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STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, REFUGEES AND INTERNATIONAL LAW

HOUSE 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 undertaken at the Subcommittee's request concerning the resettlement of Indochinese refugees in the United States. We will discuss several problems we identified in the placement of Indochinese refugees in this country and in the programs designed to assist them. We will also elaborate on our September 1981 testimony before the Subcommittee on the medical screening and treatment of 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. As I discuss each of the concerns, I will share with you our preliminary views regarding the actions needed to deal with them.

PLACEMENT DECISIONS ARE HEAVILY INFLUENCED BY REUNIFICATION EMPHASIS

Placement decisions involving Indochinese refugees depend heavily on the location of family members and friends already living in the United States. The emphasis on family 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 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 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 expresses an interest in settling in a particular location without family reunification necessarily being involved. These cases are assigned to an agency that expresses interest.

"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. Concerns expressed by communities that were continuing to absorb large numbers of Indochinese refugees prompted the American Council of Voluntary Agencies to identify, in November 1981, certain areas affected by refugee resettlement where it would temporarily limit or refrain from placing "free cases." The long-term effect of this action remains to be seen, since many refugees, including some "free cases," are still going to those areas.

Further action is needed if the impact on areas with high concentrations of refugees is to be contained. This could include limiting reunification of refugees with distant relatives and friends. Also, new resettlement areas, which would be conducive to achieving effective resettlement and prompt self-sufficiency, need to be identified.

In October 1981, the administration gave responsibility for developing placement policy to the Office of Refugee

Resettlement (ORR) within the Department of Health and Human Services (HHS). The State Department's Bureau of Refugee Programs retained administrative and fiscal responsibility for intial placement activities of voluntary agencies. HHS recently circulated for comment an interim placement policy that

--redefines free cases to include refugees with distant relatives and friends in the United States and

--prohibits, except under special circumstances, placing free cases, as redefined, in impacted areas.

We think there are merits to deemphasizing reunification involving distant relatives and friends when placing new arrivals. We examined a sample 1/ of refugee cases for each month in 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 that number had close relatives, such as parents, children, siblings, or spouses.

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. 2/ Our review was designed to provide

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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.

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

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 had been in this country 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, 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 rapid refugee self-sufficency as a major objective, there is much room for interpretation as to what that term means. Absent definitive guidance, rapid self-sufficiency has often been interpreted to mean self-sufficiency within the period of available Federal funding for cash assistance. As you know, until this month, 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 eligiblity 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 is quite high and occurs almost immediately upon arrival. In fact, 71 percent 1/ of the total employable age members of our sample were found to have registered for 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, where benefit levels are quite low, to 87 percent in San Francisco, California, where payment levels are higher.

Available data on how long refugees stay on or actually require cash assistance are limited. Based on a survey of selected States, as of June 1, 1981, HHS projected a nationwide dependency rate of

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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.

67 percent for refugees here less than 3 years. Sixty-five percent of refugees in our sample were still receiving public assistance as of October 31, 1981, 4 to 6 months after arriving in the United States. The rates then ranged from 41 percent in Harris County to 84 percent in San Francisco. We cannot predict how long the remaining refugees will be dependent on public assistance, whether others in our sample will later require it, or whether those who went off assistance within the first few months will again begin receiving it.

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 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. Surprisingly, the percentage of refugees receiving cash assistance did not vary greatly between those who were sponsored by former refugees and those who were not, since voluntary agencies generally accepted former refugees as sponsors regardless of whether they were self-sufficient.

The State Department recently directed voluntary agencies not to use former refugees on welfare as sponsors. Voluntary agencies can easily circumvent this prohibition by using former refugees to assist new arrivals without formally designating them as sponsors. Thus, former refugees currently on welfare may still be very much involved in helping to resettle newly arriving refugees and providing services for which voluntary agencies would otherwise be responsible.

