BRIEF

TABLED AT THE COMMITTEE ON LABOUR AND THE ECONOMY

January 20, 2021

Bill No. 59

An Act to modernize the occupational health and safety regime

FIQ | SECTEUR PRIVÉ

Foreword

The Fédération interprofessionnelle de la santé du Québec–FIQ and the Fédération interprofessionnelle de la santé du Québec | Secteur privé–FIQP represent 76,000 healthcare professionals in nursing and cardio-respiratory care, which includes the majority of nurses, licensed practical nurses, respiratory therapists and clinical perfusionists in Quebec health and social services institutions. The FIQ and FIQP's strong foundation in the health network enriches their expertise, one that is valued and recognized by decision-makers from all over. The FIQ and FIQP represent healthcare professionals with diverse work experience who provide care across all areas of the health and social services network.

As first-hand witnesses of the healthcare system's daily operations, healthcare professionals see the effects of socioeconomic inequality on the population's health, as well as the sometimes deplorable impacts of the decisions made at all levels of the political and hierarchical structure. The FIQ and FIQP are labour organizations with a nearly 90% female membership, composed of healthcare professionals, public and private network employees, and citizens who use these services. Through their orientations and decisions, the FIQ and FIQP strive to protect social gains and to achieve greater equality and social justice.

They have a strong mission to defend the interests and concerns of their members and the population.

Table of Contents

Summary

As labour organizations representing nearly 76,000 nurse, licensed practical nurse, respiratory therapist and clinical perfusionist members working in Quebec healthcare institutions, it is crucial for the FIQ and FIQP to give their stance on the modernization of the occupational health and safety regime.

Workers who are victims of employment injuries must have their claims validated by different authorities in order to gain reparation. Oftentimes, the process of obtaining this very validation is detrimental to their health. With a few exceptions, a number of provisions amending the *Act respecting industrial accidents and occupational diseases* are unfavourable and even represent a step backwards for workers with employment injuries. Some changes to definitions could potentially harm workers, especially the definition of suitable employment. The law introduces new time limits for submitting claims, which undermine workers' rights. The Federations are concerned by the withdrawal of the preponderance of the attending physician's opinion in several provisions of the Bill. This applies both to provisions concerning vocational rehabilitation and provisions dealing with evaluations by a member of the Bureau d'évaluation médicale. In any case, the loss of the preponderance of the attending physician's opinion is harmful to workers and goes against the objectives of the law. The Federations firmly believe that the preponderance of the attending physician's opinion must be restored in the Bill.

Moreover, the Federations fail to see why this opportunity was not taken to expand the list of recognized occupational diseases, especially in terms of psychological disorders. The only addition concerns post-traumatic stress disorder and the criteria to have it recognized are so restrictive that access to compensation is almost purely theoretical. Similarly, it is disappointing that diagnoses for adjustment disorder and depression were not added to the list. Workplaces cause not only physical injuries but psychological ones too. Mental health should be considered on par with physical health.

In this respect, the Federations applaud the addition of the identification and analysis of psychosocial risks at work that may affect workers' health in the prevention program. For several years, it has been recognized that these risks are highly present in all workplaces and the health network is no exception. Healthcare professionals work in difficult conditions with staff shortages, mandatory overtime, work overloads and insufficient healthcare professional-to-patient ratios and it is high time that these risks are recognized. However, they believe that a mandatory training program on the topic would be necessary for health and safety representatives and health and safety committee members and that these risks should be identified jointly by the health and safety committee.

The COVID-19 pandemic has been ongoing since March 2020. Healthcare professionals are exposed to the virus every day. They suffer the direct consequences of not having a culture of prevention in the health and social services network. Poorly protected, many of them contracted COVID-19. For them to be able to continue to offer essential care and services to the population, the law has to offer them a healthy and safe work environment.

On that note, the Federations are very pleased about the application of all prevention mechanisms in the healthcare sector. Nonetheless, they deplore the fact that workers will have to wait several more years before they see the effects of these new measures. They believe that it is possible and preferable to put them in effect sooner. The Federations also find it incomprehensible that the risk for certain establishments, such as hospitals, was rated low, while every day workers in these environments are likely to carry out tasks that have quite high risk levels, both to their physical and psychological well-being. Consequently, they request that the risk classification and risk assessment be removed from the current Bill so that prevention measures may be applied the same across the board.

The Federations represent nearly 90% women and as such, they would like to highlight the addition of protocols to identify dangers and the associated working conditions for the purpose of applying the preventive withdrawal of pregnant or breastfeeding women. The FIQ and FIQP have wanted this for a long time. That said, they believe it is essential that these protocols be developed with the precautionary principle in mind, as well as women's health. As feminist labour organizations, they also commend the integration of the obligation for employers to take measures to ensure worker protection in situations of physical or psychological violence, including domestic and family violence. Given the sensitive nature of these situations, the FIQ and FIQP recommend that there be a mandatory training program for employers, and that it be based on domestic and family violence expertise developed by groups of women. Also, they believe that predominantly female work environments have always been neglected in terms of occupational health and safety. To truly modernize the regime, it is essential that the law stipulate that the scientific committees set up must take into account the particular effects work environments have on women's health, that there be representation for predominantly female sectors on the CNESST's board of directors and that there be an intersectional gender-based analysis (GBA+) of the AOHS and the AIAOD.

Introduction

The *Act respecting occupational health and safety* (AOHS) was passed over 40 years ago. The main objective of the Act is to eliminate dangers, at the source, to the health, safety and physical well-being of workers.[1] In 1985, the *Act respecting industrial accidents and occupational diseases* (AIAOD) came into effect with the objective to provide compensation for employment injuries and the consequences they entail for beneficiaries.[2] Despite the clear evolution of work environments and science, these laws have not been modernized since they were passed. This is why, for several years now, labour organizations, civil society groups and workers' rights groups have been calling for a reform of the preventive regimes for occupational health and safety and compensation for employment injuries.

First, in 1979, the government put Quebec's various organizations into categories, dividing them into 30 activity sectors that were then divided into six groups.[3] The law stipulated a gradual implementation of the various conditions provided for in the AOHS, limiting the application of certain sections to the two first priority groups. Even if the initial plan was to subject the other groups to all provisions, this never happened.

However, over the years, the statistics were clear. Implementation of all of the prevention mechanisms for certain groups tangibly decreased the number of compensated accidents. Unfortunately, group VI, the group that included the health and social services network, did not benefit from all of the mechanisms provided for in the Bill even though they demanded it. Since their founding, the Federations have always fought for the health sector to be recognized as a priority sector and for it to be subject to the four prevention mechanisms in the AOHS.

There is no question that it is essential to update the occupational health and safety regime. Since it was put in place, Quebec has fallen way behind in terms of prevention. It has an obligation to make up for this and to adopt a new, innovative regime that properly protects workers. It must be more in line with today's workplace realities and recognize those of healthcare professionals who work with the dying and deliver care to vulnerable people every day. The new regime must also promote development of a true culture of prevention across work environments. When the bill was presented on October 27, 2020, Minister Jean Boulet said himself that it is a necessity that workers work in healthy and safe environments where prevention is part of the work culture.[4]

For years they have been driving home the importance of prevention in the health network and the pandemic has exacerbated and highlighted the health network's vulnerability in this area. They made repeated requests to employers and government authorities to apply the precautionary principle and to give healthcare professionals appropriate personal protective equipment. Unfortunately, these requests went unanswered and a high number of workers

---

[1] *Act respecting occupational health and safety*, R.S.Q. 1979, c. S-2.1, s. 2

[2] *Act respecting industrial accidents and occupational diseases,* R.S.Q. 1985, chapter. A-3.001, s. 1

[3] LEGAULT, M-J. and DIONNE-PROULX, J. (2003). Problèmes de sécurité au travail, Québec, Télé-université, p. 23.

[4] https://www.quebec.ca/nouvelles/actualites/details/projet-de-loi-modernisant-le-regime-de-sante-et-de-securite-du-travail-le-ministre-jean-boulet-depos/ [Viewed on January 6, 2021]

contracted COVID-19. According to the Federations, the shortage of personal protective equipment and the prohibition to use some of the equipment contributed to the spreading of the virus, especially in residential centres.

The Federations recognize that the proposed reform shows some initiative to reinforce prevention. However, they remain concerned about the impacts of the changes to the regime on compensation for workers with employment injuries. While prevention can help to reduce work accidents, employment injuries will continue to occur. Workers must be able to count on a simple, effective, and fast compensation regime. There needs to be faster processing when a matter is contested. This regime also needs to reflect the modern reality of work environments and the impacts they have on workers' mental health. The Federations find that this Bill, despite some steps forward, does not contain provisions that promote recognition of work-related psychological disorders. Only post-traumatic stress disorder is found in the section on mental disorders and the criteria for its recognition are quite restrictive. This list must be expanded to recognize more diagnoses and to show a true desire to destigmatize mental health in the workplace.

