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► OSH and the COVID-19 pandemic: A legal analysis

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Abstract

This study provides an analysis of how occupational safety and health (OSH) regulation responded to the circumstances of key workers during the COVID-19 pandemic. It explains the objectives of OSH regulation, including its main elements and how it has evolved over time. It draws from national country studies to explain how different jurisdictions address safety and health in their regulatory frameworks and how these frameworks operate in practice, including during the COVID-19 pandemic.

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▶ Introduction

The objective of this global background report is to provide an analysis of how occupational safety and health regulation (OSH regulation), also referred to in this report as the regulation of safety and health at work¹ responded to the circumstances of frontline² (or key) workers during the COVID-19 pandemic.³ The report addresses the following matters:

1. What OSH regulation is and why it is important.
2. The key elements of OSH regulation, including an account of how they evolved.
3. How various jurisdictions have addressed safety and health at work in their regulatory frameworks.
4. How these frameworks have operated in practice.
5. How these frameworks have operated in response to the COVID-19 pandemic.

It draws extensively from national country studies from Africa (Rwanda); Asia (China, Japan, Republic of Korea); Europe (Italy, Spain, United Kingdom); North America (United States) and South America (Brazil and Colombia). These studies are not necessarily representative of wider patterns; they simply provide examples of some of the responses, both sound and poor, to the pandemic, and assist in illustrating the various dimensions of OSH regulation. There will also be reference to other jurisdictions, such as Australia and Singapore, which provide examples of positive innovation.

Why is this report opportune? Studies of the OSH impacts of COVID-19 on frontline workers are now emerging.⁴ These studies suggest that frontline workers have been at higher risk of adverse effects from the virus, including higher mortality rates. Health workers have been badly affected and the evidence to date suggests that, while there are country variations, transportation, construction, retail and security workers often fared even worse.

Of course, it is obvious that those workers who are most exposed to the virus are more likely to contract it. However, the available evidence suggests that *the institutional setting* in which frontline workers operated significantly affected their probability of being infected.⁵ For example, there is evidence that informal and self-employed workers are at greater risk from COVID-19 than formal employees, especially where those formal employees are unionized. A plausible explanation for this is that formal workers, and especially professional and unionized workers, are engaged in work settings where relatively robust OSH systems are in place. These systems can lead to safer and healthier work practices and equipment. This report therefore investigates the role OSH frameworks played during the pandemic in the study countries.

¹ This terminology originated in the Robens report and is reflected in the laws of several common law jurisdictions, such as Australia, New Zealand, Singapore and the United Kingdom (often “workplace” is used in place of “work”). However, the term “occupational” is preferred in the United States, India and other jurisdictions. Canada uses both expressions.

² This term is used in preference to “essential” workers, given the juridical association in reference to legal limitations imposed by many countries on the right to strike of workers performing essential services.

³ This background paper was prepared as an input into the ILO flagship report, *World Employment and Social Outlook 2023: The Value of Essential Work*.

⁴ See the review of studies prepared for the WESO 2023.

⁵ See WESO 2023 section 2.1.

▶ 1 Method and structure

A central challenge confronting this report is how to *evaluate* how well the OSH frameworks responded to the pandemic. A robust empirical evaluation would include the assessment of OSH outcomes before and after regulatory interventions in response to COVID-19, but there is as yet little such information to hand, nor have there been generally accepted yardsticks developed to measure effectiveness in this context.⁶

The situation is further complicated for an international comparative study because the context of interventions differs from jurisdiction to jurisdiction: both the OSH and general legal frameworks diverge and the wider economic, social and political environments vary greatly. It is thus very difficult to assess, in relative terms, which national interventions have been more effective than others and more challenging still to determine whether an intervention which was successful in one country could be productively “transplanted” into another.⁷

But this does not mean that evaluating OSH frameworks, and, more specifically, OSH interventions during COVID-19, is impossible. We may not be able to demonstrate definitively that a measure is causally effective in reducing harm (although it is certainly plausible that it is), or that it can be transferred successfully across borders, but it is certainly possible to assess a measure by other criteria. For example, we can ask whether an intervention is *coherent, comprehensive, collaborative and clearly defines rights and obligations*, whether it promotes a *culture of prevention and compliance* and whether it *co-ordinates* with other regulatory systems.⁸ Criteria such as these are not merely ad hoc categories; they are commonly employed in regulatory analysis.⁹ Most importantly, they are normatively grounded in ILO standards.

Consequently, this report will assess health and safety interventions in response to COVID-19, and the framework in which they operate, against *key norms in relevant ILO instruments*. Chief among those instruments are the following Conventions (which each have an associated Recommendation):¹⁰

- The Occupational Safety and Health Convention, 1981 (No. 155);¹¹ and
- The Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187).¹²

At its 110th Session in June 2022, the International Labour Conference decided to amend paragraph 2 of the ILO Declaration on Fundamental Principles and Rights at Work (1998) to include “a safe and healthy working environment” as a fundamental principle and right at work.

⁶ Indeed, there is relatively little research on assessing OHS interventions in general. There is evidence well-designed laws can reduce harm in the workplace if appropriately designed and enforced, but a direct causal relationship is hard to establish: for literature reviews, see Anya R. Keefe et al., “A Scoping Review to Identify Strategies That Work to Prevent Four Important Occupational Diseases”, *American Journal of Industrial Medicine* 63, (2020): 490–516; Emile Tompa et al., “A Systematic Literature Review of the Effectiveness of Occupational Health and Safety Regulatory Enforcement”, *American Journal of Industrial Medicine* 59, no. 11 (1 November 2016): 919; European Commission, Directorate General Employment, Social Affairs & Inclusion. *Evaluation of the practical implementation of the EU Occupational Safety and Health (OSH) Directives in EU member states. Main Report*, 2015; Worksafe Australia, *The Effectiveness Of Work Health And Safety Interventions By Regulators: A Literature Review*, April 2013.

⁷ For a classic analysis into the problems of regulatory transplants, see Gunther Teubner, “Legal Irritants: Good Faith in British Law or How Unifying Law Ends up in New Divergences”, *The Modern Law Review* 61, no. 1 (1998): 11–32.

⁸ Compare 2017 General Survey paragraphs 21–25, 35 and Chapter V.

⁹ See, for example, in relation to the application of these or analogous concepts, studies such as the classic Ian Ayres and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, 1992); see also Robert Baldwin and Julia Black, ‘Really Responsive Regulation’, *Modern Law Review* 71, no. 1 (2008): 59–94; 59.9; Tess Hardy and Sayomi Ariyawansa, *Literature Review on the Governance of Work* (International Labour Office, 2019)

¹⁰ The List of Occupational Diseases Recommendation, 2002 (No. 194) will also be referred to. At the time of writing, Conventions No.155 and No.187 were on the agenda of the 2022 International Labour Conference for possible inclusion among the fundamental Conventions.

¹¹ See also Protocol of 2002 to the Occupational Safety and Health Convention, 1981; Occupational Safety and Health Recommendation, 1981 (No. 164).

¹² See also Promotional Framework for Occupational Safety and Health Recommendation, 2006 (No. 197).

Two other important Conventions that will be referenced are:

- The Occupational Health Services Convention, 1985 (No. 161);¹³ and
- The Violence and Harassment Convention, 2019 (No. 190).¹⁴

These Conventions are all concerned with designing policies, systems and programmes to improve health and safety in the world of work. They have been formulated in light of the experience of members states and so are grounded not only in the ILO's foundational values but also in practical learnings. They therefore provide sound criteria for this report's evaluation of national initiatives. The report will also draw on the elaboration of these OSH design principles in the *General Surveys* of the ILO Committee of Experts,¹⁵ as well as other ILO publications, such as the *Support Kit for Developing OSH Legislation (OSH support kit)*.¹⁶ In addition, there are excellent external studies which can buttress the analysis, whether from academic sources¹⁷ or from institutions.¹⁸

The remainder of this report is structured as follows. Part 3 sets out a brief history of safety and health regulation, explaining why the first generation of laws and practices proved deficient and how they were replaced by more responsive approaches, increasingly reflected in ILO instruments. Part 4 then examines what constitutes, in light of those instruments, a well-designed general framework of safety and health regulation. A "general framework" refers to the overarching policy aims of regulation, the institutional arrangements, and the strategies employed to achieve the aims. The general framework determines the level of regulatory coherence; influences the underpinning regulatory culture (ideally, a culture of prevention); and establishes who makes and implements rules, who is covered by them, what a "workplace" is, who owes what duties to whom and how the system induces compliance. Drawing on the Conventions, the report identifies seven key dimensions of a sound framework.

The second half of the report turns to the country studies, which are examined by reference to the dimensions identified in the preceding analysis. Part 5 examines the overall design of the individual national frameworks. Part 6 considers the COVID-related measures. The discussion on the general OSH framework connects to the more specific COVID-focused aim of the report in that it shows how the general framework radically shapes particular legal and policy responses to the plight of frontline workers. For example, we will see that in some jurisdictions, many frontline workers enjoy limited protection or even fall entirely outside the scope of OSH law. While their circumstances may be addressed by interim COVID-19-specific emergency public health measures, these may not embed long term improvements in work practices that may be needed in the face of a virus that is very much still present or indeed, in the face of other future crises.

Part 7 concludes with a number of suggestions drawn from the analysis.

¹³ See also Occupational Health Services Recommendation, 1985 (No. 171).

¹⁴ See also Violence and Harassment Recommendation, 2019 (No. 206).

¹⁵ See the General Surveys of 2009 and 2017.

¹⁶ See also, for example, International Labour Organization, *In the Face of a Pandemic: Ensuring Safety and Health at Work* (2020).

¹⁷ See, for example, Joanna Gaitens et al., "COVID-19 and Essential Workers: A Narrative Review of Health Outcomes and Moral Injury", *International Journal of Environmental Research and Public Health* 18, no. 4 (4 February 2021); Neil Gunningham and Richard Johnstone, *Regulating Workplace Safety: System and Sanctions*, Oxford Socio-Legal Studies (Oxford, UK: Oxford University Press, 1999); David Walters et al., *Regulating Workplace Risks: A Comparative Study of Inspection Regimes in Times of Change* (Edward Elgar, 2011).

¹⁸ See, for example, David Walters et al., *Securing Compliance: Some Lessons for EU Strategy on Occupational Health and Safety* (Brussels: ETUI, 2021).

▶ 2 The evolution of safety and health regulation

Modern safety and health regulation began to emerge in the early nineteenth century, with the advent of industrialisation. Early statutes, such as the Factory Acts of the United Kingdom, combined specific prohibitions or mandates together with a penalty system enforced by inspectors. The first statutes addressed working hours and child labour, with other safety measures being progressively introduced.¹⁹

Factory Acts and similar statutes in other sectors such as docks and mines were transplanted by colonisation and adoption throughout the world in the nineteenth and twentieth centuries. They targeted specific issues in specific industries but they failed to instil a comprehensive, collaborative, proactive approach to work safety. Rather, managers, workers and their representatives were enjoined to passively implement directives emanating from the state.

A profusion of these increasingly intricate “command and control”-style laws have left a lasting legacy in many jurisdictions, with several maintaining this style of regulation well into the twenty-first century.²⁰ Nevertheless, from the 1970s, a new approach to work safety and health emerged which imposed extensive obligations on workplace actors to take responsibility themselves for deciding how to eliminate or reduce risks. This new approach is commonly dated to the reforms introduced in the United Kingdom following a major review led by Lord Robens.²¹

The “Robens model” involved imposing general duties on employers to maintain a safe and healthy workplace. This was complemented by extensive co-regulation requirements so that employees, unions, and sometimes other parties, had a role in establishing, monitoring and enforcing workplace standards and processes. While specific government-imposed rules remained (for example, on matters such as ventilation or asbestos), these were generally located in subsidiary instruments so that they could be rapidly updated without requiring the often lengthy procedure of statutory amendment. This also meant that the primary law was not cluttered with detailed rules; its purpose instead was to set out the fundamental structure and obligations of the system. This division between general duties and detailed rules has meant too that work safety and health laws can be comprehensive and comprehensible – extending basic principles to all industries and workplaces rather than separating out factories, mines, docks and so on. Furthermore, with the Robens models, sectors which were previously unregulated – often feminised and emergent industries – were subject to OSH principles.

Robens-model systems have spread around the world and the Robens approach underpins the ILO’s fundamental safety and health Conventions. However, shifts in labour market structures have increasingly exposed limitations in the model. It was conceived in response to a form of industrial organisation prevalent in developed countries in the mid to late twentieth century: large vertically integrated manufacturing undertakings with a predominantly male, full-time, regular, local and unionised workforce. It has worked relatively well for such undertakings, where work arrangements are structured around direct and often stable employment relationships between parties to which clear legal obligations can be attached and on which clear legal rights can be conferred.

The Robens model is under greater pressure now, though, as societies are confronted with home-based, platform-based, virtual and/or contractually fragmented working arrangements (“fissured workplaces”²²),

¹⁹ See, for example, OSH Support Kit, 45-49.

²⁰ For example, until the enactment of India’s Occupational, Safety, Health and Working Conditions Code, 2020, which is relatively, but not fully comprehensive, divergent pre-Robens style work and safety laws applied in sectors such as manufacturing (covered by the Factories Act 1948), mines, plantations, motor transport, docks, construction and beedi and cigar production.

²¹ Committee on Safety and Health at Work (Committee Chair Lord Robens), Safety and Health at Work, Report of the Committee 1970-1972; GS2009 [11]-[12].

²² David Weil, *The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It* (Cambridge, Massachusetts: Harvard University Press, 2014).

in which work is often performed by migrant and un-unionized women and men, and/or on contracts that are temporary, multi-party or informal. In the context of these types of workplaces and work arrangements, which are especially widespread in developing countries, assigning rights and responsibilities is far more challenging. Although the original Robens report recommended the wide application of OSH legislation, including to the self employed,²³ legislation based on the Robens model has tended to use regular employment relationships as the central touchstone for statutory duties, leaving the position of own-account workers, as well as agency, platform and casual workers less clear.²⁴ Further, its tendency to focus on industrial workplaces leaves work performed in public spaces, online or in homes less protected. And questions of representation which are comparatively straightforward in unionised undertakings become problematic where workers cannot readily associate, whether because their work is ephemeral and dispersed or because they lack the association rights accorded to employees.

The COVID-19 pandemic has accentuated these shortcomings in the Robens-model laws, not least in relation to frontline workers. For example, drivers, cleaners and protective service workers are often engaged through complex sub-contracting chains that seek to diminish or eliminate the legal responsibilities of end users. Personal care and street workers are often self-employed and located outside industrial workplaces. Many professional workers have found themselves working remotely from their homes. And even for those front-line workers engaged in traditional industrial jobs, modes of organisation and representation have been disrupted by lockdowns and other restrictions on access to workplaces.

A further limitation in the way Robens-based systems have worked in practice – again exposed by the COVID-19 pandemic – has been a tendency to focus on physical infrastructure rather than psycho-social risks and mental health.²⁵ This is historically understandable since mines, construction sites and manufacturing installations presented obvious dangers to physical wellbeing. They are also industries with a long history of safety and health regulation prior to the Robens reforms. On the other hand, workplaces where staff can be exposed not only to physical threats but also to forms of psychological abuse and aggression have received less attention. For example, health professionals – who are very often women – have been subject to gender-based violence and harassment. The extreme pressures placed on health services by the pandemic have exacerbated this.

The emphasis on physical infrastructure has also tended to overshadow responses to occupational diseases, although these have received greater attention than harassment and other mental health risks. Whereas harm from dangerous machinery, for example, can be immediate and dramatic, occupational diseases often develop gradually and a causal link between a disease and a workplace may be harder to establish, as the history of asbestos regulation demonstrates.²⁶ Nonetheless, ILO instruments have long recognised many kinds of occupational diseases,²⁷ and the obligation of nation states to address them.²⁸ The ILO's List of Occupational Diseases Recommendation, 2002 (No. 194), which was last updated in 2010, provides a basis for a systematic classification of potential hazards to health, including biological agents and infectious diseases. COVID-19 is obviously a potential express addition to this list although, as discussed in section 6.1 below, most Member States have not yet recognised it as an occupational disease other than for specific industries or on a case-by-case basis.

This sketch of the broad arc of safety and health regulation provides a backdrop to the more detailed examination of the constituent parts of safety and health regulation that follows. It suggests that, if it is to be responsive to present and future changes in social and economic context, as well as to emerging risks to health and safety, regulation must be a dynamic process. This is why, for example, we see an evolution in the thinking behind the key ILO Conventions examined in this report; from Conventions Nos. 155 and 161, formulated in the wake of the Robens report, to Convention No. 187, where greater attention is given to

²³ Robens at [173]-[177].

²⁴ Although see decisions such as *R v Associated Octel Co Ltd*, [1996] 4 All ER 846; UKHL 1.

²⁵ This is notwithstanding the fact that mental health is specifically covered in Convention No. 155 (article 3(e)).

²⁶ Jock McCulloch and Geoffrey Tweedale, *Defending the Indefensible: The Global Asbestos Industry and Its Fight for Survival* (Oxford: Oxford University Press, 2008).

²⁷ See Employment Injury Benefits Convention, 1964 (No. 121), Schedule I, amended in 1980.

²⁸ C155 article 11(c) (d) and (f).

system-wide questions of regulation, to the most recent Convention No. 190, where questions of fissuring, informality and psychological, sexual and economic wellbeing are squarely addressed.

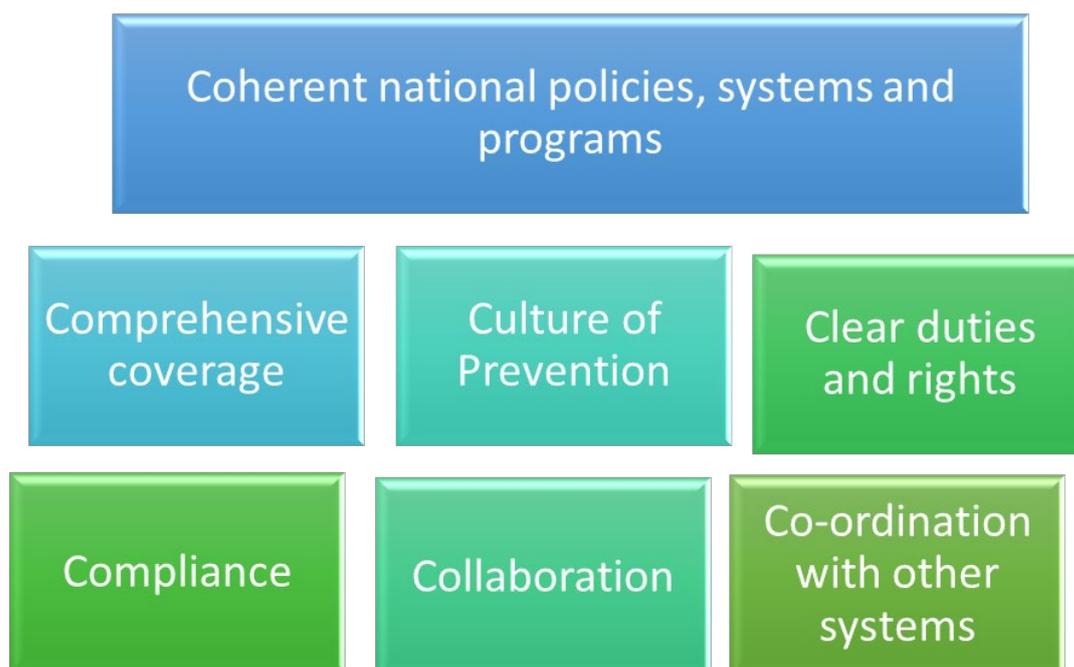
The next part of this report examines the four key Conventions in more detail order to identify key components of a sound system of safety and health at work.

▶ 3 ILO Conventions and the elements of effective regulation of work safety and health

There are more than twenty ILO Conventions and Protocols dealing with health and safety at work,²⁹ as well as an even larger number of Recommendations. Most of these concern a specific danger (such as major industrial accidents, asbestos or chemicals) or a specific industry sector (such as mines, construction or agriculture). But there are four Conventions - Conventions Nos. 155, 161, 187 and 190 - that focus on system-wide issues. As we saw in Part 3, these Conventions do not construct a static, rigid scaffold for regulating safety and health; rather, they map out a dynamic framework.³⁰

Synthesising the four Conventions, and in particular the two fundamental Conventions, we can derive seven key dimensions of effective OSH regulation (see Figure 1). These are examined in turn.

▶ **Figure 1: Seven key dimensions of effective Safety and Health at Work**



3.1. Coherent national policies, systems and programmes

We begin with the structure that should underpin effective OSH regulation. This is set out in Conventions Nos. 155 and 187. These envisage the establishment of a *coherent* overarching national framework whose constituent parts have been constructed in a methodical, mutually reinforcing way. Having such a framework

²⁹ See, for example, the Annex to Recommendation No. 197.

