

Immigration and Public Health

by Wayne Lutton

One of the areas where the United States and other Western nations progressed dramatically during the late 19th through 20th centuries was in the area of public health. Swamps were drained, sanitation and personal hygiene improved, vaccines were discovered. All of these contributed to the improvement of health to the point where, by the late 1970s and early 1980s, many once common diseases all but vanished from the United States.

Historically, the United States government enforced health standards for immigrants. Even today, under section 212 of the Immigration and Nationality Act (8 U.S. Code 1182), the Attorney General is not to admit aliens if they are afflicted with certain mental or physical conditions, any “dangerous contagious disease,” or any defect, disease or disability that may affect their ability to earn a living. Public Health Service regulations include infectious leprosy, active tuberculosis, and venereal diseases among the dangerous infectious diseases disqualifying someone from migrating to the United States.

A turning point in the U. S. government’s policy toward the entry of persons infected with contagious

diseases came on March 15, 1980, when the Attorney General, acting on a request from the State Department to expedite the processing of Indochinese refugees, decided to lower the health qualifications for admitting designated refugees to our country. From this point on, refugees have been permitted to enter and settle in the United States who earlier would have been excluded, including people afflicted with active tuberculosis, mental retardation, and infectious leprosy. During the Clinton Administration, people carrying the deadly AIDS/HIV virus were permitted to legally enter the United States.

Mass immigration – a consequence of the 1965 Immigration Act (which opened the door to large-scale immigration from the Third World), the Refugee Act of 1980, and refusal by federal authorities to control illegal immigration – has contributed to a new threat to our nation’s health. Diseases once practically eradicated are breaking out again. Tropical diseases, previously unheard of in the United States, but prevalent in Third World countries, are appearing. Medieval ailments are resurfacing. The immigration/disease relationship demolishes the claims that high immigration levels, with hundreds of thousands of people entering the U.S. uninspected every year, is entirely benign.

Warnings Unheeded

In recent years, health professionals have tried to alert government authorities and the general public about certain of the newly emergent health dangers. During the Reagan Administration, J. Michael McGinnis, deputy assistant secretary of the U. S. Department of Health and Human Services, warned of problems in the American Southwest originating in Mexico, “Along the border we have a prevalence of diseases that we shouldn’t be seeing much of in modern Western society. We have higher rates of such things as malaria, tuberculosis, measles, rubella, rabies, and pertussis (whooping cough).” He added that physicians trained in the United States where such diseases are not prevalent, have difficulty recognizing them in new patients.¹

The 1995 Ebola virus outbreak in Zaire drew new

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attention to the emergence of drug-resistant forms of tuberculosis, whooping cough, and pneumonia. Interviewed by *Fox Morning News*, Dr. Nils Daulaire of the U. S. Agency for International Development was asked if he was trying to sound an alarm here about infectious diseases? Dr. Daulaire replied,

Yes. There's a real serious issue that has gone unnoticed by a lot of people in this country, and that is that we are no longer secure as we were in the 1950s and '60s and '70s from the threats of these diseases. At that time we thought we had the problem basically licked. We had good vaccines, we had good antibiotics for a lot of the bacteria, tuberculosis was on a steep decline and we thought basically we could move out of the area of infectious diseases into things like heart disease and diabetes, the chronic diseases...

We've had a very severe reminder over the last several years with the emergence of the Ebola, with tuberculosis spreading rampant in much of the Third World and in inner cities in the U.S. and with the development of antibiotic resistance.

Asked the cause of these developments, Dr. Daulaire, continued:

First of all, as human populations expand and move into areas of tropical rain forest, which are the most biologically diverse areas on earth, we're having face-to-face contact between species that really haven't had contact or significant contact before. And so we're getting increased spread of new pathogens, new microbes that haven't been in the human population, like Ebola ... And they are being brought out in developing countries, in places where populations are growing tremendously. And then, and this is the part that is particularly worrisome for the U.S., there's no place in the world anymore that's more than 24 hours travel from any port of entry in the U.S., so these things can move very quickly to the U.S. where they pose a real risk.

Fox News: "Some people say, 'Oh, come on, these are Third World problems. We don't have to worry about

that...it can't happen here."

