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When the right to be counted doesn't count: The politics and challenges of researching the health of asylum seekers

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Abstract

A fundamental prerequisite of population health research is the ability to establish an accurate denominator. This in turn requires that every individual in the study population is counted. However, this seemingly simple principle has become a point of conflict between researchers whose aim is to produce evidence of disparities in population health outcomes and governments whose policies promote (intentionally or not) inequalities that are the underlying causes of health disparities. Research into the health of asylum seekers is a case in point. There is a growing body of evidence documenting the adverse affects of recent changes in asylum-seeking legislation, including mandatory detention. However, much of this evidence has been dismissed by some governments as being unsound, biased and unscientific because, it is argued, evidence is derived from small samples or from case studies. Yet, it is the policies of governments that are the key barrier to the conduct of rigorous population health research on asylum seekers. In this paper, the authors discuss the challenges of counting asylum seekers and the limitations of data reported in some industrialized countries. They argue that the lack of accurate statistical data on asylum seekers has been an effective neo-conservative strategy for erasing the health inequalities in this vulnerable population, indeed a strategy that renders invisible this population. They describe some alternative strategies that may be used by researchers to obtain denominator data on hard-to-reach populations such as asylum seekers.

Keywords: *Asylum seekers, research, barriers to data, hard-to-reach populations, health inequalities*

Introduction

A fundamental prerequisite of population health research is the ability to establish an accurate denominator and this in turn requires that every individual in the study population be counted. However, this seemingly simple principle has become a point

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of conflict between population health researchers whose aim is to produce evidence of disparities in population health outcomes and governments whose policies promote (intentionally or not) social inequalities that are the underlying causes of these health disparities. Such is the case with establishing a population health profile of asylum seekers.

Since 2001, the trend of asylum applications in industrialized countries has declined substantially (UNHCR, 2005). These trends are possibly attributed to a combination of a lessening of major refugee crises in some regions and the introduction by governments of increasingly restrictive asylum policies (UNHCR, 2006). Among these policies are direct pre-entry measures, such as carrier sanctions, offshore processing, and visa requirements, and indirect measures, such as status-determination policies, decline in recognition rates, detention and the removal of welfare benefits (UNHCR, 2006).

Although there is a growing body of evidence documenting the adverse affects of some of these restrictive asylum policies on both healthcare access (British Medical Association, 2002; Norredam, Mygind, & Krasnik, 2005) and on the physical and psychological well-being of asylum seekers (Keller et al., 2003; Steel & Silove, 2001; Steel et al., 2004), this evidence has been dismissed by some governments as being unsound, biased and unscientific (O'Neill, 2005). Yet the policies of these governments have been a key barrier to the conduct of rigorous population health research among this population (Black, 2003; Robinson, 1998). Among these are the deficiencies (deliberate or not) in the provision of accurate data on asylum seekers (Reed, Haaga, & Keely, 1998; Schmeidl, 2000; Stewart, 2004), which prevents the establishment of an accurate denominator.

In this paper we discuss the challenges of obtaining sound data on people seeking asylum and the limitations of the data made available in a number of industrialized countries. We then examine the impact of neo-conservative policies on population health research that aims at documenting health disparities among marginalized and vulnerable populations. We argue that the lack of accurate statistical data on asylum seekers has been an effective strategy for erasing the health inequalities in this vulnerable population, indeed a strategy that renders invisible this population. Finally, we describe some proxy measures or alternative strategies that may be used by researchers to obtain denominator data on hard-to-reach populations such as asylum seekers.

The challenges of counting asylum seekers

Counting asylum seekers is confronted with substantial difficulties, which may include definitional problems (e.g. a person who would be considered as an asylum seeker in one country might not meet the criteria for that status in another country), operational problems (e.g. asylum seekers may be dispersed and very mobile; some asylum seekers may prefer not to be identified), and political considerations (e.g. a government which is aiming to introduce more restrictive asylum policies may highlight data that shows a sharp increase in asylum applications while ignoring the proportion of applicants who have been recognized as in need of protection) (Crisp, 2000). In the context of industrialized nations, access to reliable statistical data is fundamental for undertaking any meaningful analysis of asylum-seeking policies. However, despite the importance of statistics to this field, very few scholars 'have even begun to question the source or accuracy of those statistics' (Crisp, 2000, p. 34).

