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STATEMENT OF
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BEFORE THE

SUBCOMMITTEE ON IMMIGRATION AND REFUGEE POLICY

SENATE COMMITTEE ON THE JUDICIARY

ON

# RESETTLEMENT AND MEDICAL PROBLEMS OF INDOCHINESE REFUGEES IN THE UNITED STATES

Mr. Chairman and Members of the Subcommittee, we are pleased to appear today to discuss the work we have recently completed concerning problems with both the resettlement of Indochinese refugees in the United States and in the overseas medical examinations given refugees.

Overall, we have concerns about

--the continuing placement of most refugees in a few areas in the United States;

--the lack of employment assistance given to refugees soon after their arrival coupled with the large number of them receiving public assistance;

--the limited monitoring by voluntary agencies to assure that refugees receive services needed to help them become self-sufficient;

--the fragmented Federal management of the resettlement program;

--the high incidence of serious contagious diseases among refugees admitted to this country and the expense and difficulties in providing treatment; and

--the inadequate medical examinations performed overseas.

Each of these concerns is individually significant. Collectively, they lead us to conclude that much remains to be done both to deal effectively with the social and medical problems of the Indochinese refugees who have already arrived in this country and to improve the medical examination and treatment of those expected to arrive in the coming years.

## PLACEMENT DECISIONS ARE HEAVILY INFLUENCED BY REUNIFICATION EMPHASIS

Placement decisions involving Indochinese refugees have depended heavily on the location of family members and friends already living in the United States. The emphasis on reunification is a key contributor to the fact that 70 percent of all Indochinese refugees have been placed in 10 States. Perhaps the best way to describe the family reunification emphasis is to give you an overview of the refugee allocation process. The process itself suggests that there are options for reducing the impact on some States.

The process begins overseas in refugee camps, where biographical data sheets are completed by voluntary agency representatives for all refugees who have been ruled admissible by the Immigration and Naturalization Service. The bio-data includes demographic information on the refugees, names and addresses of family members and friends in the United States, and resettlement preference, if any.

The bio-data sheets are sent to the American Council of Voluntary Agencies (ACVA) in New York, the umbrella organization for voluntary agencies. Under a funding agreement with the Department of State, the Council serves as a clearinghouse to assign Indochinese refugees to voluntary agencies for placement in U.S. communities. Reunification, which involves resettling refugees with close and distant relatives and friends, is given priority in determining where new refugees will be settled. The Council searches its files to identify and locate (1) relatives and/or friends listed on the bio-data sheet and (2) relatives previously resettled or friends and relatives who may have expressed an interest in having the refugee join them, independent of any such listings on the bio-data sheets.

The matching process generates four classes of resettlement cases which are distributed once or twice weekly to the voluntary agencies during allocation meetings.

"Family Reunification" cases where only one voluntary agency was involved in resettling earlier arriving friends or relatives. - These cases are generally assigned to the agency that handled the family member or friend.

"Family Reunification" cases involving more than one voluntary agency. - These cases are discussed among the interested agencies to decide which one will take the case.

"Geographic" cases - where the refugee designates a relative or friend in a particular location on the bio-data sheet but the Council has no record of the relative/friend or the sponsoring voluntary agency. These cases are distributed to voluntary agencies with support services in the designated areas.

"Free Cases" - where the refugee has indicated no relatives, friends, or geographic preference on the bio-data sheet and none are found by the Council's file search. These cases are divided among the voluntary agencies.

The allocation process, with its heavy emphasis on reunification, has resulted in cases being assigned to areas of the country even when key resettlement services were not effectively provided by local voluntary agency affiliates and other service providers.

We examined a sample 1/ of refugee cases for fiscal year 1981 to determine the extent to which arriving refugees had relatives already in this country. About 67 percent had relatives here; however, only about half of those were close relatives including parents, children, siblings, grandparents, or spouses. Many of these relatives resided in areas already impacted by high concentrations of refugees.

