IMMIGRATION AS A MEDICAL PROBLEM

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BEFORE I discuss the strictly medical problems which face a government undertaking a large immigration programme, it might be of interest to review the legal machinery by which the Commonwealth Government has conducted the various migration schemes which have been operated since Federation.

The Federal Government derives its authority for its various activities from the Constitution. In Section 51 of the Constitution there are laid down those activities for which the Federal Government, as distinct from the States, has the legal power to, in the words of the Constitution, "make laws for the peace order and good governing of the Commonwealth".

Under this Section we find Item XIX Naturalization and Aliens and Item XXVII Immigration and Emigration, and these are the items which concern any migration scheme. As can be expected, these have, over the years, been the subject of a number of court actions and judicial determinations on various phases of their implications. Following one such action in 1906 the High Court laid it down that arising from these provisions of the Constitution the Commonwealth had the power to determine the conditions upon which persons may be permitted to enter and remain in the country and the conditions under which they may be deported from it.

The first Commonwealth legislation in regard to immigration was the Immigration Restriction Act 1901, and the preamble defined it as an "Act to place certain restrictions on Immigration and to provide for the removal from the Commonwealth of prohibited immigrants". The original act has been amended from time to time and in 1912 the title was altered by the deletion of the word "Restriction". The act is now the "Immigration Act" and it is under the provisions of this act that medical selection of migrants is carried out. The deletion of

the word "Restriction" is not simply a matter of terminology. It can be taken as an index of the altered public attitude towards the immigration problem as a whole. The change in attitude has played its part in creating medical problems in selection, and I will refer to this aspect again later, but you will realize that if the emphasis is on restriction then the medical barrier will be higher than when an attempt is being made to attract migrants to Australia.

Under Section 3 of the present act the following persons are "prohibited migrants" and their entry into the Commonwealth is prohibited:

(*c*) any idiot, imbecile, feeble-minded person, epileptic, person suffering from dementia, insane person, person who has been insane within five years previously or person who has had two or more attacks of insanity

(*d*) any person suffering from a serious transmissable disease or defect

(*e*) any person suffering from pulmonary tuberculosis, trachoma or any loathsome or dangerous communicable disease either general or local

(*f*) any person who in the opinion of an officer is likely, if he enters the Commonwealth, to become a charge upon the public by reason of infirmity of mind or body insufficiency of means to support himself or any other cause

(*g*) any person suffering from any other disease disability or disqualification which is prescribed.

These provisions give a logical definition of the type of person who may or may not enter the Commonwealth and from them can be drawn a fairly clear outline of the intention of Parliament.

In spite of this, however, it will be readily seen that the actual implementation of Parliament's wishes is fraught with difficulties and that any scheme of medical selection will be affected by a number of considerations, many of which are of a non-medical character, in addition to the medical assessment of the particular person who might desire to enter Australia.

The first consideration that governs the medical selection is the general scope of the scheme. At its broadest a scheme could include a complete section of the community as it exists in the country from which the migrants are being drawn, a

section including whole families with the aged dependants and the inevitable percentage of unemployable crippled, invalid or mentally subnormal offspring. Such a selection could be envisaged where a new industry is started in Australia and the employees and their families are brought here. It would probably be the most welcome type of migration to the emigrating country but it would cause serious thought in a country such as Australia with advanced social welfare and large commitments to social service payments. Under such a scheme, however, there would be little medical selection and the medical examinations would in fact be limited simply to recording for statistical purposes the health and physical characteristics of the migrants.

If such a broad scheme is restricted by the application of the clauses of a law corresponding to the Australian Immigration Act, the medical selection plays an increasing part in the scheme and could be the determining factor in deciding the fate of many migrants.

Again, there are occasions when hundreds of single men require to be selected for a specific job requiring specific ability. On these occasions, the medical selection is the most important of the pre-selection procedures and the medical verdict is final. In recent years the Commonwealth has selected several boat loads of migrants specifically for work on the Queensland cane fields. These men were required to be capable of hard physical work and they were selected from the many offering. On other occasions the Commonwealth Railways has recruited a large number of able-bodied men for employment as fettlers. It is clear that the only medical problems which arise in such a selection, which could be compared to wartime recruiting, are clinical ones. Each migrant had to reach a certain set standard and no compassionate consideration need influence the medical decision. This is the simplest form of medical selection.

