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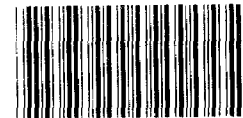
Comptroller General

OF THE UNITED STATES

Improved Overseas Medical Examinations And Treatment Can Reduce Serious Diseases In Indochinese Refugees Entering The United States

The incidence of several serious and contagious diseases, such as tuberculosis, is far greater in Indochinese refugees resettling in this country than in the U.S. population. This situation has occurred because the overseas medical examination procedures used to detect and treat tuberculosis and certain other medical conditions are inadequate. Also, immigration authorities made their decisions to admit refugees before the medical examinations were performed.

Several barriers exist which hinder the ability of health departments to effectively deal with refugees' health problems after they arrive in the United States. GAO is recommending that the overseas medical examination of refugees be improved, that treatment for certain diseases be initiated and completed overseas before the refugees are allowed to enter the United States, and that medical waivers be granted only when there are compelling reasons to do so. GAO believes the cost to perform more thorough medical examinations overseas is modest when compared to the cost to deal with refugees' medical problems after they enter the United States.



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GAO/HRD-82-65
AUGUST 5, 1982

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COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON D.C. 20548

B-203495

The Honorable Romano L. Mazzoli
Chairman, Subcommittee on Immigration,
Refugees and International Law
Committee on the Judiciary
House of Representatives

Dear Mr. Chairman:

In accordance with your request, we reviewed the medical procedures used to identify and treat medical problems in Indo-chinese refugees entering the United States. We believe that the procedures were inadequate to detect and treat communicable diseases and other serious health conditions in refugees and that, for a modest increase in cost, the procedures could be improved.

The report contains recommendations to the Attorney General and the Secretaries of Health and Human Services and State. As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Secretaries of Health and Human Services and State; the Attorney General; the Director, Office of Management and Budget; and other interested parties. Also, copies will be made available to others upon request.

Sincerely yours,

A handwritten signature in cursive script that reads "Charles A. Bowsher".

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON IMMIGRATION, REFUGEES AND
INTERNATIONAL LAW
HOUSE COMMITTEE ON THE JUDICIARY

IMPROVED OVERSEAS MEDICAL
EXAMINATIONS AND TREATMENT
CAN REDUCE SERIOUS DISEASES
IN INDOCHINESE REFUGEES
ENTERING THE UNITED STATES

D I G E S T

From April 1975 through February 1982, about 1.4 million Indochinese refugees fled their homelands, and about 580,000 (40 percent) resettled in the United States. The United States has set an admission level of 100,000 for fiscal year 1982. (See p. 1.)

Before persons can be admitted to the United States, they must be eligible under the terms of the Immigration and Nationality Act. The act denies persons, including refugees, the right to enter this country if they have certain mental or physical conditions, including several specified contagious diseases (active tuberculosis, infectious leprosy, and certain venereal diseases). (See p. 1.)

Because refugees had difficulty meeting the act's medical eligibility requirements, many were being detained in overseas camps. To expedite their movement, the medical requirements were relaxed in April 1980, and refugees were routinely granted medical waivers. About 21,000 refugees diagnosed as having certain health problems, such as active (but noninfectious) tuberculosis, were granted medical waivers and permitted to come to the United States. The Surgeon General concluded that this would not pose a problem to the health of the American public because refugees were to receive follow-up care by local health departments in the United States. (See pp. 2 and 3.)

At the request of the Chairman, Subcommittee on Immigration, Refugees and International Law, House Committee on the Judiciary, GAO evaluated the medical procedures used to screen Indochinese refugees overseas and followup procedures in the United States to see if they were adequate to protect the American public health. (See p. 5.)

INCIDENCE OF DISEASE IN
INDOCHINESE REFUGEES: A
COSTLY PUBLIC HEALTH PROBLEM

The incidence of several serious and contagious diseases in Indochinese refugees far exceeds that found in the U.S. population. Among these diseases are active tuberculosis, serious parasitic diseases, hepatitis B, malaria, and leprosy. (See pp. 8, 13, and 45.)

For example, in 1980, the incidence of tuberculosis was 12 cases per 100,000 in the United States but 407 cases per 100,000 in Indochinese refugees. Refugee children had particularly high rates of tuberculosis. (See pp. 8 and 12.)

Because these diseases could spread to others, some State and local health officials believe a potential public health problem exists. Although the Department of Health and Human Services (HHS) has maintained that there is no public health problem, it has encouraged health departments to make special efforts to monitor and treat refugees. (See pp. 2, 10, 14, 15, and 45.)

The Federal Government provided about \$173 million in fiscal year 1981 and will provide about \$217 million in 1982 for medical services to refugees in the United States--about 77 percent of whom are Indochinese. (See p. 16.)

Several State and local health departments said that refugees pose more of a financial burden than a public health problem and that their diseases could be controlled provided adequate funding was provided. The health departments also said that providing services to Indochinese refugees has proven costly and hindered their efforts to provide services to the general population. (See pp. 16 to 19 and 43.)

IMPROVED OVERSEAS
MEDICAL EXAMINATIONS
AND TREATMENT NEEDED

To determine refugees' medical conditions, physicians of the Intergovernmental Committee for Migration conduct medical examinations overseas using Public Health Service criteria. (See p. 1.) However, these medical examinations were

--cursory and not in conformance with medical procedures commonly used in the United States or by other countries admitting refugees and

--inadequate to detect and treat certain diseases and health conditions.

As a result, serious contagious diseases, as well as other medical problems, went undetected and untreated overseas. These problems became difficult to deal with once refugees were dispersed into the U.S. population. Moreover, Immigration and Naturalization Service authorities made their decisions to admit refugees before medical examinations were performed; therefore, the examinations' results were not considered in the decisionmaking process. (See pp. 20 to 26.)

While local health departments had succeeded in making initial contact with most refugees, a number of barriers (such as refugees' movement within the United States) hindered their ability to provide follow-on care. (See pp. 13 and 26.)

GAO believes that the overseas medical examination and treatment procedures for refugees should be improved to preclude many of the difficulties confronting U.S. health departments in dealing with refugees' health problems. These improvements would result in granting medical waivers only for compelling reasons in contrast to the current procedure of routinely granting such waivers. (See p. 34.)

GAO estimates that adequate overseas medical examinations for an expected 100,000 refugees could be accomplished for about \$5.8 million in fiscal year 1982. This would represent a \$3.1 million increase over the \$2.7 million now expected to be spent on overseas medical examinations--a modest increase in cost compared to the \$217 million the United States will spend to take care of refugees' medical problems in 1982. (See pp. 31 to 33.)

GAO also believes that the results of the medical examinations should be made available to immigration officers for use in making final determinations concerning whether refugees are eligible for admission into the United States. (See p. 34.)

RECOMMENDATIONS

GAO is making several recommendations to the Secretaries of State and HHS to improve the Government's overseas capability for detecting and treating refugees' health problems and minimize the potential of communicable diseases being transmitted to the U.S. population. (See pp. 34 and 35.)

Also, several recommendations are being made to the Attorney General to (1) assure that refugees are not admitted to this country until the medical requirements of the Immigration and Nationality Act are met and (2) grant refugee medical waivers only when there are compelling reasons to do so. (See pp. 35 and 36.)

AGENCY COMMENTS AND GAO'S EVALUATION

Federal, State, and local agencies made numerous comments on the issues and recommendations discussed in GAO's report. HHS and the State Department took action to improve the usefulness of refugees' medical records and medical examinations to both the Immigration and Naturalization Service and health departments. However, HHS--the lead agency responsible for setting health admissions criteria for Indochinese refugees--generally disagreed with GAO's recommendations to improve the medical procedures used in Southeast Asia. (See pp. 36 to 44.)

HHS said that GAO's report generally overstated the public health risk posed by diseases in refugees. HHS cited several factors, such as sanitary conditions and medical care in the United States, which it believed rendered such diseases to be personal health problems and of minimal public health importance. HHS believed the American public's health was adequately protected by the current medical system. (See pp. 36 and 37.)

Many State and local health departments said that the overseas medical process should be improved but saw some difficulties in doing this. Some believed the overseas medical work would be unreliable. Some said that the chronic nature of refugees' diseases would necessitate reexamining them after arrival in the United States. (See pp. 41 to 44.)

The seriousness of refugees' diseases and the protection afforded to the American public is a matter of judgment; however, GAO believes that it would be more prudent to prevent the introduction of diseases into the United States rather than attempt to deal with them afterward. Therefore, GAO believes that the overseas medical examination and treatment procedures should be improved. (See pp. 37 to 41.)

In May 1982, the House Committee on the Judiciary, in a report on pending refugee assistance legislation (H.R. 5879), authorized \$14 million in fiscal year 1983 to defray costs to health departments for medical screening and treatment of refugees. The Committee also instructed HHS, State, and Justice to improve the overseas medical processing of refugees. The Committee's 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. (See p. 44.)

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ABBREVIATIONS

CDC	Centers for Disease Control
GAO	General Accounting Office
HHS	Department of Health and Human Services
ICM	Intergovernmental Committee for Migration
INS	Immigration and Naturalization Service
PHS	Public Health Service

CHAPTER 1

INTRODUCTION

From April 1975 through February 1982, about 1.4 million Indochinese refugees fled their homelands, and about 580,000 (40 percent) resettled in the United States. As of February 1982, 248,000 refugees were in camps in Southeast Asia awaiting resettlement. The flow of refugees is expected to continue in the foreseeable future, and about 125,000 are expected to leave their homelands in Vietnam, Laos, and Kampuchea in fiscal year 1982. The United States has set an admission level of 100,000 Indochinese refugees for fiscal year 1982.

The number of refugees coming into this country is relatively small compared to (1) the estimated 200 million visits by aliens and travelers from around the world who legally entered this country in 1981 and (2) the approximately 130 million returns to the United States by U.S. citizens who visit other countries. However, the number of Indochinese refugees and their health status when they arrive has to be viewed in the context that they are not visitors, but permanent residents who will be fully integrated into American society.

CRITERIA FOR ADMITTING INDOCHINESE REFUGEES INTO THE UNITED STATES

For immigrants and refugees to be admitted to the United States, they must be eligible under the Immigration and Nationality Act (8 U.S.C. 1101), administered by the Attorney General through the Immigration and Naturalization Service (INS). Among other things, the act denies aliens the right to enter the United States if they have (1) certain mental conditions; (2) any physical defect, disease, or disability which may affect their earning ability; or (3) any dangerous, contagious disease.

Public Health Service (PHS) regulations (42 C.F.R. 34.2) define the dangerous, contagious diseases as active tuberculosis, infectious leprosy, and certain venereal diseases--chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and infectious syphilis. To determine refugees' medical conditions, INS relies on medical examinations conducted overseas by physicians employed by the Intergovernmental Committee for Migration (ICM) 1/ under a State Department contract. PHS established the criteria the overseas physicians use in conducting the medical examinations.

1/An international organization founded in Europe to handle refugee resettlement problems after World War II.

Many refugees had difficulty meeting the act's medical requirements. As a result, by March 1980, about 2,300 refugees were being detained in overseas camps because examinations had revealed medical conditions which would deny them entry into the United States. Since most refugees emigrate in family units, the detention of one individual often resulted in the detention of the entire family. Thus, the detention of 2,300 refugees for medical reasons resulted in delaying about 7,800 other family members, causing over 10,000 refugees to remain in refugee camps. According to the Department of Health and Human Services (HHS), these camps were crowded and conducive to the spread of disease.

REFUGEE ACT OF 1980

In March 1980, the Refugee Act of 1980 (8 U.S.C. 1101 note) was enacted to provide for a permanent and systematic procedure for admitting refugees 1/ to the United States and to assist them in resettlement. Regarding medical examinations, the act provided that the Secretary of HHS, in consultation with the U.S. Coordinator for Refugee Affairs, 2/ would

--provide for identifying refugees with medical conditions affecting the public health and requiring treatment and

--develop and implement methods for monitoring and assessing the quality of medical screening and related health services.

These requirements have been implemented through overseas examinations of refugees by ICM physicians and through periodic review of the screening activities in refugee camps by HHS officials.

When the overseas examinations reveal excludable conditions, the act authorizes the Attorney General to waive them in certain circumstances, such as for humanitarian purposes or to assure family unity. Because of the backlog of refugees who were unable to meet the medical criteria, the Attorney General used this authority, at the Secretary of State's request, to expedite refugee processing. Essentially, the Attorney General decided to admit Indochinese refugees even though they had certain excludable health conditions after the Surgeon General concluded that such a policy

1/The act defined a "refugee" as any person outside his country of nationality or his place of habitual residence who is unable or unwilling to return to that country because of fear of persecution. The act also authorizes the President to designate other persons as refugees under special circumstances.

2/The Coordinator's role is to provide policy guidance and coordination for all U.S. international and domestic refugee program activities.

would not endanger the health of the American people. The Surgeon General's conclusion was based on advice provided by the Centers for Disease Control (CDC).

The Surgeon General's revised medical admission criteria allowed waivers to be granted to refugees with active, noninfectious tuberculosis; mental retardation; previous attacks of insanity; and infectious leprosy. 1/ Refugees with infectious tuberculosis, insanity, drug addiction, alcoholism, or untreated venereal disease were still to be excluded. In April 1980, the Department of State notified the overseas camps of the revised medical processing criteria and directed that they be implemented.

Through August 1981, the Attorney General had granted about 21,000 medical waivers, most of which (18,000) involved refugees with noninfectious tuberculosis. The waiver authority, along with the revised medical admissions criteria, reduced the number of refugees detained overseas from 10,000 to about 3,900 persons by May 1981.

In relaxing the medical admissions criteria, the Surgeon General established several preentry conditions. For example, refugees with active or suspected active tuberculosis were to be admitted only if they (1) were determined to be noninfectious as evidenced by negative sputum smears 2/ on 2 consecutive days and (2) agreed to report to local health authorities in their area of initial resettlement within 1 week after arriving in the United States. Preentry conditions were also established for refugees with mental retardation, insanity, and venereal disease.

Voluntary agencies sponsoring refugees were to assist those with health problems to obtain follow-on medical care in the United States. Such follow-on care was to be provided by local health departments.

SYSTEM FOR TRACKING AND MONITORING REFUGEES GRANTED MEDICAL WAIVERS

The Refugee Act of 1980 provides that the Secretary of HHS and the U.S. Coordinator for Refugee Affairs are to

1/A PHS official told us that, although infectious leprosy cases were authorized to be admitted to the United States, this policy was not implemented.

2/A sputum smear consists of taking matter ejected from the lungs, bronchi, and trachea through the mouth and studying it microscopically by spreading the material across a slide. Individuals with positive sputum smears are infectious.

- assure that sufficient staff are available at refugee disembarkation points in the United States and that all necessary medical records are available and in proper order,
- assure that State or local health officials at refugees' resettlement destinations in the United States are promptly notified of arrivals and provided with all applicable medical records, and
- provide for monitoring refugees with medical conditions affecting the public health to insure that they receive appropriate and timely treatment.

The system for notifying health departments of refugee arrivals and tracking and monitoring those with health conditions was established by HHS. However, HHS' system is designed only to get refugees into the local health departments for an initial medical evaluation and not to provide continued tracking to assure continuity of treatment and care.

The system begins with the refugees' arrival at the U.S. ports of entry, where CDC personnel are stationed to meet arriving refugee flights. The CDC personnel are not physicians, and their duties consist mainly of verifying that refugees have the necessary medical records. Medical examinations are not routinely performed on arriving refugees. Refugees with medical waivers are instructed by the CDC personnel to promptly report to the health department at their resettlement destination, and CDC staff notifies the State health department at the refugee's destination.

