set of healthcare priorities, and medical research questions. As tuberculosis lost its grip on the public imagination and its potency in political debate, wider changes acted to bring new 'immigrant' diseases to the fore.

Part Three of *Contagious Communities* focuses on nutritional and genetic conditions. Each chapter examines the impact of new medical models of disease and new patterns of morbidity on public, political, and medical responses to immigration and ethnicity. Moreover, these chapters will unpick the increasingly complex nexus of relationships between racial politics, patients, communities, and the medical professions in the context of race relations legislation, major NHS reforms, and rising patient and community health activism. They examine the changing valence of 'race' in medicine and society during and after the advent of race relations

legislation in the late 1960s and '70s. How does—and how should—the modern state engage with culturally distinctive communities who also apparently share certain heritable traits and susceptibilities? Responses to 'Asian rickets' and the genetic haemoglobinopathies illuminate aspects of a biomedical present dominated by molecular understandings of disease and risk, but also by ever-louder state calls for individual responsibility on one hand, and increasingly vociferous patient and community activism on the other. Thus, these chapters document the transformation of Britain's West Indian and South Asian communities from scrutinized 'immigrants' to domestic political actors.

Chapter 5 explores the childhood deficiency disease rickets (and its adult form osteomalacia), and the perspective it offers on 'race', assimilationism, and community agency—as well as the persistence of 'colonial' medicine. Questions of nutrition and diet were high on the healthcare agenda in post-war Britain, buoyed by the government's generally successful management of the tightly rationed wartime food supply in accordance with nutritional science, and by enduring practices of welfare feeding linked to maternal and child health. Nutritional deficit diseases like rickets, once a familiar feature of Britain's epidemiological landscape, had like TB all but disappeared from the indigenous population, to the not inconsiderable gratification of medical professionals, health policy makers, and the public alike. Their absence revealed an underlying stratum of complex inherited metabolic disorders, and a new clinical and biochemical frontier: the opportunity to unravel the mysteries of normal metabolism. It is at this critical juncture that the interests of Britain's elite biochemical research community and its growing immigrant and ethnic minority communities coincided: by the 1960s, rickets, like TB before it, was making an ominous but useful reappearance in the bodies of children born to Britain's new ethnically Asian populations.

At the same time, nutritional policy was increasingly being shaped by a cadre of professionals whose skills had been honed in Britain's tropical colonies. Their responses to nutritional deficiency in Britain projected those experiences and sensibilities onto a population that must have looked hauntingly familiar, if unexpectedly close to home. Thus while elite biochemists and general practitioners alike called for a return to the direct interventions that had eradicated rickets during the war, those making central policy assumed that such responses would be culturally unacceptable (as well as economically unpalatable). Instead they sponsored health education intended to teach 'Asians' how to adapt to British climes and norms. Yet as racism was itself increasingly pathologized in the 1970s, the tentative 'race relations' discourse of the mid-1960s gained new force. New actors interpreted the ill health of Britain's racialized minorities as an indicator of failings in the Welfare State. By the mid- 1970s, the persistence of what had become 'Asian rickets' prompted shocked commentary in the media and some sectors of the medical press. When Margaret Thatcher's Conservative government took power, such criticism finally provoked a response from the medical state. Framed by neoliberal ideologies of self-help and utterly resistant both to direct interventions and to any hint of biological distinctiveness, the 1981 'Stop Rickets' campaign mixed old-fashioned assimilationism with a new drive to actively engage and medically integrate affected

communities. It thus offers a unique perspective on 'race' and racialization at the intersection of race relations and molecular biology.

In Chapter 6, sickle cell anaemia and thalassaemia offer another route through this dangerous intersection, and another perspective on the international communities, both lay and professional who populate it. While racial politics and poor access to healthcare poisoned relations between US researchers and the affected African–American population, Britain's old imperial connections provided British clinical and research geneticists with a treasure trove of baseline data. Its newly diverse domestic populations and universally accessible National Health Service offered ample and in one case enthusiastic 'clinical material'. Preoccupied with contagious disease throughout the 1960s, government authorities initially ignored growing medical concern about genetic conditions. However, if the medical state declined to intervene, British medical elites increasingly saw and seized an opportunity to gain a competitive edge in its battle for international standing, especially in comparison to the USA. At the same time, affected individuals, families, and communities sought new ways to navigate Britain's medical systems. This case study explores the use of racial politics as leverage against entrenched resistance to targeting resources specifically towards 'minority' needs. Here, too, I consider the role of genetics in the revival of 'race' as a biological entity in medicine and society, tracking evolving professional and political interpretations of race through the optic of genetic disease.