The Refugee Act of 1980 directed both the U.S. Coordinator for Refugee Affairs and the Director, Office of Refugee Resettlement, (ORR) to consult with State and local governments and voluntary agencies concerning the sponsorship process and placement of refugees.

1/ The sample was designed to be projectable to the total number of cases for FY 1981 at the 95-percent confidence level with a maximum sampling error of 6.5 percent.

ORR and the U.S. Coordinator's Office have held meetings with representatives of these groups around the country during the past two years in an effort to obtain State and local views on the refugee program. However, representatives of State and local governments have often not viewed these meetings as giving them significant or meaningful input into the sponsorship and placement process. They have been concerned about the strain on local resources such as employment, housing, and community support services associated with continued placements of large numbers of refugees in the same areas.

Some voluntary agency affiliates have made attempts on their own to lessen the impact on local resources such as accepting only close family reunification cases for resettlement or placing refugees in clusters in peripheral areas away from impacted areas. In November 1981, ACVA, in response to concerns over the impact on local resources expressed by communities which were continuing to absorb large numbers of Indochinese refugees, formally designated a number of areas as impacted by refugees where member agencies would temporarily limit or refrain from placing "free" cases. Since then, two additional areas have been added to the list of areas to refrain from placing "free" cases.

In the past, refugee placement decisions were left up to the voluntary agencies with ad hoc policy guidance from the State Department and the U.S. Coordinator for Refugee Affairs. In October 1981, the Administration gave responsibility for developing a refugee placement policy to ORR. However, the State

Department's Bureau for Refugee Programs retained administrative and fiscal responsibility for voluntary agencies' initial reception and placement activities.

The placement policy issued in July 1982, provides a framework for containing the impact on areas with high concentrations of refugees. We agree that efforts to more closely scrutinize reunification in resettling cases involving distant relatives and friends when they would otherwise go to areas of high refugee concentration are needed, particularly where employment conditions and other factors are not conducive to quick self-sufficiency. We also agree that more attention needs to be given to identifying, in cooperation with state and local officials, new resettlement areas conducive to refugees achieving self-sufficiency quickly.

REFUGEE RESETTLEMENT ACTIVITIES

Our basic approach to examining resettlement activities was to look at a statistically valid sample of refugees initially placed in five counties during April and June 1981. Those cases represented the placement of 1,011 individual refugees, of which 594 were of employment age. 1/ Our review was designed to provide information covering a short period of time; that is, a snapshot of what services are being provided to refugees during their first months in the United States and what emphasis, if any, is given to quick self-sufficiency.

We chose the two months indicated to assure that the refugees

1/See attachments 1 and 2 for a further breakout of counties, voluntary agencies, and other general information regarding our sample.

had been in this country generally between 4 and 6 months--long enough to have potentially benefited from available services but not so long as to preclude our obtaining information because of inadequate records. Still, because of the limited records available, we often had to rely on interviews and voluntary agency case workers' recollections for information. We focused on obtaining information from providers rather than interviewing refugees. Let me elaborate on what we found.

Cash Assistance Dependency

The Refugee Act of 1980 provides Federal funding for cash and medical assistance, as well as social services, such as language instruction, training, and other services to foster self-sufficiency. Although the act emphasizes quick refugee self-sufficiency as a major objective, there is much room for interpretation as to what that term means. Absent definitive guidance, quick self-sufficiency has often been interpreted to mean self-sufficiency within the period of available Federal funding for cash assistance. As you know, until April 1982, that period was 36 months for all refugees, and now it is half that for refugees not meeting regular Aid to Families with Dependent Children eligibility requirements or residing in States or counties not having general assistance programs.

Since the early years of Indochinese refugee movements to the United States, many voluntary agencies have maintained that cash assistance should be used as a last resort when refugees' needs exceeded available sponsorship resources and sponsors were unable

to help refugees become employed and self-sufficient. State Department funding of the voluntary agencies was intended to supplement the agencies' own resources, including additional local community resources, to help with resettlement needs.