Dr. Daulaire: "Well, that was true a hundred years ago, it was probably even true 40 years ago. But with the amount of travel and international commerce that takes place now, in fact, one-third of the tuberculosis in the U. S. is foreign-born, so there's a lot of importation."²

The National Science and Technology Council (NSTC) issued a report in September 1995, *Infectious Disease — A Global Health Threat*, which spurred demands for a new national public health policy for dealing with ominous threats of emerging and reemerging infections. This prompted the White House to convene a Committee on International Science, Engineering, and Technology (CISSET), chaired by then Vice President Al Gore. CISSET issued their own report, which confirmed that HIV (AIDS), the periodic outbreaks of new and reemerging infections, and the realities of drug-resistant tuberculosis and of many nosocomial infections, are irrefutable confirmation of those threats.

Why, the CISSET report asked, "are infectious diseases reemerging as major threats to human health?" Answers included population growth, unprecedented travel, and other movements of population (migration and immigration). Both CISSET and NSTC concluded that high among the needed responses was global surveillance and security against infection, requiring closer scrutiny of "persons, animals or material" traversing our borders.³

In late 1996, the *Journal of the American Medical Association* again warned that the United States was "importing tropical illnesses." The publication cited remarks made by Om Sharma, M.D., professor of medicine at the University of California, Los Angeles, School of Medicine, to attendees of the annual meeting of the American College of Chest Physicians. *JAMA* reported, "like vagabonds hopping the next freight train, infectious diseases once confined to the tropics and subtropics are traveling the globe via tourists, business travelers, and immigrants." Dr. Sharma noted that disease killers accompanied by respiratory symptoms can turn up anywhere in the world. Among them are malaria, paragonimiasis (often mistaken for TB), and schistomiasis (often found in patients with lung disease and associated liver or urinary tract disease).⁴

Marsha Goldsmith, writing in *JAMA* in 1998, cautioned,

Travel is broadening. Unfortunately, it may also be diarrhetic, emetic, toxic ... that is to say, a vehicle for exposing the body to unfamiliar ills even as it opens up new vistas for the mind.

She went on to observe that physicians in the U.S. and other developed countries

are finding their diagnostic acumen challenged by diseases that have disappeared from, or were never common in, the places where they practice. ...Medical professionals in North America and Europe are also encountering patients who visit or migrate from their native countries, sometimes leaving behind everything but their endemic illnesses.⁵

Diseases Cross U. S. Open Borders

Alarms raised by health care and national security professionals have not led to the policy changes required to secure our country from foreign threats. There are 301 official air, land, and sea ports of entry into the U.S. On a typical day, over 1.1 million passengers enter, over 57,000 trucks and containers and 323,622 other motor vehicles are processed, 580 vessels hove into ports, and 2,459 aircraft land.⁶ The Division of Global Migration & Quarantine of the federal National Center for Infectious Diseases currently has a staff of 39 employees in the field and 42 at its Atlanta-based headquarters administration. Field officers have the power to detain, medically examine, or conditionally release individuals and wildlife suspected of carrying an infectious disease. But with examiners stationed at barely one-tenth of our ports of entry, it is clear that the federal government has all but abandoned any pretense of properly screening overseas visitors, immigrants, and refugees.

Overseas screening of visitors, immigrants, and refugees is likewise inadequate. In a system rife with fraud, prospective entrants to the U.S. submit certification of health. Inspections by visa officials and at U. S. ports of entry are cursory, often taking less than 5 seconds. These procedures are rarely able to detect foreigners carrying contagious diseases and parasitic infections, nor identify persons with other personal problems, such as mental illness, mental retardation, alcohol and drug addiction, and many other major health

problems, including heart and kidney disease, diabetes, and cancer.

What are some of the contagious diseases – a number long thought to have been eradicated, or never before seen in the United States? The troubling list includes:

TUBERCULOSIS

Tuberculosis reemerged in the United States in the late 1980s, carried by immigrants and refugees from Third World countries. Once dubbed the “white plague,” TB was the leading cause of death for young adults in the early part of the 20th century. By the 1970s, many experts thought TB was conquered in the United States, even as it remained a major health problem in Third World countries. The steady decline in the incidence of TB in the U.S., from 101.5 cases per 100,000 people to 18.3 in 1970, came to a halt in the mid-1980s.

