INJURED WORKERS
COMMUNITY LEGAL CLINIC

**REPRESENTING INJURED WORKERS
FREE OF CHARGE SINCE 1969**
A community directed not for profit legal aid clinic

March 28, 2023

WSIB Consultation Secretariat
200 Front Street West
Toronto, Ontario M5V 3J1

Sent by email to: consultation_secretariat@wsib.on.ca

Dear Consultation Staff,

Re: The WSIB's Draft Policy on Communicable Illnesses

The Injured Workers Community Legal Clinic is a legal aid clinic with a province-wide mandate. We have specialized in the area of workers' compensation since 1969. As a legal aid clinic, our services are provided to people with little or no income for no charge. In addition to legal advice and representation, our mandate includes community development, public legal education and participation in law and policy reform.

Thank you for the opportunity to make a submission. We support the WSIB's initiative to develop a policy for communicable illnesses.

Summary of Positions on the Draft Communicable Illnesses Policy

1. Overall, our primary concern with the draft policy is that it is highly restrictive and that it does not apply the proper legal test for causation (significant contribution test), which will lead to a disproportionate number of claim denials relative to other types of injuries. Ultimately, this will create a chilling effect in which workers will not report their claims for these types of illnesses to the Board, based on an assumption that the claim will be denied.

2. We would submit that there should be paragraph(s) at the beginning of the Communicable Illnesses Policy clearly explaining in plain wording: 1. the standard of proof in workers' compensation claims: the balance of probabilities; 2. the benefit of doubt provision; 3. the legal test for causation: a significant contributing factor; and 4. the thin skull doctrine.

3. Furthermore, the proposed policy should adopt a framework pertaining to the "nature of the exposure" to assess each case, rather than a model based on the "general population", which is not individualized to the specific worker, and is therefore, contrary to foundational compensation principles.

4. It is our clinic's position that COVID-19 should be removed from this draft policy and that a separate policy specific to COVID-19 should be established with more comprehensive information on the illness, and that it be subject to periodic review.

1. Highly Restrictive Policy Will Lead to Denied claims

Tel: (416) 461-2411
Fax: (416) 461-7138

411-815 Danforth Ave
Toronto, ON M4J 1L2

The policy as proposed is highly restrictive and the threshold for entitlement so great, that in our estimation, the vast majority of claims will be denied, with the exception of a narrow subset of workers in a specific type of work setting. While the policy makes passing reference to the significant contribution test for causation, in reality, when reviewing the totality of the policy, it appears that the predominant cause legal test for causation will be indirectly/unconsciously applied by the Board. The policy should be explicit in stating that the test for entitlement is whether it is more likely than not that the workplace exposure(s) made a significant contribution to the worker's injury/illness/disease.

We see parallels between the Chronic Mental Stress (CMS) policy and this draft policy insofar as both are contrary to established legal principles, and both lead/will lead to higher denial rates for entitlement relative to other types of injuries.

Freedom of Information (FOI) data from the WSIB for CMS claims reveals that the percentage of accepted claims for entitlement from 2018 to 2022 ranged from 4.5% to approximately 9%[1], compared to an overall acceptance rate for all registered WSIB claims of close to 80%, from 2018 to 2020.[2] This is a marked difference. The reason why CMS claims are denied at such a high level is that the policy contains a legal test for causation (the predominant cause) and other provisions that create a higher threshold for entitlement compared to all other injuries. We believe that this draft policy contains a number of provisions, which will raise the bar for entitlement and lead to a substantial number of denials, similar to the CMS policy.

FOI data from the WSIB provides insight into how claims pertaining to pneumonia/influenza have been adjudicated over a 10 year period. As you can see, the numbers are low, comparable to CMS claims.

Pneumonia/Influenza WSIB Claims – 2012-2021

Year	Accepted Claims	Denied Claims	Total Claims	Acceptance Rate
2012	9	115	124	7.2%
2013	10	165	175	5.7%
2014	9	152	161	5.6%
2015	10	378	388	2.6%
2016	8	42	50	16%
2017	21	59	80	26.2%
2018	26	187	213	12.2%
2019	14	101	115	12.1%
2020	9	116	125	7.2%
2021	4	15	19	21%[3]

In 5 of the 10 years, the acceptance rate was in line with CMS claims. In only 3 years did the acceptance rate exceed 15%, and those three years had fewer claims than the other years with higher

[1] FOI Data from the WSIB - # 6940. The dataset only had CMS data to November 2022.
[2] FOI Data from the WSIB - # 6297. The dataset contained information only to 2020.
[3] FOI Data from the WSIB - # 6985. The dataset did not contain operations level data for 2022.

denial rates. Ultimately, the acceptance rates are significantly lower than the average acceptance rates for all registered claims, which hover around 80%. It's clear that adjudication in communicable illness claims at the Board has been flawed and will continue to be flawed with the introduction of this draft policy – if no changes are made.