Despite that general philosophy, cash assistance use by newly arrived refugees has been quite high and occurs almost immediately upon arrival. In fact 71 percent 1/ of the total employable age members in our sample were found to have registered for and received cash assistance. Of those registering, 88 percent did so within 30 days of arrival and most did so within 2 weeks. The percentages of employable age refugees having received cash assistance ranged among counties from about 52 percent in Harris County, Texas, to 87 percent in San Francisco, California.

Available data on how long refugees stay on or actually require cash assistance is limited. Based on a survey of selected States, as of June 1, 1981, HHS projected a nationwide dependency rate of 67 percent for refugees here less than 3 years. Sixty-five percent of the refugees in our sample were still receiving public assistance as of October 31, 1981, 4 to 6 months after arriving in the United States. While the percentage of refugees on cash assistance in our sample dropped an average of 6 percentage points, the largest reduction, 11 percent, occured in Harris County, Texas, where benefit levels are lowest among the counties examined.

1/ If the universe from which this percentage was calculated were adjusted to eliminate persons who migrated elsewhere before signing up for cash assistance or those for whom we could not determine whether they had been on cash assistance due to similarity of names, the registration rate would increase several percentage points.

Using former refugees as sponsors has become an accepted practice of all voluntary agencies we reviewed. It is increasingly replacing what voluntary agencies described as their more traditional practice of resettling refugees in communities, assisted by paid caseworkers or volunteer help of Americans, individually and in groups. Relying on former refugees has resulted not only from a preference by some voluntary agencies/ affiliates for former refugees to sponsor new arrivals, but also from the voluntary agencies' increased difficulty in finding traditional sponsors.

Former refugees sponsored 58 percent of the refugees in our sample. Voluntary agencies often used other refugees in the sponsorship process with limited assessment of whether or not they were self-sufficient. Although some voluntary agencies considered themselves to be the real sponsor, the agencies often relied on former refugees to provide services for which the agencies were responsible for providing or assuring they were provided.

Recognizing that former refugees on welfare will inevitably have a major influence on the resettlement of their relatives, the State Department, in September 1981 reiterated in writing its policy that voluntary agencies not use welfare recipients as sponsors. The letter stated that in cases where an incoming refugee joins a family on welfare, the agency should ensure

some other means of providing resettlement services. Shortly following this State Department correspondence, we did some limited checking of agencies' reactions to the directive. Some agencies which had previously used former refugees as local sponsors and had maintained records designating them as sponsors simply stopped recording those persons as sponsors, yet continued to use them to provide resettlement services. Others were continuing to use former refugees as sponsors to further family reunification irrespective of the former refugees' self-sufficiency.

Next I want to focus on employment related services to refugees.

Quick Employment Has Little Emphasis

The Refugee Act emphasizes the goal of refugees achieving economic self-sufficiency as quickly as possible. Some limited guidance on how soon self-sufficiency should begin to occur is embodied in the act, HHS program instructions, and terms of the State Department funding agreements for voluntary agencies.

The act exempts refugees from work registration requirements during their first 60 days in the United States. HHS program instructions state that refugees' inability to communicate in English does not make them unemployable. At the same time, however, these instructions authorize delayed work registration requirements for refugees in approved training programs. The

State Department requires that voluntary agencies provide job counseling and job placement assistance to refugees on their arrival or thereafter as necessary and appropriate.

Our review showed that neither early employment nor concurrent employment and training have been emphasized for recent refugee arrivals. Despite the State Department requirement that voluntary agencies provide refugees with job counseling and job placement assistance, little of this assistance was provided to the refugees in our sample. Voluntary agency staffs said they had provided job counseling to less than half the employable age refugees and job placement assistance to 10 percent. Although infrequently documented, voluntary agencies sometimes told us they referred refugees elsewhere for employment services, mostly to HHS-funded providers.