³⁰ For a comprehensive account, see the ILO's *Support Kit for Developing Occupational Safety and Health Legislation* as a key resource. The two most recent *General Surveys* on work health and safety (2009 and 2017) are also key sources of information.

obviates a situation in which measures are merely reactive, with governments responding to a specific, salient, crisis in a piecemeal, fragmented manner. The danger with such a reactive approach is that short-term fixes are adopted, leaving long-term and broad deficiencies in law and policy unaddressed. We have already seen that earlier forms of OSH regulation, which targeted specific dangers in specific industries, became obsolete and unwieldy. They also created inequity, because some workers were protected against dangers while workers in the unregulated sectors were not.

This is of course not to say that emergency measures are never warranted. Sometimes an immediate, initial response is required in the face of an unanticipated disaster, as the pandemic illustrates. But there is a need to move beyond the interim and make systemic adjustments so that a future disaster is avoided or mitigated. Hence the emphasis in the Conventions on formulating and regularly reviewing a coherent set of *policies, systems and programmes*. This is the starting point for effective OSH regulation.

How are national policies, systems and programmes distinguished from each other and why are all three necessary? A *national policy* here refers to a policy on “occupational safety, occupational health and the working environment”³¹ whose aim is:

“to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising, so far as is reasonably practicable, the causes of hazards inherent in the working environment.”³²

The policy should promote *basic OSH principles*.³³ It should also address the main “*spheres of action*”.³⁴ This means taking account of “the material elements” of work (workplaces, machinery, biological substances and so on); the work processes which relate these material elements to workers; training; communication and co-operation and the protection of workers and their representatives from retaliation.³⁵ It should clarify the functions and responsibilities of the various stakeholders³⁶ and be regularly reviewed.³⁷ Furthermore, the national policy should extend to the provision of *occupational health services*, which advise stakeholders on how to prevent injuries and diseases.³⁸ The purpose of a national policy is thus to establish a sound foundation for all regulatory interventions relating to work safety and health, be they laws, strategies, educational measures or the creation of administrative and other OSH-related agencies.

³¹ C155 article 4(1); 187 (1)(a)

³² C155 article 4(2).

³³ C187 article 3(3).

³⁴ C155 article 5.

³⁵ C155 article 5. See also C187 article 3.

³⁶ C155 article 6.

³⁷ C155, articles 4, 6 and 7; GS 2017, [92].

³⁸ C161 article 2.

▶ **Box 1: Article 11: Convention No. 155 (On Occupational Diseases)****Article 11: The competent authority or authorities shall ensure that the following functions are progressively carried out:**

- (c) the establishment and application of procedures for the notification of occupational accidents and diseases, by employers and, when appropriate, insurance institutions and others directly concerned, and the production of annual statistics on occupational accidents and diseases;
- (d) the holding of inquiries, where cases of occupational accidents, occupational diseases or any other injuries to health which arise in the course of or in connection with work appear to reflect situations which are serious;
- (e) the publication, annually, of information on measures taken in pursuance of the policy referred to in Article 4 of this Convention and on occupational accidents, occupational diseases and other injuries to health which arise in the course of or in connection with work;
- (f) the introduction or extension of systems, taking into account national conditions and possibilities, to examine chemical, physical and biological agents in respect of the risk to the health of workers.

A *national system* refers to the “infrastructure for implementing the national policy and national programmes on occupational safety and health.”³⁹ In order to give practical effect to the national policy, Member States need to develop appropriate institutions and to regularly review them through tripartite mechanisms.⁴⁰

Convention No. 187 refers to four essential elements of a national system:⁴¹ *laws and other regulatory instruments* (which may include collective agreements); *a regulatory authority or authorities; compliance mechanisms*; and, *arrangements to promote labour-management co-operation*. The Convention also refers to eight additional mechanisms pertaining to safety and health at work which can complement these: a national tripartite body or bodies; information and advisory services;⁴² training; health services (which are described in detail in Convention No. 161⁴³ and Recommendation No. 171); research; data collection and analysis;⁴⁴ collaboration with social security schemes; and support for micro-, small- and medium-sized enterprises and the informal economy.⁴⁵ The position of high-risk and vulnerable groups and the impact on workers of different genders should be taken into account in system design.⁴⁶

In the context of the COVID-19 pandemic, it is especially relevant to note that the national policy and system should address not only occupational accidents, but occupational diseases (see Figure 2).

A national system should be designed with regard to specific national circumstances⁴⁷ and so a wide range of institutional variation is to be expected. This variation will include, in some jurisdictions – and especially those with federal constitutional structures – multiple laws and regulatory authorities. It will also include different administrative arrangements; for example, an OSH regulator may be located within a labour department, or a health department or be a stand alone statutory authority. These variations, and in particular the multiplicity of institutions within one member state, can promote experimentation and innovation. When sub-national jurisdictions adopt different institutional approaches, it may be possible to evaluate which is more effective. It may also be possible to tailor institutional structures to respond to

³⁹ C187 article 1(b)

⁴⁰ C187 article 4 (1)

⁴¹ C187 Article 4(2) GS2017 123

⁴² See also C155 article 10.

⁴³ See in particular articles 3 and 5.

⁴⁴ See also C155 article 11(e).

⁴⁵ C187 article 4(3) GS 2017 124. See also Recommendation No. 197 paragraphs 2-5.

⁴⁶ R197 paragraphs 3 and 4.

⁴⁷ GS2017 [124].

local circumstances – such as a local jurisdiction which is predominantly rural and agriculture as opposed to one which is urban and industrial.

Nonetheless, this multiplicity can be problematic if there is no underlying cohesion, especially if, as in the case of the COVID-19 pandemic, a crisis is experienced not merely at a sub-national level but nation-wide. Thus Convention No. 155 requires Member States, in consultation with social partners and other appropriate actors, to “ensure the necessary coordination between various authorities and bodies” so as to ensure policy coherence.⁴⁸

A *national programme* refers to programmes which include “objectives to be achieved in a predetermined time frame, priorities and means of action formulated to improve occupational safety and health,” as well as methods of assessing progress”.⁴⁹ Again, these should be formulated, implemented and reviewed in a tripartite manner.⁵⁰ These programmes should be directed at promoting a culture of prevention and eliminating or minimising risks.⁵¹ They should be based on a review of the national situation and include objectives, targets, progress indicators and priorities.⁵²

The purpose of a national programme is to ensure that the national system operates in a responsive and dynamic manner, promoting continuous improvement. The original intention was to promote the adoption of medium term strategic plans which provided a realistic time frame for significant improvements.⁵³ However, this approach to time frames was formulated prior to the pandemic, which initially necessitates a shorter horizon.

The interrelationship between national policies, systems and programmes is set out in Figure 3. Once they are in place, they enable a member state to approach the regulation of safety and health at work in a methodical, rigorous way, reducing the potential for contradictory, chaotic, partial and ad hoc interventions. The substantive dimensions of this framework are explored in the following sections.

⁴⁸ C155 article 15. See also R164 paragraph 7; GS2017 [139].

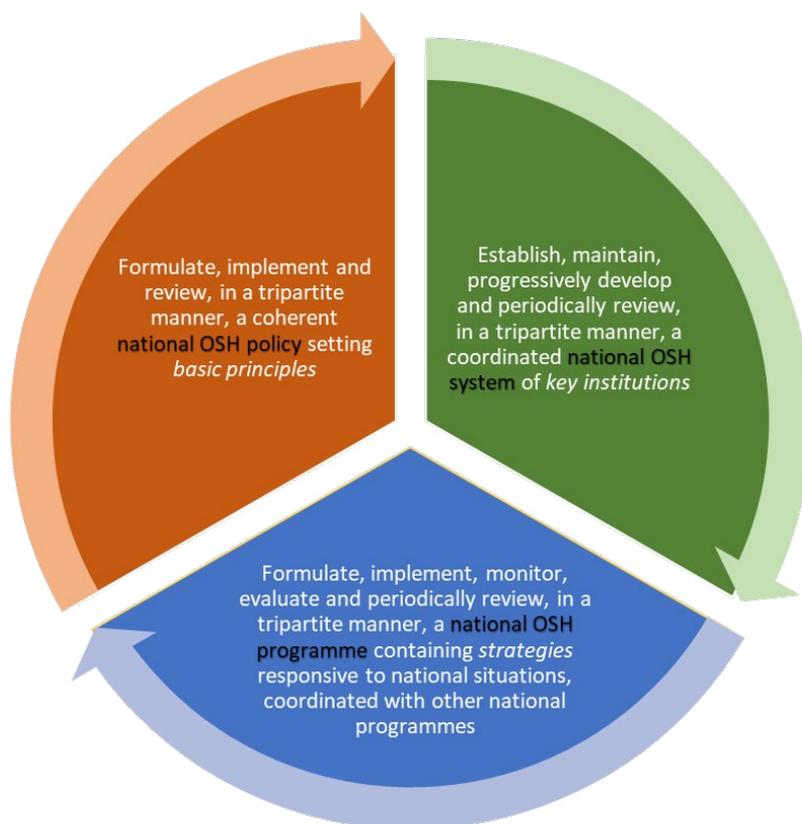
⁴⁹ C187 article 1(c). Programmes should be formulated on the basis of a national profile, which sets out the key elements of a national OSH framework: R197 paragraphs 13-14.

⁵⁰ C187 article 5(1).

⁵¹ C187 article 5(2)(a) and (b).

⁵² C187 articles 5(2)(c)-(d).R197 paragraph 8.

⁵³ For example, for five years: GS2017, article 147.

► **Figure 2: Obligations of members states in relation to national OSH Policies, Systems and Programmes**

3.2. Comprehensive Coverage

The obligations in the key ILO Conventions apply to “all branches of economic activity”.⁵⁴ While the Occupational Safety and Health Convention (No. 155), adopted in 1981, permits Member States to exclude some branches of economic activity because of “special problems of a substantial nature”,⁵⁵ these exclusions are intended to be temporary and subject to the provision of adequate protection for the relevant workers.⁵⁶ They must also be transparent, tripartite and accountable (reported to the ILO).⁵⁷

In the most recent ILO Convention, the Violence and Harassment Convention (No.190), the evolution of OSH understanding has meant that no sector is excluded; there is no option for Member States to restrict the operation of the Convention to certain groups of workers.⁵⁸ The Convention clearly articulates a comprehensive approach to coverage (see Figure 4). The Convention refers to protecting “workers and other persons” and makes clear that not only employees are covered but “persons working irrespective of their contractual status”, persons in training, volunteers and so on.⁵⁹

Furthermore, the obligations in the Convention apply to the “world of work”. This is broadly defined to include, for example, work-related travel and social events, work in private locations and online, and commuting.⁶⁰

⁵⁴ C155 article 1(1). See also Chapter 2 of the *Support Kit*.

⁵⁵ C155 article 1(2).

⁵⁶ C155 article 1(3); GS2017 [131]; GS2009 [46].

⁵⁷ GS2009; [17]-[26]; [46].

⁵⁸ C190 article 2(2).

⁵⁹ C190 article 2(1).

⁶⁰ Article 3.

And the level of responsibility of business entities is determined not by contractual arrangements; responsibilities are instead to be imposed “commensurate with their *degree of control*”.⁶¹

Now, it does not follow from the requirement that coverage be comprehensive that all stakeholders must be subject to identical rules. As indicated earlier, the Robens approach to regulation of safety and health at work distinguished between a statement of universally applicable *general principles, rights and obligations*, on the one hand, and *detailed rules* applicable to specific work contexts, on the other. Thus, considering the present case of frontline workers during the COVID-19 pandemic, all those workers (irrespective of their contractual status) and the entities that engage them should be covered by OSH policies, systems and programmes. For example, all entities should be required to ensure that, so far as is reasonably practicable, workplaces under their control are safe and without risk to health.⁶² However, what this means, in practical terms, for transport workers will differ from it means for health workers. This detail should be spelt out in supporting instruments, not the primary legislation.

3.3. Culture of prevention

Among the universally applicable OSH principles is one which is accorded the highest priority: prevention.⁶³ Convention No.187 mandates the development of a national preventative safety and health culture so that “individual and group values, attitudes, perceptions, competencies and behaviours [...] contribute to health and safety management, and its development” in a dynamic and progressive way.⁶⁴

⁶¹ C190 article 9.

⁶² C155 article 16(1).

⁶³ C187 (1)(d), article 5(2)(a). GS2017 [23], [34], [312].

⁶⁴ C187 (1)(d), GS2017 [312]-[352].

▶ **Box 2 : Violence and Harassment Convention, 2019 (No. 190)**

Article 2

1. This Convention protects workers and other persons in the world of work, including employees as defined by national law and practice, as well as persons working irrespective of their contractual status, persons in training, including interns and apprentices, workers whose employment has been terminated, volunteers, jobseekers and job applicants, and individuals exercising the authority, duties or responsibilities of an employer.
2. This Convention applies to all sectors, whether private or public, both in the formal and informal economy, and whether in urban or rural areas.

Article 3

This Convention applies to violence and harassment in the world of work occurring in the course of, linked with or arising out of work:

- a) in the workplace, including public and private spaces where they are a place of work;
- b) in places where the worker is paid, takes a rest break or a meal, or uses sanitary, washing and changing facilities;
- c) during work-related trips, travel, training, events or social activities;
- d) through work-related communications, including those enabled by information and communication technologies;
- e) in employer-provided accommodation; and
- f) when commuting to and from work.

In realising the prevention principle, the concept and practical application of *risk assessments* is fundamental.⁶⁵ This involves a methodical process of identifying hazards at work (anything that has the potential to have a detrimental effect on safety and health), considering the risk of harm and then acting to eliminate or, if that is not reasonably practicable, minimise the risk. There are various formulations of how to conduct risk assessments from the ILO⁶⁶ and Member States.⁶⁷ They commonly involve evaluating and prioritising risks by considering the likelihood of occurrence of a hazardous event, its potential severity and the available measures of eliminating or minimising the risk.⁶⁸ They also involve specifying who is responsible for implementing the measures, the time frames and a review process.

In evaluating the available measures to control risks, the concept of the *hierarchy of controls* is frequently employed;⁶⁹ it involves the ranking of measures from the highest level of protection and reliability to the lowest and least reliable. Although there is no one definition of the concept, it involves a gradation from elimination, to controlling the risk at source (for example, through replacing the hazard), to minimising the risk through engineering and management/administrative controls (for example, by redesigning work processes and practices to reduce exposure), to using personal protective equipment.

Risk assessments will naturally lead to the adoption of different kinds of measures depending on the nature of the hazard. So, for example, in most countries it is not now possible to eliminate the risk of being infected

⁶⁵ C187 article 3.

⁶⁶ See C187 [354]; ILO, *A 5 Step Guide for Employers, Workers and Their Representatives on Conducting Workplace Risk Assessments*, 2014.

⁶⁷ See, for example, Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work article 6. See also the European Agency for Safety and health at Work Online interactive Risk Assessment: <https://oiraproject.eu/en>.

⁶⁸ See ILO OSH Support Kit, p.128.

⁶⁹ This can also be formulated in different ways; see ILO OSH Support Kit, p.130-132; US National Institute for Occupational Safety and Health (NIOSH), *Hierarchy of Controls*.

with the COVID-19 virus while at work. Therefore, safety and health measures involve minimising the risk of harm (social distancing, ventilation, disinfection and so on) and requiring the use of PPE (such as masks).⁷⁰

3.4. Clear duties and rights

As we saw in section 4.3, a culture of prevention involves identifying and assessing hazards in the workplace. This entails assigning responsibilities to various actors in the workplace and also specifying rights.⁷¹

Article 16 of Convention No. 155 requires employers to “ensure, so far as is reasonably practicable” that a range of matters “under their control” are “safe and without risk to health”.⁷² Those matters are the workplace in general, machinery, equipment, processes, as well as substances and agents. Where they cannot eliminate risk, employers need to provide “adequate PPE”⁷³ without cost to the worker.⁷⁴ While this Convention uses the terminology of “employers”, it is possible to frame the duties in a more comprehensive way focusing on the capacity of people and entities to *influence safety and health* at work rather than on contractual arrangements (see discussion in section 5.2).

These obligations are not absolute. Two key limiting phrases in the Convention are “so far as is reasonably practicable” and “under [the employer’s] control”. These qualifications link back to risk assessments. An undertaking does not have to prevent any safety and health incident from occurring. Rather, it must undertake risk assessments at regular intervals in order to implement feasible measures to eliminate, or if that is not possible, to minimise hazards.

In conducting risk assessments pursuant to these duties, undertakings are not left to their own devices. As indicated above, in a well-functioning OSH system, the general duties are complemented by detailed delegated rules – such as regulations and guidance materials issued by agencies authorised under general OSH statutes. These rules are frequently industry or activity-specific. Thus, an undertaking will need to consider not only the general duty but specific regulations on, say, noise, ventilation and toxins if they are relevant to its activities. Specific rules can also be used to provide detail around obligations to prevent risks to safety and health through other dangers such as excessive working hours and sexual harassment. Delegated rules provide a means of directing undertakings to systematically address the threat of COVID-19 and, as rules are easier to update than statutes, they can evolve as knowledge about combatting the spread of the virus deepens.

This primary duty to provide a safe and healthy workplace is complemented by the obligations to provide measures to deal with emergencies and accidents, including first aid⁷⁵ and to consult, inform and train workers and their representatives; this later obligation is explored more fully in section 4.5.

In many workplaces, there is not just one undertaking with overall control. On a major construction site, for example, there will often be many sub-contractors carrying out work. The same is increasingly the case in many other industries given the prevalence of fissuring. This problem is addressed in article 17 of Convention No. 155 which provides that:

“Whenever two or more undertakings engage in activities simultaneously at one workplace, they shall collaborate in applying the requirements of this Convention.”⁷⁶

⁷⁰ See generally the various ILO publications on OSH during the pandemic, including: Protecting workers: occupational safety and health in response to the COVID-19 pandemic Rapid Needs Assessment & Response Plans: Preparation Guidelines for Country Level Interventions; The ILO Action Checklist: Prevention and Mitigation of COVID-19 at Work; A safe healthy return to work during the COVID-19 pandemic. Policy brief; Safe return to work: Ten action points; Managing work-related psychosocial risks during the COVID-19 pandemic.

⁷¹ See also Recommendation No. 164 paragraphs 10, 14 and 15; GS2009 [169]-[204]

⁷² C155 article 16 (1) and (2).

⁷³ C155 article 16 (3) PPE should be used as either a last resort or to further enhance existing measures: GS2009 [170].

⁷⁴ C155 article 21; R164 paragraph 10(e).

⁷⁵ C155 article 18.

⁷⁶ See also R164 paragraph 11.

It is not only undertakings that have obligations in a well-designed OSH system. Workers and their representatives are required to co-operate with employers in relation to safety and health.⁷⁷ In order to do so, they need to be given appropriate information and training.⁷⁸ Alongside the co-operation obligation, workers have the right to remove themselves from a work situation which they have “reasonable justification to believe presents an imminent and serious danger to [their] life or health” without being subject to reprisals.⁷⁹ This means that if cooperation breaks down, such as where a manager refuses to acknowledge a serious danger that may lead to production being suspended, workers can nevertheless act to safeguard themselves. In such cases, as well as situations where workers have complained in good faith about an undertaking’s breach of its health and safety obligations, the law should protect them against reprisals.⁸⁰

The right of workers to complain about risks to safety and health, and to remove themselves from the workplace, poses particular challenges for undertakings which want vaccinated workers to return to a physical location where the virus might be present. Whether this would constitute “an imminent and serious danger to their life or health” is likely to depend on a range of factors, including the safety measures instituted by the undertaking, whether a worker is immunocompromised, the prevalence of the virus and of course public health measures. This issue is considered further in section 6.3.

3.5. Tripartite Collaboration

As we have seen, the ILO’s OSH instruments, and in particular the fundamental Conventions No.155 and No.187, provide that the national policies, systems and programmes referred to in those Conventions need to be formulated “in consultation with the most representative organisations of employers and workers”.⁸¹ Indeed, a standing national tripartite advisory body should be established to address OSH issues.⁸² Many such bodies have been active in the formulation of national policies to address COVID-19.⁸³ To be sure, the tripartite nature of collaboration does not entail the exclusion of other interested parties (for example health professionals); these can also be involved in national consultations.⁸⁴

Convention No.155 also requires consultation arrangements on “all aspects of occupational safety and health associated with their work” *at the level of the undertaking*.⁸⁵ Co-operation between management and workers is mandated as “an essential element” of action at that level.⁸⁶ Co-operation arrangements should include⁸⁷ the appointment of worker safety delegates, and worker and/or joint worker-management safety and health committees with at least equal worker representation.⁸⁸ Recommendation No. 164 sets out the functions, rights and protections of these representative bodies.⁸⁹ The ILO Committee of Experts has reiterated in the two most recent General Surveys on OSH that without such co-operative arrangements between employers and workers “no tangible progress ... can be achieved”.⁹⁰

⁷⁷ C155 article 19(a) and (b); article 20; R164 paragraph 16.

⁷⁸ C155 article 19 (c) and (d). R164 paragraph 14.

⁷⁹ C155 article 13. See also article 5(e) and article 19(f).

⁸⁰ R164 article 17.

⁸¹ For example, C155 articles 4, 8, and 15; C 187 articles 2, 3(3), 4 and 5; R197 paragraph 10.

⁸² Where appropriate. C187 article 4(3)(a).

⁸³ ILO, *Enhancing social dialogue towards a culture of safety and health, Presentation*, 28th April 2022.

