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STATEMENT OF
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HUMAN RESOURCES DIVISION
BEFORE THE
SUBCOMMITTEE ON IMMIGRATION, REFUGEES,
AND INTERNATIONAL LAW
HOUSE COMMITTEE ON THE JUDICIARY
ON
MEDICAL SCREENING AND TREATMENT
OF INDOCHINESE REFUGEES

C/S 657

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the preliminary results of our review of the adequacy of medical screening and treatment of Indochinese refugees for health problems before they depart for, and after they arrive in, the United States. Although our review, undertaken at the request of the Subcommittee, will require several more months to complete, information obtained to date raises questions as to whether adequate attention is being given to potential public health problems posed by the large influx of Indochinese refugees.

Our concerns center on whether

- the types of medical tests used overseas are reliable enough to insure that refugees with serious infectious diseases and other health problems are identified, and
- adequate mechanisms exist to insure that those refugees with identified health problems receive adequate treatment before they depart for the United States and after they arrive.

State and local public health officials expressed concern to us about the increases in tuberculosis and other infectious diseases they are experiencing with refugees. Our preliminary analysis of the Department of Health and Human Services' position as expressed in its letter dated

September 10, 1981, on the issues we are raising, indicates a greater degree of satisfaction with the current refugee processing policies and procedures than the rising health problem in this country warrants. We believe that the Federal Government should take all reasonable steps to protect the public health consistent with its humanitarian obligation to the refugees of the world. The reexamination of this country's policies and procedures by this Subcommittee should serve to advance this end.

Before getting into the details of what we found in our review, I would like to outline the legal framework within which the overseas medical screening process takes place.

CRITERIA FOR ADMITTING
INDOCHINESE REFUGEES
INTO THE UNITED STATES

Under section 212 of the Immigration and Nationality Act, as amended (8 U.S.C. 1182) the Attorney General is not to admit aliens into the United States 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 (42 C.F.R. 34.2) define the dangerous contagious diseases as:

- Infectious leprosy.
- Active tuberculosis.

--Venereal diseases. 1/

On March 15, 1980, the Attorney General, acting on a request from the Secretary of State to expedite the processing of Indo-chinese refugees, decided to admit refugees with certain excludable health conditions. The Attorney General made this decision after the Surgeon General of the Public Health Service (PHS) concluded that the policy of allowing refugees to depart for the United States with certain previously excludable health conditions would not endanger the health of the American people. No study was done to support the Surgeon General's conclusion, which was based on the advice of the Centers for Disease Control (CDC).

The Surgeon General revised the criteria for processing refugees to allow refugees with active, noninfectious tuberculosis; mental retardation; previous attacks of insanity; and infectious leprosy to depart for the United States. Refugees with infectious tuberculosis; insanity; drug addiction; alcoholism; or untreated venereal disease would continue to be excluded.

In revising the criteria for admitting refugees with excludable health conditions, the Surgeon General established several conditions to be met. For example, refugees with active or suspected active tuberculosis are to be admitted

1/Chancroid, gonorrhoea, granuloma inguinale, lymphogranuloma venereum, and infectious syphilis.

to the United States only if they (1) are determined to be noninfectious as evidenced by negative sputum smears on two consecutive days and (2) agree to report to local public health authorities in their area of initial resettlement within 1 week of arrival in the United States.

In addition, the Surgeon General required voluntary agencies sponsoring refugees to assist those with health conditions in obtaining followup medical care in the United States. The Surgeon General also established preentry conditions for mental retardation, insanity, and venereal disease.

On March 17, 1980, the Refugee Act of 1980 was enacted to amend the Immigration and Nationality Act. Among other things, it authorized the Attorney General to waive the section 212 health provisions of the Immigration and Nationality Act, subject to certain conditions. In April 1980, the Department of State notified the overseas posts processing Indochinese refugees of the Surgeon General's revised medical processing criteria and directed that refugees be processed accordingly. Through June 1981, the Attorney General had granted about 5,600 medical waivers, most of which were for refugees with tuberculosis.