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, nonuniform 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. Further guidance is needed if quick employment and job assistance to refugees is to be emphasized.

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 fical 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 job offers.

If self-sufficiency for refugees in a short time period is to be a meaningful goal, greater emphasis on employment is needed, beginning with voluntary agencies and extending to other service providers. Services need to be better prioritized and better linked to securing employment opportunities for refugees, even while they are receiving training. Employment services are critical for refugees anytime, but especially in a tight job market, where competition for jobs is keen. In our opinion, the emphasis on refugee employment should begin as soon as possible after refugees' arrival. We believe the 60-day work registration exemption is unnecessary in view of the ability of many employed refugees to obtain their employment within 60 days of arrival.

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. Even in cases where voluntary agency contact lasted longer, the extent of contact was minimal and generally initiated by the refugee.

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. A few 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.

In late 1981, two counties, Arlington, Virginia, and San Francisco, California, began operating central intake and referral systems to better assist new arrivals. Arlington requires refugees to register with a service provider before registering for cash assistance. The San Francisco system, part of a statewide effort to integrate and better coordinate service delivery, provides for central screening and development of a refugee service plan. In July 1981, a system was instituted in Cook County, Illinois, requiring refugees to register with one of the HHS-funded service providers offering job assistance as a condition of receiving public assistance. Although these systems are new, they seem to be steps toward better assuring that refugees receive needed services. Monitoring should be done by voluntary agencies to fulfill their funding agreements. It can be enhanced through coordinated efforts with other service providers and public assistance offices.

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 responsibility 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, reporting to the President and the Secretary of State; 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, 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 believe that HHS will have difficulty developing and administering 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.

LEGISLATIVE RECOMMENDATIONS

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

We recommend:

--Amending section 412(a) of the Refugee Act to require that (1) priority attention be given to quick employment and economic self-sufficiency including placement in unskilled, entry level jobs, if necessary, 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 recognize that the Refugee Act gives the President discretion to decide which agency should administer the program

of initial placement. The President, based on a limited study conducted by the U.S. Coordinator's Office in 1980, decided to retain responsibility for the program with the State Department. We believe, however, 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 suggest 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.

Permit me now to bring the Subcommittee up to date on our work regarding the medical examinations and treatment of refugees.

HEALTH IMPACT OF INDOCHINESE REFUGEES IN THE UNITED STATES

The United States relaxed its usual medical admission requirements specified in the Immigration and Nationality Act in order to expedite refugee admissions. Under this relaxed procedure, refugees with noninfectious tuberculosis, mental retardation, and certain other health problems who would normally have been excluded were granted medical waivers and allowed to enter this country.

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. For example, tuberculosis, which around the turn of the century was the second leading cause of death in the United States, had declined to an incidence 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 about 400 cases per 100,000 population, about 34 times greater than the overall U.S. rate. In the United States, local health authorities have found the overall rate of tuberculosis in refugees, including those diagnosed overseas and those diagnosed after arrival, 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.

State and local health officials in California, Maryland, Texas, Virginia, and Washington were concerned about the high rates of disease found in refugees and believe a potential public health problem exists.

The decision to relax the usual medical eligibility requirements for Indochinese refugees 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 was to be the cornerstone in providing medical care to Indochinese refugees after their arrival. However, several barriers hinder health departments' efforts to provide effective follow-on care. These barriers 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.

In addition, health departments' efforts to provide medical care have been expensive. For example, the United States spent about $173 million to provide medical care to refugees in fiscal year 1981 and is expected to spend about $217 million in 1982.