Drawing together the evidence of all five case studies, the Conclusion reflects on British strategies for responding to immigration and diversity, as well as their medical sequelae. My interest in this volume is not specifically with what has been described as the 'racialization' of British immigration policy, although of course, the rewriting of British citizenship in the post-war and post-imperial period is an important element of my story. The historical record comprehensively demonstrates that 'race'—and especially fears about Britain becoming a multiracial nation—played a central, but by no means a solo role in the post-war reformation of British citizenship and identity. Instead, this book asks how and why medical actors, policies, expertise, and assumptions became entangled in this process. It documents tensions between views of science as authoritative and forces that made it politically weak; and tensions between the urge of the medical state to intervene and its desire to avoid the twin traps of politicization and racialization. And it seeks to demonstrate the ways in which the balance between these tensions shifted along with attitudes towards race. In short, *Contagious Communities* explores complex British responses to the medical—and the diversely medicalized—challenges posed by the post-war increase in racial and cultural diversity. Its case studies expose both changes and continuities in popular and medical understandings of 'race', and reveal the roles played by such conceptions in biomedical, political, and institutional interpretations of migrant and ethnic health and illness.

PART I

TUBERCULOSIS IN BLACK AND WHITE: MEDICINE, MIGRATION, AND RACE IN 'OPEN DOOR' BRITAIN

Tuberculosis was a quotidian fact of daily life in Britain in the early years of the National Health Service (NHS), just as it had been since the first decades of the twentieth century. So familiar that two letters (TB) sufficed to designate it in almost any context, tuberculosis remained endemic across the British Isles, as well as Europe and much of North America. Contemporary Britons witnessed its symptoms and knew the rigours of its treatment; a half-century of campaigning, intensified during the Second World War, rendered many equally well-aware of the means by which the disease could be prevented. However, its familiarity in no way erased the stigma experienced by TB sufferers, nor obscured its still-heavy death toll in the mid-twentieth century. In the immediate post-war period, TB remained Britain's most deadly contagious disease. As a 'disease of civilization'—a term rooted in the realization that tuberculosis endemicity followed in the wake of exploration and empire—its presence was naturalized as an inevitable feature of urban industrial life, and even a portable marker of modernity.[1] So how did this endemic British disease become, in the final third of the twentieth century, the archetypal 'immigrant problem' and 'imported illness'?

In 1950s Britain, TB prompted two narratives that impinged on each other without ever being fully integrated. For most of the population, in most of the UK, the story was one of declining mortality, morbidity, and visibility. Tuberculosis became a disease of old men and 'problem families'. These changes played out slowly in Scotland, Wales, and Northern Ireland, more quickly in England's prosperous suburban south. Rural agricultural communities (and urban consumers) also experienced the transformation of milk and meat production as tuberculosis was eliminated from the national herd. This story of decline was, of course, one of mass miniature radiography, screening campaigns, antibiotics, and for some, the

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[1] Mark Harrison and Michael Worboys, 'A Disease of Civilisation: Tuberculosis in Britain, Africa and India, 1900–1939', in Lara Marks and Michael Worboys (eds), *Migrants, Minorities and Health: Historical and Contemporary Studies* (London: Routledge, 1997), 93–124.

Bacillus Calmette–Guérin (BCG) vaccine; but also of gradually-emptying tuberculosis sanatoria and wards—and of reconstruction, re-housing, and improving nutrition. The eradication of tuberculosis, so confidently predicted as the decade began, proved to be a fairytale, but for many thousands of infected Britons, there was certainly a much happier ending than even the most optimistic experts would have predicted a decade earlier.

The second tuberculosis narrative, and the one which will preoccupy the next two chapters, was told in more sombre tones by and to medical experts, general practitioners, public health workers, politicians, municipal authorities, and the residents of Britain's devastated inner cities. This story was one of progress retarded, health undermined, and modernity spoiled by newcomers who never quite 'belonged', whose motives in coming to Britain were inherently suspect, and who were often perceived to exploit what many indigenous Britons felt they (alone) had earned through the privations and sacrifices of the Second World War: the benefits and protections of the Welfare State. The exact objects of local suspicion changed over the course of the decade. European refugees and migrant workers, then Irish immigrants, later the West Indians, and finally Indian and Pakistani migrants all in their turn assumed the leading role in this tuberculosis discourse.