By the early 1990s, public health officials were issuing new warnings about the danger of resurgent TB. Representative of the reporting on this issue was a story in the *Chicago Tribune*, “TB Makes A Deadly Comeback,” Feb. 20, 1992. The newspaper revealed that “the number of new cases has risen steadily. ...Illinois has the fifth-highest number of drug-resistant cases, among the 13 states where these forms of the disease have been diagnosed.” John Kuharik, head of Chicago’s TB program, declared, “We are looking at the possibility of an explosive outbreak if the people who have the drug-resistant strains are not treated and infect other people.”

In 1993, the Centers for Disease Control revealed that TB was tied to immigration, with 53 percent of the new cases in the United States centered in four states that are magnets for immigrants – California, New York, Texas, and Florida. The highest number of reported TB cases was in California, with 61 percent of them among the foreign born. Dr. Sarah Royce, chief of the TB control branch of the California Department of Health Services, emphasized, “Anybody can catch tuberculosis. It’s an airborne infection, and any person untreated can spread it to others. It’s something everybody needs to be concerned about. It’s totally preventable. We need better screening.” CDC officials noted that TB statistics represent only reported cases. They don’t know how many illegal aliens may be carrying and spreading the disease.⁷

By 1995, the number of foreigners living in the U.S. with TB rose 55 percent from 1986, as a growing number

of infected immigrants entered the country, the CDC reported. Most were people from Mexico, the Philippines, and Vietnam. Dr. Patrick Zuber of the CDC's Division of Tuberculosis Elimination admitted that people entering the country, as non-residents were not required to be tested for TB before obtaining a visa to enter the U.S. "We would like to find a way to more effectively identify persons who enter the U.S. with tuberculosis. We may have to re-evaluate the criteria of inclusion for persons who have to be screened."⁸

Despite concerns expressed by public health officials, TB continued to rise among foreign-born persons living in the U.S. In 2000, CDC revealed, "Immigration is a major force sustaining the incidence of tuberculosis in the United States." Six states (California, New York, Texas, Florida, New Jersey, Illinois) reported 73.4 percent of the foreign-born cases. Approximately two-thirds of these cases were originally from Mexico, the Philippines, Vietnam, India, China, Haiti, and South Korea.⁹

Many immigrants do not know they are infected when they enter the U.S. Others come here for the purpose of obtaining treatment at American taxpayers expense. The prevalence of TB in the countries from which most immigrants to the U. S. originate is 10 to 30 times greater than in this country.¹⁰ A study conducted by health officials along the Texas-Mexico border discovered that among the 17,651 illegal aliens apprehended in the Port Isabel, Texas region in 1999, 49 percent tested positive for the TB bacterium. The rate of full-blown tuberculosis in the lower Rio Grande Valley is triple the national average, according to the U. S. Public Health Service in Port Isabel.¹¹ On average, a person with active TB infects 20 others annually.¹² At the high end, a boy adopted from the Marshall Islands infected 56 persons in a small North Dakota town.¹³ Lax screening of legal immigrants and refusal to halt illegal immigration triggered the return of this deadly disease.

HIV/AIDS

HIV/AIDS is a deadly virus that originated in Africa and spread throughout the Caribbean (especially Haiti), Latin America, and parts of Asia. Immigrants and illegal aliens from these areas have helped circulate the disease. In 1992, U.S. Surgeon General Antonia Novello confirmed that Hispanics, then 8 percent of the U.S. population, accounted for more than 16 percent of reported AIDS cases.¹⁴

Ten years later, George Lemp, director of the AIDS Research Program at the University of California, said that a study of men aged 18-29 years old indicated that young Hispanic men in the border area of San Diego and Tijuana, Mexico, have AIDS/HIV infection rates three to four times higher than the rates in other California cities (18.5 percent in Tijuana and 35 percent in San Diego). Nationwide, Hispanics represented 13 percent of the U.S. population in 2000, but accounted for 19 percent of the total number of new reported AIDS cases (many cases go unreported). Overall, the AIDS incidence rate