We contacted the HHS-funded social service providers who provided employment-related services in the five counties. Some of those providers were also State Department funded voluntary agencies. Only 29 percent of the employable age refugees received job counseling from these providers and 12 percent received job placement assistance.

Indications are that refugees are often not considered to be job ready without English speaking ability. Only 22 percent of the employable age refugees in our sample were described by voluntary agencies as having fair to good English speaking ability. The most predominant reasons given to us by voluntary agencies for refugees not being employed were that they needed more English

instruction or they were taking English. Other reasons included refugees' (1) receiving no offers of employment, (2) not aggressively seeking employment, (3) needing additional training, and (4) caring for dependents at home.

Some States and counties are giving added emphasis to employment services in fiscal year 1982. However, when the refugees in our sample arrived in fiscal year 1981, HHS-funded service providers often placed more emphasis on social services, such as orientation and English language training, which they considered employment services, than on more directly related employment services, such as job development and placement. Often, refugees taking English language training attended such training less than full time without working either full or part time.

Providers that focused on job development and placement were able to place refugees--even those with poor language skills--in unskilled, entry-level jobs. In fact, the voluntary agencies described 40 percent of the refugees who they knew were employed as having little or no conversational English when they got jobs.

Of the 594 employable age refugees in our sample, only 83 (or 14 percent) were known by voluntary agencies to have been employed any time since their arrival in the United States. Over half of the 83 refugees had obtained jobs within 60 days of arrival.

Obtaining employment for unskilled non-English-speaking refugees often requires the assistance of interpreters or persons who can intercede between refugees and potential employers. State

employment offices, where many refugees register for work, often did not have the resources to do this.

Voluntary agencies and other service providers told us that many refugees preferred training over immediate employment. There were some reported instances of refugees being reluctant to go on job interviews; however, the extent of this is not clear. We found few instances of refugees actually turning down specific job offers.

Some recent steps have been taken toward providing more emphasis on employment. H.R. 5879, the Refugee Assistance Amendments of 1982, passed by the House repeals the 60-day work registration exemption for refugees. We believe the 60-day exemption could inhibit those refugees who are capable of working from seeking employment. Also, based on our sample, we know that some refugees are capable of finding work shortly after arrival in this country. HHS/ORR, issued revised program guidelines which became effective August 1 1982 which tighten employment requirements for cash assistance recipients by not (1) recognizing attendance in a college program (for a person age 18 or over) as a reason for delaying work registration and (2) exempting persons attending part-time training from accepting employment.

We view these as positive steps toward emphasizing early employment.

## Little Monitoring Of Refugees' Progress

If refugees are to become self-sufficient as soon as possible, monitoring progress toward this goal is important to assure needed services are received to facilitate that progress. The results of our case samples indicated only limited monitoring was taking place.

Voluntary agencies, under funding agreements with the State Department, are required to assure that refugees receive, as needed, such services as reception, provision of temporary care, job counseling and job placement. Some services, such as assistance with housing and food, are required only during the refugee's first month here. Other services, such as job counseling and job placement assistance, are to be made available longer. In fiscal year 1981, that period was 1 year; in fiscal year 1982, it was reduced to 90 days.

For refugee cases we sampled, voluntary agencies and their affiliates performed only limited monitoring of the refugees' progress toward self-sufficiency. In 30 percent of the cases, no contact existed between the agencies and their case members beyond 30 days. By 90 days there was no contact with 50 percent of the refugees.

Extended contact between refugees and voluntary agencies did not necessarily mean the agency staff knew whether the refugees were receiving social services important to achieving self-sufficiency. As noted, voluntary agencies' staffs told us of having referred refugees to HHS-funded service providers, particularly for employment-related services. Contacts with these providers, however, turned up no record of registration for many of the refugees.

