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Worker Participation in a Time of COVID

A Case Study of Occupational Health and Safety Regulation in Ontario

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Article abstract

This study examines worker voice in the development and implementation of safety plans or protocols for covid-19 prevention among hospital workers, long-term care workers, and education workers in the Canadian province of Ontario. Although Ontario occupational health and safety law and official public health policy appear to recognize the need for active consultation with workers and labour unions, there were limited – and in some cases no – efforts by employers to meaningfully involve workers, worker representatives (reps), or union officials in assessing covid-19 risks and planning protection and prevention measures. The political and legal efforts of workers and unions to assert their right to participate and the outcomes of those efforts are also documented through archival evidence and interviews with worker reps and union officials. The article concludes with an assessment of weaknesses in the government promotion and protection of worker health and safety rights and calls for greater labour attention to the critical importance of worker health and safety representation.

ARTICLE

Worker Participation in a Time of COVID: A Case Study of Occupational Health and Safety Regulation in Ontario

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Abstract: This study examines worker voice in the development and implementation of safety plans or protocols for COVID-19 prevention among hospital workers, long-term care workers, and education workers in the Canadian province of Ontario. Although Ontario occupational health and safety law and official public health policy appear to recognize the need for active consultation with workers and labour unions, there were limited – and in some cases no – efforts by employers to meaningfully involve workers, worker representatives (reps), or union officials in assessing COVID-19 risks and planning protection and prevention measures. The political and legal efforts of workers and unions to assert their right to participate and the outcomes of those efforts are also documented through archival evidence and interviews with worker reps and union officials. The article concludes with an assessment of weaknesses in the government promotion and protection of worker health and safety rights and calls for greater labour attention to the critical importance of worker health and safety representation.

Keywords: COVID-19, worker voice, worker representation, occupational health and safety, joint committees, labour unions, public health, long-term care, health care, public schools

Résumé : Cette étude examine la voix des travailleurs dans l'élaboration et la mise en œuvre de plans ou de protocoles de sécurité pour la prévention du COVID-19 chez les travailleurs hospitaliers, les travailleurs de soins de longue durée et les travailleurs de l'éducation dans la province canadienne de l'Ontario. Bien que la loi ontarienne sur la santé et la sécurité au travail et la politique officielle de la santé publique semblent reconnaître la nécessité d'une consultation active avec les travailleurs et les syndicats, il y a eu des efforts limités – et dans certains cas aucuns efforts – déployés par les employeurs pour impliquer de manière significative les travailleurs, les représentants des travailleurs (délégués), ou des responsables syndicaux pour évaluer les risques liés au COVID-19 et planifier les mesures de protection et de prévention. Les efforts politiques et juridiques des travailleurs et des syndicats pour affirmer leur droit de participer et les résultats de ces efforts sont également documentés par des preuves d'archives et des entretiens avec des délégués et des responsables syndicaux. L'article se termine par une évaluation des faiblesses de la promotion et de la protection par le gouvernement des droits des travailleurs en matière de santé et de sécurité et appelle à une plus grande attention des travailleurs à l'importance cruciale de la représentation en matière de santé et de sécurité des travailleurs.

Mots clefs : COVID-19, voix des travailleurs et travailleuses, représentation des travailleurs et travailleuses, santé et sécurité du travail, comités paritaires, syndicats, santé publique, soins de longue durée, soins de santé, écoles publiques

THE COVID-19 PANDEMIC IMPOSED an unwelcome stress test on our institutions and social arrangements, often revealing their underlying weaknesses and flaws. Regimes of occupational health and safety (OHS) regulation are one of them. Many workplaces became sites of major outbreaks, affecting the employees, their families, and the communities in which they reside. For example, in the first wave of COVID-19, between 15 January and 23 July 2020, Canadian health care workers accounted for nearly 20 per cent of all recorded cases and roughly 13,000 filed workplace injury claims, representing the majority of COVID-related claims.¹ Overall, in the first two years of the outbreak, over 150,000 health care workers were ill with the virus, leading to at least 46 deaths.² In Ontario, many of these deaths were in long-term care (LTC) facilities with well-documented evidence of horrendous conditions for workers and residents.³ Several Canadian studies have also demonstrated the wider toll on physical and mental health suffered by overworked and overstressed health care workers.⁴ While teachers did not experience the same burden of COVID infections, in part because schools were closed shortly after the initial outbreak, they too experienced enormous stress. A survey of Toronto teachers found that only 20 per cent of teachers felt safe at work and only 30 per cent said they were satisfied with the safety procedures put into place to protect their health and with the school boards' communication on

1. Canadian Institute for Health Information (CIHI), *COVID-19 Cases and Deaths in Health Care Workers in Canada*, 31 March 2022, <https://www.cihi.ca/en/covid-19-cases-and-deaths-in-health-care-workers-in-canada>; Carrie Tait, "Roughly 13,000 Health Care Workers File Workplace Injury Claims Tied to COVID-19," *Globe and Mail*, 15 July 2020, <https://www.theglobeandmail.com/canada/alberta/article-roughly-13000-health-care-workers-file-workplace-injury-claims-tied/>.

2. CIHI, *COVID-19 Cases*.

3. Ontario, Long-Term Care COVID-19 Commission, *Final Report* (2021), 159, <https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf>; Office of the Auditor General of Ontario, *COVID-19 Preparedness and Management: Special Report on Pandemic Readiness and Response in Long-Term Care* (Toronto, April 2021), 11, https://www.auditor.on.ca/en/content/specialreports/specialreports/COVID-19_ch5readinessresponseSLTC_en202104.pdf.

4. Ellen Badone, "From Cruddiness to Catastrophe: COVID-19 and Long-term Care in Ontario," *Medical Anthropology* 40, 5 (2021): 389, doi:10.1080/01459740.2021.1927023; James T. Brophy, Margaret M. Keith, Michael Hurley & Jane E. McArthur, "Sacrificed: Ontario Healthcare Workers in the Time of COVID-19," *New Solutions: A Journal of Environmental and Occupational Health Policy* 30, 4 (2021): 267; Peter M. Smith, John Oudyk, Guy Potter & Cameron Mustard, "The Association between the Perceived Adequacy of Workplace Infection Control Procedures and Personal Protective Equipment with Mental Health Symptoms: A Cross-Sectional Survey of Canadian Health-Care Workers during the COVID-19 Pandemic," *Canadian Journal of Psychiatry/La Revue Canadienne de Psychiatrie* 66, 1 (2020): 1, doi:10.1177/0706743720961729.

these policies. Seventy per cent reported feeling burnt out.⁵ These outcomes suggest that employers and government regulators failed to protect the health and safety of these workers, many of whom, often with the assistance of their unions, struggled to secure a safer work environment. These latter efforts are the focus of this study.

In this article, we provide case studies of three groups of “essential” workers and their unions attempting to influence government policy and workplace COVID plans in Canada’s most populous province, Ontario: teachers, hospital workers, and LTC workers. We chose these groups because most are unionized and employed in the public sector and presumably, therefore, well positioned to give voice to and act on their OHS concerns. Ontario public school teachers are fully unionized and required to be members of province-wide unions designed to represent their sector, including the Ontario English Catholic Teachers’ Association (OECTA), the Elementary Teachers’ Federation of Ontario (ETFO), and the Ontario Secondary School Teachers’ Federation (OSSTF). There are about 126,000 full-time-equivalent public school teachers in Ontario, employed by 72 public school boards and teaching over 2,000,000 students.⁶ Collective bargaining takes place both at a central table, where province-wide issues are addressed, and at local school board tables.⁷ School boards also employ education support workers, support staff, and maintenance workers, many of whom are unionized and represented by a variety of unions including the Canadian Union of Public Employees (CUPE) and the Ontario Public Service Employees Union (OPSEU).

The situations of hospital and LTC workers are more varied. Hospital workers are quite a diverse group, including nurses and technical and support staff. In 2020 there were about 225,000 hospital employees in the province; most were unionized and represented by seven different unions, the three largest being the Ontario Nurses’ Association (ONA), OPSEU, and the Ontario Council of Hospital Unions/CUPE (OCHU-CUPE). The Ontario Hospital Association (OHA) bargains a master agreement on behalf of about 140 of Ontario’s 371 hospitals. Other hospitals negotiate individually.

Unlike hospitals, which are almost all public institutions, the LTC industry in Ontario consists of public and private facilities – an artifact of Ontario’s neoliberal policy of promoting privatization.⁸ There are over 100,000 workers

5. Nadine Yousif, “Most Students Feel Safe from Catching COVID in the Classroom: The Same Can’t Be Said for Teachers, TDSB Survey Reveals,” *Toronto Star*, 24 February 2021.

6. Ontario, Ministry of Education (MOE), “Education Facts, 2019–2020 (Preliminary),” last modified 21 April 2021, <http://www.edu.gov.on.ca/eng/educationfacts.html>.

7. Sara Slinn & Karen Schucher, “A Cross-Jurisdictional Study of Collective Bargaining Structures for K–12 Education in Canada,” in Sara Slinn & Arthur Sweetman, eds., *Dynamic Negotiations: Teacher Labour Relations in Canadian Elementary and Secondary Education* (Montréal & Kingston: McGill-Queen’s University Press, 2012), 13–50.

8. Nicole Molinari & Geraldine Pratt, “Seniors’ Long-Term Care in Canada: A Continuum of

employed in nursing and residential care facilities, about 58 per cent of whom are personal support workers, while registered nurses account for about 25 per cent. Other staff include allied professionals and service workers who provide housekeeping, etc.⁹ The workforce is disproportionately racialized and immigrant and much of the work is part time. The four largest unions in this sector are ONA, CUPE, OPSEU, and the Service Employees International Union (SEIU).