As feminist labour organizations with members in the public and private sectors, the FIQ and FIQP had high expectations for this Bill. Since they were shortchanged in terms of prevention, the Federations welcome the application of all prevention mechanisms in the health network. This change will, in part, resolve the systemic discrimination against healthcare professionals in terms of prevention. That said, the FIQ and FIQP deplore the assignment and assessment of risk levels to establishments as they don't account for the observable reality in the health sector. Furthermore, they feel this Bill should be improved to better protect the rights of workers with employment injuries and to recognize the preponderance of the attending physician's opinion in terms of employment injuries and preventive withdrawal. The following sections present the Federations analysis of this Bill from the point of view of the nurses, licensed practical nurses, respiratory therapists and clinical perfusionists they represent.

Chapter 1 - *Act respecting industrial accidents and occupational diseases* (AIAOD)

The *Act to modernize the occupational health and safety regime* tabled on October 27, 2020, substantially changes the provisions in the AIAOD. For nearly 30 years, the FIQ and FIQP have been representing workers who are victims of employment injuries before the various bodies of the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) and before the Administrative Labour Tribunal (TAT). Consequently, the Federations believe it is important to pass their recommendations onto the lawmakers concerning the amendments to the Act's provisions.

DEFINITION OF SUITABLE EMPLOYMENT

The AIAOD stipulates that suitable employment must be determined when a worker retains their functional disability, which prevents them from returning to their job after an employment injury.

Currently, the Act requires that all of the suitable employment's tasks respect the functional disability of the worker resulting from their employment injury.

However, the new definition of suitable employment in the Bill includes the introduction of the notion of "essential tasks and the characteristics of that type of employment." This amendment to the definition means suitable employment can be determined when the essential tasks and the characteristics of it respect the functional disability of the worker. Consequently, non-essential tasks that the worker still has to perform as part of the suitable employment are not taken into account when determining the suitable employment.

For example, a technical assistant job in a pharmacy requires the worker to regularly lift boxes of medication weighing over five kilos. It is not an essential and characteristic task of the job, but it is a related duty that has to be done as part of the job. As such, even if a healthcare professional retains a functional disability and cannot lift loads over five kilos, the job could still be deemed suitable.

The Federations believe this amendment to the definition of suitable employment could compromise the original objective, which is to determine a job that a worker could reasonably hold while retaining their functional disability, which prevents them from returning to their pre-injury employment. Who would hire a worker who cannot do all of a job's duties? In reality, the worker would not only no longer be able to hold their pre-injury job but, in addition, would not be able to hold the suitable employment determined by the CNESST.

Recommendation 1

The FIQ and FIQP recommend maintaining the former definition of suitable employment as set out in section 2 of the AIAOD.

THE CAPACITY TO HOLD THEIR EMPLOYMENT OR AN EQUIVALENT EMPLOYMENT

Currently, section 48 of the AIAOD stipulates that the CNESST must assess the capacity of the worker to return to their pre-injury employment once their injury has consolidated with their functional disability.

The section also stipulates that if the worker refuses to return to their employment or equivalent employment, the CNESST will cease payments of the income replacement indemnity. The notion of equivalent employment is therefore currently a criterion that can be used to cease the payment of the income replacement indemnity if the worker has the capacity to return to their pre-injury job, and that job is no longer available, and they refuse to hold available equivalent employment.

In section 17 of the Bill amending section 48 of the AIAOD, the notion of "equivalent employment" was added before the first comma of the first clause in the section. This addition implies that the notion of equivalent employment will now also be used as a criterion to determine a worker's capacity to return to work.

The definition of equivalent employment is already provided for in section 2 of the AIAOD. It means employment of a similar nature to the employment held by the worker when he suffered the employment injury, from the standpoint of vocational qualifications required, wages, social benefits, duration and working conditions.

Healthcare professionals can occupy a vast diversity of positions. The Federations submit that the new definition would be detrimental to the workers they represent.

For example, the tasks of a healthcare professional who works in the emergency department are not the same as those of a healthcare professional who works for Info-Santé. And yet, these two healthcare professionals have the same professional qualifications and are subject to the same collective agreement. This means they have the same salary, the same social benefits, the same employment length and the same working conditions. All in all, the jobs of these two healthcare professionals could be qualified as "equivalent" as per section 2 of the AIAOD.

The new section 48 of the AIAOD could therefore allow for an assessment of the worker's capacity, not only based on the job they have, but also based on another job with the same job title that they cannot do.

Moreover, the notion of equivalent employment is also in sections 132 and 167.2 of the AIAOD. It explicitly states that the Commission shall cease to pay the income replacement indemnity if the worker does not need rehabilitation to do equivalent employment or to indicate that a gradual return to work could be planned if the worker has the capacity to hold equivalent employment.

Recommendation 2

The Federations request to withdraw the words “or an equivalent employment” before the first comma in section 48 and in sections 132 and 167.2 of the AIAOD.

INTERNSHIPS

The healthcare professionals represented by the Federations have to do internships to complete their studies. Consequently, the FIQ and FIQP applaud the improved protection for students who do an unpaid shadowing internship or work internship in the definition of the notion of a worker, which ensures they have full coverage under the law.

OCCUPATIONAL DISEASES

Section 29 AIAOD

Since the AIAOD was adopted in 1985, the list of presumed occupational diseases has not changed. This has created a major gap between the list of diseases in Schedule 1 of the Act, current scientific knowledge and international recommendations on their recognition.

The Federations therefore applaud the replacement of Schedule 1 of the AIAOD by a new regulation determining the list of occupational diseases, covered by section 29 (AIAOD), which is more up-to-date and easier to amend than a legislative text.

Furthermore, the Federations underline the addition of the post-traumatic stress disorder diagnosis in the diseases covered by section 29 of the AIAOD, but they recommend expanding the list of psychological diagnoses to include others that should also be covered by the regulation.

Confronted with increasingly difficult working conditions, healthcare professionals are more at risk of developing psychological occupational diseases, such as adjustment disorder and depression. The work overload and insufficient healthcare professional-to-patient ratios are just a few of the causes of exhaustion for these workers. Work environments should be safe places that promote mental health and the Act should take this reality into account in order to achieve reparation objectives and no longer neglect workers’ mental health.

What’s more, the draft regulation does not provide for the application of the presumption for a worker diagnosed with post-traumatic stress disorder after having been physically assaulted or threatened with bodily harm at work.

Lastly, the Federations believe that the new criteria for applying the presumption, which are even more coercive than those in the current schedule, are an added obstacle to gaining recognition of the application of section 29 of the AIAOD. This will make it even more difficult for healthcare professionals to qualify for occupational diseases.

Recommendation 3

The Federations recommend adding adjustment disorder and depression to the list of presumed occupational diseases.

Recommendation 4

The Federations propose to expand the grounds for the presumption of post-traumatic stress disorder diagnosis.

Section 30 AIAOD

The Federations question the eligibility criteria for an occupational disease covered by section 30 of the AIAOD found in section 8 in the Bill. These eligibility criteria that will be determined by regulation are in addition to those already set out in the current Act. The FIQ and FIQP believe that these criteria will limit the eligibility for these occupational diseases and be harmful for healthcare professionals and all workers.

Recommendation 5

The Federations recommend keeping the current text of section 30 of the AIAOD or removing the new part saying "...and who meets the eligibility criteria for the claim that may be prescribed by regulation..."

NEW SECTION 31.1 (SECTION 10 OF THE BILL)

A worker may discover years after being diagnosed with a disease that it has to do with their work. For example, a cancer that is related to material in the walls of a facility or a lung problem that is related to a defective ventilation system.

For this type of situation, the Bill introduces a limitation for the different indemnities that a worker can get. When a claim is submitted more than three years after a worker receives a diagnosis, there is a new presumption that the date on which the worker became unable to carry on their employment is the date on which the claim is filed. It aims to limit the amounts covered by the CNESST, especially for the income replacement indemnity, for prosthetics or orthopaedics, travel expenses, rehabilitation expenses, medical assistance and adapted equipment.

So, workers who, for reasons out of their control, learn more than three years after receiving a diagnosis that it was their workplace that made them sick will not have access to these benefits and reimbursements. That means that these workers not only have a difficult medical condition but they are also subject to economic injustice.

Recommendation 6

The Federations request to withdraw section 10 of the Bill amending section 31 of the AIAOD because it is harmful to workers.

INCOME REPLACEMENT INDEMNITIES

The Federations applaud the modification to section 44 of the AIAOD. This amendment introduced in section 16 of the Bill codifies the case law and makes it easier to understand its application. From now on, evaluations for the right to indemnities and the capacity to return to work will be based on the job held at the time the injury occurs, regardless of whether the worker held that same job at the time of the evaluation.