Another variation in responsibility occurs in the selection of children. Over the years many children have come to institutions in Australia either as orphans or, for one or other reason, without their parents. Many of the institutions are branches of parent institutions overseas, but even then a conflict of outlook can arise. The parent body naturally wishes to give every child a chance of a new life. The receiving branch is more inclined to desire only perfect physical specimens.

I remember one batch of teenage youths who had a varying but not abnormal degree of carious teeth, enlarged tonsils and

astigmatism. Apart from these defects, which were in reality of a minor nature, they were excellent types and had every likelihood of becoming very useful new citizens. The parent organization in the United Kingdom was rightly proud of them. On arrival in Australia, however, they were again medically examined and of course the impressive list of urgent requirements created much consternation among the authorities of the receiving institution who gathered the impression that they were receiving the cast-offs from overseas. Certainly these boys were not medically perfect, but how important was the cost of the necessary limited treatment when weighed against the economic gain to Australia of such good young new citizens? This same problem recurs throughout much of the field of migration selection: is the migrant an overall economic gain to the country in spite of whatever disabilities he possesses? The other large problem is how great a humanitarian gesture can be made when a migrant is not an economic gain. At the time of the incident which I have described, no tonsillectomies were being done in England owing to an epidemic of poliomyelitis, so that the children in question would have been denied the opportunity of a new life in Australia. Incidentally, one of the most important pieces of information necessary in the case of children going to institutions is the presence or absence of a history of enuresis. Those of you who have been associated with children's institutions will know the trouble caused by such children and will agree that one such case would bring more local disrepute to the medical selection than half a dozen cases of congenital heart disease. This illustrates in a simple manner the point that immigration selection problems do not always march in parallel with clinical problems.

Reverting to our cane-cutters, I said that this type of selection was the simplest of all, and of course that is so. However, once these single men have settled in Australia, they create a number of new complications, as do all new arrivals who proceed to found a family tree. Many proceed to send home for fiancées, proxy wives, or parents and other close relatives. It is a standing rule in all Australian selection work that if the breadwinner of a family is being considered for selection all his immediate family relations who are dependant on him must be examined for fitness and suitability, before he, the breadwinner, will be accepted. Hence, little problem should arise in regard to wives and children. However, it is neither appropriate nor practical

to examine the possible future wife, or the parents, or other relatives outside the immediate family. Many of the older relatives have initially no intention of migrating. They may eventually be persuaded by stories received from Australia, or the father may die and the mother then wishes to join her children in Australia.

Another complicating factor is that many migrants, particularly those from southern European countries, send large sums of money back to Europe to support their parents and other relatives. Many of the parents are unemployable by reason of age and infirmity. Is it better that the sons in Australia should send sustenance money to their aged parents in Europe or should the unemployable parents be allowed to come to Australia? There will be many who favour the latter course, but if it is taken medical standards must be relaxed. I doubt if anyone would agree that a parent supported in a mental institution or a tuberculosis sanitorium in Europe should be allowed to come to Australia to proceed immediately to a similar institution. It may be that persons who fall into the category of being "fit for their age" should be accepted, but this is quite a difficult category to define or to administer in the field. To take such an individual problem as blood pressure, at what height does a raised blood pressure become abnormal or of significance in persons over 70? Instead of those "fit for their age", we could perhaps admit those who could be cared for by their relatives, that is, those who would not require institutional care. Again the medical problem arises of, for example, how far an aged person with some loss of faculties, some breathlessness, some mild oedema of the legs and faint heart sounds can be cared for by relatives, and what is the rate of deterioration expected by which they will eventually require trained nursing care? I might refer here to conditions such as Parkinson's disease or senile palsy. This disease has a very varied rate of progression but the usual termination is a long period of bedridden invalidity without shortening of the life span. You will see the problem posed by such a condition in a person whose general health is good and you may compare it with the case of a person with a blood pressure of 220/120 mm. of mercury, where the finale may be expected to be sudden and without a long period of incapacity. The latter subject has the more serious sickness of the two but he could easily require less hospital care and medical attention.

