BARRIERS IN ACCESS TO COMPENSATION

of Immigrant Workers Who Have Suffered Work Injuries

ABSTRACT

Canada, like many other countries, has an immigration policy that favors qualified candidates. Through economic necessity, however, immigrant workers accept jobs with dangerous conditions that are inappropriate for their qualifications. The prevalence of work injuries is higher among immigrants than among other workers. Not knowing their rights, and frequently having communication barriers, these workers who have had work injuries experience many difficulties in the course of claiming compensation.

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The situation of immigrant workers in Québec is of concern. On the one hand, many of them live in conditions in which economic integration is difficult.[1] On the other hand, residential instability, economic insecurity, and the precariousness of their living conditions force them to accept jobs in sectors where the risks of accidents and of occupational diseases are high. Whether or not they are qualified, these workers, during their first years here, often work in manual labor jobs that are inappropriate for their training and their skills, thereby increasing the risks of work injuries.[2] As is the case for access to public services in general, immigrant workers who have had work injuries encounter barriers in access to compensation. The results of the present study demonstrate that immigrant workers encounter many difficulties, and that these may occur at any stage in the compensation process.

Background

The immigration of workers is a growing international phenomenon; it is sustained by the immigration policies of large countries in need of manpower, as well as by countries that, in the grip of uncontrollable unemployment, export workers. In 1990, in North America alone, 8.6% of workers were immigrants.[3] For the countries exporting manpower, the money that enters the country from expatriates abroad, destined for their family members, represents an important amount that can reach close to 10% of the GDP.[4] Foreign manpower consists of three types of workers: qualified workers who leave as part of a "brain drain," workers who are qualified in sectors that are not hiring, and unqualified workers employed in temporary or seasonal jobs. All of these workers are at risk of occupational injuries.

The end of the 1970s and the 1990s marked the publication of studies on the prevalence of work injuries among immigrant workers. In the first period, studies focused on the sociology of employment among temporary immigrants in Europe; the second period concentrated on the situation of agricultural workers in the southern U.S., and other industrial sectors in need of low-price labor. Between these two periods, studies tended to focus on ergonomic, physiologic, bacteriologic, and toxic risks to workers.

The prevalence and severity of occupational injuries among immigrant workers have always been important. During the 1970s, in Germany,[5] there were 2.7 immigrant workers injured for every German worker injured, while in France, immigrant workers made up 10% of the workforce, yet experienced 21% of accidents.[6] More recently, from 1996 to 2000, in the United States,[7] the mortality rate of Latin American workers was 20% higher than that of whites and African Americans.[8] Furthermore, these workers are more likely to develop subsequent problems, since their living conditions do not allow an adequate recovery from an injury,[9] and they suffer from inadequate access to health services and compensation.

Immigrant workers very often hold jobs in sectors that have high risk[10,11,12,13,14] and offer few opportunities for the future.[15] In the state of California alone, Latin American workers constitute 17% of the workforce, yet they represent 62% of agricultural workers, 25% of manufacturing workers (textiles, foods, machinery), and 20% of construction workers[16] – the industrial sectors with the highest prevalence of permanent and fatal injuries.[17] The work conditions are deplorable, and difficult and repetitive tasks[18] are carried out under pressure in unhealthy and noisy environments.[19] These jobs are often seasonal or temporary,[20] which prevents the worker from acquiring enough

experience to accomplish the task without risk. Furthermore, an inadequate knowledge of the language leads to isolation of the worker, lack of comprehension of security regulations,[21] and lack of understanding of rights and procedures for receiving compensation.