In practical terms, asylum seekers are not generally included in migrant inflows unless they are subsequently granted refugee status. Statistical data on asylum seekers are usually

available from government sources, but the data made available vary widely across countries (OECD, 2003). Deficiencies in asylum data have been reported in a number of industrialized countries. In a comparison of available asylum data between the UK, Sweden and Australia, Stewart (2004) found an 'unacceptable scarcity of asylum and refugee data in the UK' (p. 45), with incomplete and problematic datasets that offered little cross-tabulation, and focused on principal applicants only. An earlier study conducted by Robinson (1999) reported a 'culture of ignorance' concerning refugee and asylum seekers' needs (and numbers) among service providers in Wales, which was 'enforced by central government's unwillingness to collect or disseminate appropriate data' (p. 87). This 'culture of ignorance' contributed to a 'culture of disbelief' in which poor services were justified on the basis of lack of proper data (Robinson, 1999). The UK government's presentation of asylum data on applications for government support has been found to be 'materially misleading' (Comptroller and Auditor General, 2004, p. 4). It includes only applications from asylum seekers considered eligible for support while those deemed ineligible are shown separately. This may lead users of data to misread the total number of people applying for support.

In Italy, 'institutional invisibility', that is the lack of adequate reception policies (including data collection) and proper provision of government-funded services, has forced asylum seekers to rely on the private sector, self-help strategies and migrants' networks (Puggioni, 2005). Similarly, regulations introduced by the Australian government restricting work rights, government-funded assistance and access to publicly funded healthcare services to asylum seekers living in the community on Bridging Visa E (DIMA, 2006), have seen the emergence of community-based organizations (CBOs) that, although responding well to the challenge, have struggled with limited resources to meet the numerous needs of asylum seekers (McNevin & Correa-Velez, 2006). Similar issues have been identified among CBOs in the UK (Zetter & Pearl, 2000). In addition to limited resources, CBOs have been affected by the Australian government's reluctance to provide precise figures on the number of asylum seekers with no work rights and no healthcare access (McNevin, 2005; Senate Legal and Constitutional Legislation Committee, 2004; Telfer, 2003). Double standards appear here in which government sources claim a lack of sound research documenting the impact of government policies on the health and welfare of asylum seekers (O'Neill, 2005), while at the same time it is the government that denies access to the most reliable source of data: its own.

Neo-conservatism and population health research

Population health research has a long and rich tradition of being centrally concerned with revealing disparities in health and identifying the root causes of the social conditions of populations. Beginning with the development of social statistics in France in the 1600s (Hacking, 1990), the epidemiology of infectious diseases in the 1800s (Karlen, 1995), the social epidemiology of the 1950s (Lilienfeld & Stolley, 1994), and more recently the epidemiology of inequalities and health (Draper, Turrell, & Oldenburg, 2004; Kawachi & Kennedy, 2002; Wilkinson & Marmot, 2003), the explicit aim has been to provide a rigorous body of evidence documenting the impact of social inequalities on the health of the population. This long and strong tradition of rigorous scholarly work has provided sound argument based on solid evidence for reform within public health (Geronimus, 2000; McKeown, 1975), medicine (Leon, Walt, & Gilson, 2001;

Mackenbach & Bakker, 2003) and social policy (Black, Morris, Smith, & Townsend, 1980; Kawachi, Daniels, & Robinson, 2005; Wilkinson, 1996).

