EMPLOYERS' FORUM

June 7, 2020

Ms. Louise Kim
Senior Manager
Policy, Regulation and Research Division
WorkSafeBC
P.O. Box 5350 Station Terminal
Vancouver BC V6B 5L5

Dear Ms. Kim:

Re: Adding Diseases Caused by Communicable Viral Pathogens, including COVID-19, to Schedule 1 of the *Workers Compensation Act (Act)*

The Employers' Forum appreciates the opportunity to comment on the Discussion Paper: Adding Diseases Caused by Communicable Viral Pathogens, including COVID-19, to Schedule 1 of the *Workers Compensation Act (Act)*.

By way of background, the Employers' Forum, established in 1992, is an organization representing employers from major sectors of the provincial economy, including forestry, oil and gas, manufacturing, construction, retail, agriculture, marine, tourism, hospitality, services, professions, technology, food processing, road builders, utilities, transportation, trucking, security, education, health, municipal and other public sector employers. Our members are small, medium and large employers. The primary focus of the Employers' Forum is the British Columbia Workers Compensation System. We currently represent approximately 80 employers and employer organizations. Our current membership list is available at the Employers' Forum website.

Issue

On April 20, 2020 WorkSafeBC's (WSBC) Board of Directors directed the Policy, Regulation and Research Division (PRRD) to amend Schedule 1 of the *Act* to add a presumption for COVID-19 (or potentially more broadly coronaviruses or respiratory communicable diseases). As outlined in the Discussion Paper, a central issue is how to describe the disease and the corresponding process or industry in Schedule 1 for the purposes of creating a new presumption. Before responding to the "issue" it is important to first provide some relevant background and context.

Discussion

It is important to outline the employer's perspective regarding the nature and purpose of Schedule 1 of the *Act* and its role in the Workers Compensation System. As a no-fault insurance scheme, it is critical the system has the necessary structures and processes in place to ensure every worker who is unable to earn full wages because of a workplace injury or disease is appropriately compensated. Compensation for work related injury or disease is at the heart of the historic compromise and the basis of the long-standing agreement between employers and workers. Policy makers must resist contemporary pressures to expand WorkSafeBC's mandate beyond its lawful structure no matter how real and pressing the current societal concerns that British Columbians face.

The federal and provincial responses to this pandemic have been rapid and coordinated. At the behest of citizens including strong representations from the BC business community, Premiers Horgan, Silver and Pallister recently issued a joint statement, requesting the federal government create a federally-funded national sick pay program under the auspices of the Canada Emergency Response Benefit Program and/or the Employment Insurance Act for the duration of the COVID-19 pandemic. Prime Minister Trudeau has publicly committed to work jointly with the provinces to provide sick leave to ensure Canadians comply with public health directives. In our view, a publicly funded sick pay program would obviate the need for presumptive coverage.

Insufficient scientific information and nature of this pandemic means the Workers Compensation System can only effectively address claims on a case-by-case basis, much as public health officials are currently doing within the contact tracing process. This pandemic – like all pandemics – is a public health crisis not a workplace health crisis. The provincial government recognized this in its management of the crisis going to extraordinary lengths to close public spaces, while also keeping more workplaces open than other provinces. Accordingly, the Employer's Forum strongly believes there needs to be social program solutions to this pandemic.

The addition of a presumption under Schedule 1 of the *Act* would bring a public health pandemic into the ambit of the Workers Compensation System thereby upsetting the careful and long-standing balance established in the historic compromise. Requiring employers to fund a presumption transfers public health costs to the workers compensation system which is funded by employers. Shifting public health costs onto employers through WorkSafeBC premiums has no basis in science and is a betrayal of historic agreement. If COVID-19 were added it would be the first and only element of Schedule 1 that places public health costs squarely onto employer payrolls. Embedding public health costs in WorkSafeBC premiums could be ruinous for businesses who are unable to absorb any further fixed or variable cost increases because of the ongoing fallout from COVID-19, and could undermine the long-term financial stability of WSBC.

To be clear, we believe unequivocally that every worker in British Columbia who is disabled from contracting COVID-19 as a result of their employment must be compensated for lost wages. The

nature of a pandemic creates a nexus between public health and occupational health. Addressing workplace cases of the disease requires thorough analysis and adjudication to ensure the integrity of the compensation system is not compromised by addressing real and pressing public health and social concerns through the Workers Compensation System.

We are also perplexed by the timing and stated urgency. The proposed addition to Schedule 1 will do nothing to address most COVID-19 claims arising in 2020. WSBC has a dedicated and professional team of adjudication personnel who are processing COVID-19 related claims and accepting or denying them as expeditiously as possible. It is our understanding there is currently no backlog nor is one anticipated. And there is no adjudicative rationale for the proposed amendment.

Supported by decades of jurisprudence and practice, in our view Schedule 1 is a tool for adjudicative expediency, not a tool to create entitlement. This is a critical distinction. Schedule 1 abbreviates the adjudication process and codifies institutional experience. As the proposed changes are outlined however, the issue under consideration is "how to describe the disease and the corresponding process or industry in Schedule 1 for the purposes of creating a new presumption." As stated in the Consultation Paper, it appears that a new presumption will be added to Schedule 1 – irrespective of what expert and scientific evidence demonstrates.