⁸⁴ R197 paragraphs 2(b) and 9.

⁸⁵ C155 article 19 (e).

⁸⁶ C155 article 20.

⁸⁷ “Where appropriate and necessary ... in accordance with national practice”.

⁸⁸ R164 paragraph 12(1). See also R197 paragraph 5(f).

⁸⁹ R164 paragraph 12(2).

⁹⁰ GS2009 at [205]; GS2017 at [195].

One important reason for this at the level of the undertaking is compliance. As we will see in section 4.6, enforcement by an inspectorate is an important means of achieving compliance. However, as the ILO's Committee of Experts has put it:

“no government would ever have the resources needed to carry out the necessary inspections that were really required to ensure, as far as possible, that people worked in a safe and healthy environment; co-operation between employers and workers in this area [is] essential.”⁹¹

There is strong international evidence that the active involvement of worker representatives in the formulation and implementation of OSH measures generally leads to better health and safety outcomes.⁹² For example, the presence of union representatives can encourage individual or groups of workers to speak out when they encounter a breach of OSH rules.⁹³

The importance of worker involvement at the level of the undertaking extends beyond compliance with existing laws to the formulation of new OSH policies, the active identification of risks and the adoption of new measures to eliminate or mitigate the risk. Extensive worker involvement promotes dialogue not only on existing problems but also planned changes. It creates opportunities to investigate problems and communicate with staff and facilitates the provision of training and information.⁹⁴

Unfortunately, as mentioned above, changes in the nature of the workplace – the rise of home-based, platform-based, virtual and fissured work, together with the prevalence of informal employment in many countries – have made consultation and co-operation arrangements more difficult to achieve. Traditional representative bodies for workers are relatively uncommon in these settings, often because workers are defined as being outside the boundary of an undertaking.⁹⁵

The COVID-19 pandemic, by accelerating developments such as virtual work and working from home, has exacerbated these difficulties at a time when representation is sorely needed. Innovative methods of ensuring that all workers' voices are heard in the formulation and implementation of OSH measures require development and diffusion.

3.6. Compliance and enforcement

Policies, systems and programmes designed to promote workplace health and safety (and labour laws generally) will be radically undermined if there are not adequate enforcement systems in place.⁹⁶ The ILO instruments recognise this. Convention No.187 provides that a national system shall include “mechanisms for ensuring compliance with national laws and regulations, including systems of inspection”.⁹⁷ Clearly, an “adequate and appropriate system of inspection”⁹⁸ is an essential element of this, together with appropriate sanctions.⁹⁹ States and the regulators also have important informational responsibilities in relation to

⁹¹ GS2009 at [205]. Indeed, as discussed above, this insight was a key driver of the Roben's reforms that led to our modern OSH frameworks.

⁹² See, for example, David Weil, “Enforcing OSHA: The Role of Labor Unions”, *Industrial Relations* 30, no. 1 (1 January 1991): 20; David Walters, “One Step Forward, Two Steps Back: Worker Representation and Health and Safety in the United Kingdom”, *International Journal of Health Services* 36, no. 1 (1 January 2006): 87–111; Neil Gunningham, “Occupational Health and Safety, Worker Participation and the Mining Industry in a Changing World of Work”, *Economic and Industrial Democracy* 29, no. 3 (1 August 2008): 336–61. See also Harter et al.,

The Relationship Between Engagement at Work and Organizational Outcomes 2020 Q12® Meta-Analysis: 10th Edition (Gallop, 2020).

⁹³ On the need for workplace monitoring independent on employer control, see generally Cynthia Estlund, *Regoverning the Workplace: From Self-Regulation to Co-Regulation* (New Haven: Yale Press, 2010).

⁹⁴ Walters, “One Step Forward, Two Steps Back: Worker Representation and Health and Safety in the United Kingdom”: 94–95.

⁹⁵ Representative structures are also difficult to established in small and micro-enterprises, although several countries have devised innovative means of representing workers in such cases GS2017 at [201].

⁹⁶ See, e.g. Linda Dickens, ed., *Making Employment Rights Effective: Issues of Compliance and Enforcement* (Hart Publishing, 2012); Gunningham and Johnstone, *Regulating Workplace Safety: System and Sanctions*.(Oxford University Press, 1999); David Weil, “A Strategic Approach to Labour Inspection”, *International Labour Review* 147, no. 4 (2008): 349–75.

⁹⁷ C187 article 4(2)(c).

⁹⁸ C155 article 9 (1).

⁹⁹ C155 article 9(2).

providing guidance to undertakings¹⁰⁰ and more broadly in providing OSH content in education and training programs.¹⁰¹ Unfortunately, in many jurisdictions the resources directed towards OSH enforcement have been diminished in recent years.¹⁰² There also remains considerable debate about the best mix of punitive, persuasive and educative approaches inspectors should take, the powers inspectors should have, and the most effective way to target resources. The 2017 General Survey makes extensive comments on these matters.¹⁰³

Enforcement is only one aspect of compliance.¹⁰⁴ Many firms and workers can be induced to institute sound OSH practices within a culture of prevention without direct intervention of an inspector.¹⁰⁵ Social norms, corporate social responsibility systems, incentive schemes, and, most importantly, tripartite collaboration and stakeholder involvement are some of the factors which greatly influence firm and worker behaviour. The presence of worker representatives, particularly unions, is also highly significant as it tends to promote compliance.¹⁰⁶

Whether state-based, firm-based or implemented with the participate of third parties, all of these compliance measures should be regularly evaluated based on robust research and data collection.¹⁰⁷

3.7. Co-ordination with other systems

The discussion in this Part has so far focused on OSH regulation. But OSH is of course one of a number of interacting regulatory systems pertaining to work, safety and health. These systems include labour and social security law (which governs matters such as income support, hours of work, leave and workers compensation); health regulation (including biosecurity measures, vaccine mandates and protective personal equipment (PPE) rules); and private law (including the law of obligations, which creates financial incentives on employers to avoid exposing themselves to litigation as a result of workplace injuries and diseases). Each of these systems can have its own goals, rules, authorities and implementing measures. Often they are mutually reinforcing; for example, public health orders often address OSH issues.

However, other systems do not always align with those of OSH systems. The problem that then arises is that the systems can create conflicting incentives. For instance, labour statutes, contracts or collective agreements may provide for additional money for undertaking hazardous work (sometimes called “danger money” or hazard pay). While this makes sense from a remuneration perspective, there is a risk that it could create a perverse inducement to firms and workers to treat a safety and health at work as a “cost of doing business” rather than eliminating or reducing the risk. In short, hazard pay should not exempt an employer from health and safety obligations. It is better seen as analogous to an overtime premium; in some contexts, a better alternative might be to offer additional leave and rest time.

Again, while a sound OSH system confers on workers the right to cease work in a dangerous situation, this right may not be exercised if it is contradicted by work rules or contractual obligations, even if these do not legally prevail (most managers and workers are not lawyers and may not be aware of the hierarchies of legal validity). Nor may the right be exercised if there are not arrangements in place (for example, through a collective agreement or the social security system) to ensure that workers who leave a dangerous situation continue to be paid.

¹⁰⁰ C155 article 10; R164 paragraph 4(d).

¹⁰¹ C155 article 14.

¹⁰² See, for example, Walters et al., *Regulating Workplace Risks: A Comparative Study of Inspection Regimes in Times of Change*, 310–30 (Edward Elgar Publishing, 2011); Paul Almond and Mike Esbester, “Regulatory Inspection and the Changing Legitimacy of Health and Safety”, *Regulation and Governance* 12, no. 1 (March 2018): 46–63.

¹⁰³ GS2017 [437]-[444], [467]-[482].

¹⁰⁴ See the discussion in GS2017 Chapter V.

¹⁰⁵ Christine Parker and Vibeke Nielsen, eds., *Explaining Compliance: Business Responses to Regulation* (Edward Elgar, 2011); David Walters et al., “Improving Compliance with Occupational Safety and Health Regulations: An Overarching Review”, *European Risk Observatory* (Bilbao: European Agency for Safety and Health at Work, 18 May 2021).

¹⁰⁶ See, for example, Laia Ollé-Espluga et al., “What Is the Impact on Occupational Health and Safety When Workers Know They Have Safety Representatives?”, *Safety Science* 74 (1 April 2015): 55–58.

¹⁰⁷ C187 article 4(3)(f); R164 paragraph 4©; GS2017 [156]-[167].

We have already seen that different OSH authorities within a member state (such as a federal state) should *coordinate* with each other.¹⁰⁸ Likewise, there needs to be coordination between OSH and other forms of regulation. Recommendation No.197 provides for such strategic coherence:

“The national programme on occupational safety and health should be coordinated, where appropriate, with other national programmes and plans, such as those relating to public health and economic development.”¹⁰⁹

As we will see in the second part of this report, the failure of agencies in some members states to coordinate with each other blunted their capacity to deal with the OSH consequences of the pandemic in a consistent way. The ILO has recommended that measures formulated in response to COVID-19 should consider involving not only OSH authorities, labour inspectorates and occupational health services, but also public health services and health providers; social security institutions; employers’ and workers’ organizations; and civil society organisation such as UN agencies, religious organisations and community groups.¹¹⁰ It has provided guidelines to assist in developing a coordinated approach across agencies to face the present and future pandemics.¹¹¹

Further, while we do not explore this question in this study, there is also a need for *international* collaboration. By definition, the pandemic did not stop at national borders. In industries such as air travel or shipping, inconsistencies between national regulatory regimes and gaps in coverage impede health and safety measures and may fail to prevent pathogens being transmitted across borders. Of course, the more robust national systems are, the less likely it is that major gaps between nations will occur. The focus in this report on improving national systems thus may help to lay the groundwork for better international coordination.

* * *

The remainder of this report applies the seven evaluative dimensions derived from the ILO instruments to the country studies. The culture of prevention and clear rights and duties dimensions are closely interlinked and they are treated in consolidated sections

¹⁰⁸ See discussion on C155 article 15 above.

¹⁰⁹ This elaborates on the obligation in C187 article 5(2)(e).

¹¹⁰ ILO, “Protecting workers: occupational safety and health in response to the COVID-19 pandemic Rapid Needs Assessment & Response Plans: Preparation Guidelines for Country Level Interventions”, April 2021, p.4.

¹¹¹ Ibid.

▶ 4 Work safety and health systems: a comparative assessment

The remaining parts of the report analyse the country studies on the basis of the discussion in Part 4. Part 5 examines the OSH national frameworks in the lead-up to the pandemic, since structural strengths or weaknesses greatly influenced the operation of the pandemic-specific measures. These specific measures are considered in Part 6.

It is worth restating that the countries examined vary radically in their legal, political, economic and social circumstances.¹¹² There are many contextual factors that affect the operation of OSH systems. To mention just a few: the degree of informality; the structure of the labour market; the structure of the state and the consequent modes of administration; the impact of supra-national entities, such as the European Union; the role of the judiciary; prevailing ideological and social norms, including about the appropriate role for government in workplace safety; and so on. As mentioned in Part 2,¹¹³ these factors should caution against too readily adopting an apparently successful initiative without modification into another jurisdiction. On the other hand, it may be possible to draw lessons from the difficulties countries have encountered both in their overall OSH administration and in their response of that administration to COVID-19, since these are often common to many jurisdictions.

4.1 Coherence

All countries examined have developed quite robust regulatory frameworks. Core legislation is complemented by detailed regulations about matters including PPE, the control of dangerous substances, worker representation and reporting.¹¹⁴ Sometimes, safety and health is specifically mentioned in paramount laws. In Brazil, for instance, OSH rights, and broad public health rights, are entrenched in the national Constitution¹¹⁵ and ILO Conventions on OSH ratified by Brazil¹¹⁶ form part of the legal hierarchy.

Many countries, including Brazil, China, Japan, the Republic of Korea and Rwanda, have national OSH policies and/or plans.¹¹⁷ In Japan, for example, the Industrial Safety and Health Act in Japan specifically mandates the formulation of a plan.¹¹⁸ The most recent plan (13th Occupational Accident Prevention Plan), which commenced in 2018, has an increased focus on mental health and the prevention of harassment. It also promotes risk assessments, the appointment of industrial physicians as part of the in-house occupational health services and better health and safety management within firms.¹¹⁹

The study countries all have OSH systems. The main elements of these systems (statutes and regulator/inspectorates) are set out in Figure 5 (this is not exhaustive). While the systems are generally coherent, several jurisdictions have structures which can lead to a degree of fragmentation; these often derive from highly decentralized OSH structures and administrative complexities.

¹¹² See, with reference to developing countries in particular, Tzehainesh Teklè, *Labour Law and Worker Protection in Developing Countries* (Oxford: Hart Publishing, 2010).

¹¹³ See note 4 and accompanying text.

¹¹⁴ See section 5.3.

¹¹⁵ Federal Constitution of Brazil, articles 6, 7, items XXII, XXIII, XXVIII, 196, 200 item VII.

¹¹⁶ Including Conventions No. 155 and No. 187

¹¹⁷ Such as Brazil's National Policy on Safety and Health at Work (NPSHW) was established by Decree n° 7,602/2011; Work Safety Law of the PRC article 8. The Republic of Korea and Japan have five year industrial accident prevention plans; see also Rwandan Ministry of Public Service and Labour, *Occupational Safety and Health National Policy*, 2014.

¹¹⁸ Industrial Safety and Health Act (Japan) Chapter II.

¹¹⁹ In Rwanda, in addition to an overarching OSH plan, there is a National Occupational Safety and Health Strategy 2019-2024 formulated by Ministry of Public Service and Labour. The plans in China and the Republic of Korea have also a five year time horizon.

► **Table 1: OSH Regulators and Applicable legislation in the study countries**

	MAIN NATIONAL BODIES RESPONSIBLE FOR IMPLEMENTING OSH REGULATION (ENGLISH NAME)	MAIN LAWS
Australia	<ul style="list-style-type: none"> • Safe Work Australia • State governments are primarily responsible for work health and safety; each have their own regulators which generally implement a common national model 	<ul style="list-style-type: none"> • Work Health and Safety Act 2011. (WHS Act) (last amended 2018) • State “mirror” WHS Acts
Brazil	<ul style="list-style-type: none"> • Ministry of Labor and Social Security (Labour Tax Auditors) • Public Labour Prosecutor Office 	<ul style="list-style-type: none"> • Federal Constitution • Consolidation of Labour Laws, Chapter V • Regulatory Norms.
China	<ul style="list-style-type: none"> • Ministry of Emergency Management • Ministry of Health (National Health Commission) • Multiple other ministries have their own OSH jurisdiction • Implementation through provincial and local governments 	<ul style="list-style-type: none"> • Work Safety Law of the PRC (last amended 2021) • Law on Prevention and Control of Occupational Diseases (last amended 2018)
Colombia	<ul style="list-style-type: none"> • Consejo Nacional de Riesgos Laborales • Ministerio del Trabajo • Ministerio de Salud y Protección Social • Administradoras de Riesgos Laborales 	<ul style="list-style-type: none"> • Many laws and regulations including: • Ley 1562 de 2012 • Código Sustantivo del Trabajo • Decreto 1295 de 1994 • Ley 9 de 1979 • Plan Nacional de Seguridad y Salud en el Trabajo 2013-2021
Italy	<ul style="list-style-type: none"> • Ministry of Health (including a national commission and local health authorities) • Ministry of Labour and Social Policies (including a national commission and National Labour Inspectorate) • Other agencies such as mines 	<ul style="list-style-type: none"> • Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work • Decree 9.04.2008 No.81 (Consolidated Law on Health and Safety Protection in the Workplace) • Mines inspectorate
Japan	<ul style="list-style-type: none"> • Labour Standards Inspection Office, Ministry of Health, Labour and Welfare 	<ul style="list-style-type: none"> • Industrial Safety and Health Act (last amended 2018)
Korea (Republic of)	<ul style="list-style-type: none"> • Korean Occupational Health and Safety Agency (KOSHA) 	<ul style="list-style-type: none"> • Occupational Safety and Health Act (last amended 2021) (KOSHAct).

	MAIN NATIONAL BODIES RESPONSIBLE FOR IMPLEMENTING OSH REGULATION (ENGLISH NAME)	MAIN LAWS
Rwanda	<ul style="list-style-type: none"> Labour Directorate, Ministry of Public Service and Labour (Mifotra) Various other government ministries have OSH policy obligations 	<ul style="list-style-type: none"> Law regulating labour in Rwanda (N°66/2018 of 30/08/2018), Chapter V (Labour Law of Rwanda) Ministerial Order N°02 of 17/05/2012 Determining Conditions for Occupational Health and Safety Ministerial Order N°01/Mifotra/15 of 15/01/2015 Determining Modalities of Establishing and Functioning of Occupational Health and Safety Committees¹
Spain	<ul style="list-style-type: none"> Ministry of Employment and Social Security National Institute for Occupational Safety and Health Labour and Social Security Inspectorate The 17 autonomous communities have their own OSH specialists and institutes 	<ul style="list-style-type: none"> Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work Law 31/95, the Prevention of Workplace Risks Law (Prevención de Riesgos Laborales) [based on the Directive]
United Kingdom	<ul style="list-style-type: none"> Health and Safety Executive (HSE) (for parts of Britain) HSE has devolved arrangements, particularly with Scotland and Northern Ireland 	<ul style="list-style-type: none"> Health and Safety at Work etc. Act 1974 (last amended 2017) Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (until amended by UK law)
United States	<ul style="list-style-type: none"> Occupational Safety and Health Administration (OSHA) Mine Safety and Health Administration 	<ul style="list-style-type: none"> Occupational Health and Safety Act (US OSH Act) (last amended 2004) Mine Safety and Health Act (last amended 2006)

¹ The legal status of the two ministerial orders is uncertain, as they predate the enactment of the new labour law in 2018. A replacement order on OSH committees has been drafted but not yet promulgated. However, they are assumed to be still valid to the extent that they are not inconsistent with the new law.

Federal/decentralised systems

In several states, jurisdiction over health and safety at work is shared between national and sub-national jurisdictions. Consistency across sub-national areas is not always possible. For example, in Spain, national OSH regulations are administered by 17 autonomous communities. Differences in resourcing and approach between regions can inhibit common responses to problems such as undeclared and platform-based work.¹²⁰ This is emphatically not to say that OSH systems should in all cases be operated by the central government; the point is rather that ongoing co-operation between regions on OSH is necessary. For instance, in Australia, coherence has been achieved across multiple sub-national jurisdictions not by moving to a federal regulator, but by enacting common laws and regulations agreed between the various governments.¹²¹

In contrast, in the United States, some sub-national governments have not co-operated in establishing a nation-wide coherent and comprehensive OSH system. There are multiple federal statutes covering health and safety, the most significant being the Occupational Health and Safety Act (US OSH Act)¹²² and the Mine Safety and Health Act (the Mine Act).¹²³ The US OSH Act sets out a national OSH policy assuring that “so far as possible every working man and woman in the Nation safe and healthful working conditions”. It covers private sector employers outside the mining industry in all states, although states may seek federal approval and provide primary OSH protection, as long as it is “at least as effective” as that provided by the federal agency. This results in a patchwork of different protections across the country, with some states (such as California) providing enhanced OSH protections for all workers, and others enforcing OSH laws with less vigour.¹²⁴

Administrative organization of OSH responsibility

Even within unitary states, issues of policy and system coherence can arise where there are multiple agencies responsible for OSH. In China, prior to 2018, there existed an agency which was the primary body responsible for work safety; the State Administration of Work Safety (SAWS), which was directly under the State Council (China’s highest administrative organ).¹²⁵ However, workplace disease was, and continues to be, the responsibility of the Ministry of Health.¹²⁶

In a major reform in 2018,¹²⁷ SAWS was abolished and its functions transferred to a new Ministry of Emergency Management,¹²⁸ whose overall objective is to deal with disasters, including those resulting from climate change.¹²⁹ However, some other Ministries retained their responsibility for work safety (such as transport, housing and aviation)¹³⁰ and the special laws pertaining to those industries prevail over the Work Safety Law.¹³¹ The Ministry of Emergency Management is required to play a co-ordinating role among the various parts of the government, but only in relation to safety, not health.¹³²

Moreover, general labour law and social security matters (which may sometimes overlap with OSH issues) are handled by yet another Ministry, the Ministry of Human Resources and Social Security. There is therefore a dispersal of authority in relation to work safety and health among multiple entities (and their inspectorates), none of which have safety and health at work as its main focus and many of which have the power

¹²⁰ European Commission. *Factsheet on Undeclared Work – Spain*. <https://ec.europa.eu/social/ajax/BlobServlet?docId=18178&langId=en>
¹²¹ <https://www.safeworkaustralia.gov.au/law-and-regulation/model-whs-laws>. (note that Western Australia and Victoria are exceptions).

¹²² 29 U.S.C.A. § 651 et seq.

¹²³ 30 U.S.C. § 801 et seq. The US OSH Act is the statute of general application; its provisions are weaker than the special statutes, especially the Mine Act.

¹²⁴ 22 states currently have this power, and these state plans cover state and local public sector workers as well. <https://www.osha.gov/stateplans/>.

¹²⁵ A separate agency existed to regulate mine safety.