Since their creation, North American and European compensation systems have evolved. Coverage of compensable injuries and illnesses has expanded, and certain countries have adopted "no-fault" systems.[22, i] These improvements have brought with them an increase in costs without, however, compensation for the most vulnerable victims. Whether unionized or not, workers prefer to continue to work while undergoing treatment, despite their pain,[23] in order to maintain their connection to the labor market. They are afraid of being fired, of losing their right to remain in the country, or even of becoming poor because the compensations for replacement of income are insufficient.[24,25] For those who succeed in overcoming their fears of reprisals, access to compensation is not automatic. Many studies[26,27,28,29,30] have demonstrated the existence of barriers in accessibility to the compensation system, from the point of entry throughout the entire compensation process. Dembe et al. *2003*[31] have described three mechanisms that succeed each other in prejudicing the process of making a claim and gaining access to compensation:

- block entry to the system by discouraging workers from initiating the procedure;
- impose rules structuring access to the system through unavoidable delays and by fixing the amounts of compensation without regard to the impoverishment of workers; and
- minimize the needs of workers by underestimating their capacity to return to work, as well as the risks of relapse and recurrence.

Whether looked at from the medical,[32] administrative,[33] or legal[34] point of view, several players are involved in the dynamics of limiting access: employer, colleague, union, physician, legal advisor, and compensation agent. Despite the diversity of analyses, few studies have investigated the course of compensation according to the status of workers.

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Methods, sampling, and recruitment

A retrospective study comparing immigrant and non-immigrant workers was conducted in Montreal[35] in order to answer the following questions:

- do immigrant and non-immigrant workers who experience work injuries have equal access to the compensation system?
- at what points in the compensation process do factors appear that limit or facilitate access?

Researchers interviewed 104 workers who experienced work injuries concerning the circumstances surrounding the accident and the course of the compensation process.

The convenience sample was composed of one-half immigrants (51%) and one-half non-immigrants (49%) and, in the same proportion, of men (53%) and women (47%). Subjects were recruited through the list of clients of the collaborators in the project: a polyclinic specializing in industrial medicine (40%), an organization working for the rights of workers who have experienced work injuries, offering legal and medical assistance (31%), and a law office providing defense for workers (15%). Some subjects (14%) were also recruited through newspapers and ethnic radio stations. From the initial list of 363 clients, 184 were recruited. The rate of refusal was 43% (80/184).

The workers recruited had to be working for an employer at the moment of the injury. The claim for this injury had to be filed in the period beginning in January 2000. Immigrant workers must have been born outside of Canada, and must have lived in Canada for fewer than 20 years, regardless of their status.[ii]

The data for this study come from two sources: a) individual interviews: one focusing on the stages of the administrative process, and another on the conditions of return to work; and b) the transcription of claims and of the description of events surrounding the accident or the appearance of symptoms of the occupational illness. The interviews were carried out by multilingual interviewers; the first interview lasted an average of one hour and 45 minutes, while the second lasted an average of 45 minutes. This process took place between December 2002 and December 2003. Interview data were analyzed using SPSS software (chi-square analyses and tests of mean differences). Transcriptions of claims were obtained and analyzed using NVivo; these data were then converted into dichotomous variables and added to the files of interview data.

Results

The first results present the characte-ristics of the workers. The others describe the main barriers to access encountered by the workers, following the chronological order of the different stages in the compensation process.

An occupational illness was the presenting problem for 26% of subjects, while 76% were injured as a result of an accident. Women (35%) experienced more occupational diseases than did men (22%) as did immigrant workers (32%) compared to non-immigrant workers (24%). Almost one third (30%) of injured workers had been employed by their company for less than one year, while 55% had been at their jobs between one and nine years. The vast majority (81%) were carrying out their usual tasks.

Figure 1
Rate of Refusal of Compensation by Status of Workers

Decisions rendered - Refused	Immigrants	Non-immigrants
Events surrounding accident or appearance of symptoms	52 %	23 %
Diagnosis	49 %	34 %
Connection between job and accident or illness	52 %	32 %
Functional limitations	64 %	48 %
Date of consolidation	78 %	56 %
Conditions of return to work	58 %	69 %

Whether concerning an illness or an injury, most workers reported the problem to their supervisor (52%) or to a colleague (30%), but some did not know to whom it had been reported (11%). The work environment is a risky one, since 68% of workers have known a colleague with a similar disease or injury.

