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1 Drawing on a larger research project, this article focuses on the pathways to healthcare among precarious status migrants who, due to their ineligibility for other forms of income support, can be assumed to be dependent on employment for economic survival : Temporary Foreign Workers (TFWs, eligible for medicare but not for welfare) and undocumented workers (ineligible for medicare, welfare, and nearly all other social benefits).[1] We focus here on their pathways to healthcare in light of how their immigration status and their health entitlement may intersect to influence their occupational health trajectories.

2 While it is clear that these categories of precarious status migrants face work-related barriers in accessing healthcare (Gravel and Raynault, 2010 ; Hanley et al., 2010), the pathways that migrant workers follow in trying to increase their access and get the care they need are less well-known ? Our results document their pathways to healthcare, indicating how migrant workers find their way through a complicated healthcare system

as they balance their physical and mental health needs with their need for both continued paid employment and a secure immigration status. For OHS professionals aiming to understand migrants' occupational health trajectories, it would be important to take health entitlement and healthcare-seeking behaviour into consideration.

3 We begin this article with a review of the literature on immigration status, immigrant health entitlement and migrant workers' access to workers' compensation. We describe our conceptual framework before explaining our methods. In the findings section, we report on the healthcare pathways that workers take when they have health problems, whether it be by seeking advice and help from friends, family, or coworkers, or by going through the Quebec health system or consulting health professionals back in their countries of origin. We conclude with a discussion about how migrant workers' entitlement to healthcare, and therefore their pathways to services, may be influencing their access to occupational health and safety and workers' compensation protections.

1. Immigration status, access to healthcare and OHS challenges

4 Immigration status is widely recognized to have a significant impact on migrants' work and health experiences (Gushulak et al., 2011 ; Hennenry, 2010), while workplace health and safety issues have also been shown to affect immigrants and racialized workers disproportionately and differently than other workers (Premji et al. , 2010). In addition, the policy and social barriers that migrants (particularly women and precarious status migrants) face in trying to access health and social services have been well documented both internationally and in Canadian and Quebec research (Magalhaes et al., 2010 ; Vanthuyne et al., 2013). Here, we provide an overview of how these themes are addressed in the academic literature.

1.1 Immigration status and work

5 At the core of our concern here are workers who begin their time in Canada with a "precarious immigration status" (Goldring et al., 2009). Of the roughly 600,000 annual migrants to Canada, more than half come on a temporary basis (CIC, 2010b ; 2012). For a certain number, they make a clear choice to come temporarily (e.g., the majority of foreign students) but an even larger number of these migrants wish to stay in Canada, usually for economic or security reasons (Moss et al. 2010). There has been a phenomenal growth in the number of workers recruited through the Temporary Foreign Worker Program (TFWP). Many of them wish to stay and, as a result, the TFWs have come to outnumber permanent residents accepted to Canada each year (Faraday, 2012). Precarious immigration status, however, puts migrants in a legal category denying them the permanent right to stay in Canada and often enforces a dependence on a third party (i.e., an employer or family member) (Hanley and Shragge, 2009). Precarious immigration status refers to a continuum of statuses outlined in the Immigration and Refugee Protection Act (CIC, 2001). These range from the most insecure, illegal immigrants (smuggled or trafficked into the country or having overstayed a legal visa) through to refugees (claimants, accepted or refused) and temporary residents (e.g., students, temporary foreign workers) right up to the most secure, sponsored family members (who are permanent residents but whose status is dependent on their sponsor). The proportion

of precarious status migrants versus those with full immigration status (permanent residents) has been steadily increasing over the last few decades (Faraday, 2012). This situation makes migrants more vulnerable to exploitation, abuse and stress (Oxman-Martinez et al., 2005).

6 Precarious status migrants disproportionately find themselves in difficult work conditions, with low pay, long hours and stressful labour relations (Choudry and Henaway, 2012 ; Rodriguez and Mearns, 2012). It is not only those without permanent status who find themselves in precarious situations in the labour market, however. Longitudinal studies have shown that immigrants who have arrived since the 1970s are not faring as well as those of earlier decades. Today's immigrants, despite high levels of education and professional qualification, suffer higher unemployment and greater rates of poverty, and appear less likely to "catch up" with the average Canadian worker, even over two or more generations (Krahn et al., 2000 ; Li at al., 2003 ; Picot, 2004 ; Picot et al., 2007). As a consequence, there are a large number of immigrant workers who are trapped at the bottom of the labour market (Teelucksingh and Galabuzi, 2009), with Canadian-born racialized workers facing similar exclusions (Galabuzi, 2006). Add to this the increasing number of workers with precarious status (CIC, 2010a) and you have a pool of cheap labour that needs to work to be able to survive in Canada and to send remittances to their families in their countries of origin (Hanley et al., 2012).

