Temporary migration, chronic effects: the health of international migrant workers in Canada

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Increasing numbers of international migrant workers, particularly those filling low-skill occupations in agriculture and private households, present new health challenges. One concern identified by affluent countries receiving migrant workers is that the sending countries tend to have higher rates of disease and weaker and less accessible health care systems, which increases the risk of disease importation. Whereas the United States and France are Canada’s leading source countries for highly skilled migrant workers, Mexico and the Philippines — middle-income countries with high prevalences of infectious diseases — are major sources of low-skill workers. This has important implications for public health systems in Canada and in the countries of origin.

Canada welcomes more net immigrants per capita than any other country. Although Canada’s immigration policy includes humanitarian and social concerns, attracting skilled workers for economic purposes has been paramount. In 2008, economic immigrants accounted for 60.3% of those admitted as permanent residents. Accordingly, permanent migration flows of skilled workers have tended to dominate policy and research agendas on immigration, whereas much less is known about migrant workers on temporary visas who are invited to work but not to stay.

The number of workers entering Canada on temporary visas has increased dramatically in recent years. Some 60% of migrant workers are filling occupations designated as low skilled, primarily as farm workers and live-in caregivers (Table 1). In 2002, the federal government began implementing measures designed to liberalize flows of migrant workers, including launching an initiative that allows employers in any economic sector to hire workers from abroad to fill low-skill occupations. Although the economic downturn has brought these strategies under review, provincial and federal governments remain committed to hiring migrant workers for certain jobs.

The growing recruitment of migrant workers is occurring across the industrialized West. Labour migration takes many forms, such as the free movement of European Union citizens from poorer member states to richer ones, and the largely unauthorized (but tacitly accepted) movement of Mexicans to the United States. Canada is unique internationally, because most of its migrant workers enter under legal work permits such as temporary employment authorizations.

Migration and public health

Increased labour migration poses challenges with respect to public health management. One concern identified by affluent countries receiving migrant workers is that the sending countries tend to have higher rates of disease and weaker and less accessible health care systems, which increases the risk of disease importation. Whereas the United States and France are Canada’s leading source countries for highly skilled migrant workers, Mexico and the Philippines — middle-income countries with high prevalences of infectious diseases — are major sources of low-skill workers. This has important implications for public health systems in Canada and in the countries of origin.

**Key points**

- Increasing numbers of international migrant workers, particularly those filling low-skill occupations in agriculture and private households, present new health challenges.
- Migrant workers tend to arrive healthy but work in jobs with existing health and safety concerns.
- Other health risks include those associated with substandard working or living conditions.
- Reasons why migrant workers may not seek health care include economic and language barriers, work schedules and a fear that use of health services might threaten their employment or immigration status.

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income countries with arguably less robust health care systems — supply most of Canada’s low-skilled migrant workers (Box 1†).

For example, the rapid spread of pandemic (H1N1) influenza in Mexico in April 2009 and its outbreak worldwide led to fears among Canadians of potential transmission from the 18,000 migrant farm workers who travel from Mexico to Canada annually.12,13 Although the World Health Organization recognized that containment through restrictions on international travel was not feasible, Mexican officials immediately implemented pre-departure screening of farm workers in anticipation of negative public opinion that could threaten flows of migrant workers.14,15 Meanwhile, the Public Health Agency of Canada issued bulletins outlining the process of screening migrant farm workers and provided information to employers regarding how to identify and respond to suspected cases of pandemic (H1N1) influenza.16

Initial public reaction to “swine flu” that focused on the risk of migrant workers importing the disease reflects how migration and health issues are often framed. First, migrant workers — often people belonging to racially defined groups — are seen as potential vectors of disease.14,16 Scientific evidence shows, however, that migrant workers often are healthier upon entry than their counterparts in receiving countries or their nonmigrating peers at home because of medical prescreening, selection bias and healthy behaviours, referred to as the “healthy migrant effect.”19 Second, although labour migration does play a role in disease transmission, other factors such as increased trade and tourism are more salient.20 Finally, a focus on disease importation often results in health risks to migrant workers within receiving countries being under-examined, despite their potential to adversely affect migrant workers’ health or to lead to serious public health concerns.21,22