When tuberculosis has been identified overseas, the CDC staff completes forms indicating whether the disease is active or inactive. Copies are mailed to the appropriate State and local health departments and to CDC headquarters in Atlanta, Georgia. Also, copies of the CDC forms, chest X-rays, immunization records, and other immigration documents are given to the refugees to take with them when they report to the health department. After local health officials examine refugees with medical waivers, they are required to complete a form indicating the examination results and submit it to CDC.

Using the forms originally submitted by the port of entry staff, CDC generates a computerized tracking list to monitor refugees with tuberculosis. Tuberculosis cases remain on CDC's list for 1 year or until CDC is notified by health departments that the refugees have been examined. After a year, CDC's tracking efforts are discontinued. CDC maintains similar tracking systems and notification for venereal disease, mental retardation, previous attacks of insanity, and leprosy.

Regarding the tracking and monitoring of refugees with medical conditions, PHS concluded, based on a 1979 study in California and Hawaii, that:

"* * * the risk of disease transmission from refugees to the overall population is minimal when proper examination and follow up takes place and vigilance can be maintained."

In commenting on a letter of inquiry we sent to HHS in August 1981, it stated that the

"* * * examination and treatment of refugees in Asia, augmented by the special procedures * * * are appropriate and consistent with modern concepts of epidemiology, disease control, and disease prevention. These policies and procedures will continue to protect effectively the health of refugees and safeguard the health of the American public."

OBJECTIVES, SCOPE, AND METHODOLOGY

This review was made at the request of the Chairman, Subcommittee on Immigration, Refugees and International Law, House Committee on the Judiciary. It was performed at the headquarters offices of HHS, the Department of Justice, the Department of State, and CDC. We also did fieldwork in Southeast Asia and various parts of the United States.

In Southeast Asia, we visited refugee camps and transit and processing centers in Hong Kong, Bataan (Philippines), Singapore, Kuala Lumpur (Malaysia), and Thailand. At these locations, we observed camp conditions, camp medical facilities and programs, and the medical processing and examinations of refugees destined for the United States and other countries. We interviewed State Department personnel; ICM physicians and staff; CDC personnel; physicians and staff working for voluntary health agencies; and local practicing physicians, including radiologists and chest specialists, involved in refugee processing to discuss a variety of issues related to admitting refugees. In Geneva, Switzerland, we met with officials of ICM and the United Nations High Commissioner for Refugees primarily to discuss the handling of medical records. 1/

1/The Office of the U.N. High Commissioner has been the international focal point in efforts to resolve the Indochinese refugee problem. One of its most important responsibilities is the international protection of refugees. It provides financial assistance for the care of refugees through governments of asylum countries and voluntary agencies. This assistance includes support for medical care.

In the United States, we did fieldwork in California, Texas, and Washington--the three States with the largest refugee populations (estimated at 269,500 as of December 1981)--and in Hawaii, Maryland, Virginia, and the District of Columbia (with a combined estimated refugee population of 31,000 as of December 1981). We observed the disembarkation processing of refugees at three ports of entry--Los Angeles, Seattle, and Honolulu. To determine the medical admission requirements for refugees destined for the United States, we analyzed legislation and Federal procedures.

To ascertain whether refugees accounted for increases in U.S. disease rates, we determined the serious diseases prevalent in refugees and the trend of these diseases in the United States since refugees started to arrive. We compared the incidence of certain diseases in refugees with the incidence in the overall U.S. population. Through interviews with health officials, we determined how these diseases are managed and treated in this country.

For other health conditions that could affect a refugee's earning ability (such as mental problems, cancer, and heart disease), we attempted to determine the extent of these problems in refugees. States do not report this information to CDC, and information on these conditions in refugees was scarce. As a result, our review focused primarily on communicable diseases.

We analyzed the medical records of refugees who were diagnosed in the United States as having certain diseases, such as tuberculosis and leprosy, and obtained information from State and local health officials on the extent to which refugees had other diseases, such as hepatitis, malaria, and certain parasites. We focused on tuberculosis, since this was the excludable disease most prevalent in refugees and for which State and local health authorities had the most data. In analyzing medical records, we reviewed cases of tuberculosis diagnosed in refugees in the United States from January through June 1981. Specifically, we identified what type of tuberculosis was diagnosed (infectious or noninfectious) and whether it developed after the refugee arrived in the United States or was missed in the overseas examinations.

Through interviews with State and local officials, we determined whether refugee medical needs impaired the health departments' ability to serve the nonrefugee population. We also determined whether any barriers hampered health departments' efforts to provide refugees with medical care.

We interviewed Federal, State, and local officials to determine the adequacy of the notification system for refugee arrivals. For refugees who arrived in the United States in April 1981, we verified whether States and/or localities we visited had received adequate notification. For refugees who were diagnosed with tuberculosis from January through June 1981, we determined whether local authorities were notified of these cases and whether refugees reported for follow-on care and how long it took them to report.

We evaluated whether the medical procedures used in admitting refugees and providing follow-on care and treatment were adequate to safeguard the health of the American public. Throughout this assignment, our audit staff was guided by GAO's Chief Medical Advisor, who

- observed medical conditions in Southeast Asia;
- evaluated the adequacy of medical procedures used to admit refugees;
- reviewed refugees' medical records;
- discussed medical procedures and refugee health problems with Federal, State, local, and international health organizations; and
- compared medical procedures used for refugees destined for the United States with those used for refugees destined for other countries.

Our review was performed in accordance with the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

CHAPTER 2

HIGH INCIDENCE OF DISEASES IN INDOCHINESE

REFUGEES POSES A COSTLY PUBLIC HEALTH PROBLEM

Several serious and contagious diseases occur far more frequently in Indochinese refugees than in the U.S. population. Among these are active tuberculosis, serious parasitic diseases, malaria, hepatitis B, and leprosy. Because of this and because these diseases could spread to others, some State and local health officials believe a potential public health problem exists. With regard to tuberculosis, health officials said that the problem will be with us for years. Although HHS has maintained that admitting refugees with certain dangerous, contagious diseases does not present a potential public health problem, it has encouraged health departments to make special efforts to monitor and treat these refugees.

The Federal Government provided about \$173 million in fiscal year 1981 and will provide about \$217 million in 1982 for medical services to refugees after their arrival in the United States. Indochinese refugees represented about 77 percent of refugees from throughout the world admitted to this country in fiscal year 1981.

Several State and local health department officials told us that their departments' provision of health services to Indochinese refugees has proven costly and hindered their efforts to provide services to the general population.

The extent of refugees' health problems is discussed below using tuberculosis and parasitic diseases as illustrations. Both CDC's records and our fieldwork showed that Indochinese refugees exhibited a high incidence of hepatitis B, malaria, and leprosy, all serious and contagious diseases. Appendix I discusses the incidence of these diseases in Indochinese refugees and the U.S. population.

TUBERCULOSIS

Tuberculosis is a serious disease which may produce considerable disability and even lead to death. In 1980, about 28,000 cases of active tuberculosis were reported to CDC, and about 1,800 people in the United States died from it. Tuberculosis is generally spread by droplet infection (breathing, coughing, sneezing) from infectious persons. It can be transmitted among people in close contact particularly in crowded and poorly ventilated areas.

Incidence of tuberculosis at U.S. locations visited

Around the turn of the century, tuberculosis was reported by States as the second leading cause of death in this country, but by 1980, its incidence had declined to 12 cases per 100,000 population.

In contrast, CDC reported that refugees who entered the United States in 1980, with no evidence of disease when screened overseas, had a reported rate of 407 cases per 100,000 population, about 34 times higher 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. In some Southeast Asia camps the number of refugees with tuberculosis has been reported to be as high as 10,000 cases per 100,000 population.

The following table shows, in the U.S. locations we visited, the reported tuberculosis rates in refugees. The rates varied greatly, ranging from 115 to over 2,000 cases per 100,000 population, which may partly be due to different criteria used to identify tuberculosis cases in some localities. However, regardless of the criteria used, refugees have much higher rates of tuberculosis than the general population.

Tuberculosis Case Rates
Per 100,000 Population (note a)

<u>Location</u>	<u>Year</u>	<u>Refugee rate</u>	<u>Total population rate (including refugees)</u>
Orange County, California	1980	362	26
	1981	488	27
Los Angeles, California	1980	195	19
	1981	b/204	(c)
Montgomery County, Maryland	1980	2,000	12
	1981	278	12
Dallas County, Texas	1980	175	14
	1981	b/115	b/10
Jefferson County, Texas	1980	259	15
	1981	b/133	b/12
Fairfax County, Virginia	1980	1,600	7
	1981	b/2,272	b/9

a/Many localities' refugee populations are less than 100,000 persons. Thus, the tuberculosis rates in refugees should be used for comparison purposes only and should not be equated with the actual number of cases of tuberculosis that occurred.

b/Projected rate based on partial year results as of September or November 1981.

c/Not available.

State health officials in Maryland and Virginia told us that the high incidence of tuberculosis in refugees may pose a public health problem. Local health officials in Orange and Los Angeles Counties, California; Montgomery County, Maryland; and Fairfax County, Virginia, expressed similar concern.

In 1979, Virginia's tuberculosis case rates per 100,000 population were 794 for refugees and about 14 for the overall population. During 1980, the tuberculosis rate for refugees increased to 1,954, and Virginia's 1981 CDC grant application indicated that tuberculosis in refugees was an identifiable public health risk. In commenting on our draft report, Virginia's Assistant Health Commissioner said that refugees with tuberculosis will increase the State's disease statistics. He added that Virginia estimated its tuberculosis rates would decrease to 1.0 cases per 100,000 population by the year 2020; however, as a result of tuberculosis cases in refugees " * * * that estimate must be pushed back at least thirty years (to 2050)."

In 1980, Washington State's tuberculosis rate was 10 cases per 100,000 for the overall population, compared to 2,200 cases per 100,000 population for refugees. A July 1980 letter from the State's Director, Health Services Division, to the director of the Seattle-King County Health Department stated that

"The State's tuberculosis incidence for the first six months of this year has shown a 42 percent increase over the same period last year. Refugees currently account for 33 percent of the 206 new cases."

In January 1981, at the request of the Los Angeles County Health Department, CDC sent a team from its Tuberculosis Control Division to assess the quality and efficiency of the county's tuberculosis control services. Finding a significant problem involving refugees with tuberculosis, CDC concluded

"The size of the tuberculosis problem in Los Angeles County is immense: * * * and special situations related to refugees * * * contribute to the overall complexity of the control efforts.

"Because Los Angeles has become one of the primary settlement areas for Indochinese refugees, and because of the high prevalence of tuberculosis infection in this population, surveillance, containment and assessment activities relating to tuberculosis in refugees are of special importance."

In commenting on our draft report, Los Angeles County's Medical Director said that, in 1981, 41 percent of the refugees given tuberculosis skin tests 1/ reacted positively, compared to a 6-percent rate for Whites and a 14-percent rate for Blacks. He added that refugee skin test reactions were lower than those of some other ethnic groups, such as Hispanics (including illegal aliens) who have a 50-percent reaction rate.

Prince Georges County, Maryland, health officials said it would take from 3 to 5 years to determine the full impact of tuberculosis in refugees and expressed concern about future public health problems.

The high rates of tuberculosis in refugees are a cause for concern because the disease can be spread to others. For example, a 16-year-old refugee arrived in Seattle, Washington, in September 1979 and departed almost immediately for Montgomery County, Maryland. In October 1979, the county health department performed a chest X-ray on this individual. The results showed suspected, active tuberculosis. Further examination from a sputum culture showed the refugee had infectious tuberculosis.

Followup examinations of the refugee's school contacts were performed. In February 1980, 175 school contacts were given skin tests for tuberculosis; 13 positive results were found, and the individuals were placed on drug therapy. County officials were unable to determine if any of these persons were infected as a result of contact with the refugee. However, a followup examination of the same 175 contacts in May 1980 showed another 10 persons with positive results. The county's chief of tuberculosis control believed that these 10 persons were infected with tuberculosis as a result of contact with the refugee. These persons were also placed on drug therapy.

Health department officials told us that the refugee came to the county with no medical records and no overseas diagnosis of tuberculosis. This individual later told health department officials that he was not given any medical records to bring with him, although he had an X-ray overseas while in a refugee camp.

CDC has also expressed concern about the impact of refugees with tuberculosis. It found that Indochinese refugees accounted for about 3 percent of the tuberculosis cases counted nationally in 1979 and about 8 percent in 1980. In December 1980, the chief of CDC's Tuberculosis Control Division stated that

1/A test consisting of an injection which has no reaction on non-infected persons, but causes inflammation in infected persons.

"The gradual increase in the average age of the patient with tuberculosis experienced by the Nation as a whole has not been shared or has been reversed in areas with large numbers of Indochinese or other recent immigrants from areas of the world where tuberculosis is more common. In addition to other and more favorable effects that many of these persons will have on our society, they represent a swell of cases of tuberculosis that will ripple across the age groups in the decades ahead."

Refugee children have high rates of tuberculosis

Under HHS' medical criteria used overseas, refugee children under 15 years of age are not examined for tuberculosis unless they are ill or a family member has the disease. However, refugee children have high rates of tuberculosis compared to the U.S. population.

A CDC study of refugees who arrived in 1979 and 1980 showed that:

- In the 4 and under age group, the tuberculosis case rate in Indochinese refugees (439 per 100,000) was about 88 times greater than that in the U.S. population (5 per 100,000).
- In the 5 to 14 age group, the tuberculosis case rate for these refugees (301 per 100,000) was about 215 times greater than that in the U.S. population (1.4 per 100,000).

Symptoms of active tuberculosis become apparent after arrival in the United States

Although Indochinese refugees may have been examined overseas and found not to have active tuberculosis, symptoms of the disease may not become apparent until shortly after they arrive in the United States. Virginia health officials said refugees who arrived in 1975 and later are now starting to develop active tuberculosis. For example, in 1980 Virginia found six refugees with active tuberculosis who arrived in the United States from 1975 to 1977 with no overseas diagnosis of tuberculosis. Prince Georges County, Maryland, health officials said that the full impact will not be known until the younger generation of refugees starts developing active tuberculosis 3 to 5 years from now. Accurate data on the extent that refugees have developed tuberculosis after arriving in the United States were not available.

Most refugees possessing waivers
for active tuberculosis
report to health departments

More than 80 percent of the arriving refugees having active tuberculosis and medical waivers for that condition were seen at least once by local health departments in this country. CDC developed information which showed that 1,009 refugees possessing medical waivers for active tuberculosis were admitted to the country between January 1 and June 30, 1981. Nineteen percent of these persons reported to a health department within 14 days, 51 percent within 30 days, and 81 percent within 60 days.

Data on refugees who arrived during the same period for the U.S. locations we visited showed that, of 450 refugees with active tuberculosis medical waivers, 83 percent had reported to health departments--32 percent within 7 days, 48 percent within 14 days, and 74 percent within 30 days. Based on these data, it appeared that health departments succeeded in making contact with most refugees. However, 17 percent were never examined by a health department primarily because they had moved. The State of Hawaii's Director of Health said that, since CDC began its grant program (see p. 27), all of the refugees given tuberculosis waivers overseas reported for follow-on care in Hawaii and that 95 percent of all other newly arrived refugees reported for tuberculosis examinations.

Voluntary agencies under contract with the State Department have played a major role in referring refugees with active tuberculosis waivers to health departments, for both initial treatment and followup care. Although some voluntary agencies were conscientiously attempting to fulfill this role, others were not. For example, some voluntary agencies in Los Angeles and Orange Counties took no responsibility for assuring that refugees with active tuberculosis waivers received any medical services beyond a routine tuberculosis skin test. Voluntary agencies in these counties brought refugees to the health departments only for initial health examinations but assumed no responsibility for assuring that they received medical care resulting from the initial examination. District of Columbia, Hawaii, Virginia, and Prince Georges County, Maryland, health officials told us that some voluntary agencies were not bringing refugees in for medical examinations. Virginia officials said that, as a result, the State health department has assumed the responsibility for assuring that all refugees entering Virginia are examined. In commenting on our draft report, Hawaii's Director of Health stated that the voluntary agencies' performance in Hawaii had improved.