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per 100,000 persons was 22.5 among Hispanics, more than 3 times the rate for Whites (at 6.6), but lower than the rate for Africans living in America and American Blacks (58.1).¹⁵ In Minnesota, where African "refugees" and new immigrants have been settling, Africans drove up the state's HIV rate by 6 percent in 2002. African immigrants make up less than 1 percent of Minnesota's population, but account for 20 percent of new HIV infections.¹⁶

CHOLERA

Cholera is a communicable disease that re-emerged in South America in the early 1990s and entered the United States by Latino migrants. It usually comes from drinking, bathing or washing with water contaminated by fecal matter. Eric Niiler, in *Scientific American*, reported, "In addition to exposing themselves, the migrants (from central and southern Mexico), may be exposing others – in the fields, factories and restaurants where they find work. The Centers for Disease Control and Prevention found that California has twice the rate of infections of two food-borne pathogens associated with human sewage – campylobacter and shigella – of another other state tested."¹⁷

MEASLES

Measles is a disease that, in 1999, the Centers for Disease Control stated “has been all but stamped out in the United States.” Virtually all of the new cases were brought into the country by immigrants (legal and illegal). “If we didn’t have importation, we wouldn’t have measles,” said Dr. Mark Papania, the then acting chief of measles elimination at CDC.¹⁸

RUBELLA

Rubella (German measles) is another once-common disease that vaccinations practically eliminated among Americans. There have been fresh outbreaks of this disease in Texas, New York, and Connecticut (among other states), spread by Hispanic immigrants. It is especially dangerous to pregnant women, who can have miscarriages, or deliver children subject to deafness, blindness, heart disease, and brain damage.¹⁹

HEPATITIS

Hepatitis A is a highly contagious virus that affects the liver. The virus is transmitted through unclean food and water and can be spread by infected food handlers and processors. On the U.S. side of the Texas-Mexican border, and in California, the disease rate is two to three times the national average.²⁰

Hepatitis B is endemic in many parts of Asia and the Pacific Islands. The foreign born account for 40-60 percent of all cases found in the United States. Asians constitute 4 percent of our population, but they account for more than 50 percent of the Hepatitis B cases in the U. S. The Hepatitis B rate is about 70 percent greater for Asians than the percentages for Whites and Hispanics, and 14 times greater than for American Blacks. Up to a quarter of them will eventually die from liver failure or liver cancer.²¹

MALARIA

Malaria was eradicated in the United States by the early 20th Century. In the mid-1990s it re-emerged as a serious health problem, with new cases springing up from Texas to New York and New Jersey. The New York metropolitan cases were the first in more than four decades. “Nearly all those cases have involved *vivax* parasites carried by Mexican and Central American immigrants,” according to Dr. Anne Barber of the CDC malaria branch.²² In 1995, mosquito-transmitted malaria was discovered in Michigan. The CDC noted that sources of mosquito infection include imported cases of malaria in Michigan, and unrecognized or unreported

cases among immigrants, migrant workers, and travelers from malaria-endemic countries.²³

WEST NILE VIRUS

West Nile Virus was discovered in the African country of Uganda in 1937. It made its first appearance in the United States in 1999, when 8,200 people residing in the New York metropolitan area (most of them foreign born) came down with West Nile encephalitis.²⁴ The virus is carried by birds and transmitted to humans via mosquitoes. It is thought that humans can carry this disease. West Nile virus has spread from New York to other parts of the East Coast, with the first death from the disease in Georgia reported in the fall of 2001. Health officials expect it to spread throughout the Southwest and on into Mexico and Central America.²⁵

DENGUE FEVER

Dengue fever, a potentially deadly, mosquito-borne disease, began appearing in the United States along the U. S.-Mexican border in the mid-1990s. Dengue, also known as Break Bone Fever, causes fever, bone pain, exhaustion and nausea. Hemorrhagic dengue fever causes bleeding from the nose and gums, and internal bleeding. The Pan American Health Organization reports that it is widespread in Brazil, Costa Rica, the Dominican Republic, El Salvador, Honduras, Nicaragua, Panama, Venezuela, and Mexico. The first cases in the Americas were detected in 1991 in Cuba.²⁶