The health risks to migrant agricultural workers in particular have been underexamined. In North America, employers often provide overcrowded housing for farm workers, which increases the risk of transmission of infectious diseases such as tuberculosis.23,24 Poor sanitation and inadequate means to refrigerate and heat food, along with insufficient toilet and handwashing facilities at worksites, may also heighten the risk of farm workers developing and spreading enteric, food- and waterborne diseases.25,26 The implications for Canada’s food system, given the increasing numbers of migrant workers employed in agriculture, meat processing and food services, is a major public health concern.27 In 2007, for example, more than 30,000 confirmed positions for international migrant workers were in the agrifood sector, including jobs such as hand-harvesting, meat cutting and butchering, and the processing, preparation and serving of food and beverages.28

**Health risks to migrant workers**

In most affluent countries, reliable statistics are not available to determine whether international migrant workers are in a higher risk category than local workers.27 Research in Europe indicates, however, that migrant workers may be at increased risk of workplace injuries or accidents because they are concentrated in occupations typically rejected by local residents because of existing health and safety concerns.27–29 Jobs in agriculture and live-in caregiving constitute two such occupations in Canada and worldwide.30,31 Studies have shown that migrant farm workers face elevated workplace health and safety risks,

### Table 1: Number of positions approved for international migrant workers on temporary work permits by skill level from 2006 to 2009*

| Skill level of position | 2006 | 2007 | 2008 | 2009 |
|-------------------------|------|------|------|------|
| Low skill               |      |      |      |      |
| Pilot Project for Occupations Requiring Lower Levels of Formal Training (National Occupation Classification codes C and D)† | 12 304 | 32 277 | 66 460 | 30 488 |
| Live-in Caregiver Program | 25 632 | 33 532 | 34 732 | 20 861 |
| Seasonal Agricultural Worker Program | 24 050 | 26 622 | 28 231 | 27 654 |
| Total, low skill        | 61 986 | 92 431 | 129 423 | 79 003 |
| High skill (managerial/professional/skilled)‡ | 52 893 | 63 057 | 74 545 | 52 371 |
| Total                   | 114 879 | 155 488 | 203 968 | 131 374 |

*Figures reflect positions approved by Human Resources and Skills Development Canada through a labour market opinion as opposed to the number of actual positions filled. In addition, not all people with a temporary work visa require a labour market opinion to receive a work permit.
†National Occupation Classification (NOC) codes identify skill levels that correspond to the type and amount of training or education typically required to work in an occupation (0 = management occupations, A = professionals, B = skilled and technical, C = intermediate and clerical, D = elemental and labourers). For this table, codes B, A and B refer to high-skill positions, and codes C and D refer to low-skill positions.
‡This category includes occupations designated as high skilled (NOC codes 0, A and B) as well as occupations outside of the programs listed in the table.
Source: Human Resources and Skills Development Canada.11

### Box 1: Facts and figures about temporary migrant workers in Canada in 2008

- Number of migrant workers admitted to Canada: 192 519
- Top sending countries: United States (31 399), Mexico (20 900) and the Philippines (19 253)
- Ratio of men to women admitted: 2:1
- Total number of migrant workers in Canada as of Dec. 1, 2008: 251 235
- Three top employers by province: Ontario (91 276), British Columbia (58 307) and Alberta (57 707)

Source: Human Resources and Skills Development Canada.11
with common health problems related to chemical exposure, single-event injury and musculoskeletal injuries. A study of farm workers in the United Kingdom, most of whom were migrant workers, showed that self-perceived health status was significantly lower than population norms. For migrant caregivers, working conditions have also been linked to a range of physical and mental health problems.

Migrant workers may also face additional risks in their status as new workers. They may receive less training than local workers or confront language barriers that render training less effective. Given the considerable wage differentials between countries sending and those receiving migrant workers, migrant workers may also act to protect their jobs in ways that could increase workplace health and safety risks. For example, research has shown that migrant workers are less likely than local workers to request safety equipment or report potential hazards or accidents, and more likely to accept unsafe work or work when ill or injured, because of a fear of loss of employment or legal status. Migrant workers often work longer hours than local workers because of the precarious nature of their jobs, a desire to maximize earnings and limited social commitments outside work, since many are not allowed or able to migrate with their families. Research in the United Kingdom has shown that, in addition to working longer hours, migrant workers are more likely to be employed in working patterns or conditions that can contribute to health and safety risks, such as night shifts.