REHABILITATION

Rehabilitation before consolidation

The current Bill introduces a new notion of rehabilitation measures before the consolidation of an injury.

It gives significant powers to the CNESST, which it doesn't currently have, allowing it to order professional rehabilitation measures without even getting an opinion from the attending physician. This could conflict with the care or treatment prescribed by the worker's physician. These new powers could also conflict with the refusal of the physician who is in charge of authorizing the worker to do temporary assignment work.

As such, it constitutes a huge step back in terms of respect for and the importance given to the attending physician's opinion, which is crucial under the current Act.

Such measures ordered by the CNESST could even compromise the health of workers since the CNESST is not in the best position to evaluate the medical condition of a worker during their occupational injury consolidation period. CNESST agents do not have medical training qualifying them to do so.

Moreover, the current section 179 already sets out the conditions for temporary assignments and gives priority to the attending physician.

Recommendation 7

The Federations applaud the introduction of rehabilitation measures before injury consolidation but recommend limiting the CNESST's discretionary power and restoring the preponderance of the attending physician's opinion.

Recommendation 8

The Federations recommend specifying the type of rehabilitation measures required by the worker's health condition that could be set out in the regulation with the new section 145.2 of the AIAOD, introduced by section 27 of the Bill.

Recommendation 9

The Federations also recommend withdrawing the new section 145.4 of the AIAOD set out in section 27 of the Bill because the conditions of the temporary assignment are already determined in section 179 of the AIAOD.

Return to work with a permanent impairment and functional disabilities

The notion of undue hardship, introduced in sections 170, and those that follow, of the AIAOD is the codification of a 2018 decision by the Supreme Court of Canada.[5]

The Tribunal affirms that the Charter of Human Rights and Freedoms must be part of the AIAOD's rehabilitation process and orders the CNESST to ensure that the obligation to show reasonable accommodation is respected for workers who suffered an employment injury.

The Federations commend the introduction in section 37 of the Bill of the notion of undue hardship for an employer within the scope of reinstating a worker who retains damage from their employment injury, and the alignment of sections 170 to 170.3 of the AIAOD with case law on returns to work with after-effects.

The Federations also commend the implementation of a financial administrative sanction for an employer who refuses to comply with the obligations to collaborate in the process of determining a suitable employment as provided in sections 170.1 and 170.2 of the AIAOD. However, they question the compensation that the worker will receive should the employer refuse to comply with its obligations.

Recommendation 10

The Federations recommend that any worker for whom the employer refuses to comply with their legal obligations within the process of determining suitable employment receive income replacement indemnities for as long as and until a final decision has been rendered. The worker acquires these indemnities regardless of the final decision.

Workers aged 55 or 60

[5] CNESST c. Caron, 2018 CSC 3

Under the current Act, there is a presumption of disability for a worker aged 55 or older at the time of the onset of an occupational disease or at age 60 or older if they are the victim of a work accident.

As such, a worker who meets these criteria and is unable to resume their employment at the time of consolidation due to the after-effects of their injury will be entitled to income replacement indemnities until age 68 based on the conditions set out in section 56 of the AIAOD. Furthermore, the CNESST will not determine a suitable employment for the worker.

Section 19 of the Bill abolishes this age distinction and increases application of the section 53 of the AIAOD to age 60. In addition, the same section 19 of the Bill abolishes the presumption of disability. Consequently, the worker will likely have more difficulty holding suitable employment given the reality of the labour market, thus putting them at risk of undergoing a major financial hit if they do not take on the employment determined by the CNESST.

The Federations also highlight that the change from age 55 to 60 constitutes an unjustified loss of right for workers.

Recommendation 11

The Federations request the withdrawal of the age eligibility modification set out in section 19 of the Bill and demand to maintain the current text in section 53 of the AIAOD.

Physical rehabilitation

The current Act provides for three types of rehabilitation: physical, social and professional rehabilitation. Each one has a specific objective and is detailed in specific sections in the Act.

Now, Bill 59 abolishes, without explanation, the whole rehabilitation component, which is intended to eliminate or mitigate the physical incapacity resulting from an employment injury and to allow the worker to develop their residual capacity.

The elimination of this component, which is huge for workers, clearly aims to reduce costs of the regime and it takes away important workers' rights.

The new section 189 of the AIAOD, amended by section 51 of the Bill, will be a lot more restrictive than the current one. It could restrict the type, number and financial limit for necessary treatments, without consideration for the worker’s medical condition or the attending physician’s opinion. The CNESST’s agents do not have medical training and should not be permitted to act as a substitute for the attending physician and decide on the care required without even evaluating the worker. This decision should be based on the reasoning and clinical judgement of the worker’s attending physician.

Furthermore, the list of health services to which a worker with an employment injury is entitled is not exact. There needs to be a better definition of the notion of required health services.

Recommendation 12

The Federations recommend restoring the sections on physical rehabilitation after consolidation (146 to 150 AIAOD).

Social and professional rehabilitation

The social and professional rehabilitation programs are provided for in sections 152 and 167 of the AIAOD. For these programs, there is a non-exhaustive list of what they may include, which uses the term "in particular."

In section 33, the Bill removes the term "in particular," thus limiting the measures to what is set out in the Act or even in a future regulation.

Recommendation 13

The Federations recommend keeping the current text of sections 152 and 167 of the AIAOD.

Progressive return to work

Section 34 of the Bill introduces the progressive return to work within the scope of the professional rehabilitation measures, a concept which did not previously exist.

The length of the progressive return was set, without explanation, at a maximum of eight weeks, without taking the preponderance of the attending physician's opinion into account.

This measure should be determined so as to maximize the success of a progressive return to work. The attending physician has more in-depth knowledge of the worker's medical condition than a CNESST agent.

Recommendation 14

The Federations commend the introduction of the progressive return to work but request that its duration be determined by the attending physician.

Temporary assignment

The Federations commend the improved framework for temporary assignments, especially the mandatory use of the temporary assignment form in section 179 of the AIAOD, with a view to standardization.

They commend the clarification in section 180 of the AIAOD regarding the payment of income replacement indemnities for days not worked during a temporary assignment.

THE BUREAU D'ÉVALUATION MÉDICALE (BEM)

The current Act grants the worker's attending physician a crucial role with regard to five medical matters as set out in section 224 of the AIAOD: the diagnosis, necessity or adequacy of the care or treatment, the date of the consolidation and the permanent impairment of the worker. Unless the case has been evaluated by a member of the BEM, the CNESST is currently bound by the findings of the worker's attending physician regarding these five points.

When a worker is evaluated by one of the BEM's physicians because there is a dispute over one or several of these medical matters, the CNESST is then bound by the BEM's findings.

Time periods

The wait times for obtaining an evaluation from a BEM member can be extensive, especially for certain medical specializations, i.e., in psychiatry.

The Federations commend the introduction in section 63 of the Bill of new time periods for appointing a BEM member.

Distorted arbitration

In contrast, the Federations completely disagree with the content of section 64 of the Bill to amend section 219 of the AIAOD, which stipulates that if a BEM member cannot be appointed within the time period set out in section 218.1 of the AIAOD, either within 90 days or 120 days for some exceptions, the CNESST becomes bound by the report it obtained from the health professional it designated. As such, the attending physician's opinion, stored in a complementary report, is completely ignored despite their opposition to the conclusions of the CNESST's appointed physician. This totally distorts the very point of medical arbitration.

Moreover, the legislative amendment does not stipulate what would apply if the request to BEM follows the procedure set out in section 209 of the AIAOD, i.e., the medical evaluation done by the physician appointed by the employer. In such cases, could the CNESST have the worker evaluated and once again ignore or bypass the attending physician's opinion?

There would be a real risk of undue delay in appointing BEM members, in particular for certain more costly cases. This could allow things to go beyond the set time lines and indirectly rule out the attending physician's opinion, forcing the worker to return to work too early in an effort to save money for the regime.

Recommendation 15

The Federations request a full return to the full application of sections 224 and 224.1 of the AIAOD and all of their effects.

Discretionary power

The discretionary power of the BEM member is converted to an obligation in section 221 of the AIAOD.

In fact, section 66 of the Bill creates a new obligation for the BEM member to state their opinion on the consolidation and functional limitations of the injury. The opinion of the worker's attending physician is completely dismissed and they will not get another opportunity to give their opinion on these medical matters even though they are the best person to do so, having done the medical follow-up for the duration of the injury consolidation.

In addition, the Federations believe that the attending physician should always be consulted when they haven't yet given their opinion on the medical matters covered by section 224 of the AIAOD, for the same reasons mentioned in the previous paragraph.

Recommendation 16

The Federations recommend removing the obligation for the BEM member to state their opinion on the consolidation and functional limitations of the injury.