LEPROSY

Leprosy is a Biblical disease often spread by coughing, as the bacteria pass through the respiratory droplets of an infected person. Untreated infections can lead to serious complications, including the loss of toes or limbs. Forty years ago the U. S. had 900 reported cases. In February 2003, health officials said there are more than 7,000 people living in America who have leprosy and health officials have declared it now endemic to the Northeastern United States for the first time in our nation’s history. Most of those infected in the U. S. are immigrants from such global leprosy hot spots as Brazil, the Caribbean, and India. Officials in New York have encountered cases of leprosy from people who have contracted the disease in the United States.²⁷

SARS

Severe Acute Respiratory Syndrome (SARS) is a deadly, pneumonia-like ailment imported to the United States from China and Hong Kong in early 2003. It is easily spread, and U.S. healthcare workers have contracted SARS through patient contact. In one of the first cases of the disease reported outside of Mainland China, a doctor who caught the illness in a Guangdong hospital traveled to Hong Kong in mid-February 2003. Within a short time, people staying or visiting on the same floor of a hotel where he was staying contracted SARS. In turn, they carried the disease to Vietnam, Singapore, and Canada.²⁸

Costs to American Taxpayers

Exposure to imported illnesses not only endangers Americans' physical well-being, it costs taxpayers billions of dollars. Additionally, funds diverted to cover the medical expenses of foreigners, are leading to severe cutbacks in services available to U. S. citizens in areas enduring especially high rates of immigration.

The total dollar costs for health services provided to foreigners nationwide is not available. Rice University economist, Professor Donald Huddle, calculated the 1996 cost of Medicaid for legal and illegal immigrants to be a net \$14.5 billion. Legal immigrants are estimated to account for more than 80 percent of the net cost of Supplemental Security Income (SSI), which pays for disability and medical conditions not covered by Medicaid.

Public records give an indication of what mass immigration is costing the American health care network. Data from states with large foreign-born populations include:

CALIFORNIA

Over the past decade, medical costs associated with the care of aliens have skyrocketed. In 1993, San Diego County reported that two-thirds of its funds for emergency medical services for the poor was going to pay for the care of illegal aliens and foreign citizens.

During fiscal years 1997-1998, California spent \$84 million on prenatal care for 70,000 female illegal aliens. Mexican-born women accounted for 57 percent of births to Hispanic women in 1995.

By March 2003, Los Angeles County's public health care system was teetering on the edge of collapse and local officials said there is little they can do without a massive injection of federal funds. The \$3 billion

department was forced to slash services to residents, including the shutting down of public health clinics and a nationally respected rehabilitation hospital. Uninsured patients, whose care is covered by local taxpayers, have bankrupted the system. Although California officials are reluctant to discuss it publicly, recent immigrants, including hundreds of thousands of illegal aliens, play the decisive role in the county's crisis.²⁹

ARIZONA

Half the patients obtaining services at Arizona hospital emergency rooms are not paying for their care, forcing hospitals to slash services. A majority of the non-paying patients are illegal aliens, Sen. John Kyl said in January 2002. The American Hospital Association estimated that in 2000, the 24 southernmost counties accrued \$832 million in unpaid medical care, a quarter directly attributable to illegal immigrants.

The *New York Times* reported that "the financial pressures are spreading north into larger cities, pushing the overall unpaid bills well into the billions of dollars and straining a health care system already stretched thin by rising numbers of the uninsured. Officials at hospitals throughout the Southwest say they are treating more illegal immigrants every year."

Dr. Michael Christopher, director of emergency medical services at St. Joseph's Hospital in Phoenix, said Internet websites widely-known in Mexico tell Mexicans how to claim care at American hospitals and include maps on how to get to them.