1.2 Immigration status and access to healthcare

7 Research in Quebec and Canada indicates that, in general, migrants do not benefit from equitable access to healthcare services (Lebrun, 2009 ; Rousseau et al., 2008). For instance, research has shown a significant proportion of migrants experience delays, complications, or denial of medically necessary treatment when accessing the healthcare system (Caulfordand Vali, 2006). Those with precarious immigration status experience more barriers to accessing healthcare and, as a result, experience long-term health concerns and unrecognized morbidity (Kuil et al., 2007 ; Wilson-Mitchell and Rummens, 2013). In the legal analysis that we undertook to provide a basis for the current study, we documented the Québec, Ontario and New Brunswick regulatory frameworks for access to healthcare for all precarious migrant statuses, including healthcare paid for by workers' compensation boards (Sikka et al., 2011). The regulatory obstacles were particularly important for undocumented workers, but other categories of workers were, in practice, also found to face barriers, although the nature of the services available varied between provinces.

8 For workers with precarious immigration status, barriers to health services are likely a composite of legal, institutional, socio-economic and cultural factors (Magalhaes et al., 2010 ; Pottie et al., 2011). Canadian researchers have thus far examined precarious immigration status and access to healthcare from two dominant angles : policy barriers to health and practitioners' perceptions of these barriers (Vanthuyne et al., 2013). Medicare policies and the exclusion of immigrants from health services for the initial three months of their residency act as a serious impediment to equitable healthcare (Oxman-Martinez et al., 2005).

9 Such policies are compounded by bureaucratic barriers, such as misfiling or miscommunication that increase the time for receiving medicare and services (Kuile et al., 2007), and a lack of administrative data within public health and occupational safety

agencies necessary to demonstrate the extent and severity of accidents among immigrant workers (Gravel and Kane, 2003).

1.3 Immigration status, occupational health and safety (OHS), and workers' compensation

10 It is well documented in Canada that immigrant workers face an overexposure to workplace health and safety problems due to a host of factors (Gravel et al., 2011 ; Kosny and Lifshen, 2012 ; Premji et al., 2010 ; Smith and Mustard, 2010), a vulnerability which is also documented among migrant workers in other industrialized countries (Anderson and Naidu, 2010 ; Benach et al., 2010 ; Guthrie and Quinlan, 2005 ; Panikkar et al., 2012). The increased risk takes many forms. Immigrants in jobs where there is a high expectation of hiding emotions, low possibilities for development and low levels of support from coworkers – all conditions reported by precarious status workers – report more mental health difficulties (Font et al., 2012). Challenges attributable to language barriers, for example, mean that workers have fewer possibilities of communicating hazards or understanding health and safety training information provided by the employer or the union (Premji et al., 2008). And yet, despite this vulnerability, very little information is available for recent migrants about employment standards, occupational health and safety, and workers' compensation (Kosny and Lifshen, 2012).

11 At the end of the 1970s and again at the end of the 1990s, two important symposiums on the health of immigrant workers were held by the International Labour Organization (in 1977) and Sweden's National Institute for Working Life and its cooperative research program SALTSA (in 2001). With 20 years between them, the conclusion was the same : the prevalence and gravity of injuries were greater among immigrant than native-born workers, regardless of the host country (Auer et al., 2006 ; Gravel, 2013 ; Wren and Boyle, 2001). Worse, in some countries (such as the United States), the frequency and gravity of injuries, including fatal injuries, appeared to increase in the 2000s among immigrant workers, in contrast to lowering rates among native-born workers (Loh and Richardson, 2004).

12 In terms of Quebec's Workers' Compensation legislation, immigration status is not explicitly mentioned in the definition of "worker," but access to compensation remains uncertain for undocumented workers. This does not however appear to be the case in Ontario and New Brunswick (Sikka et al., 2011). Aside from the actual issue of coverage, the regulatory effectiveness of compensation protections can be undermined when temporary foreign workers have to leave Canada before their claim is fully resolved (Preibisch and Hennebry, 2011). As is illustrated in our regulatory study, access to compensation and continued benefits can be compromised when the necessary follow-up medical exams are conducted by a physician in the country of origin. The issue is particularly problematic if the employer requires a second opinion to be provided by the physician of his choice. Aside from bureaucratic and communicational challenges, employers have been known to contest claims by challenging the legitimacy of a foreign doctor to provide valid evidence to the workers' compensation board (Beauvais et al., 2007). Timely access to a treating physician is key to a successful workers' compensation claim and, in some cases, those who delay consulting a physician are confronted with obstacles in their workers' compensation claim (Sikka et al., 2011). In some cases, the severity of the occupational injury was exacerbated by delayed treatment, and the

employer successfully required that the costs of compensation be transferred out of his own account and instead be paid for by the general workers' compensation fund. In Ontario, obstacles such as a worker's inability to seek timely healthcare or difficultly in renewing a work permit when a disability makes it impossible to make an early return to work can lead to his claim being cut short (Sikka et al., 2011). The Law Commission of Ontario has also emphasized difficulties in the application of workers' compensation legislation when foreign workers are "deemed" to be able to occupy another Ontario job, a process that puts an end to their benefits, even though they are no longer in the Ontario labour market and in no position to access Ontario wages (LCO, 2012). Although an equivalent study is yet to be conducted, this critique could very well apply to the Québec legislation.

