

Low Wage Injured Workers and Access to Clinical Care: A Policy Analysis

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Background

Access to comprehensive clinical occupational health services for low-wage immigrant workers¹ in California is currently hindered by multiple obstacles, including underreporting of injuries and illnesses, lack of health insurance and other benefits, low rates of unionization, fear of reporting injuries, lack of knowledge of workers’ compensation benefits, language barriers, and minimal occupational health expertise among health care providers available to this population. After an injury occurs, it is often difficult to gain employer cooperation to remedy the unsafe working conditions for the low wage worker, thereby delaying prevention efforts for the rest of the workforce. If low wage workers do report their injuries, they may be affected by recent changes in workers’ compensation law which restrict choice of physicians within medical provider networks, proscribe treatment according to ACOEM guidelines, and reduce wage replacement in the event of permanent disability.

¹ This report looks at problems confronting low-wage and immigrant workers in California and elsewhere. Immigrant workers may be documented or undocumented, sometimes referred to as legal and illegal immigrants under federal immigration law. Some of these workers have access to health insurance through their jobs, but many do not. In many cases, the status is unknown, but as shown in the body of the paper, the greatest risks occur to those who are undocumented and who do not have English as their primary language.

There is currently no comprehensive system in California to provide coordinated occupational clinical, preventive and legal assistance to low wage workers. Occupational health care is delivered by hundreds, if not thousands of individual clinics and health care providers in California. For the individual practitioner, designing the comprehensive services that are needed is beyond their limited capacity, and for many they are not aware of referral resources that may be available. The County and community clinics that provide general health services to uninsured California workers typically cannot take on the additional time and resources that would be needed to provide occupational health services as well. Many for-profit clinic chains operate on a fee for service basis and are not reimbursed for provision of the comprehensive services that are needed by low wage workers. University-based occupational medicine or occupational health and safety programs are designed for consultation, training and research, and cannot provide easy access to direct care that is needed by injured workers.

Overview and Objective

Low wage immigrant workers are vulnerable members of society. Law and policy toward undocumented workers, at federal, state and local levels is an evolving area. In many cases, Federal policy has been to criminalize unlawful work by immigrants without permits or papers; for instance, Federal immigration agencies have staged raids on workplaces to find and penalize workers while posing as agents of the Occupational Safety and Health Administration. Some states and localities have passed laws criminalizing residence or receipt of benefits by undocumented immigrants.

In the national Congress, 2007 will likely be the stage for crafting new federal immigration policy. The new leadership in the House and Senate have given notice that they seek to overturn aspects of the 1996 immigration law and restore due process protections to permanent residents. As of early 2007, the Democratic plank promotes four principles:

- Immigration policies must support family reunification
- Eligible immigrants should be allowed to apply for earned legalization
- Border safety must address practical realities, and bridge gaps between current immigration policies and the dangerous realities facing migrants.
- Enhanced temporary worker programs providing a mechanism for workers who wish to move from their home country to do so with a process toward permanent residency if desired.

California State policy on workers' compensation (LC 3351) clearly says that as long as someone is working, whether "lawfully or unlawfully employed", whether naturalized or immigrant, the injured worker is entitled to rights and benefits as an employee. Under new initiatives to insure the uninsured, State policy as to the relationship of workers' compensation to health insurance benefits is also in flux. The governor's proposals of 2007 includes a pilot revival of the "one-window" concept first tested officially in California in 24-hour projects of the early 1990s, during another era of major interest in insuring the uninsured. The 24-hour concept is meant to reduce the

expensive determination of causation and responsibility by combining all health coverage into a blanket policy, including care for injuries on the job.

The treatment of low wage immigrant workers who are injured on the job is an issue that crosses many topic areas. This report analyzes federal and state law and policy about rights and access to clinical care services for both prevention and treatment of worker related injury/illness for low wage workers, and makes recommendations to create a sustainable set of services for this vulnerable population. The report describes:

- The population of low-wage immigrant workers (LWIW) in California;
- To the extent possible, the occupational injury and illness burden, and health and safety problems among the population;
- Obstacles to access to comprehensive clinical occupational health services for low-wage workers;
- Formal law and informal practice with respect to use of the workers' compensation system by LWIW;
- The role of community health clinics and other health care providers in providing care to injured workers in the sector; and makes recommendations regarding improving access to care and reimbursement policies for care to vulnerable populations.

The report is intended to be part of an ongoing investigation into the nexus between public health injury and illness prevention efforts and workers' compensation policy, particularly in California. In researching the report, it became clear that the issues of low wage and immigrant workers are national problems that are manifesting in many different types of industries and workplaces, and in many regions, and that there is little consensus among the various states in how to deal with the issues. At this point, much of the policy development, legal decisions, and service options are unstable and there is no clear direction for the future. The overall goal of this project is to discuss and provide an understanding of these background issues in order to develop policy options and methods for establishing a program in California for the delivery of coordinated, comprehensive occupational health and workers' compensation services for low wage workers and their employers, at all levels of prevention. The results are intended for informed discussion of health and compensation policy development and for implementation at regulatory and legislative levels.

The bigger picture is that the decisions made at the juncture of huge issues such as immigration policy, the social safety net, homeland security, and access to health care and healthy working environments help define what kind of society we want to live in and how we treat the vulnerable populations among us. As increasing amounts of global trade and interaction continue, we must look for a basic justice and dignity for all workers.

“The great void in the US discussion of immigration policy, which today seems to split the society as well as its political representatives, is the absence of a clearly articulated vision of the role of immigration in the society's future. It combines dangerously with the deeply rooted sense of American exceptionalism, which keeps many Americans from recognizing that we can learn from other nations' experiences and inspires far too many to believe that we can solve our immigration dilemmas by ourselves. Accordingly, the current discussion is

excessively and narrowly focused on the border problems of the recent past and the present, most critically of course on the growing magnitude of unauthorized immigration, while these issues are stripped of the historical contexts that might help Americans better understand and transcend them.”

Richard Alba, 2006

Immigration and the Economy: Demographics and trends of Immigration

While immigration policy is a federal responsibility, the effects are concentrated in states such as California where most immigrants live. The Center for the Continuing Study of the California Economy (CCSCE) has reported that “The conclusion of most research is that immigration provides net economic benefits to domestic residents, although some individuals may suffer losses of income— there are winners and losers” (p. 26). The CCSCE looks at both economic effects (impacts on employment, unemployment, wages, prices) and fiscal effects (impacts on state provision of services, and the funds to pay for them). Future changes in the labor force are strongly influenced by immigration, as have been the changes in recent past. Immigration is currently the primary part of growth of the labor force in California. “Almost all of California’s workforce growth between 2005 and 2030 is likely to come from immigrants and their children.” (p. 9) In 2004, one in four Californians was foreign-born. One-quarter of the foreign born, or 2.4 million persons, were unauthorized. Seventy two percent of these unauthorized immigrants were ages 18 to 39, and 80% of them were from Mexico and Latin America. Fifty percent have less than a high school education.

California has more Hispanic residents (11 million in 2000) than any other state (U.S. Census Bureau). While California has the largest Hispanic population, its current growth rate is actually lower than many other states. California was not among the top ten states in rate of growth of Hispanic population between 1990 and 2000. (The percent change in Hispanic population from 1990-2000 in other states was: North Carolina 394%; Arkansas 337%; Georgia 300%; Tennessee 278%; Nevada 217%; South Carolina 211%; Alabama 208%; Kentucky 173%; Minnesota 166%; and Nebraska 155%.) Nationally, more than 9 in 10 Hispanics live within a metropolitan area and nearly half of all Hispanics live in a central city within a metropolitan area.

In the U.S., about 7.2 million unauthorized migrants were employed in March 2005, accounting for about 4.9% of the civilian labor force. They made up a large share of all workers in a few more detailed occupational categories, including 24% of all workers employed in farming occupations, 17% in cleaning, 14% in construction and 12% in food preparation. (Estimates Based on the March 2005 Current Population Survey, Jeffrey S. Passel, Pew Hispanic Center.)

Among the over 25 million Californians of working age, 16 million are in the labor force. (see table 1, Source: U.S. Bureau of the Census, 2000) This labor force participation rate of 62.4% is slightly above the rate for Hispanic or Latino residents of 60.6%. However, official labor force participation indicates someone is holding or

seeking a job². The official unemployment rate for Hispanics (10.2%) in 2000 is nearly 1 ½ times that of the total population (7%).

Table 1: Labor Force Participation of Total Population by Hispanic/Latino Ethnicity

Data Element Person count - 16 Years and Older	Total Population	Hispanic or Latino (of Any Race)	Hispanic/Latino As % of Total
Total Population	25,596,144	7,304,131	28%
Total Labor Force	15,977,879	4,429,163	28%
Labor Force Participation Rate ²	62.4%	60.6%	
Armed Forces	148,677	23,798	16%
Civilian Labor Force	15,829,202	4,405,365	28%
Civilian Labor Force Participation Rate	61.8%	60.3%	
Employed	14,718,928	3,957,539	27%
Unemployed	1,110,274	447,826	40%
Unemployment Rate	7.0%	10.2%	
Not in Labor Force	9,618,265	2,874,968	30%

Day Laborers and the (re)Development of Worker Centers

Day laborers are one special category of low wage immigrant workers, who because of their status, language, and mobility are exceptionally difficult to study. The National Day Labor Survey bills itself as the first systematic and scientific study of the day-labor sector and its workforce in the United States. Based on a national survey of 2,660 day laborers, randomly selected at 264 hiring sites in 139 municipalities in 20 states and the District of Columbia, the report describes the increasingly prevalent day-labor market as being “rife with violations of worker rights.” “Day laborers are regularly denied payment for their work, many are subjected to demonstrably hazardous job sites, and most endure insults and abuses by employers.” The researchers conclude that the growth of day-labor hiring sites combined with rising levels of workers’ rights violations is a “national trend that warrants attention from policy makers at all levels of government” (Valenzuela, 2006).

The Day Labor study estimates that nearly 120 thousand workers per day seek work or are working as day laborers. The researchers estimate that three-quarters of the day labor workforce are undocumented migrants. This does not equate to recent immigration, however; 40 percent of day laborers have lived in the U.S. for more than 6

² **Labor force participation rate (LFPR):** The LFPR (used in the [CPS](#)) is the number of people who are in the labor force divided by the number of people in the population. The labor force participation rate is a primary measure in labor market analysis. In the [NHIS](#), labor force status is ascertained for the two weeks preceding the Health Interview Survey interview. A person who had a job, was on temporary layoff, or was looking for work during those weeks is considered to be in the labor force.

years. One in nine of the undocumented day labor workforce is seeking legal adjustment in their immigration status.