PARASITIC DISEASES

Where hygiene and sanitary conditions are poor and food, soil, and water are contaminated by feces, individuals can contract parasitic infestation. Parasites are worms or other organisms that

live in the human intestine. While many parasites produce only mild symptoms, amebiasis and giardiasis may become quite incapacitating. Amebiasis essentially results in dysentery, which causes much illness in third world countries. It can produce intestinal infection, ulcers, diarrhea, and liver abscesses. Giardiasis is an upper intestinal infection which may cause cramps, diarrhea (which can last more than 2 weeks), and weight loss.

In the United States the risk of transmitting parasites from person to person is limited because of modern sanitary conditions (waste disposal and water treatment facilities). However, persons with amebiasis or giardiasis can spread these diseases by failing to practice good personal hygiene after using toilet facilities and having direct contact or indirect contact (such as through food handling) with others. Some cases of these diseases have occurred in the native U.S. population. In 1981 about 5,300 cases of amebiasis and 11,000 cases of giardiasis occurred in the United States.

Between July 1979 and December 1980, CDC analyzed the results of six studies on the prevalence of intestinal parasites in refugees. Overall, CDC's analysis showed that about 48 percent of refugees had at least one parasite. CDC concluded, however, that the public health risk of intestinal parasites in refugees was not significant, except for amebiasis and giardiasis, and recommended against routinely examining all refugees overseas. However, CDC recommended that examinations for parasites be done after refugees arrive in the United States.

Incidence of parasites
at U.S. locations visited

Of the continental U.S. locations we visited, only the State of Maryland and Fairfax County, Virginia, routinely examined all refugees for parasites. Since April 1981, refugees arriving in Hawaii have routinely been given examinations for parasites.

In examining 1,268 refugees between June 1, 1979, and August 31, 1980, Maryland found that 8.4 percent had giardiasis and 2.0 percent had amebiasis. Fairfax County health officials believed that intestinal parasites in refugees are a serious problem. In examining 2,046 refugees between August 1979 and April 1981, county officials found that about 62 percent had one or more parasites, including amebiasis (1 percent) and giardiasis (22 percent). Overall, in 1980 the State of Virginia reported 64 cases of amebiasis, of which 35 (55 percent) were in refugees and 22 (34 percent) were in the nonrefugee population. 1/

1/For seven cases (11 percent) information was not available to determine whether the individual was a refugee.

Virginia also reported 396 cases of giardiasis, of which 239 (60 percent) were in refugees and 90 (23 percent) were in the nonrefugee population. 1/

A study conducted by the University of Hawaii from August 1975 through January 1979 showed that 72 percent of refugees had parasites. Of 580 refugees examined, 111 had giardiasis (19 percent) and 31 had amebiasis (5 percent).

Although the Orange County health department did not screen all refugees for parasites, it has maintained separate statistics for refugees since 1980. The following table shows that refugees have a high incidence of amebiasis and giardiasis.

Incidence of Parasites in Indochinese Refugees
Orange County, California
January 1980-December 1981

<u>Disease</u>	<u>Year</u>	<u>Number of cases</u>		<u>Incidence rates per 100,000 population</u>	
		<u>Total</u>	<u>Refugee</u>	<u>Total</u>	<u>Refugee</u>
Giardiasis	1980	377	131	20	218
	1981	502	122	25	261
Amebiasis	1980	181	34	9	57
	1981	134	29	7	62

Other California health departments have also maintained statistics on the incidence of parasites in refugees. For example, the City of Long Beach found that about 81 percent of the refugees examined in 1980 and 1981 had parasites. Based on information from the local level, the State of California has reported that about 51 percent of refugees had parasites, including amebiasis and giardiasis.

In Washington State, three local health departments tested refugees for parasites between 1979 and 1981. One of these studies, which included about 72 percent of the refugees tested, showed that 69 percent of the refugees had at least one parasite, and 32 percent had two or more, including amebiasis and giardiasis.

According to Prince Georges County, Maryland, health officials, parasites pose a public health problem. In 1980, the county found that 51 percent of the refugees examined had at least one intestinal parasite and 46 percent had two or more. Twenty-one percent of all those with parasites had giardiasis. 2/

1/For 67 cases (17 percent) information was not available to determine whether the individual was a refugee.

2/The county did not identify any cases of amebiasis in refugees in 1980.

State and local officials told us that, because refugees often are employed in the food handling industry, the high incidence of amebiasis and giardiasis becomes significant. Except for the District of Columbia and Los Angeles County, the States and localities we visited had no requirements that persons be examined for parasites before working in the food industry.

REFUGEES HAVE INCREASED COSTS AND WORKLOADS AT HEALTH DEPARTMENTS

The Refugee Act of 1980 authorized the Federal Government to reimburse State and local governments for up to 100 percent of the costs incurred in providing medical services to all refugees. In fiscal year 1981, \$173 million ^{1/} in Federal funds was provided for medical services to refugees after their arrival in the United States. The Office of Refugee Resettlement provided about \$134 million, and the Medicaid program provided another \$39 million. In fiscal year 1982, Federal funds amounting to about \$217 million will be provided for similar medical services to refugees. Although these funds apply to refugees from throughout the world, the Indochinese represented about 77 percent of the refugees admitted to this country in fiscal year 1981. ^{2/}

Some health department officials told us that, because many of the services provided to refugees have not been federally reimbursed, their departments have had to absorb substantial costs. Also, because of the high incidence of disease in refugees and the limited resources of health departments, providing services to Indochinese refugees has hindered their efforts to serve the overall population.

Refugee care has been costly to health departments

According to HHS, State and local health authorities have expressed concern over the long-term costs of providing medical services to refugees, especially for tuberculosis prevention and treatment. Some of the services provided to refugees are not covered in States' Medicaid plans. As a result, the cost of these services is not reimbursable, and local health departments have to absorb it. For example, from August 1979 to April 1981, Fairfax County, Virginia, spent about \$270,000 to provide refugees initial health screening, which included a physical examination; blood, parasite,

^{1/}HHS' Medicaid criteria are used as the basis for reimbursement.

^{2/}Neither dollar amounts nor admission data include Cubans and Haitians.

and tuberculosis tests; and immunizations. ^{1/} During this period, the county was reimbursed \$61,235 and absorbed the other \$207,845.

The Prince Georges County health department estimated that in 1980 it cost \$238 to screen and treat each refugee for communicable diseases. The health department received no reimbursement for these services. In providing care to refugees with tuberculosis, the county absorbed about \$35,000 for treating 347 refugees in 1980. Los Angeles and Orange Counties, the State of Hawaii, and the District of Columbia have experienced similar problems.

The Texas Commissioner of Health said that refugees are brought to this country as a result of Federal policy and actions. They are then resettled into, and become the responsibility of, States and communities without prior clearance and without adequate Federal compensation for needed services, thereby placing a burden on governments at a time when budgets have already been reduced.

In commenting on our draft report, Hawaii's Director of Health stated that, while the funds provided by CDC for health screenings (see p. 27) have helped offset the costs of providing health services to refugees, the funds were not adequate for tuberculosis treatment and control. The State of Washington's Director of Health said that the State now screens 97 percent of all refugee arrivals but the CDC funds covered only 10 to 20 percent of the actual costs incurred by local health departments. The largest expense, according to the Director, is not screening, but long-range preventive treatment services provided to refugees to prevent outbreaks of diseases, such as tuberculosis.

Virginia's Assistant Health Commissioner said that screening each refugee costs \$110 and that the CDC funds for fiscal year 1981 and 1982 covered 13 to 15 percent of the costs of Virginia's refugee screening program. As a result, in June 1982, Virginia reduced the scope of its screening program, and according to the Commissioner, the CDC funds provided will cover about 50 to 60 percent of the State's costs.

California's Deputy Director for Administration, Department of Social Services, said that refugees do not pose a medical threat, but are an extreme financial burden on the State. He added that the arrival of 260,000 refugees in California, from areas where infectious diseases are common, seriously burdens the State's public health resources.

^{1/}The county had additional costs for the period August 1979 to May 1980; however, the county was not able to specifically attribute the amount of those costs to its refugee medical activities.

Refugees have caused
increased workloads

A February 1981 study performed for HHS stated that:

"The ability of a community to plan and develop health services is directly related to the availability of financial resources. Limited resources may sometimes find community agencies in the dilemma of shrinking services for one population while trying to find additional resources for the steadily increasing number of refugees."

We found that refugees accounted for a large part of some health departments' workloads. This has caused some health departments to curtail or limit service to their general population.

Maryland State health officials said that refugees were placing a burden on the health departments' resources. Maryland State health officials also said that, as a result of adding health care services for refugees, some health departments have had to reduce services to the nonrefugee population. For example, in Montgomery County, refugees account for less than 1 percent of the population but represent more than 50 percent of the workload in some of the health department's clinics. Regarding tuberculosis, refugees accounted for 24 percent of the county's new cases in 1979 and 64 percent in 1980. County health officials said that, because of the increased workload caused by refugees, it is no longer able to provide routine screenings to certain other groups of the county's population.

Orange County, in an effort to cope with its refugee workload, acquired additional clinic space, new X-ray equipment, and temporary staff. However, more staff is needed, according to county officials, because the increased workload has affected the county's ability to follow up on tuberculosis cases.

The Virginia State Health Department cited the impact of refugees on health departments in its fiscal year 1981 application for a CDC health grant:

"The workload has been growing and local health budgets and manpower are stressfully strained to provide the required protection of public health and meet the needs for assessing health care status and making referrals for care * * * the influx of Indochinese has imposed unforecasted costs and provided a disastrous impact on local budgets * * *."

Hawaii's tuberculosis control branch chief estimated that about 10 percent of its workload resulted from refugees. At the request of the branch chief, CDC reviewed Hawaii's tuberculosis program in 1980. CDC found that the program was severely backlogged and understaffed and has not been able to follow up adequately on refugee cases.

In commenting on our draft report, Hawaii's Director of Health reiterated that the tuberculosis branch did not have enough staff and funds to adequately track refugees to provide preventive chemotherapy. He said that providing screening, diagnostic, and treatment services for active tuberculosis cases in refugees has caused the State to shift emphasis in treatment services available to the general population. Further, the Director said that, under CDC's refugee health screening project, the State is attempting to remedy this situation and provide tuberculosis services to both refugees and the general population.

CONCLUSIONS

The incidence of active tuberculosis, parasitic diseases, and other contagious diseases is higher in Indochinese refugees arriving in this country than in the Nation's overall population. While HHS has maintained that the medical conditions of arriving refugees do not pose a public health problem, information we obtained from Federal, State, and local health officials indicates that a potential problem may exist.

Both the Federal Government and State and local health departments have spent substantial sums of money dealing with refugee medical problems. Also, health departments' workloads have been increased by the need to provide both initial and follow-on medical care for refugees. We believe that the medical conditions of Indochinese refugees admitted to the United States have and will continue to require substantial Federal, State, and local resources.

CHAPTER 3

IMPROVED OVERSEAS MEDICAL EXAMINATIONS AND

TREATMENT NEEDED TO DEAL WITH REFUGEE HEALTH PROBLEMS

The overseas medical examinations given to Indochinese refugees are inadequate, and the results of those examinations are not considered in making final decisions on the admissibility of refugees. As a result, serious, contagious diseases and other medical problems go undetected and untreated overseas. These medical problems become difficult to deal with once refugees become dispersed into the U.S. population.

Local health departments are the cornerstone of efforts to deal with refugee health problems in the United States. While these health departments had succeeded in making initial contact with most refugees, a number of factors hindered their ability to provide follow-on care in the United States.

Improved overseas medical examinations of refugees could preclude many of the problems currently confronting health departments. The cost of improving the overseas medical examination procedures is modest when compared to the costs and difficulties of dealing with refugee health problems after the refugees have been dispersed into the U.S. population.

SERIOUS CONTAGIOUS DISEASES AND OTHER HEALTH PROBLEMS GO UNDETECTED AND UNTREATED

The overseas medical examination process is cursory, and the medical procedures used to detect and treat certain excludable health conditions, such as tuberculosis, are inadequate. In addition, no evaluation procedures are performed for certain diseases which, although not excludable under PHS regulations, are serious, contagious diseases common in Southeast Asia.

More thorough medical examinations and treatment overseas would benefit both refugees and the U.S. population with whom the refugees will ultimately come in contact. The cost of improving the medical examinations of refugees bound for the United States appears modest and would make the medical examinations more consistent with procedures used in this country and those of some other countries that admit refugees.

Overseas medical screening process is cursory

CDC developed the overseas medical examination criteria for refugees that call for:

- A brief medical history.
- A visual inspection of the body's skin surface.
- A chest X-ray for individuals 15 years of age and over.
- A blood test for syphilis for those 15 years of age and over.
- An observation for excludable mental conditions.
- A more comprehensive physical examination if excludable conditions are indicated.

According to CDC officials, the overseas medical examinations were designed to identify only excludable conditions and begin treating them. They were not designed to be a complete diagnostic evaluation.

We observed the medical examination process at six refugee camps and processing centers. No medical histories were taken, and the ICM Chief of Medical Services told us that ICM was not instructed to do so. A complete medical history is an essential part of a physical examination and often gives the physician important information which may guide the extent and nature of the examination.

The visual or physical inspection of refugees was quick. For example, at one location, 250 refugees were examined in 1-1/2 hours, an average of about 20 seconds per examination. On this occasion, the part of the process that took longest involved determining the expected delivery date of pregnant women. Also, no part of the examinations we observed was devoted to determining the existence of mental conditions, alcoholism, or drug addiction, and only overt evidence of mental retardation could be detected.

Overseas medical evaluation procedures for tuberculosis and other excludable conditions were inadequate

Overseas medical examination procedures were inadequate to detect certain excludable diseases, namely active tuberculosis and infectious leprosy, in refugees. Moreover, treatment for tuberculosis, when identified, was not initiated in accordance with CDC criteria.

Tuberculosis

Each refugee 15 years or older receives a chest X-ray. Younger persons are X-rayed only if a family member has been found to have active tuberculosis, or if they are ill. If an X-ray is positive or suspicious, two sputum smears are taken on consecutive days. If the smears prove negative and the refugee

does not have obvious signs of illness, nothing further is done for at least 2 months, when the individual is to be X-rayed again. However, CDC's procedures allowed refugees to depart for the United States before the 2-month period expires. Physicians overseas told us that many refugees whose chest X-rays are read as positive or suspicious left within 2 months. These refugees were supposed to report to local health departments for follow-on care.

CDC's procedures require that, if the sputum smear is positive, refugees cannot depart for the United States. Although the procedures call for treatment of smear positive cases, physicians overseas said that they do not begin treatment for these cases unless there is evidence of extensive disease or the refugee has obvious signs of illness. Rather, another X-ray is taken in 2 months. If there is evidence of change on the X-ray, the refugee is placed on a supervised drug treatment. After two sputum smears are negative, the refugee is considered to be noninfectious, given a 2-week supply of antituberculosis drugs, and permitted to leave for the United States.

Several radiologists and chest physicians working at the refugee camps in Southeast Asia were critical of what they considered to be lax procedures for detecting tuberculosis and said they use more comprehensive procedures for their own (nonrefugee) patients. These physicians, as well as physicians in the United States, told us that sputum smears alone do not represent a reliable way of identifying tuberculosis and could result in some infectious cases not being detected.