13 The one major category of worker explicitly excluded from Workers' Compensation in Québec, however, is domestic workers, an occupation in which immigrant women are highly overrepresented (Tastsoglou and Preston, 2012). This exclusion is still in the legislation in 2014, despite a nearly decade-long grassroots campaign to include domestic workers in the Québec workers' compensation legislation (Hanley et al., 2010) and the Quebec Commission des droits de la personne et des droits de la jeunesse's ruling that the Quebec exclusion violated the equality rights guaranteed by section 10 of Quebec's *Charter of Human Rights and Freedoms* (Campbell, 2008).

14 Aside from challenges relating to regulatory or access obstacles to healthcare, the ability to access workers' compensation for immigrant workers is often compromised by such factors as language barriers and a lack of knowledge of workers' compensation benefits or procedures for making claims (Gravel et al., 2007 ; Gravel and Raynault, 2010). Ultimately, structural and personal barriers result in migrant workers underreporting their workplace accidents and illnesses (Gravel and Raynault, 2010), with irregular or undocumented migrants facing enormous barriers to any form of recourse (Guthrie and Quinlan, 2005 ; Magalhaes et al., 2010 ; Nessel, 2012 ; Quinlan, 2012). What is more, the lack of recourse for work accidents sometimes even pushes TFWs to becom undocumented (Preibisch and Hennebry, 2011).

2. The "Right to Healthcare" Project

15 Our project developed out of a combination of the research team's academic experience and their collaboration with community-based organisations engaged in access to healthcare and social services for migrants to Quebec. Our overall aim was to explore to what extent migrants to Quebec have the right to healthcare in both law and practice. The project was therefore designed to answer the following research questions : *How does immigration status intersect with legal and socio-economic factors to shape access to Quebec medicare and Workers' Compensation ?* and *What strategies – whether individual, family or collective – do migrants employ to overcome barriers in access to medicare and Workers' Compensation ?* This article draws on the results related to the second question, focusing on undocumented workers and temporary foreign workers.

16 Using an international human rights framework that assumes migrants' right to healthcare, this study explored the connection between socio-legal conditions and migrants' agency in accessing healthcare. As argued by the World Health Organization's Commission on the Social Determinants of Health (WHO, 2003), the determinants of health influence a person's ability to act on their own behalf, which in turn influence a

person's health. In other words, when people experience socio-legal barriers to health, they have reduced options for agency, which has a negative impact on their health (Anand, 2004 ; Ruger, 2005). In this article, we follow the work of Benach et al. (2010) and Gravel et al. (2010) in bringing together such factors as immigration status and health entitlement to examine how the social determinants of health may be influencing migrant workers' access to OHS services.

3. Methods

17 Covering both men and women with a range of precarious immigration statuses (undocumented, refugee claimants, temporary foreign workers, foreign students and permanent residents on the 3-month delay before medicare), the study targeted populations who had been in Canada 10 years or less when they met with researchers in 2010-2011. The categories we established were : people ineligible for medicare (undocumented, permanent residents on the 3-month delay) ; foreign students who were ineligible for Medicare but likely to have private insurance ;[2] refugee claimants insured by the Interim Federal Health Program ;[3] and Temporary Foreign Workers who were eligible for medicare but whose difficulties accessing healthcare are well documented (Hennebry, 2010 ; Mysyk et al., 2009). Data were collected through both a survey (n =211) and follow-up interviews with a subset of survey respondents who identified barriers in access to healthcare (n =31).

18 Due to the great difficulty of identifying the precarious status population (Benach et al., 2010), migrants were either referred to the project by medicare- and Workers' Compensation-related agencies or recruited through community outreach via ads in newspapers targeting ethnic minority communities, posters in community stores, etc. We screened people according to the following inclusion criteria. They had to : have precarious status ; have been in Canada less than 10 years ; and have experienced a health concern since arriving in Canada. We aimed for balance of gender, immigration status and diversity in terms of countries of origin. We were able to administer the survey in English, French, and Spanish. Because of language difficulties and people's level of comfort with the research process, it was preferable to administer the survey in person, though a few were completed by phone. The survey questions were centred on migrants' experiences in accessing medicare and Workers' Compensation, and covered legal and socio-economic aspects. The implications of any potential barriers were identified, whether in terms of family relations, social relations, employment, or community involvement. We also delved into their strategies in overcoming any potential barriers. Compilation and statistical analysis of survey data were completed using the latest version of SPSS. Interviews deepened our understanding of the same themes, and were later transcribed verbatim (with the Spanish interviews translated into French) and coded using NVIVO. All data collection was done in accordance with our certification from the McGill Research Ethics Board.

4. Findings : Pathways to healthcare for migrant workers

19 Of the 211 respondents, 78 could be considered precarious status workers either because employment was required by their immigration status (temporary foreign workers) or because their status made work a likely necessity for survival (undocumented migrants).

It is the data of these 78 "workers" that is analysed in this article. Of these, the 26 undocumented workers (16 women, 10 men) were completely ineligible for medicare, while the 52 temporary foreign workers (TFWs – 36 women, 16 men) reached by the survey were covered by medicare but were documented as having major barriers in accessing care (Hanley et al., 2012).

20 As shown in the table below, the 211 survey respondents reported a range of health problems. Preventative, dental, and mental care – all areas of care that can be delayed but which can ultimately lead to more serious problems – were less commonly reported issues of health concern for precarious status migrants in our study. Although not the subject of this article, those with chronic problems, many of them manageable if properly treated, reported some of the highest barriers to accessing care.