However, more recently there has been a conservative backlash to the science of social inequalities and health by shifting attention away from the role of the state in the distribution of resources to the level of the individual and his/her responsibility for health (Colgrove, 2002). Consequently, it has become increasingly difficult to conduct research documenting health disparities among marginalized and vulnerable populations especially when such populations are 'politically' contentious. These barriers to data can be attributed to the rise of neo-conservative agendas whose social policies protect the wealth and power of the few rather than pursuing policies of social justice and equitable distribution. For example, in his paper revisiting the historical roots of the population health approach, Szreter (2003) argues that the New Right's interpretation of McKeown's hypothesis serves specific interest groups concerned more with promoting economic growth and competition rather than social equity. Briefly, McKeown argues that the decline of mortality in England during the twentieth century was due primarily to improvements in living standards and quality of life—not to medical interventions (McKeown, 1975). In discrediting McKeown's evidence on which his hypothesis is based, neo-conservative interpretations of declines in mortality are focused away from state-based welfare policies and interventions and more towards free-market explanations. For example, Szreter (2003) argues that the neo-conservative proposition that 'to reduce global mortality, the number one priority was to produce as much economic growth as possible' (p. 428) has weakened the critical capacity of states 'to collect reliable vital statistics covering the most marginal sections of the population—child workers, low-paid workers, black market workers, migrants, refugees, and remote rural communities' (p. 429). In other words, the neo-conservative obsession with economic growth has undermined the ability to document the impact of economic policies on vulnerable populations. This in turn has resulted in erasing epidemiological evidence of the negative impact of free-market policies on the health and welfare of disadvantaged populations. Neo-conservative policies have had significant consequences not only for these socially disadvantaged communities but also for epidemiology as a discipline, public health practitioners, researchers and the community sector as a whole. Szreter (2003) argues that one of the greatest risks to population health research is increasing restrictions on people's right to be counted. Indeed, he argues that the consequences of a failure to be counted are to render vulnerable populations invisible and, thus, social inequalities that cause health disparities are swept under the carpet.

Practical implications: Alternative strategies for obtaining sound data on asylum seekers

The rich body of methodological research on hidden or 'hard-to-reach' populations (Faugier & Sargeant, 1997; Jandl, 2004; Lambert, 1990; Sudman & Kalton, 1986) can provide some useful strategies for obtaining denominator data on asylum seeker populations.

'Residual' estimation methods

The residual method compares aggregate datasets (Jandl, 2004). It has been used to estimate unauthorized or illegal migration in the United States (Costanzo, Davis, Irazi, Goodkind, & Ramirez, 2002) and in the UK (Woodbridge, 2005) by comparing census

data with a number of migration datasets. This technique may be useful in estimating subpopulations of asylum seekers such as those with no right to publicly funded health services (by comparing for instance migration and healthcare enrolment datasets).

'Multiplier' estimation methods

The multiplier estimation technique assumes a stable relationship between the size of the unknown variable to be estimated (such as the stock of asylum seekers) and a variable that can be measured (such as the stock of 'authorized' resident migrants) (Jandl, 2004). This method works by making informed assumptions about the 'right' multiplier(s), which may originate from previous research or historical data.

Relative trends

Data from service providers (either government or non-government) do not give the actual number of the asylum-seeker population (or sub-population) but can provide an estimate of relative trend (Stimson et al., 2003). For instance, if the number of asylum seeker clients seen in a CBO increases (or decreases), this can reflect changes in the population size (other things being equal). The more data sources and methods used, the more robust the estimates will be.

Snowballing

The usefulness of snowball sampling for creating a sampling frame depends on the size of the population and on how well asylum seekers know and trust each other (Sudman & Kalton, 1986). Government policies, such as compulsory dispersal of asylum seekers in the UK (Secretary of State for the Home Department, 2002), which promotes intense social exclusion (Sales, 2002), can seriously limit the applicability of snowballing techniques for developing a sampling framework because those socially isolated are likely to be missed. Snowballing can also be used as a nomination technique using a multiplier approach (Stimson et al., 2003). Participants are asked to nominate friends or acquaintances and then estimate how many of these people share a specific characteristic in common: the multiplier (e.g. asylum seekers with no work rights). Again, this technique is limited when asylum seekers are living in social isolation and where a lack of trust prevents the sharing of information within social networks.