MEDICAL SCREENING
OF REFUGEES OVERSEAS

We question whether the medical screening of Indochinese refugees overseas adequately identifies those with

dangerous contagious diseases and other health problems that could have an adverse impact on U. S. citizens. The medical screening is performed by the Intergovernmental Committee on Migration, a private international organization, under an agreement with the Department of State and in accordance with guidelines provided by CDC. We observed the screening process at selected locations in the Far East, 1/ and interviewed various officials and physicians involved in the refugee program.

A basic issue is whether the screening, as we observed overseas, ensures that all dangerous diseases and other important health problems are identified. CDC's guidelines provide that the screening procedures shall consist of

- a brief history of present or previous illness,
- a visual inspection of the body's skin surface,
- an observation for excludable mental conditions,
- a chest X-ray for tuberculosis for persons 15 years of age and older, 2/
- a blood test for syphilis for persons 15 years of age and older, and
- a more comprehensive physical examination if excludable conditions are indicated.

1/Hong Kong, Bataan (Philippines), Singapore, Kuala Lumpur (Malaysia), and Phanat Nikhom (Thailand).

2/Chest X-rays for persons under 15 are to be performed if the individual is ill or has a family member with tuberculosis.

Questionable reliability of
screening for tuberculosis

We question whether the methods used for detecting and treating refugees with tuberculosis are adequate to prevent the admission of refugees with active, infectious tuberculosis.

Sputum smears, performed on refugees whose X-rays show evidence or suspicion of tuberculosis, constitute the only method being used to determine whether the disease is infectious. When an X-ray is read as positive or suspicious for tuberculosis and two sputum smears performed on consecutive days are reported as negative, the refugee may depart for the United States. Three basic questions concerning this process are whether (1) the sputum smears are being collected and tested properly, (2) such smears, even if done properly, are the most reliable method for diagnosing tuberculosis, and (3) admitting refugees with active but noninfectious tuberculosis creates the possibility of the disease becoming infectious after their arrival in the United States.

The question of whether the sputum smears are being done properly is raised by the unusually low number of positive results of smears taken from refugees whose chest X-rays were read as positive or suspicious for tuberculosis. According to a December 1979 assessment by the Surgeon General, an estimated 10 percent of refugees with such X-rays would be infectious. Moreover, a State official in charge of

tuberculosis control told us that, if done properly, sputum smears from persons whose X-rays are positive or suspicious for tuberculosis should show up as positive in approximately one-third of the cases. In contrast, the Chief of Laboratories at the Bangkok General Hospital told us that results of such smears from thousands of refugees with positive or suspicious X-rays show that less than 1 percent were reported as positive. Further, a physician involved in the overseas medical screening process reported to CDC that during a 9-month period in 1980 and 1981, only two of 1,040 sputum smears taken from refugees whose chest X-rays were read as positive or suspicious for active tuberculosis were reported as positive. This physician questioned the accuracy of the smears.

Concerning the question of whether sputum smears constitute the most reliable method for diagnosing tuberculosis, the State tuberculosis control official referred to previously told us that sputum cultures of persons with positive or suspicious X-rays would ordinarily show up positive in about 20 percent more cases than would sputum smears. Also, a pulmonary disease consultant to the Social Security Administration (formerly president of the American Lung Association and presently honorary member of the board of that organization) told us that he does not consider two negative sputum smears performed on two successive days an adequate method

of determining whether an individual has infectious pulmonary tuberculosis. He said that only after three successive daily sputum cultures have been performed and reported as negative would one have any hope of believing that a person having a positive or suspicious chest X-ray is, in fact, noninfectious.

On the question of admitting refugees with active but noninfectious tuberculosis, we were told by physicians involved in the overseas screening that refugees found to have infectious disease are treated overseas only if the refugee has overt evidence of illness, the X-ray shows advanced disease, or a second X-ray taken two months after the initial examination shows some changes. When treatment for tuberculosis is initiated, it might not be continued long enough to render the disease noninfectious. Sputum smears are repeated and when two consecutive smears are negative, the patient may depart for the United States with a two-week supply of anti-tuberculosis medication. The pulmonary disease consultant, referred to previously, told us that refugees who have infectious tuberculosis could communicate the disease to others in the community until such time as they are rendered noninfectious by thorough treatment.