Now, we will comment on more specific provisions of the draft policy and how they will establish a highly restrictive adjudicative environment negatively impacting injured and ill workers.

Determining whether the worker contracted a communicable illness

The draft policy states:

> "In addition to other relevant evidence gathered during the adjudication of a claim, one or both of the following will generally be necessary to establish the worker has or had at the relevant time a specific communicable illness:
>
> - laboratory confirmation of current infection (e.g., positive laboratory or diagnostic test result), or
> - a diagnosis by a treating health professional qualified to provide such a diagnosis based on a clinical assessment of the worker during the period of illness." [4]

Recommendation: This section of the draft policy is unclear and will be interpreted in a manner that leads to the inappropriate denial of initial entitlement. Only one of the two – *laboratory confirmation or a diagnosis* – should be required to establish that a communicable illness existed at the relevant time, not both. Based on current adjudicative practices utilized at the WSIB, it is more likely than not that Eligibility Adjudicators/Case Managers will require both a laboratory confirmation and a diagnosis, which may not be necessary and/or feasible for the injured worker, making the process cumbersome.

The draft policy further states:

> "In the absence of laboratory or clinical evidence of current infection, a decision-maker will determine whether the worker has or had at the relevant time a specific communicable illness based on the available evidence including, but not limited to:
>
> - a laboratory test to detect a previous infection (e.g., antibody test)
> - the worker's presentation (i.e., signs and symptoms) and whether it is compatible with the signs and symptoms of the communicable illness established to exist in the workplace."[5]

Recommendation (re the second bullet point): Claims should not be denied when key symptoms consistent with the illness are present, along with symptoms that may not yet be recognized for that specific illness, as with newer illnesses like COVID-19, the full range of symptoms is still not known, as there are new variants and mutations that manifest and present in slightly different ways.

Recommendation: If a claim is denied because of unrecognized symptoms, but then the medical literature is updated to include those symptoms, the Board should reconsider and grant retroactive entitlement to those claims which were denied because of previously unrecognized symptoms.

---

[4] Draft Communicable Illnesses Policy.

[5] Ibid.

Recommendation: The Board should permit the filing of late applications when at the date of illness, the symptoms were not recognized as part of the illness.

Determining whether the communicable illness was contracted in the course of employment

On Page two, the draft policy states:

"... the decision-maker must gather and weigh the evidence related to potential work-related and non-work related exposures to the communicable illness."[6]

Recommendation: There should be an explicit reference to the WSIB's benefit of doubt provision when there is a statement regarding the weighing of evidence.

Page three of the draft policy states:

"In the absence of a specific work-related contact source, the decision-maker must determine the issue of whether the communicable illness was contracted by the worker while in the course of employment after weighing all of the available relevant evidence."[7]

Recommendation: The section should make reference to the benefit of doubt provision and the significant contribution test. Moreover, this section should specify that entitlement can be granted in the event there are multiple non-work-related exposures. The available and relevant evidence reviewed should be individualized and not based on the general population.

Determining whether the communicable illness arose out of employment

This section does not follow established workers' compensation legal principles. Page 3 states:

"A worker's employment will have made a significant contribution to contracting a communicable illness when the decision-maker is satisfied that:

- the employment placed the worker at an increased risk (i.e., increased likelihood) of contracting the communicable illness as compared to the risk experienced by the general public during ordinary or routine activities of daily living, and
- the communicable illness was contracted by the worker from exposure that occurred in the course of their employment as a result of the identifiable increase in risk.

The worker's employment will generally not have made a significant contribution to contracting the communicable illness when these conditions are not met."[8]

This wording does not capture the significant contributing factor test for causation and it creates a higher threshold for workers to obtain entitlement. The reference to "general public" is unclear and vague. With illnesses like COVID, the "general public" did not behave in a homogenous manner. For example, some people followed precautions strictly, while others were more laissez-faire and continued their lives as normal. Therefore, any attempt at determining what constitutes the "general public", will be flawed from the outset.

---

[6] Ibid.
[7] Ibid.
[8] Ibid.

The reference to "increased risk" is also problematic. As stated, the legal test for entitlement is whether on a balance of probabilities the workplace exposure made a significant contribution to the worker's injury/illness/disease. There is no precedent in WSIB policy or law that the worker must demonstrate that their workplace had an "increased risk" of illness/injury. The reference to "increased risk" is not relevant to WSIB law or policy.