Most hiring sites for day labor are informal and involve a transaction between a buyer and seller of labor in front of a business (24%) or home improvement store (22%), at gas stations (10%) or on busy streets. One in five day laborers seek work at more formal day-labor worker centers. Typically, day laborers search for work full time, relying on jobs as construction laborer, gardener or landscaper, painter, roofer, or drywall installer. Their primary employers tend to be either homeowners or renters (49%) or construction contractors (43%). Day laborer wages are low, typically amounting to poverty level for full time work. Working conditions are often poor involving wage theft, denial of food/water or breaks while on the job, and hazardous conditions resulting in high rates of work-related injury (20 percent overall). Day laborers in the survey typically experience denial of merchant services and report harassment by merchants and police authorities.

Worker centers are emerging to assist in a comprehensive response to the issues surrounding day labor. At the time of the Day Labor study, at least 63 day-labor worker centers in 17 states, and another 15 community organizations “served, organized or advocated on behalf of day laborers.” Other cities have started the process of opening and resourcing worker centers and the numbers are growing.

By April 2006, the NY Times reported more than 140 worker centers nationwide, up from roughly 25 a decade ago. “The centers played a pivotal role in getting tens of thousands of workers to the giant demonstrations seeking a path to citizenship for illegal immigrants and protesting a House bill that would turn illegal immigrants into felons. Some of these centers focus on a particular nationality, like Korean Immigrant Worker Advocates in Los Angeles and the Chinese Staff and Workers Association in Manhattan, while some focus on an industry, like the Mississippi Poultry Workers' Center and the New York Taxi Workers Alliance” (Greenhouse, NYTimes, 4-26-06).

Some researchers describe the emerging worker centers as distinct from conventional membership-based unions but rather as community-based organizations that engage in advocacy, service work and organizing among low-wage immigrant workers. “These centers have taken off because we're seeing an increase in the number of workers in precarious employment situations,” said Janice Fine, a professor of labor relations at Rutgers University and author of *Worker Centers: Organizing Communities at the Edge of the Dream* (2006). “Over the past decade we've seen the biggest influx of immigrants in our nation's history and at the same time a decline in resources for wage and hour enforcement at the state and federal level...These centers have become a safety net that's tried to enforce the laws.”

A century ago, settlement houses for recent immigrants provided similar services. An example is Hull House in Chicago. The objective of Hull House, as stated in its charter, was: “To provide a center for a higher civic and social life; to institute and maintain educational and philanthropic enterprises, and to investigate and improve the conditions in the industrial districts of Chicago.” As described nearly 100 years ago by Jane Addams, their “main purposes were to provide social and educational opportunities for working class people in the neighborhood, many of whom were recent immigrants. There were classes in literature, history, art, domestic activities such as sewing, and many other subjects, concerts free to everyone, free lectures on current issues, and clubs both

for children and adults. The settlement also gradually was drawn into advocating for legislative reforms at the municipal, state and federal levels, addressing issues such as child labor, suffrage, and immigration policy. At the neighborhood level they established the city's first public playground and bathhouse, pursued educational and political reform, investigated housing, working and sanitation issues..." At the state level their residents influenced legislation on child labor laws, occupational safety and health provisions, compulsory education, immigrant rights, and pension laws. These experiences "translated to success at the federal level working with the settlement house network to champion national child labor laws, women's suffrage, a Children's Bureau, unemployment compensation, workers' compensation and other elements of the Progressive agenda during the first two decades of the twentieth century."

UC Santa Cruz researchers found that immigrant worker programs and strategies, such as those in worker centers, generally fall into four broad categories: service provision, advocacy, organizing, and enterprise development. These activities are similar to strategies pursued by a wide range of other immigrant organizations around the country, and follow many of the same principles of the earlier settlement house movement (Benner, UCSC, 2005).

UCLA's Ruth Milkman sees worker centers as modern day settlement houses, supportive of collective action, whether by unions or other means. "... for Latino immigrants in particular, class-based, collective organizations like unions are highly compatible with past lived experience and world views—whereas native-born workers tend to have a more individualistic orientation. And crucially, the shared experience of stigmatization among immigrants, both during the migration process itself and continuing after many years of settlement, means that when unions or worker centers reach out and offer a helping hand, it is often welcomed with enthusiasm." (Milkman, 2006.)

Milkman writes that most observers of the wave of Latin American and Asian immigrants that entered California in the 1970s and 1980s downplayed its impact on the labor or political scene. "Least of all did anyone expect the burgeoning population of undocumented workers from Mexico and Central America—most of whom had minimal formal education and few economic resources—to become a significant force." Milkman details how immigrant workers have greatly contributed to the strength of an alliance between Labor and Latin political forces, leading to both increasing union membership in service workers, home health workers and hotel workers, and developing considerable political might.

"Immigrant organizing in California began with a series of successful union drives among low-wage immigrant workers, many of them undocumented. The most famous example is the SEIU's "Justice for Janitors" campaign, which made a key breakthrough in Los Angeles in 1990 and went on to consolidate its gains thereafter. At the same time the 'worker center' movement expanded in the region, with an explicit focus on immigrant rights yet with an approach that eschewed conventional unionism. The worker centers systematically engaged unauthorized immigrants in various forms of civic and political participation, despite their inability to vote and their lack of official citizenship rights."³

³ Milkman questions popular wisdom about the lack of voting among naturalized immigrants. "On the national level, voting rates are lower for Asians and Latinos (regardless of citizenship status) than for other ethnic groups. However, thanks in large part to the efforts of the labor movement to naturalize

Her conclusion is that the new movements can lead to significant social change: “There is good reason to expect that the political dynamic that unfolded in California in the 1990s could now be replicated on a national scale. If that occurs, unionism could once again become a key agent of social transformation, as it was for southern and eastern European immigrants in the 1930s and 1940s, when the labor movement helped narrow the inequalities between the haves and have-nots, and propelled many first- and second-generation immigrants into the middle class.”

Occupational Injuries Among Immigrant and Hispanic workers

“As for safety, the question is not whether any workers will be hurt but how often, how many, and how badly. Within one two-year period as an advocate for immigrant workers, I worked with a Salvadoran mechanic whose ribs and legs were mangled when he was pinned by a car in an underground auto-repair shop; a Salvadoran woman whose hands were covered with blisters from operating the hot press in a commercial laundry with only thin cotton gloves; a Guatemalan restaurant worker whose boss intentionally burned him with pans of hot oil when he did not chop vegetables and wash dishes fast enough; a Salvadoran day laborer whose arm was crushed by falling scaffolding; and a Honduran who inhaled so much toxic paint while sanding yachts that he would die within months. A 2001 Newsday investigation concluded that “Hispanic immigrants are particularly at risk for getting killed in the workplace,” a conclusion graphically corroborated two years later by a National Academy of Sciences study that estimated that Latino immigrants die on the job at a rate nearly 250 percent higher than do workers, on average, in the United States.”

Jennifer Gordon, 2005

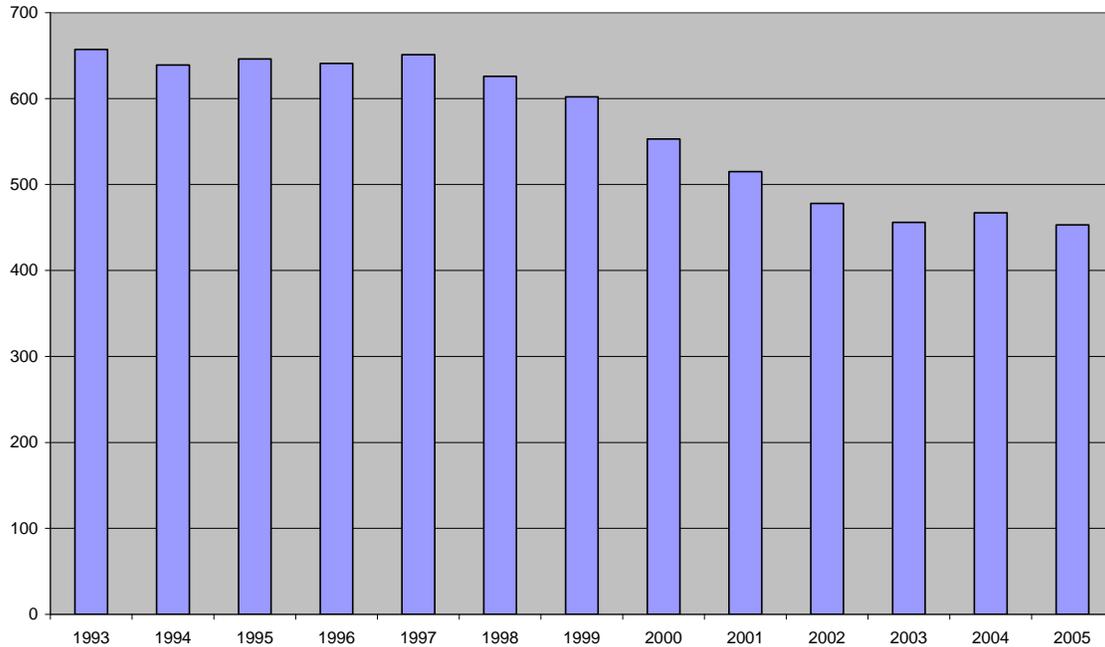
No official occupational safety and health statistics are kept that allow specific analysis of injury and illness rates among low wage immigrant workers. Public statistics categorizing job hazard outcomes by citizenship or immigration status, or by wage, do not presently exist. Statistics that classify job related fatalities and lost time injuries into racial and ethnic categories that include Hispanics are extremely limited. For purposes of this analysis these are the only available official data, and must be supplemented by anecdotal and journalistic information. This section looks first at available statistics on job related fatalities, and follows this with discussion of nonfatal injuries among the immigrant, low wage population.

those eligible and to increase electoral participation, the gap between California Latinos and whites in voting rates has virtually disappeared. If one controls for age, citizenship, and socio-economic status, Latino turnout rates in the state were only 1 percentage point lower than those of comparable whites from 1994 to 2000; in the 1998 election, when labor mobilized especially energetically because of an anti-union referendum item on the state ballot, Latino turnout was 4 percentage points higher than that of comparable whites.”