ONCOLOGICAL DISEASES

The Federations commend the introduction of the provisions on occupational oncological diseases in section 73 of the Bill.

Since this medical field requires specific expertise on these diseases, and part of the role of the committee is to analyze the results of the worker's various medical exams and determine if the worker is suffering from an occupational disease, the committee must be composed of members specialized in oncology.

Recommendation 17

The Federations recommend that the committee be composed solely of members who are specialized in oncology.

TIME LIMITS

Upon reading the Bill, it is clear that there are some efforts being made to attempt to speed up the judicial process. The FIQ and FIQP commend this, as it is positive for workers awaiting recognition of their employment injury. However, this stance must not work against workers' rights. The Federations would like to point out that the objective of the AIAOD should be to maximize access to the benefits provided for in this Act by way of broad and liberal interpretation.

The time limit for submitting a claim to the CNESST

Currently, a worker must submit their claim to the CNESST within six months of finding out that their disease is occupational.

The modifications in section 88 of the Bill covering section 272 of the AIAOD and the introduction of sections 272.1 to 272.3 create two parallel systems for occupational diseases.

Section 272.1 states that occupational diseases that fall within the presumption of section 29 of the AIAOD are subject to a time limit for filing the claim that is now six months from the date of the diagnosis. This takes away rights from workers who find out about the link between the disease and their work after the diagnosis was given.

The same section adds that in the event of a death related to an occupational disease, the claim must be filed within six months of the date of death if the disease had not been diagnosed at the time of death or within six months after the diagnosis was received. This addition takes away rights from a worker's beneficiary who learns too late about the link between the disease and work.

Section 272.2 implies that if the CNESST amends the regulation related to section 29 of the AIAOD, the worker will have six months from the coming into force of the amendment to file a claim. Therefore, in addition to the possible lack of immediate knowledge of the link between work and the disease, the Bill adds an additional constraint by requiring the worker to know the regulatory amendments made.

Section 272.3 maintains the time limit at six months from learning that the disease is occupational in the cases covered by section 30 of the AIAOD. This is in compliance with the interpretation of the former section 272 of the AIAOD.

Consequently, section 88 of the Bill creates injustice, procedural iniquities and two parallel systems based on the fact that the occupational disease is subject to the procedure in sections 29 or 30 of the AIAOD.

Recommendation 18

The Federations request to maintain the current section 272 of the AIAOD by removing section 88 of the Bill. They also maintain that the time limit for filing a claim should be within six months from the time they learn that the disease is occupational.

Change in circumstances

In section 102, the Bill introduces the right for the CNESST to render a new decision, at any time, if a change in circumstances affects a beneficiary's entitlement to a benefit.

This provision is a direct violation of the principle of stability in judgements. It would allow the CNESST to unilaterally and retroactively retract a previous decision to affect a worker's rights. Furthermore, this discretionary power given to the CNESST would not be limited in time since the section states "at any time." Remember that the CNESST already has the power to reconsider, which must be done within a determined time limit.

Recommendation 19

The Federations recommend removing section 102 of the Bill. In addition, if the section is not removed, they request that there be a time limit on its power to render a new decision. This time limit must be the same as the one set for the requests for reconsideration set out in section 365 of the AIAOD.

Claims past the time limit

When a worker files a claim outside of a time limit stipulated in the AIAOD, they must demonstrate that there were reasonable grounds for the failure to comply. The Commission may exceptionally relieve a worker from the consequences of a failure to file a claim within the prescribed time limit thus allowing them access to the benefits provided for in the Act.

Section 103 of the Bill amends section 352 of the AIAOD by introducing the time limit of three years. This is a direct attack on a worker's ability to access the regime. The Act already sets out prescribed time limits. A worker who files a claim after these time limits already has to carry out a huge task by showing credible and justified evidence.

Case law already exists on the interpretation of the seriousness and degree of proof required to be relieved of such a failure to comply. Adding the prescribed three years will only prevent workers from exercising rights that they were unable to exercise within the required time limits. It is totally unjust and goes against the objective of the Act.

Recommendation 20

The FIQ and FIQP request to remove section 103 of the Bill and to maintain the current section 352 of the AIAOD.

Time limits for contesting a decision and applying for administrative review before the Administrative Labour Tribunal (TAT)

The Federations commend the fact that the time limit for contesting a decision before the TAT is extended to 60 days. This amendment in section 108 of the Bill makes sense as it standardizes the time limit for contesting a decision before the TAT with that of the Tribunal administratif du Québec (TAQ) for exercising rights set out in other compensation regimes, in particular for automobile accidents.

However, the Federations deplore the fact that the time limit for requesting an administrative review of a CNESST decision, as set out in section 358 of the AIAOD, remains 30 days. To compare, a person who was in a car accident has 60 days to request an administrative review

at the SAAQ.[6] Administrative time limits should be standardized at all levels of the process of contesting a decision to guarantee that the principles of access to justice and fair treatment under the Act are respected.

Recommendation 21

The Federations request to amend section 106 of the Bill in order to introduce a 60-day time limit for filing a request for an administrative review.

Contesting before the TAT

The FIQ and FIQP commend the option to go before the Tribunal if the worker applied for a review and the CNESST has not rendered a decision within 90 days of receiving the application.

Furthermore, the Federations commend the option set out in section 110 of the Bill to go before the Tribunal in the cases covered by section 360 of the AIAOD, especially with regard to decisions following a BEM evaluation.

In addition to the objective to standardize rules among Quebec's administrative tribunals, these two measures will help to speed up the process of contesting a decision, which is a big step forward.

Recommendation 22

The FIQ and FIQP recommend that the option to go directly before the TAT apply to all decisions rendered by the CNESST.

Time limit for death benefits

In section 22, the Bill adds a prescribed time limit for claiming death benefits.

There will be a 5-year limit to claim death benefits after a worker's death, which could be damaging in any case when the connection between the employment injury and work is discovered late.

[6] *Automobile insurance Act*, L.Q. 1997, c. A-25, s. 83.45

Recommendation 23

The Federations recommend removing section 22 of the Bill because it is harmful for the beneficiaries of the deceased worker.

SCIENTIFIC COMMMITTEE ON OCCUPATIONAL DISEASES

The Federations commend creating a committee that will submit opinions and recommendations to the CNESST to determine the list of occupational diseases and keep it updated according to scientific advances. However, it is important to point out that the committee must pay special attention to the health of women at work. There are several blind spots in research on women's health at work. For example, Karen Messing found that several studies disregard the differences between men's and women's working conditions (employment conditions, type of duties, stress exposure, etc.) and how they could affect their health differently.[7] That means this lack of knowledge could also affect our compensation program. The huge discrepancy in cases of occupational diseases that were filed and accepted for women (11%) and men (89%) should be seen as a warning sign that there should be more investigation into the differences.[8] The Federations believe it is impossible for the scientific committee on occupational diseases to carry out its work without taking the specific impacts of work environments on women's health into account.[9]

Recommendation 24

The Federations recommend amending section 101 of the Bill in order to introduce into section 348.2 the obligation for the committee to carry out its work while taking into account the specific impacts of work environments on women's health.

[7] MESSING, Karen. 2000. *La santé des travailleuses : la science est-elle aveugle ?* Montréal : Éditions du remue-ménage.

[8] Commission des normes, de l'équité, de la santé et de la sécurité du travail du Québec, 2020, *Statistiques annuelles 2019*, Québec, p 96.

[9] For more information on these issues, please refer to the brief submitted by the Intersyndicale des femmes to the Commission de l'économie et du travail for the same Act.

Chapter 2 - *Act respecting occupational health and safety* (AOHS)

The AOHS was adopted in 1979 and has not had any major updates since it came into force. The Federations have long been waiting and hoping for this Act to be updated. For the FIQ and FIQP, there are major shortcomings in how the AOHS is applied, especially in the health and social services sector.

PROTECTIVE REASSIGNMENT

Protective reassignment due to exposure to a contaminant

The Federations commend the creation, in section 134 of the Bill, of a certificate prescribed by the CNESST for requests to apply section 32 of the AOHS. The FIQ and FIQP have been requesting that the certificate be created throughout the COVID-19 pandemic. Without it, it is difficult to apply for a protective reassignment in cases of exposure to a contaminant.

As it stands, neither the CNESST nor the Santé publique agents know their role for applying section 32 of the AOHS since there is no procedure to follow in the current context. The procedure and agents' role and responsibilities need to be clarified.

In addition to replacing the title of the physician in charge of health services within the establishment by that of physician in charge of occupational health, the Bill changes the way in which the latter is designated. Designating the physician in charge of occupational health is no longer a joint endeavour and falls under the employer's discretion. This physician is involved in the decision-making related to the process provided in section 32 of the AOHS. Consequently, the Federations recommend reviewing the process of appointment in the section about the health and safety committee in this brief.