Recommendation: The work exposure(s) and non-work-related exposure(s) of the individual worker are what should be examined when determining entitlement. A comparison to the "general population" is unnecessary and contrary to law, as are references to "increased risk". As such, the policy should be amended to remove these phrases. The policy should reflect the correct legal test for work-relatedness.

Employment Risk Factors

The draft policy states:

"the rate of communicable illness is significantly higher in the worker's place of work than in the general population (e.g. widespread outbreak in the workplace, treatment or care of populations with a significantly higher rate of the illness, or travel to a region with a significantly higher rate the illness), and/or

the worker's employment activities create opportunities for exposure to and transmission of the communicable in excess of the opportunities associated with ordinary or routine activities of daily living."[9]

The WSIB already has specific presumptions for entitlement when there is evidence that the workplace created an increased risk of exposure/injury.

Recommendation: This section of the policy should be rewritten to include a provision creating a presumption of work-relatedness for any worker who contracts a communicable illness while employed in a workplace with increased risk or when their job duties create excess risk. Examples of a higher risk workplace, *include but are not limited to*: widespread outbreak in the workplace, treatment or care of populations with a higher rate of illness, or travel to a region with a higher rate of the illness. Examples of job duties creating excess risk, *include but are not limited to*: prolonged close contact with a person known to have the illness, direct contact with infectious substances, staying in employer-provided accommodations with one or more people with the illness.

To be clear, we are recommending that "increased risks" *only* be referenced in the policy as it relates to the Board adding a presumption.

Community-Acquired Communicable Illnesses

It is true that the common cold and influenza are prevalent in the general population. However, we vehemently disagree with the WSIB's position that "a worker who contacts one of these communicable illnesses in the course of employment is generally not entitled to benefits unless the worker's employment increase their risk of contracting the communicable illness in some additional way." It is absurd that a worker is denied benefits unless their "employment increased the risk" of contracting the communicable illness. If we were to apply this logic, then someone who works at a

[9] Ibid.

computer desk would be denied entitlement for lifting and moving a heavy object at work because their employment does not put them at "increased risk" of physical injury.

Recommendation: This section should be removed from the draft policy, as it creates a presumption against entitlement and is contrary to the foundational principles of the workers' compensation system.

Public Health Emergencies

It should be noted that these declarations can be arbitrary and politically-motivated. For example, there was widespread opposition in the medical community when some of the public health measures were reduced or eliminated in Ontario.

Recommendation: The WSIB should be cautious and not over reliant on politically-motivated and arbitrary public health emergencies. It can become problematic for the WSIB to adjudicate matters one way because of a public health emergency, but then modify its adjudication once the public health emergency is rescinded; transmission, infections and deaths may remain just as high once the public health emergency is no longer in effect.

Loss of Earnings (LOE)

In the section on Loss of Earnings (LOE) and the period of communicability, there is no mention of disability/impairment. For instance, the period of communicability for an illness may be 5 days. However, the worker may be unable to work for 10 days due to the onset of more severe symptoms.

Recommendation: The section should note that LOE can be provided beyond the period of communicability if there is medical evidence stating the worker is unable to work or if they require restrictions that cannot be accommodated by their employer.

This is particularly important because some individuals will experience more intense symptoms for an unknown reason or possibly because of a pre-existing condition.

Recommendation: This above-noted section should highlight the thin skull doctrine, which is pertinent to this area of the policy.

Prevention of communicable illnesses

In the section on the prevention of communicable illnesses, a worker free of illness who may be told to self-isolate or be sent home would be denied WSIB benefits.

This section is inconsistent with Policy 16-02-17 which states, "Uranium miners and mill workers who have been exposed to the maximum radiation exposure level of 2 Working Level Months (WLM) per quarter and 4 WLM per annum may be entitled to benefits while the workers are obliged to remain out of the radiation exposure environment."[10]

[10] WSIB Policy 16-02-17.

Furthermore, this section is also inconsistent with the definition of occupational disease: "(c) a medical condition that in the opinion of the Board requires a worker to be removed either temporarily or permanently from exposure to a substance because the condition may be a precursor to an occupational disease."[11]

Recommendation: If a worker is exposed to a communicable illness in the workplace and remains free from said illness, but requires their preventative removal from the workplace for a medical condition, or due to instructions from their employer or because of an order from Public Health, WSIB entitlement should be granted.

Appendix

The Appendix in the Draft policy contains general information and guidelines for a variety of illnesses.

Recommendation: There should be a statement explaining that the information contained in the chart is subject to periodic review in order to remain up-to-date with the most contemporary scientific information.

Recommendation: There should be a qualifying statement which outlines that the information in the chart is general in nature and that if an individual's symptoms are different or prolonged, that they may still be entitled to WSIB benefits. The concern is that decision-makers will unfairly deny entitlement because the symptoms are not identical to those on the chart or the symptoms last for a prolonged period of time.