In Canada, migrant workers filling low-skill jobs are particularly vulnerable because their work visas are tied to a single, named employer, and changing employers is difficult. In Canada, migrant farm workers and caregivers often live on their employers’ property. For farm workers, weak regulation and poor enforcement has meant that some housing is dilapidated, unsanitary, overcrowded and poorly ventilated. In surveys of migrant farm workers, 37% in British Columbia and 27% in Ontario perceived their housing to be damaging to their health. For migrant caregivers, the live-in arrangement has left some women vulnerable to sexual harassment, while fears of interference or threats to their employment and immigration status have impeded the reporting of complaints. Marginalization, discrimination and isolation augment the stress and loneliness experienced by migrant workers coping with family separation, social and geographic isolation, and little or no opportunities for recreational activities.

Research in Korea has shown that isolation and the anonymity afforded while being in a foreign country lead some migrant workers to take risks that expose them to sexually transmitted infections. Lack of knowledge about prevention programs further increases the likelihood of transmission between migrant workers and people in the communities in which they reside. In the United States, migrant farm workers have been found to be at higher risk of depression, anxiety, suicide and substance abuse than the general population. Research has corroborated similarly heightened risks of sexually transmitted infection and mental illness among migrant farm workers in Canada.

As stated earlier, Canada is unique internationally because most of its migrant workers are employed under legal employment authorizations. Migrant workers without legal documents face different challenges that affect their health status. They tend to undergo long, dangerous journeys, spend periods living precariously in transit to their destinations and are often confined upon arrival in detention camps. The health-related issues that result have been less acute in Canada than in other affluent Western countries that receive high numbers of unauthorized migrant workers, such as the United States, France and Spain.

Canada’s increasingly restrictive immigration and refugee policies, however, are cause for some concern. For one, migrant workers must resort to ever more dangerous routes to enter the country, as highlighted by the 76 Tamil would-be migrant workers who arrived off Vancouver Island in October 2009. Second, few migrant workers entering on a temporary work visa (which lasts 24 months at most for lower-skilled workers) have legal avenues to stay in the country after the

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**Box 2: Factors that heighten vulnerability of migrant workers in low-skill occupations**

- Frequent and temporary migration
- Migration status dependent on employment status, work permit tied to employer
- Concentration in occupations with existing health and safety concerns
- Insufficient health screening in countries of origin and destination
- Barriers to health care, health insurance
- Lack of independent monitoring of health and safety violations
- Insufficient safety equipment and training
- Lack of information, representation and support
- Poor and underregulated housing
- Social exclusion, isolation
- Linguistic and cultural differences, high rates of illiteracy
- Lack of mechanism to assist workers in changing employers
- No direct path to permanent residency
- Debts to third-party recruiters and intermediaries
Analysis

• Cross-national and international comparative analyses are hampered by the lack of a single accepted definition of migrant status and methods of identification, as well as a lack of reliable and valid health care data.

Migrant workers are a heterogeneous population. Researchers must take into account diverse premigration histories, the circumstances under which migration occurs, and distinct realities of employment and settlement. Cross-national and international comparative analyses are hampered by the lack of a single accepted definition of migrant status and methods of identification, as well as a lack of reliable and valid health care data.

Box 3: Research gaps

- Knowledge of health issues associated with labour migration to Canada and internationally is inadequate.
- Clinical studies involving migrant workers in Canada are lacking, as is a greater understanding of the social context of health issues of migrant workers.
- Challenges to research involving migrant workers — a less visible population within Canadian society — are further hindered by restrictive access to government data.
- Migrant workers are a heterogeneous population. Researchers must take into account diverse premigration histories, the circumstances under which migration occurs, and distinct realities of employment and settlement.
- Cross-national and international comparative analyses are hampered by the lack of a single accepted definition of migrant status and methods of identification, as well as a lack of reliable and valid health care data.