¹²⁶ See Law on Prevention and Control of Occupational Diseases of the PRC article 13.

¹²⁷ 关于国务院机构改革方案的说明, item 7 available at http://www.gov.cn/guowuyuan/2018-03/14/content_5273856.htm.

¹²⁸ See Work Safety Law of the PRC article 10.

¹²⁹ It also took over the disaster management functions of various other ministries, such as those responsible for agriculture, forests, land, firefighting, earthquakes and floods.

¹³⁰ Work Safety Law of the PRC article 10.

¹³¹ Work Safety Law of the PRC article 2.

¹³² Work Safety Law of the PRC article 12

to draft national standards. This arrangement has the advantage that in the case of a major industrial accident, such as a chemical or gas leak or a major equipment breakdown, a holistic disaster approach can be taken which addresses the consequences not only to workers but to the general public. On the other hand, the radical administrative and legal division between health and safety, and between the general safety law and industries which are separately regulated, may lead to a lack of consistency and bureaucratic wrangling.¹³³ As this arrangement is new, it is too early to assess the consequences.¹³⁴

4.2 Comprehensive coverage

As mentioned in Part 3, traditional vertically-integrated workplaces have increasingly given way to home-based, platform-based, virtual and/or contractually fragmented working arrangements, many of them involving workers who may not be in employment relationships. OSH frameworks vary greatly in their ability to respond to these circumstances and to forms of work that have traditionally escaped regulation, such as domestic work. The Conventions require comprehensive coverage, but this goal can be undermined by limitations in the kinds of entities to which health and safety regulation may apply, as well as by specific exclusions. This section begins by examining attempts by national systems to achieve very broad coverage before moving to examples where coverage is unduly restricted.

Turning first to examples of where a thoroughgoing re-conception of OSH scope has occurred, in Australia, work safety and health law has been thoroughly recast so as to replace terms such as “employer” and “employee” with wider terms such as “person conducting a business” and “worker” (see Figure 6).¹³⁵ This approach has also been adopted in New Zealand.¹³⁶ Moreover, in both these countries, as well as other English-language jurisdictions such as the United Kingdom, Singapore and Canada, the terms “work health and safety”, “workplace health and safety” and “health and safety at work” are increasingly used in preference to “occupational safety and health” in order to highlight that protection is not confined to particular “occupations”.

China also avoids use of employer and employee terminology and its Work Safety Law. It refers to “entities engaged in production operations (从事生产经营活动的单位)”¹³⁷ and uses a broader term *congye ren yuan* (从业人员) instead of the narrower term found in other labour statutes.¹³⁸ The Law specifically provides that a business entity is responsible for temporary agency workers,¹³⁹ platform workers¹⁴⁰ and for entering into arrangements with sub-contractors to protect the safety of workers that are contracted out.¹⁴¹ However, the Law on Prevention and Control of Occupational Diseases uses the narrow “employment relationship” language of other labour statutes, so that the self-employed and sub-contractors, for example, are excluded, although temporary agency workers are covered.¹⁴² Moreover, it only applies to a list of occupational diseases which does not include mental health issues – or, at the time of writing, COVID-19.¹⁴³

Some other countries have not changed terminology but rather have extended the meaning of existing concepts and/or complemented them. Thus, in Italy, the term “worker” (*lavoratore*) is defined as “a person

¹³³ Sarah Biddulph, ‘The Impact of Transparency and Accountability Mechanisms on Bureaucratic Inertia: A Case Study of Work Safety Regulation’ in ed. Sarah Biddulph and Ljiljana Biukovic, *Good Governance in Economic Development: International Norms and Chinese Perspectives* (UBC Press, 2019), pp.291-322; see also, noting that they predate the 2018 organisational change: Mimi Zou, ‘Falling through the Legal Cracks: The Fragmentation of China’s Occupational Safety and Health Regime’, *LAWASIA Journal* (2016): 1–18; ILO, *Review of the Work Safety and Health Inspection System in the People’s Republic of China*, August 2010.

¹³⁴ In the case of COVID-19, the relevant legislation was work health law (strictly disease law), not work safety law.

¹³⁵ Richard Johnstone, ‘Regulating Work Health and Safety in Multilateral Business Arrangements’ 32 *Australian Journal of Labour Law* (2019): 41–61.

¹³⁶ Health and Safety at Work Act 2015.

¹³⁷ Work Safety Law of the PRC article 2 (从事生产经营活动的单位).

¹³⁸ See the National People’s Congress interpretation of the law at http://www.npc.gov.cn/npc/c2180/flsyywd_list.shtml.

¹³⁹ Work Safety Law of the PRC articles 28 and 61.

¹⁴⁰ Work Safety Law of the PRC article 4.

¹⁴¹ Work Safety Law of the PRC article 49.

¹⁴² Chinese labour law is actually based around “labour relationships” which have some significant differences from “employment relationships” in other countries: see Sean Cooney, ‘Legal Segmentation in China, India, Malaysia and Vietnam’, 161(4) *International Labour Review* 1-19 (2022).

¹⁴³ Law on Prevention and Control of Occupational Diseases of the PRC article 2.

who, regardless of the type of the contract, carries out a work activity within the organization of a public or private employer, with or without pay, even for the sole purpose of training"¹⁴⁴ and "employer" (*datore di lavoro*) is given an extended meaning.¹⁴⁵ Similarly, in Singapore, the term "employer" is complemented with the concept of "occupier" which is very broadly defined and "employee" is also given a very expansive meaning to achieve broad coverage.¹⁴⁶

▶ **Figure 3: Work Health and Safety Act 2011 (Australia)**

Section 19. Primary duty of care

(1) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, the health and safety of:

(a) workers engaged, or caused to be engaged by the person; and (b) workers whose activities in carrying out work are influenced or directed by the person;

while the workers are at work in the business or undertaking.

(2) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.

Other jurisdictions have made more limited amendments to their OSH laws, extending coverage in certain specific situations. In the Republic of Korea, the Occupational Health and Safety Act (KOSHAct), which was originally confined to employees in parallel with general labour law, has recently been extended to cover various forms of sub-contracting arrangements, which are regulated in detail in the legislation, with the responsibility of business owners at various points in the contracting chain clarified.¹⁴⁷ These include arrangements at construction sites, in certain hazardous forms of manufacturing, in the delivery industry, and for certain forms of temporary agency work and franchise relationships.¹⁴⁸

While Japanese OSH law appears to cover principally employees (so that gig workers and domestic workers, for example, are excluded),¹⁴⁹ it does, like the Republic of Korea, extend to a range of contracting arrangements (including protecting workers not directly employed by lead contractors on construction sites).¹⁵⁰ In the United Kingdom, self-employed workers are specifically covered.¹⁵¹

Where, as in the examples cited above, laws are broadly drafted or specifically extended to non-employees, responsibilities are no longer tied to specific contractual classifications but rather to the capacity to influence

¹⁴⁴ Consolidated Law on Health and Safety Protection in the Workplace article 2.

¹⁴⁵ Consolidated Law on Health and Safety Protection in the Workplace article 2. "The holder of the labour relationship with the worker or, in any case, the subject who, according to the type and structure of the organization in which the worker is employed, has the responsibility of the organization itself or of the production unit, exercising decision-making and spending powers".

¹⁴⁶ Occupier includes "the person who has charge, management or control of those premises" irrespective of ownership. Likewise the term "employee" is given a very expanded meaning, covering volunteers, agency workers, and trainees. Workplace Safety and Health Act 2006 sections 4 and 11.

¹⁴⁷ KOSHAct Chapter V.

¹⁴⁸ This precise applicability is determined by Presidential Degree. Some public sector workers, such as firefighters, police and teachers are governed by separate legislation.

¹⁴⁹ Industrial Safety and Health Act article 2(ii).

¹⁵⁰ Industrial Safety and Health Act articles 15, articles 62-76.

¹⁵¹ See Health and Safety at Work etc. Act (United Kingdom), section 3.

safety and health in practice.¹⁵² Under this approach, a head contractor on a building site, for example, has obligations to all workers on that site, irrespective of whether they are direct employees, self-employed, or otherwise engaged through a succession of contracts. Further, representation rights may be extended to all workers and workplace are broadly defined to include any place where a worker is “at work”. This kind of regulatory architecture stands a better chance of underpinning a broad, coherent, OSH response to events such as the COVID-19 pandemic, whose impact on the world of work is not differentiated according to contractual forms.

Nonetheless, many of the OSH systems continue to use limit scope to “employers” and “employees” and/or to exclude certain categories of workers. For example, the European Union Framework Directive currently does not cover all self-employed workers and specifically excludes domestic workers,¹⁵³ although the question of scope is currently under debate and some individual Member States provide for broader application in their OSH provisions. In Brazil, OSH law is generally tied to the employment relationship, as are social security payments, although regular and casual workers must be accorded equal rights¹⁵⁴ and agency workers are covered.¹⁵⁵ Non-employees, such as the self-employed workers must provide their own safety equipment and take out their own accident insurance.¹⁵⁶ Moreover, around 40 per cent of the workforce is informal, and work outside the protection of OSH and social security systems.¹⁵⁷ One issue in this context is that OSH legislation forms part of a larger Code. The risk with this is that definitional sections pertaining to the entirety of the Code will be narrower than those in a stand-alone OSH law (because they address matters such as minimum wages which do not apply to self-employed or volunteers).

In the United States, as mentioned above, some employees are not covered by OSH law at all, namely state and local employees in those states without their own OSH law, of which there are more than twenty.¹⁵⁸ As many frontline workers (such as health workers) are engaged by states or local governments, this is a particularly serious lacuna, at least where there is no collective agreement coverage. Furthermore, self-employed, students and volunteers are not covered.¹⁵⁹ Small farms and undertakings are exempted from, or not included in OSH inspection programs.

Of course, coverage under the technical scope of the law does not equate to coverage in practice. Informal workers, especially, are often outside the effective scope of the law. For example, in Rwanda, the scope of the OSH chapter in the Labour Law is very broad, covering self-employed, interns and apprentices and informal workers.¹⁶⁰ However, 77% of the workforce is informal (mostly in agriculture and construction) and not included in OSH statistics;¹⁶¹ particularly vulnerable informal workers include those who are mostly migratory, illiterate and seasonal. Data from Rwanda also shows that observation of OSH law varies from sector to sector, with high compliance in the service sector (76 per cent) to low compliance in construction

¹⁵² Tanya Goldman and David Weil, “Who’s Responsible Here? Establishing Legal Responsibility in the Fissured Workplace”, *Berkeley Journal of Employment and Labor Law* 42, no. 1 (2021): 55–116.

¹⁵³ Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (OSH Framework Directive) article 3(a). The Directive uses the term “worker” rather than “employee”. On the meaning of worker, see Nicola Kountouris, “The Concept of “Worker” in European Labour Law: Fragmentation, Autonomy and Scope”, *Industrial Law Journal* 47, no. 2 (2018): 192–225.

¹⁵⁴ Federal Constitution of Brazil, article 7 item XXXIV. This is despite the fact that there are specific laws on rural work, domestic work and temporary work.

¹⁵⁵ Law No, 6019/1974 article 4-C.

¹⁵⁶ IBGE. (2020). Desemprego cai em 16 estados em 2019, mas 20 têm informalidade recorde. Agência IBGE. <https://agenciadenoticias.ibge.gov.br/agencia-noticias/2012-agencia-de-noticias/noticias/26913-desemprego-cai-em-16-estados-em-2019-mas-20-tem-informalidade-recorde>.

¹⁵⁷ Guilherme Guimaraes Feliciano and Olivia de Quintana Figueiredo Pasqualetto, “Balanced working environment: analysis of the Brumadinho case”, *Veredas Do Direito* 16 (2019):181–205. <https://doi.org/http://dx.doi.org/10.18623/rvd.v16i36.1556>.

¹⁵⁸ See <https://www.osha.gov/stateplans>.

¹⁵⁹ US OSH Act, Section 3, Definitions, 29 U.S.C. § 652. See also <https://www.osha.gov/temporaryworkers/>.

¹⁶⁰ See Labour Law of Rwanda article 2; Ministerial Order N°02 of 17/05/2012 Determining Conditions for Occupational Health and Safety, article 2. There is a separate law covering certain public servants.

¹⁶¹ National Institute of Statistics of Rwanda, Labour Force Survey 2018; Ministry of Public Service and Labour, OSH Country Profile, June 2019. “Informal sector employee” is defined in article 3(22) to mean “an employee working for an enterprise or an individual for an employment that is not registered in the register of companies or with a public authority”.

(42 per cent).¹⁶² This industry variation (often together with regional variation within countries) is common across jurisdictions.¹⁶³

4.3 Culture of prevention, clear rights and duties

The jurisdictions studied in this Report all impose preventative health and safety duties upon employers and employees (or, as we have seen, broader categories).¹⁶⁴ Several jurisdictions explicitly provide that the core duties are non-delegable functions of the management of undertaking.¹⁶⁵

The duties are formulated in different ways depending on the jurisdictions. The US OSH Act distinguishes between a general employer duty to keep work free from “recognized hazards” and a specific duty tied to promulgated standards.¹⁶⁶ These are alternatives in the sense that once a specific standard applies, a breach must be determined in relation to that standard, not the general one. In other countries (such as the European Union member states, Brazil, the United Kingdom, Rwanda and Australia) the broad general duties are always relevant and the starting point for determining obligations.¹⁶⁷

Chinese law provides for very extensive duties for persons who are primarily responsible in a business entity, including establishing, improving and implementing internal safety and health systems, including risk assessments and training.¹⁶⁸ These systems involve the specification of clear responsibility within an undertaking¹⁶⁹ and a clear budget.¹⁷⁰ The Korean OSH Act and its Japanese counterparts are comparatively prescriptive,¹⁷¹ with less emphasis on general duties in favour of more detailed standards accompanied by specific penal provisions.¹⁷² However, the Japanese statute contains provisions requiring employers to prepare a “safety and health” improvement plan following a serious accident, in consultation with unions or, if there are none, worker representatives.¹⁷³

One distinctive “early warning” feature of Japanese OSH systems that played an important role in the pandemic is the position of “industrial physician” in larger workplaces (more than 50 employees).¹⁷⁴ Industrial physicians are members of Health (or Health and Safety) Committees¹⁷⁵ that must be established in larger undertakings¹⁷⁶ and are central to regular physical and mental health check-ups of workers.¹⁷⁷

One overall comment that can be made here is that, while specific standards are very useful in providing clear guidance to firms about what measures to implement, making them rather than the general safety and health duty the centrepiece of OSH regulation undermines the fundamental nature of post-Robens

¹⁶² Rwanda Labour Inspectors Compliance Audit Report 2015-2018.

¹⁶³ See, for example, the analysis of the Australian Productivity Commission, Performance Benchmarking of Australian Business Regulation: Occupational Health and Safety Research report (April 2010).

¹⁶⁴ Compare, for example: Health and Safety at Work etc. Act 1974 section 2; US OSH Act Section 5 (29 USC § 654(a); Work Safety Law of the PRC articles 20, 21 et seq; Labour Law of Rwanda article 77; Ministerial Order N°02 of 17/05/2012 Determining Conditions for Occupational Health and Safety articles 4 and 5.

¹⁶⁵ For example, Consolidated Law on Health and Safety Protection in the Workplace (Italy) article 17; Work Health and Safety Act 2011 (Australia) section 14.

¹⁶⁶ US OSH Act section 5 29 USC 654 (a).

¹⁶⁷ See, for example EU OSH Framework Directive articles 5-9; Consolidation of Labour Laws (Brazil) articles 157 and 158; Work Health and Safety Act (Australia) section 19.

¹⁶⁸ Work Safety Law of the PRC article 21; Law on Prevention and Control of Occupational Diseases of the PRC article 20, 34.

¹⁶⁹ Work Safety Law of the PRC article 22; Law on Prevention and Control of Occupational Diseases article 26.

¹⁷⁰ Work Safety Law of the PRC article 23; Law on Prevention and Control of Occupational Diseases article 21.

¹⁷¹ For example, KOSHAct articles 38 and 39; Industrial Safety and Health Act (Japan) Chapter IV.

¹⁷² KOSHAct Chapter XII. Industrial Safety and Health Act (Japan).

¹⁷³ Industrial Safety and Health Act (Japan) Chapter IX Section 1.

¹⁷⁴ Industrial Safety and Health Act (Japan) article 13. Other countries, such as France, also have a system of industrial physicians: compare Code du travail (France) articles L4622-2, 3, 4, 8 and L4623

¹⁷⁵ Japanese law provides for both separate and consolidated health and safety committees.

¹⁷⁶ Industrial Safety and Health Act (Japan) articles 18 and 19.

¹⁷⁷ Industrial Safety and Health Act (Japan) articles 66-66(10).

systems¹⁷⁸ (and the regulatory approach taken in the fundamental Conventions). That is, firms and workers should go beyond merely implementing governmental rules; they should pro-actively assess *all* the safety and health risks at the workplace, irrespective of whether there is a specific rule in place.

Risk assessments and the hierarchy of controls

As just stated, risk assessment systems are central to safety and health at work, as conceived of in the Conventions. All the jurisdictions studied here have OSH systems that (to greater or lesser extent) are based on risk assessments and preventive measures.¹⁷⁹ Several specifically set out a hierarchy of controls.¹⁸⁰ In Brazil, risk reduction is mentioned in the Federal Constitution and has been interpreted as a duty of continuous improvement.¹⁸¹ In China, the Occupational Diseases Law contains quite extensive provisions about early prevention of diseases.¹⁸² The key statute in the Republic of Korea is more prescriptive; there is a provision requiring that business owners conduct general risk assessments,¹⁸³ but unlike specific standards, this is not tied to a specific penalty. However, larger companies must formulate an annual health and safety plan,¹⁸⁴ and must have designated officers with responsibilities pertaining to general safety and health.¹⁸⁵ Japanese law does not appear to specifically require risk assessments but OSH guidelines made under the Industrial Safety and Health Act prescribe them.¹⁸⁶

OSH laws also provide that, for larger undertakings at least, managers must be advised by dedicated health and safety professionals¹⁸⁷ and must provide regular health and safety information and training to workers.¹⁸⁸

Specific standards

In conformity with Convention No. 155, jurisdictions (apart from Japan)¹⁸⁹ also complement the general legislative duty with specific standards in delegated legislation, as well as reporting requirements. For example, in Brazil, the details are set out in mandatory “Regulatory Norms”,¹⁹⁰ and in China, by regulations promulgated by the State Council.

One issue here is the need to have accessible and consolidated of delegated legislation; this make it easier for undertakings and workers to be aware of their rights and obligations rather than trying to familiarize themselves with an array of different instruments. Some jurisdictions, such as Australia,¹⁹¹ Brazil, the

¹⁷⁸ See Part 3.

¹⁷⁹ See, for example, Work Health and Safety Act (Australia), sections 17 and 18; Work Safety Law of the PRC articles 21(5) and 41; Law on Prevention and Control of Occupational Diseases of the PRC articles; Consolidated Law on Health and Safety Protection in the Workplace (Italy) articles 17 and 28.; Labour Law of Rwanda article 81; EU OSH Framework Directive article 6. See also National Occupational Safety and Health Strategy 2019-2024 of Rwanda which is strongly aimed at creating a preventative work culture.

¹⁸⁰ See EU OSH Framework Directive article 6(2); <https://www.osha.gov/safety-management/hazard-prevention>.

¹⁸¹ Article 7, item XXII.

¹⁸² Law on Prevention and Control of Occupational Diseases of the PRC articles 14, 15 and 17, 18-20.

¹⁸³ KOSHAct article 36.

¹⁸⁴ KOSHAct article 15.

¹⁸⁵ KOSHAct articles 16-23.

¹⁸⁶ Seichi Horie, "Occupational Health Policies on Risk Assessment in Japan", *Safety and Health at Work* 1, no. 1 (1 September 2010): 19–28.

¹⁸⁷ See, for example, EU OSH Framework Directive, article 7.

¹⁸⁸ KOSHAct Chapter III; EU OSH Framework Directive, articles 10 and 12.

¹⁸⁹ The Japanese legislation refers to the delegated instruments as guidelines and breach of guidelines themselves does not appear to attract a penalty. However, the primary duties in the legislation to which the guidelines attach do attract penalties. See Industrial Safety and Health Act (Japan) article 28. This appears to be an instance of Japan's distinctive preference for “administrative guidance” as a mode of regulation.

¹⁹⁰ See, in particular Regulatory Norms No. 6 (PPE); No. 15 (unhealthy activities and operations); No.16 (dangerous activities and operations); No. 32 (safety and health at work in health services); No. 33 (safety and health when working in confined spaces).

¹⁹¹ Work Health and Safety Regulations; there are also Codes of Practice (which have lesser legal effect).

Republic of Korea¹⁹² and Rwanda¹⁹³ maintain one comprehensive set of OSH regulations. In other jurisdictions, such as the United Kingdom¹⁹⁴ and China,¹⁹⁵ the material appears to be less systematized.

