

IMMIGRATION AND THE NATION'S HEALTH

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Nothing is more vital to the safety and survival of Western nations than the enduring health of their populations. During earlier periods of population migration, countries that encountered high immigration levels, such as the United States during the 1880s and early 1900s, took stern measures to restrict the flow of immigrants, in part out of public health concerns. Poor hygiene among immigrants and inadequate screening measures by public health officials during these high-influx periods triggered legislative reforms that severely restricted immigration levels to the United States. Lately, public health officials have considered another potential risk of importing infectious diseases.

A recent panel discussion featuring speakers from the Harvard University School of Public Health warned of diseases being newly introduced into the United States. Increasing risk, they said, was linked to 25 million Americans who travel annually to third world countries. Who would have considered that American tourists could become such a risk to their local communities, contaminating hearth and home with infectious diseases from abroad!

What, then, of infections brought into the United States through immigration, by the approximately 1.2 million legal and half-million illegal aliens who enter each year? It is American travelers who are the threat, not immigrants, insisted the Harvard panelists. Their stark message was that nothing could be blamed on immigration.

The U.S. Centers for Disease Control (CDC) deal, rather more forthrightly, in facts. An impartial concern for public health drives their frequent reports on the rising incidence of tuberculosis, hepatitis (A, B, C, and E), malaria, and various contagious or infectious diseases long thought to have been defeated — or never before seen — in the United States.

Tuberculosis (TB) is a prime example. The bacterium that causes tuberculosis “infects one third of the world’s population.”¹ Keeping pace with the increasing impact of post-1965 immigration from the third world, America’s TB rate has been growing since 1984. The prevalence of TB in the countries of origin of most immigrants to the United States is 10 to 30 times

greater than in this country.² Risk is greatest where recent immigrants concentrate. For example, a 1996 investigation of an Alexandria, Virginia, high school found that one-quarter of the students carried tuberculosis bacteria.³

In December 2000, the *Journal of the American Medical Association* cited the CDC's conclusion that tuberculosis is continuously being reintroduced by new immigrants.⁴ The TB rate among foreign-born U.S. residents was 32.9 per 100,000 persons over a six-year observation period ending in 1999, more than five times as great as the native-born rate of 5.8 cases per 100,000. Through late 1999, immigrants accounted for 42 percent of the 18,000 identified cases of TB.⁵ The CDC estimates that the rate among the foreign-born will continue to escalate, as it has already in California, New York City, and Northern Virginia.⁶

In Canada, immigrants account for two-thirds of active TB cases. Twenty per 100,000 of foreign-born persons carry the TB bacterium, a rate fifteen times as great as among native-born Canadians (excluding Indians).⁷

Until recently, legal immigrants to the United States were screened only for active disease, and illegal immigrants have evaded screening measures altogether. The majority of foreign-born with active TB tend to have had a reactivation of a latent condition. Their impact on the U.S. healthcare system is magnified through transmission to the native-born population. Approximately half of cases among U.S.-born persons are new. That is, they result from contact with someone who is infected, rather than from a reactivation of latent infection.⁸

On average, a person with active TB infects 20 others annually,⁹ although, at the high end of the range, a boy adopted from the Marshall Islands into a small town in North Dakota infected 56 persons, including his unrelated legal guardian.¹⁰ In Toronto and Hamilton, Canada, dozens of people infected by one Gaspare Benjamin, recently arrived from the Dominican Republic, are suing the Canadian government for short-comings in its health-screening process.¹¹

A complicating factor is multi-drug resistant cases of TB, which develop if the (six-month) treatment program stops before the bacillus is totally eliminated from a patient's system. The World Health Organization reports that countries formerly part of the Soviet Union, the Philippines, Peru, India, Bangladesh, China, various sub-Saharan African countries, and South Africa have a high proportion of drug-resistant strains among their TB caseloads. In 1999, multidrug-resistant strains accounted for 1.3 percent of TB cases in the United States,¹² and the proportion is rising.

Crowded housing, early childhood and old age, or compromised immune systems linked to other medical conditions create vulnerability for contracting TB. The bacterium is airborne, so risk is also associated with being eight hours or more in confined spaces, such as trains or planes.¹³

CHILDREN ESPECIALLY AT RISK

American children are increasingly at risk not only from introduced diseases, but also from preventive measures against these diseases. For example, since 1991 the CDC has recommended that all babies born in the United States should receive vaccinations against hepatitis B virus. The three-shot vaccination confers lifelong immunity against a disease that is transmitted by blood or intimate contact, much like HIV, except that it is many times more contagious than HIV.