Worker participation in OHS regulation was legally mandated beginning in the 1970s, when the regime shifted from what might be characterized as a weak command-and-control model, in which highly prescriptive rules were poorly enforced, to one described as regulated self-regulation. Under this latter model, employers are still required to control workplace hazards, often according to prescriptive standards, but in other areas they have leeway to design workplace policies and procedures that comply with the general duty “to take every precaution reasonable in the circumstances for the protection of the worker.”¹⁰ To that end, they are required to have written health and safety policies that must be maintained and implemented. Successive Ontario governments since the 1970s have emphasized the importance of this so-called internal responsibility system (IRS) by identifying it as the foundation of OHS regulation.¹¹

Governments, however, also accepted the principle that effective injury and disease prevention requires worker participation in the employer’s IRS. The law gives workers three participatory rights: the right to know, the right to participate, and the right to refuse. Employers are required to inform workers of hazards present in the workplace and to provide training. Larger workplaces (with twenty or more employees) are required to establish bipartite joint health and safety committees (JHSCs) with worker representatives, while smaller places with at least six employees must have a single worker health and safety representative (HSR). HSRs, JHSCs, and worker representatives (reps) participate in the IRS in a variety of ways, including being consulted in the

Soft to Brutal Privatisation,” *Antipode* (2021), doi:10.1111/anti.12711; Pat Armstrong, Hugh Armstrong & Krystal Kehoe MacLeod. “The Threats of Privatization to Security in Long-Term Residential Care,” *Ageing International* 41 (2016): 99.

9. Long-Term Care Staffing Study Advisory Group, “Long-Term Care Staffing Study” (Ministry of Long-Term Care, Ontario, July 30, 2020), 6, <https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf>.

10. Occupational Health and Safety Act, RSO 1990, c O.1 (hereafter cited as OHSA), s. 25(2)(h).

11. Robert Storey & Eric Tucker, “All That Is Solid Melts into Air: Worker Participation in Health and Safety Regulation in Ontario, 1970–2000,” in Vernon Mogensen, ed., *Worker Safety Under Siege: Labor, Capital, and the Politics of Workplace Safety in a Deregulated World* (Armonk, New York: M. E. Sharpe, 2006), 157–186; Gary Gray, “The Responsibilization Strategy of Health and Safety: Neoliberalism and the Reconfiguration of Individual Responsibility For Risk,” *British Journal of Criminology* 49, 3 (2009): 326; Alan Hall, “The Depoliticization of Health and Safety Committees and Representatives: The Ontario Case,” *Capital & Class* (advance online publication 30 November 2021), doi:10.1177/03098168211061584.

development of workplace OHS policies and procedures and conducting periodic workplace inspections.¹² Finally, workers have a protected right to refuse work they reasonably believe may harm themselves or another worker.

Despite these legal rights, research demonstrates a history of significant constraints on the capacity of Canadian workers and reps to exercise them in a consistent and effective manner.¹³ The same literature also reveals variations in worker participation over time and in different places, yielding significant differences in health and safety outcomes. It is against this background that we examine the efficacy of worker voice and the institutional arrangements that are supposed to provide workers with a meaningful capacity to influence OHS regulation and employer policies and practices in the context of the COVID outbreak.

Notwithstanding the primacy given to the IRS, there remains an external responsibility system (ERS), operated principally by the Ministry of Labour, Immigration, Training and Skills Development (MOL), that sets and enforces prescriptive standards and compliance with IRS requirements, including worker participation. The law vests OHS inspectors with the authority to enter workplaces in response to complaints (reactive enforcement) or on their own initiative (proactive enforcement) and empowers them to issue compliance orders and stop-work orders or impose minor penalties for violations.¹⁴ Thus, an inspector can order or fine an employer who fails to provide workers with prescribed safety equipment or to comply with the IRS mandate to, for example, inform workers of hazards or hold required JHSC meetings. Inspector orders (or failure to issue an order) can be appealed to the Ontario Labour

12. Our case studies did not involve smaller workplaces and thus is limited to the experience of worker representatives on JHSCs. However, some of the government documents we quote refer both to health and safety representatives in smaller workplaces and to worker representatives on JHSCs, so it is important to remember the difference between the two.

13. Alan Hall, *The Subjectivities and Politics of Occupational Risk: Mines, Farms, and Auto Factories* (London: Routledge, 2021); Marcia Facey, Ellen MacEachen, Anil Verma & Kathy Morales, "The Everyday Function of Joint Health and Safety Committees in Unionized Workplaces: A Labour Perspective," *Policy and Practice in Health and Safety* 15, 2 (2017): 160; Alan Hall, Anne Forrest, Alan Sears & Niki Carlan, "Making a Difference: Knowledge Activism and Worker Representation in Joint OHS Committees," *Relations industrielles/Industrial Relations* 61, 3 (2006): 408; Annalee Yassi, Karen Lockhart, Mona Sykes, Brad Buck, Bjorn Stime & Jerry M. Spiegel, "Effectiveness of Joint Health and Safety Committees: A Realist View," *American Journal of Industrial Medicine* 56, 4 (2013): 424; Gary Gray, "A Socio-legal Ethnography of the Right to Refuse Dangerous Work," *Studies in Law, Politics, and Society* 24 (2002): 133; John O'Grady, "Joint Health and Safety Committees: Finding a Balance," in Terrence Sullivan, ed., *Injury and the New World of Work* (Vancouver: UBC Press, 2000), 162–197; Eric Tucker, "And Defeat Goes On: An Assessment of Third Wave Health and Safety Regulation," in Frank Pearce & Laureen Snider, eds., *Corporate Crime: Contemporary Debates* (Toronto: University of Toronto Press, 1995), 245–257; Robert Sass, "A Case Study: The Limits of Workplace Health and Safety Reform in Liberal Economies," *New Solutions* 3, 1 (1993): 31.

14. Inspectors may recommend more serious deterrence measures, but they cannot impose them.

Relations Board (OLRB). As well, sitting somewhere between the IRS and the ERS for unionized workers is the collective agreement, which may impose OHS obligations on employers in addition to those imposed by statute. The union can enforce an alleged breach of the employer's collective bargaining obligations through arbitration.

While the structure of the IRS centres on the workplace, there are avenues for workers and their unions to participate in the development of OHS policies at the provincial and sectoral levels. For instance, Ontario's *Occupational Health and Safety Act* (OHSA) establishes a province-wide Prevention Council that must include representatives from trade unions and non-unionized workers.¹⁵ However, for the most part, worker and union voice and participation above the workplace level is not legally mandated and therefore those channels exist at the discretion of government or employers.

Data Sources and Analysis

THE CASE STUDIES RELY ON THREE DATA sources: archival documents and media reports, government OHS enforcement and injury statistics, and interviews with labour union informants. All documents and communications pertaining to COVID safety planning were collected from government websites – including MOL, Ministry of Health (MOH), Ministry of Long-Term Care (MLTC), and Chief Medical Officer of Health (CMOH) – covering the time frame of 1 February 2020 to 1 April 2021. Content regarding safety plans was identified and organized by themes relating to direct orders and consultation. Injury and compensation statistics were collected from the Workplace Safety and Insurance Board and enforcement statistics (inspections, orders, work refusals) from the MOL covering 1 March 2020 to 31 December 2020. Open-ended qualitative interviews were conducted with provincial and local executive officers and provincial and local worker representatives on JHSCs (n=25) from three main health care unions (ONA, OPSEU, and CUPE) and four main public school unions (OECTA, ETFO, OSSTF, OPSEU). Interviews with provincial staff were focused on outlining provincial-level activities aimed at supporting union and worker input into safety plans and providing overviews of local experiences, while interviews with local officials were aimed at obtaining more detailed accounts of their participation in safety planning.¹⁶ Analysis was focused on identifying and describing (a) key experiences of safety plan involvement and voice and (b) activities aimed at gaining involvement. Officials also provided us with additional documents and data on their communications, grievances, MOL inspections, and other legal activities.

15. OHSA, s. 2.2(2).

16. Both authors conducted the interviews over Zoom, with a rotation of the interviewer and note taker roles. Since interviews were not recorded, the cited quotes in this article reflect our best efforts to replicate accurately what was said.

Ontario's Approach to COVID in the Workplace

BEFORE TURNING TO THE CASE STUDIES, it is important to first understand how Ontario's system of OHS regulation – regulated self-regulation – responded to COVID-19. As a starting point, as mentioned, the *OHSA* imposes a general duty on employers to take every precaution reasonable in the circumstances for the protection of a worker, and this includes protection from infectious diseases that may be spread in the workplace.¹⁷ However, no specific regulations directly address the control of infectious diseases. Rather, consistent with the regulated self-regulation approach, regulations require employers, in consultation with the JHSC, to develop policies and procedures to control the risk of infection.¹⁸ In line with that general approach, early COVID-related communications from the MOL emphasized that the employer was responsible for protecting workers, which included preventing exposure to COVID. Accordingly, as COVID spread in Ontario, the provincial government required that all employers develop specific COVID “safety plans” as outlined in a guide and template.¹⁹

The recommended process for developing a safety plan involved two key steps: first, identify and assess the risks of contracting and spreading the virus within the workplace; and second, identify and implement control measures. Employers were advised “to discuss and share your safety plan with everyone at work,” but there was no explicit instruction to involve JHSCs in a plan's development and implementation.²⁰ Other MOL communications recommended that “employers *should* [our emphasis] assess the workplace in consultation with the joint health and safety committee or health and safety representative,” but there was no instruction that employers were legally required to do so.²¹ None of the government's safety plan materials made any mention whatsoever of employer consultation or communication with the workers' unions where they were present.

While the MOL was advising employers about workplace safety plans, it was letting the CMOH and district public health officers take the lead in setting

17. *OHSA*, s. 25(2)(h); Ontario, Ministry of Labour, Immigration, Training and Skills Development (MOL), “COVID-19 and the Occupational Health and Safety Act,” 19 May 2020, <https://www.ontario.ca/page/covid-19-occupational-health-safety-act>.