Recommendation: There should be a statement and information in this chart on Long COVID.

It should be emphasized that the WSIB is mandated to apply the law and its policies in a liberal fashion, per the *Legislation Act*.[12] Based on the way this draft policy is written, it does not appear that the WSIB will abide by its legal obligations.

2. Legal Tests and Definitions

The WSIB's legal test for causation is the significant contributing factor test. In the Draft Occupational Disease Framework, the WSIB defines the significant contributing factor in the following terms: "To be a significant contributing factor, the worker's employment need not be the only cause or even the primary cause of the disease, the contribution of the employment only needs to be more than de minimus.[13]

As stated, the Communicable Illnesses draft policy appears to violate this legal test on a number of occasions, thereby increasing barriers for workers to obtain entitlement to benefits. Ultimately, the policy as written will indirectly/unconsciously result in decision-makers using the predominant cause test for causation, which requires a higher threshold.

---

[11] WSIA.
[12] *Legislation Act*.
[13] WSIB Draft Occupational Disease Framework.

Recommendation: The beginning of the Communicable Illnesses Policy should incorporate the definition of a significant contributing factor test quoted above. This will create clarity for decision-makers and for injured workers. There should be additional statements explaining that scientific certainty is not required for WSIB entitlement and that entitlement can still be granted even if there are multiple non-work-related exposures.

Recommendation: For further clarity and making the process more open and transparent, the beginning of the policy should also contain definitions pertaining to the balance of probabilities, the benefit of doubt, and the thin skull doctrine.

3. Framework for Assessing Exposures

Recommendation: The Communicable Illnesses policy should focus on individual exposures at work and on an individual's activities of daily living, which is already the case in gradual onset/disablement type injuries. The Board should not be comparing a worker to the general population.

4. Creation of Separate WSIB Policy for COVID-19

Recommendation: COVID-19 should be severed from the draft Communicable Illnesses policy and a specific policy for COVID-19 should be created by the Board, open to consultation and review from all stakeholders.

Combining a relatively new illness such as COVID-19 with longstanding illnesses such as the common cold and influenza is problematic, as the science on the former is changing daily, while much of the science on the latter is settled and health outcomes are fairly predictable. With the recent emergence of COVID-19, long COVID remains a widely debated issue as new scientific studies are released on a regular basis, complicating adjudication for the Board.

Furthermore, COVID-19 required multiple partial government shutdowns of the economy and the school system as the virus spread at an alarming rate and led to an unprecedented surge in hospitals. As precautionary measures, masks, testing and vaccines were required for entry into facilities and became a new condition of employment in some workplaces. Other illnesses such as influenza have not required shutdowns and closures, nor has widespread testing, masking and vaccination become required for seasonal influenza, with some exceptions (i.e. vaccination for some health care workers). While influenza can cause severe sickness, hospitalization, and death, in recent times, influenza has had a lower mortality and morbidity rate compared to COVID-19. We would suggest that COVID-19's recent emergence and the evolution of the virus and the science makes it paramount that a separate policy is created. This is also necessary, because it is possible that new strains/mutations may develop that require a re-emergence of precautions due to increased mortality and morbidity rates.

Recommendation: We would submit there should be a thorough and comprehensive description of COVID-19 based on the most up-to-date and authoritative medical science, subject to periodic review.

We are in agreement with the submission from Michael Green in which he states on Page 2 that there should be a description of the different characteristics of aerosol vs droplet transmission and the fact that COVID is transmitted through inhalation, which impacts multiple systems throughout the body – neurological, cardiovascular, immunological, gastrointestinal, urological – and that symptoms may emerge soon or long after the infection.[14]

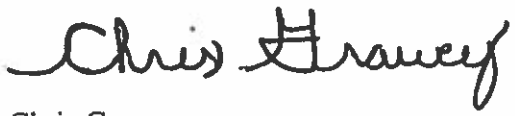
The key takeaway is that while there are general trends with symptoms, transmission and infection, there are often many people whose personal experience differs from the accepted science. Ultimately, it is important that a divergent personal experience with an illness should not be an impediment to entitlement.

Recommendation: In both the proposed Communicable Illnesses Policy and our proposed COVID-19 policy, there should be an explicit statement that WSIB entitlement is granted in the event that a vaccination required for employment leads to side-effects causing lost time from work and/or healthcare treatments.

Conclusion

In closing, thank you for reviewing our submission. Should you have any questions, please contact me via email: chris.grawey@iwc.clcj.ca. We would be more than pleased to meet with you for further discussion.

Sincerely,



Chris Grawey
Community Legal Worker
Injured Workers Community Legal Clinic

[14] Michael Green Submission, page 2.