TABLE 1. HEALTH PROBLEMS

Type of health problem reported by survey respondents	Proportion of all respondents	Proportion of undocumented workers	Proportion of TFWs
Chronic health problem : long-term health concerns such as muscular pain (especially back, neck, legs), diabetes, high blood pressure, thyroid, asthma, eye problems (allergies), cancer	37 %	31 %	44 %
Acute health problem : a sudden onset problem such as a broken bone (ankle, arm, leg), heart attack, appendicitis, burns, sprained back	21 %	8 %	19 %
Minor health problem : a common health concern such as a bad cold, the flu, conjunctivitis	12 %	0 %	15 %
Pregnancy and childbirth	11 %	23 %	4 %
Accident : such as automobile, fall	8 %	15 %	6 %
Mental health concern : depression, anxiety, etc.	5 %	15 %	4 %
Dental problem	3 %	8 %	4 %
Preventative health problem : Pap smear, checking blood pressure, etc.	2 %	0 %	4 %

21 We can also see some important differences in the patterns of problems that have implications for OHS professionals. Of note is that 16 people (8 % of all survey respondents) reported back pain, with a further 13 people reporting other types of muscular pain. The proportion of people reporting back pain was higher among undocumented workers (15 %) and similar for TFWs in terms of back pain (8 %), but with

TFWs reporting higher than average other types of muscular pain (10 %). Also, undocumented workers (obviously the women among them) reported much higher rates of pregnancy and childbirth than the overall survey sample. As undocumented workers, these women would not be eligible for any of the preventative leave or job reassignments normally available to women whose job puts their pregnancy at risk. Undocumented workers reported nearly double the average rate of accidents reported by the survey sample, a trend which might also indicate more risk at work. And finally, 15 % of the undocumented workers reported mental health concerns.

22 In looking at the patterns of TFW health concerns, we see that they are much closer to the sample average but quite different from undocumented workers. In particular, their chronic health concerns and interest in seeking care for minor health concerns may reflect the fact that they were screened for health problems prior to receiving their work permits and were eligible for public health insurance. Also, pregnancy was significantly lower among TFWs, a reflection perhaps of their drive to complete their contracts during the time allotted by their work permits. Pregnancy and childbirth during this time would have put them at risk of losing their jobs (illegal termination of contracts for pregnancy is relatively common (Hanley and Shragge, 2009)) and therefore their status. TFWs have difficult access to parental leave since they lose their status in many cases when they lose their jobs. Of particular interest for OHS professionals is the fact that a large number of our TFW respondents were actually Live-In Caregivers, women for whom it is very difficult to access the preventative leave provisions of Quebec's Loi sur la santé et la sécurité au travail (LSST) and who are explicitly excluded from worker compensation provisions (Hanley et al., 2010).

4.1 "What are friends for ?" : the ambiguous role of social networks

23 Given the known difficulties of migrants in accessing healthcare, we wanted to know where they turned for help when health concerns arose. Did they discuss their problem with others ? Seek advice on either how to care for themselves or where to go for help ? When we asked the migrant workers who responded to the survey, "Did you ask a friend or someone else you know for advice about the health issue experienced ?" the majority of them (65 % of undocumented workers and 67 % of TFWs) answered "yes." Clearly, social networks can be important sources of health information for migrant workers and may be an important target for the dissemination of information about health rights, health services and OHS concerns.

24 When we asked survey respondent migrant workers, "When did you ask for advice ?" the majority of them told us that they sought advice as soon as their health symptoms appeared (82 % of undocumented workers and 78 % of TFWs). Still, a number of them waited up to a year before seeking any advice from social networks (18 % of undocumented workers and 16 % of TFWs), while 6 % of TFWs waited more than a year.

25 And to whom within their social networks did migrant workers turn when they had health concerns ? For nearly half of the survey respondents (53 %), friends were the trusted persons but this proportion was somewhat lower for undocumented workers (46 %) and TFWs (44 %). Families were turned to for advice by 33 % of survey respondents but, again, rates were lower among undocumented workers and TFWs (23 % for both groups). Survey respondents only turned to other acquaintances in 6 % of cases ; this was much higher however among undocumented workers, who turned to others in 19 % of

cases, and among TFWs, 10 % of whom did so. Of particular interest in the context of this article, coworkers were the chosen confidantes for 9 % of undocumented workers (equal to the survey average), while 15 % of TFWs sought advice from colleagues, who were often the core of their social networks in Canada.

26 Our follow-up interviews indicated that the types of information sought included self-diagnosis, tips on self-care, seeking help with care or handling personal responsibilities (childcare when parents themselves were sick or having to attend medical appointments, for example). Undocumented workers needed to find health services that were open to those without health insurance and offered reasonable pricing. More specifically, undocumented migrants sought health services in which they felt free from the threat of denunciation to immigration authorities. TFWs often sought to hide their illness from their employers. Nevertheless, if they decided they did need to seek medical help, they often consulted friends to find out where the health services were located and, if possible, find services outside of work hours.