Occupational Fatalities

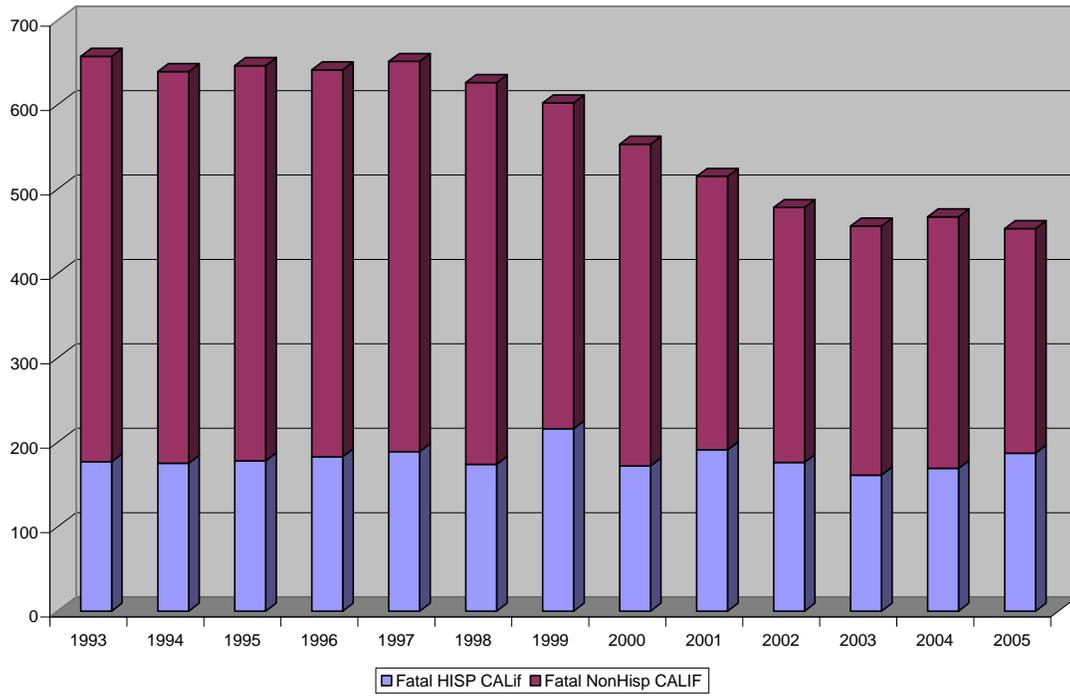
Since the middle 1990s, the number of occupational fatalities in California has dropped significantly, from over 47 per million workers in 1993 to 27.4 per million in 2005. The following figures show the reported numbers of cases for the total population and for Hispanics only.

Work Related Fatalities Decreasing Overall In California. 1993-2005



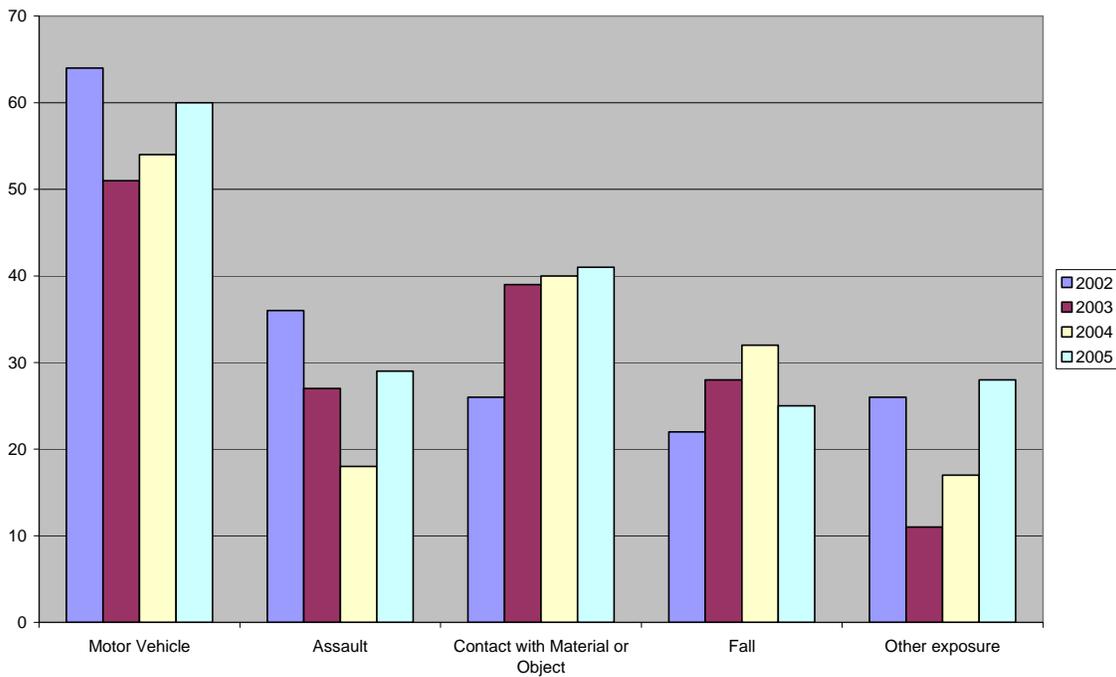
While reported fatalities among non-Hispanics dropped from 480 to 266 in that period, the number of fatalities among Hispanics peaked in 1999 at 216, and has stayed high, accounting for 187, or 41% of fatalities in 2005. (In 1993, only 27% of California work fatalities were accounted for by Hispanic workers.)

Hispanic Fatalities Remain High as other Fatalities Decrease



The type of injury causing occupational fatalities among Hispanics is detailed in the table below.

Event Leading to Fatalities among Hispanics - California 2002-05



Overall, Hispanics have a job related fatality rate of 47 per million workers, while the general population is under 31 per million. The type of hazards that tragically lead to fatalities continue to be dominated in number by transportation related injuries, including roadway, transit and air events. Among the general employed population, 11 persons per million die in transportation related events, while 6 die from violence, 5 from contact with objects or equipment, and 4 from falls. Among Hispanics motor vehicle and contact with equipment are the biggest risks, 50-100% higher than to the general employed population.

Table 2 Job-Related Fatalities per Million Employed Persons, 2005

	Total	Motor Vehicle	Violence	Contact with object	Falls	Exposure
All	30.8	11.2	5.9	5.2	4.0	4.4
Hispanic	47.3	15.2	7.3	10.4	6.3	7.1
White	25.8	11.1	4.1	3.2	4.1	3.1
Black	32.2	9.9	12.4	6.2	-	-

Compared to the general employed population, Hispanic workers have higher occupational fatality rates from nearly all factors that are measured: motor vehicle hazards, contact with materials or objects, falls and other exposures. Black workers also experience higher death rates at work compared to the total population, and exceed Hispanic workers in rates of death from workplace violence. Appendix 1 shows detail on the causes of trends in fatalities from 2002 to 2005 among all employed California workers and among Hispanic workers.

Disabling Occupational Injuries

Official statistics likely mask the true incidence of disabling and non disabling occupational injury. An increasing body of research is documenting such underreporting. Rates of nonfatal injury are calculated based on existing state and national surveillance systems of occupational injury and illness. In a recent study employing capture-recapture analysis⁴, a team of Michigan researchers matched employer reported injuries from a Bureau of Labor Statistics survey with other databases and found that the BLS survey “markedly underestimates the magnitude of these conditions.” There is no evidence that California official counts are radically better than those projected for Michigan. In 1987, a National Academy of Sciences study showed that BLS missed 50% of acute work-

⁴ “Capture-recapture methods in epidemiology are attempts to estimate or adjust for the extent of incomplete ascertainment using information from overlapping lists of cases from distinct sources.” Capture-Recapture Methods in Epidemiology: Methods and Limitations Ernest B. Hook and Ronald R. Regal, *Epidemiology Review* Vol. 17, No. 2, 1995

related deaths in its annual survey estimates. The results prompted establishment of the Census of Fatal Occupational Injuries, a “complete census that uses multiple data sources, covers all workers, and is not dependent on an employer either being aware of the condition or responding to a survey” (Hook & Regal, p. 357). “A more comprehensive system, such as the one developed for traumatic workplace fatalities, that is not solely dependent on employer based data sources, is needed to better guide decision-making and evaluation of public health programs to reduce work-related conditions” (Rosenman, 2006). In other words, what cannot be measured, cannot be managed.

Several other researchers have come to similar conclusions. For instance, a paper by Azeroff, et al. (2002) described the conceptual filters and obstacles that lead to underreporting in the general population on public surveillance systems, compared to the “real” number of injuries on the job.

The researchers show a series of obstacles limiting ultimate success. Prior to receipt of benefits, the worker needs to report injury/illness or medical care to supervisor, the health care provider needs to recognize and acknowledge work-relatedness, treatment needs to be charged to workers’ compensation by the provider; (for illnesses) the health care provider needs to participate in a disease reporting system; and the injury or illness needs to be reported by the employer to the payer. Throughout the process, the injured worker must trust and understand the process and understand their rights. Even if 90% of cases were correctly labeled and passed to the next stage on this 4-5 point continuum, the authors note that only 2/3 of cases would be “counted.”

In workers’ compensation the most complete set of research on the claims process and the costs involved, come from insurance industry information collected after a worker applies for and receives workers’ compensation. Because not all injuries that occur result in a successful claim for compensation benefits and end up being reported and counted, our understanding of the nature of the problem may be based on inadequate, and incomplete information.

It is plausible and likely that underreporting of injuries among the low-wage immigrant worker population is more serious than of the general population. Even without an assumption of undercount, the official injury and illness statistics --most recent BLS and Census figures-- show that, in California, Hispanic workers are injured much more frequently than other workers. In 2004, Hispanics comprised 26.9% of the employed labor force and accounted for 35.4% of nonfatal injuries involving days away from work. In some industries, Hispanics suffered even higher portions of cases involving lost workdays: 44% of lost time cases in construction, 50% of lost time cases in manufacturing; and 80% of lost time cases in natural resources and mining. (see Table 3) In rates of injury, Hispanics chance of disabling injury were about 33% higher than the general population. This level was almost triple the rate for whites, and 57% above the rates for African Americans. In addition, once off work, the injuries suffered by Hispanics kept them off the job longer than any other identified group (BLS, California, 2004, Table 8).

Table 3, Lost Time Injuries and Days Off Work Due to Injury among Hispanics and Other Groups

California-Private Industry	Employed, 2000, U.S. Census	Lost Time injury, 2004, BLS	Lost Time per 100,000 Workers	Median Days Off Work
All Employed	14,718,928	148,850	1,011	10
Hispanic	3,957,539	52,860	1,336	10
White	7,766,487	36,890	475	9
Black	806,328	6,840	848	7

Source: Census Bureau, BLS/DOL

Occupational injury statistics divided by race/ethnicity on all cases, lost time and non-lost time do not exist. BLS collects personal identifiers only on individuals with days away from work. The California first report of injury form does not ask employer respondents to list the race or ethnic group of the injured worker. The current version (Revision 7) of Form 5020 (8 CCR 14300.7) requires the employee’s name, sex, home address, social security number, date of birth, date of hire, employment status, usual work day/week in hours, gross wages/salary, and other payments not reported as wages or salary, but it does not ask for or have a data field for the injured person’s race or ethnicity. The physician’s report of injury, (CCR Title 8, Section 14003(a)) requires every physician, as defined in Labor Code Section 3209.3, who attends an injured employee to file, within five days after initial examination, a complete report of every occupational injury or occupational illness to such employee, with the employer's insurer, or with the employer, if self-insured. The doctor’s first report, asks for name, sex, date of birth, age, address, telephone number; occupation; Social Security Number; where and when injured, when last worked and date and time of first medical treatment after injury. But no race or ethnicity code, or information on immigration status, appears in the official statistics.

