A World Apart: Geography, Australian Quarantine, and the Mother Country

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Abstract. In many respects the Australian colonies were what one person called “the proud offspring of a grand old mother.” Yet when it came to the prevention of imported infectious disease, Britain’s Australian colonies were not a chip off the old block. British opposition to the lengthy and costly imposition of quarantine had intensified throughout the nineteenth century, eventuating in the abolition of human quarantine in 1896. The Australian colonies, on the other hand, which had based their first quarantine regulations on British law and remained constantly aware of changing medical trends in the mother country, gradually expanded the breadth and capabilities of their maritime quarantine as the century progressed. Although other European powers and British colonies progressively adopted systems of medical inspection more in line with British port prophylaxis and away from quarantine, the Australian colonies invested increasing amounts of time and money into more elaborate quarantine stations and regulations. In this article I examine some of the basic features of coastal disease prevention in the Australian colonies and how they differed from British controls. Australia’s distance from Britain was emphasized in the quarantine debates geographically as well as in policy. I argue that the often controversial differences in quarantine policy were for the most part a product of Australia’s geographical location. The natural prophylactic of Australia’s remoteness was not a reason to minimize quarantine in the colonies but rather served to increase it; whereas, it was argued that “the geographical position of England deprived it of the advantages . . . derived from a comprehensive quarantine system.” I discuss this seeming anomaly in light of other arguments that have claimed that the close proximity of a state to the acknowledged origin of a disease was likely to increase its eagerness to quarantine. Keywords: Australia, Britain, quarantine, Port Sanitary Authorities, infectious disease, public health, vaccination, sanitation.
OR most of Australia’s history as a white settler colony and federated nation, close ties have been maintained by a significant part of the population with a far-removed, and now completely anachronistic, mother country. Britain, even for those who never went there, was esteemed as a spiritual homeland, where ancestors of any repute were born, where unseasonable traditions emanated, and where things always seemed to be done the way they should be. It is only very recently that people have come to realize that more Australians now have their roots in other parts of the world and that the idea of a British mother country is misplaced in a modern Australia. Yet for a long time, Australia, its laws, and its customs did represent a distant if not slightly altered reflection of Britain. The colonies were what one contributor to the 1899 Intercolonial Medical Congress of Australia called, “the proud offspring of a grand old mother.” The continent of Australia, until federation in 1901, consisted of six settler colonies within the British Empire and as such was greatly influenced in its development by Britain and the Empire. Indeed, in many respects the Australian colonies were very British indeed, never veering too far from the social, political, or economic models provided “back home.”

On one particular issue, though, the colonies followed a very different path from that taken in Britain. When it came to the prevention of imported disease, Britain’s Australian colonies were not a “chip off the old block.” Britain had led the way in reducing and even doing away with quarantine as a method of disease control and actively argued that other states, particularly her own colonies, should do the same. Quarantine was berated in England as being “anti-commercial, anti-social, and anti-Christian,” but in Australia it was relied on as one of the most important elements in the colony’s public health, where it developed into one of the most strictly enforced quarantine systems in the world. This article will outline some of the ways that Australian quarantine in the colonial period

differed from disease control in British ports and will examine some of the reasons why they occurred.

A contributor to the *Australian Medical Journal* in 1883 highlighted some of these differences and offered an explanation.

The subject of quarantine is one which has a very special interest at the present time. Its advantages and disadvantages have lately been warmly discussed in nearly every civilised country, and very curious differences have been found to exist. . . . In these Colonies, up until recently, the problem has been a comparatively simple one, and it by no means follows that the practice adopted, voluntarily or under pressure of circumstances, in the mother country, is necessarily the most desirable here. . . . In these colonies we are rather differently situated [from England]. Even now, in these days of short voyages, we are far enough from the great centres of population to allow of almost any contagious disease developing itself between the ports of arrival and departure.3

Much has been made in both the Australian and British cases of their relative distance from disease and so-called “disease founts.”4 Distance is cited in the context of both opposition and endorsement of quarantine in Australia and Britain by nineteenth-century commentators and by historians. Looking particularly at prefederation Australia, this article will show how some recent attempts to use geography as an almost exclusive explanation for the use or abandonment of quarantine in the nineteenth century are insufficient and how other factors need to be addressed to understand the different development of disease control in Australia.

There are a number of key points of departure that occur in a comparison between the coastal disease control practices and policies of Britain and Australia in the nineteenth century. At the beginning of the century, British and Australian colonial quarantine was more or less the same. New South Wales’s first quarantine legislation, passed in 1832, was essentially a mirror of the 1825 British Quarantine Act. However, over the following decades the similarities lessened, with British opinion and public health shifting further away from quarantine from the 1850s–60s, whereas the Australian colonies became more reliant on quarantine for providing an essential first line of defense against imported infectious disease. By the end of the century,

Australian and British maritime disease control almost could not be more different.