18. For example, see Health Care and Residential Facilities, O. Reg. 67/93, ss 8, 9(1)4.

19. Ontario, MOE, “Approach to Reopening Schools for the 2020–2021 School Year,” 19 June 2020, <https://www.ontario.ca/page/approach-reopening-schools-2020-2021-school-year>; Ontario, MOE, “Guide to Reopening Ontario's Schools,” 30 July 2020, <https://www.ontario.ca/page/guide-reopening-ontarios-schools>.

20. Ontario, MOE, “Guide to Reopening.”

21. Ontario, MOL, “Guide to Developing Your COVID-19 Workplace Safety Plan,” 16 June 2020, <https://www.ontario.ca/page/guide-developing-your-covid-19-workplace-safety-plan>.

policy, much as it had during SARS, for which it was heavily criticized.²² For example, and as will be discussed in more detail below, beginning in March 2020 the CMOH issued a series of directives regarding precautions and procedures to be followed by health care and LTC workers, including access to personal protective equipment (PPE), under the authority of the *Health Promotion and Protection Act*.²³ While a deputy minister from the MOL was at least involved in revising some directives, along with deputy ministers from MOH, MLTC, and the Ministry for Seniors and Accessibility, at no point did the MOL promulgate its own regulations, despite its authority to do so.²⁴ Not surprisingly, the directives were very limited in their acknowledgement of the need for worker, JHSC, or union involvement in safety plans. Most directives simply advised *communicating* with employees rather than involving JHSCs or worker reps in safety planning.²⁵ Public health officials' lack of concern with worker participation reflected the government's dismissive attitude toward collective bargaining rights, seen in its earliest emergency orders empowering hospitals, LTC facilities, retirement homes, municipalities, and other agencies providing social services to override collective agreements to redeploy their workforces, without any obligation to first consult with affected unions.²⁶

Finally, in addition to taking a back seat to public health officials, the MOL did not step up its enforcement activities in response to the crisis. Initially, to protect the health and safety of inspectors, most inspections were conducted remotely. But even as in-person inspections became more frequent, orders were issued sparingly. Between March and December 2020, 33,047 proactive and reactive COVID-related inspections were conducted but only 33,460 orders were issued, or a little more than 1 per inspection.²⁷ By contrast, in fiscal year

22. Ontario, SARS Commission, *Spring of Fear: Final Report*, 2 vols. (Toronto, 2006).

23. RSO 1990, c H.7, s. 77.7.

24. See, for example, Ontario, Ministry of Health (MOH), "Update regarding Directive 5," 7 April 2021. The *Health Protection and Promotion Act* specifies (in section 77.7(5)) that in the event of a conflict between directives issued pursuant to that act and regulations issued pursuant to the *OHSA*, the *OHSA* regulations prevail.

25. For example, see Ontario, Chief Medical Officer of Health (CMOH), "Directive #1 For Health Care Providers and Health Care Entities," 21 December 2020. Directives also stated that employers were required to comply with the *OHSA* and its regulations.

26. Harry Glasbeek & Eric Tucker, "The Anti-union Virus inside the Emergency Powers: Lessons for Workers," *The Bullet*, 26 April 2020, <https://socialistproject.ca/2020/04/antiunion-virus-emergency-powers/>.

27. Mario Possamai, *Fatal Choices: COVID-19, Nursing and the Tragedy of Long-Term Care* (Toronto: Ontario Nurses' Association, 2021), <https://www.ona.org/wp-content/uploads/fatal-choices-ltc-report-2021-f.pdf>; Ontario, Freedom of Information Data Request to the Ontario Ministry of Labour, G2021-00016, 2021 (hereafter cited as FOI 2021). A total of about 53,000 proactive and reactive inspections were conducted during this period and about 58,000 orders were issued, or a little more than one per inspection.

2017–18, about 3.5 orders were issued per inspection.²⁸ Of the COVID-related orders issued, about 1,500 related to failure to consult or non-compliance with other JHSC requirements.²⁹ During that same March to December 2020 period, only one employer was fined and none were prosecuted.³⁰ MOL inspectors also rarely supported work refusals. In the first few months of COVID, inspectors were called to over 200 COVID-related work refusals but did not uphold one, and after a year and half the ministry had upheld just 8 of 482.³¹

Against this background of limited enforcement or state support for worker and union participation in safety planning, the sections that follow examine the efforts of workers and unions within the education and health care sectors to influence COVID safety planning at the provincial, sectoral, and workplace levels.

Worker Voice in COVID-19 Safety Planning in Public Education

Education worker voice at the provincial level

On 12 March 2020, the Ontario Ministry of Education (MOE) closed Ontario's public schools; they remained closed until September 2020.³² Although some workers were still required to work on-site, the move to online teaching provided some time for the development of school safety plans and an opportunity for teachers and other educational workers to influence those plans. As noted, the government took the view that each employer would need to develop its own plan, but its various ministries provided guidance. Guidance was also provided by provincial safety associations. Thus, while the *OHSA* is focused primarily on *workplace* OHS policies and procedures, unions actively sought to be involved in policy decisions at whatever level or institutional location they were happening.

28. Ontario, MOL, "Quick Reference Guide," unpublished guide, 2018.

29. FOI 2021.

30. Sara Mojtahedzadeh, "Thousands of Workers Got COVID-19 on the Job: But the Ministry of Labour Has Fined Just One Employer," *Toronto Star*, 19 December 2020, <https://www.thestar.com/news/gta/2020/12/19/thousands-of-workers-got-covid-19-on-the-job-but-the-ministry-of-labour-has-fined-just-one-employer.html>.

31. Sara Mojtahedzadeh, "Many Ontario Workers Are Trying to Refuse Work due to COVID-19 Fears – But the Government Isn't Letting Them," *Toronto Star*, 27 April 2020, <https://www.thestar.com/business/2020/04/27/many-ontario-workers-are-trying-to-refuse-work-due-to-covid-19-fears-but-the-government-isnt-letting-them.html>.

32. The provincial government ended in-person teaching in April 2021 because of the third wave of COVID infections. We conducted our interviews over the summer of 2021 and thus are unable to consider the experience of Ontario teachers and education workers since the schools' reopening in September 2021. Ontario Secondary School Teachers' Federation v Ontario (Education), 2020 CanLII 75024 (ON LRB), para 5.

One potential avenue of input was through the Provincial Working Group – Health and Safety (PWGHS), established in the 2014 round of central bargaining between the province and the teachers’ unions. One of its objectives was to support the IRS by, among others, reviewing health and safety issues with system-wide application and making recommendations to the MOE and MOL, as well as to local school boards. Its function was to complement, not usurp, existing local structures and legal obligations under the *OHSA*.³³ While this was an obvious space for early consultations over COVID planning, the province had suspended PWGHS meetings in June 2019 until a current round of collective bargaining was completed. Notwithstanding the COVID outbreak, and despite unions pressing for its resumption, the province refused to reactivate the PWGHS until 24 June 2020, after all unions had ratified new agreements.³⁴

In the following months, the unions unsuccessfully sought to secure a commitment from the MOE to hold biweekly meetings of the PWGHS in the hope of establishing province-wide minimum standards for matters such as class size, cohorting, and ventilation, and of securing increased funding to implement these standards.³⁵ According to one union representative, even when the PWGHS did meet, it was micromanaged: “mostly smoke and mirrors” with “nothing getting done.” That said, the PWGHS did establish occupationally specific COVID working groups for support staff, custodians, skilled trades, and educational assistants, among others. In at least one subgroup, the unions found the MOE representative sympathetic to their concerns and were able to get MOE support in pressuring reluctant school boards to follow the working group’s guidelines regarding masking, distancing, and other protective measures.

In addition to the PWGHS and its working groups, unions sought to influence the Public Services Health and Safety Association (PSHSA), the sectoral safety association established under the *OHSA* and funded by the Workplace Safety and Insurance Board. While primarily an association for employers, the PSHSA has a labour representative on its board of directors. In April 2020, the association issued guidance to its members, *inter alia*, reminding them of the legal responsibilities of a JHSC and emphasizing that support from senior leadership is essential to ensure JHSC effectiveness. It specifically reminded employers that it is their duty to provide JHSC members with access to the latest information on COVID and that the JHSC “plays a key role in supporting

33. *OSSTF*, para 13.

34. *OSSTF*, para 14; Caroline Alphonso, “Ontario High School Teachers Reach Tentative Deal with Province,” *Globe and Mail*, 20 April 2020, <https://www.theglobeandmail.com/canada/article-ontario-high-school-teachers-reach-tentative-deal/>. The PWGHS existed at the discretion of the government and was not a part of the collective agreement.

35. *OSSTF*, para 14.

the Internal Responsibility System of the organization.”³⁶ This was significant because a number of school boards had cancelled JHSC meetings and worker rep inspections following the school closure.

The MOL’s June 2020 guidance document was less directive, stating only that it was important for employers to “talk to workers and JHSC members or health and safety representatives, if any, for their input on the plan.”³⁷ As in its other communications, the MOL did not state that consultations were mandatory. Two days later, on 17 June 2020, the MOE directed school boards to prepare school reopening plans for the 2020–21 school year and issued guidance for their preparation. In a section entitled “Collaboration with Employee Representatives,” the ministry’s guide noted the presence of almost 200,000 staff in school workplaces and stated, “The significant adaptations that may be necessary in the next school year will require careful communication and collaboration with teacher federations, education worker unions and employee representatives. School boards are encouraged to work closely with these partners as they undertake planning for the next school year.”³⁸

A guideline issued by the MOE later in July was thinner but more directive: “Joint Health and Safety Committees are required to be established, engaged and meeting regularly to inform the reopening plan and ongoing operations.”³⁹ It is, perhaps, ironic that the MOE seemed to take worker participation more seriously than the MOL, emphasizing *collaboration* with *unions*, not just *communication* with *workplace JHSCs and worker reps*. Yet despite the MOE’s more positive messaging, trade union officials expressed frustration at their inability to have an impact on provincial planning for school reopening:

We tried to influence but they did not reach out ... Nothing with respect to actual safety planning/participation. There was no movement on getting more involvement at provincial or workplace level.