“Because they are not part of mainstream society, there is no clear picture of how many undocumented Latino immigrants are injured or killed on the job. Any statistical evidence is incomplete. But Latino illegals are widely assumed to constitute the bulk of the nation's estimated 7.2 million unauthorized workers, and most experts say they have driven up the casualty count” (Stephen Franklin and Darnell Little. “Throwaway Workers: Fear of retaliation trumps pain -- Deaths, injuries on the job soar for illegal immigrants.” Chicago Tribune, September 3, 2006).

The data issue is pervasive and widespread. In places that were once known as relatively homogeneous, such as Utah, new problems are emerging with immigration. The Deseret Mountain News reported: “Utah is becoming more diverse... and the labor market is tight. Employers are hiring more foreign born workers – many in industries prone to injuries– and too many are getting hurt, and killed on the job...Language proficiency is just one of the challenges faced by multicultural or non-English speaking workers and their employers when it comes to workplace safety. Others can include cultural differences and fear of termination, or sometimes, deportation.” Like California, the state of Utah has no official reports of injuries by ethnicity. The state’s workers’ compensation director describes the problem. “In Utah, we don’t track it too well, and that lack of data is troubling.” The overall numbers of Utah work injuries has declined

from 81,056 in 2000 to 66,462 in 2004, but (State workers' compensation chief Joyce) Sewell acknowledges that "there is some indication from the more detailed reports of fatalities, claims against the Uninsured Employers Fund and from reports from the state's largest workers' compensation insurance carrier, that there is a higher number of injuries for non English speaking workers in Utah in the past three to four years." (Deseret Morning News, June 18, 2006).

Exploitation of Immigrant Workers

While it is difficult to get a full picture of the occupational health and safety status of low wage immigrant workers and day laborers, there are plausible explanations as to why their fatal and nonfatal injury rates might be so elevated. Conventional labor market theory contends that under such conditions, a hazard differential might be paid, or working conditions would have to be improved significantly to attract workers at low pay levels. But the segmentation of the labor market that includes an underground economy confounds many of the traditional economic assumptions. Buchanan (2004) cites inadequate training and experience, the use of substandard safety equipment, and language and cultural barriers as contributing factors to high incidence rates, while not necessarily unique to this population.

Through an ethnographic survey of day laborers in San Francisco, UCSF Medical Center and Anthropology researchers (Walter, et al., 2002) discussed the same obstacles to preventive factors, and found that workers remained at hazardous jobs because they were aware of an oversupply of labor and worried that complaints about safety hazards would jeopardize their future employment. Many had debts, sometimes to those who had helped guide them across the border. Health and safety concerns simply were not as important as staying employed, and many felt that the oversupply of workers appeared to limit their ability to protest unsafe or abusive workplaces. The competition for work made it important to mask any deficiencies. "Day laborers believe that employers pick the youngest, strongest bodies; the injured feel marked for rejection." Culturally, "workers downplayed their occupational health risks while emphasizing their sense of worth and masculinity, and their fear of appearing vulnerable" (Walter, et al., 2002, p. 256.).

A study by Pransky, et al. (2002), found greatly elevated rates of occupational injuries among immigrant Latinos in Virginia. Fewer than 1/3 had received any safety training, despite being exposed to significant chemical and physical hazards on the job (Pransky, et al., 2002). Other studies raise similar themes.

The lack of health insurance and reluctance to use available resources further compound the issue. Reasons cited in a Kaiser Family Foundation study for lack of ability to use needed health care included affordability, lack of insurance, fear due to immigration status, lack of transportation, lack of time and long clinic waiting times (Schur, 1999.)

Regarding agricultural work, a study conducted by the California Research Bureau identified ethnic diversity, low income, housing, sanitation, health care access, and education as key aspects diminishing farm worker health. The report compared farm work with the other major occupational categories in the state, and noted that farming had the highest percentage of workers living below the poverty line, working the longest hours, and having the lowest proportion of health insurance coverage, and the lowest

educational level. The report also included data on the implementation of the 1986 OSHA Sanitation Standard, indicating that about 60% of farms surveyed in California were out of compliance with the standard (Bugarin, 1998).

The inability to quantitatively estimate injury and illness rates, compounded by the transitory nature of the labor force in geography and even type of work, makes it difficult to research the problem in traditional academic fashion. There have, however, been several recent mainstream news stories documenting the plight of the unauthorized workforce. A McClatchy newspapers investigation found several instances of exploitation of injured undocumented workers. “Bosses often fire them, threaten them with deportation, and commit an array of other misdeeds to avoid responsibility for workers’ injuries. Some insurers refuse to pay their claims, citing reasons related to their illegal status. As a result, injured workers often go without medical care or go to emergency rooms for treatment – and taxpayers get stuck with the bills” (Chandler, “Illegal immigrants frequently denied compensation,” McClatchy Newspapers, September 15, 2006).

Regulatory mechanisms are failing as well, as the number of inspections and the staffers to do them has dropped. “The nation’s 2300 inspectors check 1 percent of 7 million employers each year, and critics say fines are so low that risk operators consider them a cost of doing business.” In California, the annual number of onsite inspections conducted by the Division of Occupational Safety and Health have dropped from 12,580 in 1992 to 8,176 in 2006, a 35% decline. Inspections in fiscal year 2005-06 dropped 66% in Agriculture, 5% in construction and 28% in the garment industry from the average number inspections of the previous 10 years (between 1995 and 2004). The number of violations cited fell from 29,259 to 16,467 during that time. (Source: DOSH Performance Statistics, November 22, 2006.)

Other news articles, cited in the McClatchy series, point out situations across the nation:

- In Boston, when a Brazilian restaurant worker stabbed his hand with a knife, his supervisor, acting as translator, told doctors the injury happened at home, legal advocates said.
- At a Mississippi poultry plant, bosses questioned the immigration status - then fired - an undocumented employee after he sought medical treatment for injuries to both arms, according to the worker and his case manager.
- In Florida, a 15-year-old Guatemalan boy picking peppers was run over by a truck in the field, then dumped at a hospital 25 miles away with no name or contact information for his employer.
- “It’s not unusual for bosses, known to workers only by nicknames and cell phone numbers, to abandon injured workers in unfamiliar areas without fear of reprisals” (Chandler, 2006).

Texas attorney Richard Pena, the chair of the American Bar Association’s immigration committee describes the situation as an “ugly secret.” “The employers and insurance companies profit... (while) immigrant workers often go back to their home countries broken and in pain.”

Despite such hardships, there is certainly no consensus among citizens or policy makers that undocumented workers should be eligible for health care or workers’

compensation benefits. According to a poll by the Survey and Policy Research Institute at San Jose State University, a majority of California residents do not believe the state should ensure access to health insurance for undocumented immigrants. (See for example, reaction to Governor Schwarzenegger's statement about including undocumented workers in his proposed health insurance expansion (Skelton, Los Angeles Times, 1/11/2007). [See also section on immigrant legislation, below.] Workers are denied benefits in many ways. Employers may go without workers' compensation insurance, or report only a portion of their payroll, or misclassify their workforce to keep costs down. Insurance analyst and writer Peter Rousmaniere calls it a toxic cocktail. "You have employers who have great incentive to cheat workers, and you have large numbers of illegal workers who will accept lower labor standards. It's causing our safety standards to erode – and that hurts legal workers too" (Rousmaniere, 2006).

A Chicago Tribune investigation found that injuries are undercounted because illegal Latino immigrants stay away from public health care facilities when possible. If they get care, they are often afraid to report the cause. "You say this accident has to be reported and they say, 'You don't understand, I need my job. I have to feed my family.'" Using figures from the Illinois Trauma Registry, a University of Illinois-Chicago physician found that since 1997, Latino workers had an injury rate twice that of others, and that the rate of amputations of fingers or hands was three times that of other groups. (Franklin and Little, "Fear of Retaliation Trumps Pain" Chicago Tribune, 2006.) And the reporters write that things are getting worse. Before the recent debate about illegal immigrants (occasioned by Congressional deliberations and immigrant reaction in mid 2006), a Chicago based advocacy group for the disabled would refer injured Latino workers to public health agencies which might overlook immigrant status and provide help. "Now with all of the strict background checks, [agencies] won't do it."

The Occupational Safety and Health Administration (OSHA) is also challenged by this issue. Few of the overcommitted inspectors speak Spanish or other languages of immigrants. During the present administration, the politicization of the immigration issue has impacted public health prevention strategies. OSHA's attempts to build partnerships and win the trust of Latino community groups were set back by fears caused in 2005, when Homeland Security officials, posing as OSHA representatives, called a "mandatory" safety workshop in North Carolina and arrested illegally employed immigrant workers who showed up (Barab, February 7, 2006). As reported by the trade publication "Inside OSHA", and quoted by Jordan Barab in *Confined Space* (2006), despite statements to the contrary, "Immigration and Customs Enforcement (ICE) officials told immigration and labor groups during a closed-door meeting Jan. 30 (2006) that the department will continue to have its agents pose as officials from other agencies, including OSHA, to nab illegal immigrants at work sites, despite earlier signals the policy would be dropped. The meeting was set up to discuss last year's controversial sting operation where ICE officials posed as OSHA employees, which had prompted an outcry from labor groups and concerns from OSHA." The original action was condemned by many groups, including the American Public Health Association, whose executive director called the policy inappropriate and counterproductive. "...It will significantly damage the credibility of OSHA and undermine citizen confidence in government. By making workers fearful of attending workplace safety programs it will set back our

efforts to prevent injury and death on the job. This is a national goal, which we have worked tirelessly with employers, unions and government agencies, to ensure.”

In South Carolina, despite legal obligations of the general contractor to provide benefits to injured workers regardless of legal status, and directives from the district director of the Department of Labor’s wage and hour division, reporters found multiple problems. The director of the Immigration Justice Center of the Southern Poverty Law Center describes the problem. When workers with wage-related complaints or issues about safety try to get things changed, they are “blackmailed.” “If you insist, I’ll call the authorities” is what they are told.