This repeated re-framing and re-direction of popular, political, and professional attention was based in part on rates of migration and the visibility of different migrant groups. It also reflected shifting medical models of tuberculosis epidemiology, and changes in the practices and organization of public health. As we will see, the publication of official and semi-official data on the incidence of TB among different populations in 1953, 1957, and 1960 had significant effects. Alterations in the wider—sometimes much wider—context, too, were crucial: in Whitehall and Westminster, on hospital corridors, and in the streets, attitudes towards different migrant groups responded to the availability of housing and employment; cultural perceptions of the in-comers themselves; current events in Britain (for example, the Coronation and the Notting Hill riots); and Cold War geopolitics (marked here by the failed Hungarian uprising and subsequent refugee crisis, as well as delicate negotiations with non-aligned India and Pakistan).

In this Part's first chapter, I sketch the relationship between tuberculosis and immigration from the early years of the National Health Service to the mid-1950s. At the beginning of this period, immigrants were 'discovered' to be the immunologically naïve victims of a more sophisticated bacteriological environment. By its end, discussions of the tuberculous migrant were becoming increasingly entangled with assumptions about 'colour' and 'race'. The second chapter examines the varying responses made to different groups of 'suspect' migrants as 'imported' disease became ammunition in a social and political battle over the definition of Britain's national and international identity. Yet despite the marked interpretive shifts which these chapters will document, close scrutiny reveals a period during which health and immigration policy were relatively stable. If senior figures in Whitehall and Westminster looked ahead with foreboding, they certainly showed little inclination to reveal or act on their fears. This Part therefore explores the intersections between public, political, and expert understandings of 'immigrant tuberculosis' just before those discourses gained operational definition and force.

1

Suspicions and 'Susceptibility'
The Tuberculous Migrant 1948–1955

Relatively little scholarly work has been done on the rhetoric and practices surrounding tuberculosis in post-war Britain. In general, authors addressing tuberculosis in this period have been preoccupied by a set of transformational technologies and their effects: specifically, mass miniature radiography, tuberculin-based diagnostic testing, Bacillus Calmette-Guérin (BCG) vaccination, antibiotic chemotherapies, and the closure or repurposing of TB sanatoria, chest clinics, and other public health institutions previously dedicated to this demoted 'captain of the men of death'.[1] Like many medical practitioners both at the time and since, historians have been captivated by the astonishing decline of TB in the developed world, rather than its

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[1] Tuberculosis has been the subject of extensive historical investigation, resulting in a rich scholarly literature. The classic study is René Dubos and Jean Dubos, *The White Plague: Tuberculosis, Man and Society* (Boston: Little, Brown and Co., 1953). Thomas McKeown, *The Modern Rise of Population* (London: Edward Arnold, 1976) used tuberculosis as a key example illustrating his argument that improved standards of living, rather than medical interventions, had prompted the demographic transition. However, national histories of tuberculosis have rarely extended detailed analyses into the post-war period (1950, in particular, has become a favoured terminus): e.g. Lynda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988); Greta Jones, *'Captain of all these Men of Death': The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam: Rodopi, 2001); William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge, MA: Harvard University Press, 1995); Katherine McCuaig, *The Weariness, the Fever and the Fret: the Campaign against Tuberculosis in Canada 1900–1950* (Montreal: McGill-Queen's University Press, 1999); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, MA: Harvard University Press, 1996); F.B. Smith, *The Retreat of Tuberculosis, 1850–1950* (London: Croom Helm, 1988); Michael E. Teller, *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era* (Westport, CT: Greenwood Press, 1988). In the last decade, scholarly articles have broached the post-war period to address international health efforts (often in conjunction with the new technologies) and campaigns targeting particular marginalized groups: e.g. Niels Brimnes, 'Vikings against Tuberculosis: The International Tuberculosis Campaign in India, 1948–1951', *Bulletin of the History of Medicine*, 81 (2007), 407–30; Laurie Meijer Drees, 'The Nanaimo and Charles Camsell Indian Hospitals: First Nations' Narratives of Health Care, 1945 to 1965', *Histoire sociale/Social History*, 43 (2010), 165–91; David S. Jones, 'The Health Care Experiments at Many Farms: The Navajo, Tuberculosis, and the Limits of Modern Medicine, 1952–1962', *Bulletin of the History of Medicine*, 76 (2002), 749–90; Barron Lerner, *Contagion and Confinement: Controlling Tuberculosis along Skid Row* (Baltimore: Johns Hopkins University Press, 1998), and the essays in Flurin Condrau and Michael Worboys (eds), *Tuberculosis Then and Now: Perspectives on the History of an Infection Disease* (London: McGill-Queen's University Press, 2010). Other recent work has examined late twentieth and twenty-first century TB in conjunction with AIDS/HIV and the emergence of multiple drug resist strains: e.g. Richard Coker, *From Chaos to Coercion: Detention and the Control of Tuberculosis* (New York: St. Martin's Press, 2000). Helen Bynum, *Spitting Blood: The History of Tuberculosis* (Oxford: Oxford University Press, 2012) likewise offers a quick sketch of the post-war period, but her focus is largely international.