Questionable screening
for other health problems

Under the overseas medical screening process, refugees may enter the United States with other diseases and health

problems that are not detected or not known to U. S. officials. In the case of venereal diseases, the blood test performed is designed to identify syphilis. If a blood test is positive, treatment is started in the Far East, but the treatment is not required to be completed before the refugee leaves for the United States. Also, except for a cursory visual inspection, no testing methods appear to be used for detecting other venereal diseases.

In the case of leprosy, the cursory nature of the visual inspection could, in our judgment, leave some cases of early leprosy undetected. Some of the visual inspections we observed took as little as 5 seconds.

The CDC medical screening guidelines do not require reference to previous medical history records. In the locations we visited, refugees were under the health care of physicians working for voluntary agencies under contract with the United Nations High Commissioner for Refugees (UNHCR). We were advised by officials of the Commissioner's office that the records of health problems and treatment of refugees are not transferred to the Intergovernmental Committee for Migration. When we observed the medical screening of refugees in the Far East, the screening physicians used no prior medical histories. Under these procedures, the only medical records accompanying

the refugees to the United States are those created during the screening process. In addition, while viewing several hundred examinations, we observed no instances where "a more comprehensive examination," as provided in the Surgeon General's criteria, was performed. In fact, our observation of the medical screening process of refugees in the Far East showed that it consisted of

--a cursory visual inspection,

--a chest X-ray for persons 15 years of age and older,

and

--a blood test for syphilis for persons 15 years of age

and older.

Refugees who successfully complete this process are then allowed to depart for the United States. These procedures do not appear to be adequate to detect refugees with other contagious diseases, such as malaria, hepatitis, or parasitic infestations. In addition, the procedures may not identify refugees with problems such as mental illness, mental retardation (except mongolism), alcohol and drug addiction, and many other major health defects, such as heart and kidney disease, diabetes, and cancer, which could affect the ability of the refugee to earn a living.

Canadian screening of refugees

According to an official from the Canadian Department of Health and Welfare, the Canadian medical screening procedures differ from U. S. procedures in that (1) the Canadians require a more comprehensive examination, including a medical history,

information concerning psychiatric problems and mental retardation, blood pressure reading, stethoscopic examination and (2) in addition to the chest X-ray and blood test for syphilis, stool and urine examinations are required. The Canadian Government also deals with tuberculosis cases in refugees differently than the United States. A refugee with a positive or suspicious X-ray for tuberculosis will not be admitted to Canada until there has been a complete evaluation of the tuberculosis status and, if necessary, sufficient treatment to render the disease inactive. This may take up to 2 years. According to the Canadian official, some refugees rejected or delayed by Canada's process file for admission to the United States.

MEDICAL PROCESSING OF REFUGEES
AT U. S. PORTS OF ENTRY

Title II of the Immigration and Nationality Act (8 U.S.C. 1224) states that aliens arriving at U.S. ports are to be examined by at least one PHS medical officer 1/ or a surgeon (with at least 4 years' experience) to determine if they have any physical or mental defects or disease. The act authorizes the Attorney General to detain aliens for such a determination. The act provides that, in diagnosing insanity, mental defects, and certain other excludable conditions, PHS medical officers

1/According to PHS officials and official position descriptions, a PHS medical officer is required to be a licensed physician.

with special training in these fields shall be assigned to ports of entry and provided with suitable facilities for detaining and examining aliens suspected of having these conditions.

The Refugee Act of 1980 does not authorize any deviation from the medical examination requirements in the Immigration and Nationality Act. However, our observations of the procedures to admit refugees in Honolulu, Los Angeles, Seattle, and King County (Washington) and discussions with PHS officials showed that (1) PHS has no physicians stationed at the ports of entry and (2) examinations for medical conditions or mental defects are not being performed on arriving refugees. PHS has personnel from CDC stationed at the ports of entry, but these individuals are not physicians and their processing of refugees involves mainly verifying that the required medical records are present. These medical records, which consist only of records developed during the medical screening overseas, are then forwarded to CDC, the sponsor organization, and State and local health departments.

In commenting on this matter, the Department of Health and Human Services (HHS) told us that routine medical screening by a physician at the port of entry would be superfluous because of the previous overseas screening and inconsistent with usual procedures for processing aliens on arrival based on long-standing interpretations of statutory and regulatory requirements.