In Massachusetts, “employers are outsourcing cleanup, construction, and other risky work to small firms. An increasing share of the bottom quarter of the workforce is undocumented. Most of those workers are undereducated; many do not speak English; all fear deportation.” Peter Rousmaniere believes that state policy is partially to blame. “State regulators and insurers have not been up to the task of stemming abuses at the small level. As a result, the state is replete with employers who do not purchase workers’ compensation insurance or who steer their workers from workers’ compensation benefits” (Rousmaniere, January 4, 2006).

Enforcement of labor law

Under U.S. and California law, as well as the law of many other jurisdictions, workers are promised a safe and healthy working environment. In the event of on the job injury and illness, they are promised access to medical care and related wage replacement benefits. As indicated below, California’s workers’ compensation law is broad in its coverage and specifically includes all employers and all injured workers.

Labor Code Section 3351 defines employee as meaning “every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes: a) aliens and minors.” Labor Code section 3700 requires all employers, except the state, to secure the payment of compensation by being insured with an authorized insurance carrier, or securing consent to self-insure. Public agencies insure or self-insure their obligations to provide benefits to injured workers.

Despite the coverage and compliance requirements, some injured workers find obstacles to using their rights. Uninsured and underinsured employers, as well as some fully insured employers, may: fail to inform workers of their rights to benefits; put up barriers to reporting injury; keep workers from using the insurance system to obtain access to medical care or income replacement benefits; threaten workers with sanctions, dismissal or referral to immigration authorities; or restrict access to services by withholding information about medical networks or insurance coverage. Workers seeking to use their rights may be frustrated by: lack of information in a language they understand and in a culturally appropriate manner; too complex a process or misleading information; lack of training about requirements of deadlines or restrictions; lack of access to a reasonable medical care provider with whom they are comfortable; and/or inability to get information or assistance either through a governmental agency or a private attorney or representative.

There are a panoply of state agencies and units who are charged with enforcing the law, but this task often exceeds their resources. For instance, California employs

approximately 50 information and assistance officers and central call-center helpdesk workers for an injured population of several hundred thousand new cases annually. While not every case requires state intervention, assistance or information, the caseload per worker does not allow for significant help in any individual case. By law, written information for injured workers under Labor Code 139.6 must include a pamphlet advising workers of their basic rights, in easily understandable language, in both English and Spanish. The information and assistance program is also required to establish and maintain liaison with persons in the local geographic area, and with organizations representing injured workers, employers, insurers and the medical community. Vast improvements in staffing and technology have begun to enable the state's outreach ability. But until recently, information and assistance workshops and services were predominantly in English only, and only in the past year have regular Spanish language sessions had any significant outreach. The requirements, while laudable, are difficult to accomplish given the large volume of work. Given current patterns of immigration, language use, and literacy, they are incomplete. Many immigrant workers are not English or Spanish speaking, are unable to read or write, or are distrustful of the agencies that should be guaranteeing their rights. In a state where approximately 4.5 million workers do not speak English, there are only 26 Division of Occupational Safety and Health field personnel who are certified for bilingual pay. (See regulations at <http://www.documents.dgs.ca.gov/ohr/pom/BILINGUAL%20PAY.pdf>.) Low wage immigrant workers also have limited access to on-site occupational health and safety personnel, for example, occupational health nurses, whose role it is to prevent injury and illness at worksites, and educate and advocate for injured workers (Lashuay, 2006).

The requirement of full workers' compensation insurance coverage is also inhibited in several ways. Some employers, especially new small businesses, or those who move to California from other jurisdictions with less complete coverage mandates, may not know of the requirements to cover all their workers. Some employers will illegally "assure" their employees that any injury and its costs and medical care will be handled internally, or they will assume that since no recent injuries have occurred that they do not need coverage. Some employers may, in a seemingly rational decision mode, choose to ignore the law and risk being cited and penalized for noncompliance. The low risks of being caught and the high cost of buying insurance may make this decision appear reasonable. While the ultimate sanctions against an uninsured employer may be closure of the business, or the ability of the injured worker to bring a tort claim against the employer without the latter being able to claim limited liability, such actions are rarely taken. Recent studies in New York state have indicated uninsurance rates of 20% or more of payroll (Greenhouse, 2007).

Labor law enforcement entities, called "labor commissioners" in California have many laws to choose from when regulating businesses. The Division of Labor Standards Enforcement's objectives are voluminous; its objectives are described by the state budget as: "...(1) the enforcement and interpretation of Industrial Welfare Commission Wage Orders and sections of the Labor Code which relate to wages, hours of work, and conditions of employment, including anti-discrimination laws relating to employees engaged in protected activities; (2) the determination and collection of unpaid wages; (3) the licensing of farm labor contractors, industrial homework firms, talent agencies, the registration of garment manufacturers, the certification of studio teachers, the registration

of car washing and polishing businesses, and the registration of entities and individuals using minors in door-to-door sales; (4) field enforcement of laws governing public works, workers' compensation insurance, child labor, unlicensed contractors, oversight of rules governing meals and rest period, the payment of overtime and minimum wage, the licensing of specific industries, and the cash payment of wages without required deductions; and (5) in partnership with state and federal agencies, vigorous and targeted enforcement against unscrupulous businesses participating in the "underground economy".

Enforcement priorities depend on a number of factors, and resources are scarce. Labor commissioners may see even illegal lack of insurance, especially in the absence of an occupational injury, to be less important than accurate and timely payment of wages, adequate safety and health protections, or enforcement of restrictions on hours worked, child labor, or other important social goals. The table, from the 2007 state budget, shows the budget (in \$1000) and proposed number of positions for each division within the state's industrial relations Department. (Note: while the number of positions have increased, some of these positions have been unfilled.)

PROGRAMS

The following table presents total proposed budget year positions and expenditures for each budgeted program area. These expenditures include all funding sources that support the state agency's programs.

Program	Proposed 2007-08*	
	Positions	Dollars
Self-Insurance Plans	24.7	\$3,778
Mediation/Conciliation	16.6	2,359
Workers' Compensation	1,140.8	179,024
Commission on Health and Safety and Workers' Compensation	9.5	3,080
Division of Occupational Safety and Health	724.2	96,652
Division of Labor Standards Enforcement	423.7	50,382
Division of Apprenticeship Standards	69.3	11,207
Division of Labor Statistics and Research	33.3	3,904
Claims, Wages, and Contingencies	0	34,132
Administration	296.9	31,366
TOTAL	2,739	\$415,884.00

Code	Program	Actual 2005-06	Estimated 2006-07	Proposed 2007-08
10	Self-Insurance Plans	24.3	24.7	24.7
20	Mediation/Conciliation	15.5	16.6	16.6
30	Workers' Compensation	1,036.6	1,144.8	1,140.8
36	Commission on Health and Safety and Workers' Compensation	8.5	9.5	9.5
40	Division of Occupational Safety and Health	651.9	706.8	724.2
50	Division of Labor Standards Enforcement	363.3	417.1	423.7
60	Division of Apprenticeship Standards	51.9	62.7	69.3
70	Division of Labor Statistics and Research	34.3	35.2	33.3
80	Claims, Wages, and Contingencies	-	-	-

94.01	Administration	275.8	289.7	296.9
94.02	Distributed Administration	-	-	-
Total Positions (All Programs)		2,462.1	2,707.1	2,739.0

There are positive actions being taken to combat these problems. There is growth in budget (increase of 11% from 2005 to 2007) and positions (+60 over 2 years) for labor standards enforcement. Sanctions against workers' compensation fraud, and funds to help fight those abuses, are increasingly available for state and local law enforcement and prosecution agencies in the area of employer lack or inadequate amounts of insurance. The Fraud Assessment Commission, an independent entity associated with the California Department of Insurance, allocates upwards of \$30 million per year to prosecutors and investigators to fight fraud, and an increasing amount of attention in recent years has been on combating uninsured employers. The counties and district attorneys of San Diego, Contra Costa, Monterey and others have been among the leaders in these efforts. In Monterey County, for instance, a Workers' Compensation Enforcement Collaborative, convened by the Watsonville Law Center, meets with the goal of ensuring that low wage immigrant workers have access to medical and related workers' compensation benefits. The group includes representatives of Department of Insurance fraud investigators, district attorney staff (attorneys and investigators, claimant attorneys, advocacy workers, government researchers, workers' compensation judges, private self-insured employers, and law students.

Federal Immigration law and policy toward work and workers' compensation

The Immigration Reform and Control Act (IRCA) (8 USC section 1324(a) (1986) was intended to discourage employment of illegal aliens by requiring employers to attest in writing that they had verified the identity and work authorization of all newly hired workers. The statute criminalizes the use of fraudulent documents by individuals attempting to circumvent the employer verification process, but does not penalize illegal aliens who merely accept employment (INS v. National Center for Immigrants' Rights, Inc., [502 U.S. 183](#), 194, and n. 8). Among other things, IRCA established an extensive "employment verification system," [8 U.S.C. § 1324a\(a\)\(1\)](#), designed to deny employment to aliens who (a) are not lawfully present in the United States, or (b) are not lawfully authorized to work in the United States, §1324a(h)(3). It also makes it a crime for an unauthorized alien to subvert the employer verification system by tendering fraudulent documents, §1324c(a).

The Supreme Court in a split decision in *Hoffman Plastics Compounds, Inc v. NLRB* (535 U.S. 137) held that Federal immigration policy, as expressed by Congress in IRCA, foreclosed the Board from awarding back pay to an undocumented immigrant who has never been legally authorized to work in the United States. The Court found that allowing the Board to award back pay to illegal aliens would unduly trench upon explicit statutory prohibitions critical to federal immigration policy. It would "encourage the successful evasion of apprehension by immigration authorities, condone prior violations of the immigration laws, and encourage future violations."

In dissent, Justice Breyer questioned “where in the immigration laws can the Court find a “policy” that might warrant taking from the Board this critically important remedial power? Certainly not in any statutory language. The immigration statutes say that an employer may not knowingly employ an illegal alien, that an alien may not submit false documents, and that the employer must verify documentation. See 8 U.S.C. § 1324a(a)(1), 1324a(b); 18 U.S.C. § 1546(b)(1). They provide specific penalties, including criminal penalties, for violations (Ibid., 8 U.S.C. § 1324a(e)(4), 1324a(f)(1)). But the statutes’ language itself does not explicitly state how a violation is to effect the enforcement of other laws, such as the labor laws. What is to happen, for example, when an employer hires, or an alien works, in violation of these provisions? Must the alien forfeit all pay earned? May the employer ignore the labor laws? More to the point, may the employer violate those laws with impunity, at least once—secure in the knowledge that the Board cannot assess a monetary penalty? The immigration statutes’ language simply does not say.”

For purposes of this report, the question arises as to whether the Supreme Court ruling affects whether a worker’s illegal status makes him or her ineligible for state workers’ compensation benefits in the event of an occupational injury.