Network sampling—the ethnosurvey

Since asylum seekers are typically spread across towns and cities, it can be difficult to construct a representative sampling frame. New sampling techniques such as multiplicity or network sampling (Sudman & Kalton, 1986) may solve this problem (Massey & Capoferro, 2004). Network sampling can be incorporated into the ethnosurvey (Massey, 1987), a multimethod technique that combines ethnographic and survey methods. The ethnosurvey moves back and forth between quantitative and qualitative approaches and uses a multilevel design to gather data concurrently for individuals, households, communities and even the nations in which they live (Massey & Capoferro, 2004). A key characteristic of the ethnosurvey is the thorough selection of sites, which may be chosen according to particular criteria or at random from a universe of potential sites. In the case of asylum seekers living in the community, the sites selected may be CBOs providing services to this population. The combination of quantitative and qualitative methods may help to identify double counting of individuals who may receive services

simultaneously from several CBOs. The ethnosurvey can therefore provide a more accurate population estimate.

Survey techniques—the Delphi method

The Delphi method (Woudenberg, 1991) can be used to estimate the size of a population by surveying ‘experts’ on the subject and taking an average of their estimations as a multiplier. This method provides an approximation to the actual value of multipliers and the results depend on the choice of statistical compilation (e.g. adjusted average, median, range) (Jandl, 2004).

Capture–recapture methods

The capture–recapture method involves counting a population at two specific moments in time and at one precise location. ‘The amount of the population *not* present at that specific moment and location can be estimated by using the Poisson parameter and so the total population can be counted’ (Jandl, 2004, p. 5). For example, a sample of 100 asylum seekers is counted and identified at a specific CBO that provides services to this population. Later, a second sample of 100 asylum seekers is counted at the same location. It is found that 10 of them have been previously identified. The ratio of identified asylum seekers in the second sample (10%) is applied to the first sample. The 100 in the first sample are assumed to be 10% of the total population, which is estimated to be 1000 (Stimson et al., 2003). Existing records from agency sources can also be used and the overlap of cases between the two data sources is measured. The capture–recapture method has some limitations (Jandl, 2004). It assumes that the sample is homogeneous (in the case of asylum seekers, ‘capture’ rates can differ according to sex, age, living area and social isolation), and that the population is stable during the sampling period, which may not be the case for asylum seekers.

The value and applicability of some of the strategies described above differ across countries depending on data-collection and data-reporting practices. Given the challenges faced when counting asylum seekers and the limitations of data from government sources, a key strategy for obtaining sound data on this hard-to-reach population is through collaborative work with CBOs, whose local knowledge of and access to asylum seekers are vital (McNevin & Correa-Vélez, 2006). It is important to acknowledge, however, that counting asylum seekers through CBOs would still exclude those not accessing these services and therefore most vulnerable.

Concluding remarks: The right to be counted

When it comes to health and human rights more often than not asylum seekers do not count. Asylum seekers are the invisible underclass. Fleeing from their own countries, they are increasingly becoming the invisible non-citizens making up a portion of other nation-state populations.

We argue that explicit neo-conservative government strategies have actively imposed restrictions on researchers’ access to asylum-seeker population data. For example, in Australia it has been impossible for researchers to obtain data from the Federal government on the number of asylum seekers there are in the community (McNevin, 2005; Telfer, 2003). The failure to obtain such data serves to uphold current policies that are unjust. These policies have a negative impact on the health and well-being of those

most socially disadvantaged, and work in favour of conservative voters who lack empathy and in favour of 'vote maximising politicians' (Dollery & Wallis, 2001, p. 14). Without government support or with active government obstruction of data, marginalized groups are further marginalized.

Asylum seekers everywhere have the right to be counted. Furthermore, socially responsible research must inform policy and advocate for social change. As Callahan and Jennings (2002) argue, 'the ethical persuasion most lively in the field [of public health] is a stance of advocacy for those social goals and reforms that public health professionals believe will enhance general health and well-being, especially among those least well off in society' (p. 172). Moreover, 'public health can best serve the cause of responsible politics...when it makes available good data, when it is sensitive to community sentiments...'. (Callahan & Jennings, 2002, p. 174). There is an imperative for liberal democratic governments to guarantee researchers access to unidentified data concerning the most marginalized and vulnerable populations as a matter of course. Further, governments have a responsibility to ensure the open discussion and debate of evidence-based knowledge that can inform social policies aimed at enhancing the health and well-being of those most in need. The right to be counted counts for everyone. Is not this a fundamental principle of a liberal democracy?

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