persistence. Yet tuberculosis did persist, even under the new dispensation of 'communitarian medicine' exemplified by the NHS.[2] Its near-disappearance from Britain's majority population only rendered more visible—and more threatening—those marginal groups among whom TB had not been conquered. Britain's immigrants fell exactly into this category.

In post-war Britain, medical practitioners, politicians, and the public alike believed that uncontrolled migration could only expand the shrinking TB 'infector pool' of hygienically and medically intransigent individuals, thus perpetuating the disease. Worse, while the continued prevalence of a curable infectious disease threatened British claims to medical modernity and burdened the NHS, mounting evidence of racial bias in popular and political responses to immigration undermined cherished British myths of national tolerance, and its status as a model for its 'multicultural' empire. The apparent stasis of official responses to 'immigrant tuberculosis' in the 1950s camouflages a finely-balanced struggle between those (mainly politicians and medical professionals) eager to medicalize the political problem of immigration, and those (principally within the Ministry of Health) who adamantly resisted such a change. But what was the status quo ante: in what contexts and on what platforms were assumptions and arguments about infectious immigrants built? In the succeeding sections, I will delineate the social and economic context, and assess the positions towards immigrant tuberculosis taken—and largely held—by politicians, civil servants, medical specialists, and the press between 1948 and 1955.

In Britain, the period of post-war reconstruction was marked by full employment and labour shortages. In response, public and private bodies actively recruited both skilled and unskilled labour, initially from Europe's refugee camps (European Volunteer Workers, or EVWs).[3] Economic conditions simultaneously escalated

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[2] John Pickstone, 'Production, Community and Consumption: the Political Economy of Twentieth-Century Medicine', in Roger Cooter and John Pickstone (eds), *Companion to Medicine in the Twentieth Century* (London: Routledge, 2003), 1–20 at 3.

[3] It is worth noting that these programmes routinely excluded Europe's surviving Jewish populations, ironically on the grounds that their presence might stimulate British anti-semitism (and subtextually, that they were neither racially compatible with the English nor physically suited to the jobs available). See Wendy Webster, 'The Empire Comes Home: Commonwealth Migration to Britain', in Andrew Thompson (ed.), *Britain's Experience of Empire in the Twentieth Century* (Oxford: Oxford University Press, 2012), 122–60, at 140–1; Gavin Schaffer, *Racial Science and British Society, 1930–1962* (Basingstoke: Palgrave Macmillan, 2007), 107–14. For further analysis of European migrant groups, see Kathy Burrell, *Moving Stories: Narratives of Nation and Migration among Europeans in Post-war Britain* (Aldershot: Ashgate, 2006); Tony Kushner, 'Anti-semitism and Austerity: the August 1947 Riots in Britain', in Panikos Panayi (ed.), *Racial Violence in Britain in the Nineteenth and Twentieth Centuries* (London: Leicester University Press, 1996); Tony Kushner, *We Europeans? Mass Observation, 'Race' and British Identity in the Twentieth Century* (Aldershot: Ashgate, 2004); Louise Ryan and Wendy Webster (eds), *Gendering Migration: Masculinity, Femininity, and Ethnicity in Post-War Britain* (Aldershot: Ashgate, 2008). Those Jews who were admitted were chosen for and encouraged to maintain 'invisibility'—which may in part explain the compete silence of these files about health and disease among ethnically or religiously Jewish migrants. See Claudia Curio, '"Invisible" Children: The Selection and Integration Strategies of Relief Organizations', *Shofar: An Interdisciplinary Journal of Jewish Studies*, 23 (2004), 41–56, and Tony Kushner and Katharine Knox, *Refugees in an Age of Genocide: Global, National and Local Perspectives during the Twentieth Century* (London: Frank Cass, 1999), 126–216.