Recommendation 25

The Federations request to establish a clear procedure and to determine the exact roles of the various people involved in applying the processes tabled under section 32 of the AOHS.

Preventive withdrawal and reassignment of a pregnant or breast-feeding worker

As proposed in section 142 of the Bill, the Federations commend the provincial standardization of protocols to identify dangers and the associated working conditions for the purpose of applying the preventive withdrawal of a pregnant or breastfeeding worker as outlined in the *For a Safe Maternity Experience* program.

That said, the COVID-19 pandemic highlighted the absence of a culture of prevention in the health and social services network. This shortcoming is particularly evident given the absence or lack of consideration for the precautionary principle. The Federations believe the precautionary principle must be applied when determining provincial protocols for the

preventive withdrawal of pregnant or breastfeeding workers. Furthermore, these protocols must also take into account the best practices of the various branches of regional public health management in order to maximize the protection of pregnant and breastfeeding workers and to comply with the Act's objectives.

The FIQ and FIQP represent over 90% women and thus believe it is necessary and relevant that women's health be taken into account when developing, evaluating and updating provincial protocols. The Federations believe that it is essential that there be a permanent multidisciplinary and independent committee to support the provincial public health director in carrying out their new obligations.

Recommendation 26

The Federations officially request that provincial protocols be developed based on the precautionary principle and that the best practices currently used in the various branches of regional public health management be integrated into provincial protocols.

Recommendation 27

The Federations recommend setting up a permanent, independent, multidisciplinary committee to collaborate with the provincial public health director to develop, implement, evaluate and update protocols, and that the committee be composed of women's health experts.

Moreover, the Federations point out that objectives to standardize the right to preventive withdrawal should also be aligned with the specificities of each worker's working conditions. To achieve this objective, the opinion of the physician providing pregnancy care for the worker must be taken into account.

However, section 139 of the Bill would limit the role of the physician providing pregnancy care as regards determining dangers. According to the Federations, this new section does not respect the specificities of each worker's working conditions and could endanger the health and safety of the pregnant or breastfeeding worker and that of the unborn child.

Recommendation 28

The Federations request that the opinion of the physician providing pregnancy care always be prioritized regardless of whether the danger has or hasn't been identified by a protocol so as to take into account the specificities of each worker's working conditions.

DOMESTIC VIOLENCE

Domestic violence doesn't stop when victims leave home. In a Pan-Canadian survey conducted in partnership with the Canadian Labour Congress, 53.5% of respondents who are victims of domestic violence said that domestic violence followed them to work.[10] The risks associated with domestic violence in the workplace are increasingly recognized and taken into account in different programs and legal frameworks (occupational health and safety programs in other Canadian provinces, C190 - Violence and Harassment Convention, etc.) and Quebec has been falling behind. For example, the last government action plan on domestic violence only aimed to "Support initiatives in the workplace that aim to prevent and counter domestic violence."[11]

That is why the Federations commend the introduction of the obligation for employers to take measures to ensure worker protection in situations of physical or psychological violence, including domestic and family violence.

It is nonetheless important to point out that employers cannot simply improvise in providing people to help with domestic violence. In this respect, the Federations are concerned about the application of this obligation, which could have adverse effects if it is not done in a rigorous manner or if it does not use the knowledge and experience of specialized resources in matters of domestic violence. For example, an employer who interprets their obligation in a way that obliges the victim of domestic violence to divulge their situation would actually be harming the victim's chances of freeing themselves from their situation. Consequently, the Federations would like to flag the importance of providing adequate guidance for employers in complying with this new obligation.

Recommendation 29

The FIQ and FIQP recommend a mandatory training program on managing cases of domestic and family violence for employers. They recommend that the program be based on women's groups' expertise on domestic and family violence.

Recommendation 30

The FIQ and FIQP recommend that the employer-implemented prevention programs and intervention methods be developed using an approach that promotes women's well-being

[10] WATHEN, C. N., MACGREGOR, J. C. D., MACQUARRIE, B. J. with the Canadian Labour Congress. (2014). Can Work be Safe, When Home Isn't? Initial Findings of a Pan-Canadian Survey on Domestic Violence and the Workplace. London, ON: Centre for Research & Education on Violence Against Women and Children.

[11] GOUVERNEMENT DU QUÉBEC. (2018) *Government Action Plan on Domestic Violence 2018-2023*, p. 29

and autonomy. Furthermore, that resources specialized in domestic and family violence must be consulted.

PREVENTIVE MECHANISMS

The FIQ and FIQP feel it is important to mention that the health and social services sector has never been recognized as a priority group as regards the AOHS. This lack of recognition means that for far too long occupational health and safety prevention for healthcare professionals in healthcare institutions has been subject to employers' discretion or goodwill. To this end, in 2010 they issued their observations and recommendations to the task force on Quebec's occupational health and safety regime, chaired by Viateur Camiré.

This issue has many consequences. Still very much a problem, the fact that employers of the health and social services sector are not subject to the AOHS's regulatory provisions related to joint prevention mechanisms means that healthcare professionals are deprived of important leverage that would otherwise enable them to take steps to protect their health and safety. Whether it be the prevention program, an institution's own health program, the health and safety committee or the prevention representative, had these mechanisms been used, then the necessary resources could have been dedicated to truly implementing preventive measures. However, very few employers actually put the necessary effort and care in to voluntarily implement such mechanisms and to tackle occupational health and safety problems preventively because they are not obliged to.

The Federations can only speculate as to why the health and social services sector is still today not recognized as a priority group. The statistics are clear though and show that it is high time to act preventively in this sector. Why do employers and their representatives show so much resistance to applying what is in the Act and regulations? Is it due to the potential cost of implementing joint prevention mechanisms? Is it because of the co-management that casts a shadow on some of their management rights, which they do not want to part with? Or both? Why does it take a bill to enforce what should have been done for many years now?

The Federations firmly believe that to reduce the number of employment injuries in the health sector, which is predominantly female, you must implement specific, efficient prevention mechanisms in all network institutions. It is time for this sector's workers to benefit from all of the rights and prevention mechanisms set out in the AOHS and its regulations, just like the predominantly male sectors.

In the past, the Federations have always pleaded in favour of applying the Act's provisions without needing to make legislative changes. Indeed, all that would have been required would have been to progressively enforce them, as initially planned when the Act was adopted in 1979. However, that is not what happened and now here is Bill 59 attempting to correct that.

Prevention program

The FIQ and FIQP are very happy that from now on “every employer must prepare and implement a prevention program specific to each establishment employing at least 20 workers,” as provided in section 146 of the Bill and amending section 58 of the AOHS. That said, they believe it is still possible, in some cases, to group together institutions that carry out similar activities to develop and roll out one sole prevention program (section 58.1 of the AOHS). This is particularly true for the health and social services sector where the notion of “establishment” refers more to the reality of the “facility.” That said, the relevance of such groups would have to be evaluated and determined in collaboration with the unions and not unilaterally by the employer. It is absolutely essential that the workers’ and their representatives’ expertise be taken into account in the evaluation.

Recommendation 31

The Federations recommend that groupings of institutions that perform similar activities be determined by an agreement between the employer and the unions (section 58.1 of the AOHS).

Furthermore, the Federations are in favour of the addition to section 147 of the Bill regarding the identification and analysis of the risks that may affect the health of the establishment's workers, including psychosocial risks related to the work.

The FIQ and FIQP are very pleased about the introduction of the notion of psychosocial risks into the Bill. Specifically providing for their identification, recognition and analysis in the legislative provisions speaks to the urgency (now admitted) to tend to them. Stress, psychological harassment and workplace violence, increased absenteeism and presenteeism and mental health problems related to work are all increasingly concerning and can no longer be ignored, downplayed or swept under the rug.

For years, healthcare professionals' increased work pace and load has been denounced. A workplace that relentlessly pushes workers to do more with less resources has serious repercussions. In particular, organizational constraints like staff shortages, excessive workloads and overuse of mandatory overtime are all things that add to healthcare professionals' mental load. Furthermore, it also has a huge impact on the meaning they derive from their work, a profession that is focused on human relations. Consequently, it is crucial that the mental health of healthcare professionals become a priority for both employers and the government.

The findings of several mental health studies helped to identify psychosocial risk factors which, when present in a workplace, seriously contribute to psychological health problems. The psychosocial risk factors in the workplace are defined as "factors related to the organization of work, management practices, work conditions and social relationships that increase the likelihood of causing harm to the physical and psychological health of the people exposed to them."[12] (Unofficial translation) To properly address them would require basic prevention, which has been neglected for far too long.