In the United States, the general practice in examining patients with suspected tuberculosis is to perform a chest examination (including several chest X-rays, often from different views) and take sputum smears and cultures. Individuals with positive sputum smears or cultures are infectious. The culture is performed by placing a sputum specimen on a culture medium and incubating it for 6 to 8 weeks. This is a more sensitive and accurate test than the sputum smear, although the smear gives a faster result.

It is also routine practice in the United States to start treating a person whose examination shows clear evidence of active tuberculosis, even in the absence of positive sputum. Treatment usually requires at least two drugs in daily doses for 9 to 18 months. However, in the active stage, tuberculosis usually becomes noninfectious within a few weeks of starting therapy.

This contrasts with the treatment of active, progressive tuberculosis observed in the Bataan refugee processing center. A 25-year-old woman destined for the United States had received a chest X-ray in Thailand on February 21, 1981, which showed tuberculosis in both lungs. Sputum smears performed on February 25 and 26 were negative. This woman arrived at the Bataan refugee processing center on March 24, 1981, and did not receive another

X-ray until May 12. This X-ray showed "moderately advanced active tuberculosis." Sputum smears performed on May 5 and 6 were reported as negative. On June 29, a few days before we arrived at Bataan, another chest X-ray was reported by the radiologist as showing "far advanced active tuberculosis." As of July 6, 1981, no additional followup sputum smears had been performed, and no antituberculosis treatment had been initiated.

Other excludable conditions

Examinations for other excludable conditions--namely infectious leprosy, mental illness, or problems which could affect the refugees' earning ability--were inadequate. As mentioned, CDC said the overseas examinations are not designed to be a complete diagnostic evaluation. In addition, HHS told us that

"* * * Personal health problems, such as cancer or heart disease, can be detected only to the extent that signs or symptoms of such conditions can be elicited through medical history, visual inspection, chest x-ray examination, or any combination of these. Although specific examinations are not performed for these illnesses, our records show that 26 refugees with cancer and 599 with heart disease were identified during the screening process."

Because medical histories were not done and the visual inspections of the body were cursory (see p. 21), the overseas examinations appeared inadequate for detecting most excludable conditions.

Inadequate overseas medical examinations fail to detect excludable conditions

Providing follow-on medical care in the United States depends heavily on cases being accurately diagnosed overseas. However, in California, Hawaii, Maryland, Texas, Virginia, Washington, and the District of Columbia, many refugees were diagnosed as having infectious tuberculosis (an excludable disease) by local health authorities shortly after arriving in the United States.

For example, Virginia, which performs routine tuberculosis testing on all arriving refugees, added 32 cases to its 1980 tuberculosis register who had not been diagnosed overseas. We analyzed the medical records on these 32 refugees and concluded that 16 cases were missed overseas. We reached this conclusion because the disease was diagnosed very shortly (generally within

2 months) after the refugee arrived in the United States. Fourteen of these 16 cases had infectious tuberculosis. 1/

In commenting on our draft report, Virginia's Assistant Health Commissioner criticized the Surgeon General's criterion of declaring refugees with infectious tuberculosis to be noninfectious after 2 consecutive days with negative sputum smears since some refugees had positive smears when examined in Virginia, indicating the presence of infectious tuberculosis. The Commissioner said this was due to the chemotherapy regimen not being administered long enough overseas to render the refugees permanently noninfectious.

Cases of active, noninfectious tuberculosis were also missed overseas. In some instances, this was because no tuberculosis examinations were done overseas. In other instances, refugees were mistakenly diagnosed with inactive tuberculosis.

State and local officials pointed to the particular problem of refugees under 15 years of age who are not X-rayed overseas even though this age group has a high incidence of tuberculosis. Health departments have found refugee children with active tuberculosis. For example, during our 6-month sample period, Dallas County, Texas, diagnosed five cases of active tuberculosis in refugee children, Virginia diagnosed seven such cases, and Orange County and Seattle each diagnosed three such cases. None of these cases had been detected overseas. In commenting on our draft report, Hawaii's Director of Health said that, from July to December 1981, the State identified six cases of active tuberculosis in refugee children.

We examined the medical records of refugees in Maryland; Virginia; Harris County, Texas; and Hawaii who were diagnosed overseas with inactive tuberculosis to ascertain the extent of misdiagnosis. These refugees arrived in the United States from January 1 to June 30, 1981. The health departments determined that, of 117 refugees diagnosed overseas with inactive tuberculosis, 16 had active tuberculosis when examined in the United States. Most of these refugees were examined by health departments within 2 months after arrival.

In commenting on our draft report, Hawaii's Director of Health stated that the health department found, for the most part, few misdiagnosed cases of tuberculosis in refugees. Instead, the Director said the overseas physicians tended to overdiagnose the presence of tuberculosis in refugees.

1/In the other 16 cases the refugee either developed tuberculosis after arrival in the United States (9); the overseas examinations had apparently diagnosed tuberculosis but Virginia was not notified by CDC (4); or information in the medical records was insufficient to allow us to make a determination (3).

Also, in a November 1981 letter to us, the Director of the National Hansen's Disease Center stated that 209 refugees admitted to the United States from 1975 through November 1981 had leprosy. According to the Director, 122 (58 percent) of these were not detected overseas. The Center Director stated that most of these cases were diagnosed soon after entry into this country.

No medical examination procedures
are performed for serious
nonexcludable diseases

No specific medical procedures were performed to detect serious nonexcludable diseases--namely, certain parasites (amebiasis and giardiasis), hepatitis B, and malaria--even though these diseases are serious, contagious, and common in Southeast Asia. Refugees from that part of the world have a high incidence of these diseases, as discussed in chapter 2 and appendix I.

In the United States, amebiasis and giardiasis are generally detected by stool examinations. Hepatitis B and malaria are generally detected by blood tests.

HHS officials told us that, although Indochinese refugees are not examined overseas for malaria, they are treated for the disease if symptoms are identified.

Medical records handling procedures
hinder the ability to meet the act's
medical eligibility requirements

While visiting refugee camps in Southeast Asia, we observed two weaknesses in the handling of refugee medical records that diminished the value of the medical examination process.

The first weakness was that medical records developed while the refugees were in the overseas camps and maintained at those locations were not available to physicians employed by ICM to do medical admissions examinations. According to officials of the U.N. High Commissioner for Refugees office (which provides care and protection to refugees while in the camps), these medical records are destroyed. An official from the High Commissioner's office said that individuals providing medical care in the overseas camps are somewhat reluctant to release the medical records because this might hamper the timely movement of refugees to the United States.

We brought this matter to HHS' and the State Department's attention in August 1981. In December 1981, the State Department sent a cable to the U.S. embassies in Southeast Asia and to the U.S. mission in Geneva, Switzerland (ICM headquarters), requesting them to discuss the feasibility of obtaining medical records

from the refugee camps. The cable emphasized the need for examining physicians to review refugees' medical records before making a final medical evaluation. Further action has been taken to provide refugees' medical records to physicians. (See p. 40.)

The second weakness was that the results of the overseas medical examinations were not factored into INS decisions regarding the admissibility of individual refugees into this country. The standard procedure used in Southeast Asia is for INS staff to interview refugees and either approve or reject them for entry to the United States before a medical examination. Justice said that this procedure was established to save the costs of providing medical examinations to refugees who would not be accepted into the United States. For those refugees approved, a medical examination was done later. If excludable health conditions, which can be waived under HHS criteria, are found, the procedure was to go back to INS to obtain a medical waiver; not to reconsider the refugee's eligibility for entry to the United States. INS headquarters officials and staff in overseas camps we visited told us that refugees' medical results were not considered in its eligibility review and that INS field staff were rarely given such results. Therefore, INS had no basis for determining whether refugees are medically eligible for admission. Action has been taken to correct this practice, and INS now is given refugee medical examination results in time to use in its decisionmaking. (See p. 41.)

BARRIERS TO PROVIDING EFFECTIVE FOLLOW-ON CARE IN THE UNITED STATES

Follow-on care by local health departments was the basis of HHS' decision to relax the refugee medical admission requirements. As discussed on page 13, data we developed for the period January 1 through June 30, 1981, at the U.S. locations we visited showed that, of 450 refugees with active tuberculosis medical waivers, about 74 percent had reported to local health authorities within 30 days of entering the United States. Therefore, it appeared that health departments succeeded in making initial contact with most refugees within a reasonable time.

However, local health departments' efforts to locate and examine refugees varied greatly, and a number of barriers made it difficult for local health departments to effectively provide follow-on care. These barriers included refugees moving without notifying health authorities, failure of refugees to take prescribed treatment, and missing or incomplete medical records.

State and local health programs for refugees vary

Local health departments' efforts to locate and examine refugees varied greatly--ranging from minimal efforts to conscientious attempts to medically examine all refugees.

Of the U.S. locations we visited, only Maryland, Virginia, and Washington required all refugees to have a skin test for tuberculosis. California State health officials also recommended these tests be done because they believed that the overseas examination was inadequate and could result in some missed cases. In addition, Maryland recommended that its local health departments examine all refugees for other conditions, such as parasites, hepatitis B, and venereal diseases. Fairfax County, Virginia, also examines all refugees for parasites and venereal diseases.

Texas, which has the second highest population of Indochinese refugees, does not require its local health departments to perform any refugee medical examinations. In commenting on our draft report, Texas' Commissioner of Health said that the local health departments are not controlled by the State but by city or county governments. He said that, although refugee health examinations are not required, in 1981 Texas requested 13 counties with large refugee populations to submit proposals to establish refugee health screening programs. Only four health departments (Austin, Dallas, Houston, and Port Arthur) submitted proposals because, according to the Commissioner, these programs would be costly to them and there was concern about the political ramifications of singling out a particular group and providing services for them but not for the general population. The four health departments began providing health services to refugees from April to September 1981.

The nature of the health examinations in Texas varied. For example, the Dallas Health Department performed limited medical examinations on a sample of refugees who voluntarily entered the health department beginning in September 1981. Harris County's (Houston) program does not include general health assessments. Instead, medical histories and symptoms are recorded, and refugees are referred to other medical providers for general physicals, tests, and treatment.

In the District of Columbia, where about 200 refugees arrive each month, no medical examinations are routinely performed until it has been determined the refugee will remain there.

At the Federal level, CDC established a grant program in 1980 for States and localities to provide medical examinations to refugees. About \$4.8 million was available in each of fiscal years 1980 and 1981, and about \$5.1 million is available for fiscal year 1982. The program was designed to have medical examinations performed on newly arrived refugees. As of January 1982, 30,263 refugees (about 5 percent of those resettled in the United States) have had medical examinations under CDC's program. In addition, CDC has stationed personnel in several localities to help manage cases of tuberculosis.

Refugees move without
notifying health authorities

Secondary migration, the movement of refugees from their initial resettlement location, generally bypasses the notification or information systems for refugees. Refugees who move usually arrive in a new locality without notifying public health authorities and with little or no record of health care provided elsewhere. Secondary migration of refugees makes it difficult for health authorities to identify those in need of follow-on care and to provide such care to refugees with diseases, such as tuberculosis.

A 1980 report by HHS' Inspector General showed that, of 350 refugees interviewed, 43 percent had moved from their initial arrival location, most (61 percent) to another State. Of our sample of 450 refugees with active tuberculosis, 39 (9 percent) had moved before being examined by health departments.

Virginia officials found 13 cases of active tuberculosis in refugees who were secondary migrants during our 6-month sample period. While a diagnosis of tuberculosis had been made overseas and in other States on some of these individuals, Virginia officials were not notified of the refugees' arrival in Virginia or any prior medical care provided in most of these cases. Three of these 13 had positive sputum smears, and 6 had positive sputum cultures, indicating infectious tuberculosis. Virginia also found an additional 13 refugees with active tuberculosis during our sample period. Information was not available to show whether these refugees were secondary migrants; however, Virginia officials said that the State was not notified of the arrival of these refugees. Orange County, California, found 23 cases of active tuberculosis in refugees who were secondary migrants during our sample period.

The following examples demonstrate the difficulties health departments have in providing follow-on care to refugees.

In January 1981, the District of Columbia reported that 99 refugees with tuberculosis, according to CDC, had arrived during 1980. The District's Tuberculosis Division had contacted 77 and had no information on the other 22.

In our sample of 450 refugee arrivals with active tuberculosis, we found that the District was notified by a voluntary agency of the arrival of 5 refugees, in addition to 18 brought to its attention by CDC notification. Of these five cases, four had either moved or were otherwise lost before the District health department could examine them.

Another refugee was diagnosed overseas with active tuberculosis in June 1980 and placed on drug therapy. In January 1981, he was examined in the District of Columbia and placed on medication, which

he failed to take regularly. In April 1981, he moved to Arlington, Virginia, without notifying Arlington health authorities. The refugee later moved to Fairfax County and was examined by the county's health department in May 1981 and diagnosed as having active, infectious tuberculosis. Medical records showed that Fairfax officials had not been notified of his arrival. Fairfax officials have since experienced problems locating him for follow-on care.

Another refugee diagnosed overseas with active tuberculosis arrived in Boston in January 1981. Boston authorities later learned that he was moving to Norfolk, Virginia, and notified Virginia authorities on April 19, 1981. However, in the interim, he resettled in Alexandria, Virginia, without the knowledge of Virginia authorities and went to the Alexandria health department for examination. The health department lost contact with the refugee, and he was later found in Fairfax County, Virginia. According to Virginia medical records, he was later lost again.

Failure of refugees to take prescribed treatment

The treatment of active tuberculosis requires a long time during which the patient should be on medication, tested for disease status, and monitored. HHS has stated that:

"Those refugees in whom a diagnosis of active tuberculosis is verified receive or continue treatment * * * difficulty with treatment compliance is a major impediment to control of tuberculosis everywhere, but there is no evidence that refugees are particularly noncompliant * * * Continuity of follow up and treatment is critical for therapeutic success."

HHS did not provide any statistics or studies to support its statement. Based on our analysis of refugee medical records and discussions with local health authorities, the extent to which refugees took prescribed treatment varied considerably. In some locations, health officials said that refugees frequently did not take prescribed treatment, but in other locations, the problem was less extensive. One reason why refugees failed to take treatment was that they are unaccustomed to long-term treatment regimens. The process of secondary migration further complicates the ability of health authorities to monitor whether refugees are taking their prescribed treatment.

For example, health and voluntary agency officials in Honolulu, Hawaii, said refugees sometimes fail to complete treatment because of language, education, and cultural differences and because refugees give health care lower priority than housing and employment. In commenting on our draft report, Hawaii's Director of Health added that maintaining contact with persons who have

tuberculosis and require drug therapy for several months is a significant problem in any population. If drug therapy is interrupted, there is an increased risk of developing resistant strains of the disease, according to the Director. The Director said that other groups of people in the United States also fail to complete treatment for diseases because of the length of time required.

Virginia's Assistant Commissioner of Health, in commenting on our draft report, said that language and cultural differences are the main reasons why refugees fail to complete treatment. He added that, because Virginia's public health nurses were spending considerable time providing health education to Indochinese refugees, refugee treatment compliance was acceptable in Virginia. Dallas County health officials said that refugees returned for the review of X-ray readings, but seldom returned for medication if the X-ray confirmed tuberculosis. Texas' Commissioner of Health said that the absence of interpreters until late 1981 in the Dallas County program contributed to this situation.

California health officials also said refugees are not familiar with the concept of long-term treatment and that ensuring they complete treatment requires diligent efforts by the health department.

Los Angeles health officials said that 56 percent of refugees complete preventive therapy and that this compliance rate was achieved by adding bilingual staff to provide translation and health education services.