Maricopa County Hospital has uncompensated health care losses approaching \$100 million annually. In 2001, the five major medical providers in the county amassed \$318 million in uncompensated services. Other services are being reduced, with the wait for intensive care beds often lasting several days and some emergency room patients forced to wait 24 hours or more to see a doctor. Plans to upgrade equipment have been delayed.³⁰

FLORIDA

Foreign nationals who seek emergency and long-term care in Florida hospitals have created a crisis in Central and South Florida. The Florida Hospital Association reported in January of 2003 a steady rise in the numbers of illegal aliens and uninsured foreign visitors who show up at emergency rooms with serious illnesses requiring weeks or months of hospitalization without

funds or insurance to cover medical bills. While hospitals throughout the state are affected, the problem is acute in Central and South Florida, areas with Florida's highest concentrations of foreign nationals. The FHA suggests that some foreign nationals travel to the United States on legal tourist visas for the purpose of obtaining medical care at American hospitals, since they know that federal law mandates that hospitals provide emergency room and natal care for all who come. The FHA report stated, "Noncitizens or their children with severe diseases obtain tourist visas, either legally or illegally, and take taxis directly from airports to hospital emergency rooms."

Just one illegal alien involved in a car accident, Guatemalan native Luis Jimenez, incurred \$2 million in bills at Martin Memorial Medical Center over the past 2½ years. Neither Jimenez, his American employers, or the government of Guatemala has reimbursed the medical facility. After a long fight with Florida Legal Services, dubbed "an immigrant advocacy group," Martin County Circuit Judge John Fennelly agreed that the hospital could fly the illegal alien back to his homeland where he could rejoin his family. Jackson Memorial Hospital spokeswoman Conchita Ruiz-Topinka said that his ruling "recognizes the hospitals' right to repatriate these patients and relieve themselves of the burden of taking care of patients from other countries with no means. It also puts countries on notice that there are certain expectations that they have to meet and take these folks back."

Earlier this year the Florida Hospital Association reported that a major problem facing hospitals is lack of cooperation from foreign governments for the care of their citizens at U.S. medical facilities. The Association recommended that foreign countries be required to accept medical transfers of their citizens. The Bush Administration has indicated no interest in addressing this issue.³¹

NEW YORK

In 1989, the New York City budget for TB was \$2 million. By 1999, with the immigrant-driven resurgence of TB rates, the budget rose to \$50 million. During 1997, NYC hospitals provided \$1.2 billion in health care to immigrants who could not pay.³²

IMMIGRATION AND THE HEALTH INSURANCE CRISIS

Mass immigration is contributing to the ranks of the uninsured. According to a study prepared by the Center

for Immigration Studies, immigrants who arrived between 1994 and 1998 and their children accounted for 59 percent of the growth in the size of the uninsured population since 1993 (2.7 million persons). Nearly a third of persons living in immigrant households lacked health insurance, more than twice the 13.9 percent of native citizens. The refusal of federal officials to reduce immigration levels has made it much more difficult to reduce the size of the uninsured population.³³

MANDATING INTERPRETERS

The Office of Civil Rights in the U.S. Department of Health & Human Services ruled that physicians, who receive federal payments, including Medicaid reimbursement for low-income patients, must provide at their own expense a trained clinical interpreter for all their limited-English proficiency patients, regardless of whether the patient is covered by insurance. The Clinton Administration designated people with limited English proficiency a protected group under antidiscrimination law. The mandate does not provide funds to doctors to pay for interpreter services. With an estimated 21.3 million people speaking English "less than very well," according to 2000 Census data, up from 13.9 million in 1990. Translation services cost \$30 to \$400 per hour and the total costs for such services is staggering.³⁴

MEDICARE FRAUD

States across the country report that their Medicaid/Medicare support systems have reached the disaster level, with massive budget shortfalls projected for years to come. The budget crises come not only from the cost of spending hundreds of millions of dollars on patients who are foreign nationals. The system is rife with fraud perpetrated by foreigners operating in the United States.