27 Of course, it is equally important to understand why migrant workers would not turn to their social networks for health advice. Among those who did not consult family, friends or acquaintances, 53 % simply felt no need to talk to others. But 14 % were embarrassed to talk to others, 10 % were unable to reach the people they would have liked to talk to, and 10 % didn't want to worry others. In interviews, precarious status migrants mentioned that their relationships simply lacked intimacy or that they desired privacy from co-workers, while others were worried that their employers would find out about their health problem if they told their co-workers. Fear of denunciation to immigration authorities was also a factor that lowered precarious status (especially undocumented) workers' comfort in consulting social networks, as we see in this exchange :

> "Q : When you were sick in bed, did you have any friends that you called to ask them what to do ?
> A : I didn't. Many of my friends did not even know that I was illegal because my wife and I choose to hide that. Because it's dangerous because they can call immigration. Because immigration give you $ 1000 when you show one person illegal.[4] That's why it was complicated.
> Q : So you couldn't share what was going on with any of your friends ?
> A : ...No, no, just the two friends, I can explain everything. But my other friends, no, because it's very sensitive. Maybe they're going to call immigration. Every time I hear a noise in the building, I think 'Oh, today's the day they're going to come to get me' – It's very hard, very hard." (Interview 201)

4.2 Time for a professional !

28 What about professional help ? When the 78 migrant workers had health problems, what proportion of them sought professional medical care ? When we asked the survey respondents, "Did you consult a health professional in Quebec about the health issue experienced ?" 77 % of the undocumented workers said "yes," while only 62 % of TFWs did so. When we asked them what type of health professional they consulted, the answers were diverse.

TABLE 2. HEALTH PROFESSIONALS CONSULTED IN QUEBEC

Type of Quebec health professional consulted[5]	All survey respondents (n =211)	Among undocumented workers (n =26)	Among TFWs (n =52)
Family doctor or GP	46 %	38 %	46 %
Specialist doctor	20 %	27 %	10 %
Nurse	7 %	8 %	4 %
Info-Santé (health info line)	6 %	4 %	8 %
Emergency services (911)	5 %	4 %	4 %
Pharmacist	4 %	4 %	2 %
Psychologist or psychiatrist	3 %	8 %	4 %
Social worker	3 %	0 %	0 %
Dentist	3 %	4 %	2 %
Other professional (midwife, physiotherapist)	4 %	12 %	0 %

29 We can observe that undocumented workers consulted family doctors or GPs less often than the average but had higher consultation of specialists, especially perhaps obstetricians due to the high rates of pregnancy among these workers. TFWs had a lower than average use of specialists, perhaps for related reasons and perhaps because most chronic health problems would have been identified prior to arrival in Canada. Waiting times are of course making it difficult for everyone in Quebec to see specialists at the moment. A surprise to us was that undocumented workers consulted Quebec professionals more often than did the TFWs. Our interviews indicated two reasons for this. First undocumented workers relied heavily on friends and family to lead them to sympathetic healthcare workers and were generally prepared to pay cash for these visits. For minor concerns, this worked out well, but the cost was prohibitive when the problem was more serious. For some precarious status workers, fear of losing their jobs was an impetus to seek healthcare when they were afraid their condition might impede their ability to work – however, they also reported waiting as long as possible before making the decision :

> "From Thursday until the next Wednesday... I was going around vomiting and shivers in my body [but still working], and I just didn't know what to do anymore. It got into my head that maybe I could call an ambulance, but I decided not to out of fear of the reaction of the employer. So that Thursday was my day off and I took advantage of it to bother a Quebecois friend...And it was because of him that I was able to get to the hospital, where I spent about 7 hours. My sickness was a virus that I had—if it weren't for that friend I don't know what would have happened to me. I don't know what risks I would've been running..." (Interview S01)

30 When we asked survey respondents where they consulted professionals, 22 % of them consulted by appointment in a professional's office. This was higher among undocumented workers (27 %) and slightly lower among TFWs (19 %). Private walk-in clinics were used by both groups at rates similar to the average (29 % overall ; 27 % undocumented workers ; 31 % TFW) but we can see that TFWs made much more use of walk-in clinics than family doctors. This is perhaps due to the clinics' more flexible opening hours that may better correspond to TFWs often heavy work schedules. Undocumented workers and TFWs made significantly less use of hospital emergency rooms than the average survey respondent (28 % overall ; 15 % undocumented workers ; 12 % TFWs). Both groups of workers may have seen hospitals as representatives of the state and more likely to share information with immigration services. Quebec's network of public community clinics (CLSCs), meant to be an accessible door of entry into Quebec's healthcare system, accounted for only 17 % of overall consultations, with only 8 % of undocumented workers and 4 % of TFWs making use of them. Even when they did see a professional, however, they often encountered barriers (N.B., these are addressed in another section of the survey). Immigration status and healthcare entitlement were frequently an issue :

> "Being a permanent resident or an accepted refugee or something, that was a status that allows them to help you. We had another kind of status. I mean, we have access to healthcare "in quotation marks"... (Interview S03)

31 For TFWs who lived on the employer's premises – especially farmworkers – transportation to a health professional was key and, often, they were reliant on the employer to identify and transport them to healthcare services :

> "What happens is that the company doesn't take you to the hospital when you want, but when *they* want to... They took me to the hospital and all they did was give me some medicine so that I could keep working." (Interview S07)