the familiar cycle of migration and return which had long characterized migration from the Irish republic to the UK. The employment boom—combined with new restrictions imposed by the 1952 McCarran-Walter Act on would-be Caribbean migrants to the USA and political turmoil in the Indian subcontinent—also prompted the first wave of mass migration to the UK from Britain's 'New Commonwealth'.[4] Invisible to border controls under the 1948 British Nationality Act, all Commonwealth, colonial, and Irish citizens were entitled to free entry and right of abode in Britain, their imperial 'home'. Whatever their ethnicity or national origins, such migrants' ready access to the 'mother country' and their entitlement to its tax-funded welfare and health services provoked controversy. As this chapter will demonstrate, generic anxieties about the distribution of public resources were gradually amplified by tensions around 'colour' and by fears that the arrival and settlement of racialized groups would spoil Britain's nascent post-imperial identity as a progressive, egalitarian, and modern nation—still world leading, if no longer ruling a global empire.

'KEEP AN EYE ON YOUR CHEST': TUBERCULOSIS AND THE MAJORITY POPULATION, 1948–1958

One aspect of post-war British identity was rooted in welcome improvements in the health and life-spans of indigenous Britons, and especially their reduced morbidity from preventable diseases, including tuberculosis. By the mid-twentieth century, tuberculosis was a disease in decline in Britain, as in much of the industrialized world. Building on the sometimes polemical work of an earlier generation of historians interested in the causes for this decline (theories have focused variously on improved nutrition, better housing stock, public health campaigns, and a variety of medical interventions), scholars including Anne Hardy have explored perceptions of the disease and its decline, and have studied organized efforts to sustain the plummeting trend in tuberculosis incidence in the middle years of the twentieth century.[5] The massive demand for labour created by the Second World War prompted major changes in state responses to tuberculosis, with the advent of social support systems including allowances, rehabilitation services, and a rapid increase in hospital beds for tuberculosis patients.[6] In the war's aftermath and with the arrival of the National Health Service, popular and professional attention began to focus on the possibility of eliminating the disease altogether. A 1949 *Times* lead article, for example, excoriated British 'backwardness' for allowing an estimated 400 people a week in England and Wales to die of TB. Why, it asked,

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[4] The term 'New Commonwealth' came to refer to all of the emerging nations and remaining colonial territories of Britain's disintegrating empire except the old Dominions of Australia, Canada, and New Zealand (and for some, white South Africa).

[5] Anne Hardy, 'Reframing Disease: Changing Perceptions of Tuberculosis in England and Wales, 1938–70', *Historical Research*, 76 (2003), 535–56.

[6] Linda Bryder, *Below the Magic Mountain*, 227; John Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Oxford: Peter Lang, 2000), 149–57.

were doctors not emulating Britain's veterinarians, already committed to using all available technologies to eradicate tuberculosis in the national herd? New technologies and treatments could, the editors claimed, eliminate TB as 'a national ailment', if only they were applied. The article despaired of 'experts quibbling over statistics', a reference to the drawn-out process by which the BCG vaccine was grudgingly approved for limited use in the UK in 1949. Echoing an article in the esteemed *Lancet* medical journal, the editors demanded more active Ministry of Health leadership, and condemned '[c]omplacency and lack of enthusiasm'.[7] In the weeks following this editorial exhortation, the *Times* published a series of letters from chest physicians, anti-TB campaigners, other medical practitioners, and members of the public. Each letter supported the *Times*' position and demanded further action, often comparing Britain unfavourably to other nations and decrying the economic and human costs of failures in prevention, detection, and cure. The solutions proposed by these correspondents, concerned with TB among Britain's majority population, clearly endorsed the broad approach to population health associated with social medicine, rather than the narrower biomedical methodologies linked to an emerging model of health as a matter of individual risk and responsibility. They called for 'continuously improving nutritional and general social standards' and, like the National Association for the Prevention of Tuberculosis (NAPT), described high-quality nutrition and housing as the best tools of TB prevention.[8] TB among indigenous Britons was, for these experts, a social disease, and one to be eradicated not just through new technologies, but through raising living standards for all.