For example, in September 2003, Surinder Singh Panshi, a Pakistani, was sentenced to 16 years in state prison for using Southern California clinical laboratories to cheat the Medi-Cal program out of an estimated \$20 million. Labs controlled by Panshi ran a black market for blood and stole the identities of patients and doctors. They billed Medi-Cal for thousands of false tests sometimes performed on blood drawn on unsuspecting patients or purchased from runaway children, the homeless, and drug addicts. The California Attorney General's Bureau of Medi-Cal Fraud reports that Medi-

Cal fraud is a multi-billion dollar problem and is responsible for a huge chunk of the state budget deficit.³⁵

In Arizona, the state Department of Health and Human Services uncovered an elaborate Medicare fraud that netted over \$15 million. Twenty defendants, most of them Nigerian nationals, pled guilty. Nigerians set up more than two-dozen stores in Arizona and other states dealing in prescription medical supplies, such as wheelchairs, hospital beds, and diet supplements. Going under the name Dona Medical Distributors Inc., they fraudulently secured patient names and manufactured false documents, and then billed Medicare for supplies that were either not delivered or were grossly overpriced. Doctors' signatures were forged thousands of times, and a nurse was hired to create false medical histories.³⁶

In Miami Federal Court, Alfredo Omar Rodriguez pled guilty to masterminding a \$20 million Medicare fraud, one of the largest scams in South Florida history. Rodriguez controlled 18 shell corporations that billed health providers for unnecessary or excessive knee braces, charging over \$1,200 apiece. Rodriguez attempted to move cars, yachts and other assets to Costa Rica before authorities arrested him and over 20 other accomplices.³⁷

The cases cited here are just the tip of the iceberg. Federal and state authorities are understaffed and often stumble across cases long after millions of dollars have been stolen. As one Nigerian criminal remarked, "I love Americans...they are so trusting!"

Recommendations

The importation of new diseases and escalating costs incurred by legal and illegal immigrants is compelling evidence that the United States should take effective measures to sharply reduce legal immigration, halt illegal immigration to the greatest extent possible, and expel the estimated population of 8 to 11 million illegal aliens residing in our country.

- Health inspectors should be on duty at all ports of entry. People exhibiting signs of illness should be detained for further examination.
- Visas should not be issued without proof of insurance.
- The federal government should seek reimbursement from foreign countries for the uninsured medical bills of their citizens.

- The Citizen-Child loophole which grants citizenship status to the American-born children of non-citizens (and thus access to a host of benefits, including education and health care) should be closed.

Americans have worked hard since the founding of this nation to provide a clean, safe environment for themselves and their families. All of that progress is being threatened because federal officials refuse to curtail mass immigration. Unless swift action is taken, the United States is in danger of experiencing a public health calamity. •

NOTES

1. "Malaria outbreak called border problem," *San Diego Union*, August 31, 1986.
2. Fox Morning News, WTTG-TV Fox Network, Washington, D.C., AIDS/Infectious Diseases, July 25, 1995, broadcast excerpt.
3. Joshua Lederberg, "Infectious Disease: A Threat to Global Health and Security," *Journal of the American Medical Association (JAMA)*, August 7, 1996, pp. 417-419.
4. Quick Uptakes, Importing Tropical Illnesses, *JAMA*, December 25, 1996, p. 1941.
5. Marsha F. Goldsmith, "Health Woes Grow in Shrinking World," *JAMA*, February 25, 1998, pp. 569-571.
6. Customs & Border Protection, U.S. Department of Homeland Security, General Statistics for 2002, April 18, 2003 (www.cbp.gov).
7. Carol Innerst, "TB Tied to Immigration," *Washington Times*, March 21, 1993, pp. A1, A6.
8. Immigration/tuberculosis, Atlanta, September 28, 1995, Reuter report.
9. Elizabeth Talbot, MD, et al, "Tuberculosis Among Foreign-born Persons in the United States, 1993-1998," *JAMA*, December 13, 2000, pp. 2894-2900; August Gribbin, "CDC Report Links TB, Immigrants," *Washington Times*, December 13, 2000, pp. A1, A12.
10. Virginia Abernethy, Vanderbilt Medical School, "Third World Hospital Deluxe," *Population and Environment* 17, no. 3 (1996); pp. 191-193
11. Eric Niiler, "Diseased Passage," *Scientific American*, July 2000, pp. 23-24.
12. August Gribbin, "CDC Report Links TB, Immigration," *Washington Times*, December 13, 2000, pp. A1, A12.
13. J. McConnaughey, "Immigrant Child Takes Tuberculosis to Country Town," *San Francisco Chronicle*, November 11, 1999, p. A16.