Most workers consulted someone the same day, but immigrant workers who developed occupational diseases sometimes waited more than six months (28%), unlike non-immigrant workers (8%). Not having family doctors, workers consulted doctors in emergency departments in private clinics (64%) or in hospitals (37%). These patients saw one doctor after another throughout their convalescence, with only 25% of workers continuing to see the same doctor that they saw initially. The absence of continuity in the medical follow-up was such that many men (40%), and especially immigrants (64%) felt that they had been examined inappropriately and been given an imprecise diagnosis (23%). For all workers, the impact of the injury or disease has been very important on their professional lives (78%), their daily lives (56%), and on their leisure activities (61%).

In principle, the worker writes his or her own s tatement; 92% of non-immigrant workers were able to do this, compared to only 42% of immigrant workers. This gap is all the more worrisome, because immigrant workers often ask their employer (21%) or a third party, a friend, or a member of the family to prepare the statement (37%).

Workers may be contacted up to five weeks (25%) after having filed their claim. These delays are such that immigrants were much less satisfied (75%) with the contacts they had with compensation agents than were non-immigrant workers (49%).

Decisions handed down by the compensation services may[iii] concern several aspects of the case: the description of the events, the diagnosis, the connection between the injury or illness and the job, the functional limitations of the worker, the date of consolidation[iv], and the conditions of return to work[v]. Rates of refusal are higher for immigrant workers, with the exception of the conditions of return to work, as shown in the following table. The level of disappointment is so high that 59% of workers expect to contest the decisions.

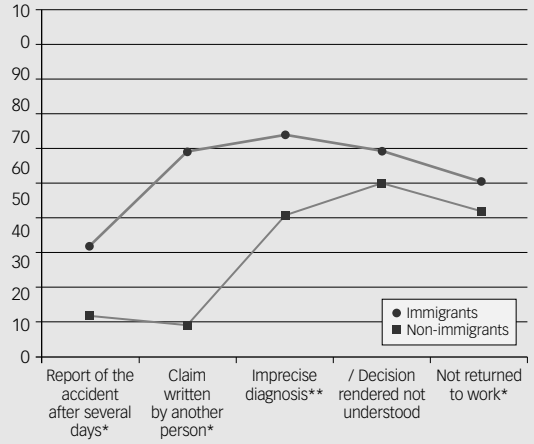
Many workers do not understand the procedures and decisions (62%); this leads 82% of immigrant workers and 76% of non-immigrant workers to seek legal advice. The compensation board of Québec (CSST) prefers to communicate in writing with workers. However, 54% of workers do not understand these communications, regardless of their status, their education, or the board's decision. For immigrant workers, the problems are not limited to this correspondence, since 55% state that they have had difficulty in making themselves understood, and 58% have not grasped the meaning of the decision.

At the point of the second interview, 51% of immigrant workers, compared to 43% of non-immigrant workers, had returned to work. However, 72% of workers with little education subsequently lost their jobs. Because of economic necessity or through fear of reprisals, workers returned to work in spite of chronic (61%) or occasional (25%) pain. For immigrants, important constraints of transport (47%) and of communication (47%) hindered the continuation of their treatment. Relapses, recurrences, and worsening of the condition were frequent occurrences, regardless of type or of status. Relations with employers deteriorated, especially for immigrant workers (51%) compared to non-immigrants (36%). Many workers (64%) saw their future degraded, particularly immigrant workers (76%).