King and Pierce County, Washington, health officials said getting refugees to take medication is difficult. According to these officials, some refugees have discarded their medicine or changed the required dosage or length of treatment. For example, 5 of the 15 refugees in Pierce County with active tuberculosis in our sample had stopped taking their medication for up to 3 months. Two of these were later lost and were no longer under medical supervision.

Missing or incomplete medical records

The Refugee Act of 1980 required the Secretary of HHS and the U.S. Coordinator for Refugee Affairs to ensure that refugees' medical records were available and in proper order. This is the responsibility of CDC staff at U.S. ports of entry. State and local health department officials told us they were experiencing problems because refugees' medical records were either missing or incomplete. The Director of the Seattle-King County, Washington, Health Department stated that since February 1980, when CDC changed the system for notifying States of refugee arrivals by sending medical records to a single point, the situation had improved.

A problem results since records of medical histories are not taken overseas. According to health officials, health departments' attempts to develop histories on refugees have been complicated by differences in language and cultural beliefs and a lack of understanding of U.S. medical practices. Health officials in the District of Columbia, Montgomery County, and Los Angeles said that language differences are a major problem in trying to develop medical histories. Montgomery County officials said that it can take 2 to 3 hours for a refugee medical examination compared to 20 to 30 minutes for others.

HHS has acted to provide refugees' medical records to health departments. (See p. 41.)

COST OF IMPROVING OVERSEAS MEDICAL EXAMINATION PROCEDURES IS MODEST

The cost of improving overseas medical examination procedures to make them more comprehensive and comparable with those generally performed in the United States is modest. This is particularly true when the cost is compared to the costs associated with dealing with the medical problems of refugees after they have been dispersed into the U.S. population. Improving the medical examinations would also make them more comparable to those used by other countries that accept large numbers of refugees.

We could not determine the extent of the cost savings which may result if refugees receive a more thorough medical examination and treatment overseas. However, if refugees are diagnosed and treated overseas, where medical care is less expensive than in the United States, they are likely to need less medical care after arriving in this country. In addition, performing a thorough and reliable examination overseas with proper documentation in refugees' medical records should reduce the need for health departments to routinely examine refugees upon arrival.

Estimated costs of improving overseas medical examinations

The overseas medical examinations were not designed to be a thorough medical evaluation. The State Department estimates that the medical examinations overseas cost about \$25 per refugee in fiscal year 1981 and will cost about \$27 per refugee in fiscal year 1982. This would amount to about \$2.7 million for the 100,000 refugees that can be admitted to the United States in fiscal year 1982.

of A thorough examination in the United States usually consists

- taking a complete medical history;
- thoroughly inspecting all parts of the body, then examining each organ system using observation, followed by palpation;
- examining the chest and heart using a stethoscope; and
- taking blood pressure readings.

This examination is designed to give the physician information concerning whether the body's systems are functioning within normal limits. If the physician wishes to go further to arrive at a specific diagnosis, or if the examination left uncertainties, X-ray procedures or other tests of the urine or blood might be performed.

In an October 1981 statement to the Subcommittee on Immigration, Refugees and International Law, the Director of HHS' Office of Refugee Resettlement made reference to an earlier PHS effort to estimate the cost of giving more comprehensive overseas medical examinations to refugees. He commented that

"* * * In late 1978, the PHS estimated that overseas medical screening consisting of a brief physical examination, medical history, observation for excludable mental conditions, immunizations, chest x-ray for tuberculosis, and blood test for syphilis would cost approximately \$13.00 for each refugee. If medical screening were to include an extensive physical examination, medical history, complete blood work, stool examination, as well as routine immunizations, chest x-ray and blood test for syphilis, the screening would cost at least \$33.00 for each refugee screened."

Because the above cost estimates were several years old, in December 1981 we asked the ICM Director to estimate the per-person cost of an overseas medical examination which included the following:

"* * * 1. A medical history to be taken on each refugee. This could be carried out at the time of the ICM physician's examination; alternatively, a history questionnaire could be developed and completed prior to the physical examination to be made available to the physician at his examination. It would be further understood that the medical records accumulated while the refugee is in the camp under the care of other physicians would be made available to the ICM physician at the time of his examination.

A part of the history would be specifically devoted to information concerning the refugee's mental status, any prior information concerning mental illness, alcoholism, drug addiction, or mental retardation.

2. A physical examination such as would be performed in a physician's office and including an inspection of the body together with an examination of organ systems such as heart, lungs, abdominal organs, genito-urinary tract and the central nervous system using palpation, percussion, the use of a stethoscope and including blood pressure readings. We are assuming that these examinations would take, on average, 10-15 minutes per person.

3. Blood tests for syphilis, malaria, hepatitis B, and anemia.

4. Urine examination for sugar and albumin.

5. Stool examination for parasites.

6. A chest X-ray on all individuals followed by three consecutive daily sputum smears and cultures on those whose X-rays appear positive or suspicious for tuberculosis.

7. Treatment for those individuals found to have malaria, amebiasis, giardiasis or a venereal disease. Treatment for those found to have active tuberculosis until the tuberculosis is rendered inactive. Treatment for those found to have leprosy until it is determined by biopsy, to be rendered noninfectious."

In March 1982, ICM informed us that such an examination would cost about \$58 per person if performed in Southeast Asia. This would amount to approximately \$5.8 million for the 100,000 Indochinese refugees that can be admitted into the United States in fiscal year 1982--an increase of about \$3.1 million over the \$2.7 million estimated cost of the existing procedures for fiscal year 1982.

Medical examinations used by Canada and France are more comprehensive

Canada and France have accepted large numbers of Indochinese refugees and require much more comprehensive medical examinations of refugees than are required for admission to the United States. These governments refuse to admit refugees with serious, contagious diseases into their countries until they have been thoroughly examined and, if necessary, treated for their medical problems. A more detailed discussion of these countries' examination procedures is contained in appendix II.

CONCLUSIONS

Steps should be taken to improve the overseas medical examination of refugees. The improved procedures should include a medical history and an examination for tuberculosis, leprosy, parasites, hepatitis B, and malaria using appropriate medical procedures. An examination for any mental health problems and other problems that could affect the refugees' earning ability should also be made. Increases in costs of improved overseas examinations would be modest. The results of the more thorough evaluations should be made available to INS officials to be used in determining whether refugees are eligible for admission into the United States.

Providing follow-on treatment to refugees after their arrival in this country has proven to be expensive and difficult. Therefore, we believe that, for refugees with active tuberculosis, malaria, amebiasis, or giardiasis, treatment should be initiated and completed in Southeast Asia before the refugees are cleared to enter the United States. Treatment for leprosy sufficient to render the patient noninfectious should be completed before the refugee is cleared by INS to enter this country.

Improving both the overseas examinations and treatment of refugees before they are cleared for arrival in the United States would result in the granting of medical waivers only when there are compelling reasons to do so. This would be in contrast to the current procedures, under which the granting of such waivers is routine and designed to expedite the flow of refugees to this country.

We believe that adopting improved overseas procedures would both reduce the number of Indochinese refugees with serious and contagious diseases entering the United States and improve the overall health condition of these refugees. It should also reduce the costs and difficulties of dealing with refugee health problems after the refugees have been resettled in the United States.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

We recommend that the Secretary of HHS arrange with the Secretary of State to change the procedures for giving overseas medical examinations to Indochinese refugees destined for the United States and request that a medical history and examination for each refugee be performed by a physician using medical procedures commonly used in the United States. This examination should include:

- An examination for diseases commonly found in Southeast Asia--tuberculosis, leprosy, parasites, hepatitis B, and malaria. The examination for tuberculosis should include analyses of sputum cultures to further verify the presence or absence of the disease.
- An evaluation for mental illness.
- An examination of body systems to help the physician determine if the refugee is suffering from a health problem which may affect his or her ability to earn a living in the United States.

Because of the high incidence of tuberculosis in refugees under age 15 and the significant number of cases undetected overseas in this group, we recommend that the Secretary require that all refugees under age 15 be tested for tuberculosis.

We also recommend that treatment be initiated and completed in Southeast Asia for refugees with active tuberculosis, malaria, amebiasis, or giardiasis before they are cleared to enter the United States. In the case of leprosy, the treatment should be sufficient to render the patient noninfectious.

In addition, we recommend that the Secretary transmit to the State or local health department at the refugee's destination all pertinent medical information available on the refugee.

RECOMMENDATIONS TO THE SECRETARIES OF STATE AND HEALTH AND HUMAN SERVICES

We recommend that the Secretaries ensure that medical records developed and maintained while refugees in overseas camps are under the care of the U.N. High Commissioner for Refugees are transferred to the overseas physicians before they perform the medical admissions examinations.

We also recommend that the Secretaries require that the results of overseas medical examinations be provided to INS officials for use in INS' final determinations of eligibility of refugees for entry into the United States.

RECOMMENDATIONS TO THE ATTORNEY GENERAL

We recommend that the Attorney General:

- Not admit refugees into the United States until they have received a thorough medical examination to diagnose health conditions specified in the Immigration and Nationality Act.

--Require that the results of medical examinations be used in making final determinations concerning the eligibility of refugees for admission.

--Not admit refugees with active tuberculosis, infectious leprosy, amebiasis, giardiasis, and malaria until treatment for these diseases has been completed, unless compelling reasons exist to justify a medical waiver.

FEDERAL AGENCY COMMENTS ON REPORT ISSUES AND OUR EVALUATION

A draft of this report was provided for comment to the Departments of Health and Human Services, Justice, and State. (See apps. III, IV, and V.)

The State Department commented only on our recommendations dealing with the transfer of medical records and the timing of overseas medical examinations. HHS and Justice commented on both specific issues discussed in the report and our recommendations.

HHS' comments on report issues

HHS had numerous comments on our report. Our analysis of its comments showed that they focused on three major issues--the potential public health risk posed by refugees' medical conditions, the feasibility of performing thorough medical examinations and treatment overseas, and the impact of improved overseas medical examinations on the cost of and need for refugee health care in the United States.

Potential public health risk posed by medical conditions in refugees

HHS made several comments relating to the potential public health risk posed by communicable diseases in refugees. It said that our report raised undue fear that refugees are spreading diseases to the U.S. population. According to HHS, while refugees have high rates of certain diseases, which has placed an economic burden on health resources in the United States, this is not a public health threat. HHS added that refugees' health problems are personal and of minimal public health importance. It believed that, because of (1) the low transmissibility of refugees' diseases, particularly tuberculosis in refugee children, (2) sanitary conditions existing in the United States, (3) good personal hygiene, and (4) U.S. medical practices, changes were not needed in the overseas medical examination and treatment procedures. However, HHS said it would consider (1) identifying refugees with hepatitis B overseas so that they may receive the vaccine after arriving in the United States and (2) the value of doing routine chest X-rays on refugees under age 15.

The seriousness of the diseases present in refugees and the adequacy of protection being afforded to the health of the American public are matters of judgment. However, it should be remembered that tuberculosis was once common in the United States and in 1980 was still responsible for 1,800 deaths in this country. The tuberculosis found in refugee children under the age of 15 was active and in some cases infectious. Therefore, as a practical matter, it was no different medically from cases found in refugee adults. In our opinion, these cases are a potential public health problem, and we believe HHS should act now to require better overseas examination of refugee children under age 15.

We also question whether parasitic infestations, malaria, hepatitis B, and leprosy, all of which are communicable diseases, should be viewed only as personal health problems. While living conditions and health care in the United States may reduce the potential for the spread of disease, varying degrees of risk remain, depending on the nature of refugees' contacts with others. For example, tuberculosis can be spread from a cough or sneeze; amebiasis and giardiasis can be spread through contaminated food; hepatitis B can be spread through blood transfusions; malaria can be spread through the bite of the anopheles mosquito; and leprosy can be spread by prolonged or intimate contact. Since there are more than 500,000 Indochinese refugees in the United States, the potential for spreading diseases to the U.S. population seems to exist. As the number of refugees increases, so may the risk.

HHS' statement that the economic burden on health departments from providing medical care to refugees is not a cause for concern is unrealistic. As health departments have expended considerable resources for such care, some have reduced services to their general population. Others have chosen to provide only modest services to refugees. Neither situation seems to be in the best interest of the health of the American public. While the flow of refugees has been reduced, many continue to enter the United States. In January and February 1982, nearly 13,000 Indochinese refugees came to the United States, and as of March 31, 1982, nearly 243,000 were waiting resettlement overseas. Because of the continuing flow, health departments will continue to be faced with the difficult question of how to balance the distribution of health services between refugees and their general population.

Feasibility of performing
thorough examinations and
treatment overseas

HHS made several comments on the feasibility of performing more thorough medical examinations and treatment overseas. HHS reemphasized that the overseas medical examination is only a screening procedure to detect statutorily excludable diseases and conditions. It said that performing a thorough medical examination in Southeast Asia would be difficult. For example, doing

additional, reliable diagnostic procedures for tuberculosis, including sputum culture examinations, would require laboratory capabilities which are limited overseas. HHS believed that it would be better for the refugees' and the American public's health if refugees were brought to the United States quickly, since a U.S. standard of reliable medical care does not exist in Southeast Asia.

HHS also said that the overall system of overseas screening and treatment, notification on arrival, and followup has been improved since 1979 and is functioning well now. It claimed that, because over 500,000 Indochinese refugees have come to the United States since 1975 without major adverse public health consequences, there was no reason to change the overseas procedures. However, HHS did say that, because refugees now remain in Southeast Asia for 4 to 5 months after medical screening for English language and other training, it was developing alternative approaches for in-camp care, including further diagnosis of refugees with suspected active tuberculosis and hepatitis B.

We believe HHS may be overstating the difficulties of doing thorough medical examinations and providing treatment in Southeast Asia. Hundreds of thousands of refugees, destined for the United States and other countries, have received medical examinations with HHS relying on laboratory analysis work done in Southeast Asia. Although some cases of disease were missed, we believe this usually related to inadequate medical protocols rather than inadequate laboratory work. One of our recommendations adds a laboratory examination of sputum culture for tuberculosis, which is not a particularly sophisticated or complex procedure. Physicians overseas told us it is commonly done in Southeast Asia. Our visits to the camps and medical facilities in 1981 and our discussions with ICM physicians indicated no reason why a more thorough examination and laboratory analysis work could not be done. In fact, ICM physicians conducted such examinations on refugees destined for certain other countries. In response to our inquiry on the costs of doing a more thorough examination, ICM gave no indication that what we suggested was not possible overseas.

We do not share HHS' opinion that the overseas examination process is functioning well and the absence of major adverse public health consequences is a measure of success. While we know of no method for determining whether diseases, such as tuberculosis, have been spread from refugees to others in the U.S. population, refugees have known high rates of disease, and as their numbers increase, so may the potential for spreading diseases. Since HHS said that refugees will remain overseas for 4 to 5 months after medical screening, our recommendations for improved medical examinations and treatment, including the taking of sputum cultures, would not further delay refugees once they receive the appropriate clearance. We agree that some extra HHS effort may be required to assure the reliability of the improved procedures. However, in our opinion, such action would better serve the interests of the American public.

Impact of improved overseas
medical examinations on costs
and need for health care in
the United States

HHS commented that our work did not show that improved medical examinations overseas would reduce health care costs or the need for medical care by refugees after their arrival in the United States. It said that refugees will continue to require such services as medical and dental care, maternal and child health services, surgical procedures, and other routine health services similar to those needed by U.S. residents.

We agree that refugees will continue to need health care services after arrival in the United States. Many of the diseases prevalent in refugees, such as tuberculosis, even when rendered noninfectious and inactive, still require periodic followup by health care personnel. However, if refugees with active tuberculosis are treated overseas and their disease is rendered inactive, the amount and costs of medical care in the United States are likely to be less than if they arrived with active tuberculosis.