Earlier I referred to the altered terminology of the Immigration Act as an indication of the public's altered approach to migration, and, as a final illustration of the outside factors which influence medical selection, reference might be made to this altered attitude. It is obvious that taking prospective migrants as a whole, there are many applicants who are medically fit by any standards and many who are not acceptable no matter how great the need for extra population. Between these two groups is a further group whose upper and lower border moves according to economic standards and necessity. After World War I, Australia embarked on an immigration programme and then, as now, it was based on combined planning by the Federal and State Governments. In that scheme, two States were adamant that they would not accept workers who had lost one eye. Nowadays, if a one-eyed person is rejected, the usual reaction is one of criticism that such action should have been taken. Similarly, in the earlier scheme, the adult who was somewhat backward mentally, or even the village idiot, was put forward as "suitable for farm work". Present farming conditions provide little scope for such types, nor would the Australian farmer appreciate being allotted those who were good for nothing else.

Apart from these "outside" factors influencing medical selection, there are factors of a medical nature which create difficulties. There are no absolute standards of fitness which can be applied. Medical opinions on the significance of a particular disease and on its progress vary. I remember one radiologist in Greece who reported as "normal" the radiograph of a coalminer which showed obvious markings due to anthracosis. On being taken to task, he said quite sincerely that the picture was normal for a man who had been a coalminer for so long. On another occasion, one of our Australian medical officers wrote regarding thyroid enlargement: "This is very common and has always been the source of some trouble. This trouble springs from the fact that it is obvious that the method of treating the frank goitre differs in Europe and Australia. For instance, we see a woman with a large goitre, sufficiently large to be an object of lay curiosity. We refer her for care of the goitre. We receive an answer from the local specialist saying that there is no thyrotoxicosis and therefore no treatment is required. Their attitude probably arises because a simple goitre is not sufficiently abnormal locally to warrant treatment." This

medical officer had trained in a Tasmanian thyroid clinic where enlargements of the thyroid gland in persons over 21 were regarded as being nodular and as warranting surgical treatment whether there were toxic symptoms or not. I think the conclusion to be drawn from these incidents is that if we want accurate and consistent reports the work must be done by doctors trained to an equal standard of proficiency and with a common outlook or approach to their task. This means in reality that the selection should be by Australian doctors with their Australian viewpoint and applying standards drawn up to suit Australian requirements. At the present moment migrants are coming to Australia from practically every country in the world so that it is not possible to insist that every migrant shall be examined by an Australian doctor. Where large schemes are in operation, however, teams of Australian doctors have been established. At the present moment teams, totalling three radiologists and twenty-six other medical officers, are established in the United Kingdom, Germany, Austria, Holland, Italy, Greece and Denmark. All are well briefed in Australian requirements and they make their selection according to defined standards. From Rome, teams cover Malta and from Greece teams cover Cyprus, the Lebanon and other nearby areas.

Even this number of medical officers is not sufficient to carry out all the examinations and so they are reinforced by local panels. In the United Kingdom there is a local referee in all the large towns and cities. In the countries of Europe and elsewhere selected panels carry out such work as cannot be done by the full-time Australian medical officers. All members of the various panels have been well tutored in Australian requirements and all have proved their reliability and capability over the years.

The great value of the local panels lies in their knowledge of the people and in their ability to speak the local language. Whilst most of the Australian medical officers learn the local language in due course they cannot learn it to a degree which would enable them to conduct a psychiatric examination, which is one of the most important requirements. Mental disease remains the most difficult problem in all migration selection. Many of our migrants arrive after passing through longer or shorter periods of physical and mental stress. On many the process of emigration imposes further mental stress. The fundamental problem, however, arises from the fact that psychiatric

medicine is the Cinderella of all branches of medicine. In recent years much attention has been given to it and much valuable progress has been made. It still remains based on the history, the past behaviour and the family history, and on individual reaction to conflict and stress. Unfortunately the past history and past behaviour are not available in the case of many migrants and selection has to be based on present behaviour and on such family history as the migrant cares to disclose. Also, unfortunately, there is no simple test for mental disease. Accurate assessment requires long and painstaking work by a specialist. In practice, applicants for migration who become suspect at their clinical examination by reason of their family or past history or by reason of their present behaviour are referred to psychiatric specialists. Similarly, children whose intelligence is in doubt are referred, where facilities exist, for determination of their intelligence quotient. The sparsity of specialists or of psychiatric clinics in certain countries adds greatly to the difficulties experienced and has probably resulted in the rejection of some actually suitable migrants.