PWGHS is where the government thinks consultation takes place but there is only talk.

The government loved to say consultation was taking place but they always talked to the union after decisions were made.

Unable to have their concerns addressed through established consultative channels, the unions delivered a lengthy letter to the MOL and the MOE on 17 August 2020 requesting an urgent meeting with them, representatives of various school trustee associations, and designated employer bargaining agencies and for an MOL OHS inspector to be present. The letter outlined the unions’ OHS concerns and alleged that the MOE failed to take every reasonable

36. Ontario, Public Services Health & Safety Association, “Maintaining an Effective Joint Health and Safety Committee (JHSC) during Emergency Situations,” n.d. [2020], <https://www.pshsa.ca/resources/maintaining-an-effective-jhsc-during-emergency-situations-covid-19>.

37. Ontario, MOL, “Guide to Developing.”

38. Ontario, MOE, “Approach to Reopening.”

39. Ontario, MOE, “Guide to Reopening.”

precaution necessary to protect the health and safety of education workers. They also asked the OLRB to issue province-wide OHS orders for schools. The MOE did not respond, but the MOL did, explaining what its inspectors were doing to enforce the OHS in schools. It also met with the teachers' unions on 24 August 2020 without the participation of the MOE or employer bargaining agencies, or an MOL inspector, and no OHS orders were issued. In a final effort to get province-wide orders, the unions appealed the failure to issue orders to the OLRB on 31 August 2020.⁴⁰ The turn to a legal strategy was a longshot and was unsuccessful. On 1 October 2020, the OLRB found that since no health and safety inspector had been involved in the meeting with the MOL, no health and safety inspector had refused to issue an order. The board also held that, in any event, inspectors do not have the authority to issue province-wide orders against multiple employers.⁴¹

Union support for education worker voice at the local level

As unions became increasingly aware of their inability to influence provincial planning, the need to support their members in the development and implementation of local safety plans became more pressing. For example, in mid-June ETFO provided local leaders with a guide for dealing with OHS issues related to school reopening as well as copies of submissions it had made to various regulatory and advisory bodies. It issued further guidance to local executives and worker representatives in August emphasizing the importance of strong worker voice, expressly identifying and supporting "knowledge activism" as an effective approach.⁴² The guide advised,

It will be important for the JHSC, and the union, to be involved in ensuring that employers are taking every reasonable precaution according to the *Occupational Health and Safety Act* and that members' fundamental rights: right to know, right to participate, and right to refuse unsafe work are respected and protected. In addition to following the advice from the local health authorities, the employer must also respect the role of the JHSC as outlined in the *Occupational Health and Safety Act*. ETFO expects JHSCs to be involved with the employer in the following: [ten items listed, including continuation of meetings and workplace inspections; consultations on COVID-related issues; and submitting formal recommendations to the employer].⁴³

40. OSSTF, paras 21–28.

41. OSSTF, paras 34–38.

42. Knowledge activism has been identified in the research literature as a relatively effective approach to worker representation grounded in the strategic use of research, data, and science. See Alan Hall, Andy King, Wayne Lewchuk, John Oudyk & Syed Naqvi, "Knowledge Activism and Effective Worker Representation in Health and Safety," *American Journal of Industrial Medicine* 59, 1 (2016): 42; David Walters, Richard Johnstone, Michael Quinlan & Emma Wadsworth, "Safeguarding Workers: A Study of Health and Safety Representatives in the Queensland Coalmining Industry, 1990–2013," *Relations industrielles/Industrial Relations* 71, 3 (2016): 418.

43. Elementary Teachers' Federation of Ontario, "Preparing for and Monitoring the Implementation of the Safe Reopening of Ontario Elementary Public Schools in the COVID-19

On 13 October, ETFO circulated an OHS strategy package to local leaders and reps, advising that because the teachers' OHS concerns were not being addressed provincially, "collectively we need your assistance to bring individual concerns forward at the local level." It provided a number of templates and checklists to help reps evaluate local OHS conditions. Anticipating employer resistance, ETFO advised that worker co-chairs had the power unilaterally to make written recommendations if good-faith efforts to reach consensus failed. Finally, the package provided guidance for assisting members with work refusals and with complaints to the MOL.⁴⁴

The other teacher and education worker unions engaged in similar efforts, informing local leadership and representatives of the inadequacy of provincial guidelines and encouraging and supporting them to address issues locally by distributing checklists, educational modules, and weekly updates and organizing workshops. As well, the unions co-operated through the Ontario Federation of Labour (OFL) to produce a guide for education workers that focused on the right to refuse and advice for JHSC members.⁴⁵ The reps we interviewed identified their unions as a primary source of information and expressed satisfaction with their unions' efforts to support them.

The experience of education worker voice at the local level

Before reviewing the experience of workers at the local level, we first need to clarify the structure of JHSCs in the public school setting. As a matter of law, a JHSC is required at each workplace with twenty or more employees, which in the school context means there should be a JHSC for each school. However, some school boards and unions have agreed to create multi-site committees that cover several schools, though in some cases separate site committees may conduct local safety inspections.⁴⁶ As well, each JHSC has a representative from each bargaining unit, so that there are several workers representatives on most committees. As a general matter, school boards have JHSCs that operate according to legally prescribed requirements.⁴⁷ Their efficacy is another matter.

Pandemic," unpublished paper, 21 August 2020, 5–6.

44. Elementary Teachers' Federation of Ontario, "Memorandum: COVID-19 Health and Safety Strategy Package for ETFO Local Leaders and Health and Safety Representatives," unpublished memo, 13 October 2020.

45. Ontario Federation of Labour, *A COVID-19 Health and Safety Rights Guide for Education Workers* (Toronto, February 2021).

46. As a matter of law, MOL approval is required for such arrangements (OHSA, ss 9(3), 9(3.1)) but it seems that some school boards and unions have operated multi-site committees for years without obtaining formal approval. See *Toronto Catholic District School Board v Ontario English Catholic Teachers' Association*, 2021 CanLII 44852 (ON LA), paras 147–159.

47. Between March and December 2020, OHS inspectors issued over 1,400 orders related to violations of the sections of the OHSA requiring worker health and safety representatives and JHSCs. No such orders were issued to school boards (FOI 2021).

Regardless of the structure of JHSCs, school boards universally opted to create board-wide school reopening policies. Yet, despite the government advice to include JHSCs in OHS planning, few school boards did. Rather, most boards developed their plan based on guidance from the MOE and the MOH (guidance that the unions challenged at the OLRB for failing to adequately protect workers) and presented it to the JHSC at the beginning of the school year. Many reps we interviewed commented that plans were developed without JHSC involvement or that it was a top-down rather than a collaborative process.

When the plans were presented to JHSCs, reps had an opportunity to comment, but many reported significant employer resistance when they expressed their concerns on matters such as masking, distancing, and ventilation. Boards often fell back on the fact that the plan was developed in consultation with the local public health unit and complied with its current guidelines. Some reps pushed for more protective measures than were required by the guidelines, without success. A few tried going directly to public health officials. In one case, a public health official refused to engage with the union, saying that they worked with the board, not its employees. In another, the public health official clarified that they had reviewed and commented on board plans but did not approve them. When the representative raised this at the JHSC, the employer objected to the member having contacted the public health official.

In the few instances where boards adopted a more collaborative process for developing reopening plans, it was because the board's OHS manager was committed to worker participation and the JHSC had been functioning well prior to COVID. School reopening plans were subject to continued revision as conditions changed. Thus, there were ongoing opportunities for worker reps to attempt to influence OHS policies and practices after the schools reopened in September 2020. However, most of the reps we interviewed found it difficult to make headway, as many employers treated the JHSC as a vehicle for ensuring the plan was being followed, rather than a site for workers to assert their autonomous interests.

Three legal responses are available to workers if they believe the employer is not following its health and safety plan or is failing to take every precaution reasonable in the circumstances for the protection of a worker. One is to refuse unsafe work, but this is only available where the worker reasonably believes that the physical condition of the workplace is likely to endanger the worker. However, teachers cannot refuse when their action might endanger students.⁴⁸ Our informants noted that teachers are extremely reluctant to exercise this right, in part out of a fear of retaliation. Still, we were told about a number of work refusals, most of which were resolved by notifying the employer and having the worker's concern addressed with the assistance of a worker rep.

48. OHSA, s 43(3)(b).

Since no administrative records exist of these stage-one refusals that do not involve the MOL, we know relatively little about their frequency.

If the refusal is not resolved at stage one, it can be elevated to stage two, which involves calling an OHS inspector. These are recorded, and in the eighteen months following the outbreak, only 44 work refusals were taken to this stage. None were upheld.⁴⁹ The experience of teachers was not unique.⁵⁰ Inspectors regularly found that the circumstances that gave rise to the refusal did not endanger the worker's health and safety and thus they were not "valid" work refusals. As a result, inspectors treated work refusals as "complaints" but rarely wrote orders requiring action by the employer (see below). Understandably, many union representatives came to view work refusals as "dead ends," and the frequency of stage-two refusals declined over the course of 2020.⁵¹

A second legal response for concerned workers is to complain to the MOL, which triggers an inspection. The MOL conducted a total of 421 reactive COVID-related inspections in the education sector from March to December 2020, as well as about 239 proactive COVID inspections – both relatively small numbers in comparison with enforcement activities in other sectors, such as health care. Across the total of 660 COVID-related inspections, only 147 orders were issued, or on average slightly less than 1 per 4 inspections. This is a very low ratio, even compared with the overall low rate of orders in COVID-related inspections of just over 1 per inspection, arguably reflecting a particular reluctance to intervene in the education sector.⁵²

Worker representatives reported a variety of experiences with OHS inspectors. While some developed a good working relationship and felt the inspector was supportive of worker concerns, most of our informants found inspectors reluctant to issue orders as long as employers were seen to be adhering to general public health guidelines. As noted earlier, the MOL and its inspectors took a back seat to public health, refusing to interpret the employer's legal duty under the *OHSA* to take every precaution reasonable in the circumstances to protect the health and safety of a worker as requiring any action beyond the public health guidelines.⁵³

49. Sara Mojtehdzadeh, "Ontario's Labour Ministry Has Rejected All Teachers' COVID-19 Work Refusals – And Almost Everyone Else's. Internal Memos Hint at Why," *Toronto Star*, 24 August 2021, <https://www.thestar.com/news/gta/2021/08/24/ontarios-labour-ministry-has-rejected-all-teachers-covid-19-work-refusals-and-almost-everyone-elses-internal-memos-hint-at-why.html>.