Court cases on rights to workers’ compensation

In recent years, most states have concluded that immigration status is irrelevant as to whether a worker who is injured or killed on the job should be entitled to workers compensation benefits. Some states have reaffirmed this principle following Hoffman.

California law appears to specifically include undocumented workers under the compensation system. Labor Code 3351 defines eligibility of workers. “Employee’ means every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes aliens and minors.” Further, Labor Code 3357 states that “Any person rendering service for another, other than as an independent contractor, or unless expressly excluded herein, is presumed to be an employee.” Other labor code relevant include Section 1171.5: “The Legislature finds and declares the following: “ (a) All protections, rights, and remedies available under state law, except any reinstatement remedy prohibited by federal law, are available to all individuals regardless of immigration status who have applied for employment, or who are or who have been employed, in this state. (b) For purposes of enforcing state labor and employment laws, a person’s immigration status is irrelevant to the issue of liability, and in proceedings or discovery undertaken to enforce those state laws no inquiry shall be permitted into a person’s immigration status except where the person seeking to make this inquiry has shown by clear and convincing evidence that the inquiry is necessary in order to comply with federal immigration law.”

In California, the state Appeals Court found in *Farmer Brothers Coffee v. Ruiz* that despite the Hoffman decision, there are no preclusions of awards of medical and wage loss benefits to undocumented workers under state law. (*Farmer Brothers Coffee v. Ruiz*, 133 CalApp 533 (2005).) “The purpose of the California Workers’ Compensation Act is to furnish, expeditiously and inexpensively, treatment and compensation for persons suffering workplace injury, irrespective of the fault of any party, and to secure workplace safety. (Cal. Const., art. XIV, § 4; *Sea-Land Service, Inc. v. Workers’ Comp.*

Appeals Bd. (1996) 14 Cal.4th 76, 85.) It is remedial and humanitarian. (Bartlett Hayward Co. v. Indus. Acc. Com. (1928) 203 Cal. 522, 529.) Its benefits are not a penalty imposed upon the employer. (State Dept. of Corrections v. Workmen's Comp. App. Bd. (1971) 5 Cal.3d 885, 890-891.) There is no provision in the Workers' Compensation Act imposing civil or criminal sanctions for the employment of illegal aliens. Thus, it does not conflict with the IRCA's (Immigration Reform and Control Act) express preemption provision."

"California law has expressly declared immigration status irrelevant to the issue of liability to pay compensation to an injured employee. (§ 1171.5). Were it otherwise, unscrupulous employers would be encouraged to hire aliens unauthorized to work in the United States, by taking the chance that the federal authorities would accept their claims of good faith reliance upon immigration and work authorization documents that appear to be genuine. Other jurisdictions have come to the same conclusion with regard to their workers' compensation laws. (See for example, Dowling v. Slotnik (1998) 244 Conn. 781, 791, cert. den., Slotnik v. Considine (1998) 525 U.S. 1017; Mendoza v. Monmouth Recycling Corp. (N.J.Super. 1996) 712 A.2d 396, 402.)

As described by the National Employment Law Project, in places where this policy is weakly defined or vague, there may be incentives for employers to hire undocumented workers, sometimes to evade health & safety costs (NELP, August 2004). "Employers in low-wage, high injury industries often hire undocumented workers. Some employers hire immigrant workers with a general knowledge that some in their workforce lack authorization to be employed in the U.S. Others have more specific knowledge that many in their workforce are undocumented. In the worst cases, employers seek out undocumented workers for the purpose of taking advantage of them in order to gain an economic advantage. This has been observed by courts considering the issue, as noted in Fernandez-Lopez v. Jose Cervino, Inc., 288 N.J. Super 14, 20; 671 A.D.2d 1054: "the public policy against illegal immigration may actually be subverted by refusing to grant undocumented aliens workers' compensation benefits. Employers might be anxious to hire illegal aliens rather than citizens or legal residents because they will not be forced to insure against or absorb the costs of industrial accidents."

In Dowling v. Slotnik, 244 Conn. 781, 712 A.2d 396 (1998), Connecticut's highest court found that awarding workers' compensation benefits to illegal aliens cannot reasonably be considered an inducement for aliens to seek work unlawfully. "Potential eligibility for workers' compensation benefits in the event of a work-related injury realistically cannot be described as an incentive for undocumented aliens to enter this country illegally."

In Rajeh v. Steel City Corp. et al, (9/21/04) an Ohio Appeals Court upheld an undocumented workers' right to workers' compensation. The court looked at whether Rajeh fit the definition of "employee" under Ohio's workers' compensation statute and whether or not federal law precludes undocumented workers from receiving benefits under the statute. The court cited the plain language of the workers' compensation statute, specifically the section that defines "employee." The court emphasized that the definition expressly includes "aliens and minors," and rejected Steel City's argument that the legislature intended "aliens" to mean "legal aliens" only.

In Balbuena, et al. v. IDR Realty LLC, et al., New York's high court ruled that undocumented workers injured on the job are not precluded from being awarded lost

wages (5/23/06). In *Wet Walls, Inc. et. al. v. Ledezma*, a Georgia Court upheld a deported worker's right to receive workers' compensation (8/9/04).

Other states appeals courts have taken the view that immigration status does matter for provision of workers' compensation benefits. In Virginia, the lower court, relying on the Supreme Court's decision in *Hoffman Plastic Compounds v. NLRB*, disregarded the Virginia legislature's expanded definition of "employee" and held that the Immigration Reform and Control Act of 1986 (IRCA) forecloses an undocumented person's workers' compensation claim because "even where an illegal alien suffered an intentional wrong at the hands of his employer, to award the illegal alien 'not only trivializes the immigration laws, it also condones and encourages future violations.'" The court therefore ruled that the plaintiff's immigration status was relevant to determining whether he may recover workers' compensation benefits under Virginia law. (The case was actually settled in the claimant's behalf on a ruling concerning his constitutional rights against self-incrimination, but the court's decision stands to allow the relevancy of the immigration status.)(*Xinic v. Quick, et al.*, 2005 Va. Cir. LEXIS 266, Nov. 14, 2005).

Changes in workers' compensation law proposed and passed

In Spring 2006, the National Employment Law Project listed five "anti-immigrant" workers compensation bills that were proposed in state legislative sessions during 2006. Arizona House Bill 2073 would exclude an illegal alien from the definition of employee, workman, worker, and operative, and define illegal alien. Colorado Senate Bill 98 limits eligibility to workers compensation to "legally documented aliens who are lawfully employed," and specifically excludes "an unauthorized alien, as defined in 8. U.S.C. 1324 A(H)(3)." It specified that wage loss shall not be attributable to on the job injury for unauthorized aliens, and precluded unauthorized aliens from recovering all forms of benefits. Maryland House Bill 37 would define "undocumented immigrant" with the stated goal to deny coverage to such undocumented persons. New Jersey Senate Bill 1134 and Assembly bill 654 would exclude from definition of employee "employees who are aliens unless they were lawfully admitted for permanent residence at the time the employment was performed, were lawfully present for the purpose of performing the employment, or otherwise were permanently residing in the United States under color of law at the time the employment was performed." It also provided that no temporary disability benefits will be payable "for any period during which the claimant would be ineligible for unemployment benefits." And in South Carolina, Senate Bill 4598 would define "illegal alien" as "a person who has gained employment through fraudulent means or methods, or both, including, but not limited to, falsification of application, invalid social security number, or falsified or invalid immigration papers." It would criminalize an employer granting benefits to an injured undocumented immigrant by specifying that "an employer who does not withhold worker's compensation contributions from an employee's compensation, who is an illegal alien, is guilty of a misdemeanor." Finally, it would provide for seizure of employer property. None of these bills passed during the 2006 sessions.

In Georgia, the Security and Immigration Compliance Act (SB 529) was signed in April 2006. It includes a measure preventing illegal immigrants from using state health services. The bill requires citizenship verification for individuals using Georgia's public services to ensure they are legally eligible to receive those services. Governor Sonny

Perdue, in signing the bill, stated that “this bill makes it clear that Georgia is a welcoming state that wants to treat our guests with Southern hospitality. But we cannot tolerate activity that distracts us from our ability to embrace those who come here legally.” (April 17, 2006).

Other listings of state legislation restricting benefits for immigrants or promoting State and Local enforcement of immigration laws were published for 2005 by the National Immigration Law Center. Listings of State Employer Sanction bills during 2006 were published by the National Employment Law Project. Counteracting some of these initiatives, some states and localities are attempting to improve immigrant access to social services, and encourage cooperation with law enforcement agencies. The National Employment Law Project highlighted three policies in New York, NY, Philadelphia, and Durham North Carolina. In New York 2003, the city adopted a “privacy policy” protecting individuals from being asked by city workers about their immigration status, as well as having their immigration status shared by city workers. In Philadelphia, a similar policy was established that individuals can seek assistance of city agencies “regardless of personal or private attributes and without negative consequences to their personal lives.” The policy also clarifies circumstances under which questions about immigration status may be properly asked. In Durham, the policy makes city assistance available regardless of immigration status (NELP, December 2003).

Immigrant Access to Health Care

Access to quality health care involves being able to get to and pay for coverage, being able to communicate with the health care provider, and being able to procure followup care and necessary treatments and drugs after the initial and subsequent visits. Immigrant access to health care, then, is conditioned on health insurance or other means of payment, on interacting with a health care provider in a language understood by both parties or assisted by interpreters of language or culture, with management of this care.

Lack of health insurance coverage is a significant issue facing low wage immigrant workers. Non-citizen minorities, especially those with limited or no English language capacity, are more likely to be uninsured than other minorities or white citizens. Compared to white English-speaking citizens, a 2003 Kaiser Commission study found that non-citizen English-speaking Latino adults are twice as likely (55% vs. 28%) to be without health insurance coverage, while primarily Spanish-speaking Latino adults are three times (72% vs. 28%) as likely to be uninsured (Ku and Waldmann, 2003). Among all minority groups studied, Spanish speaking Latinos experience the most significant problems of access to health care, and have greater problems communicating with their health care providers, contributing to poorer quality care. Thirty seven percent of low income non-citizens reported not having a usual source of care, twice as high as the figure for low income citizens.

Among low wage workers, there is also continuing erosion of health benefits. A 2004 Commonwealth Fund study found that premiums for job-based coverage grew faster than income, and deductibles rose quickly. Low wage workers had the least access to paid time off for doctors’ visits and paid sick leave, and, not surprisingly, also the highest percentage of health problems. Access to care, measured by having a regular doctor, having had a blood pressure check in the past year, and having a check of

cholesterol levels in last five years, was lowest for workers earning less than \$10 per hour (Collins et al., 2004).

