Response to COVID-19: Gathering experiences of OHS authorities in developed countries

The COVID-19 pandemic has posed many challenges for individuals, communities and policy-makers. Among them has been how to minimize transmission of the virus in workplaces and prevent the spread of infection from workplaces to the community. Concern about infection transmission resulting from work has extended far beyond health-care institutions. In various countries, significant outbreaks have been identified in meat and poultry processing facilities, grocery stores, manufacturing operations and construction sites, and among workers in public transportation and corrections facilities, among others. This Issue Briefing looks at the way OHS authorities (also referred to as OHS regulators and OHS inspectorates) in developed countries responded to these pandemic challenges.

In early 2021, a group of researchers led by Cameron Mustard, DSc, president and senior scientist at the Institute for Work & Health (IWH) based in Toronto, Canada, developed a questionnaire to gather information from authorities responsible for occupational health and safety (OHS) in developed countries about how they had, to date, addressed the unprecedented challenge of COVID-19. The other members on the research team were: Gregory Wagner, MD, Harvard T.H. Chan School of Public Health; David Michaels, PhD, MPH, George Washington University Milken Institute School of Public Health and former assistant secretary of the Occupational Safety and Health Administration, U.S. Department of Labor; and Louise Logan, JD, national project director, XXII World Congress on Safety and Health at Work.

The questionnaire was sent between February and April of 2021 to leaders at selected OHS authorities in North America, Europe, Asia and Australia. Fifteen jurisdictions responded (see page 2 for list of participating OHS authorities). Their responses, grouped thematically, are summarized below.

Coordination between labour and public health authorities

A key issue examined by the study was the degree to which labour inspectorates coordinated their COVID-related activities with public health authorities. Respondents reported that they maintained contact at a strategic level with public health authorities on the prevention of COVID-19 transmission, and also shared information with them.

KEY MESSAGES

- Supporting workplace efforts to minimize the transmission of COVID-19 has posed challenges for occupational health and safety (OHS) authorities in developed countries.
- In most jurisdictions, the response of OHS authorities evolved over the course of the pandemic. In particular, as OHS authorities accumulated experience, their coordination with public health authorities increased, as did their on-site inspections of workplaces.
- OHS authorities typically provided both general and sector-specific guidance to employers on the prevention of COVID-19.
- Identifying and compiling data on workplace transmission of COVID-19 remains a challenge for OHS authorities. So, too, does making firm-specific data available to the public—such as data on inspection results and workplace outbreaks of COVID-19.

Operationally, however, they worked separately from public health authorities, for the most part.

In most jurisdictions, contact tracing, outbreak investigations and vaccination have been solely the responsibility of public health authorities. Singapore is an exception, where the Ministry of Manpower worked closely with the Ministry of Health on contact tracing and outbreak investigations.

"The COVID-19 pandemic revealed how public or individual health can disrupt the workplace and vice versa. The conventional occupation-centric safety and health model alone is inadequate to deal with the impact of the pandemic at the workplace. Combating COVID -19 required a deeper strategic integration between public health and labour policies (such as OHS and human resource considerations)."
—Ministry of Manpower, Singapore

In another example, the United Kingdom's Health & Safety Executive participated in infection management teams led by public health to help establish whether workplaces are potential causes of transmission.

Although contract tracing, outbreak investigations and vaccination remained largely in the hands of public health, some OHS authorities reported examples of coordination in other areas between labour inspectorates and public health authorities. The examples of coordination increased in recent months as many countries began experiencing a new wave of the pandemic.

The inspectorate in Norway established a formal collaborative group with public health in the early months of the pandemic. In Norway, the occupational health service (where such service is mandated) or the municipal health service can be contacted if employers need assistance to assess the risk of infection and prepare action plans. The inspectorate in Norway also worked with public health on the enforcement of regulations related to quarantine and accommodation of migrant workers.

"In essence, NLIA's efforts could be summarized in two phases. First from March to October and then from November until now. In phase one, we have been strategic, but with more emphasis on guidance. In phase two, we have been both strategic, more operative and quite active in our preventive efforts vis-à-vis Covid-19."

—Norwegian Labour Inspection Authority (NLIA)

In Italy, the labour inspectorate coordinated inspections with provincial public security authorities. Prefects, among their other duties as provincial public security authorities, have been responsible for the coordination of COVID-related inspections carried out both by the labour inspectorates and other inspection bodies, such as the local health authorities.

In Ontario, Canada, the labour ministry worked with local public health units on the enforcement of emergency requirements related to COVID-19. Sweden created a special temporary unit to coordinate OHS actions related to COVID-19. And the labour inspectorate in the Netherlands also coordinated with the public health authorities.