Areas where hepatitis B is endemic include Asia and the Pacific Islands. *The foreign-born account for 40-60 percent of all U.S. cases.* As of 1991, an estimated 1.25 million carriers, capable of infecting others, lived in the United States, and an estimated 22,000 newborns, annually, acquire the virus from their mothers.¹⁴ Only half of hepatitis B carriers show early symptoms, but up to a quarter eventually die of liver failure or liver cancer.

The hepatitis A virus also affects the liver and is highly contagious. On the U.S. side of the Texas-Mexican border, and in California, residents have a disease rate that is two to three times the national average. The virus is transmitted through unclean food and water and spread by infected food handlers or processors. In 1997, frozen strawberries grown in Mexico and processed in San Diego sickened consumers as far away as Michigan.¹⁵ Young children are at highest risk because of unreliable hygienic practices in school and play environments.¹⁶

Vaccinations against measles/mumps/rubella (MMR) are routinely administered to American-born babies, and immunization records must usually be provided before enrollment in kindergarten. Nevertheless, epidemics break out in school systems because immunization may not be checked when children, even those from countries that lack preventive public health programs, enter at later grades. American children are subjected to repeat MMR booster shots if epidemics break out in their school.

North Carolina leads the nation in incidence of rubella, and "Latinos" account for 80 percent of the cases. The measles-like viral infection causes severe birth defects if contracted by a woman in the early stages of pregnancy.¹⁷

ASSORTED DISEASE AGENTS

Americans who come into direct or indirect contact with immigrants are exposed to an array of infectious agents that they would otherwise not encounter in this country. Infection may result in discomfort, severe illness, or death.

Public health alarms near ports of entry or in single communities have been raised in connection with many conditions in addition to the more commonly introduced diseases, such as TB and hepatitis. Among these are cholera

(endemic in South America), the West Nile virus (identical to a strain identified in Israel that killed four people in New York City), bubonic plague, ebola virus, and leprosy. Then there is the neurocysticercosis parasite, increasingly prevalent among children in the United States and endemic in Mexico, where it is a principal cause of seizures; the parasite uses pigs as a vector and is spread through accidentally ingesting infested feces or eating pork infected with the parasite's ova.¹⁸

PUBLIC COSTS

Public health measures as well as treatment for disease are costly to taxpayers. Public expenditures directed toward the care of individual immigrants have been most studied, but are not the whole story. For example, New York City allowed a decline in tuberculosis surveillance and care because it seemed largely unneeded when the disease was receding. The city's 1989 budget for all expenditures on TB was \$2 million. The shock of discovering the immigrant-driven resurgence in TB rates drove the 1991 budget to \$50 million, with annual increases to come.¹⁹ The wake-up call to treat multiple-drug resistant TB eventually cost the city \$1 billion.²⁰

Economist Donald Huddle, at the behest of the Carrying Capacity Network, evaluated the fiscal impact of health-related payments and medical care for immigrants. The 1996 cost of Medicaid for legal and illegal immigrants was found to be *\$14.55 billion*, net of contributions by immigrants. The net cost of Supplemental Security Income (SSI) was \$2.76 billion. Legal immigrants accounted for more than 80 percent of these costs.²¹

Social Security records obtained under the Freedom of Information Act show that elderly and disabled immigrants apply for SSI shortly after arriving in the United States, despite promising the U.S. government that they would be supported by relatives. The Associated Press reports that, "Immigrants made up 11% of SSI rolls in December 1992, up from 3.3% a decade ago."²²

The Center for Immigration Studies (CIS) in Washington, D.C., focuses on how immigration affects the number of U.S. residents without healthcare insurance. Principal findings of a July, 2000, CIS study are that "[i]mmigrants who arrived between 1994 and 1998 and their [U.S.-born] children accounted for an astonishing 59 percent or 2.7 million of the growth in the size of the uninsured population since 1993." Compared to the 13.9% without healthcare insurance in native American households in 1998, "32.4 % of persons living in immigrant households ... lacked health insurance."²³

Not surprisingly, immigrants are heavy users of the nation's hospital emergency rooms. In 1997, New York City hospitals provided \$1.2 billion in care to immigrants "who could not pay."²⁴ The foreign-born also account disproportionately for use of maternity services. In 1999, 20.2 percent of U.S. births were to the foreign-born, contributing to the 56 million foreign-born

residents and children of immigrants who were in the United States at the time of the year 2000 census.²⁵ Approximately half of married, illegal Latino aliens have a child who is a U.S. citizen by birth.²⁶

INFORMING PUBLIC POLICY

Immigration's costs are varied and high. Children, the poor, and those with compromised immune systems are at greatest risk from deteriorating public health, crowded clinics, and higher ambient levels of contagious disease. Local and state taxpayers bear the increased fiscal weight of disease—both for treatment and prevention.