50. Mojtehdzadeh, "Thousands of Workers."

51. FOI 2021.

52. FOI 2021.

53. The auxiliary role of the OHS regime during COVID has been noted in other jurisdictions. See Andrew Watterson, "COVID-19 in the UK and Occupational Health and Safety: Predictable Not Inevitable Failures by Government, and Trade Union and Nongovernmental Organization

The third legal response for unionized employees is to file a grievance claiming that the employer violated the collective agreement. While many collective agreements contain general language about OHS, relatively few COVID-related grievances addressed OHS issues.⁵⁴ Instead, most were about collateral matters such as employers requiring doctors' notes for sick days. One reason why unions may not have grieved COVID-related OHS concerns is because their resolution can be drawn out, especially if the matter goes to arbitration.⁵⁵

In April 2021 the provincial government shut down in-person classes for most students amid a rapidly rising third wave of infections. Schools reopened in September 2021 just as a fourth wave of infections reached Ontario, but this wave was much lower than the previous one and schools remained open. Yet many teacher concerns remained unaddressed in the province's reopening plan, again crafted without responding to teacher demands for smaller class sizes to enable physical distancing, ventilation upgrades, and so forth.⁵⁶

In sum, teachers had limited success influencing government policy or school board practice, notwithstanding formal recognition of the importance of worker participation and the existence of legally compliant JHSCs in most school boards. This limited success was evident in relation to each of the three worker rights in the IRS: the right to know, the right to participate, and the right to refuse. Not surprisingly, some worker reps felt burnt out given the responsibilities they carried, the limited time they were given to fulfill those responsibilities, and the frustration they experienced because of their limited success in securing improvements. As one representative put it,

As of July I'm moving to another union role and leaving the co-chair position. Another active co-chair is leaving too. The JHSC was working better but we are burnt out. There is no actual allowance of time for her; she is not being paid for her representation work. One worker rep gets covered for inspections by the board but that's it; there is no paid time for prep, research, investigations, interacting with the MOL and members. The burden we're carrying – it's why I'm leaving.

Responses," *New Solutions* 30, 2 (2020): 86; Elizabeth Bluff & Richard Johnstone, "COVID-19 and the Regulation of Work Health and Safety," *Australian Journal of Labour Law* 34, 1–2 (2021): 112.

54. A search of CanLII on 3 November 2021 found no reported arbitration awards for COVID-19 OHS grievances involving school boards.

55. Bruce Curran, "Event History Analysis of Grievance Arbitration in Ontario: Labour Justice Delayed?," *Relations industrielles/Industrial Relations* 72, 4 (2017): 621.

56. Katherine DeClerq, "'Lots of Questions': Teachers' Unions Look for Answers after Release of Ontario Back-to-School Plan," CTV News, 3 August 2021, <https://toronto.ctvnews.ca/lots-of-questions-teachers-unions-look-for-answers-after-release-of-ontario-back-to-school-plan-1.5533310>; Elementary Teachers' Federation of Ontario, "Ford's School Reopening Plan Risks COVID-19 Outbreaks and Further Disruption to Learning," media release, 3 August 2021, <https://www.etfo.ca/news-publications/media-releases/back-to-school-plan>.

Worker Voice in COVID-19 Safety Planning in Health Care

Health care worker voice at the provincial level

Unlike the schools, the health care sectors did not have the option of closing. Indeed, as hospitalizations and LTC outbreaks quickly mounted, they were among the earliest to be affected by the pandemic. With the 2003 SARS epidemic still somewhat fresh in the minds of many health workers, they and their unions knew what a pandemic would mean for their workload and stress. The lessons of that earlier crisis had also made it clear that early planning and collaboration among all the workplace parties were essential.⁵⁷ While the health care unions appealed to the government and hospital administrators for early consultations, little was done prior to the 17 March 2020 emergency declaration in Ontario.

Part of the problem was that there were no active provincial government or sectoral OHS committees that could be mobilized for action. A standing province-wide health sector OHS committee involving hospital employers and unions created during SARS had been disbanded before COVID arrived. As well, although the MOL had invoked section 21 of the *OHSA* after SARS to form a standing health care sectoral union and employer advisory committee, it refused to call meetings of the committee early in the pandemic. Some unions, like ONA, used standing monthly labour relations meetings with ministers/senior officials of the MOH and the MLTC in January and February 2020 to seek assurances that the precautionary principle would be applied to require protections based on aerosol transmission and that there were adequate PPE supplies. While assurances were given, they proved to be false. The first official government outreach on COVID-19 that included the unions occurred on 19 March 2020, when the government formed a “Collaboration Table” involving ministry officials, medical and health experts, employer representatives, and union representatives.⁵⁸ Although the minutes of these weekly meetings suggest some exchange of information and ideas, union participants described these weekly meetings as chaotic with little opportunity for meaningful planning or input into policy.⁵⁹

Frustrated with the lack of action, the unions pressed the MOL and other ministries. For example, on 14 February 2020, ONA wrote to the MOL, asking it to conduct proactive inspections and ensure the precautionary principle was being applied. ONA provided specific examples of problems of access to PPE in hospitals and LTC facilities. It also proposed that the government create a

57. Ontario, SARS Commission, *Spring of Fear*.

58. Ontario, MOH, “Report from Collaboration Table,” 19 March 2020, https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/memos/Report_from%20Collaboration_Table_Summary_March_19_2020.pdf.

59. For example, see Ontario, MOH, “Collaboration Table Update,” April 2, 2020, https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/memos/Collaboration_Table_Update_April_2_2020.pdf.

joint OHS table with all three ministries and labour and employer representatives, as was done throughout the SARS crisis. Finally, ONA demanded that JHSCs should be doing workplace risk assessments as a key first step in safety planning process. The MOL did not act on any of ONA's demands or those of the other health care unions, opting instead to rely exclusively on the MOH-led Collaboration Table.

In their early dealings with hospitals, the health care unions, consistent with their collective agreements, received commitments from hospitals to apply the precautionary principle and assume airborne contamination in the absence of evidence to the contrary. That commitment initially gave some health care workers access to appropriate PPE, such as N95 masks. By early March, however, ONA and the other health care unions were hearing from locals and members about PPE rationing in both hospitals and LTC facilities. Neither government nor employers would answer the unions' questions about supply until finally someone leaked a document revealing that the PPE stockpile created after SARS was not usable.⁶⁰ The next day the CMOH issued Directive 1, without union consultation, abandoning the precautionary principle by limiting precautions to droplet transmission in most health care circumstances. The OHA told the unions that the CMOH directives overruled the collective bargaining agreement's commitment to the precautionary principle.

ONA and the other health care unions fought back through legal, lobbying, and media efforts aimed at reimplementing the precautionary principle. Faced with grievances and complaints to the MOL over OHS violations, some hospitals settled with the unions on certain issues. Facing public pressure, the government finally invited the ONA leadership to discuss the issue. ONA thought they were negotiating a revision of Directive 1 to reintroduce the precautionary principle, but instead the issue was resolved via the new Directive 5, issued on March 30, giving individual front-line hospital nurses the power to conduct their own point of care risk assessment (PCRA) to determine whether additional precautions (e.g., N95 masks) were warranted.

Although the government's early response to the pandemic was late and less than adequate in the hospital sector, it was substantially worse in LTC. As noted in the report of the Long-Term Care COVID-19 Commission, a key contributor to COVID's deadly toll in LTC facilities was the lack of coordination between LTC and the rest of health care system:

Long-term care was not prioritized in the early government response. Instead, the focus was on hospitals, despite early reports warning that it was not only hospitals that were at risk but also long-term care and other congregate settings. When preparing a letter of recommended precautions to health care workers, the Office of the Chief Medical Officer

60. Rosie DiManno, "Province Stockpiled 55 Million Face Masks – Then Destroyed Most of Them," *Toronto Star*, 25 March 2020.

of Health (CMOH) and the MOH discussed whether settings such as long-term care homes should be included. [But] ultimately, they limited the recommendations to hospitals.⁶¹

An independent report from the Office of the Auditor General of Ontario came to similar conclusions regarding the extreme lack of preparation and infection-control measures.⁶²

ONA believed initially that Directive 5 would be applied to other health care workers and the LTC sector, but it took heavy pressure from CUPE, OPSEU, and other unions before that happened on 10 April. Although there were issues of non-compliance in hospitals, the problem was much greater in LTC facilities, which were experiencing very high rates of infection and fatality. The scale and speed of the LTC crisis shifted ONA's strategy to launch expedited legal actions as it became clear that local representatives and members were unable to affect any change through their grievances and MOL complaints. Employer opposition to expediting grievances led ONA to apply for and obtain a court injunction in April requiring four named LTC homes to comply with the CMOH directives related to PPE and to take all reasonable protective measures for the safety of ONA employees.⁶³

Although the injunction applied only to the four named LTC homes, LTC employers subsequently acceded to the union's request for an expedited multi-employer arbitration, which was heard by arbitrator John Stout in May 2020. ONA asserted that the homes breached the collective agreement by failing to take adequate measures to ensure the safety of registered nurses and health care professionals, failing to provide adequate PPE, and failing to follow the precautionary principle, among other things. Arbitrator Stout agreed.⁶⁴

Notwithstanding these political and legal victories, union informants reported that members continued to experience problems accessing appropriate PPE. As one senior union official put it,

We thought N95s cannot be unreasonably denied but they [management] started finding reasons to deny N95 masks. To complicate matters, they designed prescriptive conditions for care risk assessment to prevent workers from being able to make their own assessment. Late April we realized, there is no PPE in the stockpile. One hospital went out and bought masks and the joint committee put in their protocol where these masks were used. But it was not really successful in most locations because immediately after negotiations, we heard that people were being denied masks. How it got translated at each workplace is another thing. The government says one thing in a meeting to us and then we call town hall meetings to explain the new directive with members but then we would immediately hear

61. Ontario, Long-Term Care COVID-19 Commission, *Final Report*, 159.

62. Office of the Auditor General of Ontario, *COVID-19 Preparedness*, 11.

63. Ontario Nurses Association v Eatonville/Henley Place, 2020 ONSC 2467; Eric Tucker, "Court Orders Should Not Be Required for Health Care Workers to Get PPEs," *Toronto Star*, 30 April 2020, <https://www.thestar.com/opinion/contributors/2020/04/30/court-orders-should-not-be-required-for-health-care-workers-to-get-ppes.html>; Possamai, *Fatal Choices*, 91.