Use of special legislation

The study asked participating jurisdictions about the extent to which OHS authorities responded to COVID-19 with new laws. Most COVID19-specific legislation/regulation came from public health, or in the form of emergency legislation led by public health, with input from labour inspectorates. Sometimes, regulations specifically for workplaces (e.g. requirements for employers to develop safety plans specific to COVID-19) were included within COVID-19 public health legislation.

Participating OHS authorities

Asia

Singapore: Ministry of Manpower

Australia

Safe Work Australia

Europe

Austria: Ministry of Labour

Finland: Ministry of Social Affairs and Health, Finnish Institute of Occupational Health

Italy: Italian Labour Inspectorate

Netherlands: Inspectorate of Social Affairs and Employment

Norway: Norwegian Labour Inspection Authority

Sweden: Swedish Work Environment Authority

United Kingdom: Health & Safety Executive

North America

State of Minnesota, U.S.A.: Department of Labor and Industry, Occupational Safety and Health

State of Nevada, U.S.A.: Department of Business and Industry, Division of Industrial Relations

State of Oregon, U.S.A.: Department of Consumer and Business Services, Occupational Safety and Health

State of Washington: Department of Labor and Industries, Division of Occupational Safety and Health

Province of British Columbia, Canada: WorkSafeBC

Province of Ontario, Canada: Ministry of Labour, Training and Skills Development

Inspectorates have also relied on pre-existing OHS regulations related to biological agents. In some cases, COVID-19 was explicitly added to a list of biological hazards.

That said, some OHS authorities did develop new legislation or regulations specific to COVID-19. For example, in Singapore, the Ministry of Manpower worked with tripartite partners to introduce a "safe management measures" system, tailored to the COVID-19 context. Norway developed special COVID-19-related regulations for migrant workers. COVID-19 legislation in the Netherlands gave the inspectorate the power to close a workplace in the event of severe employer non-compliance with measures needed to reduce the risk of COVID-19 infections.

In the United States, Oregon's Occupational Safety and Health Authority adopted a temporary rule addressing COVID-19 in labour housing and agricultural field work in May 2020, a temporary rule addressing COVID-19 in all workplaces in November 2020, and new rules to replace both temporary rules in May 2021. The Division of Occupational Safety and Health in the state of Washington issued directives early in the pandemic concerning respirator requirements and the use of face coverings.

In some jurisdictions where most of the workforce is covered by collective bargaining arrangements (e.g. Italy), special COVID-19 prevention protocols were developed between the government and the "social partners" (employer and worker organizations).

In one jurisdiction (Sweden), a worker representative ("safety representative") has the authority to suspend work, pending investigation by the regulatory authority, in the event of immediate or serious danger to the lives of employees. During 2020, this happened due to pandemic-related issues 103 times (out of a total of 171 instances).

Guidance for prevention of COVID-19

All jurisdictions reported that they provided both general and sector-specific guidance to employers through documents, webinars and other mechanisms.

"A great deal of work has been undertaken to both insert occupational health and safety requirements into prevailing guidance from the Ministry of Health…, and to prepare and disseminate guidance tailored to a variety of workplace sectors that has been generated both by the MLTSD and by its partners in the health and safety system."
—Ministry of Labour, Training and Skills Development (MLTSD), Ontario, Canada

"We put in place a multi-channel dedicated COVID-19 enquiry service to offer advice and guidance to employers, employees and citizens."
—Health & Safety Executive, United Kingdom

In some jurisdictions (e.g. Finland), employer and worker organizations worked together to prepare COVID-19-related guidance for workplaces. In some cases (e.g. British Columbia, Canada), the OHS authority sought input from industry and labour groups in the development of these materials.

On-site vs remote inspection and other inspection strategies

Inspectorates participating in the study were asked how COVID-19 affected their approach to workplace inspections. In the early months of the pandemic, most labour inspectorates curtailed or stopped on-site inspections, replacing all or most of them with some form of remote inspections (e.g. by video). Later in the pandemic, some jurisdictions resumed on-site inspections with appropriate personal protective equipment (PPE) and other precautions.

"To assess complaints/signals related to COVID-19, a triage table was formed for central coordination. At the beginning of the pandemic, the Inspectorate SZW used "No, unless…" as a starting point for the follow-up of complaints/signals. This meant that physical inspections and enforcement work on location did not happen, unless it was crucial to do so, e.g. when urgent accident investigation was necessary or to protect people who urgently needed protection against serious (labour) exploitation. This was done to prevent the spread of COVID-19 and to ensure the safety of our own employees. Over the course of the pandemic this approach changed to "Yes, provided that…". This means that the Inspectorate SZW carries out inspections, provided that this can happen safely with regards to the health of the inspector(s)."
—Inspectorate of Social Affairs and Employment, Netherlands

WorkSafeBC in British Columbia, Canada developed an exposure control plan for personnel conducting on-site consultations or inspections. WorkSafeBC noted that employers and workers in industry sectors they don't normally inspect got to know WorkSafeBC's mandate and the role of its prevention officers where otherwise they wouldn't have. It suggested this may be helpful going forward.

