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Perspective

Obligations of Australian health services as employers during COVID-19

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Abstract. The COVID-19 pandemic has brought into focus obligations for health services to protect the health and safety of their staff, arising from Occupational, Health and Safety legislation and the duty of care owed by a health service as an employer. Health workers, by nature of their work, are a particularly at-risk population in the context of COVID-19. This article examines the legal standard of care that healthcare employers owe their staff in terms of reduction of risk exposure, both physically and psychologically, to COVID-19, the obligation to provide staff with personal protective equipment, adequate hygiene, cleaning and the consequences for breaching these standards. This article also explores the right to dismiss employees who are non-compliant with their obligations.

What is known about the topic? It is well known that health workers are an at-risk population for COVID-19, particularly those with direct exposure to affected patients. Since early 2020, healthcare services have faced substantial challenges in managing employee risk while complying with Occupational, Health and Safety law in Australia.
What does this paper add? This paper explores the standard of care that healthcare services owe their staff in terms of reduction of risk exposure within the current Australian legal framework, as well as the rights and obligations of healthcare service employees.
What are the implications for practitioners? Health services should be aware of the range of legal obligations to protect healthcare workers from the consequences of COVID-19 in order to minimise risk as much as reasonably practicable for employees. This includes ensuring access to adequate personal protective equipment, psychological support, adequate hygiene and cleaning of the physical workspace as well as the appropriate reporting of incidents and exposures.

Keywords: epidemic, governance, health law, health services.

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Introduction

The COVID-19 pandemic has brought into strong focus the obligations for health services to protect the health and safety of their staff. These obligations arise from Occupational, Health and Safety (OHS) laws and the duty of care owed by a health service as an employer. Victoria's 'second wave' COVID-19 outbreak demonstrated significant transmission risks within healthcare settings, with over 4000 coronavirus infections in healthcare workers,[1] including 3573 cases in clinical healthcare workers, with 72.9% of these infections acquired in a healthcare setting. An additional 596 non-clinical staff, including cleaners and administrative staff, contracted coronavirus, with 57.6% of infections acquired in a healthcare setting. COVID-19 is therefore a significant risk for any healthcare employer due to the increased risk of clinical staff compared with the general population, combined with the potential for life-threatening outcomes. Furthermore, this risk can be relatively easily mitigated and thus imposes an obligation upon employers to be proactive in this regard.

Duty to staff

The Standard

OHS law requires that hospitals, as employers, implement control measures to eliminate or, if not possible, minimise risks to workers. This is provided for at a federal level by the *Work Health and Safety Act 2011* (Cth), which has corresponding state and territory laws, including the *Occupational Health and Safety Act 2004* (Vic) and *Work Health and Safety Act 2011* (NSW). Staff exposure to COVID-19 is a risk to workers that is arguably impossible to eliminate entirely within a health service, but may be minimised. The standard to which health services would be held is unclear, because paradigms of pandemic response, available resources and information regarding virus transmission and treatment have evolved continuously over recent months.

OHS obligations dictate a higher standard than traditional negligence thresholds, as an employer is required to go as far as is 'reasonably practicable' to minimise the risk (*Work Health and Safety Act 2011* (Cth), s. 17). In interpreting the meaning of 'reasonably practicable', WorkSafe suggests employers consider: the likelihood of the risk occurring, the harm that would result from the hazard or risk, what a person knows (or should know) about the hazard or risk and ways to eliminate or reduce it, availability and suitability of ways to eliminate or reduce risk and the cost of eliminating or reducing risk (*Work Health and Safety Act 2011* (Cth), s. 18). COVID-19 has been shown to be highly contagious and, in a proportion of cases, fatal.[2] The risk of transmission can be effectively reduced with appropriate, generally low-cost precautions.[3] Therefore, if any interventions to reduce the risks associated with COVID-19 are shown to be of benefit, and implementing them would be reasonably practicable, they should be implemented.

Elimination and risk exposure reduction

Health services should aim to eliminate the risk of COVID-19 exposure to staff wherever possible. Given the need to treat patients with COVID-19, this is unlikely to be universally possible across a health service. However, the risk to individuals and some business areas of a health service may be eliminated by facilitating work-from-home arrangements for non-clinical staff. In areas with community transmission, facilitating outpatient clinics via telehealth reduces staff exposure to potentially infectious patients. Even for staff working in COVID-19 wards, the frequency of exposure may be reduced; for example, by minimising in-person medical team attendees and engaging with patients via inpatient telehealth, including virtual ward rounds.

Employers' duty of care to ensure health and safety, so far as is reasonably practicable, extends to all workers (*Work Health and Safety Act 2011* (Cth), s. 19). Vulnerable groups, such as healthcare workers aged >70 years, are at increased risk of serious illness and death from COVID-19.[4] The Australian Health Protection Principal Committee recommends risk assessment and mitigation of risk be undertaken for any vulnerable worker undertaking essential work.[5] Risk mitigation may include moving vulnerable healthcare workers to non-patient-facing roles or task reallocation to enable working from home. If risks to vulnerable workers cannot be mitigated, alternative arrangements, such as special leave, must be considered.[6]

Personal protective equipment

Personal protective equipment (PPE) has a key role in protecting health service employees in clinical settings where the risk of COVID-19 cannot be fully eliminated or controlled. Employers are expected to offer staff the highest level of PPE that is 'reasonably practicable'. Physical distancing in a clinical environment is not always feasible, particularly in contexts requiring direct physical examination or procedural work, and, indeed, the standard designs of wards, theatres and emergency departments are non-conducive to this. General statements advising clinicians to practice physical distancing in the absence of providing adequate PPE are unlikely to acceptably satisfy employers' obligations.