Although voluntary agencies and their affiliates frequently relied on local sponsors, such as former refugees, to provide services or help the refugees obtain them, the agencies and their affiliates did little to assure such aid was provided. Some voluntary agencies had formal followup systems to check on refugees' status. These called for oral or written communication with either the refugee or the local sponsor intermittently up to several months after the refugees' arrival. However, those reports were often not done for refugees in our sample until we inquired about them.

Welfare offices can also refer public assistance applicants to appropriate service providers; however, many times this was not done. Welfare offices frequently were required to send refugees to register with State employment offices in conjunction with their application for cash assistance. Despite recognizing that State employment offices in the five counties were providing littl

assistance to refugees, the welfare offices frequently did not refer refugees to other service providers for cases in our sample.

In an attempt to alleviate some of these problems with refugee referrals, four of the five counties took some action. Cook County, Illinois instituted a system in July 1981 requiring refugees to register with one of the HHS funded service providers offering employment services before registering for cash assistance. Ramsey County, Minnesota, also in July 1981, ceased requiring refugees to register with the State employment office in order to receive cash assistance and established a work and training unit within the welfare office to facilitate refugees receiving needed services. In the Fall of 1981, two counties, Arlington, Virginia, and San Francisco, began operating central intake and referral systems to better assist new arrivals. Arlington began requiring refugees to register with a service provider before registering for cash assistance. The San Francisco system, part of a state-wide effort to integrate and coordinate service delivery, provided central screening and development of a refugee service plan.

The newness of these changes did not permit us to evaluate them. However, we see them as much needed improvements directed toward assuring refugees receive needed services.

ORR issued a program instruction, effective August 1, 1982, requiring State welfare agencies to contact refugee sponsors or resettlement agencies as part of determining (or redetermining) refugees' eligibility for cash and medical assistance, to determine whether the refugees have refused employment offers or voluntarily quit a job without good cause. We believe these program changes can only be effective to the extent that voluntary agencies remain in contact with refugees and that voluntary agencies and other service providers are actively engaged in offering job development and placement assistance to refugees.

FRAGMENTED FEDERAL MANAGEMENT

The complex process of resettling refugees and helping them to become self-sufficient as quickly as possible is more cumbersome at the Federal level than it needs to be. Although three Federal offices have key roles in domestic refugee resettlement, none has clear responsibilty and authority for the program. We believe these roles should be addressed in the reauthorization of the Refugee Act.

The three key offices with responsibilities for domestic refugee resettlement include the Office of U.S. Coordinator for Refugee Affairs; the State Department Bureau for Refugee Programs; and the HHS Office of Refugee Resettlement. The mandate of the Refugee Coordinator's office is wide ranging and overlaps the work of the other two agencies.

The Coordinator's functions include policy development, coordination and consultation concerning refugee admissions and placements. The Coordinator is also charged with representing and negotiating on behalf of the United States with foreign governments and international organizations concerning refugee matters. The State Department Refugee Bureau administers the Government's international refugee programs and the initial domestic resettlement program carried out by the American Council of Voluntary Agencies and its affiliates. HHS' Office of Refugee Resettlement is responsible for administering programs of cash and medical assistance, and social services to refugees settled in the United States.

The roles of the three offices are tangled without any one having overall authority over domestic resettlement management and policy functions. For example, both the U.S. Coordinator and the Office of Refugee Resettlement are charged by law with consulting with State and local governments and voluntary agencies concerning the sponsorship process and placement of refugees. Yet, it is the Refugee Bureau that administers voluntary agencies' funding for initial reception and placement activities.

As mentioned, the administration recently assigned placement policy responsibilities to HHS, while leaving administration of voluntary agency funding for initial placement services with the State Department. We are concerned about how effectively HHS

can administer placement policy without control of voluntary agencies' funding and the agreements under which they operate.

In our opinion, a realignment of domestic refugee responsibilities among the key Federal offices is needed.