32 The migrant workers who did not consult a medical professional had diverse reasons. Of those who did not consult, 17 % of the undocumented workers and 5 % of TFWs chose not to because they were confident they did not need a health professional to deal with their health concern. Others chose not to consult a doctor out of preference, out of avoidance of barriers, or out of fear of being denounced to immigration authorities or employers (33 % undocumented workers ; 40 % TFWs). Furthermore, 83 % of undocumented workers and 25 % of TFWs who did not consult a health professional in Quebec did not do so because they were able to consult a health professional in their country of origin, a rate much higher than the overall survey respondents (19 %). But disturbingly, a high proportion of migrant workers who did not consult *tried to* but were prevented from doing so. Fully 50 % of undocumented workers and 35 % of the TFWs who did not consult were blocked in their efforts to do so by a host of barriers, including the personal chaos that can accompany precarious status, as we hear from this agricultural agency worker :

> "I don't have a normal job, I don't have a normal income, and I don't have that time to go through all that [figuring out how to consult a health professional] because I already adjusted my lifestyle to that craziness. It kind of makes the other side [regular appointments] impossible." (Interview 125)

33 In the survey, respondents reported such barriers as a professional's refusal to accept uninsured patients, the high cost of fee-for-service, lack of knowledge about where to get help, lack of time off work, discrimination, and language barriers. For the TFWs, health problems are well-known reasons for workers to either be sent home or, in the case of

SAWP workers, not called back to work in Canada the following year, as we see in this story :

> "There was a young guy who was my friend. Everybody at work really placed trust in him, and friendship. And from one minute to the next this friend got very bad, he had some kind of psychological problem that was really bad, for which they treated him like an animal at work. Because what the supervisors did was to send everyone else to work and to keep him in the bus all day. ...Eventually, this youth was returned to Guatemala and I don't know what became of him in our country. What happened is that we demanded of our employer that they take him to the hospital, but they spent a number of days being pretty discriminatory with him, because they put him in the bus, or left him in the cafeteria there all alone, and the truth is he was in pretty bad shape." (Interview S01)

34 The TFWs interviewed reported avoiding seeking healthcare if it was at all possible for them to continue working, thereby avoiding the risk of the employer discovering they were sick.

4.3 Transnational health consultations

35 Another interesting phenomenon we encountered was that consulting in Quebec did not preclude consulting a health professional in the country of origin. Transnational consultations – whether via telecommunications (phone calls, e-mail) or via a trip to the country of origin – were very common, with a notable 42 % of undocumented workers contacting someone in their country of origin, 29 % among TFWs, and 30 % among overall survey respondents. When we asked the respondents why they chose to engage in transnational consultation, the answers were varied.

TABLE 3. REASONS FOR TRANSNATIONAL CONSULTATIONS

Reason for transnational consultation[6]	**Among all survey respondents**	**Among undocumented workers**	**Among TFWs**
Less expensive	18 %	27 %	27 %
More confidence in professionals from country of origin	39 %	36 %	53 %
More accessible (e.g., contacting professional, no language barriers)	22 %	55 %	20 %
Relative or friend in country of origin who was health professional	7 %	18 %	0 %
Other	15 %	9 %	27 %

36 Here an agricultural agency worker explains his reluctance to seek treatment for his health problem :

> "I was more concerned, generally, that I keep a low [health] profile. Because they ask you a lot of questions in immigration about your health status. I mean, I would never have told them that I have narcolepsy. I would have never told them if I had

> anything. I mean, nobody tells these things because you don't want... You get confused, right ?" (Interview 125)

37 While the survey captured the range of types of transnational consultations, the interviews flushed out more details, such as having medications or medical equipment sent from the home country, returning to the home country for convalescence, or requesting a family member from home to come and help care for them or their family while they were sick.

38 This finding was an important indication of the way in which migrant workers find solutions for accessing healthcare that are less common among Canadian-born workers. If we want to understand their responses to difficulties in accessing the public health system or to discomfort with and lack of knowledge of this system, it is essential to take transnational consultations into account.

5. Discussion : how might migrant workers' pathways to healthcare be influencing occupational health trajectories ?

39 It is well established that migrant workers will be of increasing importance to Canadian society (Faraday, 2012 ; Worswick, 2010) and that the increase in diversity is essential to consider if we aim to promote equity in access to healthcare and social services (Gushulak et al., 2011 ; Oxman-Martinez and Hanley, 2005). As migrant workers enter Canada with a variety of immigration statuses, these statuses translate into an array of entitlements ranging from no access to public healthcare (for undocumented workers, permanent residents during their 3-month waiting period before receiving RAMQ, international students[7]), to limited forms of public health insurance (for refugee claimants, people on moratorium, and accepted refugees who are offered the Interim Federal Health Program[8]), to full coverage by RAMQ (for temporary foreign workers) (Sikka et al., 2011). In line with a concern to uphold ethical standards in ensuring equal access to OHS services for workers regardless of their immigration status (Gravel and Raynault, 2010), this article suggests that migrant workers with two particular statuses (undocumented workers and TFWs) have surprising and varied pathways to healthcare that may have an impact on their occupational health trajectories.