Justice's comments on
report issues

Justice commented on both technical matters in the report and certain issues discussed. Its technical comments dealt with the granting of waivers and certain provisions of the Immigration and Nationality Act regarding persons eligible for refugee status. We revised our report where appropriate to deal with these comments.

Justice shared our concern about the seriousness of refugees' health problems. It said that, because followup on refugees in the United States is difficult, those with contagious diseases should not be admitted until treatment has been completed or the disease has been controlled. According to Justice, there may be logistical and other difficulties involved in implementing our recommendations. It also believed that additional resources and medical facilities would be needed to detain refugees overseas while thorough medical examinations and treatment were undertaken. Further, Justice was uncertain whether refugees would receive better care overseas than in the United States.

Regarding Justice's logistical concerns, HHS stated that refugees remain overseas for 4 to 5 months after medical screening for English language training. This seems to be ample time to perform a more thorough medical examination and initiate appropriate treatment. If refugees required longer periods of treatment, some extra costs and logistical problems may result. However, we do not believe these problems would be insurmountable since other countries, such as Canada, use more stringent medical procedures,

such as detaining refugees overseas for extended periods. In short, we believe that both the refugees and the American public would benefit by using the 4- to 5-month time period to improve refugee health status.

The approach of relying on the U.S. health departments to provide medical care to refugees after they arrive in the United States is clearly an alternative. However, because of the barriers to providing health care and the difficulties experienced at the State and local levels, we question whether it is the best alternative. While we agree that health care in the United States would generally be better than what refugees would receive overseas, we found little basis to conclude that the physicians overseas could not perform a more thorough examination and provide appropriate treatment.

FEDERAL AGENCY COMMENTS ON REPORT RECOMMENDATIONS AND OUR EVALUATION

In our draft report, we proposed several administrative recommendations to the Attorney General and the Secretaries of HHS and State. HHS agreed to implement some of our recommendations; however, it generally disagreed with those designed to improve the overseas medical examinations and treatment procedures for refugees.

According to Justice, it relies on PHS to set medical requirements. Justice said that, if PHS concludes that the existing procedures are inadequate and establishes more stringent medical requirements, it would implement them. Justice also said that it is preferable to have refugees' medical examinations completed before INS' admissibility review and that refugees with infectious diseases should not be admitted to the United States until treatment for their diseases has been provided overseas.

The State Department commented only on our recommendations dealing with the need to transfer medical records from refugee camps to the ICM physicians and to provide INS with medical examination results to use in its decisionmaking. State said that, as of October 1981, its overseas posts were instructed to assure that camp medical records were forwarded to ICM physicians in time to be used in the medical examination process and that the ICM physicians take a medical history from each refugee. Also, according to State, ICM was instructed to inform INS of the existence of medically excludable conditions in refugees before INS determines their eligibility to enter the United States.

HHS agreed to consider testing all refugees under age 15 for tuberculosis. Because of the high rate of tuberculosis in this age group, we believe that HHS should require tuberculosis tests for all such refugees. HHS also agreed to continue to treat infectious leprosy patients for at least 6 months before they were permitted to travel to the United States. While this procedure appears adequate for identified leprosy cases, we believe that,

unless the overseas medical examinations are improved, the potential for missing leprosy cases remains.

HHS also concurred with our recommendations dealing with the need for (1) examining physicians to have access to medical information developed in refugee camps, (2) INS to have medical examination results for use in its decisionmaking, and (3) U.S. health departments to be given medical information on refugees. As stated on page 40, action was taken to assure that examining physicians overseas have access to refugees' medical records. HHS also commented that INS now receives the results of refugee medical examinations in time to use in its admissibility reviews. Further, HHS said that it will send to U.S. health departments copies of medical records for refugees identified overseas with serious health conditions.

HHS disagreed with our recommendations to improve the overseas medical examination and treatment procedures. Specifically, HHS said it would not change its policies to provide treatment for tuberculosis patients sufficient to render their disease inactive or to include an examination of refugees for malaria, amebiasis, and giardiasis. As stated earlier, HHS' position is that it would be better for the health of the refugees and the American public if refugees are brought from Southeast Asia to the United States as rapidly as possible and treated by health departments.

While this is a matter of judgment, we believe that acting to improve the overseas medical examinations would ease the burden on local public health departments and minimize future public health problems. It seems far more prudent to prevent the introduction of disease into the United States than attempt to deal with it after it arrives--particularly in view of the barriers to providing care discussed in this chapter.

STATE AND LOCAL AGENCY COMMENTS AND OUR EVALUATION

Our draft report was provided for comment to State and local health departments in California, Hawaii, Maryland, Texas, Virginia, Washington, and the District of Columbia. ^{1/} These agencies made numerous comments on facts and issues discussed in the report, as well as our recommendations. We revised our report, where appropriate, to respond to their comments on factual matters and certain specific issues. Our analysis of their responses showed that they focused on two main issues--(1) the impact of the overseas medical examinations on refugees' need for medical care in the United States and (2) the nature of the health problems posed by refugees. Their comments are summarized below along with our response.

^{1/}Because of the large number of comments, the individual State and local responses were not included as appendixes.

Many of the health departments saw a need to improve the overseas medical examination for refugees. However, many also discussed the difficulties they foresaw in accomplishing this and their belief that refugees would continue to need some medical care in the United States even if the overseas procedures were strengthened.

Many health departments also commented on the nature of the health problem posed by refugees' diseases. Some believed the nature and extent of the diseases posed a public health problem; others believed it was more of a financial burden and that refugees' health problems could be adequately dealt with if sufficient funds were available. The report was also provided to the Association of State and Territorial Health Officials, which had no comment on the matters discussed.

Impact of improved overseas medical examinations on refugees' need for medical care in the United States

Eight State and local health departments believed that the overseas medical examination and treatment procedures should be improved. Virginia said that, although the number of Indochinese refugees has been reduced, their health condition still needed attention. According to Virginia, the number of other refugees is increasing and some have acute health needs. Virginia added that, if refugees were thoroughly treated overseas for diseases such as tuberculosis, the need for followup care in the United States would be reduced.

California said that refugees should not be admitted into the United States until they have received a thorough medical examination overseas, the results of which should be considered in determining their eligibility for entry. However, California added that, because of (1) the lack of proper facilities and laboratory support overseas and (2) the questionable reliability of the overseas tests, refugees would continue to need medical examinations and workups after their arrival. State health departments in Hawaii, Texas, and Washington and local health departments in Orange County, California, and Seattle-King County, Washington, expressed similar views. Some health departments also said that, because refugees' diseases are chronic, they will periodically need to be reexamined and this could be most effectively accomplished in the United States if adequate funds were available.

Health departments in California and Hawaii said that detaining refugees overseas for a thorough medical examination and treatment may expose noninfected persons to disease or cause refugees with disease to be re-infected, unless camp conditions are improved. Los Angeles County added that, for tuberculosis, this problem could be solved by beginning treatment in refugee camps for refugees who are scheduled to come to the United States

and assuring continuity of drug therapy. Los Angeles believed this would also reduce the need for treatment and prevention services in the United States.

We agree that refugees will need some medical care after arriving in the United States. However, if a more thorough medical examination, followed by appropriate treatment, is given overseas, the need for subsequent medical care and treatment in the United States should be reduced. As mentioned earlier, an additional benefit would be minimizing the introduction of disease into this country.

Several State and local comments suggest that many health departments lack confidence in the existing overseas medical procedures and would reexamine refugees upon arrival in this country. Improving the overseas examination and treatment process should enable State and local jurisdictions to have greater confidence in the overseas results. In the long run, this may enable local health departments to more effectively use the resources available to provide health care to refugees and the general population.

The concern that refugees will receive greater exposure to diseases if they are detained overseas longer does not seem to be a valid reason for not implementing improved medical examination and treatment procedures. Refugees are currently detained 4 to 5 months after medical screening to receive English language training. Our recommendations strive to make better use of the time refugees are currently awaiting resettlement by providing them with a more thorough medical examination and appropriate treatment. While some problems may occur, such as the need to isolate infectious cases of disease, we believe that such efforts should benefit both the refugees and the American public.

Nature of health problems posed by refugees

Several health departments commented on the nature of the health problem caused by the large influx of refugees. Their opinions varied on the seriousness of the problem. State health departments in Virginia and Washington and local health departments in Los Angeles and Seattle-King County expressed similar views that diseases in refugees, particularly tuberculosis, pose a potential public health problem. However, State health departments in California, Hawaii, and Texas believed that refugees presented more of a financial burden than a public health risk and commented that their diseases could be adequately controlled in the United States if sufficient funds were available. The District of Columbia disagreed with the Surgeon General's opinion that the risk of disease transmission from refugees to the general population was minimal and said that cities and localities were being burdened with the costs of providing refugees with long-term care. It said that without such care disease transmission could

be expected. Washington and Orange County believed that, despite the high incidence of communicable diseases in refugees, their existing disease control efforts were adequate to deal with the situation.

The mixed reaction from State and local health departments on the public health problem versus the financial burden question is not surprising because the problem clearly has both elements. In our opinion, what needs to be addressed is how to improve the existing system for providing medical examinations and treatment to refugees so that refugee health status is improved and the potential for spreading diseases to the American public is reduced. While there may be different approaches to accomplishing this objective, the increasing incidence of disease, coupled with the difficulties experienced by State and local health departments in dealing with refugee health problems, suggests that the time for action is now--before the difficulties of the situation increase and diminish our ability to deal with it effectively.

ACTION TAKEN BY HOUSE
COMMITTEE ON THE JUDICIARY

In May 1982, the House Committee on the Judiciary issued its report on the bill to reauthorize refugee assistance (H.R. 5879). In that report, the Committee noted the need to more effectively deal with refugees' medical problems both in the United States and overseas. The Committee authorized appropriations totaling \$14 million for fiscal year 1983 for medical screening and initial medical treatment in the United States. The funds would be used to meet the costs of State and local health agencies for identifying and treating health conditions in refugees, especially tuberculosis. The Committee emphasized that this action alone was not enough to deal with refugee health problems and instructed the Secretaries of HHS and State and the Attorney General to improve the overseas medical processing of refugees.

Rather than choosing between the alternatives of increasing medical examination and treatment efforts overseas or in the United States, the Committee has opted to stimulate increased efforts in both areas. In our opinion, this approach, if properly implemented, should maximize the opportunities for accomplishing the dual objective of improving the health status of refugees and protecting the health of the American public. While chapter 3 of our report alludes to several barriers to providing followup care to refugees in this country, the comments we received from many State and local health jurisdictions expressed their confidence that they could deal with these problems with adequate funding. The Committee's action responds to that need for resources and should help State and local jurisdictions continue their efforts to deal with refugee health problems.

INCIDENCE OF HEPATITIS B, MALARIA, AND
LEPROSY IN INDOCHINESE REFUGEES

In addition to tuberculosis and parasitic diseases, several other diseases and conditions have been found to be prevalent among Indochinese refugees admitted to the United States since 1975. Included among these are hepatitis B, malaria, and leprosy.

HEPATITIS B

Hepatitis B is an infectious viral disease that causes inflammation of the liver. It usually spreads through contact with blood or blood products, most commonly through blood transfusions or by accidental exposure to human blood by nurses, surgeons, and dentists, who can become infected through a small wound or a cut in the skin. It can also be transmitted through sexual contact. Infants exposed to infected blood from their mother at birth can also be infected. The disease can sometimes be fatal because of liver failure. In 1980 about 21,000 cases of hepatitis B occurred in the United States. 1/

Incidence of hepatitis B
at U.S. locations visited

In the January 1980 issue of its Morbidity and Mortality Weekly Report, CDC claimed that 13 percent of Indochinese refugees are hepatitis B carriers, compared to less than 1 percent of the U.S. population. Health department statistics in the locations we visited showed that 12 to 22 percent of refugees settling in those locations had hepatitis B. In 1979 and 1980, CDC recommended that local health departments test Indochinese refugees for hepatitis to detect chronic liver disease and to insure that medical and dental personnel take precautions to protect themselves and their patients.

Of the U.S. locations visited, only local health departments in Maryland routinely examined refugees for hepatitis B. Health department examinations in Montgomery and Prince Georges Counties showed that between 12 and 18 percent of refugees were hepatitis B carriers, compared to less than 1 percent in their overall population. In addition, examinations of 6,800 refugees at the San Francisco PHS hospital from July 1979 to January 1981 showed that 22 percent had evidence of the disease.

1/CDC did not maintain information on deaths caused by hepatitis B.

MALARIA

Malaria is an infectious disease transmitted through the bite of the anopheles mosquito. Malaria causes periodic attacks of chills, fever, and sweating and sometimes causes death. After recovery from the acute attack phase, the disease can become chronic, with occasional relapses.

For centuries, malaria has been one of the most common and serious human afflictions. While not usually contracted in the United States, it is common in Southeast Asia, accounting for a great deal of incapacitating illness and many deaths. During our overseas visits in July 1981, we found that up to 600 cases per month had occurred in Thailand refugee camps.

The mosquito capable of transmitting malaria from an infected person to another person exists in many parts of the United States--including several of the locations we visited.

Incidence of malaria
at U.S. locations visited

In 1980, CDC received reports of 1,864 persons in the United States who contracted malaria; of these cases, 1,034 (55 percent) were Indochinese refugees. In 1979, only 165 cases were reported, of which 20 percent were refugees. Because of the reported increase, CDC tested 1,919 arriving refugees in the San Francisco area for malaria between April and June 1980 and found that 33 (1.7 percent) had malaria. A separate more detailed screening of 1,591 of these refugees showed that between 5 and 11 percent had either present or past infection of malaria.

CDC concluded that, because the study showed that refugees had both a low rate of infection and a low intensity of malaria, the risk of transmission was small even though the mosquito that transmits the disease is widely present on the west coast and in the southeastern United States.

However, CDC officials stated that the risk of transmission was greater when the mosquitoes were at their peak periods or when large numbers of refugees enter the country after peak transmission periods in Southeast Asia (July-October). According to the officials, it was not possible to predict with certainty the proportion of refugees infected with malaria who, despite negative finding upon examinations, could later relapse and cause infection. For these reasons, CDC recommended that local health departments follow up and provide treatment where necessary.

No location we visited routinely examined refugees for malaria. However, States and localities were experiencing increases in malaria cases which they attributed to Indochinese refugees. As the following table shows, Virginia experienced a substantial increase in malaria cases from 1979 to 1980.

Malaria Cases in Virginia

<u>Year</u>	<u>Refugees</u>	<u>Non-refugee</u>	<u>Total</u>
1979	7	23	30
1980	43	22	65
1981	11	22	33

To deal with this situation, the Virginia State Department of Health budget justification for fiscal year 1982 contains a \$280,000 annual program for mosquito control. The justification states that

"Malaria can be transmitted by some of the kinds of mosquitoes native to Virginia. Malaria has not been a problem in recent years because there has not been a reservoir of malaria cases. Now that many refugees are arriving from endemic areas such as Southeast Asia there is the possibility of malaria becoming endemic."

As the following table shows, although the total number of cases decreased in 1981, Indochinese refugees in Orange County, California, have a high incidence of malaria.

Malaria Cases in Orange County, California
January 1980-December 1981

<u>Year</u>	<u>Total</u>	<u>Refugee cases</u>		<u>Incidence rates per 100,000 population</u>		
		<u>Number</u>	<u>Percent</u>	<u>Total</u>	<u>Overall population</u>	<u>Refugee</u>
1980	78	68	87	4	0.5	113
1981	66	49	74	3	1	105

Texas has also experienced increases in malaria cases, with Indochinese refugees contributing to the increase. The following table shows the increase in malaria cases since 1977 in three Texas counties we visited.