In addition to eliminating fragmented management, specific improvements are needed in the monitoring of domestic resettlement activities at the Federal and State level. The State Department has not performed adequate program or financial monitoring of voluntary agencies. Beginning in fiscal year 1981, the State Department, for the first time, required a combination semi-annual program and financial report; however, inadequate instructions and unclear reporting criteria make these reports of little use. A State Department official acknowledged in April 1982 congressional hearings that it had never audited the voluntary agencies' use of Federal funds. Currently, the Refugee Bureau is developing procedures for monitoring service delivery of voluntary agencies under their funding agreements. The effectiveness of any future evaluations and the ability to establish measures of accountability will in large part be impacted by the extent to which the funding agreements with the voluntary agencies clarify agencies' responsibilities.

Monitoring by ORR, its regional offices and State Coordinator offices has also been limited though not to the extent we found concerning the State Department funded activities.

Officials at both ORR regional offices and State Coordinator's offices we reviewed told us that monitoring of ORR funded social service providers was difficult since no standards had been developed against which to measure program progress.

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As the Subcommittee addresses reauthorization of the Refugee Act, we believe a number of changes should be considered:

--Amending section 412(a) of the Refugee Act to require that (1) priority attention be given to quick employment and economic self-sufficiency, and (2) this priority be adhered to notwithstanding provisions for attendance at language and other employment training.

--Repealing that portion of section 412(e)(2) of the Refugee Act exempting refugees from employment registration and acceptance of job offer requirements during the first 60 days after entry.

--Amending Section 412(b) of the Refugee Act to give total responsibility for the program of initial resettlement of refugees to the Secretary of Health and Human Services.

Essentially, this last change would place all domestic resettlement activities under one department and should better concentrate efforts on helping refugees seek self-sufficiency as quickly as possible. We believe that a single agency focal point for domestic refugee resettlement is needed to deal with the problems identified

With this change in mind, we also recommend that the Subcommittee consider whether there is a need to have a separate U.S. Coordinator for Refugee Affairs. If the responsibilities for domestic resettlement activities are placed in the Department

of Health and Human Services, and the State Department Refugee Bureau maintains responsibility for the international aspects, the duties of the Coordinator could be split as appropriate between the two departments. This, coupled with a strong provision that the departments coordinate their activities, would lead to a more streamlined system for dealing with this complex area.

H.R. 5879 includes a provision requiring the Comptroller General to conduct an annual audit of funds expended under Section 412(b). Regarding Indochinese refugees, this covers the activities of twelve nonprofit voluntary and two State agencies which are funded to provide reception and placement services. Each of the voluntary agencies has numerous regional and local affiliates to which Federal monies are channeled in carrying out the program. The cost for these audits could be quite high, and place a heavy burdon on our resources.

We are equally concerned with the likelihood of reduced accountability of the Executive Branch if this provision is enacted. The State Department which currently administers the funding for agencies resettling refugees has been criticized for not monitoring or auditing the program. The proposed amendment places GAO in the position of executing a basic function that should be performed by the Executive Branch agency as a normal part of its management function. Without that responsibility, program accountability on the part of the Executive Branch could be further diminished.

As you know, committees and subcommittees having jurisdiction may request our office to perform desired reviews and, under section 204 of the Legislative Reorganization Act of 1970, as amended, we will perform such requested reviews. We believe such an arrangement, in lieu of a specific legislative requirement, would be mutually advantageous because it would permit us, through discussions with the committee, to reach agreement regarding the scope of reviews to be conducted and thus concentrate on the matters of greatest concern to the subcommittee. GAO would prefer to retain its traditional role of performing periodic audits to assess agencies' performance and encouraging more effective, ongoing oversight by Executive Branch agencies. Accordingly, we recommend that the requirement for General Accounting Office audits as contained in Section 412(b) of H.R. 5879 not be enacted.

Now permit me to summarize our recent report, "Improved Overseas Medical Examinations and Treatment Can Reduce Serious Diseases in Indochinese Refugees Entering the United States" (GAO/HRD-82-65, August 5, 1982).