Responding to such demands, medical and public health authorities were drawn into eradication efforts. However, this work was constrained by Britain's straitened finances. As the re-housing and slum clearance essential to social medicine stalled, TB control strategies were instead shaped around—perhaps even driven by—the advent of new technologies and drugs. These in turn promoted approaches rooted in medical surveillance and medicalized intervention rather than social uplift and regeneration. Mass miniature radiography (MMR) facilitated a series of popular campaigns (now tied to rebuilding Britain, as they had previously been to the war effort) to identify affected individuals in the working population. Members of the public were encouraged to take personal responsibility for the surveillance of their own health as a part of modern citizenship. 'Keep an eye on your chest', the NAPT exhorted the British public, 'Have *you* visited an X-ray unit yet?'[9] By 1953, fifty-three MMR units had x-rayed twelve million Britons. In schools too, state-authorized medical surveillance targeted TB, and BCG vaccination was finally approved for school leavers after the conclusion of Medical Research Council trials in 1953.[10]

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[7] 'Tuberculosis', *Times* (26 September 1949), 5.

[8] Frederick Heaf and F. J. Bentley, 'Tuberculosis in Britain Disturbing Figures', *Times* (30 September 1949), 5; See also Ivy Portland, Robert A. Young, and Harley Williams, 'The Control of Tuberculosis: Requisites of The Campaign', *Times* (21 October 1949), 5.

[9] Wellcome Library EPH533:4, 'Keep an Eye on Your Chest' (London: National Association for the Prevention of Tuberculosis), *c*.1950s.

[10] For contemporary comment, see 'B.C.G. Vaccination', *Times* (9 November 1953), 9.

Such efforts produced impressive results. In his 1953 annual report on the health of the nation, Britain's Chief Medical Officer was able to announce the halving of English and Welsh TB mortality rates since 1948.[11]

As Hardy has demonstrated, anti-tuberculosis campaigns were inventive and highly publicized (highlighting another, more gradual change in the medical culture of the post-war period, as professionals became more outward-looking and willing to directly engage the public).[12] For instance, a 1957–58 campaign in Glasgow, Britain's most tuberculous city, began with a six-month publicity drive, opened with a parade and fireworks, and ended (having x-rayed 87 per cent of the city's population) with thanksgiving services around the city. MMR units and contact tracing extended that net of surveillance even further. The discovery of chemotherapies capable of rendering patients swiftly non-contagious, and then curing their disease acted as the carrot to counterbalance the stick of continuing— perhaps even growing—fear and stigma around the disease.[13] Still associated with poverty, TB had over the course of the century also become a disease of non-compliance, supposedly perpetuated by irresponsible individuals and populations, at significant cost to their families, communities, and the state. Among native Britons, TB clung on only among a handful of economically marginal groups: young children and old men. While tuberculosis work had never been high status, it rapidly became the 'Cinderella of clinical medicine'.[14] Repeatedly, the national papers noted the scarcity of trained TB nurses, and the difficulty of attracting any nurses to such a difficult, poorly paid, dangerous, and low status career.[15] Nursing and other staff shortages in turn kept sanatorium beds empty, despite continuing demand for their services.[16] Likewise, in a period when academic chairs of medicine were emerging as badges of status for emerging medical specialties and research areas, the *Times* lamented that there was no professorial chair for tuberculosis anywhere in England.[17] Thus, in Britain's medical schools, the subject was often poorly taught by non-specialists.

Coverage of tuberculosis in the mainstream press between 1948 and the mid-1950s offers an excellent barometer of its changing national status. Mortality rates in the early years of the NHS remained high in England and Wales—nearly 22,000 died from the disease in 1948—but specialists reported that the urgency with

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[11] 'Trends in the Nation's Health', *Times* (11 December 1953), 9.

[12] Anne Hardy, 'Reframing Disease', 540. On the medical profession and the public, see Virginia Berridge, 'Medicine and the Public: The 1962 Report of the Royal College of Physicians and the New Public Health', *Bulletin of the History of Medicine*, 81 (2007), 286–311.