Incidence of Malaria
in Three Texas Counties

<u>Location</u>	<u>Year</u>	<u>Total cases</u>	<u>Refugee cases</u>	
			<u>Number</u>	<u>Percent</u>
Dallas County	1977	1	-	0
	1978	8	-	0
	1979	9	2	22
	1980	23	17	74
	1981	21	8	38
Harris County (Houston)	1977	12	-	0
	1978	10	-	0
	1979	12	3	25
	1980	26	15	58
	1981	49	12	25
Jefferson County (Beaumont) (Port Arthur)	1977	-	-	-
	1978	1	1	100
	1979	1	0	0
	1980	18	13	72
	1981	1	-	0

Overall, from 1977 to 1980 the State's malaria cases increased from 27 cases, of which 3 (11 percent) involved refugees, to 115 cases, of which 73 (63 percent) involved refugees.

Health officials in California, Texas, and Virginia expressed concern about the increases in malaria since the mosquito that spreads the disease exists in parts of these States.

LEPROSY

Leprosy (Hansen's Disease) is a chronic infectious disease which produces lesions in the skin and damages the mucous membranes and nervous system. It can cause paralysis, gangrene, and disfiguration.

Although only occasionally found in the continental United States, this chronic and stubborn ailment is still common in many parts of the world, including Southeast Asia. In the early stages, leprosy is not easy to identify. It has a long incubation period and requires prolonged treatment--sometimes for life. CDC has recently reported that the leprosy germ often becomes resistant to the most commonly used drug.

Even though prolonged, close contact is usually required for a person with leprosy to infect another, the possibility exists that refugees could spread the disease. CDC's examination of refugees for leprosy in 1975 found a case rate of about 150 per 100,000 population. In contrast, only 1 to 2 cases per million

have occurred in the U.S. population since 1973. At the time of our visit in July 1981, 200 cases of leprosy were under treatment in camps in Thailand.

Incidence of leprosy
at U.S. locations visited

We found cases of leprosy that had gone undetected overseas in every jurisdiction we visited, except the District of Columbia and Hawaii. For example, in Texas there were 19 cases of leprosy in refugees, of which 15 had been diagnosed in Texas. None of these refugees were on medication when diagnosed. In one case, a Port Arthur school nurse observed that a refugee (who entered Texas in October 1980) walked with a limp and referred him to an orthopedic surgeon. No indication of leprosy appeared on the refugee's medical records. The refugee was later referred to a dermatologist, who diagnosed leprosy. Currently, the refugee is an outpatient of the National Hansen's Disease Center. In May 1981, Port Arthur health department staff diagnosed another refugee with advanced leprosy. Health department staff told us that the case was sufficiently advanced that it should have been diagnosed overseas.

OTHER MEDICAL CONDITIONS

During our visits to U.S. locations, we asked to what extent refugees have excludable mental problems, venereal diseases, and substance abuse. Information on these conditions was scarce.

For mental conditions, health officials told us that some refugees experience post-arrival emotional distress, such as depression and anxiety. In addition, studies of refugees from 1975 to 1980 show that refugees have problems resulting primarily from (1) difficulties adjusting to a new life in the United States; (2) trauma caused by escaping from their homeland with little or no preparation; (3) losses of family and property; (4) lengthy stays in refugee camps; (5) separation from others from their country; and (6) social, economic, and cultural changes. Language and cultural differences make it difficult to treat refugees' mental problems.

MEDICAL EXAMINATION PROCEDURES FOR REFUGEESUSED BY CANADA AND FRANCE

Other countries that have accepted large numbers of Indochinese refugees use medical examination and treatment procedures which differ considerably from the U.S. procedures. Canada and France have each accepted about 70,000 refugees. However, according to ICM and Canadian officials, these countries do not allow refugees with dangerous, contagious diseases to enter or be dispersed in the population until they have been examined and treated.

CANADA

A Canadian government physician told us that its overseas medical examinations are generally performed by local physicians in Southeast Asia hired by Canada. Unlike the U.S. procedures, the results of these examinations are sent to officials of Canada's Department of Health and Welfare who are stationed in Southeast Asia. They review each case and make recommendations to the Canadian immigration authorities for final determination.

The Canadian medical evaluation procedures are different from the U.S. procedures in several other respects. The medical examination form requires a medical history to be obtained with responses to 70 questions. The form includes questions on the refugee's psychiatric status and on whether or not the refugee is mentally retarded.

The Canadian procedures also require a more complete physical examination, including, among other things, determining blood pressure and examining the heart. Also required are a chest X-ray for tuberculosis and other pulmonary conditions and a stool examination for evidence of parasitic infestation. A urinalysis, including microscopic examination, is also made.

Canadian immigration authorities refuse to admit refugees who have a contagious disease until the disease is treated and rendered noncommunicable. If a refugee's chest X-ray shows evidence or suspicion of active tuberculosis, the individual must have a complete evaluation before leaving for Canada. This may include additional X-rays, often with different views and a sputum culture, followed up, if necessary, by a complete course of treatment sufficient to render the patient not just noninfectious, but inactive. According to a representative of the Canadian Department of Health and Welfare, this evaluation and treatment takes at least 6 to 9 months and usually about 2 years.

Canadian authorities also told us that refugees are excluded if they have a health problem which may have an adverse economic impact.

FRANCE

ICM officials said that the French health system for refugees does not rely on medical evaluations performed in Southeast Asia but on segregating refugees immediately upon their arrival in France. Medical evaluations are then performed before refugees are allowed to disperse. All Indochinese refugees arrive in Paris and are taken to one of five transit centers. They stay at these centers for about 15 days while they are physically examined and given chest X-rays, blood tests, and stool examinations. They are required to receive treatment for any contagious health problem. If they have tuberculosis, they are sent to a tuberculosis hospital for treatment. They are also treated for any other serious health conditions detected.

Treatment must be completed before the refugee will be permitted to be sent to 1 of 43 accommodation centers or directly to a sponsor if one has been identified. Before being dispersed, refugees spend several months at the accommodation centers, which have medical facilities and personnel to provide care.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 10 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548


Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "Many Indochinese Refugees with Serious, Contagious Health Problems Enter the United States." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

You will note that I am also enclosing copies of our response to your letter of inquiry on this subject, dated August 21, 1981. We believe the readers of your report would benefit from reviewing our prior comments, and ask that you incorporate them as an appendix to your final report.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,


Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT,
"MANY INDOCHINESE REFUGEES WITH SERIOUS, CONTAGIOUS HEALTH
PROBLEMS ENTER THE UNITED STATES," DATED APRIL 8, 1982

GENERAL COMMENTS

The Department of Health and Human Services (HHS) has carefully studied the General Accounting Office (GAO) draft report, "Many Indochinese Refugees with Serious, Contagious Health Problems Enter the United States." The report reviews and criticizes overseas medical examination and treatment policies and procedures. In our opinion, the report engenders undue fear that contagious diseases are being spread by refugees to the United States (U.S.) population. Furthermore, it recommends changes in overseas procedures that will not substantially reduce the need for medical care for refugees after their arrival in the U.S.

Refugees, like most Third World population groups, have higher rates of certain diseases, such as tuberculosis, than the U.S. population. However, spread of serious diseases to the U.S. population is minimized by living conditions, sanitation, and the modern, effective health care system in this country. The most compelling testimony in response to assertions in the GAO report concerning the content and quality of medical screening abroad and speculations concerning potential spread of contagious diseases from refugees to the U.S. population is the fact that over 500,000 Indochinese refugees have been resettled in the U.S. since 1975 without major adverse consequences to the public's health.

The costs and difficulties of providing health care to refugees, whether in Asia or in the U.S., are considerable. The humanitarian decision to accept Southeast Asian refugees in this country has placed a burden on public, including public health, resources. This economic burden should not be construed as a public health threat.

The refugee flow is now almost half of the Fiscal Year 1981 level. This will decrease the impact of refugees on health services in the U.S. The GAO has not demonstrated that an increase in overseas expenditures to "improve" medical screening would effect a substantial reduction in average health care costs for refugees in the U.S. Refugees will continue to require general medical and dental care, prenatal care, maternal and child health services, surgical procedures, and all the other routine, personal health and preventive health services that U.S. residents require. The per capita personal health care expenditures for refugees in this country approximate those for U.S. citizens.

The capacity to accomplish technically reliable, comprehensive diagnosis and treatment for large numbers of refugees (equivalent to that which is available in the U.S.) does not exist in Southeast Asia. GAO has not recognized this limitation.

The current system of medical examination and treatment complies with Federal laws and regulations, protects the American public from diseases of public health consequence, and realistically fits the circumstances which exist in Southeast Asia. Based on experience and continued reevaluation, overseas medical screening and treatment, notification on arrival, and followup in the U.S., have all been improved since 1979 and are functioning well in 1982. For the past 18 months, the preponderance of arriving refugees have received health assessments under the Centers for Disease Control (CDC) administered grant program. This includes many secondary migrants who are systematically identified through program outreach efforts.

The refugees' health and the American public's health are best served if refugees can be removed from the Southeast Asian environment and brought to the U.S. as rapidly as possible. Conditions in the Southeast Asia refugee camps are crowded and unhygienic. Providing a U.S. standard of diagnosis and treatment in the camps is technically and logistically difficult. However, because most refugees now will remain in Southeast Asia for varying periods of time for English language and other training preparatory to resettlement in the U.S., we are developing alternative approaches for in-camp care.

In our response to questions asked by GAO in a "Letter of Inquiry on Certain Issues Concerning the Resettlement of Indochinese Refugees in the U.S." (letter dated August 21, 1981), we commented extensively on basically the same issues raised in the draft report. The response to the letter of inquiry was submitted for inclusion as part of the record of the hearing before the Subcommittee on Immigration, Refugees, and International Law of the House of Representatives Committee on the Judiciary on September 23, 1981. We have included that response as an attachment to the following comments on the GAO report.

We strongly restate that policies for the medical examination and treatment of Indochinese refugees in Asia are consistent with modern concepts of epidemiology, disease control, and disease prevention. These policies protect effectively the health of refugees and safeguard the health of the American public. We reiterate the opening paragraphs of our response to the August 21, 1981 GAO letter of inquiry:

"The medical aspects of Indochinese refugee processing are similar to those for other immigrants and refugees seeking admission to the U.S. The policies and procedures are based on medical, epidemiologic, and administrative management concepts developed through experience. Millions of aliens have entered the U.S., many from Asia, and many from other parts of the World with health conditions like those in Asia. Admission of these aliens in accordance with U.S. laws and regulations has not resulted in consequential adverse effects on public health in America. . . We expected Indochinese refugees to have health problems similar to those of other aliens admitted from Asia. In general, these are personal health problems and of minimal public health importance.

In particular, medical screening and treatment policies for Indochinese refugees in Asia were formulated with the benefit of knowledge and experience gained in 1975 while refugees were being housed and processed in camps within the U.S. prior to resettlement. The Department of Health and Human Services (HHS) learned what to expect in terms of the types and frequency of medical conditions in the refugee population."

GAO Recommendation

We recommend that the Secretary of HHS arrange with the Secretary of State to change the procedures for giving overseas medical examinations to Indochinese refugees destined for the U.S. and request that a medical history and examination for each refugee be performed by a physician using medical procedure commonly used in the U.S. This examination should include:

- An examination for diseases commonly found in Southeast Asia--tuberculosis, leprosy, parasites, hepatitis B, and malaria. The examination for tuberculosis should include analyses of sputum cultures to further verify the presence or absence of the disease.
- An evaluation for mental illness.
- An examination of body systems to help the physician determine if the refugee is suffering from a health problem which may affect his ability to earn a living in the U.S.

HHS Response

We do not concur that the medical screening procedures currently prescribed by the CDC need to be changed. However, these CDC procedures must be properly applied by the Intergovernmental Committee for Migration (ICM) physicians overseas.

Under current guidelines a medical history and examination must be conducted overseas for each refugee by a physician. The components, duration, and completeness of any medical examination, even in the U.S., vary according to the purpose of the examination. The examination of refugees in Southeast Asia is a screening procedure, which is not comprehensive by design, and which is limited to the diagnosis of statutorily excludable dangerous, contagious diseases, statutorily excludable mental conditions, and obvious physical defects and disabilities.

Tuberculosis: A chest X-ray examination for tuberculosis is a component of the medical screening procedure for refugees age 15 and older and for those under age 15 if there is a clinical indication or if a family member is found to have a chest radiograph abnormality. Further diagnostic procedures for tuberculosis are dependent on laboratory capabilities, which are limited in Southeast Asia. We continue to recommend that sputum microscopy examinations (smears) be performed on all refugees with chest radiograph abnormalities suspicious of tuberculosis. Sputum microscopy is the

usual laboratory diagnostic procedure for tuberculosis in developing countries; it is relatively simple, can be performed reliably, and is amenable to quality-control. Laboratory personnel in Southeast Asia are familiar with the procedure and carry it out properly. A positive smear is also the best indicator of infectiousness, in the U.S. as well as in Southeast Asia.

Although a few laboratories in Southeast Asia can perform sputum cultures, on-site evaluation during November and December 1981 confirmed that the capability does not exist to do routine culturing of large numbers of sputum specimens reliably. We would have little confidence in the results and could not ask State and local health officials in the U.S. to accept their validity. Screening protocols developed in 1979 envisioned that refugees with suspected active tuberculosis, (noncavitary, asymptomatic, noninfectious) would depart promptly from Southeast Asia and complete their diagnostic evaluations in the U.S., where reliable sputum cultures and drug susceptibility tests could be performed to assist in making an appropriate treatment decision.

According to the Department of State, most refugees will now remain in Southeast Asia for 4 to 5 months after medical screening to receive English language training. Because of this change in refugee flow pattern, we are developing options for further diagnostic evaluation of refugees with untreated, suspected active tuberculosis who are being held in Southeast Asia.

Leprosy: The medical screening instructions provide for a brief medical history and observation of the body surface of the completely disrobed refugee. A history of leprosy may be obtained from a refugee with previously diagnosed disease. Obvious lesions of leprosy should be recognizable to the physician. Subtle manifestations may be missed. Infectious cases are treated for at least 6 months before being permitted to travel. Upon arrival in the U.S., all refugees in whom leprosy has been recognized are referred for evaluation by the Public Health Service (PHS). Refugees with leprosy undetected in Southeast Asia but recognized in the U.S. may also receive diagnostic and treatment services through PHS. Because of the extremely low transmissibility of leprosy, these persons present an extremely low risk to the public.

Parasites: The medical screening procedures do not include an examination for parasites other than ectoparasites of the skin (e.g., scabies), which are detectable by physical examination. We do not agree that adding a search for parasitic diseases to the examination procedure would result in benefit to the American public. Southeast Asians may have a number of parasitic infestations which may affect the gastrointestinal tract, liver, lungs, blood, and other organs. These infestations constitute personal health problems for the refugees, usually mild or subclinical. In Southeast Asia, many of these parasites also pose a public health problem because the conditions necessary for their transmission exist there. In the U.S., these parasitic diseases either cannot be transmitted, or have an extremely

low probability of being transmitted. They are not dangerous, contagious diseases, and have no serious public health consequence. Giardiasis and amebiasis, both of which occur in the U.S. population, can be transmitted person to person, but transmission of these parasites is minimized by the use of toilets, adequate sewage disposal, treatment of drinking water supplies, and good personal hygiene.

Diagnostic procedures for parasitic disease in Southeast Asia are recommended when clinically indicated, but not as a routine screening procedure. Refugees may acquire or reacquire parasites after they have been cleared to enter the U.S. Overseas screening and treatment will not prevent the existence of these conditions in some refugees when they arrive in this country. Also, infected refugees are treated by CDC grant supported local refugee health assessment programs.