This is very worrisome. In our view, the first issue to be considered should be:

> "At issue is to make a determination as to whether expert medical/scientific evidence demonstrates that Communicable Viral Pathogens, including COVID-19, should be added to Schedule 1; and, if so, how to describe the disease and corresponding process or industry in Schedule 1 for purposes of creating a new presumption."

From the quote it appears there is insufficient evidence for the proposed amendment. Board policy limits listing diseases on Schedule 1 to circumstances where the Board concludes that a disease is more likely to occur in connection with a specific industry covered by the *Act* than elsewhere. Specifically, page 12 of the discussion paper notes:

> "Policy states the Board of Directors may add a disease to Schedule 1 along with a corresponding process or industry where scientific and medical evidence establishes there is a substantially greater incidence of a particular disease in a particular employment than there is in the general population."

The critical point is that the addition of any new presumption to Schedule 1 is based upon "scientific and medical evidence".

The Discussion Paper reviews the available medical/scientific evidence on pages 8 & 9. Specifically, it summarizes the result of three Rapid Reviews as follows:

(a) COVID-19 – "…, the Rapid Review generally concludes there is no consistent association between workers in a specific occupation and a greater risk of COVID-19 infection."
(b) SARS – "…, the Rapid Review generally concludes there is weak evidence of a consistent association between nurses who work closely with SARS patients and a greater risk of the SARS coronavirus infection."
(c) H1N1 – "…, the Rapid Review generally concludes there is no strong evidence of a consistent association between workers in a specific occupation and a greater risk of H1N1 infection."

With respect to COVID-19, page 28 of the Discussion Paper (page 7 of the Appendix) notes:

> "The level of evidence on this important subject is currently low, as is the consistency of findings between this small mix of studies. Currently, there is some evidence from two large cohort studies documenting that the overall incidence of COVID-19 infection is higher among some HCWs when compared to the general population. However, in a single report from a local (Canadian) jurisdiction, the incidence and therefore relative risk of occupational-related COVID-19 infection, specifically, is lower in comparison to the general population."

The final bullet in the summary states:

> **"Based on the limited analytic epidemiologic research currently available, the general conclusion of this rapid review is that there is no consistent association between work within a specific occupation and a greater risk of COVID-1, SARS and H1N1 infection."** (emphasis added)

Based on the above "expert medical/scientific evidence" provided to WorkSafeBC, there is no justification to add Communicable Viral Pathogens, including COVID-19, to Schedule 1. Given the Board's existing policy framework detailed above, we do not see how any other conclusion can be reached. Adding COVID-19 to Schedule 1 would be inconsistent with the Board's binding policy and in our view could be a basis for questioning the lawful validity of any such presumption.

Turning to the second element of the presumption, we do not believe it is possible to develop policy that could effectively delineate occupational versus community-based transmission. The transmission of the virus is still not well understood but it is clear it is spread in household settings, public spaces and gatherings, transit systems, and routine activities of daily life. In the vacuum of epidemiological evidence, any presumptive language is inherently flawed and unsupportable. If risk for an occupational population cannot be determined, then adding a related presumption cannot be based on differential risk. Simply put, if there is no differential of risk, then in accordance with the *Workers Compensation Act* and policy, no presumption of work causation can be made.

Recommendation

For the reasons discussed above, the Employers' Forum supports Option 1: Status Quo. There is no scientific and/or medical evidence to delineate a differential of risk, as required by Board policy.

The Employers' Forum strongly opposes Option 2. As noted, the best available scientific and medical evidence shows no consistent association between work within a specific occupation and a greater risk of contracting COVID-1, SARS or H1N1. The process for recognizing an occupational disease is set out in policy. To reiterate, the Board may only list a disease in Schedule 1 in connection with a described process or industry when it is satisfied from the expert medical and scientific advice it receives there is a substantially greater incidence of the particular disease in a particular employment than there is in the general population. The discussion paper provides no such evidence and in fact confirms there is no such evidence.

A decision to adopt this proposal would be inconsistent with Board policy, contrary to the adjudicative principles upon which the compensation system is based, and ultimately could be considered unlawful. If, **despite manifest lack of evidence**, the Board of Directors chooses to implement Option 2, the application of differential risk analysis in the proposed policy is critical. This pandemic is a public health issue characterized by extensive community spread. Language reflecting this reality must be included to ensure the compensation system remains as closely aligned as possible to the intent of the historic compromise, which does not include employers providing compensation for illnesses firmly in the realm of public health. The existing language in RSCM policy C4-28.00, *Contagious Diseases,* is illustrative, particularly Example 1 addressing meningitis. The proposed words "***significantly greater than the public at large***" are essential to maintain the integrity of the compensation system.

Thank you again for the opportunity to comment on the Discussion Paper: Adding Diseases Caused by Communicable Viral Pathogens, including COVID-19, to schedule 1 of the *Workers Compensation Act*. If you would like to discuss the issues raised in this submission in greater detail, please do not hesitate to contact us.

Yours truly,

Managing Director