Consequently, the FIQ and FIQP commend the addition of the identification and analysis of the risks that may affect the health of the establishment's workers in the prevention program, including psychosocial risks related to the work. However, they believe that a mandatory training program on the topic would be necessary for health and safety representatives and health and safety committee members (sections 35 and 37 of the Regulation respecting prevention mechanisms).

[12] https://inspq.qc.ca/risques-psychosociaux-du-travail-et-promotion-de-la-sante-des-travailleurs/risques-psychosociaux-du-travail [Viewed on January 7, 2021].

Recommendation 32

The Federations recommend a mandatory training program on the identification and analysis of psychosocial risks for health and safety representatives and health and safety committee members (sections 35 and 37 of the Regulation respecting prevention mechanisms).

Health and safety committee

One principle that the Federations fight adamantly for is joint collaboration. It is the basis for any prevention planning/implementation and one of the factors that will determine the success of any such initiative.

For the FIQ and FIQP, joint collaboration goes well beyond the number of representatives of each party on a committee. It speaks to the importance attributed to the genuine participation of workers and their representatives, to their expertise and knowledge of the range of possible solutions for a given problem. As such, joint collaboration becomes a way of operating, a work and decision-making process in pursuit of a common goal that includes actively seeking out consensual solutions. Transparency, a commitment to cooperating, a culture of collaboration and not confrontation: these are all conditions that are essential to smooth running joint work. It is especially the case in the health and social services sector where there is a lot to gain by jointly tackling prevention. This type of co-management does not exist in Quebec's healthcare institutions because healthcare sector employers are not subject to the prevention mechanisms set out in the AOHS and its regulations.

Joint collaboration has to be genuine and not only a façade. Too often employers simply inform the union party without actually trying to get it actively involved in occupational health and safety initiatives. Joint collaboration is therefore an issue. This is all the more true in a context where health and safety committees have to be completely reorganized.

Given the situation previously mentioned, the FIQ and FIQP commend the introduction, to section 152 of the Bill, of the obligation to set up a health and safety committee within an establishment with at least 20 workers. This measure will compensate for the shortcomings in the field, such as the employers' failure to invest in such a prevention mechanism when not obliged to. What's more, the obligation to set up a health and safety committee will guarantee space for holding joint discussions on prevention rather than reparation. With its assigned functions, this mandatory committee will finally make it possible to deal with issues related to the health and safety of workers, particularly healthcare professionals working in the health and social services sector.

The FIQ and FIQP still believe, however, that it is possible to have one health and safety committee in a context where one sole prevention program applies to several establishments that perform similar activities, as mentioned earlier. However, to this end, the matter of setting up one sole committee would also have to be evaluated and determined in collaboration with the unions.

Recommendation 33

The Federations recommend that in a context where one sole prevention program would apply to several establishments where similar activities are performed, the setting up of one sole committee would have to be determined by agreement with the unions (section 68.1 of the AOHS).

Furthermore, the Federations are in favour of the option of having an expert participate, upon invitation and without the right to vote, in the health and safety committee meetings. It could be very useful in some situations to consult an external expert in order to clarify the committee's work. That said, the FIQ and FIQP have questions about the conditions of participation of the expert stipulated in section 155 of the Bill.

Recommendation 34

The Federations recommend that the selection of an expert be subject to a consensus within the health and safety committee.

Regarding the selection of a physician responsible for the health services in an establishment, the FIQ and FIQP are concerned that this function was taken from the health and safety committee. They believe that this choice should be made as part of the committee's work and not unilaterally by the employer, especially because the physician is closely tied to the process of determining the content of the establishment's health program.

Recommendation 35

The Federations recommend that the health and safety committee remain responsible for choosing the physician in charge of the establishment's health services and that section 156 of the Bill be amended in consequence.

Similarly, the FIQ and FIQP deplore the fact that this important function was removed from the health and safety committee, namely to approve the health program developed by the physician in charge of the establishment's health services.

That said, the Federations still commend the assignment of certain functions to the health and safety committee, including to:

- Determine the OHS training and information programs;
- Cooperate in the preparation, updating and follow-up of the prevention program;
- Participate in the identification and analysis of risks that may affect the health and safety of the workers (section 78 of the AOHS).

All the same, the FIQ and FIQP believe that the health and safety committee's functions should include psychosocial risks. As such, in line with section 59 of the AOHS, the identification and analysis of psychosocial risks should be clearly stipulated in the committee's functions.

Recommendation 36

The Federations recommend that section 156 of the Bill be amended so that the identification and analysis of psychosocial risks be specifically added to paragraph 6 of section 78 of the AOHS.

The Federations also commend the obligation for health and safety committee members to participate in training programs offered by the CNESST. However, the content of this training must cover all risks (section 35 of the Regulation respecting prevention mechanisms).

Recommendation 37

The Federations recommend adding "the identification and analysis of the risks, namely psychosocial risks that may affect the health and safety of the establishment's workers" to paragraph 5 of section 35 of the Regulation respecting prevention mechanisms.

The FIQ and FIQP deplore that the legislation limits the matters over which the health and safety committee can request an intervention from the Commission to decide on a dispute between the parties (section 78 of the AOHS). The Bill provides for this only in cases where there is disagreement over determining, within the prevention program, OHS training and information programs or the choice of the means and personal protective equipment best suited to workers' needs. However, the Federations are also of the opinion that an intervention by the Commission could be relevant and necessary when a dispute arises, particularly as regards the health and safety committee's level of collaboration in developing, updating and following-up with the prevention program. Such an intervention could also be necessary if there is a disagreement at the time of identifying and analyzing the risks that may affect the health and safety of the establishment's workers, or at the time of identifying contaminants and dangerous substances present in the workplace. The current health crisis clearly demonstrates how important this issue is in this field.

Recommendation 38

The Federations recommend that section 158 of the Bill be amended to introduce the option for the health and safety committee to be able to send their recommendations in writing to the employer and submit a dispute to the Commission for situations covered by paragraphs 5 and 6 in section 79 of the AOHS.

Health and safety representative

The FIQ and FIQP commend the addition to section 164 of the Bill regarding the opportunity for the health and safety representative to make recommendations to the health and safety committee and the employer regarding psychosocial risks related to work. Similarly, they are in favour of the obligation for the health and safety representative to participate in the CNESST's training programs. However, they believe that this training must specifically include notions related to psychosocial risks.

Recommendation 39

The Federations recommend that paragraph 9 of section 90 of the AOHS be amended as follows: "To participate in the identification and analysis of risks that may affect the health and safety of the establishment's workers, namely the psychosocial risks, and the identification of contaminants and dangerous substances present in the workplace."

TRANSITIONAL PROVISIONS

The FIQ and FIQP deplore the late coming into force of these prevention mechanisms. For some establishments, there will be an imposed delay of several years; it will be even longer before they will be able to see the actual impact of these measures. In reality, it will be an implementation of prevention mechanisms at "three speeds" based on the risk level associated with the various activity sectors. The Federations believe that it is possible and preferable for them to come into force sooner so that healthcare professionals can more quickly benefit from these prevention mechanisms. The urgent need for action has been demonstrated. The numbers speak for themselves and truly tackling prevention means taking concrete action and fast. The health and social services network cannot afford to wait any longer.

Recommendation 40

The Federations recommend that section 285 of the Bill be amended so as to make January 1, 2023 the date the provisions in the AOHS come into force for all activity sectors.

REGULATION RESPECTING PREVENTION MECHANISMS

The FIQ and FIQP would like to state that they firmly disagree with the classification of risk levels in Schedule 1 of the *Regulation respecting prevention mechanisms*. The proposed classification does not take the observable reality in the health and social services sector into account. For example, it is surprising that general medical and surgical hospitals are classified as having a low risk given the scope of problems that are encountered there and the observable dangers to the health and safety of healthcare professionals. Furthermore, the diversity of activities carried on in these establishments can create significant bias at the time of the risk level evaluation.

This classification has a major impact on an establishment's capacity to take preventive action. It determines the scope of the prevention mechanisms and the time limit for rolling them out. The Federations feel this classification is unnecessary. Since it is impossible to properly represent the complexity and diversity of the activities carried out in a healthcare establishment, they believe that all settings should have efficient prevention mechanisms without needing to resort to a hierarchical classification. The risks that characterize the activities carried out in the health and social services sector are very real and cannot be reduced to simple low, medium or high risk levels. It perpetuates the same problem as the notion of priority groups, which is to say the fact that employers are not subject to certain obligations and therefore do not implement prevention mechanisms in a number of workplaces that are harmful.

Recommendation 41

The FIQ and FIQP believe that the notion of risk levels should be removed from the Bill and that in its stead standard prevention mechanisms should be rapidly implemented in all sectors of activity of the health and social services network.