Hepatitis B: The medical screening procedures do not include an examination for hepatitis B. Hepatitis B is not on the list of dangerous, contagious diseases because transmission to social, school, or work contacts of carriers is not likely to occur under normal circumstances in this country. The risks of transmission can be minimized by simple hygienic precautions, disinfection and sterilization of medical and dental equipment, and rejection of carriers as blood donors. There is no treatment for hepatitis B or its carrier state, but a vaccine has been developed which provides protection to persons at risk of exposure to hepatitis B. The vaccine will be available in the U.S. later in 1982 at a cost of over \$100 per recipient. Recommendations and priorities for its use are being developed by the Public Health Service Immunization Practices Advisory Committee. Certain categories of susceptible refugees and other susceptible persons who may be exposed to refugee carriers may be among the candidates for the vaccine. Consequently, we are considering the feasibility of identifying refugee hepatitis B carriers overseas and noting the carrier state on the medical record (OF 157) so that appropriate epidemiologic actions can be instituted after the refugee is resettled in the U.S.

Malaria: The preceding comments on parasites apply to malaria also, as it is a parasitic disease. Malaria has occurred in U.S. military personnel returning from abroad, tourists, and other travelers from tropical areas. Despite 7,244 cases of imported malaria reported in the past 10 years, there have been only 6 known instances of malaria transmitted by mosquito bite in the U.S., with no instances of secondary transmission. None of the 6 cases has been epidemiologically linked to an imported case in an Indochinese refugee. Therefore, no change in current overseas procedures is warranted.

Mental Illness: Under current procedures, examining physicians are to observe refugees for excludable mental conditions. Any history of a mental condition should be obtained from the refugee, but may be brought to the examiner's attention by a family member or a voluntary agency. The availability of camp medical records may also yield this information. However, some mental illness or deficiency may be missed, because obtaining a history and evaluating behavior in a cross-cultural setting is difficult, especially by physicians who may not be experienced in psychiatry.

Body Systems: Conduct of the prescribed brief history and physical examination and the review of medical records should suffice to identify obvious health problems of which INS should be aware in making its final determination of eligibility to enter the U.S. Any health problem, past, present, or future, may affect a person's ability to earn a living. The ICM physician should note if the refugee is physically and mentally functional at the time of the examination, and record any abnormal findings. A single urinalysis or blood pressure reading cannot make the examination more predictive of ability to earn a living.

GAO Recommendation

We also recommend that the Secretary require that all refugees under age 15 be tested for tuberculosis.

HHS Response

We concur that this is an area which we should study further to determine if a change would be justified. Detection of tuberculosis in children generally is of limited epidemiologic importance because childhood forms of tuberculosis are rarely transmissible. Detection of tuberculosis in children may lead to discovery of adult cases in the child's environment, but this is not an important point for refugees because all adults are screened for tuberculosis. Tuberculosis in a child can be a serious personal health problem and Indochinese refugees under age 15 receive a chest X-ray examination if they are members of a family in which a person 15 or more years of age has a chest radiograph abnormality, or if there is a clinical indication for performing a chest X-ray examination. Very few such children are found to have tuberculosis. We plan to assess the value of doing chest X-ray examinations of Indochinese refugee children under age 15 in addition to those currently receiving an X-ray examination.

GAO Recommendation

That treatment be initiated and completed in Southeast Asia for refugees with active tuberculosis, malaria, amebiasis, or giardiasis before they are cleared to enter the U.S. In the case of leprosy, the treatment should be sufficient to render the patient noninfectious.

HHS Response

We concur that treatment should continue to be initiated for any of these conditions if diagnosed during the time a refugee is in Southeast Asia. We do not concur that completion of treatment should be a condition for entry into the U.S.

Tuberculosis: Refugees with suspected tuberculosis who have positive sputum smears and suspects with negative smears who have cavitory pulmonary lesions or who are clinically symptomatic are started on treatment in Southeast Asia. Tuberculosis treatment is continued on

refugees for whom it was started in first asylum camps prior to medical screening by ICM. Refugees with positive smears must have two negative smears before being allowed to depart for the U.S.

Procedures, developed in 1979 in conjunction with the Association of State and Territorial Health Officials, were designed to move refugees with suspected noninfectious active tuberculosis, whether already on treatment or requiring further diagnostic procedures, from Southeast Asia to the U.S. as quickly as possible. Health departments are notified immediately by telephone and mail of the arrival of all refugees with suspected active tuberculosis, and the refugees are referred for followup. Reliable sputum culture examinations and drug susceptibility tests can be done in the U.S., and an appropriate treatment decision can be made. Most of these suspects turn out not to have active tuberculosis.

The Department of State has changed the refugee flow pattern, resulting in most refugees remaining in Southeast Asia for 4-5 months after medical screening, primarily for the purpose of receiving English language training. Consequently, we are now developing options for further diagnostic investigation of tuberculosis suspects who currently do not meet criteria for starting treatment overseas. Any of this group in whom active tuberculosis is diagnosed will be started on treatment before entering the U.S. We know of no epidemiologic justification, however, for detaining refugees with noninfectious tuberculosis in Southeast Asia until treatment has been completed. We will continue to refer these refugees to health departments at their U.S. destinations for completion of treatment.

Malaria, Amebiasis, and Giardiasis: We do not plan to screen refugees routinely for these conditions overseas. Refugees in whom these conditions are diagnosed in the course of clinical evaluation for symptomatic illness will be treated. As stated previously, refugees may acquire, or reacquire, these diseases after they have been cleared to enter the U.S. Overseas screening and treatment will not prevent the existence of these conditions in some refugees when they arrive in this country. However, infected refugees may be identified and treated by health agencies in the U.S. under CDC grant-supported health assessment programs.

Leprosy: We will continue to treat refugees with infectious leprosy in Southeast Asia for at least 6 months before travel to the U.S. is permitted.

GAO Recommendation

In addition, we recommend that the Secretary transmit to the State or local health department at the refugee's destination all pertinent medical information available on refugees.

HHS Response

We concur. Health departments are routinely notified of the arrival of all Indochinese refugees and receive copies of refugee immunization

records. Health departments are also specially notified and receive medical information on refugees with diagnosed or suspected noninfectious tuberculosis, leprosy, noninfectious venereal diseases requiring completion of treatment, and mental conditions. We plan to provide copies of the form, "Medical Examination of Visa Applicants" (OF 157) to health departments at the destinations of refugees whose OF 157's note other serious or permanent physical defects, diseases, or disabilities which are not of public health significance. Any other medical records, including X-ray films, brought to this country by the refugee will continue to be left in the refugee's personal possession for later presentation to any medical care provider, as necessary.

RECOMMENDATIONS TO THE SECRETARIES OF
STATE AND HEALTH AND HUMAN SERVICES

GAO Recommendation

We recommend that the Secretaries take action to ensure that medical records developed and maintained while refugees in overseas camps are under the care of the United Nations High Commissioner for Refugees are transferred to the overseas physicians before they perform the medical admissions examinations.

HHS Response

We concur. Such action was initiated in September 1981. We will continue to work cooperatively with the Department of State, the United Nations High Commissioner for Refugees, and the ICM to assure that the examining physicians overseas have access to existing medical information on the refugees being examined.

GAO Recommendation

We also recommend that the Secretaries require that the results of overseas medical examinations be provided to INS officials for use in INS' final determinations of eligibility of refugees for entry into the U.S.

HHS Response

We concur. For logistical reasons, INS must generally make a tentative determination of eligibility for entry prior to performance of the medical examination. A finding of any defect, disease, or disability by the examining physician should be noted on the form OF 157. Such findings may include: Any statutorily excludable dangerous contagious disease; any statutorily excludable mental condition; any other physical defect, disease, or disability, serious in degree or permanent in nature, amounting to a substantial departure from normal physical well-being. This information is currently available and will continue to be available to INS to review in making a final determination of eligibility for entry.

RECOMMENDATIONS TO THE
ATTORNEY GENERAL

GAO Recommendation

We recommend that the Attorney General:

- Not admit refugees into the U.S. until they have received a thorough medical examination to diagnose health conditions specified in the Immigration and Nationality Act.
- Require that the results of medical examinations be used in making final determinations concerning the eligibility of refugees for admission.
- Not admit refugees with active tuberculosis, infectious leprosy, amebiasis, giardiasis, and malaria until treatment for these diseases has been completed, unless compelling reasons exist to justify a medical waiver.

HHS Response

The GAO draft report makes three recommendations to the Attorney General. If requested, we will provide our advice to the Department of Justice concerning an appropriate response to these recommendations. However, our general comments and specific responses to the recommendations made to the Secretary, HHS, bear directly on the recommendations made to the Attorney General and would be reflected in our advice.



U.S. Department of Justice

MAY 21 1982

Washington, D C 20530

Mr. William J. Anderson
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

This is in response to your request to the Attorney General for the comments of the Department of Justice (Department) on your draft report entitled "Many Indochinese Refugees with Serious, Contagious Health Problems Enter the United States." We have reviewed the report and note that three recommendations are directed to the Attorney General and involve the Immigration and Naturalization Service (INS). Each of these recommendations is addressed separately below.

The draft report recommends that refugees not be admitted into the United States until they have received a thorough medical examination to diagnose health conditions specified in the Immigration and Naturalization Act (Act).

While INS is responsible for making a determination that medical requirements for entry into the United States are met, the specific requirements as to what constitutes "a thorough medical examination" are not established by INS, rather, such requirements are established by the United States Public Health Service (USPHS). If it is the General Accounting Office's (GAO) intent that these requirements be made more stringent, it will be up to the USPHS to set forth new requirements. It will be INS' responsibility to see that these new requirements are met.

In terms of admission through the granting of waivers, the provisions for granting waivers are contained in Section 207(c)(3) of the Act. Such waivers are based on circumstances of a compelling nature, i.e., for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest. These three conditions for granting waivers were defined by Congress in the enactment of Public Law 96-212. Congress chose not to add restrictive phrases such as "hardship" or "exceptional hardship" as they have done with past criteria for waivers.

The report recommends that the results of medical examinations be used in making final determinations concerning the eligibility of refugees for admission.

In responding to this recommendation, it is necessary to draw the distinction between inadmissibility or excludability under Section 212(a) of the Act, and eligibility for refugee status under the provisions of Section 207 of the Act.

To be eligible for admission to the United States in refugee status, an applicant must be a refugee as defined in Section 101(a)(42)(A) or (B) of the Act. Although an applicant may be excludable under the provisions of Section 212(a), being excludable does not alter the applicant's status under Section 101(a)(42)(A) or (B). Section 207(c)(3) provides a waiver for various provisions of excludability in the case of those individuals found eligible for refugee status.

The procedure currently used in processing refugees for medical examinations was instituted to save the costs of providing examinations to refugee applicants who would ultimately not be accepted for admission into the United States. It must be remembered that this process regarding admissibility of the refugee is separate and apart from determining that the applicant is a refugee pursuant to Section 101(a)(42) of the Act.

The Department concurs with GAO that it is preferable to have the medical examination completed prior to the interview of the refugee by the immigration officer, thereby permitting any required filing and processing of medical waivers on a more timely basis. Thus, when an applicant is found eligible for refugee status, he/she will not be relocated (moved forward) until it is ascertained that as a refugee he/she is admissible to the United States.

As a final recommendation, GAO suggests that refugees not be admitted to the United States with active tuberculosis, infectious leprosy, amebiasis, giardiasis, and malaria until treatment for these diseases has been completed, unless compelling reasons exist to justify a medical waiver.

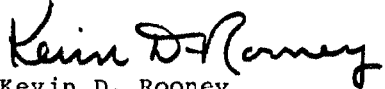
While the Department recognizes that the overall decisionmaking authority in medical matters rightfully rests with the Surgeon General of the United States, we agree in principle with GAO that refugees with infectious diseases not be admitted to the United States until treatment for these diseases has been completed overseas or brought well within tolerable limits. The followup procedure on refugees with infectious diseases after admission in the United States is difficult at best, in that, once the refugee arrives in the United States, he/she is not required to remain under USPHS control in a given area for the time necessary to ascertain that the disease is under control.

One failure of the report is the need to discuss the logistics of detaining refugees overseas while undergoing complete medical treatment. GAO provides no cost estimates other than the additional resources involved in providing more thorough medical examinations. No mention is made of the facilities and resources required to detain refugees overseas while complete medical recovery is undertaken. Certainly, that might be preferable, but there are political, economic, and foreign policy implications involved in pursuing such a policy. It is also not clear whether such facilities would provide better care than follow-on care in health units in the United States.

In conclusion, we agree that the health problems of Indochinese refugees should be of concern. The data provided by GAO showing the increase of infectious diseases among refugee groups is convincing. If the USPHS agrees that the present criteria for medical admission are inadequate, then the criteria should be examined and revised to address the problems. The INS will, of course, comply with the law and work within the guidelines established by the USPHS in providing medical waivers. In the meantime, the Attorney General remains confident that the Surgeon General's assessment of the refugee health problem is accurate.

We appreciate the opportunity to comment on the draft report. Should you desire any additional information pertaining to our response, please feel free to contact me.

Sincerely,



Kevin D. Rooney
Assistant Attorney General
for Administration



DEPARTMENT OF STATE
Comptroller
Washington, D.C. 20520

11 MAY 1982

Mr. Frank C. Conahan
Director
International Division
U.S. General Accounting Office
Washington, D.C.

Dear Frank:

I am replying to your letter of April 12, 1982, which forwarded copies of the draft report: "Many Indochinese Refugees with Serious, Contagious Health Problems Enter the United States".

The enclosed comments on this report reflect the views of the Director in the Bureau for Refugee Programs.

We appreciate having had the opportunity to review and comment on the draft report. If I may be of further assistance, I trust you will let me know.

Sincerely,

A handwritten signature in cursive script that reads "Roger".

Roger B. Feldman

Enclosure:

As Stated.

GAO DRAFT REPORT: "Many Indochinese Refugees with Serious, Contagious Health Problems Enter the United States"

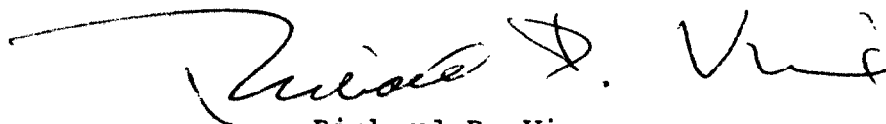
Recommendations of the GAO Audit of Medical Exams of Refugees:

"We recommend that the secretaries take action to ensure that medical records developed and maintained while refugees in overseas camps are under the care of the UNHCR are transferred to the overseas physicians before they perform the medical admissions examinations."

"We also recommend that the secretaries require that the results of overseas medical examinations be provided to INS officials for use in INS' final determinations of eligibility of refugees for entry into the U.S."

Answer:

Based on preliminary findings of the GAO audit team conveyed to the Department of State in September, 1981, the Bureau of Refugee Programs and representatives of the Communicable Disease Center in Atlanta directed the Intergovernmental Committee for Migration, who performs medical screening for the U.S. and other countries, to ensure that contract physicians, using interpreters if necessary, take a medical history of each refugee applicant seeking entry to the U.S. and perform physical examination sufficient to identify excludable medical conditions. They were also instructed to inform immigration and naturalization officers of the existence of medically excludable conditions prior to their determination on the eligibility of refugees to enter the U.S. In addition, all posts were instructed to request the assistance of the UNHCR, the host country or involved voluntary agencies to assure that camp clinical records on refugees are forwarded on a timely basis to ICM physicians performing medical screening. These new procedures have been in effect since October, 1981.



Richard D. Vine
Director
Bureau for Refugee Programs

(102065)

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