In Britain, from the first quarter of the century, quarantine was called into question, arraigned for its interference with commerce, its lack of success in affording protection against imported infections, and its apparent uselessness within the canon of disease etiology maintained by anticontagionists. In practice, by the 1870s most aspects of maritime quarantine in Britain had been replaced by alternative systems. The failure of quarantine to prevent the 1866–67 cholera epidemic was effectively the final nail in the coffin for quarantine in British domestic ports. Sanitary reform was increasingly looked to as the key defensive measure against infectious disease, and quarantine was considered to be, as John Simon remarked, “an elaborate example of leakiness.”

In 1872 British ports were incorporated into the Public Health Act and, like the urban and rural districts, were defined as port and riparian sanitary districts to which medical officers of health were appointed. Although quarantine remained on the statute books until 1896 and was still theoretically applied to imported cases of yellow fever, plague, and cholera, the practical application of coastal disease control was, on the whole, managed by the Port Sanitary Authorities.

Quarantine is condemned not merely, and not chiefly, because it is injurious to trade, but because it has been proved again and again, in almost every country which has resorted to it, to be not only useless but mischievous, whereas the system of medical inspection and isolation has been found almost uniformly effective.

This system differed from quarantine in that vessels were not detained for any longer than was needed for the inspection of their crew and passengers and for any disinfection of them and their cargo that was deemed necessary. People who arrived with symptoms of an infectious disease were removed to the isolation hospital, and everyone else on board was free to go home or to their arranged

7. See Maglen, “‘The First Line of Defence,’” for a more complete explanation of the role of the Medical Officers of Health and the Port Sanitary Authorities.
lodging house after their names and addresses were recorded. If subsequent cases were reported among the passengers and crew in the following days, local medical officers of health would undertake further inspections and monitor anyone who had had contact with infected patients. This system, known as the “English system” of sanitary surveillance, ensured that the monitoring of cases and contacts of infectious disease occurred away from the port and that vessels that arrived with infection on board were not delayed for more than a few hours. It relied on the cooperation of port, urban, and rural sanitary districts and on the sanitary condition of these districts. The prevention of disease at the ports was therefore not separated from the ordinary structures of public health but was maintained within broader domestic health schemes.

In contrast, disease control in the Australian colonies increasingly throughout the nineteenth century was particularly reliant on quarantine for the prevention of imported infectious disease. Differences occurred between New South Wales, Victoria, Queensland, and the other colonies in relation to the precise periods of detention prescribed for different diseases, but generally speaking, none of them shied from enforcing lengthy periods of isolation. From the mid-nineteenth century, the increasingly different approach of the Australian colonies to British port prophylaxis began to become apparent. Whereas sanitary surveillance in Britain minimized detention of vessels arriving with infectious disease, particularly from 1872, in the colonies it was not only those who arrived displaying signs of disease who were detained but everyone else on board ship, as well as the vessel itself and usually the entire cargo. Sometimes quarantine was carried out onboard, but in most cases the crew and passengers were landed at quarantine stations. These were usually located at a point some distance from towns and cities, mostly on geographically isolated headlands, peninsulas, or islands, and generally at places of deep anchorage so that vessels could be put at “quarantine anchor” nearby for the duration of their isolation. Quarantine in the colonies was often disproportionately longer than the accepted incubation period for infectious disease, and weary travelers could be forced, after the long journey to Australia, to endure months of waiting on sometimes

barely hospitable and remote government stations. Mail and supplies to and from quarantine were carefully disinfected, and great care was taken to prevent personal contact during the exchange. All this attempted to ensure that a spatial buffer was maintained between quarantined people and the rest of the community.

Thus coastal infectious disease control in Australia differed significantly from British port prophylaxis primarily in that in Britain the monitoring of imported infection was conducted away from the port and within the realm of the domestic, urban, and rural public health system. In Australia, everyone on board an infected vessel, and even the vessel itself, was kept isolated from the community at the safe distance of the quarantine station and anchorage until declared no longer a threat to the public health.

What was it about the Australian colonies that made them form such radically different disease control policies from those in Britain? Was Australia’s dramatic response to infectious disease shaped by its distance, as many other aspects of Australian history claim to be? Distance and geographical location are discussed in Peter Baldwin’s 1999 monograph, *Contagion and the State in Europe, 1830–1930.* In it much is made of Britain’s geographical location as a reason why opposition to quarantine was so strong there. Baldwin’s book offers the first proper analysis of geography in relation to quarantine. It therefore provides an important foundation for an examination of how distance impacted quarantine in Australia.