The other large clinical problem in selection work is pulmonary tuberculosis. Here again there are many persons whose acceptability can only be determined by observation over a period. Many people at one stage or another of their life have had a varying degree of pulmonary tuberculosis and many are cured of it. The difficulty arises when an applicant's routine chest radiograph discloses signs of an old infection of varying extent because it is not possible to say in all cases from a single film that there is now no activity. In the United Kingdom, this creates little difficulty because the reliable chest clinics in that country enable the past history to be checked and previous radiographs to be compared. The situation is different with the displaced persons of immediate post-war days where no past history and no previous radiographs were available. In these circumstances such objects have to be viewed with the utmost reserve before they can be accepted. The routine procedure whereby all persons over the age of twelve years have a chest radiograph, together with the presence of Australian radiologists overseas, has reduced the intake of active cases of tuberculosis to a negligible proportion. There remain two sources of active cases. Firstly, it is not possible to select a migrant one day, arrange a radiograph, and put him on a boat the same day. Many have to dispose of homes and businesses and of course

passages have to be organized. There must therefore remain an interval of time between the original selection and the date of arrival in Australia. During this period, which may be reckoned in months, the migrants are exposed to the ordinary risk of infection, and it is only to be expected that the usual proportion will develop a primary infection. This has been the source of some of the cases discovered by the routine check carried out at the migrant centres after the migrants have arrived in Australia. The second source arises in migrants with old lesions, healed on acceptance, who indulge in excessive sunbaking and overexposure to the sun during the voyage to Australia. Such overexposure tends to reactivate lesions which would otherwise not have caused trouble. It is difficult to persuade this type of person that the life-giving sunshine can be dangerous to him but it is a fact.

In summary, therefore, the medical selection of migrants presents a number of problems. The first is the clinical problem of determining the physical and mental state of the individual. To overcome it, a team of reliable and efficient medical examiners is required. The second problem is the conversion of the clinical disability of the individual into an economic index whereby the employment authority can assess the work potential of the migrant selected both in regard to type of work and length of working life. Working conditions in Australia, with a fixed retiring age, Workers' Compensation Acts and mechanized farming, differ considerably from those in many more closely populated countries and must be taken into account. A third problem is created by the dependant who is unemployable by reason of infirmity, and the fourth problem arises from the need to evaluate the requirements of those who may require institutional care, hospital or medical attention or otherwise make a call on the provisions of our social service system.

There are many interesting facets to the medical selection of migrants: I hope I have been able to clarify some of them.

Discussion

DR. H. A. J. FORD said that accepted figures showed that the world's population was increasing at the rate of two per cent. per annum, with the consequence that within twenty-eight years the world's population would be doubled. In the first half of the present century, the world's population had increased by only 50 per cent. These figures made it obvious that the migrant

problem would become more pressing in the relatively near future. In recent years the growth of the Australian population had been a little above the world's average and had been calculated as two and a half per cent. per annum.

The problem of the aged relative of a migrant had both economic and social aspects. One part of the economic aspect was that a large quantity of money was leaving Australia annually by way of migrants' remittances to relatives in southern Europe. These remittances were thought to amount to £18m. per year, and the size of this sum prompted him to ask whether there would not be an economic advantage in taking medical risks in bringing out aged relatives to this country. As for the social side of this particular problem, the presence in the country of the older relatives of migrants may tend to impede assimilation and may tend to preserve the use of the migrant's native language. However, in a period when there were many influences tending to produce a dull uniformity among all peoples, the emergence of groups with particular individual characteristics may be no bad thing.