COVID-related complaints sometimes led to a shift towards educational interventions, with a smaller percentage of complaints than usual leading to formal inspections.

"We have focused on using non-inspection investigatory techniques to address what was initially a 25-fold increase in our complaint workload (after it decreased slightly, we still received an average of a year's worth of complaints every month). Both because of our workload and because these were genuinely new and sometimes changing requirements, leaning hard into "education" through use of the phone/fax method made sense, so we have conducted inspections in roughly three percent of the COVID-19 complaints where in normal circumstances about half of complaints result in inspections."
——Department of Consumer and Business Services, Occupational Safety and Health, State of Oregon, U.S.A.

Some jurisdictions have continued to do inspections predominantly remotely, inspecting on-site only in the case of serious incidents. One jurisdiction said remote inspections have worked well, but another noted the difficulty of video inspections when the employer was not cooperative.

Most inspectorates have used a risk analysis to guide plans for proactive inspections. That analysis has evolved over the course of the pandemic. For example, in Ontario, Canada, the focus in the early months of the pandemic was on hospitals and long-term care facilities, but later other sectors were also made a priority.

Singapore established a team within its inspectorate dedicated to enforcement of the safety management measures put in place for the pandemic. The U.K.'s Health & Safety Executive obtained government funding to significantly enhance its capacity to undertake spot-checks and inspections related to COVID-19.

Data on inspection results, workplace transmissions and outbreaks

Some inspectorates mentioned that they maintain a database of inspection results. (Some did not answer this question.) Most jurisdictions did not indicate that this data is publicly available. Singapore noted that a summary of inspections is reported periodically in the mainstream media. The U.S. state of Nevada's COVID-19 resource page includes information by sector on the percentage of inspected establishments found to be compliant with requirements related to COVID-19 (e.g. face coverings, social distancing, sanitation).

In most jurisdictions, labour inspectorates have not maintained data on COVID-19 transmission in workplaces. Some cited the difficulty of determining the source of transmission.

In some jurisdictions, data has been kept by public health authorities on workplace outbreaks (i.e. cases where more than an established threshold number of workers have been infected). In most cases, it does not appear that this data has been publicly available other than in aggregate form. (Safe Work Australia noted that, in some circumstances, public health authorities publicly released the details of workplaces with COVID-19 cases to facilitate contact tracing.) However, this may be evolving over the course of the pandemic as workplaces get more attention as a potential source of transmission.

In some jurisdictions, the public health or labour authorities have analyzed the risk of infection by occupation.

"… the National Institute for Insurance Against Accidents at Work has distinguished two fundamental categories of workers. In the first category are workers exposed to high health risks, primarily health workers and following all workers who are in contact with the general public or customers (e.g. front office workers, cashiers, bankers, cleaning staff of healthcare facilities). The second category includes the remainder of the workers. For the first category, professional risk is identified by applying the principle of simple presumption of professional origin, given the high risk of contagion inherent in the job performed. For the second category of workers, when it is not possible to trace the episode that caused the contagion and the correlation between the activity performed and the contagion itself cannot be presumed, the generally accepted scientific and medical-scientific criterion applies, according to the following elements: epidemiological, clinical, anamnestic and circumstantial. In this case, it is very difficult to establish with certainty whether the disease was contracted in the workplace or in the social or family environment. Consequently, workers must demonstrate the correlation between the activity performed and the contagion."

—Italian Labour Inspectorate

COVID-19 and worker mental health

One jurisdiction (Sweden) noted the importance of paying attention to the effects of COVID-19 risks on the mental health of workers.

"The novel coronavirus brings more work environment risks than the risk of infection itself, such as the anxiety employee's experience. This also needs to be investigated, risk assessed, and remedied."

—Swedish Work Environment Authority

Discussion

Minimizing transmission of COVID-19 in workplaces and between workplaces and the community has been a difficult challenge for OHS authorities. In light of the unprecedented nature of this pandemic, the emergence over time of concerning variants of the virus, and the ongoing scientific analysis of transmission, vaccination responses and more, it is perhaps not surprising that, in most jurisdictions, the response of OHS authorities has evolved over the course of the pandemic. In particular, there has been more coordination with public health authorities and more on-site inspections of workplaces.

Some key challenges remain. One is identifying and compiling data on workplace transmission. Another is making firm-specific data, such as on inspection results or workplace outbreaks of COVID-19, available to the public.

OHS authorities are learning and adapting as the pandemic evolves. There are opportunities for them to learn from each other in this endeavour. Our hope is that this study assists them in doing so.

This briefing was prepared by Ron Saunders, an adjunct scientist at the Institute for Work & Health.

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