There is considerable variation in the ease with which new standards can be promulgated; in the United States, the process for permanent new standards is cumbersome, lengthy, requires significant public input, and regulations are often challenged through litigation after they are promulgated.¹⁹⁶ However, “emergency temporary standards” can also be issued and were twice used in response to the pandemic in 2021.¹⁹⁷

Jurisdictions generally have quite extensive standards on the traditional areas of safety and health, such as mining, chemicals and other physically hazardous work; these often include equipment specifications, registration and licensing requirements. On the other hand, many countries, including Australia and the United States have significant gaps concerning psycho-social health and risks such as harassment. Two notable exceptions are (1) the OSH law of the Republic of Korea which contains a specific provision requiring undertakings to protect workers dealing directly with the public, either in person or on line from “abusive language, assault, or any other conduct of customers inflicting physical or mental pain”,¹⁹⁸ and (2) the Industrial Safety and Health Act in Japan which provides that employers must, via the industrial physicians, provide physical and mental health check-ups for workers working under highly stressful conditions, such as long hours and, if the medical advice requires, implement measures such as reduced hours or duties, or additional paid leave.¹⁹⁹

Right to leave a dangerous workplace

There is also some variation on the question of whether workers (or in more restricted systems, employees) have the right to leave a dangerous workplace without retaliation. Employees in Spain, Brazil, the United Kingdom, China, the Republic of Korea and Australia have this right. In the United States, employees have some degree of protection against retaliation for withdrawing from the workplace on reasonable grounds under both the OSH and the labour laws; this protection is stronger under the Mine Act.²⁰⁰ However, it is of course one thing to have a right and another to exercise it and many workers may be afraid to leave a workplace in the face of strong employer objections.

4.4 Collaboration

Many jurisdictions provide extensively for consultation arrangements either in the main legislation or in delegated regulations.²⁰¹ At the national level, many jurisdictions have long-standing tripartite arrangements for OSH standard-setting. For example, Regulatory Norms in Brazil are made with the involvement of the Permanent Tripartite Joint Committee.

¹⁹² Rules on Occupational Health and Safety Standards.

¹⁹³ Ministerial Order N°02 of 17/05/2012 Determining Conditions for Occupational Health and Safety. However, these rules are still quite sparse and require supplementation with more specific standards on matters such as transport, explosives and food processing.

¹⁹⁴ For example in the United Kingdom: Personal Protective Equipment at Work Regulations 1992, Representatives and Safety Committees Regulations 1977 and the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 2013.

¹⁹⁵ In particular rules promulgated by the State Council.

¹⁹⁶ See *Industrial Union Dept., AFL-CIO v. American Petroleum Institute*, 448 U.S. 607 (1980) (“The Benzene Case”) and *American Textile Manufacturers Institute, Inc., v. Donovan*, 452 U.S. 490 (1981) (“The Cotton Dust Case”).

¹⁹⁷ We will see in Part 6 that in many countries there are no, or only partial, standards dealing with airborne infections.

¹⁹⁸ KOSHAct article 41.

¹⁹⁹ Industrial Safety and Health Act (Japan) article 66-8.

²⁰⁰ *Whirlpool Corp. v. Marshall*, 445 U.S. 1 (1980). See also National Labor Relations Act, 29 U.S.C. §§ 157 and 158(a)(1).

²⁰¹ See for example, Safety Representatives and Safety Committees Regulations 1977 (United Kingdom) and The Health and Safety (Consultation with Employees) Regulations 1996 (United Kingdom); EU OSH Framework Directive articles 10 and 11; Work Health and Safety Act 2011 Part 5 (Australia); Consolidation of Labour Law (Brazil) articles 163-165; Regulatory Norm No. 5 (Internal Committee for the Prevention of Occupational Accidents).

At the workplace level, most countries require, depending on the size of the firm, the establishment of a labour-management committee, whose remit is OSH;²⁰² they may coexist with other consultation bodies relating to broader labour issues²⁰³ and may also include representatives from several different legal entities operating in the one establishment, as is provided for in Rwanda.²⁰⁴

Several countries also provide for elected health and safety representatives; in some jurisdictions, such as Australia, these have inspector-like powers to inspect the workplace and (in the case of Australia) to stop work or require improvements²⁰⁵ or to carry out investigations.²⁰⁶ Unions also have the right in many jurisdictions to monitor compliance; for example in Brazil²⁰⁷ and in China (although this does not extend to mandatory powers or joint rule making).²⁰⁸

China's Work Safety Law provides also for a work safety technical management body or dedicated expert personnel in larger enterprises (and in all enterprises in certain dangerous industries); these are responsible for formulating workplace rules and systems, implementing them, and preventing and correcting acts in violation of the rules.²⁰⁹ There is a parallel structure for occupational diseases.²¹⁰ However, these are management bodies rather than labour-management committees. Japan has similar arrangements involving technical experts²¹¹ but it also mandates union or worker representatives on the safety committees and the health committees (which can be consolidated into one comprehensive committee).²¹²

The United States OSH Act does not require the establishment of labour-management committees or otherwise mandate consultation between management and labour, although some states, such as California,²¹³ have.

4.5 Compliance and enforcement

OSH regulators, including inspectorates, vary greatly between countries in their authority, strategy and operation. First, their mandates (areas of responsibility) differ. They may focus on safety and health alone (United Kingdom, the United States and Australia).²¹⁴ They may focus more broadly on labour and social security issues (such as in Japan, Rwanda,²¹⁵ Spain and Brazil). Or they may focus more narrowly, according to industry, and to whether the matter involves either health or safety (China and Italy, although Italy has recently moved to joint jurisdiction of labour and health authorities²¹⁶). A broad focus has the advantage that a holistic, comprehensive approach can be taken to workplace issues. The integration of wage, working hours, discrimination, social security and work safety functions in the national inspectorate can help to speedily resolve issues whose resolution requires attention not only to OSH law but also to questions of pay

²⁰² See, for example KOSHAct article 24; Ministerial Order N°01/Mifotra/15 of 15/01/2015 Determining Modalities of Establishing and Functioning of Occupational Health and Safety Committees (Rwanda).

²⁰³ See for example, Brazil: Article 11 of the Federal Constitution and article 510-A et seq. of the CLL.

²⁰⁴ Ministerial Order N°01/Mifotra/15 of 15/01/2015 Determining Modalities of Establishing and Functioning of Occupational Health and Safety Committees article 3. However, Rwandan labour inspectors report that few employers have managed to establish OSH committees: labour inspectorate compliance report, 2018.

²⁰⁵ See, for example, Work Health and Safety Act 2011 (Australia) Part 5 Division 7.

²⁰⁶ The Safety Representatives and Safety Committees Regulations 1977.

²⁰⁷ Law No. 8,213/1991.

²⁰⁸ Work Safety Law of the PRC articles 7, 60; Law on Prevention and Control of Occupational Diseases of the PRC articles 4 and 40.

²⁰⁹ Work Safety Law of the PRC articles 25 and 26.

²¹⁰ Law on Prevention and Control of Occupational Diseases article 26.

²¹¹ Industrial Safety and Health Act (Japan) Chapter 3.

²¹² Industrial Safety and Health Act (Japan) articles 17-19.

²¹³ Injury and Illness Prevention Program, 8 CA ADC §3203.

²¹⁴ In the Republic of Korea, inspectors are administratively allocated to either OSH or general labour matters.

²¹⁵ General labour inspection is decentralized to the district level in Rwanda and there are no OSH specialists working in the districts. There is also no structured training in OSH for new inspection recruits.

²¹⁶ The "Tax Decree", 21.10.2021, no. 146; see also law 17.12.2021, no. 215.

and compensation. On the other hand, specialisation has the advantage of expertise, often very important when dealing with complex engineering, organizational or medical questions.²¹⁷

Second, the scope of their jurisdictions differs and this does not necessarily equate to the coverage of the overall OSH legislation, considered above. They may or may not have jurisdiction in relation to domestic workers, agricultural workers and independent contractors, for example.²¹⁸ A more extensive jurisdiction is clearly preferable to avoid neglecting non-employees who are often the most vulnerable workers and frequently have no say in safety arrangements.

Third, the powers of inspectors can vary; in Australia, Brazil, China, Italy and Japan, for instance, inspectors have very wide evidence gathering and enforcement powers, including prohibiting activities and ordering improvements.²¹⁹ In contrast, American inspectors under the US OSH Act must consult with their superiors before issuing orders requiring workplace improvements and must seek court orders to shut down any dangerous operations. On the other hand, inspectors under the Mine Act have broad powers to order changes or shut down operations.²²⁰ Proving violations of general duty breaches is onerous because each case requires that expert evidence be adduced on risks and abatement.

Fourth, an inspectorate's approach to enforcement can vary.²²¹ Inspectorates may be primarily educative or primarily punitive; as we saw in section 4.6, the effectiveness of each of these methods is a question of considerable debate.²²² Education is particularly useful for those firms which are committed to safety and health but do not have sufficient knowledge to implement best practice systems. On the other hand, it is of limited value to recalcitrant firms which, whether through crude cost-benefit calculations, reckless disregard for workers or irrationality ignore external information. For these firms, a more punitive firm is needed.²²³ This requires a more assertive approach from inspectorates, which are sometimes reluctant to be sufficiently confrontational, as where their perspective excessively aligns with managements.²²⁴ In short, then a strategic combination of enforcement methods is required.²²⁵

Inspectorates also vary in relation to how much they simply respond to complaints, as opposed to also conducting proactive audits (which occurs in Brazil, for example). They diverge too in their educative and monitoring operations; in keeping with Japan's focus on a strong medical dimension to OSH issues, the labour inspectorate includes physicians who can respond to health issues, including diseases.²²⁶

²¹⁷ See also Michael Piore and Andrew Schrank, "Toward Managed Flexibility: The Revival of Labour Inspection in the Latin World", *International Labour Review* 147 (2008): 1–23; John Howe, Tess Hardy and Sean Cooney, "Mandate, Discretion, and Professionalisation in an Employment Standards Enforcement Agency: An Antipodean Experience", *Law & Policy* 35, no. 1–2 (2013): 81–108; Wenjia Zhuang, Kinglun Ngok, "Labour Inspection in Contemporary China: Like the Anglo-Saxon Model, but Different", *The Palgrave Handbook of Local Governance in Contemporary China* 153, no. 4 (2019): 561–586.

²¹⁸ See, for example, Adelle Blackett, Assata Koné-Silué, "Des approches innovantes pour assurer l'accès des travailleurs domestiques au travail décent en Côte d'Ivoire: ce que l'administration du travail et le système judiciaire ont pu faire dans le cadre du régime général du Code du travail", *Revue internationale du Travail* 158, no. 1 (2019): 39–65.

²¹⁹ Work Health and Safety Act 2011 (Australia) Parts 9 and 10. See Regulatory Norm No.3(Brazil); Work Safety Law of the PRC articles 65, 70; Law on Prevention and Control of Occupational Diseases of the PRC articles 63 and 64, 77; in China, powers of inspectors and penalties were strengthened in 2021; Industrial Safety and Health Act (Japan) Chapter X.

²²⁰ US OSH Act section 13(a), 29 USC § 662(a).

²²¹ Some laws mandate enforcement priorities; see, for example, US OSH Act section 8, 29 USC § 657. In Rwanda, there is insufficient material setting out a consistent approach to inspection: see Ministry of Public Service and Labour, "An assessment Report on the need for Rwanda to ratify conventions": C181- private employment agencies convention-1997; C155- occupational safety and health -1981; C187- promotional framework for occupational safety and health - 2006; C150- labour administration- 1978, May 2014, pp 43.

²²² Roberto Pires, "Promoting Sustainable Compliance: Styles of Labour Inspection and Compliance Outcomes in Brazil", *International Labour Review* 147, no. 2–3 (2008): 199–229 and references at n.117; Julien Etienne, "The Politics of Detection in Business Regulation", *Journal of Public Administration Research and Theory* 25, no. 1 (2015): 257–84; Julien Etienne, "The Politics of Detection in Business Regulation", *Journal of Public Administration Research and Theory* 25, no. 1 (2015): 257–84; Steve Tombs and David Whyte, "The Myths and Realities of Deterrence in Workplace Safety Regulation", *British Journal of Criminology* 53, no. 5 (1 September 2013): 746–63.

²²³ Steve Tombs and David Whyte, "The Myths and Realities of Deterrence in Workplace Safety Regulation", *British Journal of Criminology* 53, no. 5 (1 September 2013): 746–63.

²²⁴ Julien Etienne, "The Politics of Detection in Business Regulation", *Journal of Public Administration Research and Theory* 25, no. 1 (2015): 257–84.

²²⁵ Strategic enforcement was pioneered by David Weil in the United States – see

²²⁶ David Weil, "A Strategic Approach to Labour Inspection", *International Labour Review* 147, no. 4 (2008): 349–75. Industrial Safety and Health Act (Japan) articles 91(2), 95.

The severity of sanctions can also differ. In China, specific provisions in the Criminal Code imposing prison sentences for serious work safety breaches, particularly for managers responsible for safety,²²⁷ mean that public prosecutorial authorities can be involved in the event of accidents. Similarly, In Brazil, there is also a branch of the Public Prosecutor Office which can investigate labour-related complaints.²²⁸ Specific criminal penalties are applicable in Italy too. And in Australia, industrial manslaughter laws had come into effect in most states and territories by March 2022.²²⁹

Lastly, the work of inspectorates can be shaped or even inhibited by the relative ability of regulatates to challenge their actions through administrative litigation.²³⁰

4.6 Coordination with other systems

Another area in which there is considerable national variation is the extent to which OSH and other systems coordinate. In Spain, for example, the fragmentation of both OSH and public health systems through the decentralised approach to government, while allowing for region-specific responses to work safety issues, can result in restricted capacity, especially under conditions of underinvestment. In the United States, some low wage essential workers have no health coverage.²³¹ In China, as we have seen, occupational diseases form part of the health ministry's jurisdiction; this is quite separate from the work safety authorities.

In relation to labour law and social security, there is again divergence. Most countries have paid sick leave and extensive workers' compensation systems. However, in the United States, and in the Republic of Korea, there is no nationally mandated requirement for paid sick leave, although 13 US states and some municipalities do provide for some degree of paid sick leave and the Republic of Korea is piloting a new sick leave scheme.²³² Many countries also protect against discrimination on the basis of disability, and include a right to reasonable accommodations.²³³ These protections could potentially be relevant to persons suffering from "long COVID".

* *

What can be learned from the survey in this Part 5? On the one hand, many of the divergences reflect different – often nationally appropriate – regulatory styles and approaches that are consistent with the seven key OSH dimensions set out in Part 4. On the other hand, there are some clear deficiencies in how states address questions of coverage, for example. It may be surmised that these strengths and weaknesses shaped the response of these OSH frameworks to the COVID-19 pandemic. The report therefore turns to see how they fared during that often overwhelming challenge.

²²⁷ See Criminal Code of the PRC articles 134-139(1).

²²⁸ The Public Labour Prosecutor Office.

²²⁹ See, for example, Work Health and Safety Amendment Bill 2021 (Australian Capital Territory).

²³⁰ For example, in the United States, see *National Federation of Independent Business v. Department of Labor*, Occupational Safety and Health Administration, 142 S.Ct. 661 (2022); on China, see Biddulph, above.

²³¹ See Katherine Keisler-Starkey and Lisa N. Bunch, Health Insurance Coverage in the United States, Report No. P60-274 (September 2021).

²³² <https://koreajoongangdaily.joins.com/2022/06/15/national/socialAffairs/Korea-COVID19-sick-leave/20220615164205094.html>.

²³³ See, for example, 42 U.S.C. § 12101 et seq.

▶ 5 Evaluating specific OSH measures during the pandemic

This Part discusses OSH actions taken by governments and other actors in response to the pandemic. As with Part 5, the material is organised by reference to the key dimensions set out in Part 4. The analysis does not examine each dimension in relation to every country; rather it highlights matters considered to be particularly significant or, in some cases, problematic, in the study countries.

At the beginning of Part 5, we reaffirmed the need for caution in drawing comparative lessons. In this Part, which focuses more directly on COVID-19, there is an additional contextual factor that needs to be considered; countries varied greatly in how well they were able to control the spread of the virus. To take one measure, the number of deaths per capita, there were huge differences between the USA, South America and the European countries, on the one hand, and Rwanda, Australia and the three East Asian jurisdictions on the other.²³⁴ At the time of writing, China continued to implement a zero-COVID strategy and had experienced relatively few outbreaks; Australia, Japan and the Republic of Korea were able to maintain a zero-COVID strategy, or at least very low case numbers, well into 2021.

Of course, these differences are attributable to a wide range of factors (severity of isolation and lockdowns, the extent of sick leave and furlough programmes, the extent of compliance and vaccination and so on). It is not suggested that they are connected in any immediate way to OSH systems. The caution here is rather that the prevalence of the virus may have affected the feasibility and urgency of particularly policy responses.

5.1 Coherence

Adjusting policies, systems and programmes under the pressure of the pandemic

Countries obviously had to rapidly adapt their OHS policies, systems and programmes to address COVID-19. Unfortunately, the methodical, deliberative processes envisaged in Conventions No. 155 and No. 187 were not fully feasible under the emergency conditions brought about by the virus. On top of the need to act swiftly, there were several circumstances that inhibited an effective response.

First, OSH frameworks were generally not well prepared to deal with a pandemic. Sometimes this was from insufficient previous experience (and thus low saliency), as was the case, for example, with the United Kingdom, even though its general OSH system is quite comprehensive. Although public health measures had been considered in the wake of the Swine Flu, Ebola and Zika epidemics, these did not extend to safety and health at work. In Italy, the national respiratory diseases plan had not been updated since 2006 (a new one was formulated in 2021).

But even previous experience did not guarantee a complete response. Japan had adopted measures, including stockpiling PPE, to deal with pandemics after swine flu epidemic in 2009. It had also passed an important law, the Act on Special Measures Against Novel Influenza of 2012 (the Novel Influenza Act).²³⁵ This did not initially cover COVID-19, but it was amended in March 2020 to do so temporarily. Despite these

²³⁴ Data from John Hopkins University accessed on 29 June 2022: per 100,000 people, the number of deaths were Brazil (316), USA (308), Italy (278), Colombia (275), the United Kingdom (266) and Spain (231) compared to South Korea (47), Australia (39), Japan (21) and China (1).

²³⁵ A second relevant piece of legislation is the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases (Infectious Diseases Act).

preparations, Japan nonetheless appeared to have lowered its guard and allowed the PPE stockpiles to run down by 2019. It did not include pandemic preparedness in its 2018-2022 OSH national OHS plan.

Other countries, though, had a directly applicable legal framework and/or a well-prepared workforce. Brazil had a Regulatory Norm dealing with unhealthy activities including exposure to viruses.²³⁶ California (but not the federal US) had a pre-existing standard on airborne diseases, which it built upon to draft a specific COVID-19 related measure that had broad coverage and addressed matters such as ventilation.²³⁷ And while Rwanda did not have a specific law, its experience with Ebola meant that its frontline health service workers were relatively well prepared to deal with COVID-19.²³⁸

Second, there was often inadequate data that would enable a clear picture of the risk to emerge. In the United Kingdom, although a sound notification system was in place, there was widespread underreporting of cases. The same occurred in Spain and in many other countries.

Third, in all jurisdictions, there was a surge of legal and administrative measures responding to the pandemic; these were often interim, issued by multiple authorities and changed frequently. European Union member states, for example, measures could be issued at supra-national, national and sub-national levels. This surge was perhaps inevitable, but it did not always produce a cohesive, overarching structure for dealing with COVID-19 that minimized public confusion.

Countries with decentralised OSH systems were at particular risk of inconsistent and chaotic responses. In the United States, where states were authorized to act under approved state plans, there were significant discrepancies that emerged among states. In some jurisdictions, efforts to maintain coherence included the adoption of parallel measures at sub-national level; this occurred in Australia and Spain, for instance. In Australia a “national cabinet” was created that consisted of the leaders of the federal, state and territory governments. This led to a relatively high degree of policy coordination. Departures from a common standard could be warranted where it better reflected the regional context. In Spain, regional authorities coordinated but also developed guidelines specific to their industry structures.²³⁹

As the pandemic progressed, countries have begun to develop comprehensive new laws to consolidate the lessons learned from temporary measures. Thus, in late 2021 the Republic of Korea enacted the Essential Work Designation and Workers’ Protection and Support Act. This law sets up national and regional committees (which include representatives from experts and unions) and which are charged with designating and financially supporting key workers. Mostly, though, the regulatory space at the time of writing is still occupied by interim measures. These are examined in more detail in section 6.3.

Classifying COVID-19 as an occupational disease

One issue which went to the heart of OSH frameworks was whether COVID-19 should be treated as an occupational disease and if so for what purposes (as we saw in section 4.1, a system for dealing with occupational diseases is a key component of Convention No. 155). A comprehensive classification of COVID-19 as an occupational disease would enable well-established work safety and health processes to be invoked, reducing the need for the profusion of interim measures.

While the consequence of classifying a pathogen as a disease varies from country to country, it commonly has importance consequences for:

- Risk assessments and the hierarchy of controls;
- Consultative mechanisms at work;

²³⁶ Regulatory Norm No. 15.

²³⁷ COVID-19 Prevention, 8 CCR§3205.

²³⁸ WHO, COVID-19 in Rwanda: A country’s response, 20 July 2020.