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, in Fairfax County, Virginia, refugees comprised only about 1 percent of the population, but accounted for 53 percent of the new tuberculosis cases in 1980. From August 1979 to April 1981, the county spent more than $270,000 in providing medical care to refugees, of which only about $61,000 was reimbursed by Medicaid. Prince Georges County, Maryland, estimated that it costs $238 to treat each refugee with tuberculosis, but the county is reimbursed only $138 for each refugee treated. In 1980, the county absorbed about $35,000 for treating 347 refugees with tuberculosis. Los Angeles and Orange Counties, California, and the District of Columbia 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 also showed that refugees accounted for a large part of some health departments' workloads, which has caused some departments to curtail or limit service to their general population. For example, in Montgomery County, Maryland, refugees account for less than 1 percent of the population but cause more than 50 percent of the health department's workload. Because of the large refugee workload, the county has stopped routine screenings for contagious diseases for the 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.

In our September 1981 testimony we reported that the overseas medical examinations were cursory and the medical procedures used were not in accordance with the 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 U.N. 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.

The results of this more thorough evaluation should be made available to U.S. immigration officers in time to be used in deciding whether refugees are eligible for admission to the United States.

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 current practice of relying on U.S. health authorities to provide follow-on care after refugees are dispersed in this country has proven to be expensive and difficult. Therefore, we believe that the routine practice of granting medical waivers for excludable conditions should be discontinued and waivers should be granted only when there are compelling reasons to do so.

The cost of implementing our recommendations will be modest. The Intergovernmental Committee on Migration, which is responsible for performing refugee medical examinations in Southeast Asia, told us that the improved medical procedures we just described could be done at a total cost of about $58 per refugee--$31 more than what is currently spent on the cursory screenings. If the authorized level of 100,000 Indochinese refugee admissions is met in fiscal year 1982, this would result in an increased cost of about $3 million. When one compares this increase to the more than $170 million the Federal Government spent in fiscal year 1981 to provide refugees with medical care and the estimated $217 million we will spend in fiscal year 1982, the $3 million estimated increase is modest. The added protection to the American public health that will result if these procedures are implemented is well worth this small cost increase.

Mr. Chairman, the recently introduced H.R. 5879 would limit the notification to State health officials of refugee arrivals to only those refugees having medical conditions diagnosed overseas. As we stated, the current medical examinations performed overseas are inadequate and have resulted in some missed cases of disease. Since many refugees are diagnosed with disease by health departments in screening programs after arrival, we believe that notification of refugee arrivals is beneficial in their efforts to examine and monitor refugees. Unless the overseas examinations are improved, as we suggested, we do not believe the notification to State health officials of refugee arrivals should be stopped.

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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

State/County 1/	Number of Refugee Cases 2/	Total Case Members	Number of Case Members of Employable Age 3/
Arlington County, Virginia	34	119	70
Cook County, Illinois	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

1/States were selected in response to 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 refugees.

2/The cases represent a statistically valid sample of refugee family groups initially placed in the five counties during April and June, 1981.

3/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 of 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 Services	2	4	10	2	5	23
Luthern Immigration and Refugee Service	0	10	4	2	6	22
World Relief	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 resettling Indochinese refugees, except for one small agency, the Buddhist Council, which resettles few cases.

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SUMMARY OF GAO TESTIMONY BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, REFUGEES AND INTERNATIONAL LAW

HOUSE COMMITTEE ON THE JUDICIARY

ON RESETTLEMENT AND MEDICAL PROBLEMS OF INDOCHINESE REFUGEES

IN THE UNITED STATES

Resettlement and medical problems encountered by Indochinese refugees have placed substantial burdens on both Federal and federally assisted organizations responsible for refugee resettlement. GAO discusses the following concerns about various aspects of the resettlement and medical screening and treatment processes for refugees:

--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.

--The inadequate medical examinations performed overseas.

Each of the concerns is individually significant; collectively, they lead GAO to conclude that much needs to be done both to deal effectively with the social and medical problems of the Indochinese refugees already in this country and to improve the medical examination and treatment of those expected to arrive in the coming years.

Because the Subcommittee is continuing its deliberations on the reauthorization of the Refugee Act of 1980, GAO is presenting its preliminary views on actions needed to deal with the problems it has identified.