Although the subject of maritime quarantine has attracted surprisingly little attention, some interesting discussions have arisen. These have generally approached the issue of quarantine from the viewpoint of medical theory, that is, the correlation between notions of contagion or anticontagion and the disease control practices and policies that are imposed by a state. The majority of these discussions have been made in response to Erwin Ackerknecht’s classic 1948 paper, “Anticontagionism between 1821 and 1867.” In it he suggested

that there was a causal link between the medical theories of contagion and anticontagion and the respective political ideologies of reaction and liberalism and that an essential link in these relationships was quarantine. The essay has tended to be discussed in relation to its treatment of etiological theory as an ideological by-product, ignoring Ackerknecht's central premise that "the whole discussion was . . . never a discussion on contagion alone, but always on contagion and quarantine." Baldwin responds directly to this assertion but suggests instead that geography, rather than ideology or medical theory, was the underlying motivation behind whether a state was pro- or anti-quarantine. The political and economic principles of each of the Australian colonies were, I would agree with Ackerknecht, important factors in determining their quarantine policies, but what I wish to discuss in this article is the applicability of Baldwin's assertion. I want to test how geographical location impacted Australian ideas of infectious disease and examine what role, if any, geographical remoteness might have played in the extreme application of maritime quarantine in the Australian colonies.

Baldwin uses geography in two ways to explain differences in port prophylaxis in Europe. The first of these is the idea of a "geoepidemiological learning curve" in which those countries farthest from the source of a disease are more likely to impose less strict quarantines because they are able to prepare for the arrival of a disease in the process of watching it approach through other countries. Using the example of cholera prevention in the development of his thesis, Baldwin argues that the Mediterranean countries, whose proximity to the "Oriental founts" of the disease in South Asia, were more quarantinist in their approach to the disease than "Atlantic nations," whose distance allowed them to benefit from the "mistakes" committed by those nations closer to the source. The more distant nations were also able to take comfort in the bulwark of precautions offered by countries to their east.

The second way Baldwin uses geography to explain prophylaxis is topography. By this he means a country's particular geographical

14. I do not engage with Ackerknecht's thesis either with regard to political ideology or medical theory in this article.
15. Baldwin, Contagion and the State, p. 211.
16. Ibid., p. 212.
features, population, and demography, for example. By introducing this further geographical explanation Baldwin is able to account for the anomalous maintenance of strict quarantine in, for example, Sweden, located far from the founts of disease and certainly at an advantageous position on the geoepidemiological learning curve. Situated at the far northwest of Europe, Sweden’s location on the periphery of “currents of transmission had made it strikingly clear from early on that cholera arrived only . . . from across the borders [and] . . . was introduced only through foreign shipping.”17 It therefore subscribed to a contagionist understanding of cholera’s etiology and as such, to quarantine. Furthermore, Baldwin argues, Sweden was approached from the east at its sea borders rather than from its northern land borders. Maritime borders were easier to protect, and entry to the country could be controlled from only a few quarantine stations along the coastline. Its comparatively low level of trade and sparse settlements further benefited a system of quarantine, and the vast expanses of its thinly populated interior would have made the practice of sanitary surveillance almost impossible to execute.18

So are either of Baldwin’s models useful in understanding Australian use of quarantine? Unlike in some of the Mediterranean states, until the final years of the nineteenth century the proximity of the Australian colonies to so-called “Oriental disease founts” was of surprisingly little concern in the formulation of Australian quarantine. Up until the 1880s at least, quarantine was imposed on more vessels from Europe than from Asia. Journey times to Australia, although lessening rapidly throughout the nineteenth and twentieth centuries, were, for the most part, considerably longer than the accepted incubation period of most infectious diseases. The colonies were, as J. Ashburton Thompson wrote in the report of the Australasian Sanitary Conference in 1884, “separated from the rest of the world by a barrier of time-distance which at present is of some practical value to them as against contagious disease.”19 Being at such a distance, they were most favorably situated on Baldwin’s geoepidemiological learning curve. If Britain appeared to benefit from its distance from the Oriental

17. Ibid., p. 222.
18. Ibid., p. 223.
founts of disease in South Asia and was subsequently less reliant on quarantine, surely Britain's distant Australian colonies would also dismiss the necessity for quarantine on similar grounds. An article in the *British Medical Journal* argued:

Of all countries, probably Australia would be the least benefited by quarantine. All emigrant ships carry surgeons who are competent to notify disease, and the voyage is so lengthy that there is ample time for its development. Even M. Fauvel admitted that it was unnecessary for England to quarantine vessels from Alexandria during the late cholera-epidemic, as the voyage lasted ten days, and probably no-one was so infatuated with the fancied merits of quarantine as he.20

On the other hand, in Baldwin's model the colonies were also in a position similar to Sweden. They were certainly on the "periphery of currents of transmission," their settlements were sparsely arranged along the coast, and the interior was extremely thinly populated. As the governor of the Colony of Victoria wrote in a letter to the secretary of State for the Colonies in 1859,

Greater facilities nowhere exist for enforcing quarantine than in this colony—Port Philip being its sole medium of intercourse with other countries, whilst the Promontry of Point Nepean which forms one of the headlands at its entrance is all but isolated from the rest of its still thinly inhabited Eastern shore.21

Distance seemed to play a dual role for Australia, both placing it beyond the reach of disease and also providing the ideal circumstances for the application of quarantine.