²³⁹ National Institute of Occupational Safety and Health, Prevención de riesgos laborales vs. COVID-19 - Compendio no exhaustivo de fuentes de información, June 2020.

- The application of OSH standards, such as those on airborne diseases (where extant);
- The provision of equipment, such as PPE;
- Compensation payments for infected workers;
- Rehabilitation and phased return to work for sick workers (which could be particularly important for workers with long COVID);
- The application of notification and reporting requirements; and
- The priorities of inspectors and other compliance institutions.

Generally speaking, the classification of a disease as “occupational” creates a presumption that it is a risk to a workplace, that it should be the subject of consultation, that its acquisition in the workplace is compensable and so on. This contrast with other diseases, such as malaria, where workers would face a heavier onus to show that it should be considered in risk assessments or that its acquisition was connected to workplace exposure.

Most jurisdictions now recognise that COVID-19 can be an occupational-disease on a case-by-case basis²⁴⁰ (although in Rwanda there was no list of occupational diseases at the time of writing and COVID-19 was not considered a work-related injury). And the temporary measures countries have adopted make clear that COVID-19 is to be considered a health and safety issue at the workplace. Nonetheless, most jurisdictions have resisted classifying COVID-19 *systematically* as an occupational disease for the general purposes of OSH law.²⁴¹ The ILO’s list of occupational diseases has not been revised since 2010, and thus does not include COVID-19.²⁴²

For instance, China has a standalone Law on the Prevention and Control of Occupational Diseases which provides a comprehensive framework for diagnosis, reporting, training, occupational health services and most importantly, systematic action at the workplace level to assess the potential hazard from diseases and to prevent them (including through PPE). In cases where a worker is diagnosed with an occupational disease, they are entitled to workers’ compensation and rehabilitation (which may include reassignment).²⁴³

However, at the time of writing, COVID-19 had not been classified as an occupational disease for the purposes of the Law. Instead COVID-19 related measures took the form of extensive Guidelines issued by the State Council with little or no reference to the Law.²⁴⁴

The reluctance to classify COVID-19 fully as an occupational disease may be because it is difficult to quantify the financial impact on compensation systems and because COVID-19 can of course, like influenza, be acquired outside the workplace. Since most governments implemented temporary financial support packages, it may have been thought that triggering occupational disease provisions was unnecessary and potentially overly onerous. But addressing the compensation issues through other mechanisms does not deal with other matters such as risk assessments, rehabilitation and compliance that form part of a standard occupational diseases approach.

There is some movement occurring here, however. The European Commission is moving to update its Recommendation on occupational diseases to recognise COVID-19 in “in health and social care and in

²⁴⁰ https://www.ilo.org/global/topics/geip/publications/WCMS_768009/lang-en/index.htm.

²⁴¹ And in Brazil, the question of whether COVID-19 is an occupational disease has contested through conflicting regulatory instruments, court proceedings and technical advisory notes.

²⁴² COVID-19 could potentially fall within item 2.1.12 in the Annex to Recommendation No. 194: “Other respiratory diseases not mentioned in the preceding items where a direct link is established scientifically, or determined by methods appropriate to national conditions and practice, between the exposure to risk factors arising from work activities and the disease(s) contracted by the worker.”

²⁴³ Law on Prevention and Control of Occupational Diseases of the PRC articles 56, 58, 59, 60.

²⁴⁴ See, for example, Pandemic Control and Prevention Guidelines for Return to Work and Production in Enterprises and Public Institutions 国务院应对新型冠状病毒感染肺炎疫情联防联控机制关于印发企事业单位复工复产疫情防控措施指南的通知（国发明电〔2020〕4号）；The Implementation Opinions to Ensure Employment to Address the Impact of COVID-19 Pandemic 国务院办公厅关于应对新冠肺炎疫情影响强化稳就业举措的实施意见（国办发〔2020〕6号）；the Instruction Opinions to Ensure Prevention and Control in the Normalization Context of COVID-19 Pandemic 院应对新型冠状病毒感染肺炎疫情联防联控机制关于做好新冠肺炎疫情常态化防控工作的指导意见（国发明电〔2020〕14号）。

domiciliary assistance and, in a pandemic context, in sectors where there is an outbreak in activities with proven risk of infection”.²⁴⁵ The recognition of COVID-19 for the purposes of workers’ compensation is a matter within the competence of member states but Recommendations of the Commission are very influential. Spain, like many other member states, has already classified COVID-19 as a disease with respect to health and aged care workers. Italy has adopted a similar measure for both health and non-healthcare personnel working in a healthcare setting.²⁴⁶

Similar developments are occurring outside the EU. In Colombia, COVID-19 is now considered an occupational disease with respect to health sector workers.²⁴⁷ Californian legislation now contains a presumption that COVID-19 is work-related for the purpose of workers’ compensation²⁴⁸ and Japanese authorities have produced similar administrative guidance.

As COVID-19 appears to be endemic and to have long term consequences for many people, and since the many temporary financial assistance packages have expired, it seems appropriate to revisit the classification issue and consider whether all key workers, and not just health workers, should be included. As section 1.3 of the 2022 WESO indicates, key health workers, while they have suffered greatly, are not the worst affected by the virus. In countries with available data, morbidity rates were highest among transportation workers and also elevated for security and retail workers, in addition to health workers. As such, the plight of these other key workers could be alleviated by classifying COVID-19 as an occupational disease for them too.

5.2 Comprehensive coverage

Application of COVID-related legislation to all workers

We saw in the previous section that the reluctance to classify COVID-19 as an occupational disease, especially for workers other than health workers, has an exclusionary impact on the coverage of OSH. This is only one of a number of examples of pandemic measures being narrower than the underlying safety and health legislation, which, as we saw in Chapter 5, may itself be too narrow in scope. For example, some COVID-19 related measures excluded domestic and self-employed workers, as well as many members of the public service, as occurred in Spain where they were not classified as ‘vulnerable’ for the purposes of OSH regulation. In the Republic of Korea, although, as indicated in Chapter 5, the scope of OSH law has been substantially expanded, it appears that it still does not cover care workers, because they are not included in the categories of self-employed workers now covered by the amended OSH laws.

On the other hand, there are examples of the pandemic leading to a broader interpretation of legislation. In the United Kingdom, the pandemic provided a catalyst for a judicial expansion of the main OSH law’s scope; the UK High Court found in a COVID-19 related case in 2020 that existing UK law did not comply with retained EU directives²⁴⁹ and extended the right to remove oneself from work and PPE standards to all dependent workers, not simply employees.²⁵⁰

The identification of frontline workers

Irrespective of the general coverage of OSH law, and independently of whether COVID-19 was classified as an occupational disease, most countries identified specific sectors that merited special regulatory measures

²⁴⁵ See, recent EU Commission press release on members states and social partners agreeing on the need to recognise COVID-19 as an occupational disease: https://ec.europa.eu/commission/presscorner/detail/en/ip_22_3117.

²⁴⁶ INAIL circular no. 13/2020.

²⁴⁷ Artículo 13 del Decreto de 2020.

²⁴⁸ As for example in California: State of California, Executive Order N-62-20, May 6, 2020, available at <https://www.gov.ca.gov/wp-content/uploads/2020/05/5.6.20-EO-N-62-20.pdf>. See also CA LABOR § 3212.86. T.

²⁴⁹ Council Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work (the so-called ‘Framework Directive’) and Council Directive 89/656/EEC on the minimum health and safety requirements for the use by workers of personal protective equipment (PPE) at the workplace.

²⁵⁰ R (on the application of the IWGB) – v – Secretary of State for Work and Pensions and others, [2020] EWHC 3050 (Admin).

to continue operating during lockdowns because they provided “essential services”.²⁵¹ These measures raised their own coverage issues, because they varied in scope, often applying to some frontline workers but not others. In the United Kingdom, around one third of workers were defined as “key workers”, the largest group of which worked in the health and social care sectors, with transport, food and education workers also featuring prominently.²⁵² However, some measures against violence at work did not extend to retail and transport workers, who, though frontline staff, lacked criminal law protections afforded to health and police officers.²⁵³

In the United States, an even broader range of workers were classified as “essential”,²⁵⁴ although there were variations at State level. In Italy, there has been no one consistent definition. In Brazil, most categories of key workers were already the subject of Regulatory Norms, and most COVID 19-related regulatory initiatives did not specifically target key workers; where there were definitions of key workers, they were not consistent across legislative instruments and sometimes established priorities not only for essential workers (for example, in relation to vaccination) but between classes of essential workers.

China does not have a specific category of frontline or essential workers that are treated differently under the two safety and health laws. However, as was also the case in Spain and Rwanda,²⁵⁵ healthcare workers were the particular focus of regulatory interventions by the State Council and its ministries.²⁵⁶ These interventions stressed the importance of preserving the mental health of health practitioners, including through avoiding work intensification, providing leave and making mental health services available. They also made them eligible for workers’ compensation from COVID by ministerial letter, rather than (as discussed in section 6.1) by classifying COVID-19 as an occupational disease for all workers.²⁵⁷

As mentioned in section 6.1, in late 2021, the Republic of Korea enacted a new law concerning essential workers. The new law creates a permanent system for assisting essential workers in a time of crisis. It includes a general definition of essential work²⁵⁸ and a committee for determining precise categories needing assistance, for conducting empirical research and for recommending support plans (which include a labour representative).²⁵⁹ On the basis of deliberations by the Committee, the relevant ministry (the Ministry of Employment and Labour) formulates and evaluates a support plan.²⁶⁰

This survey suggests that, apart from the recent Republic of Korea example, there do not appear to be examples of jurisdictions which have a systematic mechanism for *both* identifying key workers *and* attaching specific OSH duties and rights to them in a way which is calibrated to the actual risk. The measures to date are mostly piecemeal, extending only to a subset of key workers – mostly health workers. But as mentioned above, it has been not just the particular subsets that have been disproportionately susceptible to COVID-19; accumulating evidence suggests that some of the other key workers have been at least as at risk of serious illness and death.

²⁵¹ In some jurisdictions, this term could include both frontline workers and those could work from home.

²⁵² “COVID-19 Risk by Occupation and Workplace”, February 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965094/s1100-COVID-19-risk-by-occupation-workplace.pdf; ONS.

²⁵³ Assaults on Emergency Workers (Offences) Act 2018.

²⁵⁴ <https://www.cisa.gov/identifying-critical-infrastructure-during-COVID-19>.

²⁵⁵ Ministry of Public Service and Labour, Regulations on Occupational Health and Safety (OSH) in Health Sector, 11 October 2019.

²⁵⁶ For example, the Notice to Improve Frontline Health Care Workers’ Physical and Mental Health “国务院办公厅转发国家卫生健康委、人力资源社会保障部、财政部关于改善一线医务人员工作条件切实关心医务人员身心健康若干措施的通知（国办发〔2020〕4号）”；and the Notice of Social Security Protection for Work-related COVID-19 Infection of Health Care and related Personnel 人力资源社会保障部 财政部 国家卫生健康委关于因履行工作职责感染新型冠状病毒肺炎的医护及相关工作人员有关保障问题的通知

²⁵⁷ Notice of the Ministry of Human Resources and Social Security, the Ministry of Finance, and the National Health and Health Commission on the protection of medical staff and related staff who are infected with the new coronavirus pneumonia due to the performance of their duties 人力资源社会保障部、财政部、国家卫生健康委关于因履行工作职责感染新型冠状病毒肺炎的医护及相关工作人员有关保障问题的通知，人社部函〔2020〕11号。

²⁵⁸ Essential Work Designation and Workers Protection and Support Act, 2021. Article 2 provides that “‘Essential work’ means work necessary to protect people’s lives and bodies or to maintain social functions even in the event of a disaster.”

²⁵⁹ Articles 6-8. Regional committees may also be established.

²⁶⁰ Article 11.

Vulnerable workers

There appears to be a relationship in many jurisdictions between the key workers who were less protected by OSH measures and vulnerable groups. This vulnerability could derive from the characteristics of the workers (race, gender, age, migrant status) and/or from their work arrangements (self-employed, temporary workers, seasonal workers, workers on zero-hours contracts, platform workers,²⁶¹ informality and so on). Some governments identified these groups for particular attention,²⁶² although this did not ensure that adequate measures were taken to address these vulnerabilities. For example, in the United Kingdom, workers from black, Asian and minority ethnicities (BAME) were likely to have a higher risk of infection and mortality because they particularly worked in occupations that involved higher physical contact with people (such as in carer roles) and/or across multiple sites (such as cleaners).

In the United States, a disproportionately high number of key workers, especially in areas such as personal care, are immigrants and people of colour who worked in low paid jobs and poor conditions. These workers, who often had inadequate health insurance, experienced particularly high rates of infection by COVID.²⁶³

In Spain, while special measures were addressed to certain vulnerable workers (immuno-compromised, pregnant and older workers), the temporary work status of many of them, including in the public sector, undermined systemic training and participation in OSH systems, as temporary workers could be engaged for only a month or less, even in areas such as health care. In an outbreak in a Chinese airport, rural, female temporary agency workers were disproportionately infected.²⁶⁴ In the Republic of Korea, poor and illegal immigrant workers and workers engaged for extremely long working hours had difficulties accessing public health, despite universal national health insurance. Immigrants (especially in agriculture) were also particularly vulnerable in Italy,²⁶⁵ as were horticultural workers in Rwanda.²⁶⁶

And in general workers in smaller enterprises were more vulnerable because those enterprises lacked the OSH infrastructure of larger firms (such as specialist staff, including, in the case of Japan, medically trained staff, and worker-management OSH committees).

5.3 Culture of prevention, clear rights and duties

The discussion in this section turns from the broad questions of overall policy and coverage to specific issues of implementation in workplaces. It considers how the well-established systems of prevention, rights and duties and general and specific standards fared in the face of the pandemic.

The regulatory challenge facing undertakings and workers

In the early days of the pandemic at least, undertakings and workers faced considerable challenges in determining what preventative measures should be applied in their workplaces. The exact nature of the virus and the threat it imposed only emerged over the course of 2020-2021; the changing state of medical knowledge meant that the appropriate OSH measures were moving goalposts. It was not therefore possible for undertakings and workers to determine by themselves the best forms of protection against COVID-19 pandemic through usual risk assessment and consultative processes. They were reliant on information

²⁶¹ On the shortcomings of OSH systems to gig workers, see Karen Gregory, "My Life Is More Valuable Than This": Understanding Risk among On-Demand Food Couriers in Edinburgh', *Work, Employment and Society* 35, no. 2 (2021): 316–331; Government Centre for Work Health and Safety, *Work health and safety perceptions of food delivery platforms in the gig economy*, 2020.

²⁶² For example, the United Kingdom government.

²⁶³ See, for example, in relation to California, Kristin J. Cummings et al., "COVID-19 in the Workplace: The View from California", *Annals of the American Thoracic Society*, March 15 2022, available at <https://doi.org/10.1513/AnnalsATS.202112-1334VP>.

²⁶⁴ 72 Presidential Policy Directive 21 (PPD-21), available at <https://obamawhitehouse.archives.gov/>.

²⁶⁵ Yujun Liu et al., 'Occupational Characteristics in the Outbreak of the COVID-19 Delta Variant in Nanjing, China: Rethinking the Occupational Health and Safety Vulnerability of Essential Workers', *International Journal of Environmental Research and Public Health* 18, no. 10734 (1 October 2021): 10734–10734.

²⁶⁶ Italy – Revaluation of Working Conditions and Wages for Essential Workers (europa.eu).

²⁶⁶ Rwanda Women Network, "Impact of COVID-19 on Women Workers in Horticulture sector in Rwanda" (Fair Society, July 2020).

from governments. Where the health advice subsequently proved erroneous – which, as will shortly be discussed occurred on multiple occasions – inadequate measures could be introduced at the workplace. Such mistakes could not reasonably be attributed to management and workers failing to apply OSH principles.

On top of this, undertakings faced huge workforce disruptions flowing from lockdowns, furloughs and an influx of retirees, trainees and volunteers, such as in often overwhelmed hospital settings. Regular methods of worker OSH training broke down, and could even be suspended by government ruling, as occurred in Brazil.²⁶⁷

Furthermore, prevention based on harm minimizing was not possible in many workplaces during the early phases of the pandemic because of the lack of adequate equipment. This occurred in many countries, including the United Kingdom, Australia, Brazil, Spain, China, the Republic of Korea and Rwanda as a result of PPE shortages, although in Rwanda drone technology was used to deliver PPE to remote areas.²⁶⁸

From an in-principle hierarchy of controls perspective, the inability to implement harm minimization measures, particularly in the early days of the pandemic when vaccines were not available, suggests that undertakings ought to have reverted to an elimination strategy, such as ceasing operations until PPE was on hand. However, for frontline workers, such as health workers and transport drivers, who needed to keep society functioning, this was not feasible. Unfortunately, this meant that in many countries, huge numbers of frontline workers were infected with the virus.

Despite these initial problems, undertakings in many countries did gradually adopt many appropriate measures. These included “engineering” controls (ventilation, physical screens, desk spacing and so on); management controls (limiting numbers at work, working from home) and PPE controls (hand sanitising, mask wearing). These controls were subject to changing health advice. For example, after the aerosol transmission of COVID-19 was confirmed, the design and overall usefulness of measures such as physical screens had to be reconsidered.

Apart from better protecting those workers who had always needed to be physically present in their workplaces, these measures facilitated a return to traditional workplaces for those who had worked at home, although the experience of countries such as Australia suggests that a complete reversion to pre-COVID work patterns seems unlikely in the immediate future.

Specific government actions on COVID-19 and their interaction with OSH

The key source of OSH guidance for undertakings and workers during the pandemics was government, including agencies such as the World Health Organization, the Centres for Disease Control and Prevention as well as OSH regulators. But governments at first scrambled to issue regulatory measures responding to the virus. As mentioned above, as a full understanding of the nature of the disease did not emerge until several months into the pandemic, advice could be contradictory. For example, initial advice did not sufficiently recognise that COVID-19 could be transmitted through infectious aerosols. This meant that insufficient attention was paid to ventilation and that recommendations to use surgical masks capable of blocking aerosols were belated. In Spain, premature recommendations that healthcare professionals with no or mild symptoms not be tested proved flawed and needed to be revised,²⁶⁹ and 12 different versions of a Ministry of Health advice were issued in a short space of time until the advice was settled.

A further issue with these early interventions was that in several jurisdictions they were at first taken without necessarily making a connection with OSH norms. There were exceptions: in China, quite comprehensive State Council guidelines directed at risk assessments and hazard prevention were produced early on in

²⁶⁷ Provisional Measure No. 927/2020.

²⁶⁸ Noah Lewis, A tech company engineered drones to deliver vital COVID-19 medical supplies to rural Ghana and Rwanda in minutes, *Business Insider*, 13 May 2020.

²⁶⁹ Widespread COVID-19 infection among Spanish healthcare professionals did not occur by chance, *theBMJopinion* (blog), 1 June 2020.

the pandemic²⁷⁰ but even there, these measures did not extend to classifying COVID-19 as an occupational disease (as discussed in section 6.1).

As the pandemic progressed, countries gradually began to frame measures with regard to the principles of prevention and the hierarchy of controls. In Spain, for instance, the Ministry of Health was by mid-2020 carefully structuring its COVID-19 guidance around familiar OSH concepts such as risk management and appropriate notification procedures;²⁷¹ work-related and gender-based violence initiatives were also developed. In Brazil, two fairly comprehensive laws were adopted in 2020 which clarified a number of issues that plagued many jurisdictions; work absences from contagion or isolation did not affect remuneration; masks were defined as PPE and therefore to be provided free of charge; and health and transport workers quickly identified as priority groups.²⁷² However, there are still a number of remaining uncertainties and a new consolidated law encompassing ongoing provisions appears necessary.

Occupational health services

Given that guidance from governments was not always accurate or complete, the role of professional OSH experts was crucial. However, in several jurisdictions these were swamped. In Spain, some practitioners even prior to the pandemic had to cover hundreds of firms; they then had to provide over two million hours of technical advice in the early months of the pandemic.²⁷³ Systemic problems such as externalization of services, onerous regulatory requirements pertaining to facilities and equipment and excessive bureaucracy compounded the problem, diminishing the potential for occupational health services to be active agents of workplace change in response to the pandemic.

Many occupational health workers did take these trying conditions lying down but actively campaigned to improve the governmental response. In the United Kingdom, for example, the professional association of occupational health workers lobbied the government to implement a robust set of measures to prevent work-related deaths.

One jurisdiction whose existing OSH arrangements mitigated the problem of sudden high demand was Japan. As we saw in Part 5, Japan has a system of “industrial physicians” in enterprises and in the inspectorate. These were deployed to provide preventative measures such as voluntary workplace vaccinations.

COVID-19 and specific OSH standards

We have seen that a key element of a Robens system, well reflected in Convention No. 155,²⁷⁴ is that general duties are complemented by specific standards on controlling hazards to health and safety. The relevant standards in the context of COVID-19 pertain to matters such as airborne diseases and mental health. Several systems did have pre-existing standards dealing with matters such as PPE, sanitation and protection against respiratory diseases (for example, through ventilation) that could be adapted to COVID-19; for example, the State of California.²⁷⁵ On the other hand, standards in some countries, while dealing with airborne infectious diseases, suffered from number of shortcomings. For instance, the standard in the Republic of Korea²⁷⁶ applies only to health workers and workers in group accommodation (such as day-care)²⁷⁷ so it does not cover workers in cleaning, transport and logistics, or other face-to-face services. It

²⁷⁰ Min Zhang and Rokho Kim, ‘Occupational Health Protection for Health Workers during the Coronavirus Disease 2019 (COVID-19) Pandemic: 6P-Approach in China’, *Global Health Journal* 5, no. 4 (1 December 2021): 215–19.