## REFUGEES ENTERING THE UNITED STATES HAVE HIGH INCIDENCE OF DISEASES

Indochinese refugees have a far greater incidence of several serious and contagious diseases than the overall U.S. population. Among these diseases are tuberculosis, serious parasites, hepatitis B, malaria, and leprosy. State and local health departments in California, Maryland, Texas, Virginia, and Washington were concerned that the high rate of diseases in refugees may pose a public health problem.

Tuberculosis, for example, which was the second leading cause of death in the United States around the turn of the century, had declined to a rate of 12 cases per 100,000 population by 1980. In contrast, the Centers for Disease Control found that refugees who entered the United States in 1980 with no evidence of disease when examined overseas had a rate of 407 cases per 100,000 population, about 34 times greater than the overall U.S. rate. Overall, CDC found that Indochinese refugees had a reported rate of 1,138 cases of active tuberculosis per 100,000 population. Local health authorities have found the overall rate of tuberculosis in refugees, including those diagnosed overseas and those diagnosed after arrival in the United States to be as high as 2,300 cases per 100,000 population--about 192 times greater than the U.S. rate.

Other examples are the parasitic diseases amebiasis and giardiasis, which spread much illness, such as dysentery, in locations where hygiene and sanitary conditions are poor. They can

be transmitted by direct contact with others or by indirect contact through food handling--an area in which many refugees are employed. CDC has found that 48 percent of all Indochinese refugees had at least one parasite and that amebiasis and giardiasis could cause a public health problem in the United States. Our work showed that the incidence of parasites in refugees exceeded 70 percent in some locations. Refugees also have a high incidence of hepatitis B, malaria, and leprosy.

The United States relaxed its usual medical admission requirements specified in the Immigration and Nationality Act to expedite Indochinese refugee admissions. This decision was based on the belief that refugees with serious diseases identified overseas would report for treatment in the United States. Follow-on care by State and local health departments is the cornerstone in providing medical care to Indochinese refugees after their arrival. However, several barriers hinder health departments' efforts to provide such care. These include

--variances in health departments' programs to locate and examine refugees,

--refugees moving from their place of resettlement without notifying health authorities,

--failure of refugees to take prescribed treatment, and

--problems of incomplete or missing medical records.

Although the Refugee Act of 1980 authorized the Federal Government to reimburse States and localities for up to 100 percent of the costs incurred in providing medical services to refugees, this does not always occur. HHS' Medicaid criteria were used as the basis for reimbursement and Medicaid has certain gaps in services that are reimbursable. As a result, some health departments have had to absorb substantial costs in providing services to refugees. For example, from August 1979 to April 1981, Fairfax County, Virginia spent about $270,000 in providing medical care to refugees, of which only about $61,000 was reimbursed by Medicaid. Prince Georges County, Maryland, estimated that in 1980 it cost $238 to screen and treat each refugee for communicable disease, but the county received no reimbursement for these services. Health departments in California, Hawaii, Virginia, and the District of Columbia stated that they have experienced similar problems.

According to a 1981 HHS study, communities are now faced with the dilemma of shrinking resources but having to find additional resources for the increasing number of refugees. Our work showed that refugees accounted for a large part of some health departments' workloads, which caused some departments to curtail or limit service to their general population.

## OVERSEAS MEDICAL EXAMINATIONS OF REFUGEES SHOULD BE IMPROVED

To preclude many of the problems confronting U.S. health departments in providing medical care to refugees, steps need

to be taken to improve the medical examinations in Southeast Asia. The overseas medical examinations of Indochinese refugees were cursory and the medical procedures used were not in accordance with U.S. standards. The medical examinations were inadequate to detect certain excludable diseases which frequently occur in refugees, such as tuberculosis and leprosy, and were not designed to detect other diseases, such as the parasitic conditions amebiasis and giardiasis, hepatitis B, and malaria, which, although not defined as excludable, are serious, contagious, and common in Southeast Asia.