This raises the question of how Australia's distance was measured and perceived. Throughout most of the nineteenth century, it was predominantly measured from Britain and to a lesser extent from other imperial centers. Southampton was around 13,000 miles from Sydney via Suez but up to 1000 miles closer via the Great Circle Route, bypassing the Cape of Good Hope and picking up the strong westerlies of the roaring '40s. From the 1850s to the 1880s-90s, the latter was the preferred route to Australia because the winds were more favorable for sailing ships than those met in the tropics of the

21. Letter dated 13 September 1859, Dispatches from the Governor of Victoria to the Secretary of State for the Colonies, 1858–1859, A2346, No. 82, p. 4519, State Library NSW, Sydney, New South Wales.
Indian Ocean. Furthermore, sailing ships were deterred from traveling through the Suez Canal, which opened in 1869, because of "unfriendly" winds and the expense incurred from being towed through. But with the arrival of the more fuel-efficient compound engine steamships, the Suez route via Ceylon and the southwest of Australia gained popularity.22

In the second half of the century three main routes were used between Australia and Europe: Suez to Ceylon and southwest Australia; the Cape of Good Hope to Mauritius and Ceylon; and the Great Circle Route. From the 1850s a fourth easterly route was also used, which departed from Milford Haven to Navy Bay, by rail to Panama, to Tahiti, and on to either Sydney or Melbourne.23 The number of miles traveled via the Great Circle route was considerably less than the other routes, and by sailing down into the Southern Ocean, a ship could depart Britain without touching land again until it arrived in Australia.24 The other routes, on the other hand, particularly when taken by steamships, required vessels to come into port along the way to refuel and replenish supplies. Even though the Great Circle was a shorter route, the distance between ports was greater, and vessels that traveled on the longer northern routes arrived into Australia with less distance between them and their last port of call. Point du Galle in Ceylon was often the last port of call for steamships traveling between Europe and Australia and was around 6000 miles from Sydney—a distance only marginally closer than it was to Southampton.

The Oriental founts of disease in South Asia were therefore of a similar distance from Sydney as they were from London. The considerably closer proximity of Australia to Southeast Asia and the Pacific Islands is often highlighted, however, in discussion of imported disease into Australia. Alison Bashford has argued in her article, "Quarantine and the Imagining of the Australian Nation," that Australia's "racial geographies" (that is, its close proximity to Asia) was greatly influential in the development of its strict quarantine. She claims that the notion of a natural quarantine, highlighted again at the

22. Blainey, Tyranny of Distance, pp. 222–23.
23. "Map Showing the Route of the Australian Direct Steam Navigation Company From England to Sydney & Melbourne Alternatively via Panama, as Contrasted with Those of the Overland Via Suez, & That via the Cape of Good Hope & Cape Horn," The Routes to Australia: Considered in Reference to Commercial and Postal Interests /By the Directors of the Australian Direct Steam Navigation Company (London: Edward Stanford, 1854).
24. Blainey, Tyranny of Distance, p. 198.
Sydney Intercolonial Sanitary Conference in 1883, was an expression of Australia’s physical and growing emotional distance from the Old World and argues that this detachment from Europe only served to highlight the “same distance which located white Australia in an Asia constructed as dirty, diseased and all that was not white.” The “time-distance,” which benefited Australia in the prevention of imported disease was therefore, according to Bashford, only of practical advantage against diseases from the European Old World. Safe distance, she argues, was perceived only from Europe but not from Asia.

Although this may have been the case in the early twentieth century, and indeed in the last years of the nineteenth century, these perceptions of distance and proximity did not operate in the same way when the colonies’ quarantine policies were in formation in earlier decades of the nineteenth century. There were, from the 1850s, a growing number of Chinese immigrants who arrived in Australia, greatly encouraged by the gold rushes of Victoria and Queensland. There was also a very lively tea trade, which brought a large amount of cargo vessels from China, and it would be incorrect to play down the racial prejudices with which either was met. However, much as Australia’s bigotry must be recognized as a guiding force in the formation of many of its policies both before and after federation and as having considerable importance in disease control policies, it would be incorrect to overstate its influence too much, particularly in the first three-quarters of the nineteenth century.

It is important to properly locate Australia geographically in relation to Asia. As already mentioned, the majority of maritime traffic that arrived in Australia throughout most of the nineteenth century originated in the Old World ports of Britain and Europe. By the end of the century over three-quarters of Australia’s import and export trade still remained with Britain. Between 1887 and 1891, for example, only 9 percent of Australia’s imports came from Asia and the islands in the Asian trading network. More than half of these imports were tea from China and Hong Kong, and over the following twenty years almost all of this trade was transferred to India.

and Ceylon, over 6000 miles away.27 Those vessels that did arrive from Southeast Asia, however, still had a long way to travel. Sydney was 4630 miles from Singapore and 4080 miles from Batavia (Jakarta); even the farthest north point of Australia, Cape York, was 2725 miles and 2175 miles from Singapore and Batavia, respectively.28 However, it is somewhat redundant to talk about proximity to far north Queensland because even in the late nineteenth century it was very underpopulated by the European settlers for whom quarantine regulations were created.29 It was not until after the 1870s that towns north of Rockhampton began to be settled, and despite numerous attempts during the century, Darwin was not successfully settled until 1869.