	Earning < \$10/hour	\$10-15 per hour	Over \$15 per hour
Have Regular Doctor	64%	74%	89%
Blood Pressure checked in last year	74%	84%	91%
Cholesterol checked in last five years	54%	66%	85%

Source: SR Collins, et al, “Wages, Health Benefits and Workers’ Health”, The Commonwealth Fund, October 2004

Low and midrange wage workers were more likely, because of cost, to not fill prescriptions, not see a specialist when needed, skip medical tests, treatment or followup visits, or not see a doctor when sick (Collins et al., 2004). Low wage workers were also more likely to spend more than 5% of income on out of pocket medical costs, and to have problems paying medical bills.

The Commonwealth Fund also reported that 66% of uninsured Spanish speaking Hispanics did not have a regular doctor, compared to 37% among uninsured whites. Forty-four percent of surveyed Hispanics reported that they at least sometimes had trouble understanding their doctor, and that only half of those who needed an interpreter could usually have access to one.

Low wage workers were less likely to be employed by firms that offer health coverage, or to be eligible for a health plan when offered. “Even when low income workers are offered health insurance, many have difficulty paying their share of premiums for coverage that is often of inferior quality” (Collins, April 2003).

Bitler and Shi analyzed the Los Angeles Family and Neighborhood Survey (LAFANS) focusing on 3 questions: Who has health insurance? How does health care use differ among residents in Los Angeles County? And how does health status differ across population groups in the county? They found extensive gender- and age-adjusted differences in insurance coverage between Hispanics and other groups, but immigration status, as opposed to race/ethnicity, was the more important indicator. Undocumented adults were 34 percentage points more likely to be uninsured. “Documented immigrants were 11 percentage points less likely than the U.S.-born to have a usual source of care. For the undocumented, the differences were even greater—they were 20 percentage points less likely than the U.S.-born to have a usual source of care. Undocumented immigrants were also 15 percentage points less likely than the U.S.-born to have seen a dentist during the last year.” Regarding the use of care they found, surprisingly, that hospital and emergency room (ER) visits did not differ much by race/ ethnicity or immigration status. Some immigrant groups and their children may even have been less likely than other groups to have used the hospital or the emergency room (Bitler and Shi, PPIC, 2006).

These last findings were seconded by RAND and NBER researchers Goldman, Smith and Sood in a study published in Health Affairs. They found, based on analysis of the LAFANS survey, that foreign-born, and especially undocumented, workers use proportionately fewer medical services and contribute less to health care costs in relation to their population share, “likely because of their better relative health and lack of health insurance” (Goldman, et al, 2006).

Access to health insurance for Latino workers is conditioned on immigration status; for the undocumented low wage worker, the uninsured rate is growing (Shah and Carrasquillo, 2006). Using data from the March supplements of the Current Population Survey, researchers found overall, from 1993-1998, Latinos experienced a four percentage point increase in uninsurance, due to losses in Medicaid/Medi-Cal coverage that more than offset small gains in employer coverage. During the 2000-2003 period, the overall Latino uninsurance rate remained stable. However, when controlling for immigration status, Latino non-citizens experienced a continuous increase in the proportion uninsured. From 1993-1999, reductions in Medicaid coverage were disproportionately greater among non-citizens than among U.S. born Latinos. During 2000-2004, employer coverage fell and more than offset any other beneficial effects.

Cultural competency

The quality of health care received is in large part influenced by the cultural competency of the providers. Cultural competency intends to improve health care provider abilities to respond to cultural and language barriers and thereby improve communication and interaction with patients, and to enable health care providers to better treat and diagnose conditions more prevalent in minority or immigrant communities. Research has shown that language barriers create significant access issues, can create difficulties when communicating with providers, and are reflected in the perceptions of the quality of care (Perkins, Kaiser Commission on Medicaid and Uninsured, August 2003).

California passed legislation in 2003 to set up voluntary linguistic and cultural competency programs for physicians, and has considered mandatory training. In March 2005, New Jersey enacted legislation mandating that physicians receive cultural competency training. The cultural training in New Jersey was promoted after studies showing differences in patient care by race were published. The training is intended to be both as curriculum in New Jersey medical schools, and as mandatory pre-license-renewal continuing medical education. The Association of American Colleges and University reports that “Cultural competency training is a critical area of interest to regulatory bodies such as the Liaison Committee on Medical Education and the Accreditation Counsel for Graduate Medical Education. ...Arizona, California, Illinois, and New York currently have pending cultural competency legislation.”

In establishing the state Department of Public Health, the Legislature created an office of Multicultural Health. Section 152(a)(6) of the law requires the office to:

- 6) Perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care. (Senate Bill 162 (Ortiz and Runner), Chapter 241, Laws of 2006.)

Community and Occupational Health Clinics and Funding

Because a large proportion of low wage immigrant workers do not have health insurance, they are limited in their access to health care. Lashuay and Harrison (April

2006) found that most low wage and uninsured workers obtain health care at public and nonprofit community health clinics, which may have the language and cultural competency resources to serve them. Access to occupational health services is more problematic because of the full array of obstacles, cited throughout this paper, that deter injured workers from relying on the workers' compensation system or mainstream occupational health prevention activities. While some community clinics screen incoming patients for work-related causes, few knew about mandatory treatment guidelines or had protocols for dealing with the form- and report- heavy process needed to help injured workers navigate through workers' compensation. Many low wage workers, including janitors and cleaners, farm workers and their families, and laborers in demolition or construction work are also at elevated risk for chemical exposures. Lack of adequate housing and sanitation facilities may exacerbate these health and safety problems.

Finding a way to coordinate necessary health services in a culturally competent and prevention oriented health and social service clinic or center is a goal of many. There are a few North American jurisdictions that have funding schemes that provide at least basic funding for occupational health clinic networks, and use information generated by funded organizations to do outreach, research and injury surveillance.

At least two states provide some funding for outreach, clinic services, training and education, data gathering and research by individual sites or networks of occupational medicine clinics, as well as providing some resources for primary prevention activities at the workplace. While not specifically oriented to immigrant low wage workers, they are able to provide a stable source of information and services for injury and illness surveillance. The clinics attempt to assure access to those needing their services, and will take sliding fee or no fee patients when workers' compensation or health insurance coverage is not available.

Connecticut's Labor code includes grants in aid for occupational health clinics and auxiliary occupational health clinics, as well as funding to promote collection of data regarding occupational injury and illness and an occupational health clinics advisory committee. The total budget for the program in FY 07 is about \$650,000. Connecticut allocates its funding in this area as follows: 45% for grants to occupational health clinics (\$291,000 in FY 2007); 20% for grants to auxiliary occupational health clinics (\$129,000); 15% for statistical division of Workers' Compensation Commission; 10% each to the state Labor Department and the Department of Public Health, whose duties include the expenses of the Occupational Health Clinic Advisory Committee. In comparison, Connecticut's workforce is about one-tenth as large as California's.

The New York State Occupational Health Clinic Network (OHCN) is the nation's only state-based occupational health clinic network and is comprised of seven regional clinics (Buffalo, Rochester, Syracuse/Utica/Binghamton, Albany, Westchester/Hudson Valley, Long Island, and New York City) and one center (Cooperstown) with a focus on agricultural medicine. Funded from a surcharge on Workers' Compensation premiums, that typically has amounted to about 1/10th of one percent of premium, the clinics are coordinated by the Department of Health through contracts with sponsoring institutions. The Clinics are mandated to: provide objective diagnosis of suspected work-related medical problems; conduct medical screenings for groups of workers who are at increased risk of occupational illness; make referrals for treatment to other medical

specialists, if necessary; perform industrial hygiene evaluation of workplaces of concern; and provide education and prevention programs. The network was created by the State Legislature in 1987 to offer specialized medical diagnoses, and high quality care and support services for workers with occupational (work-related) diseases. By using multidisciplinary teams of physicians, industrial hygienists, health educators, and social workers, the clinic network provides, in a non-regulatory environment, consultation and advice to employees, employers, employee groups, and other healthcare professionals on steps that can reduce worker injury and illness. The OHCN works with the employers and unions to identify unsafe conditions, evaluate the risks to other workers, and develop methods to eliminate or reduce the risks. Each clinic accepts public and private medical insurance as well as Workers' Compensation. Clinics use a sliding fee scale and no worker is denied care because of a lack of resources.

The New York State Department of Health manages the network and maintains a central data base with records from each clinic. The individual clinics were begun as diagnostic clinics but in some cases have become patient centered primary care facilities. For instance, the Northeast Center for Agricultural Safety and Health is currently receiving support from assistance from the New York State Dept of Health's Bureau of Occupational Health. Total funding from the Bureau is \$624,000 per year (FY 2004 report p. 29). As a member of the bureau's Occupational Clinic Network, NYCAMH receives funding for research, prevention and clinical service activities within the state. This provides the Bureau of Occupational Health with statistics describing the pattern of occupational health problems affecting the farmers of central NY. Please see the following website: http://www.cdc.gov/niosh/oep/pdfs/agcenter_rpts/NECAnnrept03-04.pdf.

At least some of the clinics include industrial hygiene, safety engineer, and health educator services. One clinic professional indicated that an increasing amount of clinic work in recent years has been administrative and billing, and that staffing of the clinic has had to reflect more emphasis on billing problems and less on patient care. He contrasted this situation to the staffing of some clinics in single-payer Ontario where extra resources could be allocated to patient care staffing, not administrative overhead processing.

In Ontario, Canada, the Sarnia-based Occupational Health Clinic for Ontario Workers (OHCOW) received \$1.55 million (Canadian) in permanent funding in 2004. (Please refer to the following website: <http://www.ohcow.on.ca>.) The Sarnia clinic is one of five in the province of Ontario. OHCOW is governed by a twenty-one person volunteer Board of Directors. At the local level each of the five clinics has a Local Advisory Committee. The management of OHCOW is comprised of the managing director, financial manager and the executive directors of the five clinics. Each OHCOW clinic provides comprehensive occupational health services and information in five areas: An inquiry service to answer work-related health and safety questions; medical diagnostic services for workers who may have work-related health problems; group service for workplace health and safety committees and groups of workers; outreach and education to increase awareness of health and safety issues, and promote prevention strategies; and a research services to investigate and report on illnesses and injuries.

The Ontario Workplace Safety and Insurance Board has also recently released a Request for Proposals for Ontario public hospitals to become regional evaluation centers for specific disability rating questions in compensation cases. Such programs can also be

used to build expertise and provide a comprehensive occupational health and injury surveillance and treatment entity in a public facility.