The principal beneficiaries of immigration are the immigrants themselves and employers who benefit from cheap labor. Business profits from paying low wages while shifting certain of their labor force costs to the public at large. Employers enjoy the concentrated benefits of low-wage labor, whereas the cost of public services, including healthcare, education, and the infrastructure used by immigrants and their children, are widely distributed. Public debate on the costs and benefits of immigration, and the national interest in receiving approximately 1.2 million legal and half a million illegal newcomers annually, is long overdue.

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END NOTES

1. "A Weak Link in TB Bacterium Is Found," *Science* 289 (Aug. 18, 2000): p. 1123.
2. Virginia Abernethy, "Third World Hospital De Luxe," *Population and Environment* 17, no. 3 (1996): pp. 191-193.
3. "Carrying Capacity Checkup and Connections," *Network Bulletin* 1-2, no. 5 (1996). Carrying Capacity Network, Washington, D.C.
4. August Gribbin, "CDC Report Links TB, Immigration," *Washington Times*, Dec. 13, 2000.
5. Samuel Francis, "Uncontrolled Immigration Creates Serious Health Threat to U.S. Citizens," *Tribune*, Jan. 2, 2001: sec. A, p. 7.
6. Leef Smith, "TB Still on Rise in No. Va.," *Washington Post*, March 18, 2002.
7. Andre Picard, "TB Threat," *Toronto Globe and Mail*, May 18, 2002.
8. E. Geng, B. Kreiswirth, et al., "Changes in the Transmission of Tuberculosis in New York City from 1990 to 1999," *New England Journal of Medicine* 346, no. 19 (May 9, 2002): pp. 1453-1458.

9. August Gribbin, "CDC Report Links TB, Immigration," *Washington Times*, Dec. 13, 2000.
10. J. McConnaughey, "Immigrant Child Takes Tuberculosis to Country Town," *San Francisco Chronicle*, Nov. 11, 1999: sec. A, p. 16.
11. Greg Weston, "Every Canadian's Health Nightmare," *Toronto Sun*, Jan. 28, 2001.
12. M.C. Raviglione, D. Snider, and A. Kochi, "Global Epidemiology of Tuberculosis," *Journal of the American Medical Association* 273, no. 3 (1995): pp. 220-226.
13. Andre Picard, "TB Threat," *Toronto Globe and Mail*, May 18, 2002.
14. Centers for Disease Control, "Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination," *MMWR* 1991; 40(RR-13); Gale Scott, "Hepatitis in Infants 'Ticking Time Bomb,'" *Nashville Banner*, Sept. 8, 1992.
15. *Oakland Tribune*, April 3, 1997: sec. A, p. 9.
16. Philip Rosenthal, "Assessing the Hepatitis A Threat to California," *Liver Lifeline* (American Liver Foundation, San Francisco), Spring 2000: p. 6.
17. Charlie Frago, "N.C. Leads Nation in Rubella," *The News and Record* (Piedmont Triad, N.C.), Jan. 9, 2001.
18. R.I. Glass, M. Libel, and A.D. Brandling-Bennett, "Epidemic Cholera in the Americas," *Science*, June 12, 1992: p.1524; "New York's Lethal Virus Came from Middle East, DNA Suggests," *Science*, Nov. 19, 1999: p.1450; "Plague Fever," *Science*, July 31, 1998; Ken Kilpatrick, "Woman from Congo in Hamilton Hospital," *Toronto Globe and Mail*, Feb. 6, 2001; T.D. Mastro, S.C. Redd, R.F. Breiman, "Imported Leprosy in the United States, 1978 through 1988," *American Journal of Public Health* 82, no. 8 (August 1992); E.H. Kossoff, "Neurocysticercosis," *EMedicine Journal*, Dec. 13, 2001.
19. "Disease Fights Back," *The Economist*, May 20, 1995: pp.15-16.
20. Eric Stokstad, "Drug-Resistant TB on the Rise," *Science*, March 31, 2000: p. 2391.
21. Donald Huddle, *The Net Costs of Immigration: The Facts, the Trends, and the Critics*, Washington, DC: Carrying Capacity Network, October 22, 1996.
22. "Immigrant Welfare," *USA Today*, May 7, 1993.
23. Stephen A. Camarota and James R. Edwards, *Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance*, Washington, D.C.: Center for Immigration Studies.
24. R. Kennedy, "Desperately Ill Foreigners at U.S. Emergency Rooms," *New York Times*, July 1, 1999: p. 1.
25. Janny Scott, "Foreign Born in U.S. at Record High," *New York Times*, February 7, 2002: p. 18.
26. M.L. Berk, C.L. Schur, and L.R. Chavez, "Health Care Use among Undocumented Latino Immigrants," *Health Affairs*, July-August, 2000.