Thus, for most of the nineteenth century, the majority of Asian traffic arrived into one of the more southerly ports of Queensland, New South Wales, or Victoria. The distance between these ports and Asian ports, despite their perceived closeness and Bashford's arguments, was farther than the distance from Southampton to Alexandria or Suez, considered so important in Britain's opposition to quarantine. As M. Henri Monod, the director of the Public Hygiene Department of the French Ministry of the Interior, remarked in 1892 in relation to disease "founts" in India and the Levant, "England by its geographical position enjoys a natural quarantine—namely, the time vessels take to reach its shores."30 Both Britain and Australia were comforted by a perceived distance from disease. Although the perception of Australia's closeness to Asia was important in the quarantine policies implemented in the early years of the twentieth century, and quarantine played a significant role in the period of the "White Australia Policy," it must be remembered that these racist motivations were attached to public health systems already in existence in Australia. The perception of nearness to disease founts in Asia was not operating in the earlier

28. "Map Showing the Route of the Australian Direct Steam Navigation Company."
29. When discussing population in this article, I am referring to the European population rather than the aboriginal population. Although aboriginals are extremely important in addressing imported infectious disease in Australia, they were not present in contemporary consideration of disease control and were not deemed relevant to the formation of quarantine policy. This article wishes to analyze contemporary understandings of disease and its prevention among the European population and therefore does not address disease among the aboriginal population.
part of the nineteenth century when quarantine policies, practices, and infrastructures were created in New South Wales, Victoria, and later Queensland.

The idea of Southeast Asia posing a particular disease threat to the Australian colonies is certainly not apparent in the types of vessels that were quarantined in the pre-1880 period. As previously stated, in the nineteenth century, many more vessels arrived into Australian ports from Europe than from Asia; between the mid-1850s and the beginning of the 1880s, a greater proportion of vessels from British ports were placed in quarantine than those that had sailed from East and Southeast Asia. The latter is taken to include all vessels from Hong Kong, Macau, Batavia, and Bangkok, to name a few. Still, ships that departed from English ports only, not including other places in Europe, made up the majority of vessels in quarantine prior to 1880. Statistics relating to quarantine in the colony of Victoria between 1856–57 and 1880 can be found in the reports of the Sanitary Officer of the Point Nepean Quarantine Station and the Health Officer for the colony.31 These sources do not generally record the routes that quarantined vessels had taken. Because the Great Circle Route was preferred until the 1880s and 1890s, it is reasonable to assume that in the absence of further or contrary information, a majority of vessels from Britain traveled this way. Occasionally vessels are noted in the records to have arrived via Colombo or Cape Town, but rarely if ever are vessels from Britain stated to have called at an East or Southeast Asian port. This is because, as already stated, the routes from Britain and Europe only made stops in Indian or Sri Lankan ports, Mauritius, Cape Town, or one of the Pacific islands, if they stopped at all. Few vessels from Britain used the Torres Strait. Even if quarantined vessels originating in Britain had landed at an Asian port en route, it was not recorded in the sources relating to

31. These statistics are not complete but are calculated from the following years: Victoria Chief Medical Officer, Report on the Sanatory Station for the Year 1863 (Melbourne: John Ferres, Government Printer, 1864); Victoria Chief Medical Officer, Report on the Sanatory Station, Years 1866, 1868, 1870, 1871, 1872, 1873, 1877; Victoria Health Officer, Report for the Year Ending December 31st, 1855 (Melbourne: John Ferres, Government Printer, 1856); Victoria Health Officer, Report for the Year Ending December 31st, Years 1860, 1865, 1870, 1875, 1880. The figures used are taken from the “Return of Vessels Detained in Quarantine” for each of the years. Figures presented in J. H. L. Cumpston, The History of Smallpox in Australia, 1788–1908 (Melbourne: Albert J. Mullett, Government Printer, Commonwealth of Australia Quarantine Service, Service Publication No. 3, 1914), pp. 77–79, 81–83, mirror the trends found in the reports in Victoria and New South Wales.
quarantine statistics. If the perception of risk in this period had been about proximity to sources of disease in Asia, and quarantine was imposed in response to this perception, then one would assume that this would be reflected in the records by emphasizing contact with Asia.

