Politics of Quarantine in the 19th Century

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From its inception in the 14th century until the end of the 19th century, quarantine policy lacked uniformity both within and between nation states. It was often devised and implemented by local authorities in response to local crises. Variability in the use of quarantine as a public health measure often stemmed from disagreement about the factors that precipitated epidemics of infectious disease. By the mid-19th century, repeated European cholera pandemics highlighted the lack of international uniformity in quarantine practices. In response, France proposed a meeting in 1834 at which the international standardization of quarantine could be discussed. The meeting did not eventuate and it was only in 1851 that the first International Sanitary Conference was convened in Paris.

This and subsequent conferences held in the following decades were concerned with developing international consensus on the control of cholera, plague, and yellow fever. Ten conferences were assembled between 1851 and the end of the century, but it was not until 1893 that a compromise was reached concerning notification of disease and minimum and maximum periods of detention. Agreement was limited, and negotiations continued into the 20th century.

International cooperation was difficult to achieve because quarantine policies are almost always a reflection of issues other than a state’s desire to protect itself from the importation of infectious disease. It can represent the levels to which a state chooses to intervene in the activities of its citizens, and it plays an important role in the types of regulations that govern the movement of foreign persons or goods across its borders. Quarantine has been closely connected with the development of restrictive immigration policy and the protection and control of trade. It has been used as an effective tool in international relations and as a means to define the sovereignty of a state. One of the key reasons, therefore, why it took so long to reach any agreement on a standardized quarantine was because for each of the states who attended the International Sanitary Conferences, quarantine fulfilled various political and economic needs, as well as providing protection against disease.

The 1885 conference in Rome provides a clear example of how political and economic agendas prohibited open negotiation about quarantine and why consensus remained elusive for such a long time. A proposal was offered relating to the inspection and quarantine of vessels from India intending to traverse the Suez Canal. Britain objected that the free movement of its trading vessels was paramount and that such precautions would be extremely costly. France, at the same time, was angered by Britain’s unilateral assumption of power over Egypt and wanted to limit growing British dominance in the canal. Thus, the French insisted on an independent international inspection of vessels entering Suez, knowing that British ships constituted the greatest proportion of the canal’s traffic. A quarantine station at Port Said (Egypt) would provide a buffer for Europe against disease from “the East” and create an obstacle to British trade.

In a similar vein, the 1881 Washington conference was summoned to meet political expediends. This time, an international disease control convention was sought in order for the United States to achieve the aims of the National Board of Health Act, which was passed in 1879 to protect against “the introduction of contagious or infectious diseases into the United States.” The act required that “all merchant ships and vessels sailing from a foreign port where contagious or infectious disease exists, for any port in the United States, must obtain from the consul . . . at the port of departure . . . a Bill of Health.” This required US consular officials as well as the port officials of the country of departure to inspect the ship before it set sail for America. “It is hardly surprising,” Howard-Jones points out, “that difficulties arose in the enforcement of such a law, and it was evidently the realization on the part of Congress that the Act must necessarily remain a dead letter unless other nations could be persuaded to agree to it that led to the idea of an international conference.”

These 2 examples, among a long list of other such instances, show how economic and political agendas impeded negotiations that should have been focused on reaching international consensus on disease control. A ratified convention was achieved in 1893, however, at the end of what was the final European cholera pandemic in 1892. It was a further half-century and many conventions more until the formation of the World Health Organization heralded a unified and universally agreed set of international laws relating to infectious disease. International conventions were only achieved once some consensus was reached regarding the manner in which diseases are transmitted. This provided a clearer focus for the reasonable application of internationally endorsed quarantine regulations. From this point forward, the international community was able to more effectively combat infectious disease.

REFERENCES