MONITORING OF REFUGEES
WITH HEALTH PROBLEMS IN
THE UNITED STATES

The Refugee Act of 1980 established two new Federal organizations with responsibility for refugee matters--the Office of Refugee Resettlement in HHS and the U. S. Coordinator for Refugee Affairs. For refugee health matters, the act provides that the Secretary of HHS, in consultation with the U. S. Coordinator, is to

- assure that enough trained staff are available at locations where refugees enter the United States to assure that all necessary medical records are available and in proper order,
- provide for identifying refugees who have been determined to have medical conditions affecting the public health and requiring treatment,
- assure that State or local health officials at each refugee's resettlement destination within the United States are promptly notified of the refugee's arrival and given all applicable medical records, and
- provide for monitoring refugees identified to have medical conditions affecting the public health to insure that they receive appropriate and timely treatment.

Our work indicates that insuring that all refugees with serious health problems are identified promptly and treated is difficult. This is mainly because of secondary migration (i.e.,

many refugees move from their initial resettlement location). Based on interviews with 400 refugees, the HHS Inspector General stated in a January 1980 report that 41 percent of the refugees had moved, for various reasons, from their initial arrival location. Arlington County, Virginia, officials estimated that the average length of time a refugee remains in the county is less than two months.

Orange County, California, officials estimated that, because of secondary migration, their refugee population may be 50 percent higher than the official count. Los Angeles County, which estimates that it has over 58,000 refugees, is unable to determine its exact refugee population because of secondary migration. Maryland officials told us that secondary migrants account for 15 to 50 percent of refugee arrivals in that State.

Some health department officials indicated that they attempt to notify other jurisdictions of incoming refugees if they know the refugee's destination. However, this does not always occur. While there is a Federal system to identify refugees with health problems diagnosed in the overseas camps, PHS officials stated there is no Federal system for tracking refugees when they leave their initial resettlement location in the United States.

According to a refugee program guide issued by the U. S. Coordinator for Refugee Affairs and the Director of the Office of Refugee Resettlement, the States and the private voluntary agencies that sponsor refugee resettlement are responsible for

assuring that refugees get needed health services. The program guide does not contain instructions on how to monitor secondary migration.

REFUGEES HAVE A HIGH INCIDENCE OF DISEASE

Indochinese refugees have a much higher incidence of certain contagious diseases than the native U. S. population. For example, CDC statistics showed that in 1980 about 12 of every 100,000 people in the United States, including refugees, developed active tuberculosis. Among Indochinese refugees who entered the country in 1980, however, the incidence of tuberculosis was 500 per 100,000, according to CDC statistics. Local health officials in some localities we visited expressed concern that the high incidence of tuberculosis among refugees may affect the public health. Refugees also have a higher incidence of hepatitis, malaria, and parasitic infestations, according to statistics compiled by State and local health departments.

In 1980, Orange County had a total population of about 1,980,000 including 50,000 to 75,000 Indochinese refugees, according to local health officials. Disease rates in the county have risen significantly over the last several years, with major increases in 1980. Statistics compiled by the county show that Indochinese have been a major contributor to these increases. Appendices I and II show that Indochinese have a much higher incidence of contagious diseases than the county's native

population and that these diseases have increased significantly since 1975. For example, tuberculosis incidence rates in Orange County have nearly tripled between 1975 and 1980. In 1980, Orange County had a tuberculosis incidence rate of 26.1 per 100,000 population, more than twice the national rate. Refugees have contributed significantly to Orange County's tuberculosis rate with a 1980 incidence rate equivalent to 361.7 per 100,000 population. As Appendix I shows, if refugees are excluded from the Orange County statistics, the tuberculosis rate would drop sharply. Data for the first six months of 1981 show that the incidence of tuberculosis among refugees has further increased.

Orange County officials expressed concern about the incidence of tuberculosis in Indochinese refugees. County health department officials told us that tuberculosis is on the verge of becoming a public health threat.