The records show that not only were more vessels, which were stated to have arrived “from England” detained in quarantine than from all East Asian ports combined, but also that they spent the longest time in quarantine. The Donald Mackay, which arrived in Melbourne from Liverpool in March 1861, was quarantined when it was discovered that ten cases of smallpox had occurred onboard during the voyage. The vessel, which is not recorded to have landed at any other port en route, was released after a month. However, because a number of new cases of smallpox had developed among the passengers in the initial quarantine period, they remained in detention at the quarantine station until a full sixty-four days had elapsed.32 The longest period of isolation imposed on a vessel stated to have arrived from an Asian port in the period before 1880, by contrast, was thirty-one days for the SS Snaldragon from Hong Kong, which was quarantined for smallpox in 1864. The records also show that a much greater proportion of vessels recorded with an English departure port were detained for periods longer than two weeks. The available statistics show that whereas 26 percent of vessels from European departure ports were quarantined for over fourteen days, only 7 percent of East Asian vessels were.33 Similar sources for Port Jackson in New South Wales appear to follow the same trend with regard to the statistics as well as the way the origin and route of quarantined vessels are or are not recorded.34 Similarly, sources such as the 1866 Report of the Chief Medical Officer of the Colony of Victoria focus on the inspection and isolation specifically of “vessels coming from English or foreign ports”35 and do not point to any particular concern about Asian ports as a potentially dangerous source of disease.

32. Letter from Chief Medical Officer, McCrea, to the Chief Secretary of the Colony of Victoria, 14 March 1861, PROV VPRS 1189/P0, Unit 560, Item R61/1971, Public Records Office Victoria, Melbourne, Victoria.
33. See Victoria Chief Medical Officer and Victoria Health Officer.
34. Cumpston, History of Smallpox, pp. 77–79.
Instead, most discussions about quarantine in the earlier part of the nineteenth century tend to concentrate on the necessity for maintaining particular vigilance against English ships due to the fact that diseases like smallpox "are never absent from England." 36 This trend changes quite significantly around 1881 when the Sydney smallpox epidemic was believed to have been imported into the colony from China. From around this date, ideas of race and of Asia as a particular source of disease began to inform medical theory and policy more generally, 37 and a distinct racial focus was applied to existing quarantine systems in Australia that soon became a matter of policy. These ideas of race were informed by changing perceptions of proximity to Asia that also began from the early 1880s and that began to become evident in records relating to quarantined vessels.

Racialized responses to a perceived proximity to Asia and the consequential use of quarantine to define national and racial boundaries are important factors in understanding twentieth-century quarantine policies in Australia. 38 They are not sufficient in themselves, however, for explaining the severity of Australian disease control measures, even in this later period. From the end of the nineteenth century these measures were unsurpassed in their length and breadth. Australian use of quarantine at the end of the nineteenth and beginning of the twentieth centuries was exceptional when compared with all the countries that ratified the international sanitary conferences and that had gradually moved toward the British model. 39 The systematic use of quarantine by the Australian colonies against smallpox, for example, was unique among countries with a predominantly European population. They tended to confine the imposition of maritime quarantines to instances of plague, yellow fever, and cholera and generally observed an internationally agreed maximum duration of isolation. 40 Although it is clear that Australia took a distinctive stance on the application of quarantine, any

perceived threat of proximity to and arrival of disease from some racialized “other” was not unique to Australia.

In Britain a link had also been formed between imported disease and the immigration of a racialized group, for example. From 1892, particularly, cholera was closely associated in Britain with East European Jews. Trachoma, as in the United States, was also perceived to be a highly race-related disease, and as such became bound up with the introduction of Britain’s first restrictive immigration act in 1905. Under this law the Port Sanitary Authorities were granted special powers over the inspection and detention of “immigrant vessels,” over and above their ordinary duties of inspecting trade and passenger traffic at British entry ports. Fear of a diseased race “liable to introduce infectious diseases” was a part of the development of British immigration law, with its close ties to public health legislation. It did not change British attitudes or policies relating to quarantine, however. The divergence of British and Australian quarantine was already established by the time immigration regulations and medicalized ideas of race were introduced into the fabric of border control. Racially defined perceptions of disease sources changed in the late nineteenth and into the twentieth century, but Australian and British approaches to quarantine did not.

Changing perceptions of proximity from disease also did not alter the fact that sea voyages to most Australian ports still took weeks. The time/distance taken to reach Australia was, from almost all overseas departure ports, both European and Asian, longer than the accepted incubation periods of most diseases. Yet irrespective of this “natural advantage” of distance, a lengthy quarantine was still imposed on vessels that arrived having had illness on board. Time/distance from a departure port was only important when that port had been declared by colonial government proclamation to be infected—that is, where a number of cases of an infectious disease were reported to have occurred. Vessels on which there were no cases of disease but that had proceeded from “infected ports” were detained at Australian arrival ports for a few hours for compulsory

41. Krista Maglen, “Intercepting Infection: Quarantine, the Port Sanitary Authority and Immigration in Late Nineteenth and Early Twentieth Century Britain” (Ph.D. diss., Glasgow University, 2001).
42. Ibid., pp. 215–16.
inspection and disinfection. Sometimes they were held for a prescribed period of quarantine, depending on where the vessel had traveled from and how long the journey had taken. During the plague epidemic of 1900, for example, if proclaimed infected ports were further than fourteen days' journeying away from a New South Wales port, no quarantine was deemed necessary. Vessels traveling from Hawaii, for example, which was considered to be a plague-infected place, required fumigation but were not placed in quarantine because the journey time was sixteen days. Similarly, when Hong Kong was declared infected with smallpox in 1888, fast steamers arriving in Darwin after seventeen to eighteen days were detained in quarantine for three to four days until the required twenty-one days had elapsed with no sign of disease.