Discussion

These results demonstrate that barriers arise at all stages in the compensation process. From the beginning, the immigrant worker delays making a claim, which acts to his or her disadvantage. This is not surprising considering that, in general, from 20% to 45% of workers will not file a claim,[36] and that, in certain industrial sectors, not filing is the norm.[37] At the second stage, that of medical procedures, immigrant workers go to emergency departments of hospitals or clinics for treatment. They leave it up to their doctors to decide what steps to take. Physicians do not necessarily encourage them to file a claim, either because they are not familiar with the compensation system,[38] because they do not want the worker to lose his job, or because they want to avoid becoming involved in debates among experts concerning the health of the worker. At the third stage, that of filing a claim,

Figure 2 – Comparison Between Immigrant and Non-immigrant Workers at Different Stages in the Compensation Process



*Significant p<0.05 ** trend p=0.08

Statement ▸ Claim ▸ Medical procedures ▸ Administrative course ▸ Return to work

immigrant workers, even those who are educated, are bewildered. Confident that they are being looked after by the system, they are surprised at being refused and at having their claim contested by the employer. In the face of refusal, 25% of workers intend to file an appeal, a rate of contesting equivalent to that identified in other studies.[39] At the fourth stage, which consists of filing an appeal with the compensation board, all workers have difficulty understanding the decisions rendered, and many immigrant workers experience communication problems. The more the administrative process becomes complex, because of disputes, the less the workers understand the outcome of their appeal. Finally, fewer immigrant workers than non-immigrant workers return to the workplace. Non-return to work and firing subsequent to an injury are not specific to the workers in this study. Imershein et al.,[40] in 1994, stated that only 25% of workers who were victims of work injuries returned to work; among these, 96% did not have the support required for their condition, and 76% ended up quitting their jobs, disillusioned, or under threat of being fired. Instead of the dream of a better life, immigrant workers see their family lives as under threat. Here again, the results of our sample are not new, with many studies[41,42] showing that for the majority of workers, pain caused by a work injury affects equally their family lives, their marriages, their social lives, and their leisure activities.

The results of this study demonstrate that the barriers are real for the subjects in our sample. However, the representativeness of our sample is questionable. We used a convenience sample drawn from the lists of clients of collaborators in the study. Nevertheless, the workers in the sample experienced difficulties in access to compensation similar to those investigated in many studies, American as well as European.[43]

Conclusion

It is not unreasonable to question the equity of treatment accorded to immigrant workers in comparison to that accorded to non-immigrant workers. Everyone involved with workers who have experienced a work injury should cast a self-critical look at their implementation of the factors put in place to assure equal access to the most vulnerable in our society (immigrants, poorly-paid and non-unionized workers, etc.). Professional ethics require that actions taken, information transmitted, and decisions rendered be well understood by the worker, and that their consequences on physical health, professional life, and private life be thoroughly grasped. As emphasized by some studies on work injuries, we must go beyond the simple analysis of medical, familial, and economic consequences of work injuries, and consider all aspects of the impoverishment of means and abilities of workers.

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Notes

i This indicates that there is no accusation of negligence or of responsibility towards one or other of the parties in the occurrence of the accident or illness. This limits any civil suit connected to the events surrounding the accident or appearance of symptoms of an illness, except in the case of intentional negligence. North American and European compensation systems, although all of the "no-fault" type, are distinguished one from another by type of compensation (income replacement or lump sum payment), by conditions of access to services for recovery (health care, rehabilitation), and by conditions of return to work. Access to compensation is closely linked to access to the health care system. Therefore, in countries where access to health care is free and universal, gaining access to compensation and to reimbursement for medical expenses due to a work injury does not carry the same advantages as in countries where only those with private insurance can receive care.

ii There are two versions of this statement: that written by the worker, and that produced by the employer. Both appear on administrative forms of the Commission de santé et sécurité au travail (CSST) bearing the numbers 1039 (01-09) for workers and 1940 (98-11) for employers.

iii There can be several levels of judicial decisions. The first level: the Commission de santé et de sécurité au travail (CSST); the second level: la Direction de la révision administrative (DRA); the third level: the Commission des lésions professionnelles (CLP); and the last level: the Cour supérieure du Québec.

iv Date of recovery, or when no further improvement is possible.

v Lightening of tasks, modification of job, finding a different, more appropriate job.

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