JOINT SECTOR-BASED ASSOCIATION

The FIQ and FIQP are concerned about the effect of the Bill on the autonomy of joint sector-based associations (JSBA). In a sector as complex as that of health, implementing prevention mechanisms would significantly increase and diversify support requests to the JSBA. As such, the FIQ and FIQP believe it is essential to maintain the autonomy of joint associations for determining their priorities. Though JSBAs are held accountable, the role of a JSBA differs from that of the CNESST namely by the support it provides to the setting on issues, which are identified and targeted by the setting, and which sometimes go beyond the priorities set by the CNESST. Furthermore, the CNESST's methods for determining priorities have significant biases, in particular by the use of the number of injuries approved. This data does not take into account all of the risk factors present in workplaces. For example, the CNESST seldom

compensates psychological injuries, which are already seriously under-reported. Prevention actions can also cover emerging risks. The accountability introduced by the Bill, while necessary, should not limit the ability of joint sector-based associations to intervene when the setting deems it necessary. The purpose of the Act is not limited to the CNESST's priorities; preventive actions must address all risk factors identified in a workplace.

Recommendation 42

The Federations recommend that paragraph 2 of section 26 of the *Regulation respecting joint sector-based associations on occupational health and safety* be amended by inserting at the end of paragraph 2: "in particular with respect to the priorities communicated to it by the Commission."

THE CNESST

The FIQ and FIQP are concerned by the underrepresentation of predominantly female employment sectors on the Commission's board of directors, and this, despite the current appointment methods set out in the AOHS in the first subsection of the first paragraph in section 141. Today, women hold nearly half of the jobs in Quebec: the service sector occupies a more significant portion of the labour market and the healthcare sector monopolizes the largest portion of the Quebec budget. Since the Act was passed in 1979, predominantly female sectors like the healthcare sector have been largely neglected in terms of prevention, despite having a particularly high injury rate. The FIQ and FIQP believe that it is necessary to have representation for predominantly female sectors on the board of directors, in particular to reflect the evolution of the labour market.

Recommendation 43

The Federations recommend that section 187 of the Bill be amended so as to replace paragraph 2 of section 141 with: seven members chosen from lists provided by the most representative union associations, of which at least three members from union associations with at least a 51% female membership (s. 141, paragraph 2).

The FIQ and FIQP are pleased that the functions of the president and chief executive officer and the chair of the board of directors can no longer be combined in compliance with the *Act respecting the governance of state-owned enterprises*.[13] The Auditor General of Québec pointed out this shortcoming in 2015 in their report and the Federations second it.

The FIQ and FIQP are very concerned about the CNESST's ability to oversee prevention[14] and implement prevention mechanisms in Quebec. Since funding for governmental prevention inspection was withdrawn, the number of inspectors has not kept pace with the growth in the

[13] R.S.Q., c. G-1.02

[14] In Quebec, prevention and compensation fall to the same organization, unlike in other Canadian provinces such as Ontario.

number of employers subject to prevention mechanisms.[15] With over 220,000 employers registered with the occupational health and safety regime, the majority of which will eventually be subject to prevention mechanisms, monitoring and controlling the prevention measures put in place will be crucial. The healthcare sector is a complex setting where recognized and unrecognized employment injuries are constantly on the rise. There is a significant risk that the CNESST will not allocate enough resources to prevention activities, in particular to those carried out in the field. The current public health emergency clearly demonstrated the Commission's difficulties in dealing with its obligation to monitor and control prevention in the healthcare sector.

Recommendation 44

The Federations recommend setting up a working committee of experts to study the possibility of assigning the controlling and monitoring of prevention functions to a ministry or public service organization and then for it to submit its recommendations to the government.

[15] In Ontario, the Ministry of Labour is responsible for managing prevention and inspection activities, which are financed by the government.

Chapter 3 – Ensuring that health and safety laws do not discriminate against anyone

To properly and fairly protect all Quebec workers, health and safety laws must take the current reality of the labour market into account. Still today, there are major differences between jobs held predominantly by men and predominantly by women. In 2016, approximately 40% of the female workforce was concentrated in 10 professions.[16] However, occupational health and safety laws were written with a focus on the dangers of predominantly male environments, such as construction and the mining industry. While this Bill will help to improve the consideration of some aspects of issues specific to predominantly female work environments, it is indisputable that there is a lot more progress to make. What's more, another reality of the labour market deserves our attention: the concentration of certain groups or communities within certain job types. For example, in Canada, one black woman out of three works in the health and social services sector.[17] To ensure that health and safety laws do not discriminate, they must take this labour market reality into consideration, which means first it must be documented.

Access to this data and studies is therefore the cornerstone for achieving these objectives. However, as regards the study of occupational health and safety in relation to gender, the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRRST) says there are few studies on the subject.[18] Improving collective knowledge in these areas is all the more important since, among the few studies available, several reveal the difficulties for various occupational health and safety programs to protect and compensate women in the same way as men.[19]

For the FIQ and FIQP, in addition to being responsible for funding the research, the government is responsible for ensuring that data generated by enforcing occupational health and safety laws is available. The government must also take this data into account when evaluating its actions and make changes as needed. Were the government also to integrate the gender-based analysis (GBA) approach for occupational health and safety laws, well, that would also constitute true progress. The GBA "involves preventing the perpetuation or creation of gender inequalities by determining how a project like a law, regulation, policy, strategy, action plan, program, measure, service, or any relevant decision might affect the public. GBA can help fight systemic discrimination arising from the most innocuous-seeming interventions. It can be used at any stage in a project, from preparation to implementation and assessment."[20] The Federations also believe that gender-based analysis should integrate an intersectional perspective (GBA+). This perspective helps to incorporate into the analysis

---

[16]Council on the Status of Women. 2018. *Portrait des Québécoises en 8 temps.*

[17] Statistics Canada, 2020, *Changes in the socioeconomic situation of Canada's Black population, 2001 to 2016.*

[18] IRRST. 2017. *Plan quinquennal de production scientifique et technique 2018-2022*.

[19] For examples of flaws, you can refer to: Cox, Rachel and Katherine Lippel. 2008. Falling through the Legal Cracks: The Pitfalls of Using Workers Compensation Data as Indicators of Work-Related Injuries and Illnesses, *Policy and Practice in Health and Safety*, vol. 6, no 2, p. 9-30.

[20] Secrétariat à la Condition féminine. 2017. *Government Strategy for Gender Equality Toward 2021*, p. 32.

the multitude of social divisions that intersect, overlap and influence each other,[21] including race, social status, citizenship status, etc. The Canadian government has already committed to fully implementing gender-based analysis across its departments and agencies.[22] In Quebec, the Secrétariat à la Condition féminine has been working with GBA for a number of years and could integrate it into its framework legislation stemming from the *Government Strategy for Gender Equality Toward 2021*. However, if the past is any indication of the future, we shouldn't expect occupational health and safety laws to be reformed to integrate the GBA+.

Recommendation 45

The Federations recommend integrating the requirement for the government to conduct a gender-based analysis from an intersectional perspective (GBA+) of the AOHS and the AIAOD. These findings must be available to the public.

[21] HILL COLLINS, Patricia and Sirma BILGE, 2016, *Intersectionality*. Polity Press.

[22] GOVERNMENT OF CANADA, *Status of Women Canada, Privy Council Office and Treasury Board of Canada Secretariat Action Plan (2016-2020), Audit of Gender-based Analysis, Fall 2015 Report of the Auditor General of Canada*, available via this link: https://cfc-swc.gc.ca/gba-acs/plan-action-2016-en.html.

Conclusion

Overall, the Federations have mixed views on the current version of the Bill. For one, they can only commend the full application of prevention mechanisms in the health and social services sector. That said, it will be done late and use a risk classification that is disconnected from the reality in the field. The FIQ and FIQP are very concerned that past errors will be repeated in the future. Even though in 1979 the law stipulated a gradual application of the prevention mechanisms, it must be noted that at the time the Bill was tabled, they still only applied to some sectors. Today, with the introduction of the risk level classification and delayed application of measures, the law continues to deny the right of all workers, especially those in the health and social services sector, to safe workplaces.

With respect to reparation measures, the Federations are pleased with the step taken towards speeding up the judicial process for handling disputes. However, they are worried about the proposed time limit for filing claims and the criteria for having them recognized. These restrictions will violate workers' rights to be compensated for employment injuries, which is one of the law's main objectives. Furthermore, the Federations denounce the loss of preponderance of the attending physician's opinion on the evaluation, follow-up and care necessary for a worker with an employment injury or for those who exercise their right to the preventive reassignment of pregnant or breast-feeding workers. The Federations believe the attending physician's opinion should maintain authority so as to ensure workers' health and safety.