In 1980, Seattle and King County, Washington, had a population of about 1.3 million persons and 15,000 Indochinese refugees (about 1 percent). In 1975, orientals 1/ accounted for about 10 percent of Seattle and King County's total tuberculosis cases. In 1980, Indochinese refugees accounted for about 30 percent of

1/Until 1979, Seattle and King County did not maintain separate health statistics on refugees but included refugees in the totals for orientals. Thus, tuberculosis among refugees in 1975 might have been less than 10 percent of the total cases.

the tuberculosis cases. A public health official in Seattle expressed concern that the number of tuberculosis cases among refugees could be a public health problem.

In 1980, Montgomery County, Maryland, had a population of about 577,000. As of May 1981, the county had about 6,200 refugees. County officials found that refugees had a tuberculosis incidence rate equivalent to 2,000 per 100,000 population, as compared with 12 per 100,000 for the county's native population. Montgomery County health officials stated that tuberculosis in refugees could pose serious health problems to other county residents. We also found that refugees in Los Angeles and Virginia have an incidence of tuberculosis significantly higher than the overall incidence of tuberculosis in the native U. S. population.

Localities are also experiencing sharp increases in other contagious diseases. For example, Virginia's malaria cases increased from 22 in 1977 (none of which involved Indochinese people) to 65 in 1980 (43 of which involved Indochinese people 1/). Los Angeles County has also experienced sharp increases in malaria cases and attributed the increases to the influx of Indochinese refugees. Health officials in California and Virginia expressed concern about increases in malaria. These health officials said the anopheles

1/Many of these people were refugees but the records were not precise on this in all cases.

mosquito (which spreads the disease) exists in certain parts of these States, including Orange County, California.

Health officials also found that refugees have a high incidence of hepatitis. For example, in Montgomery County, Maryland, according to the county's Director of Disease Control, 12 percent of the refugees have been found to be hepatitis carriers, compared to 0.5 percent for the county's native population.

Parasites are also a problem among refugees. The Director of a clinic in Los Angeles that examines large numbers of refugees said that 80 percent of the refugees examined are infected with parasites. Long Beach, California, health department officials reported in December 1980 that 72 percent of the refugees examined had this problem. Maryland officials found similar conditions among refugees.

COMMENTS BY HHS

By letter dated August 21, 1981, we advised the Secretary of HHS of the results of our review to date and posed a series of questions on the issues for his consideration. In its response dated September 10, 1981, HHS said that its policies for medical examination and treatment of refugees in Asia are appropriate and will continue to protect effectively the health of refugees and safeguard the health of the American public. However, as I have previously noted, rates for active tuberculosis have begun to increase dramatically in those areas which have seen a large influx of Indochinese refugees.

In sharp contrast to HHS' response to our questions, CDC's annual report material for fiscal year 1981 and its budget justification material for fiscal year 1982 depict rising tuberculosis rates as a serious public health problem and attribute the problem largely to the influx of Indo-chinese refugees. The annual report material stated in part that:

"Currently 15 million persons, or about seven percent of the Nation's population, are infected with tuberculosis; each year between 25,000 and 30,000 individuals from this group develop active disease and need medical care. In 1980, 27,749 cases were reported to CDC. This represents an increase from 1979 of 80 cases (0.3 percent). It is only the second time since 1953, the year in which all States began using standardized formats to report, that the number of cases rose. The national case rate for 1980 was 12.3 cases per 100,000 population. Case rates for major cities averaged twice the national rate and ranged as high as 72.6 cases per 100,000 in San Francisco. Transmission continued to occur as evidenced by the 1,569 cases reported in children in 1980.

"CDC conducted three surveys to determine the impact of tuberculosis among refugees.

Tuberculosis among Indochinese refugees accounted for 7.8 percent of reported cases in 1980. Approximately one-third of Indochinese refugees whose sputum cultures are positive for tuberculosis in the United States have drug resistant organisms. All States were affected by the influx of Indochinese refugees with tuberculosis. In some States, these refugees comprised more than 25 percent of cases; in some metropolitan areas Indochinese refugees comprised more than 50 percent of cases.***"

The fiscal year 1982 budget justification material contained similar comments and stated that control of this disease is complicated by the influx of large numbers of Indochinese refugees.

In response to our questions concerning the overseas screening for tuberculosis, HHS stated that although the disease can be confirmed only by sputum cultures, this procedure is more sophisticated and time-consuming than examining sputum smears. HHS stated also that the sputum smears, if properly done, is a reliable method for detecting potential infectiousness of a person with suspected tuberculosis.