40 The first area of interest to OHS professionals is that of the particular **healthcare concerns** raised by our survey respondents. We noted above that the undocumented workers in our study reported higher than average rates of pregnancy and childbirth. From an OHS perspective, this is important to consider. In many occupations, pregnancy is a condition that warrants protections from occupational risks via such measures as available under Quebec OHS legislation (Lippel, 1998), including job reassignment, special protective equipment, and preventive leave. As we have mentioned above, undocumented workers are overrepresented in risky employment and have little leverage to demand the accommodations that are normally expected in the case of pregnancy. In the absence of access to doctors, whose opinions are necessary for the purpose of triggering protective reassignment rights, are undocumented women workers thereby more at risk during their pregnancies ? Do they face the difficult choice of either continuing in a risky job or losing all their income ?

41 Of particular interest to the topic of this article is that the scholarly literature has called for an understanding of immigrant resources and strategies related to health. Beiser (2005) points out that, "A comprehensive model of health and immigration must incorporate the supportive and stress-buffering effects of personal and social resources" rather than focusing exclusively on measures of good and bad health status. Our survey respondents noted their reliance on **social networks** to access important information about how to maximize their self-care and how to safely access healthcare when necessary. Studies have highlighted the lack of social support as a barrier to healthcare (Teng et al., 2007), yet few studies examine the role of social support in overcoming such barriers.

42 It is interesting that migrant workers turned to close friends and family for health-related advice, even though it is known that the information received from such networks about the healthcare system is often erroneous (Gravel et al. , 2012). Also of note is that the migrants highlighted in this article – undocumented workers and TFWs – made somewhat less use of social networks than the overall survey sample. As we noted above, these workers reported in interviews that, due to their particularly precarious immigration status, they feared the repercussions of others learning about their health problems. Because of the high stakes related to their work in Canada, they reported wanting to avoid causing stress and concern to their family members relying on their income. Of note, as well, was that TFWs reported more often than other survey respondents that they turned to work colleagues for advice and support, a reflection of the centrality of work to TFWs' social networks here in Canada. They were often separated from their families and many (with the exception of LCP workers) shared accommodation with colleagues. What does this tell OHS professionals about reaching out to migrant workers ? We can see that social networks remain important to migrant workers as transmitters of information about health and, most probably, occupational health. However, direct contact with individual workers through such formats as workshops may be more important than with the general population.

43 Despite the many barriers faced by migrant workers in accessing healthcare, most of those we surveyed managed to **consult a Quebec professional** when they made up their mind about doing so. Our study does not allow us to measure the health outcomes of these consultations but they are, at a minimum, a foot in the door. A surprise to us was that undocumented workers consulted Quebec professionals more than the TFWs, given that TFWs have RAMQ coverage while undocumented workers do not. They must usually personally pay for their healthcare consultations but still consulted more often than did TFWs. Of particular interest to OHS professionals, though, is the delay in consulting a healthcare professional. Rapid consultation with a healthcare professional in cases of workplace accidents or illnesses – and the worker specifying to the healthcare professional that the injury or illness is work-related – are critical factors to successful workers' compensation claims. As reported by undocumented workers and TFWs, they tended to delay consulting in their efforts to work through the health problem, retain their income, or avoid detection by employers or immigration authorities. This in turn would seem to have major implications for workers' compensation claims. This issue suggests a need for serious education about the importance of rapid consultation while identifying the work-related nature of the problem. This is a problem in the general population but the results of this study suggest it is exacerbated among migrant workers.

44 Finally, we were struck by the high proportion of both undocumented workers and TFWs who consulted **health professionals in their country of origin**. It is a reflection on both migrant workers' continued connection to their countries of origin but also on their resourcefulness when faced with barriers in accessing the Quebec system. It is also a reflection on their desire to keep their health problems secret both from their employers, as mentioned above, and from Citizenship and Immigration Canada, as several interviewees reported fearing that documentation of their health concerns might be held against them if they sought permanent residency. It is very difficult to have foreign medical opinions accepted for workers' compensation claims and foreign treatment is very difficult to have recognized and reimbursed. The common practice among undocumented workers and TFWs of consulting transnational health professionals makes it very difficult for them to document and maintain their claims to the required standards of the CSST.

6. Conclusion

45 The workers who responded to our survey – especially undocumented workers and temporary foreign workers – shared their strategies for seeking help when they had health concerns. As we discussed, difficulties and delays in accessing healthcare in a timely manner can have repercussions on workers' eventual compensation claims, particularly in Québec, where a file requires a medical opinion from the outset. This is also true for preventive reassignment requests by pregnant or breastfeeding workers. If a worker's access to healthcare during periods of injury or illness is compromised, either because of geographic isolation, as is the case for SAWP workers and LCP workers, or because of a lack of healthcare coverage, this can also hinder the workers' compensation board's ability to manage the claim. It is thus important for those professionals concerned with workers' compensation to better understand that, when precarious status workers do get hurt or sick on the job, they may face barriers in accessing the public system, not have the proper information about what health services are available, avoid or delay seeking healthcare due to cost, seek healthcare transnationally so that there is no Quebec record, and, finally, hide their health condition from their employer.