64. Participating Nursing Homes Sienna Madonna Care Community v Ontario Nurses' Association, 2020 CanLII 39641 (ON LA) (John Stout, Arbitrator).

that is not what is happening ... We threw everything at it we could, calling in MOL inspectors, filing grievances and nothing was really working.

ONA also had to return twice to Stout to get additional orders because some LTC facilities were not complying with the initial award.⁶⁵

Even as research evidence mounted that COVID was spread by aerosol transmission, and other public health agencies in Canada and elsewhere began altering their guidelines, the CMOH did not. Finally, ONA launched an application for judicial review of the CMOH directives.⁶⁶ However, the application was dismissed on the grounds that the directives were reasonable and that “to the extent that nurses are encountering any difficulties accessing N95 respirators, these are matters of labour law that can and should be addressed through remedies available in that context.”⁶⁷

Given this deference to public health directives, it is again important to note they did little to promote worker and worker rep involvement. For example, Revised Directive 5 instructed hospital and LTC employers to communicate PPE supply issues and control measures to the JHSC, with no mention of securing JHSC input into the formulation of OHS policy or practice.⁶⁸ Directive 3, covering LTC facilities, went marginally further, advising that “homes in consultation with joint health and safety committees or health and safety representatives, must ensure that measures are taken to prepare the home for an outbreak,” but there is no mention of consultation regarding JHSC involvement in determining the necessary measures.⁶⁹

Union support for health care worker voice at the local level: Safety plans

In the hospital sector, consultation with JHSCs occurred in some but not at all facilities, and much of the consultation that did occur was limited. According to our informants, plans were often presented as *faits accomplis*, with hospitals routinely insisting that they were simply following public health orders. In the LTC sector, there was even less consultation, in part because many LTC

65. *Participating Nursing Homes*.

66. Québec officials also initially restricted access to N95 masks, a decision Québec health-care unions unsuccessfully challenged in court. It was only in January 2021 that health officials recognized the risk of aerosol transmission and changed their guidelines. Jacob Serebrin, “Quebec updates N95 mask guidelines” *Canada Press*, 27 January 2021.

67. *Ontario Nurses’ Assn. v Chief Medical Officer of Health (Ontario)*, 2021 ONSC 3575, para 71.

68. Ontario, CMOH, “Revised Directive #5 for Hospitals within the meaning of the *Public Hospitals Act* and Long-Term Care Homes within the meaning of the *Long-Term Care Homes Act, 2007*,” 5 October 2020, 3, https://hicksmorley.com/wp-content/uploads/2020/10/Directive-5-October-5-2020-final-version_clean.pdf.

69. Ontario, CMOH, “Directive #3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007*,” 22 March 2020, 2, <https://www.oha.com/Bulletins/CMOH%20Directive%203%20-%20Long-Term%20Care%20Homes.pdf>.

facilities lacked functioning JHSCs or worker representation.⁷⁰ Where safety plans existed, they were often thrown together, usually by a single manager, with no worker input.

Nevertheless, health care unions attempted to support worker reps by developing and distributing various tools regarding risk assessments and control measures. CUPE, for example, provided reps with a checklist of COVID risks and instructions on their assessment. Unions also provided sector-specific resources for managing these risks, emphasizing that the focus should be not just on PPE but also on engineering and administrative controls. Where committees were inactive or captive by management, central OHS union staff worked with local union presidents and members to encourage action to protect their members, including filing grievances and MOL complaints. Like the education unions, the health care unions also worked co-operatively to produce a guide to worker rights that focused on the right to refuse and advice to JHSC members.⁷¹ Yet, even where local action was taken, it often had little impact. As one ONA official stated, “We filed an appeal for one hospital because the committee was not getting risk assessment and other information and when our rep did her inspection, the employer was annoyed when our rep reported in the inspection report what was wrong or what was missing. They didn’t act on the report.”

Although OHS legislation gives workers the right to refuse unsafe work, this right is limited for health care workers who cannot refuse where the hazard is inherent in or a normal condition of the work, or where their refusal would endanger residents or patients.⁷² As well, for nurses, there are professional obligations which restrict the use of the refusal right.⁷³ Nevertheless, the unions communicated information through website postings, emails, and webinars about the right to refuse. Overall, few health care workers exercised this right, and when they did, inspectors rarely found they were justified.⁷⁴

Complaints to the MOL also yielded few results. As an ONA research report outlined,

Of the field visits to health care facilities, the vast majority were reacting to complaints and work refusals rather than proactive (1,305 vs. 457). Despite the myriad of problems identified by registered nurses and unions in long-term care, the Ministry of Labour’s COVID-19

70. Our review of Ontario Ministry of Labour inspection data obtained through an FOI for 1 March to 31 December 2020 revealed that sixteen LTC facilities received orders with respect to absent worker representation, the lack of committees, or a failure to conduct inspections.

71. Ontario Federation of Labour, *A COVID-19 Health and Safety Rights Guide for Health Care Workers* (Toronto, October 2020).

72. OHSA, s 43(1).

73. For example, see Ontario Nurses’ Association, “My Right to Refuse Unsafe Work: A Guide for ONA Members,” May 2021, 10–12, https://www.ona.org/wp-content/uploads/ona_guide_myrighttorefuseunsafework.pdf.

74. 74. Mojtehdzadeh, “Many Ontario Workers.”

inspections resulted in only 323 improvement orders in the health care sector. The MOL has also issued just two fines in all the workplaces it has inspected, and one was to a worker. Only one employer has faced any kind of financial penalty for breaking workplace safety laws, and none has faced prosecution.⁷⁵

In response to the lack of enforcement orders, ONA and other unions sometimes appealed to the OLRB and were partially successful. However, one-off appeals of the lack of an order did not have a systemic effect on standards or enforcement. Similarly, filing a large number of grievances, literally hundreds for the nursing homes, was largely ineffective until ONA was able to make some progress through the injunction and the Stout arbitration.⁷⁶ As the judge E. M. Morgan stated in his decision, “The real problem raised by this labour dispute is that the arbitral process is a slow and protracted one. In effect, this leaves this court’s inherent jurisdiction as the only legal mechanism to realistically fill this void.”⁷⁷ As noted, even with the Stout arbitration, ONA had to return to the arbitrator twice because several LTC facilities were not abiding it. While the majority of the grievances and appeals were settled with the employers, some took over a year to resolve, revealing a key problem with legal processes in the context of an emergency: they are too slow.

It is also important to note that most of the pushback by unions targeted the lack of safety measures, not the lack of consultation and worker voice. To the extent that violations of participation rights were addressed, it was typically because the employer failed to notify the JHSC of workplace infections or exposures. Yet even on this matter the MOL was inconsistent in protecting the right to COVID-related hazard information.⁷⁸

The experience of health care worker voice at the local level

As in education, the hospital sector varies in how the committee system is structured. Some hospitals have a single central multi-union JHSC representing all workers at the facility, while others have departmental or building committees as well as special issue committees (violence, stress, etc.). Given their smaller size, most LTC facilities have a single multi-union JHSC (if the facility is unionized) or, if they have fewer than twenty workers but more than six, there is only a single worker rep and no committee. As noted, many LTC facilities had dysfunctional committees coming into the pandemic with little operational activity or impact. Where committees were meeting, reps encountered very limited opportunities for participation or planning. As one rep described it,

75. Possamai, *Fatal Choices*, 86.

76. Possamai, *Fatal Choices*, 90.

77. Eatonville/Henley Place, para 55.

78. Possamai, *Fatal Choices*, 86.

The committee was meeting, so this was not problem, and we even got management to meet weekly, but our efforts to get them to develop or implement a plan got nowhere. Local management insisted they needed guidance from corporate and corporate was saying to them that they needed to wait for public health or the Ministries [of LTC or health]. And managers often didn't attend JHSC meetings or had no decision-making authority – and when they did, they were the wrong people at the table.

It is important to note as well that while some reps took their union's advice to file grievances and complaints, many did not. In addition to the fact that many JHSCs were not functioning before the pandemic, our informants stressed that the speed of the crisis, the complete lack of readiness within management and local public health authorities to deal with it, and the enormous workload and stress imposed on all the staff presented enormous challenges even for the best committees and representatives.