Where cases of infection were found aboard a vessel, though, the period of detention varied according to disease and the date of its last occurrence rather than where the vessel had originated or how long the journey had taken. The duration of the quarantine was set not by the date of arrival but by the date of the last case, either when the patient was removed from the other people from the ship, or when the patient was convalescent. During the 1881–82 Sydney smallpox epidemic, for example, quarantine was imposed for a period of either fourteen days from the convalescence of the last case of smallpox or twenty-one days from the date of removal of the last case from among the persons placed in quarantine. This meant that the duration of quarantine could last for weeks if new cases continued to occur while already in quarantine. Time was calculated from the end of infection. Distance ceased to be of importance because the disease had already breached the boundaries of space and was now dangerously close.

Australia’s geographical distance, which was “of some practical value,” was therefore only reinforced by quarantine. Quarantine served to create distance from individual cases of disease, rather than, as Baldwin argues, from disease founts only. This can be seen in a report to the NSW Legislative Council in 1883:

44. “Bubonic Plague at New Caledonia,” Extracts Re. Bubonic Plague from Minutes of Board of Health, 1897–1908, 2 January 1900, p. 23, Kingswood: 5/5855, State Archives NSW.
45. 13 March 1888, Minutes of Proceedings, Board of Health, 1887–1890, Kingswood: 5/4936, State Archives NSW.
Nature has thus established a sort of prophylactic quarantine, and we will fall far short of our duty if we fail to take proper steps to isolate such cases of infectious disease as may have developed on board ships arriving at our ports, and also for detaining for a reasonable period such persons as may have been brought into contact with those so suffering. One of the great advantages of the Australian Colonies is their freedom from cholera, smallpox, typhus and yellow fever, which devastate other parts of the globe less favourably situated, and it is surely worth our while by means of an effective quarantine system to preserve our fortunate immunity in this respect.46

Although the Australian colonies enjoyed a similar distance from disease founts as Britain did, strictly enforced quarantines were still considered essential to maintain a further barrier from individual cases of disease. Distance was not enough of a defense against infectious disease. Nature’s prophylactic quarantine did not mitigate the risk of epidemic disease enough for there to be any compromise on coastal disease control. Three risk factors need to be recognized to understand the need to quarantine and for the differences that developed in Britain and Australia to be fully appreciated.

First, the sanitary conditions of Australian towns and cities were not as advanced as those of England. This meant that the “inner defences” of sanitation and public health were not to a standard that, like in Britain, could be relied on should an infectious disease be introduced into the community. Replacement of quarantine with the English system was only feasible in Britain because of the great improvements made to the sanitation of British towns since the 1850s.

The [British] Government . . . depend for their safety upon the rational system of medical inspection at the ports as the first line of defence, and upon the maintenance of an increasingly high standard of sanitation throughout the length and breadth of the land for the second line of defence in the event of the first line being broken through.47

In Australia no “second line” assurance was in place if the “first line of defence” was breached. Quarantine provided the only available protection against epidemic disease for places such as Melbourne, where a massive population growth had stretched the city to the point of sanitary crisis by the 1870s.48 Other major towns were no better

46. Legislative Council, New South Wales, Quarantine Station, North Head (Report of the Health Officer upon State and Condition of, &c.) (Sydney: 1883), [*c 49-A], p. 5.
prepared, and it was feared that if infectious diseases were introduced, they would be very difficult to contain. Imposing quarantine on any possible risk was therefore essential. In 1885, for example, all vessels that arrived in Sydney from New Caledonia were placed in quarantine for eight days, even when everyone on board was perfectly healthy. A particularly fierce epidemic of dengue fever was raging in Noumea, and although the incubation period was estimated to be from three to seven days, the New South Wales Board of Health decided that because of the “insanitary conditions of Sydney,” as well as the “similarity of climate,” a blanket quarantine policy should be imposed until New Caledonia was declared free from epidemic dengue.49

The second factor that set apart Australian and British public health in the nineteenth century was vaccination. Whereas smallpox vaccination was compulsory in Britain from the 1850s, not all of the Australian colonies legislated for mandatory vaccination. Even those of the colonies that had created Vaccination Acts did not enforce them to the extent where it could be relied on that a large percentage of the population had been vaccinated.50 What made it more difficult to ensure vaccination throughout the community was the inability to keep track of the large numbers of immigrants from around the world who arrived throughout the century, particularly during the Victoria, Queensland, and Western Australia gold rushes. As such it was believed that it was “absolutely necessary that [quarantine] should be maintained with great strictness in all parts of Australasia as long as the population in any part remains imperfectly vaccinated.”51 In an effort to increase numbers, vaccination became incorporated into the quarantine system. Quarantine was often reduced if everyone on board submitted to being vaccinated. In 1885 it was determined that it was safe to release a person from quarantine fifteen days after a successful vaccination.52 But with poor internal sanitary conditions and insufficient vaccination in a rapidly growing population, quarantine was the important first line of