Dr. Ford drew attention to the fact that under the Immigration Act a migrant found suffering from a disease such as tuberculosis within three years of his entry was classed as a prohibited immigrant unless he could discharge the onus of proving that he did not have the disease at the time when he entered. This provision, if enforced, might well lead to the concealment of tuberculosis and other diseases by migrants, a course of conduct which would tend to frustrate the campaign to eliminate tuberculosis from this country.

SIR ALBERT COATES said that the medical screening of migrants had been carried out with a high degree of knowledge and efficiency. He recalled that in 1950 the then President-General of International Red Cross had said to Sir John Newman Morris and himself that it was a matter for regret that Australia had not taken a higher proportion of sick and infirm displaced persons.

He wished to refer to the question of migrant doctors. The standards in this country were high, and it was not easy for a man trained in Europe to adapt himself to Australian methods and practice. Many who took out a new qualification in this country were very successful, but even these tended to be somewhat impatient of delays such as taking a resident position in

a hospital, which might postpone the time at which they could expect to enjoy a substantial professional income. He was disposed to think, however, that the present rule requiring three year's residence might be modified. He assured the meeting that members of the medical profession had sympathy for the problems of the migrant doctor.

JUDGE NORRIS referred to Sir Albert Coates's account of the comments of the President-General of International Red Cross, and said that he understood that pressure was always being brought to bear on receiving countries to take away from Europe people whom Europe was anxious to get rid of. His experience in the Criminal Court suggested to him that young men who had been children in displaced persons' camps were cunning and lawless and presented a serious problem.

DR. S. CRAWCOUR said that he had experience of the examination of employees in industry, and had examined some thousands of migrants in the past two years. A form had been devised for the purpose of obtaining from migrants their medical histories, and one of the striking features which emerged from the use of the form was the high percentage of migrants who had never had an illness of any kind at any time in their lives. The histories which they presented were quite useless. From his observation, the proportion of neurotics was high among European migrants, but he was not prepared to say that there was an undue proportion of psychotics. Migrants tended to bring in diseases previously unknown in this country.

There had been a striking change in the attitude of Australian workers towards migrant workers who were now accepted in industry by their fellow workers without question.

DR. J. K. ADEY asked Dr. Redshaw whether it was possible for impersonation to occur at centres for the medical examination of migrants. He said that he would like to comment on Sir Albert Coates's remarks on the subject of the three years' residential qualification for migrant doctors. The Medical Board received hundreds of inquiries from overseas asking how soon after arrival in Melbourne registration could be obtained. He felt that if a residential qualification was not required we should receive a shipload of migrant doctors next week.

DR. JOHN WILLIAMS said that the experience of psychiatrists was that many migrants who were totally medically unfit on

psychiatric grounds passed the overseas medical examinations. His present view was that it was important for this country to consider whether the children of migrants who entered would become useful citizens rather than whether the migrants themselves conformed to a high medical standard.

He added that he had found many neurotics among British migrants.

DR. REDSHAW, in reply, said that the problem of the aged relative could not be disposed of by saying that they should be admitted or that they should be provided with accommodation here. A large number of them would not want to come in any case, and these would continue to receive remittances from their relatives here. It was useless to talk about providing cottage settlements for these aged relatives. We did not compel our own people to live in institutions and to be consistent we could not compel migrants to do so.

The question of the degree to which migrants are assimilated is obscure because information on the subject is not supplied to any central body which can evaluate it.

As to Dr. Ford's observations on migrants who become prohibited migrants for medical reasons, he had himself originally favoured deporting those who, by deception, entered the country while still suffering from a disease such as tuberculosis. He had, over the years, changed this view and now considered it more important that the existence of the disease should be freely disclosed.

The sick and infirm displaced persons referred to by Sir Albert were commonly known as the "hard core" and presented an insoluble problem. If the taxpayer would provide the money some of these could be cared for in Australia. The recent Hungarian troubles provided an illustration of the problem of this group. About 50,000 Hungarians had moved into Austria and were now migrating from Austria to receiving countries, but Austria was going to be left with the old and sick and unfit.

So far as impersonation was concerned, all Australian medical officers overseas were practised in taking precautions to avoid deception, but if a new referee in, for example, an English country town were appointed, he would tend to follow the practice of a lifetime in assuming that the persons who presented themselves correctly identified themselves. However, impersonation was no longer a substantial problem.