In several other states, interactions between occupational medicine clinics and other groups have assisted in the care of low wage immigrant workers. In Idaho, the Idaho Migrant Council (IMC) has begun holding occupational health and safety training sessions with some employees, as part of their goal to “improve the economic well being of Latinos and migrant and seasonal farmworkers through education or counseling.” A first session, with a group of Head Start teachers, focused on the prevention of back injuries from lifting infants. The Council has begun cooperation with occupational medicine programs at Regional Medical Centers that have been the clinical care site for industrial employers. Some larger employers have opened on-site occupational medicine clinics. Sponsors are hopeful that the expertise of the health care providers will be used beyond the treatment of injuries to help employees get back to work quickly, to help guide employees to follow safe working procedures and prevent injuries. The health care providers will be sent to workplaces to investigate causes of injuries for prevention purposes.

The IMC’s parent organization, the Northwest Regional Primary Care Association hosted the 15th Annual Western Migrant Stream Forum in January, 2006. The Forum brought together migrant health center staff and migrant health professionals from throughout the West Coast, and included a session entitled “An Interactive Workshop: Integrating Occupational and Environmental Health Into Primary Care.”

Recommendations

There are many sets of thoughtful policy statements in the recent literature on low wage or immigrant workers. There are many overlaps in the recommendations, as shown in the following section.

The Platform for International Cooperation on Undocumented Migrants (PICUM) is a European human rights network of organizations providing assistance to undocumented migrants, who are “criminalized and chased on the one hand, and desired and exploited on the other hand.” (PICUM, 2005, p, 5.) The group proposes ten steps toward solutions to this situation: 1) Acknowledge the social and economic presence of undocumented migrants; 2) Collect data; 3) Involve local and nongovernmental organizations in research and policymaking; 4) Ratify the 1990 Migrant Workers’ Convention; 5) Safeguard the right to organize; 6) Regularize undocumented migrants, 7) Assert undocumented workers’ rights in the legal system; 8) Work with governmental agencies to promote rights; 9) Work with employers cooperatively and maintain accountability to fair labor standards through workplace inspection; and 10) Open up the debate on the future of the low wage sector.

The recommendations of the Day Labor study also call for improved worker protections, better enforcement of workplace safety conditions, increased access to legal services (to remedy rights violations), and the implementation of workforce development strategies that can help day laborers make the transition from the informal economy into better jobs, as well as realistic immigration reform, including normalizing the immigration status of undocumented migrants.

In opposition to the immigration bill passed in the House of Representatives during the last session (HR 4437) and to Senate compromise bills, the National Network

for Immigrants and Refugee Rights called upon policymakers to “stop masquerading” those proposals as immigration reform. “The rush to reach a bipartisan accord on immigration legislation has led to a compromise that would create deep divisions within the immigrant community and leave millions of undocumented immigrants in the shadow of our country(NNIRR, April 2006). They support genuine legalization opportunities for undocumented immigrants, including youth and farmworkers; restoration of rights to legal systems where they have been denied; no expansion of guest worker programs; cessation of resources for militarization of borders; strengthening of labor law protections for all workers, native and foreign born, legal and undocumented; no use of city, state or local governmental agencies in enforcement of immigration law; and no more criminalization of immigrants or their service providers.

The American Public Health Association policy statement 2005-4 on Occupational Health and Safety Protections for Immigrant Workers cites lack of data, and linguistic, cultural and legal barriers faced by foreign born workers. “Immigrants, especially new immigrants, may be unfamiliar with local laws regarding safety and health protection or workers’ compensation. In addition to increased risk for workplace injuries... they face barriers to receiving appropriate health care and workers’ compensation.” APHA recommends that OSHA policy be codified so that the agency will not refer cases involving undocumented workers to federal immigration authorities; that regional OSHA initiatives permit collaboration of OSHA and the Employment Standards Administration with local community, faith-based and other trusted worker organizations to establish and promote outreach centers “to train workers about their rights and to identify and forward complaints without fear of identification or retaliation,” and to have a stable funding source with which to do so. APHA also supports increased data gathering, including continuation of the threatened National Agricultural Workers Survey, enhanced outreach and training programs for immigrant and Hispanic workers, posting of notices of violations in languages spoken by employees, and language and culture-appropriate training situations. Further, they support increased hiring of inspectors with language capabilities to match worker populations. They propose a National Emphasis program to target recordkeeping and training requirements applied to temporary agencies and worksites or hiring halls dealing with day laborers. All required safety equipment should be provided to workers free of charge. APHA proposes ensuring that all workers injured on the job, whether documented or not, have access to the compensation system, and that they are not threatened or penalized for using it.

The Progressive Jewish Alliance opposes “simplistic or purely reactive public policy solutions,” opposes criminalization of undocumented workers, and seeks recognition that border policies result “in border crossing deaths without decreasing attempts to cross the border.” They seek immigration reform that includes: a reasonable path “toward earned permanent legal status” for undocumented immigrants; policies that allow family reunification; and improved worker protection programs, including enforcement of labor law, enforcement of rights to organize unions, and removal of restrictions placed on the application of labor rights law to undocumented immigrants (PJA, 2006).

In the Message Of His Holiness Pope Benedict XVI for the 93rd World Day of Migrants and Refugees (2007), The Church “encourages the ratification of the international legal instruments that aim to defend the rights of migrants, refugees and

their families and, through its various Institutions and Associations, offers its advocacy that is becoming more and more necessary. To this end, it has opened Centres where migrants are listened to, Houses where they are welcomed, Offices for services offered to persons and families, with other initiatives set up to respond to the growing needs in this field.”

Attention should be focused on seeing the success of worker centers as coordination and cooperation among many aspects of newly emerging communities, and of providing the 21st century equivalent of settlement houses.

The body of existing research justifies other recommendations. In order to better understand and document the problems of the low wage immigrant population, it is necessary to collect data on demographic differences and health disparities. Some first steps could include prioritizing future studies on access to care in workers’ compensation looking at differences due to language barriers, immigration status, and income of the injured person. In a population that has low levels of access to both general and occupational health care, solutions must be crafted that include improving access to both. There is need to support the establishment and funding of community tied worker centers with basic social services. The provision of occupational health services can be improved through increased cross training with community health clinics, worker centers, and other similar entities. Using the New Jersey statute as a model, medical and nursing schools and continuing education programs could assist in improving clinician understanding of cultural differences.

Past studies have concluded that workers’ compensation in California does not work for low wage immigrant workers, whatever their legal status, and that this system is too complex for vulnerable workers where work status may always be vulnerable (See Lashuay, 2006). There are several ways to begin to tackle this problem.

The state or private foundations could fund a pilot program to provide case finding and treatment of work-related injury and illness, with prevention services integrated within local county and community based primary health care clinics in conjunction with worker centers and university partners. Through recent efforts of the UCSF Community Occupational Health Project, funded by The California Wellness Foundation, many occupational health outreach and education needs of LWIW were met, with these services continuing under the auspices of Street Level Outreach. However, occupational health clinical service delivery is best met through funding an occupational health clinical expert to work side by side with other primary care clinicians within an existing primary care clinic system. In this model, there could be greater recognition and case finding of work-related injury and illness, enhanced provider education about work causation, work restrictions, and workplace interventions under the purview of the medical provider, and more effective reporting within the workers’ compensation system. To answer the question of whether such programs are cost effective, funders should put priority on an evaluation of cost, effectiveness and outcomes over multiple years. Additional support for health care provider training would also be extremely beneficial. The California Wellness Foundation should consider continuing their support and prioritized funding for Community based organizations (CBOs), by organizing efforts to discuss statewide strategies and legislative language to expand the efforts for safe and healthy workplaces for all California workers. This could be done by convening a conference/summit that brings together CBOs, academics and labor groups to specifically

discuss the models for creating an affiliated network of Community Occupational Health Programs (CalCOHP). This effort could bring these 3 groups together around the idea of forming a network that could work toward formulating a strategy for change.

CONCLUSION

Any look into the health and safety of low wage immigrant workers forces a look at the larger landscape of access to health care for any vulnerable population. A simple goal is that everyone needing health care should have access to it. Its attainment is difficult but possible. The problem of occupational injury and illness risks for low wage immigrant workers is large in depth and scope. It is a national problem, increasingly prevalent as low wage immigrant workers are being hired beyond border towns and traditionally large immigration destinations. There is some divergence in statutory law across the various states regarding access to services, and actual day to day policy is even more varied, as overlapping jurisdictions with conflicting laws and policies do not resolve the differences. Many undocumented workers are subjected to discrimination even when their rights are clear, and large portions are unaware of the rights that they have. Having rights does not mean that they are available for use. The lack of clarity in the situation has many effects. Fear of accessing primary health care services may lead to adverse health effects. Misplaced direction of criminalizing the population that has come to work at jobs that pay too little and have poor working conditions creates its own problems. As cited by a European rights group: “The government has always waged a populist campaign against undocumented migrants, as if we were the cause of unemployment, delinquency and criminalization. In fact, it’s important to make native workers aware that they’ll never earn a decent salary as long as we undocumented workers work for less in these conditions.” (Henry Cardona, President of the *Collectif des travailleurs et des travailleuses sans statut légal - Genève* (CTSSL), cited in PICUM, p. 16).

The health and safety situation confronting low wage immigrant workers cannot be solved in a vacuum; it is clearly a situation that will be improved when national policy acknowledges and values the economic and social contributions of immigrant workers. Policies must go beyond protecting undocumented workers, toward helping workers become legal and thereby fully able to assert and join in the benefits of the rights of all workers.

Appendix

Detail on Fatal Occupational Injuries

Event or Exposure for Fatal occupational Injuries						
Employed Population	Motor Vehicle	Assault/Violence	Contact with Material or Object	Fall	Other exposure	total
2002	202	96	62	58	59	478
2003	174	83	76	71	48	452
2004	168	52	80	67	48	416
2005	165	87	76	59	65	453
chg 02-05	-18%	-9%	23%	2%	10%	-5%
Employed Hispanic	Motor Vehicle	Assault/Violence	Contact with Material or Object	Fall	Other exposure	total
2002	64	36	26	22	26	176
2003	51	27	39	28	11	161
2004	54	18	40	32	17	169
2005	60	29	41	25	28	187
chg 02-05	-6%	-19%	58%	14%	8%	6%

Source USDOL/BLS, CFOI

Event or Exposure for Fatal occupational Injuries						
Employed Population	Motor Vehicle	Assault/Violence	Contact with Material or Object	Fall	Other exposure	total
2002	42%	20%	13%	12%	12%	100%
2003	38%	18%	17%	16%	11%	100%
2004	40%	13%	19%	16%	12%	100%
2005	36%	19%	17%	13%	14%	100%
Employed Hispanic	Motor Vehicle	Assault/Violence	Contact with Material or Object	Fall	Other exposure	total
2002	36%	20%	15%	13%	15%	100%
2003	32%	17%	24%	17%	7%	100%
2004	32%	11%	24%	19%	10%	100%
2005	32%	16%	22%	13%	15%	100%

Source USDOL/BLS, CFOI

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