In addition, refugees' medical conditions were not considered by the Immigration and Naturalization Service in deciding whether refugees should be admitted to the United States, and overseas examining physicians did not have access to medical records accumulated while refugees were in refugee camps under the care of the United Nations High Commissioner for Refugees.

The improved medical examinations should include

--a medical history;

--an examination for tuberculosis, leprosy, parasites, hepatitis B, and malaria using appropriate U.S. medical procedures; and

--an examination for mental health problems and other problems that could affect the refugees' earning ability.

We also believe that refugees with active tuberculosis, malaria, amebiasis, or giardiasis should be treated before they enter this country. Leprosy patients should receive treatment sufficient to render them noninfectious.

The House Committee on the Judiciary, in its report on (H.R. 5879), instructed HHS, State, and Justice to improve the overseas medical processing of refugees. The bill also authorizes $14 million in fiscal year 1983 to defray costs to health departments for medical screening and treatment of refugees. This dual approach of increasing medical care to refugees both overseas and in the United States should help improve the health of refugees and protect the American public.

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

## INDOCHINESE REFUGEES INCLUDED IN GAO REVIEW BY COUNTY REVIEWED

| County/State a/ | Number of Refugee Cases b/ | Total Refugees | Number of Case Members of Employable Age c/ |
|---|---|---|---|
| Arlington County, Virgina | 34 | 119 | 70 |
| Cook County, Illionois | 64 | 207 | 131 |
| Harris County, Texas | 87 | 276 | 157 |
| Ramsey County, Minnesota | 32 | 92 | 56 |
| San Francisco County, California | 89 | 317 | 180 |
| | 306 | 1,011 | 594 |

a/States were selected in response to the Subcommittee's request that we examine areas greatly impacted by refugees. Additionally, we wanted our sample to be geographically balanced within the 10 States that have received about 70 percent of Indochinese refugee placements. We also wanted to include States with high and low cash assistance payments. Counties were selected from those which State Refugee Coordinators considered to be most impacted by Indochinese refugee.

b/The cases represent a statistically valid stratified random sample of total refugee cases initially placed by voluntary agencies in the five counties during April and June, 1981.

c/Age 16-64

## INDOCHINESE REFUGEE CASES INCLUDED IN GAO REVIEW BY VOLUNTARY AGENCY AND COUNTY

| Agency | Number of Cases Reviewed In: Arlington | Cook | Harris | Ramsey | San Francisco | Total |
|---|---|---|---|---|---|---|
| U.S. Catholic Conference | 20 | 10 | 25 | 12 | 15 | 82 |
| American Council for Nationalities Service | 0 | 20 | 0 | 13 | 12 | 45 |
| International Rescue Committee | 3 | 0 | 20 | 0 | 15 | 38 |
| Hebrew Immigrant Aid Society | 0 | 13 | 7 | 0 | 8 | 28 |
| Young Men's Christian Association | 6 | 0 | 20 | 0 | 0 | 26 |
| Church World Service | 2 | 4 | 10 | 2 | 5 | 23 |
| Lutheran Immigration and Refugee Service | 0 | 10 | 4 | 2 | 6 | 22 |
| World Relief Refugee Services | 3 | 5 | 1 | 3 | 8 | 20 |
| American Fund for Czechoslovak Refugees | 0 | 2 | 0 | 0 | 15 | 17 |
| Tolstoy Foundation | 0 | 0 | 0 | 0 | 5 | 5 |
| Total | 34 | 64 | 87 | 32 | 89 | 306 |

Notes: (1) GAO's sample of cases was selected from monthly arrival reports of the American Council of Voluntary Agencies.

(2) The sample of cases selected for review was stratified so as to be representative of cases resettled by voluntary agencies in the five counties during the 2 months sampled, April and June 1981. Consequently, the sample includes cases from all voluntary agencies then resettleing Indochinese refugees, except for one small agency, the Buddhist Council, which resettled few cases in the areas we reviewed during fiscal year 1981.