Compared with the LTC facilities, hospitals generally had better-functioning JHSCs prior to and during the pandemic, but they varied quite substantially in terms of their strength, activism, and/or degree of capture by management.⁷⁹ Overall, the problem was not that JHSCs were not meeting or conducting inspections but rather that they were not being consulted in a meaningful way. Where JHSCs and reps were stronger, they pushed their employer to begin COVID safety planning early, and in some cases, this gave them more input. In one hospital context, for example, the worker co-chair sought to initiate COVID planning in December 2019:

We needed a plan in place – right off as workers we requested to meet with the employer several times a week, initially five days a week, to find out what was in place and what we needed. I asked about the stockpile of PPE and the employer looks at me and says it's in place; we still did not take their word for it; we want more info on inventory; they confirmed then that some supplies were actually outdated; we started pushing; we initiated a process of planning – the employer was receptive for the most part because we had the experience with SARS that few on the employer side had. They jumped on things we suggested, and we did not need to talk about timelines, they just did it.

In some other hospitals, JHSCs and worker reps met with more employer resistance. At one facility, for example, the unions repeatedly demanded an emergency meeting, to which the employer eventually agreed. The union pointed out that the hospital had no plan, had not conducted an organizational risk assessment, and was not screening. When management finally developed a plan, worker reps on the JHSC pointed to several major gaps in it. The employer then stopped JHSC meetings and workplace inspections, leading worker reps to complain to the MOL. The inspector persuaded the employer to restart meetings and inspections without issuing an order. However, problems persisted in this workplace, especially around PPE. The MOL was called in again and this time the inspector issued several orders around PPE use and reuse. The union (ONA) also filed multiple grievances. As described by the worker co-chair,

79. Hall, "Depoliticization."

We tried a multi-pronged approach – tried to keep OHS matters at JHSC where we had most leverage and when not resolved we funnelled them through the grievance process; still have ongoing grievances and issues we've tried to address in the JHSC. We had to pry information out of the employer rather than employer voluntarily sharing with us. Throughout the employer did what it did and the union made recommendations, but a good portion of these were ignored or not acted upon.

Even in those contexts where reps were initially successful, it often became harder to sustain that influence over time. As another co-chair explained,

Guidelines changed all the time making it difficult to keep up as the risk was changing so quickly. A control process got set out and then in a couple of days it would be altered; it was difficult to keep track of what the employer was doing and by the time they got back to us on some standards or protocols, they'd changed again. They would always tell us they are following public health guidelines; it was difficult and became more challenging over time.

This breakdown of local participation connects back to the subsequent efforts of the unions, notably ONA, to exert more influence over public health policy at the provincial level using every legal mechanism available to them. One central union official reported, "In smaller workplaces, we were concerned about committee and their capacity to play the role they should. Many people were off, they were not meeting. Large hospitals functioned better but even there, there were problems." While the shift to legal strategies was seen as the only way of dealing with weakness at the local level, most union officials recognized that legal victories had a limited impact. As one put it,

What became clear is how ineffective the legal system is. JHSCs should be front and centre in developing and implementing protocols, but it does not work. Grievances don't work because the process is too unwieldy. We may get some good outcomes, but it takes too long. If we could expedite, it would help enormously. The injunction did help to push the MOL to do more inspections, going into workplaces but still not much in way of orders ... I thought OLRB appeals would be more effective. I hoped that the SARS commission report would have helped to fix the problems with the law and process, but the Board process also has just not been fast enough to keep up as conditions and other things were changing so fast. Nothing we did seemed to address the underlying problem, workers getting sick, workers dying.

In sum, as with teachers, health care workers had limited success influencing COVID safety plans and policies at the provincial and workplace levels, notwithstanding the existence of legally compliant JHSCs in most settings. Also, as with teachers, health and safety reps often were exhausted by the demands placed upon them and the difficulty they experienced trying to protect the health and safety of their members. As one rep put it, "I really feel powerless, we tried, we had the meetings, we tried to hold them accountable, we brought the ministry in and they do nothing; I was outraged." Still, as in the education sector, some health care reps with the active support of their unions were able to affect some positive changes through effort and struggle, albeit often with little support from the MOL.

Conclusions

OUR CASE STUDIES POINT to four main conclusions. First, management and the Ontario government largely paid lip service to the legal requirement for meaningful workplace consultation around the assessment of occupational risks and the development and implementation of COVID prevention and control measures. While some managers and inspectors made greater efforts than others, overall, when consultation occurred it was late, limited in scope, and largely devoid of meaningful opportunities to affect changes in management thinking and actions.

While it can be argued that a crisis like a pandemic necessitates quick decision-making, research suggests that early and effective consultation with local unions, worker reps, and workers can greatly enhance the accuracy of risk assessments and the effectiveness of prevention measures.⁸⁰ Moreover, as documented in this study, an integral part of the problem is that employers and government were woefully unprepared to deal with the pandemic. The lack of both consultation and preparation was especially evident when employers and government agencies quickly abandoned the precautionary principle in the face of inadequate PPE supplies and scientific uncertainty about transmission in the first six months of the pandemic. The lack of preparation was an especially bitter pill for unions and many local worker reps who had pushed their employers and government agencies – both after SARS and in the weeks leading up to the COVID-19 outbreak – to plan and act earlier and more decisively.⁸¹

Centralized decision-making is also arguably vital to ensure consistent province-wide OHS protections during a pandemic, but regulations and advisories also need to be applied locally in relation to local workplace conditions. Defined by long-standing government policy and a large body of research, this is the critical role of JHSCs, local union officials, and individual workers, as a host of local workplace decisions and applications are improved if informed by the knowledge that workers and worker reps bring to the table. Thus, the lack of preparedness in concert with the failure of employers and public health officials to listen to local actors served ultimately to create major obstacles to effective preventive responses.

80. Wayne Lewchuk, Leslie Robb & Vivienne Walters, “The Effectiveness of Bill 70 and Joint Health and Safety Committees in Reducing Injuries in the Workplace,” *Canadian Public Policy* 22 (1996): 225; John O’Grady, “Joint Health and Safety Committees: Finding a Balance,” in Sullivan, ed., *Injury*, 162–197; David Walters & Theo Nichols, *Worker Representation and Workplace Health and Safety* (New York: Palgrave Macmillan, 2007); Hall, *Subjectivities and Politics*.

81. Ontario, Long-Term Care COVID-19 Commission, *Final Report*; Office of the Auditor General of Ontario, *COVID-19 Preparedness*; Ontario, SARS Commission, *Spring of Fear*.

Moreover, as was evident during this pandemic, public health directives were not guided purely by a science free of politics and ideology.⁸² This politicization of science was especially evident in the struggle that developed over the use of N95 masks in health care settings. As such, it is important that workers and worker reps have the opportunity and capacity at the local level to contest claims of scientific backing and their applications so they can seek better protections if they believe they are necessary. Ultimately, worker and union pressure at both the central and local levels often resulted in stronger protections, but unfortunately, those protections were delayed and hampered by the lack of attention to meaningful consultation from the outset.

While the MOL ultimately ordered employers to resume JHSC meetings and inspections where they had been cancelled, it continued its historical pattern of limiting enforcement to compliance with formal legal requirements, such as ensuring that meetings and inspections take place.⁸³ It did not assess whether reps and committees were able to provide meaningful input into COVID protections and controls. As such, the MOL's communications regarding safety plans did little more than suggest that consultation was a good idea, with no guidance regarding what meaningful consultation on safety plans should involve. Rather than ensuring a meaningful opportunity for worker input into employer decision-making, one-way employer communication of safety plans to worker reps and workers was routinely accepted by the MOL as fulfilling the employers' legal obligations for worker involvement, while at the same time serving to make workers responsible if they failed to comply with the rules.⁸⁴

The second main finding is that the pandemic accentuated what were already significant weaknesses in worker representation and JHSCs in Ontario.⁸⁵ As many senior union informants acknowledged, when the pandemic began, many of their joint committees or representatives were already non-functioning or were fully controlled by management.⁸⁶ Yet even where committees were functioning, the pandemic placed an enormous strain on the system of worker representation. We found that many reps were often sick or too exhausted in their work roles or were simply overwhelmed by the scope of the problems facing their members to be effective protagonists for voice or protection. This was particularly evident in the LTC sector, which may be partially explained by the smaller size of its worksites and the significant presence of for-profit

82. Trisha Greenhalgh, Mustafa Ozbilgin & Damien Contandriopoulos, "Orthodoxy, *Illusio*, and Playing the Scientific Game: A Bourdieusian Analysis of Infection Control Science in the Covid-19 Pandemic," *Wellcome Open Research* (2021), <https://wellcomeopenresearch.org/articles/6-126/v1>.

83. Storey & Tucker, "All That Is Solid"; Hall, "Depoliticization."

84. Gray, "Responsibilization Strategy."

85. Storey & Tucker, "All That Is Solid"; Facey et al., "Everyday Function"; Hall, "Depoliticization."

86. Hall, *Subjectivities and Politics*; "Depoliticization."

operations.⁸⁷ However, it would be a mistake to overestimate the quality of joint committees in the public hospital and education sectors. Union representatives in both acknowledged that prior to the pandemic many of their committees were weak and/or tightly controlled by management through technocratic and bureaucratic reins, such that the lack of consultation during the pandemic was simply business as usual.⁸⁸

Yet, there is also evidence that effective representation can have positive effects. Some reps had developed better relationships and standing with their managers prior to the pandemic, and even where management was less co-operative, reps were sometimes better able to protect their members' health and safety by using their own research and working with their unions and front-line workers to forcefully present and defend their concerns to management. While emphasizing knowledge-based claims, they were also willing to file grievances, make complaints to the MOL, engage in work refusals, and organize public actions and communications when management refused to listen. These reps illustrate what has been identified in the literature as "knowledge activists."⁸⁹ These workplace actions in turn helped to produce wider legal actions by their unions, benefitting a wider range of workers.