49. 19 August 1885, Minutes of Proceedings, Board of Health, 1881–1887, Kingswood: 5/2913, State Archives NSW.
50. Anderson, Cultivation of Whiteness, p. 93.
52. 17 October 1885, Minutes of Proceedings, 1881–1887.
defense and was believed to afford the best protection against imported infections. As a Melbourne physician remarked in 1893, "Our method of quarantine [is] justified by our surroundings, namely, the inefficient vaccination . . . our improper hygienic conditions, and the fact that the germ of smallpox [has] not yet acquired a local footing."53

This is the third factor that differentiated Australia from Britain in disease control. Many of the diseases that were considered endemic to Britain, or indigenous as it was sometimes called, only occurred in Australia when imported from abroad. When Britain's system of sanitary surveillance was first established in 1872, and up until the abolition of quarantine in 1896, nonquarantining sanitary methods were only employed in cases of indigenous or endemic diseases. These included measles, smallpox, scarlet fever, typhoid, whooping cough, and just about every other infectious fever apart from the three traditionally quarantineable diseases—plague, yellow fever, and cholera. They remained under the umbrella of British quarantine law under international agreement until 1896.54 In Australia, then, it should not be so surprising that a seemingly common disease like measles could encourage an enforcement of perhaps five weeks in quarantine.55 This disease, like cholera, could only occur in Australia when imported by ships arriving from overseas. As the first director-general of the Commonwealth Department of Health, J. H. L. Cumpston wrote in his private papers in the early years of the twentieth century, strict quarantine was required in Australia from the landing of the First Fleet in 1788: "A community taken for the most part from a grossly insanitary environment infected with typhus fever, cholera, dysentery, typhoid fever, tuberculosis and venereal diseases, was landed after a voyage of eight months, or longer, in a country free from all diseases and unhygienic conditions."56 Some of these diseases, of course, did become established in Australia, at

54. The British 1896 Quarantine Act altered Britain's use of quarantine and therefore had an effect on their approach to international agreements. See Maglen, "Intercepting Infection," chap. 2.
55. See, for example, the steamer Lady Norman quarantined off Magnetic Island, Queensland, from 18 April until 25 May 1900. Diseases: Infectious, Re. Townsville, COL/288-00/4210 and 00/4326, State Archives QLD, Brisbane, Queensland.
56. J. H. L. Cumpston, Essentials of Medical History, undated manuscript, MS 613, Box 7, Cumpston Papers, National Library of Australia, Canberra, Australian Capital Territory.
which point they were managed differently, but while they were exotic to Australia, they were dealt with by the quarantine authorities.

I would agree with Baldwin that geographical location and topography were of great significance to the way in which a state dealt with the problem of imported infection. In the case of Australia, where remoteness has always been part of the consciousness, this is of additional importance. Yet at the same time distance played a strange role in Australian disease control, both putting the colonies beyond the reach of many infections and also creating an intense fear of the proximity of disease when at times it did puncture the quarantine line of defense. This fear, however, must not be seen independently of other important factors at play within Australian public health, such as its relatively poor domestic sanitary conditions, its incomplete vaccination, and its lack of indigenous infections. In an article from the *British Medical Journal* in 1882 the interplay of some of these factors is described: “Smallpox is so rare in Melbourne that the doctors of the place rarely see it, and consequently know little of it. Happy Melbourne! This may be due in some measure to the remarkable fear of it which exists in Melbourne and to the consequent extreme precautions which are taken against it.”

Although race, based on a perceived proximity to Asia, is also an important factor in understanding disease control after 1881, it should not be overstated in the earlier decades of the nineteenth century. The development of quarantine from the very first Australian legislation in 1832, which closely mirrored the British act, did not have the racial agenda it acquired from the beginning of the 1880s, and it is misleading to assume that it did. The divergence of quarantine in the Australian colonies from the way disease control was practiced in Britain, and increasingly in many other parts of the world, occurred before race began to significantly affect the way the colonies/nation defined its borders. The particular rigor with which quarantine was applied in the Australian colonies continued into the period of federal nation-building and “insular territoriality,” but it did not originate there. It developed around the same time that quarantine was being abolished and the Port Sanitary Authorities were in creation in British ports. Although it is tempting to seek a

universally applicable formula and some manner of generalization about the use of quarantine in different parts of the world—whether it is through ideas of race or geography or ideology—too many anomalies arise in the face of such attempts. Instead a combination of factors—and by no means have all of them been addressed here in this article—need to be examined when undertaking an analysis of quarantine.