Access to medical care

Research on migrant workers’ access to medical care is limited. Although studies exploring their use of health care services are available, the diversity in the definition of migrant status and control of variables complicates cross-national and international comparative analyses.

Despite shortcomings in the data, research in Europe indicates systematic differences in utilization patterns among migrant workers that are likely due to problems of access to health care. Other studies have identified a range of barriers to health care for migrant workers in Europe, Oceania and North America, even in countries where access to health care is guaranteed. Economic barriers are substantial. Uncertainty regarding whether migrants will have to pay for treatment, as well as the cost of the treatment, contribute to delays in access. In Canada, many authorized migrant workers are not eligible for publicly funded health care until three months following arrival, and undocumented migrant workers may have no access at all.

Although private insurance may fill this gap, service provision that obliges users to pay up front can lead some workers to forgo medical care. Linguistic and cultural differences have been identified as barriers to migrant workers’ willingness to seek health care and the quality of treatment they receive. Lack of linguistic and cultural sensitivity on the part of health care providers and employers can lead to perceptions of substandard care among migrant workers and become a barrier to access.

In a study of the use of health services among international migrant workers in Portugal, 18% of respondents identified providers’ attitudes as a barrier to access. Medical professionals are generally not trained and lack the resources to recognize the social context of migrant workers’ health, which results in a failure to acknowledge, address and treat their health concerns adequately.

Moreover, migrant workers in low-skill occupations often work long hours, which leaves them little time to seek health care or available time that does not coincide with clinic hours. Lack of information, and physical and social isolation act as additional barriers to medical treatment, and in particular live-in caregivers may face workplace-related isolation. In Canada, migrant workers in rural or remote settings may find that walk-in clinics — often their first contact with the health care system — do not recognize private insurance or lack the diagnostic equipment or specialization to detect workplace-related health concerns.

Migrant workers may also fail to use health services out of fear that it will interfere or threaten their employment and immigration status. In Canada, stipulations that obligate migrant live-in caregivers and farm workers to reside on their employers’ property may contribute to delays in seeking medical care if migrant workers are reticent to inform employers of their health concerns. Migrant farm workers, for example, have been repatriated for becoming ill, injured or pregnant while working in Canada; this has led women to conceal or terminate pregnancies and to forgo antenatal care. Live-in caregivers may also fear that raising concerns or seeking available services could risk deportation or jeopardize their application for permanent residency, for which they are eligible after 24 months of continuous employment.

Limited literacy, language barriers and fear are also major barriers to reporting accidents or filing for workers’ compensation. At times, injured migrant workers have found themselves ineligible for compensation because they had been told to perform tasks outside their job description or to work for someone other than their employer. Research has documented instances of employers discouraging or impeding migrant workers from filing claims and of migrant workers having difficulties claiming for compensation after being deported. Finally, health care practitioners often lack sufficient knowledge of migrant workers’ eligibility for workers’ compensation or the procedures involved.
Conclusion

Popular portrayals of migrant workers as “vectors of disease” who ought to be stopped at the border are misleading. International migrant workers tend to arrive healthy, and all undergo medical screening as part of their visa application. If their health status deteriorates while in Canada, it is more likely due to their new working and living conditions than a pre-existing condition. Furthermore, migrant workers’ vulnerability may lead to delays or failure to report health concerns or receive treatment, a situation that can lead to more serious public health problems, both in Canada and in the countries of origin. Although labour migration through the Foreign Worker Program is intended to be temporary, the consequences are likely to be increasingly permanent for migrant workers and Canadians alike.

International migrant workers comprise an extremely diverse group and undoubtedly, specific categories of temporary workers will be at greater risk than others in terms of health outcomes. In this article, we have focused on the limited literature on migrant workers in low-skill occupations. More detailed and reliable information on health risks, outcomes and disease transmissibility among migrant workers is needed to provide adequate health care to this vulnerable group, to track and monitor occupational and communicable diseases, and to develop effective interventions (Box 3).

Some immediate measures to better address health issues of migrant workers include granting them immediate access to provincial health care upon arrival; exercising more stringent enforcement of workplace health and safety; implementing medical screening at the end of the work term that guarantees workers receive adequate care before returning home; and improving the delivery of health and safety information to migrant workers and health care practitioners.

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