Health care and education unions worked together with the OFL during the pandemic to encourage the development of stronger rep networks grounded in knowledge activism by organizing training materials, resource catalogues, and workshops.⁹⁰ However, the overarching finding here is that the value of worker representation and input can only be realized if workers and worker representatives have the resources, opportunities, and power to make their independent cases for controls and prevention in the face of management inaction or opposition. While the specific political steps and legal provisions needed for a more effective network of worker representatives is beyond the focus of this paper, the central point is that organized labour and labour activists need to continue to direct critical attention to strengthening worker representation and powers across the province if there is to be any hope at all of preventing the kinds of workplace disasters that have occurred during the COVID pandemic thus far.⁹¹

A third point that the case studies highlight is the paradoxical role of law. In a regime of regulated self-regulation, law is still crucial insofar as it is the

87. Badone, "From Cruddiness to Catastrophe."

88. Hall, "Depoliticization."

89. Alan Hall, John Oudyk, Andrew King, Syed Naqvi & Wayne Lewchuk, "Identifying Knowledge Activism in Worker Health and Safety Representation: A Cluster Analysis," *American Journal of Industrial Medicine* 59, 1 (2016): 42, doi:10.1002/ajim.22520; Hall et al., "Making a Difference"; Walters et al., "Safeguarding Workers," 418.

90. Ontario Federation of Labour, "Knowledge Activism: Catalogue of COVID-19 Occupational Health and Safety Resources," 13 October 2020.

91. Hall, *Subjectivities and Politics*; Walters & Nichols, *Worker Representation*.

mechanism that structures and limits self-regulation. Law requires worker participation in the employer's IRS; it does not depend on the employer's benevolence or the presence of a union capable of negotiating such rights. Nevertheless, as noted above, the existence of a legal mandate does not guarantee employer compliance, nor does compliance with the letter of the law ensure meaningful participation.

When faced with non-compliance or the absence of meaningful participation, workers have legal options to make their rights real. However, it was the absence of protection, not participation, that was most often the subject of legal enforcement actions. As we have seen, efforts to call upon OHS inspectors to support work refusals or to issue compliance orders met with limited success, especially regarding refusals. Alternatively, there was the option of filing grievances based on assertions that the employer was violating the collective agreement, but grievances normally encounter significant delays unless the parties settle or expedite them. ONA took the extraordinary step of applying for a judicial injunction to require the employer to accede to its demands prior to its grievance being adjudicated, but in most cases the status quo remains unless and until an arbitrator eventually finds in favour of the union's interpretation of what the contract requires.

The paradox, then, is that while the law appears to empower workers, absent worker power it is difficult for workers to exercise and benefit from empowering legal rights. At the same time, absent stronger legal rights, workers are often less likely to enjoy and exercise power. As some of our informants noted, even when reps and unions tried to use the best available scientific evidence to make their cases for better safety procedures, their impact was often limited by the fact that their input under the *OHSA* is only advisory.

A final point raised by these case studies is the tension that is present in mandated partial self-regulation between what is appropriately resolved at the workplace level and what should be the subject of centralized regulation. During COVID, the MOL focused on workplace safety plans, in effect downloading OHS decision-making to the workplace level. Yet, clearly, workplace-by-workplace resolution of key issues – such as full access to N95 respirators, quarantining, cohorting, and class size – was more appropriately addressed by centralized policies. This is what teachers sought, for example, when they applied to the OLRB for a province-wide order binding on all public school boards and, similarly, what the health care unions were seeking with their lobbying and legal actions on provincial rules for PPE access.

The MOL did enjoy the authority to promulgate generally applicable regulations or directives, as did the Ontario government and the CMOH, among others. However, once decision-making rose above the workplace level, workers lost their legal entitlement to be consulted. Instead, union voice depended on the discretion of government and employer decision-makers. Although Ontario once had a partially institutionalized system of “regulatory bipartism” – such as the Joint Steering Committee on Hazardous Substances and the Workplace

Health and Safety Agency, in which employers and unions had equal representation and which were vested with advisory or decision-making power – these were dissolved in 1995 by a right-leaning Conservative government.⁹² What remained was the power of the Minister of Labour to appoint advisory committees at her discretion, to which was added later union representation on a Prevention Council created in 2011.⁹³ At the time of the COVID outbreak, however, there was no section 21 committee for the education sector, and the union/employer committee that had been created after SARS for the health sector had been dissolved. Moreover, the Prevention Council did not seem to take a leading role during the COVID pandemic and was never mentioned by our informants as a pathway for influencing MOL policy.⁹⁴

In lieu of meaningful institutionalized bipartism a variety of ad hoc arrangements for union voice in sectoral OHS matters have been established, but they functioned poorly. Teachers tried to activate the PWGHS but, despite the COVID emergency, the government refused initially to reconvene the body during collective bargaining and, when meetings finally resumed, the established COVID working groups functioned poorly. In the health care sector, as mentioned, the section 21 advisory committee was not meeting and the government spurned a union initiative to create a joint OHS table with the ministries of labour, health, and long-term care, leaving only an unwieldy ad hoc collaboration table. Finally, there was no institutionalization of union voice to reach the CMOH.

In short, in the absence of institutionalized channels for union voice above the workplace level, unions were limited in their ability to have their concerns addressed provincially or by sector. Moreover, the MOL never exercised its regulatory authority during the pandemic, another indication of the way in which the body with primary responsibility for protecting workers' health took a back seat. Not only did the MOL defer to the CMOH and other agencies in promulgating protective regulations, but it also did not vigorously enforce the laws in place when employers failed to abide by them.

While the findings in this article are specific to the province of Ontario, media reports, high rates of illness and death among health care and other workers, and government inquiries from other provinces suggest similar failures and weaknesses.⁹⁵ Some provinces, like British Columbia, seem to

92. Tucker, "And Defeat Goes On."

93. OHSA, ss 21, 22.2.

94. The latest report of the Chief Prevention Officer of Ontario makes no mention of the council, with which he has a statutory duty to consult (OHSA, s 22.3(4)). See Ontario, MOL, *Prevention Works: Ontario's Occupational Health and Safety System in Action* (Toronto, n.d. [2021]), <https://www.ontario.ca/document/prevention-works/>.

95. Bethany Lindsay, "BC Teachers Ask Labour Relations Board to Step In and Help Settle COVID-19 Concerns," CBC News, 18 September 2020, <https://www.cbc.ca/news/canada/british-columbia/b-c-teachers-ask-labour-relations-board-to-step-in-and-help-settle-covid-19-concerns-1.5744444>.

have performed better than others, like Ontario, at least in terms of COVID-19 infection and death rates among health care workers and LTC residents. Researchers seeking to explain the difference in LTC performance argue that British Columbia had a number of strengths compared with Ontario, including better coordination of hospitals, LTC facilities, and public health, greater funding of long-term care, and greater reliance on non-profit facility ownership, allowing more care staff and time for residents, fewer shared rooms, and stronger inspection regimes. As well, the BC government was reportedly faster at increasing public health supports, staffing, and infection-control measures than Ontario.⁹⁶

However, it appears that worker voice in British Columbia was no more effective in shaping COVID safety policy than in Ontario, even though one might expect that the presence of an NDP government in BC would have provided workers with greater opportunity and power than in the context of a Conservative government in Ontario. Certainly, there are findings that BC health care and education workers and unions were less than satisfied with their working and safety conditions during COVID-19.⁹⁷ Moreover, while time and resource constraints limited our capacity to do a full comparison, we conducted a small number of interviews in British Columbia with union officials and reps (n=6) and reviewed BC media, government communications, and union documents. Although the interviews were too few to draw any firm conclusions, they and the documentary evidence suggested similar problems with limited worker voice in safety planning and implementation,

19-concerns-1.5729156; Health Canada, "COVID-19 Infections among Healthcare Workers and Other People Working in Healthcare Settings," last updated 4 March 2022, <https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19/epidemiological-economic-research-data/infections-healthcare-workers-other-people-working-healthcare-settings.html>; "Unions Representing Front-Line Workers Were Not Consulted for Report on COVID-19 and Long-Term Care," *PressProgress*, 9 February 2021, <https://pressprogress.ca/bc-unions-representing-frontline-workers-were-not-consulted-for-report-on-covid-19-and-long-term-care>.

96. Michael Liu, Colleen Maxwell, Pat Armstrong, Michael Schwandt, Andrea Moser, Margaret J. McGregor, Susan E. Bronskill & Irfan A. Dhalla, "COVID-19 in Long-Term Care Homes in Ontario and British Columbia," *Canadian Medical Association Journal* 192, 47 (2020): E1540, doi:10.1503/cmaj.201860.

97. Smith et al., "Perceived Adequacy," 17; British Columbia Nurses' Union (BCNU), "Nurses' Union says Health Employers are Putting Health-care Workers' Safety at Risk," news release, 4 May 2020; BCNU, "Joint Study by BCNU and UBC Researchers Links COVID-19 Pandemic and Nurses' Mental Health," news release, 29 September 2020; BC Teachers' Federation (BCTF), "Report of the 2021 BCTF Health and Safety Membership Survey," n.d.; BCTF, "Teachers in Fraser Health Call on Local Health Authority to Commit to Improved Health and Safety Standards in Schools," news release, 8 January 2021; BCTF, "Teachers Call for Stronger Safety Measures from Public Health Officer as Worksafe BC Reports Latest Jump in Covid-19 Claims," news release, 1 March 2021; "WorkSafeBC Finds More than 1,600 Violations of COVID-19 Safety Plans," CBC News, 1 February 2021, <https://www.cbc.ca/news/canada/british-columbia/covid-19-worksafe-bc-violations-health-safety-compliance-numbers-worksites-1.5893893>.

substantial disputes over access to PPE and other prevention measures, and weak enforcement of public health directives and OHS law in public education and health care.⁹⁸ More research is certainly needed to draw out and confirm the similarities and differences between provinces, but at this point, it seems likely that the constraints on worker voice in COVID prevention measures were not unique to Ontario.

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98. A short summary report of the BC findings is available directly from the authors.