²⁷¹ For example, <https://www.sanidad.gob.es/gabinetePrensa/notaPrensa/pdf/13.07130720131534059.pdf>.

²⁷² Law No. 13,979, of February 6, 2020.

²⁷³ Servicios de Prevención ajenos ASPA-ANEPA. El valor de los Servicios de Prevención Ajenos y los profesionales de la Prevención. April, 2020. <https://www.aspaprevencion.com/wp-content/uploads/2020/10/El-valor-de-los-SPA.pdf>

²⁷⁴ See, in particular, article 11.

²⁷⁵ Some US states, such as Massachusetts, also had a temporary COVID-19 workplace safety regulation that was later withdrawn: Department of Labor Standards, COVID-19 Workplace Safety Regulations, 454 CMR 31.00 (2021).

²⁷⁶ Rules on Occupational Health and Safety Standards Chapter 8.

²⁷⁷ See in particular article 593.

also does not address work intensification and mental health issues and only partially covers ventilation.²⁷⁸ The Brazilian standard lacks engineering controls. Some jurisdictions do not have standards pertaining to airborne spread of infectious diseases at all (such as many of the US states).

There were still, at the time of writing, no instances in the study countries of an existing airborne disease standard having been comprehensively revised to deal with COVID-19, or a permanent new standard on airborne infections adopted where none previously existed. In the United States, an emergency standard was promulgated by the regulator in June 2021, but it applied only to health workers and was withdrawn six months later.²⁷⁹ The regulator (OSHA) is now formulating a permanent standard, again only for health workers. The sharp division between general employer duties and standards in the United States makes the promulgation of a specific standard particularly important; enforcement is otherwise very difficult.

Mental health standards

Another relevant COVID-19 hazard that calls for an OSH standard concerns mental health. ILO Convention No. 190 is very relevant here, given that one of the major psychosocial risks to health and other frontline workers has been violence and harassment. Psycho-social harms were evident, for example, among health care workers such as nurses, as work intensification, excessive overtime abuse, and dealing with severely ill patients and in some instances personal abuse²⁸⁰ all impacted.²⁸¹ Mental health services in many countries have been unable to provide sufficient assistance to such workers. Many are now experiencing burnout.

While issues such as the shortage of PPE and ventilation have been adequately addressed in many countries, the development of comprehensive preventive frameworks relating to the adverse mental health consequences from the pandemic is in its infancy. However, there are signs that many countries are beginning to respond to mental health challenges. For instance, the European Union's "MENTUPP" project²⁸² is developing an intervention to improve mental health in small and medium-sized enterprises (SMEs) in high-risk sectors (such as construction and health). Similarly, the EU-led initiative RESPOND is working on improvements in the capacity of health systems to respond to mental health and psychosocial concerns resulting from the COVID-19 pandemic. It involves countries with different models, such as the Netherlands, Spain, Italy, Belgium, Germany, United Kingdom, Australia and France. Preliminary results have highlighted the impact of work-related stressors²⁸³ on healthcare workers (access to personal protective equipment, changes in job functions and patient prioritization decisions) and their direct association with depressive symptoms, psychological distress, and suicidal ideation. Again, the "industrial physician" infrastructure in Japan provides an example of a systematic response to mental health challenges through enabling regular mental health checks and consultations.

COVID-19 measures and rights to bodily integrity and privacy

One issue which was highlighted in the Italian country study concerned the use of technologies such as contact tracing apps, wearable devices and screening machines to respond to the pandemic. It was suggested that some technologies could violate provisions on worker dignity and freedom,²⁸⁴ although the regulatory

²⁷⁸ Mu Seong Kim and Eunsuk Choi, "Differences in the Working Environment and Health Outcomes according to the Employment Type of Delivery Workers" *Korean Journal of Occupational Health Nursing* 29, no. 4 (2020): 316-324.

²⁷⁹ Occupational Safety and Health Administration, COVID-19 Healthcare ETS, Statement on the Status of the OSHA COVID-19 Healthcare ETS (December 27, 2021).

²⁸⁰ This unacceptable conduct was compounded in jurisdictions such as Japan where prejudice against persons with potential diseases leads to discrimination against health workers.

²⁸¹ Flávia Osório et al., "Risk and Protective Factors for the Mental Health of Brazilian Healthcare Workers in the Frontline of COVID-19 Pandemic", *Frontiers in Psychiatry* 12 (2021). <https://doi.org/https://doi.org/10.3389/fpsy.2021.662742>; Jesus Molina-Mula et al., "The emotional impact of COVID-19 on Spanish nurses and potential strategies to reduce it", *Collegian* 29, no. 3 (2021): 296-310.

²⁸² Mental Health Promotion and Intervention in Occupational Settings. European Union's Horizon 2020 research and innovation programme under grant agreement No 848137. <https://www.mentupproject.eu/>. December, 2021.

²⁸³ RESPOND, Early findings and recommendations from the RESPOND project (Policy brief, November 2021).

²⁸⁴ See Workers' Statute articles 4 and 5.

authorities permitted them subject to certain guarantees.²⁸⁵ This issue was not raised systematically in the other country studies and merits further exploration insofar as it affects how technology can be deployed to improve OSH outcomes. To give an example of the tension, workers could be constantly monitored so as to minimise the risk of harms (for example, by ensuring they were a mask and socially isolated at all times). However, constant surveillance can be oppressive, particularly for women.²⁸⁶

Binding vs non-binding standards

A further issue relates to the *legal form* of pandemic OSH standards. This varied on a spectrum from recommendations and suggestions²⁸⁷ to delegated enforceable rules. There was a preference in many countries for measures to be interim and in the form of advisory communications and guidance material. Such COVID-related communications were frequently not legally binding,²⁸⁸ or might have only limited legal consequences,²⁸⁹ in contrast to a decree or statutory rule.

Selecting the appropriate legal form in response to the nature of the subject matter, and in particular to the extent to which compliance should be mandatory, is a decision that needs to be carefully pondered by a state agency. Unfortunately, the sudden and overwhelming onset of the pandemic meant that there was little opportunity for such consideration. The need to act quickly and flexibly, rather than getting bogged down in legal technicalities, as well as political aversion to abrupt, heavy-handed measures in some societies may have led to the widespread use of guidance material. The obvious risk with non-binding measures is that they can simply be ignored, unless there is a strong national practice of observing them, as appears to be the case in Japan.²⁹⁰ Some jurisdictions, such as several Australian states, adopted increasingly strict legal measures as the pandemic progressed, but these provoked considerable public protest and opposition from a small but impassioned minority. The relative merits of binding and non-binding rules in terms of eliciting adherence in the pandemic are discussed below in section 6.5. on compliance.

In the long term, permanent binding standards would seem to be necessary, in combination with complementary guidance material. This combination is of course how OSH standards on risks such as asbestos, biological hazards, toxic chemicals and plant design have been formulated in the past. Such standards should be developed through appropriate expertise and consultation – both tripartite and with other stakeholders, based on the lessons learnt from the pandemic so far. This is certainly the process contemplated by Convention No. 155. Such an inclusive process could help to allay the concerns prompted by sudden, severe, unilateral measures.

The right to remove oneself from a dangerous situation

We have seen that the right to remove oneself from a dangerous situation is stipulated in Convention No. 155. The extent to which this right can be exercised in the context of COVID-19 has troubled regulators and courts in many countries whose law provides for this right). Jurisdictions such as Spain have, at the time of writing, not settled on a definitive position. In the United Kingdom, the relevant legislation was amended to strengthen a worker's right not to be subject to detriment on the ground of exercising the right.²⁹¹ However, UK courts have held that the mere existence of the pandemic is insufficient to justify a refusal to

²⁸⁵ See opinion on the regulatory proposal for the provision of an application aimed at tracking COVID-19 infections, written by the Italian Privacy Authority on 29.04.2020; Provision of authorization for the processing of personal data carried out through the COVID-19 - App Immuni alert system, issued by the Italian Privacy Authority on 1.06.2020.

²⁸⁶ Luke Stark et al., "I Don't Want Someone to Watch Me While I'm Working": Gendered Views of Facial Recognition Technology in Workplace Surveillance', *Journal of the Association for Information Science and Technology* 7, no. 9 (2020): 1074–1088.

²⁸⁷ <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/COVID-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations>.

²⁸⁸ Depending on the legal status of particular government instruments, which varies between jurisdictions.

²⁸⁹ For example, reliance on the guidance note could constitute a legal defence.

²⁹⁰ Narufumi Kadomatsu, 'Legal Countermeasures against COVID-19 in Japan: Effectiveness and Limits of Non-Coercive Measures', *China-EU Law Journal*, 11 April 2022, 1–22.

²⁹¹ The Employment Rights Act 1996 (Protection from Detriment in Health and Safety Cases) (Amendment) Order 2021.

work if the risk is not reasonably linked to the nature of the workplace;²⁹² thus a worker may not be able to refuse to work where the employer has instituted appropriate COVID-19 safety measures.²⁹³

A further issue that has arisen, for example in the Republic of Korea and Rwanda, concerns how health workers can exercise this right in the context of a medical emergency in which patients' lives are at risk.

Standards, COVID-19 and the judiciary

Undertakings and workers can sometimes be in doubt about the legal effect or meaning of OSH measures. In such cases, courts can play an important role in clarifying rights and duties, provided that they are accessible and efficient. Nonetheless, courts can also obstruct or undermine OSH regulation, even during a crisis as serious as the pandemic. Courts in most jurisdictions were generally deferential to public health and OSH authorities, provided proper regulation making procedures were followed.²⁹⁴ In some cases, such as the example from the United Kingdom cited in section 6.2, courts ensured that OSH standards applied broadly – in that instance to all dependent workers, not just simply employees. Courts also supported employers who dismissed workers who were unvaccinated without a medical reason, again where fair procedures had been followed.²⁹⁵

In contrast, in the United States, COVID-19 rules were repeatedly invalidated. For example, a federal government order mandating either vaccines or mask-and testing programs for large employers, was stayed by a Supreme Court majority on the basis that vaccines were a matter of general public health rather than workplace health and therefore not within the authority of the OSH regulator.²⁹⁶ The three dissenting judges in that case²⁹⁷ argued that the majority “displace[d] the judgments of the Government officials given the responsibility to respond to workplace health emergencies”. Other federal measures to address the COVID-19 pandemic through work-related safety measures were either blocked or permitted to proceed by court challenges.²⁹⁸

Again, in the United States, some workers and unions (especially in the health industry) have sought court orders to require OSH authorities to exercise powers such as plant closures and to force employers to improve workplace safety. These initiatives have generally been unsuccessful to date, with two exceptions involving family members who contracted COVID-19 from workers exposed to the virus at work.²⁹⁹ Other legal actions by workers, unions and activists have been quite innovative; for example by invoking the law on corporate disclosures and on anti-discrimination (on the basis of race, given the disproportionate impacts of COVID-19 on racial minorities, and on the basis of disability). These arguments, many of which have been advanced in litigation in the meatpacking industry, have not yet met with clear success. There are also a large number of tort actions underway in various states, as well as cases alleging retaliatory termination and terminations while a worker was in quarantine.

²⁹² See, for example, *Rodgers v Leeds Laser Cutting Ltd* [2022] EAT 69.

²⁹³ See: 复工复产中的劳动用工、劳动关系、工资待遇、社保缴费等问题，权威解答来啦！, 20/02/22, Ministry of Human Resources and Social Security.

²⁹⁴ See, for example *Henry v Hazzard* [2021] NSWSC 1320 (New South Wales, Australia); *Gerner v Victoria* [2020] HCA 48 (Australia); Trib. Roma 8.12.2021; Trib. Modena 19.05.2021; Trib. Modena 23.07.2021; Trib. Roma 20.08.2021; Trib. Ivrea 23.08.2021).

²⁹⁵ See, for example, Regional Court of the 2nd Region (São Paulo) in Case No. 1000122-24.2021.5.02.0472.

²⁹⁶ *National Federation of Independent Business v. Department of Labor, Occupational Safety and Health Administration*, 142 S.Ct. 661 (2022). On the other hand, a Department of Health and Human Services mandate for health workers was upheld by the Court by a bare majority: *Biden v. Missouri*, 142 S.Ct. 647 (2022).

²⁹⁷ Breyer, Sotomayor and Kagan JJ.

²⁹⁸ Compare *Georgia v. Biden*, 2022 WL 266186 (S.D.Ga., 2022); *American Federation of Government Employees Local 2018 v. Biden*, 2022 WL 1089190 (E.D.Pa., 2022); *Lloyd J. Austin, III, Secretary of Defense v. U.S. Navy Seals 1-26 et. al.*, 595 U. S. ____ (2022)

²⁹⁹ *Hernandez v. VES McDonald's, Cal. Super. Ct.*, RG20064825, preliminary injunction granted 8/13/20; *Massey et al v. Mcdonald's Corp., Bus. Franchise Guide (CCH)* ¶ 16,679 P 16679, 2020 WL 4939293.

5.4 Collaboration

One of the most common breakdowns in OSH frameworks during the pandemics was in tripartism. In several jurisdictions where tripartite procedures were in place for consulting about new OSH regulation, these procedures were by-passed, ostensibly because of the urgency of responding to the pandemic. This occurred in Brazil, for instance, and also in China, where the State Council acted without invoking the occupational diseases statute with its tripartite mechanisms. In some instances, workers took strike action to prompt government assistance; this occurred in the Republic of Korea when unionized courier workers struck in support of reduced working hours. One exception was Italy, where national “anti-contagion” protocols were concluded between employer and worker organizations and the government in early 2020.³⁰⁰ Another was Rwanda, which had a greater lead time before its first infection in March 2020. Worker organizations representing transportation workers, farmers, and teachers negotiated with the government over the extent of COVID-10 measures.³⁰¹

After the initial urgent promulgation of measures, tripartite collaborative arrangement began to re-emerge in several jurisdictions in order to address some of the implications from the pandemic. In the United Kingdom, the National Health Service Staff Council, which has both management and union representatives has issued extensive material on work relations during COVID, including on managing long COVID-19 with sick leave, flexible working hours, pay protection and progression, overtime payments and return to work.³⁰² In Spain, a new regulatory framework for working from home was concluded after tripartite discussions and implemented through the national OSH regulator.³⁰³ The Chinese Ministry of Human Resources and Social Security encouraged an active role for unions at the enterprise level on issues such as employee return to work and extended hours.³⁰⁴ And in Australia, there was (for a time) considerable co-operation between governments, business and unions over amendments to working conditions, and the national industrial tribunal enforced workplace consultation requirements over issues such as vaccine mandates.³⁰⁵

Workplace consultation arrangements could also be used to implement COVID-19 measures. In Rwanda, some OSH Committees contributed to workplace COVID-19 risk assessments, educating workers about COVID-19, altering work organisation to avoid overcrowding and permitting working from home. There is also evidence from the United Kingdom that active union involvement in health and safety mechanisms at work contributed to improving measures to protect against COVID and to deal with the consequences of infection (for example, sick pay arrangements).³⁰⁶

Nonetheless, the pandemic has revealed the fragility of even longstanding collaborative arrangements and it is appropriate to revisit how they operate in times of crisis.

5.5 Compliance and enforcement

The pandemic posed novel challenges to compliance and enforcement practices. Firms’ efforts to promote OSH compliance by consulting, educating and training workers was impeded by workforce disruptions.

³⁰⁰ For example, see the Protocol for the prevention and safety of workers in the Health, Social and Welfare Services in relation to the health emergency COVID-19, signed on 24.03.2020; shared protocol for transport and logistics signed on 20.03.2020. See also M. Tiraboschi, G. Benincasa, COVID-19: le problematiche di salute e sicurezza negli ambienti di lavoro tra protocolli condivisi e accordi aziendali, in M. Tiraboschi, F. Seghezzi (a cura di), Welfare e lavoro nella emergenza epidemiologica. Contributo alla nuova questione sociale, Adapt e-book, 2020, 146.

³⁰¹ Interviews by the country study author.

³⁰² <https://www.nhsemployers.org/articles/nhs-staff-council-joint-statements-and-papers>.

³⁰³ Eurofound, Regulation of remote work, case ES-2020-39/1321 (measures in Spain), COVID-19 EU PolicyWatch, Dublin (2020), <http://eurofound.link/COVID19eupolicywatch>.

³⁰⁴ 复工复产中的劳动用工、劳动关系、工资待遇、社保缴费等问题，权威解答来啦！, 20/02/22, Ministry of Human Resources and Social Security. According to some reports, several local unions in China, though, appeared to deny that COVID-19 was a work safety issue and did not want to get involved.

³⁰⁵ Construction, Forestry, Maritime, Mining and Energy Union, Mr Matthew Howard v Mt Arthur Coal Pty Ltd T/A Mt Arthur Coal [2021] FWCFB 6059 (3 December 2021).

³⁰⁶ Minjie Cai et al., "The Role of Union Health and Safety Representatives during the COVID-19 Pandemic: A Case Study of the UK Food Processing, Distribution, and Retail Sectors", *Industrial Relations Journal* 53, no. 4 (1 July 2022): 390–407.

While frontline workers continued to be present at their workplaces to provide essential services, the overwhelming demands they faced often left little time for attention to work safety and health processes.

Limitations in the response of OSH regulators

OSH regulators in many countries encountered a range of problems with attempting to reduce the threat to health and safety resulting from COVID-19. To begin with, some were simply shut down. Some governments, such as Spain, suspended the enforcement operations of their regulators as part of general lockdowns, so that inspectors were not able to advise firms that remained open about new safety procedures, although they later set up dedicated units within their inspectorates to deal with COVID-19 and retargeted enforcement resources to particularly exposed sectors, such as health.³⁰⁷ In Brazil, a Provisional Measure³⁰⁸ prevented labour inspectors from issuing OSH infraction notices for a period of 180 days, except in cases of serious and imminent risk or fatalities.³⁰⁹

OSH regulator capacity was also limited in several countries as a result of previous inadequate funding. In Rwanda, labour inspectors (whose jurisdiction covers OSH matter) are severely under-resourced and under-trained; they also lack essential equipment to monitor disease. In countries such as the United Kingdom, the United States³¹⁰ and Spain, the low number of inspectors vis-à-vis the number of workers and undertakings, together with a decline in resources meant that they could neither inform or monitor firms to an adequate degree.³¹¹ In the United Kingdom, the regulator's efforts were directed to producing risk assessment information rather than being deployed to strategically target businesses so as to ensure that the law was enforced. And even where firms were inspected, there was often considerable reluctance to launch enforcement measures, such as improvement notices or prosecutions, despite widespread evidence of non-compliance.³¹² Whether this was because persuasive measures were effective, or because the regulator was timid and/or lacked independence from firms is an empirical question which merits further investigation.

In the United States, a government audit of the regulator was highly critical of its failure to conduct adequate inspections during the first year of the pandemic,³¹³ although enforcement improved after the promulgation of the emergency health sector standard. At the time of writing, fewer than one thousand COVID-19 inspections had occurred across the United States, mainly in health and aged care, and social services; other sectors, such as meatpacking were comparatively neglected despite very high rates of infections and deaths. The position varied across the country, however, with California and, to a lesser extent, Massachusetts being more proactive in developing educational materials and in transparent enforcement action.³¹⁴ In contrast, the National Labour Inspectorate in Italy carried out more than 17,000 checks in 2020.³¹⁵

Another problem was that in those systems where there are multiple agencies, the agency conducting the investigations into a workplace might not have been the one with sufficient powers to respond to non-compliance. For instance, in the United Kingdom, workplace investigations into COVID-19 outbreaks were predominantly led by public health authorities, which, unlike the Health and Safety Executive, did not have powers to close firms for breaches.³¹⁶

³⁰⁷ La Inspección de Trabajo y Seguridad Social crea una Unidad de Gestión específica para afrontar la incidencia del COVID-19 en el ámbito laboral, available at: <http://prensa.mitramiss.gob.es/WebPrensa/noticias/laboral/detalle/3753>.

³⁰⁸ Provisional Measures are norms with the force of law adopted by the President of the Republic in case of relevance and urgency, which have temporary validity if not converted into law by the National Congress, as article 62 of the Federal Constitution.

³⁰⁹ Provisional Measure No. 927/2020 (Brazil), article 31.

³¹⁰ In the United States, there is one OSH inspector for every 70,000 workers (at best), the worst ratio since the agency was established: <https://www.osha.gov/data/commonstats#:~:text=Federal%20OSHA%20is%20a%20small,officer%20for%20every%2070%2C000%20workers>.

³¹¹ See Stephen Mustchin and Miguel Martínez Lucio, 'The Fragmenting Occupation of Labour Inspection and the Degradation of Regulatory and Enforcement Work inside the British State.', *Economic & Industrial Democracy*, 23 February 2022, 1.