14. Antonia Novello, "HIV in Latinos? *Absolutamente Si*," *Los Angeles Times*, January 2, 1992.
15. August Gribbin, "Hispanic AIDS-HIV Rates Troubling," *Washington Times*, March 19, 2002.
16. Josephine Marcotty, "HIV Cases in Minnesota Rise in 2002," *Minneapolis Star Tribune*, April 16, 2003.
17. Eric Niiler, "Diseased Passage," *Scientific American*, July 2000, pp. 23-24.
18. "Measles Almost Gone," Associated Press release, July 7, 1999.
19. "Outbreak of Rubella Hits Hispanic Immigrants," *New York Times*, February 5, 1998; "Rubella has not spread to city, officials say," *El Paso Times*, April 6, 1998.
20. Virginia Abernethy, "Immigration and the Nation's Health," *The Occidental Quarterly*, Winter 2002/2003, p. 29.
21. Balance Solutions, Population-Environment Balance, Washington, D.C., October 2002.
22. Laurie Garrett, "Malaria Found in NY, NJ; First local outbreak in decades confirmed," *Newsday*, July 7, 1994.
23. "Mosquito-transmitted Malaria – Michigan, 1995," *JAMA*, June 26, 1995, pp. 1871-1872.
24. Balance Solutions, Population-Environment Balance, October 2002.
25. Vaishali Honawar, "Woman tests positive for virus: Spraying is tried to stop West Nile," *Washington Times*, September 8, 2001, p. A8; Gus Taylor, "3 More are Likely Victims of Nile Virus," *Washington Times*, September 25, 2001; James Fulford, "West De-Nile?" *VDARE.com*, August 22, 2002.
26. "WHO sounds alarm over disease spread by mosquitoes," AP, June 17, 1995; "Imported Dengue – United States, 1993-1994," *JAMA*, July 12, 1995, p. 113; Tod Robberson, "Dengue Fever Epidemic Spreads Despite Latin American Efforts," *Washington Post*, October 20, 1995, p. A22.
27. Sharon Lerner, "Cases of Leprosy on the rise in U.S.," *New York Times*, February 20, 2003.
28. CDC website: www.cdc.gov/ncidod/sars; Matt Pottinger, "Illness's Spread is Linked to Doctor," *Wall Street Journal*, March 21, 2003, p. B2; Walter Pringle, "SARS: The Immigration Dimension," www.VDARE.com, April 2, 2003.
29. Rex Dalton, "Most health funds go to migrants," *San Diego Union-Tribune*, February 4, 1993; *Migration News*, July 7, 1998; Sean Scully, "Health system faces collapse in L.A.," *Washington Times*, March 24, 2003, p. A4.
30. Dan Evans, "Arizona: Mexico's HMO," *Arizona Republic*, January 4, 2002; Jon Kamman, "Kyl focuses on unpaid medical expenses," *Arizona Republic*, January 16, 2002; Michael Janofsky, "Burden Grows for Southwest Hospitals," *New York Times*, April 14, 2003.
31. Alfonso Chardy, "Foreign visitors burden hospitals," *Miami Herald*, January 8, 2003; Liz Freeman, "Hospitals wrestle with how to handle millions in unpaid bills of noncitizens," *Naples (FL) Daily News*, January 12, 2003; Jill Barton, "Florida: Medical costs for illegal immigrants burden hospitals," *Associated Press*, April 13, 2003.
32. Balance Solutions, Population-Environment Balance, October 2002.
33. Steven Camarota and James Edwards, "Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance." Washington, D.C.: Center for Immigration Studies, 2000, online at: www.cis.org.
34. Quynh-Glang Tran, "AMA irked by US mandate on interpreters," *Boston Globe*, August 27, 2002.
35. Tim Reiterman, "Ex-Doctor Gets Prison for Fraud," *Los Angeles Times*, September 9, 2003.
36. Dennis Wagner, "Last 2 Defendants in Medicare Scam Admit Guilt," *Arizona Republic*, September 24, 2003.
37. Larry Lebowitz, "Medicare Fraud Ringleader Pleads Guilty in Federal Court," *Miami Herald*, September 23, 2003.