[13] Anne Hardy, 'Reframing Disease', 541.

[14] F. Knights, 'Tuberculosis In Britain Teaching Hospitals' Facilities', *Times* (7 February 1950), 7; Brian Thompson, 'Tuberculosis In Britain Long Waiting Lists For Treatment', *Times* (10 February 1950), 7. See also Charles Webster, *The Health Services since the War. Volume I. Problems of Health Care. The National Health Service before 1957* (London: HMSO, 1988), 7–8, 321–5.

[15] E.g. F. J. Bentley, 'Tuberculosis in Britain: Disturbing Figures', *Times* (30 September 1949), 5; Portland et al., 'Requisites of the Campaign'; 'Tuberculosis', *Times* (18 January 1950), 5; Frederick Heaf, 'Tuberculosis In Britain: "Three Lines of Attack"', *Times* (20 January 1950), 5; F. A. H. Simmonds, 'Tuberculosis in Britain: Nurses' Conditions of Service', *Times* (30 January 1950), 5.

[16] H. Senior Fothergill, 'Tuberculosis in Britain', *Times* (10 October 1949), 5.

[17] Thompson, 'Long Waiting Lists For Treatment'. See also Helen K. Valier, 'The Politics of Scientific Medicine in Manchester' (PhD dissertation: University of Manchester, 2002).

which tuberculosis had been addressed during the war had been lost.[18] In 1950, a *Times* leader lambasted the government, decrying the extraordinary fact that 400 Britons a week were still dying from the disease, and accusing the Ministry of Health of 'a certain complacency'.[19] The paper's editors pointedly questioned whether the Ministry of Health was 'strong enough for its task' and whether it was being prevented from 'getting things done'. As the politics of tuberculosis became entangled with the politics of immigration and border control after 1950, such questions would become ever more pertinent. Nonetheless, by the late 1950s, tuberculosis morbidity and mortality in the general population was so low as to be no longer newsworthy; even the miracle cures of the early 1950s became mundane. By late 1957, the President of the Society of Medical Officers of Health observed that 'tuberculosis had lost its news value'.[20]

Even in the immediately post-war period though, high rates of mortality and morbidity notwithstanding, members of the public, public health officers, and many chest specialists already saw TB as principally of historical interest.[21] In the Ministry of Health, civil servants joked about the likely future of the MMR units in this world of effective chemotherapy and declining rates of incidence. Encouraging their efforts to 'clean up tuberculosis' was, one claimed, '[r]ather like goading the Gadarene swine to go ever faster in their mad rush downhill to self-destruction!' Their demise, he enthused, was 'imminent'.[22] Many in the UK also took considerable pride in what they saw as a collective and personal achievement, and in the National Health Service and allied public health services which made such remarkable strides possible for all. At the same time, however, tuberculosis experts cautioned that the 'residual pool of infection' (the diminishing ranks of contagious TB sufferers) was becoming more and more dangerous to the rest of the population.[23] The indigenous UK populations who were least at risk of infection were becoming ever more susceptible to it as both 'herd immunity' (acquired through childhood exposure to TB) and preventive health measures simultaneously declined. Together, these two factors may help to explain the gradual revival of media, public, and medical interest in tuberculosis, in conjunction with what many saw as a novel and unwelcome source of contagion: immigrants.

IMPORTING LABOUR, IMPORTING DISEASE: EARLY RESPONSES TO THE INFECTIOUS IMMIGRANT

In Britain, as elsewhere, immigrants were historically regarded as potential carriers of disease. However, unlike the USA and the 'Old Commonwealth', Britain only

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[18] 'Tuberculosis Death Rate: Complacency Unjustified', *Times* (7 July 1949), 2.
[19] 'Tuberculosis', *Times* (18 January 1950), 5.
[20] 'Problems of Tuberculosis Control', *Public Health*, 71 (April 1957–March 1958), 426–30.
[21] Anne Hardy, 'Reframing Disease', 554.
[22] TNA MH55/2275 Daniel Thomson to Michael Reed, 29 October 1955.
[23] Fredrick Heaf, 'The New Epidemiology of Tuberculosis', *Medical Officer* cii (1959), 71–5 at 72, quoted in Anne Hardy, 'Reframing Disease', 552.