We continue to believe that the overseas screening procedures for tuberculosis are not identifying all cases of

active, infectious tuberculosis. For example, a 25 year-old refugee whose X-ray was read as positive or suspicious for tuberculosis had sputum smears which were read as negative. Some two months later, after she had been sent to a refugee processing center to await transfer to the United States, a second X-ray showed more advanced tuberculosis. Two repeat sputum smears were again negative. Six weeks later, a third X-ray showed far advanced tuberculosis. A week after the date of the third X-ray, this refugee had not been started on a treatment program.

We also noted that, from January 1 to June 30, 1981, 84 refugees in Seattle and Tacoma, Washington, were diagnosed as having active tuberculosis. In 26 of these cases, the State was not notified by CDC that the refugees had tuberculosis; 19 of the 26 had moved from their initial resettlement areas in the United States; 3 were children under age 15 who were not screened for tuberculosis overseas, 2 were adults who were misdiagnosed overseas, 1 was an adult who developed the disease after arrival in the United States; and 1 was not included in CDC's notification to the State at the time of initial resettlement.

Further, in its August 1981 application to HHS for a refugee health assessment grant, the State of Virginia stated that "discovering 54 cases of tuberculous disease in 1980 not found in the overseas screening is justification

enough for continuation of our four-point medical assessment program for refugees."

HHS also stated that certain parasitic infestations, which are known to occur with considerably more frequency among refugees than in the United States population, do represent a potential public health threat. Yet, HHS admits that screening for these conditions is not a part of its medical review of Indochinese refugees.

We are still analyzing HHS' comments and will include the results of our analysis and evaluation in our final report to the Subcommittee, which we expect to issue in April 1982.

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Mr. Chairman, this concludes our statement. We shall be happy to answer any questions that you or other Members of the Subcommittee might have.

INDOCHINESE IMPACT ON DISEASE INCIDENCE RATES
ORANGE COUNTY, CALIFORNIA
JANUARY 1, 1980, THROUGH JUNE 30, 1981

<u>Disease</u>	<u>Year</u> <u>(note a)</u>	<u>Total</u> <u>cases</u>	<u>Indochinese</u> <u>cases</u>		<u>Incidence rates per 100,000</u> <u>population</u>		
			<u>Num-</u> <u>ber</u>	<u>Per-</u> <u>cent</u>	<u>Total</u> <u>popu-</u> <u>lation</u>	<u>Excluding</u> <u>Indochinese</u>	<u>Indo-</u> <u>chinese</u> <u>only</u>
Tuber- culosis	1980	505	217	43	26.1	15.4	361.7
	1981	251	130	52	26.0	12.9	433.3
Giardiasis	1980	377	131	35	19.5	13.1	218.3
	1981	193	58	30	20.0	14.4	193.3
Malaria	1980	78	68	87	4.0	0.5	113.3
	1981	39	35	90	4.0	0.4	116.7
Hepatitis (HBs-AG- positive blood)	1980	203	65	32	10.5	7.4	108.3
	1981	75	26	35	7.8	5.2	86.7
Amebiasis	1980	181	34	19	9.4	7.9	56.7
	1981	65	14	21	6.7	5.4	46.7

a/1981 figures are for January 1 to June 30, and 1981 incidence rates were converted to an annual basis.

DISEASE INCIDENCE RATES (note a)
ORANGE COUNTY, CALIFORNIA
JANUARY 1, 1975, THROUGH JUNE 30, 1981 (note b)

<u>Year</u>	<u>Amebiasis</u>	<u>Giardiasis</u>	<u>Hepatitis- HBs-AG positive blood</u>	<u>Malaria</u>	<u>Tuber- culosis</u>
1975	2.6	(c)	(c)	.5	8.6
1976	1.3	(c)	7.2	.5	8.0
1977	2.5	(c)	2.6	.3	8.8
1978	3.1	7.5	15.5	.7	9.3
1979	5.2	14.0	5.7	.8	12.4
1980	9.4	19.5	10.5	4.0	26.1
1981 (through June 30)	6.7	20.0	7.8	4.0	26.0

a/Rates are per 100,000 population.

b/1981 incidence rates were converted to an annual basis.

c/Not available.