³¹² Tom Wall, Firms accused of putting workers' lives at risk by bending lockdown trading rules, *The Guardian*, 17 January 2021.

³¹³ U.S. Dep't of Labor, Office of Inspector General – Office of Audit, Report to the Occupational Safety and Health Administration, COVID-19: Increased Worksite Complaints and Reduced OSHA Inspections Leave U.S. Workers' Safety at Increased Risk, 25 February 2021.

³¹⁴ Citations for COVID-19 Related Violations, <https://www.dir.ca.gov/DOSH/COVID19citations.asp>

³¹⁵ See <https://www.ispettorato.gov.it/it-it/in-evidenza/Documents/Rapporto-annuale-2020.pdf>, pag. 54.

³¹⁶ Andrew Watterson, Coronavirus is spreading rapidly through workplaces – here's what is needed to make them safer, *The Conversation*, 3 November 2020.

The pandemic experience suggests that OSH regulators needed to reconsider their compliance strategies and enforcement priorities as it became clear that COVID-19 was posing a major threat to health and safety at the workplace. It also suggests that more “co-regulatory” compliance measures were needed, so that the efforts of inspectors could be complemented by those of unions and civil society actors.³¹⁷

Guidance material and voluntary compliance

Notwithstanding these limitations in OSH enforcement agencies, several jurisdictions appeared to be able to elicit broad public observance through non-enforceable guidance material, without legal mandates. A particularly controversial example was vaccines. Many countries mandated these, especially for health workers. Some countries, such as Italy and Australia, went further and mandated them for most categories of workers.³¹⁸ This approach elicited strong resistance from “vaccine hesitant” minorities who often had their employment terminated. Other countries did not have a wide employment mandate but restricted access to certain public activities. In contrast, Japan did not initially use lockdowns or mandates at all, but rather “requests” and, in some cases “instructions” (without penalty), although since February 2021 certain limited compulsory orders can be made in relation to hospitalizations and business closures.³¹⁹ Similar issues about compliance have arisen in relation to mask wearing and other forms of PPE, social distancing and restrictions on movement.

It is difficult to explain convincingly, at the time of writing, when and why compliance with COVID-19 measures could, or could not, be achieved voluntarily. Previous experience of a pandemic (as in the case of SARS1 in East Asia), longstanding modes of administration, trust in government, internalized social norms around cooperation, social pressure, institutional structures and effective communication are just some of the many possible reasons. A common explanation for social compliance is ‘culture’ but this ground is notoriously vague and often superficial; it often lacks a sound empirical basis which examines institutional incentives and other mechanism.³²⁰ Even within the one country, radically different approaches could be taken. In the United States, some state governments, such as California, adopted compulsory measures whereas others, such as Arizona, attempted to make all COVID-19 safety requirements non-binding.³²¹

It would be very valuable – although also very complex and resource intensive – to investigate, in different jurisdictions what kinds of OSH interventions prompted compliance during the pandemic. Such a study would include consideration of the nature of the relevant regulatory instruments, the enforcement strategies of inspectorates and the actions of unions and other stakeholders. There is a very extensive (and contested) regulatory literature on compliance, including in relation to labour issues, that could inform that research.³²² Much of it suggests that while voluntary compliance is widespread, there are, in most if not all countries, many instances where labour standards, including OHS standards are deliberately or recklessly violated and undertakings must be legally compelled to observe them. There are also insightful many studies about the relative effectiveness of different enforcement measures that could be used to assist a robust research design.

³¹⁷ Estlund, *Regoverning the Workplace: From Self-Regulation to Co-Regulation*. (Yale University Press, 2010)

³¹⁸ For the debate in Italy, see, for example, P. Albi et al, *Dibattito istantaneo su vaccini anti-COVID e rapporto di lavoro*, in www.rivistalabor.it, 2021;

³¹⁹ Kadamatsu, ‘Legal Countermeasures against COVID-19 in Japan: Effectiveness and Limits of Non-Coercive Measures’. Rwanda also did not mandate vaccines, although some employees were dismissed because they were unvaccinated.

³²⁰ For example, although generally using guidance material, adopted more coercive lockdown measures than Japan. Australia and Italy adopted more coercive measures than Spain.

³²¹ State of Arizona, Executive Order 2021-06, New Phase of COVID-19 Mitigation, Mar. 25, 2020, available for download here <https://azgovernor.gov/executive-orders>

³²² For a summary, see Tess Hardy and Sayomi Ariyawansa, “Literature Review on the Governance of Work” (International Labour Office, 2019).

5.6 Co-ordination with other systems

Coordination between agencies and other social organizations

The modes of coordination adopted to address the challenges of the pandemic varied considerably between countries. For example, in the United Kingdom, reflecting its robust civil society, multiple stakeholders from government, community and private sectors interacted extensively. The Industrial Injuries Advisory Council, public health authorities and the Health and Safety Executive were all focused on developing responses to COVID in the workplace. Government representatives engaged with business representative groups, unions, employers and local authorities. While these interactions were often positive, there was also inconsistency and even conflict. In the United Kingdom, the Scientific Advisory Group for Emergencies (SAGE) was criticised for not properly reviewing the workplace-related impacts of COVID-19; a rival “Independent SAGE” group formed which developed a charter for COVID-19 safe workplaces.³²³ Other NGOs also pressured governments for stronger action, such as the Institution of Occupational Safety and Health, the Society of Occupational Medicine, the British Dental Association, the British Medical Association and the professional organization for occupational health professionals.

In China, reflecting the key role of the central organs of state, coordination was driven by the State Council. As discussed above, the Prevention and Management of Occupational Diseases Law has not, it seems, been applied to the COVID-19 pandemic; instead, the COVID-19 response was led directly by the State Council in the form of advisory opinions. These were frequently issued jointly with ministries with shared jurisdiction, such as the Ministry of Health and the Ministry of Human Resources and Social Security. Given the dispersed nature of China’s OSH framework, it may be that this approach was taken to cut through the legal and bureaucratic complexities of China’s OSH law in the face of a pandemic, so that all parts of the government, not just the health ministry (the ministry responsible for the Occupational Diseases Law) acted.

In Rwanda, previous experience with Ebola meant that co-ordination arrangements could be quickly re-activated, so that rapid response teams were rolled out across 30 districts under local leadership and a cross-ministerial Joint Task Force was established, drawing on expert advice.³²⁴

Coordination between OSH, labour and social security systems

Workers were often required to stay away from their workplaces as a result of lockdowns or – especially among frontline workers – their own illnesses or their need to quarantine due to workplace or community exposures. Their capacity to do so financially was very much affected by the pay and social insurance arrangements put in place. In other words, OSH regulation had to align with labour and social security law, otherwise workers would have incentives to come to work to maintain their income, even if it was not safe to do so. Low-paid frontline workers, especially women, were particularly vulnerable.

Income maintenance

Many jurisdictions (including Spain, Brazil, Republic of Korea, the United Kingdom, China, Australia and much of the United States, including California) did in fact institute extensive payment frameworks that buttressed the income of workers who were sick, in isolation or whose firms closed.³²⁵ These measures were especially important for the low-paid. However, they were often time-limited; this was a particular problem in jurisdictions such as the Republic of Korea and the United States where there is no mandated paid sick

³²³ The Independent Scientific Advisory Group for Emergencies, Protecting People at Work: The COVID-19 Safe Workplace Charter, September 2021.

³²⁴ WHO, COVID-19 in Rwanda: A country’s response, 20 July 2020.

³²⁵ For an extensive examination see the countries studies published in a special issue of the Italian Labour Law e-Journal (Vol. 13 No. 15, 2020). See also, in the United States, Families First Coronavirus Response Act (Pub. Law 116-127, approved March 18, 2020); Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. Law 116 – 136, approved March 27, 2020; and American Rescue Plan Act Pub. Law 117 – 2, approved March 11, 2021.

leave. There were also often gaps in these systems; for instance, some social security payments, such as those in the United Kingdom, did not cover the whole illness period. Other jurisdictions did very little (such as Rwanda and, in the United States, where some states, including Arizona and Mississippi declined some federal supports).

In Brazil, a special protection law, albeit confined to the duration of the pandemic, was passed in relation to pregnant women (not limited to frontline workers)³²⁶ and another in relation to platform delivery workers,³²⁷ who were defined as essential workers. Although platform workers are generally understood to be self-employed in Brazilian jurisprudence, the law required platforms to provide accident, disability and death insurance, to provide financial assistance when workers were on leave, to provide information about contagion, masks and wipes, among other stipulations such as making potable water available. On the other hand, there were no public policies aimed at black and female workers, even though, as in other countries, they bore the brunt of the impact.³²⁸

As mentioned in section 6.2, the Republic of Korea has adopted a new specific law pertaining to essential workers in times of crisis.³²⁹ This provides for financial support plans. It has also extended employment and accident insurance schemes to certain categories of self-employed, such as delivery workers and domestic workers.

One controversial income issue concerns the payment of hazard pay to some (but not all) workers whose work forces them to be exposed to the virus. This occurred in China, the Republic of Korea, Italy, Japan and also in Brazil, where there is a constitutional right to such payments.³³⁰ As discussed in section 4.7, such payments may be analogised to overtime and shift premia, but should not distract from the obligation to eliminate or reduce the risk of a hazard. Indeed, it may be preferable for governments to accord frontline workers additional leave or reduced working time, since the major risk for some frontline workers, especially in the health sector, appears to be not so much loss of income, as overwork and burnout.

Flexible Working Arrangements

A second important issue connecting OSH to labour law more broadly is flexible working arrangements. School and childcare closures and COVID-19 outbreaks in aged care facilities meant that many frontline workers, especially women, had to simultaneously deal with increased caseloads at work while educating children and caring for elderly relatives.³³¹ Rigid workplace policies, cultural norms inhibiting men from undertaking a greater share of caring, the lack of a right to request flexible working conditions in many national labour statutes, as well as narrow interpretations of discrimination law pertaining to family responsibilities all inhibited the adoption of better working arrangements which begin to address these competing demands and thus reduce psychological pressures. In some jurisdictions, working arrangements became even more rigid; in Brazil, for instance, a Provisional Measure permitted employers to suspend vacations of essential workers and to extend hours of work.³³² On the other hand, in Colombia, working hours were modified to improve flexibility, partly in order to prevent peak use of public transport systems.³³³

³²⁶ Law No. 14.151/2021

³²⁷ Law No. 14.927/2022

³²⁸ Joana Simões de Melo Costa, et al., *Desigualdades no mercado de trabalho e pandemia de COVID-19* (Instituto de Pesquisa Econômica Aplicada, 2021). https://www.ipea.gov.br/portal/index.php?option=com_content&view=article&id=38411; Reis, A. P., Góes, E. F., Pilleco, F. B., Almeida, M. da C. C. de, Diele-Viegas, L. M., Menezes, G. M. de S., & Aquino, E. (n.d.). Gender and race inequalities in the COVID-19 pandemic: implications for control in Brazil. *Saúde Em Debate*, 44(4), 324–340. <https://doi.org/https://doi.org/10.1590/0103-11042020E423>.

³²⁹ the Essential Work Designation and Workers Support and Protection Act.

³³⁰ Federal Constitution article 7 item XXIII.

³³¹ Lidia Farre et al., “How the COVID-19 Lockdown Affected Gender Inequality in Paid and Unpaid Work in Spain”, IZA DP 12434 (2020).

³³² Provisional Measure No. 927/2020 (Brazil). Renewed by Provisional Measure No. 1,046/2021.

³³³ Legislative Decree 770 of 2020.

▶ Conclusion

The pandemic presented an immense and largely unanticipated challenge to national OSH frameworks. The national reports suggest a number of implications, both in relation to the overall frameworks and to the specific measures taken to protect frontline workers from COVID-19.

Beginning with the overall frameworks, in many countries the OSH architecture is fundamentally sound. Most have coherent policies and systems, are structured around a culture of prevention, set out clear duties and rights for employers and employees and have compliance systems. A number of shortcomings are nonetheless evident. First, many systems have gaps in coverage, often linked to a central focus on long term employment relationships. This has meant that temporary workers, domestic workers, the self-employed, platform workers, volunteers and persons in fissured workplaces have lesser, or no coverage (although some countries do make specific provision for some of these categories). In some sub-national jurisdictions in the US, OSH law does not cover public sector workers at all. The lack of comprehensive coverage has left many frontline workers – those not in regular employment relationships – exposed when the pandemic struck.

Second, mechanisms for tripartite collaboration, especially at the workplace level, are not a universal feature of OSH systems. In some jurisdictions, there is no provision for labour-management consultation, let alone a compliance role for elected OSH worker representatives. Even those systems with strong collaborative arrangements need to consider how they can be more inclusive of non-regular employees. The empirical evidence cited above suggests that a worker voice independent from management control, but willing to cooperate with management, promotes safer and healthier workplaces; it also reduces the need for government oversight.

This brings us to a third point: weaknesses in compliance mechanisms. Many countries reported a long-term decrease in resources allocated to OSH inspectors. There are also examples of inadequate enforcement powers and poor enforcement strategies, although in other countries, especially in East Asia, enforcement powers have recently been strengthened.

Fourth, some countries experience serious coordination problems. This can be because labour and social systems do not adequately buttress OSH – for example, by failing to provide for adequate and easily accessible continuation of remuneration for sick workers or by enabling flexible work practices. There can also be “turf wars” between OSH and other regulators, instead of complementary procedures; in one jurisdiction “OSH” itself is split into two statutes and two main regulators. In federal states, policy approaches can conflict.

► **Figure 4: General recommendations for OSH Systems**

Turning to the specific responses to the pandemic, again there are both examples of relatively effective initiatives and some serious shortcomings. Many governments took solid measures to provide income support for workers who were ill or who were not permitted to attend their workplace. While there were real challenges in determining what safety procedures were required to deal with the COVID-19, especially early on when the airborne nature of infection was not fully appreciated, most governments did issue important guidance materials helping employers and workers to adopt safer practices. The reports also provide good examples of tripartite initiatives that helped protect workers from the pandemic. And in most jurisdictions, courts were generally supportive of regulators, though there were notable exceptions in the United States.

On the other hand, the reports provide many examples of regulatory materials distributed by governments which were contradictory and voluminous, and not simply because of the evolving state of medical knowledge. This made it difficult for employers and workers to implement their OSH duties and to exercise rights, such as the right to withdraw from a workplace. Much of this material has been of a temporary nature, of necessity in the early days of the pandemic, but it is problematic in terms of a long-term response to COVID-19 or other future viruses.

Compliance also was a weak spot in many countries, in part because of shortages of PPE and the contradictory guidance just mentioned, but also because understaffed and faltering OSH regulators did not carry out their information, training and enforcement functions nearly as well as they might have. In some countries, occupational health services, which could have facilitated compliance were too overburdened or fragmented to respond effectively.

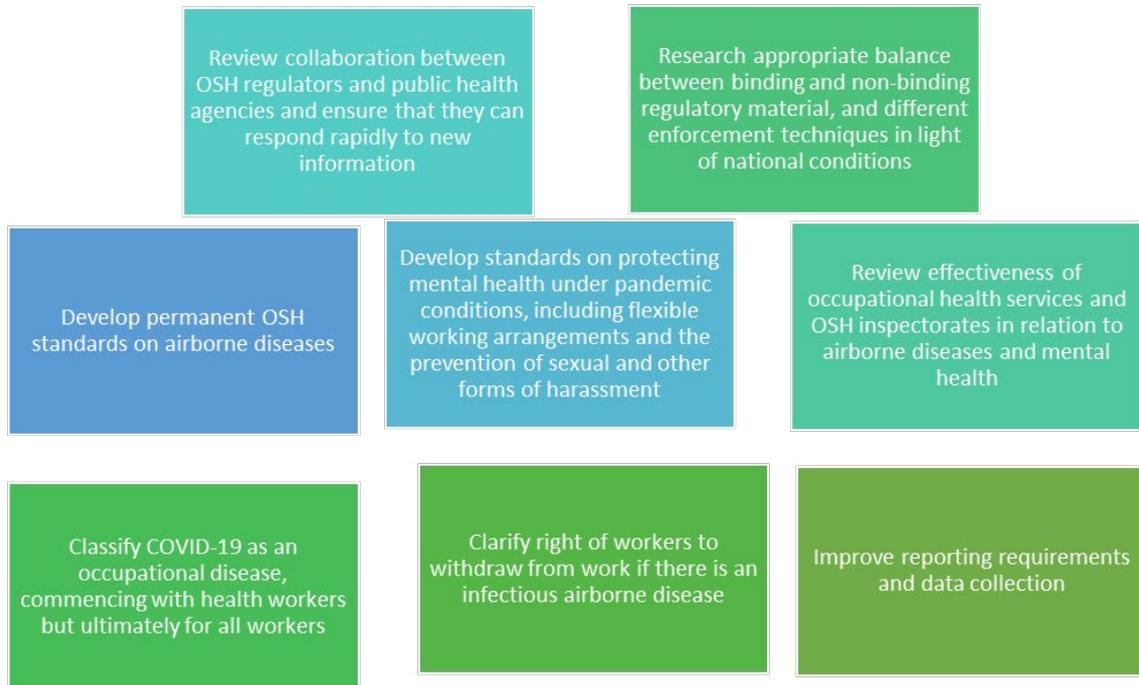
A further observation concerns the focus on health workers to the possible neglect of other key workers. Part of the problem here was that in many countries, OSH law still tends to focus on traditionally dangerous areas of work such as mining, construction, and manufacturing. With the onset of the pandemic, regulators needed to shift their attention to industries such as health and aged care, transport, food services, education and security. Health and aged care did receive particular attention in many jurisdictions – extensive interim measures directed at this sector were adopted – but other sectors less so.

Going forward, there are several issues which it would be useful to reflect on. Although these are framed in terms of the COVID-19 pandemic, they may also apply to other airborne diseases. They include:

1. The interaction between public health and OSH systems. The study revealed that the degree of collaboration between administrative bodies varied significantly between countries. As the advice about the infection changed, it was important that all these agencies respond to new information quickly and adopt new approaches based on that information.

2. The legal form that regulatory material should take. There appears to be considerable national variation here. In some countries, non-binding instruments appear to have elicited voluntary compliance and collaboration. Other jurisdictions opted for binding rules; these could be easily enforced but could also elicit opposition and legal challenge. Empirical study into the compliance effects of these different kinds of instruments, together with the enforcement strategies of OSH regulators, would shed light on appropriate future forms of government action.
3. Some permanent binding standards concerning airborne diseases may need to be formulated through a careful process of tripartite deliberation, if none currently exists. This should cover all working environments where airborne diseases are easily transmissible (not only the health sector) and address matters such as PPE and ventilation, as well as safe work practices.
4. Governments need to address the mental health consequences of the pandemic for workers, especially frontline workers. This involves consideration of intertwined issues, including clear OSH standards pertaining to mental health, sexual and other forms of harassment, sound and flexible working time rules which address work intensification, rest periods and family responsibilities, and the provision of support services.
5. Relatedly, occupational health services and inspectorates need to be resourced and trained to implement standards on airborne diseases and mental health.
6. COVID-19 should ideally be classified as an occupational disease, as this assists in making clear that COVID-19 is a workplace issue. This may have significant workers compensation implications and so the financial consequences will need to be assessed; they may necessitate a phased implementation approach. Many countries have given recognition limited to the health sector, but this limitation may not be equitable.
7. Clarification is needed around the right of workers to withdraw themselves from a workplace where COVID-19 may be present, and to be free from retaliation. This is a particularly complex question which would seem to entail an examination of the extent to which COVID-19 safety measures have been instituted at an individual workplace.
8. Mechanisms for reporting virus cases and recording data have been patchy.³³⁴ Such data are essential for formulating systematic and long-term regulation dealing with COVID-19.

³³⁴ For example, in the Republic of Korea there were at the time of writing insufficient data on which occupations had the most infections.

▶ **Figure 5: Specific Recommendations on OSH and COVID-19**

The International Labour Conference's declaration that OSH is a fundamental right, and the inclusion of Conventions No. 155 and No. 187 among the fundamental Conventions should encourage Member States to encourage in a methodical review of their regulatory frameworks. The lessons learned from the pandemic can inform such reviews, so that more robust policies, systems and programs can be implemented. Not only will this help Member States to be better prepared for future infectious diseases, but it should also lead to better health and safety outcomes overall, underpinned by collaborative workplaces imbued with a culture of prevention.

Annex: Ratification of Key OSH Conventions

	FUNDAMENTALS		OTHER	
	CONVENTION NO. 155	CONVENTION NO. 187	CONVENTION NO. 161	CONVENTION NO. 190
Australia	YES	NO	NO	NO
Brazil	YES	NO	YES	NO
China	YES	NO	NO	NO
Colombia	NO	NO	YES	NO
Italy	NO	NO	NO	YES
Japan	NO	YES	NO	NO
Korea (Republic of)	YES	YES	NO	NO
Rwanda	YES	YES	NO	NO
Spain	YES	YES	NO	YES
United Kingdom	NO	YES	NO	YES
United States	NO	NO	NO	NO

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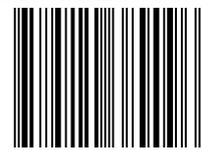
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