Moreover, the Federations are worried about the CNESST's ability to fulfil some of its compensation obligations while carrying out its role in controlling and monitoring. They believe that applying prevention mechanisms will require significant resources. Many new prevention responsibilities in workplaces will emerge and a great number of employers will now be subject to prevention mechanisms. This last year in a pandemic has shown us that there are many shortcomings in this regard.

What's more, as feminist labour organizations that represent members in the public and private sectors, the FIQ and FIQP sincerely hope to see the Bill improved in order to take into account the reality of women in the workplace. They commend the introduction of the obligation for employers to take measures to ensure worker protection in situations of physical or psychological violence, including domestic and family violence. That said, there needs to be concrete actions to, among other things, implement GBA+ in order to take into consideration the specific impacts the Bill and various healthcare regulations have on women's health and safety.

Bill 59 is the perfect opportunity to build a true culture of prevention in the health and social services sector. Healthcare professionals have waited over 40 years to obtain the same occupational health and safety rights as their colleagues in predominantly male sectors. They should be able to depend on a healthy and safe work environment. Once again, the pandemic demonstrated that healthcare professionals are essential and their work environments have high risks that can threaten their health and safety. This legislation needs to demonstrate a genuine desire to properly protect them so that they can continue to offer safe, quality care. The population's health depends on it.

List of recommendations

Recommendation 1

The FIQ and FIQP recommend maintaining the former definition of suitable employment as set out in section 2 of the AIAOD.

Recommendation 2

The Federations request to withdraw the words “or an equivalent employment” before the first comma in section 48 and in sections 132 and 167.2 of the AIAOD.

Recommendation 3

The Federations recommend adding adjustment disorder and depression to the list of presumed occupational diseases.

Recommendation 4

The Federations propose to expand the grounds for the presumption of post-traumatic stress disorder diagnosis.

Recommendation 5

The Federations recommend keeping the current text of section 30 of the AIAOD or removing the new part saying “...and who meets the eligibility criteria for the claim that may be prescribed by regulation...”

Recommendation 6

The Federations request to withdraw section 10 of the Bill amending section 31 of the AIAOD because it is harmful to workers.

Recommendation 7

The Federations applaud the introduction of rehabilitation measures before injury consolidation but recommend limiting the CNESST’s discretionary power and restoring the preponderance of the attending physician’s opinion.

Recommendation 8

The Federations recommend specifying the type of rehabilitation measures required by the worker's health condition that could be set out in the regulation with the new section 145.2 of the AIAOD, introduced by section 27 of the bill.

Recommendation 9

The Federations also recommend withdrawing the new section 145.4 of the AIAOD set out in section 27 of the Bill because the conditions of the temporary assignment are already determined in section 179 of the AIAOD.

Recommendation 10

The Federations recommend that any worker for whom the employer refuses to comply with their legal obligations within the process of determining suitable employment receive income replacement indemnities for as long as and until a final decision has been rendered. The worker acquires these indemnities regardless of the final decision.

Recommendation 11

The Federations request the withdrawal of the age eligibility modification set out in section 19 of the Bill and demand to maintain the current text in section 53 of the AIAOD.

Recommendation 12

The Federations recommend restoring the sections on physical rehabilitation after consolidation (146 to 150 AIAOD).

Recommendation 13

The Federations recommend keeping the current text of sections 152 and 167 of the AIAOD.

Recommendation 14

The Federations commend the introduction of the progressive return to work but request that its duration be determined by the attending physician.

Recommendation 15

The Federations request a full return to the full application of sections 224 and 224.1 of the AIAOD and all of their effects.

Recommendation 16

The Federations recommend removing the obligation for the BEM member to state their opinion on the consolidation and functional limitations of the injury.

Recommendation 17

The Federations recommend that the committee be composed solely of members who are specialized in oncology.

Recommendation 18

The Federations request to maintain the current section 272 of the AIAOD by removing section 88 of the Bill. They also maintain that the time limit for filing a claim should be within six months from the time they learn that the disease is occupational.

Recommendation 19

The Federations recommend removing section 102 of the Bill. In addition, if the section is not removed, they request that there be a time limit on its power to render a new decision. This time limit must be the same as the one set for the requests for reconsideration set out in section 365 of the AIAOD.

Recommendation 20

The FIQ and FIQP request to remove section 103 of the Bill and to maintain the current section 352 of the AIAOD.

Recommendation 21

The Federations request to amend section 106 of the Bill in order to introduce a 60-day time limit for filing a request for an administrative review.

Recommendation 22

The FIQ and FIQP recommend that the option to go directly before the TAT apply to all decisions rendered by the CNESST.

Recommendation 23

The Federations recommend removing section 22 of the Bill because it is harmful for the beneficiaries of the deceased worker.

Recommendation 24

The Federations recommend introducing into section 348.2 the obligation for the committee to carry out its work while taking into account the specific impacts of work environments on women's health.

Recommendation 25

The Federations request to establish a clear procedure and to determine the exact roles of the various people involved in applying the processes tabled under section 32 of the AOHS.

Recommendation 26

The Federations officially request that provincial protocols be developed based on the precautionary principle and that the best practices currently used in the various branches of regional public health management be integrated into provincial protocols.

Recommendation 27

The Federations recommend setting up a permanent, independent, multidisciplinary committee to collaborate with the provincial public health director to develop, implement, evaluate and update protocols, and that the committee be composed of women's health experts.

Recommendation 28

The Federations request that the opinion of the physician providing pregnancy care always be prioritized regardless of whether the danger has or hasn't been identified by a protocol so as to take into account the specificities of each worker's working conditions.

Recommendation 29

The FIQ and FIQP recommend a mandatory training program on managing cases of domestic and family violence for employers. They recommend that the program be based on women's groups' expertise on domestic and family violence.

Recommendation 30

The FIQ and FIQP recommend that the employer-implemented prevention programs and intervention methods be developed using an approach that promotes women's well-being and autonomy. Furthermore, that resources specialized in domestic and family violence must be consulted.

Recommendation 31

The Federations recommend that groupings of institutions that perform similar activities be determined by an agreement between the employer and the unions (section 58.1 of the AOHS).

Recommendation 32

The Federations recommend a mandatory training program on the identification and analysis of psychosocial risks for health and safety representatives and health and safety committee members (sections 35 and 37 of the *Regulation respecting prevention mechanisms*).

Recommendation 33

The Federations recommend that in a context where one sole prevention program would apply to several establishments where similar activities are performed, the setting up of one sole committee would have to be determined by agreement with the unions (section 68.1 of the AOHS).

Recommendation 34

The Federations recommend that the selection of an expert be subject to a consensus within the health and safety committee.

Recommendation 35

The Federations recommend that the health and safety committee remain responsible for choosing the physician in charge of the establishment’s health services and that section 156 of the Bill be amended in consequence.

Recommendation 36

The Federations recommend that section 156 of the Bill be amended so that the identification and analysis of psychosocial risks be specifically added to paragraph 6 of section 78 of the AOHS.

Recommendation 37

The Federations recommend adding “the identification and analysis of the risks, namely psychosocial risks that may affect the health and safety of the establishment’s workers” to paragraph 5 of section 35 of the Regulation respecting prevention mechanisms.

Recommendation 38

The Federations recommend that section 158 of the Bill be amended to introduce the option for the health and safety committee to be able to send their recommendations in writing to the employer and submit a dispute to the Commission for situations covered by paragraphs 5 and 6 in section 79 of the AOHS.

Recommendation 39

The Federations recommend that paragraph 9 of section 90 of the AOHS be amended as follows: “To participate in the identification and analysis of risks that may affect the health and safety of the establishment's workers, namely the psychosocial risks, and the identification of contaminants and dangerous substances present in the workplace.”

Recommendation 40

The Federations recommend that section 285 of the Bill be amended so as to make January 1, 2023 the date the provisions in the AOHS come into force for all activity sectors.

Recommendation 41

The FIQ and FIQP believe that the notion of risk levels should be removed from the Bill and that in its stead standard prevention mechanisms should be rapidly implemented in all sectors of activity of the health and social services network.

Recommendation 42

The Federations recommend that paragraph 2 of section 26 of the *Regulation respecting joint sector-based associations on occupational health and safety* be amended by inserting at the end of paragraph 2: “in particular with respect to the priorities communicated to it by the Commission.”

Recommendation 43

The Federations recommend that section 187 of the Bill be amended so as to replace paragraph 2 of section 141 with: seven members chosen from lists provided by the most representative union associations, of which at least three members from union associations with at least a 51 % female membership (s. 141, paragraph 2).

Recommendation 44

The Federations recommend the formation of a working committee of experts to study the possibility of assigning the controlling and monitoring of prevention functions to a ministry or public service organization and then for it to submit its recommendations to the government.

Recommendation 45

The Federations recommend integrating the requirement for the government to conduct a gender-based analysis from an intersectional perspective (GBA+) of the AOHS and the AIAOD. These findings must be available to the public.