46 Migrant workers may face an accumulation of vulnerabilities when it comes to OHS, namely : precarious immigration status, limited public healthcare entitlements, precarious employment, low income, and racial discrimination (Jamieson et al., 2011 ; Sikka et al., 2011). A recent initiative in Quebec was the creation of a roundtable on the issue of immigration and OHS. The table brings together immigration, employment and OHS actors with the goal of improving immigrant workers' trajectory through the service system, taking into account their atypical profile within both the health and SST systems. Understanding how these vulnerabilities interact is a growing challenge facing OHS professionals, a challenge worth taking on if we are to respect the legal and human rights of migrant workers.

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NOTES

1. Undocumented migrants to Canada do not all join the workforce. Some depend on family, friends or charity for their basic needs. Without access to any form of income support, however, undocumented migrants are very likely to be working. In our sample, 20 of the 26 undocumented migrants were working at the time of the health problem described in the survey. For the sake of simplicity, we refer to all of them as "undocumented workers" in this article.
2. Foreign students must provide proof of health insurance coverage in order to receive their immigration visa.
3. This study was conducted prior to the major changes to the IFHP that came into force in June 2012. With the important cutbacks implemented with the IFHP reform (fewer services covered, certain categories of claimants receiving only very limited coverage for "public health and security" concerns), it seems a reasonable hypothesis that access to healthcare has become more difficult for refugee claimants since that time.
4. It is important to note that, in contrast to the fear of the person cited here, the Canadian government does not offer money to members of the general public for denouncing illegal immigrants. However, the Canadian Border Services Agency does maintain a network of informants who are paid to report on organized immigration offences.
5. More than one answer possible.
6. More than one answer possible.
7. International students have no public healthcare but are usually covered by a private health insurance plan as required by their visa and study permit conditions. They often work on campus and can also obtain off-campus work permits.
8. These different categories of refugees are often working with an open work permit.

ABSTRACTS

The aim of this study was to analyze the temporal dimension of seasonal work and to identify determinants for the sustainable prevention of musculoskeletal disorders. An ergonomic work activity study with a gender-sensitive approach was conducted. Sixteen female seafood-processing workers were monitored for two consecutive work seasons using a range of interviews, observations (work activity, production, and organization) and document analyses. The results led to the development of methodological elements for the study of seasonal work. The results also showed that the work activity could be seriously influenced by determinants pertaining to public policies and ministerial rules. Sustainable prevention of musculoskeletal disorders must consider these determinants.

Cet article présente les résultats d'une étude exploratoire sur l'accès aux services de santé des migrants à statut précaire. Une enquête a été menée auprès de 211 hommes et femmes migrants, et parmi ceux-ci, 31 ont été retenus pour un entretien en profondeur. Pour cet article, nous présentons les résultats concernant 78 travailleurs comprenant ceux recrutés en tant que travailleurs (travailleurs étrangers temporaires) ou qui n'ont pas d'accès au filet de sécurité sociale et doivent habituellement travailler (les sans-papiers). Une revue de la littérature est

présentée, reliant le statut migratoire à l'accès aux soins de santé et aux problèmes de santé au travail. Nous présentons la méthodologie et ensuite les résultats qui décrivent les réseaux sociaux auxquels les travailleurs migrants ont recours pour répondre à leurs préoccupations en matière de santé, comprenant notamment les professionnels du Québec, et des ressources transnationales en santé. Ces résultats pourront être utiles aux professionnels de la SST pour comprendre certains obstacles auxquels font face les travailleurs migrants ayant subi un accident du travail ou une maladie professionnelle. Les difficultés d'accès aux soins de santé peuvent-elles compromettre le recours des travailleurs migrants victimes de lésions professionnelles ?

Este artículo presenta los resultados de un estudio exploratorio sobre las experiencias de los migrantes de estatus precario cuando tratan de acceder a los servicios de salud. Se encuestaron a 211 hombres y mujeres inmigrantes y se hicieron 31 entrevistas semi-estructuradas de seguimiento. A los efectos de este artículo, se presenta los resultados de 78 encuestados que fueron reclutados, específicamente como trabajadores (trabajadores extranjeros temporales) o que no tienen acceso a la ayuda económica y que por ello deben probablemente estar trabajando (indocumentados). Comenzamos el artículo con un resumen de la literatura que vincula el estatus migratorio a un difícil acceso a los servicios de salud así como a un mayor riesgo de problemas de salud y seguridad ocupacional. Después de la presentación de los métodos, nos volvemos a los resultados, describiendo como los trabajadores migrantes utilizan una combinación de redes sociales, que comprenden profesionales de Quebec y recursos transnacionales en salud, para hacer frente a sus problemas de salud. Los resultados ofrecen información a los profesionales de salud y seguridad ocupacional que buscan entender las diferencias en cuanto a consecuencias para los migrantes que sufren accidentes o enfermedades laborales. ¿Puede el difícil acceso a los servicios médicos convertirse en un obstáculo para pleno uso de estos recursos de la parte de los trabajadores migrantes en casos de enfermedades o lesiones profesionales ?

INDEX

Mots-clés: travailleurs migrants, services de santé, santé et sécurité au travail, assurance maladie, immigration
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