State and federal guidelines around PPE and physical distancing may not be uniform and are likely to change rapidly. It is reasonable to assert that employers have a minimum obligation to provide surgical face masks and goggles or face shields for all clinical interactions, and that the level of PPE provided to public employees should align with the respective state or federal health authority recommendations. Given the potential for airborne transmission of COVID-19, following the precautionary principle, an N95-design mask would be preferable to a surgical mask in all high-risk clinical settings.[7]

The obligation on employers extends beyond simply confirming guidelines and policies instructing the use of appropriate levels of PPE. This obligation would include ensuring ready access to the appropriate level of PPE, staff training in 'donning and doffing', the provision of adequate space and time for safe PPE use and appropriate disposal of PPE used. The question of whether failure to provide adequate PPE would constitute a breach would be determined by the test of 'reasonable practicability'. Failure to provide N95-design masks based on increased costs would likely constitute a breach, but supply shortages, where significant, may not.

There is a question as to whether this obligation may also extend to mitigating fatigue and other risk factors associated with increased staff exposure. Increased workload and increasing numbers of staff on sick leave or furloughed due to viral

exposure has possibly increased the risk of staff fatigue and burnout within health services. As a consequence, current rostering practices may fail to comply with relevant employment agreements, including with regard to notification requirements, leave entitlements and break requirements.

Can staff refuse to comply with directions? Is dismissal an option?

Employees also have duties to take reasonable care for their own health and safety and the safety of others who may be affected by their act or omission (*Work Health and Safety Act 2011* (Cth), s. 28). An employee must cooperate with his or her employer and/or their health and safety representatives with respect to reasonable instructions and policies relating to OHS. Issues arising for employees include refusal to isolate if infected, refusal to quarantine if exposed to a contact with a high risk of transmission, refusal to get tested where reasonable suspicion of risk of infection exists or refusal to wear PPE in clinical practice. Many of these issues may constitute civil breaches of negligence by an individual, or employer due to vicarious liability, or breaches of contract between an employer and their employee.

Where staff are refusing to wear PPE on the basis of a medical exemption, redeployment to an area where that person is no longer a risk to others is required. Where redeployment is not available, dismissal is unlikely to be an option. In determining an individual's incapacity for work, the Fair Work Commission has affirmed that it is the 'substantive' position of the employee that is to be considered and not the modified position with or without restricted duties or a temporary alternative position.[8] Dismissal may therefore be fair where staff are ordinarily required to wear PPE, such as in theatre, but would constitute unfair dismissal where it is only a temporary requirement in the setting of the pandemic.

In areas where demand may decrease significantly, including elective surgical and medical centres, employers may be able to 'stand down' employees. Under the *Fair Work Act 2009* (Cth), section 524 provides a 'stand down' provision enabling employers to require employees not to attend work (and not be paid) if the employee cannot be 'usefully employed' because of industrial action, breakdown of machinery or equipment or cessation of work due to reasons 'for which the employer cannot reasonably be held responsible'. It is likely that the pandemic would satisfy the latter. The employer must be able to show that the employee cannot be otherwise 'usefully employed'. Where alternative work can be performed by the employee, the provision will not apply. 'Stand down' is unlikely to apply to individuals refusing or unable to wear PPE because there has not been a 'stoppage of work'; rather, there has been an environmental change resulting in a specific inability to perform currently modified 'substantive' roles.

Finally, an evolving debate continues around the mandatory requirement for vaccination of employees of healthcare services. Employees have an implied duty to comply with lawful and reasonable directions. Influenza vaccinations have become compulsory for aged care workers in recent years through specific state and territory regulations. Vaccination for certain diseases, such as hepatitis B, is a condition of employment in many jurisdictions for healthcare roles. This debate around COVID-19 vaccination is complex, with many medical, ethical, legal and political factors, and is likely to prompt the development of new guidance and regulations. A mechanism that would allow individuals who have established allergies to vaccine components is almost certain to be a part of any new regulations. Declining vaccination on the grounds of personal or religious belief will be more contentious. Section 116 of the Australian Constitution prevents the Commonwealth from passing laws that prohibit the free exercise of any religion (*Commonwealth of Australia Constitution Act 1900* (Cth), s. 116). Queensland, Victoria and the Australian Capital Territory have human rights instruments that may be relevant. It is plausible that if employees are unable to have the vaccine (or are found to be able to legally decline), employers may have a duty to redeploy such staff to roles with less exposure risk or require them to wear more protective PPE. There have been recent applications to the Fair Work Commission where employees have challenged employers' mandatory vaccination policies.[9,10] In both these cases, the Commissioners were generally supportive of the employers' vaccination policy which promoted compliance with the inherent requirements of certain positions, which in these proceedings involved the provision of care to young children and infants, and that of a care assistant visiting people in their homes and administering care.

Hygiene and cleaning

Because coronaviruses can persist on surfaces such as plastic for up to 9 days, transmission of COVID-19 from surfaces remains a concern.[11] The need for increased hygiene and cleaning procedures in health service settings has been recognised by Australian Department of Health guidelines, which suggest that, in addition to routine cleaning, frequently touched surfaces should be cleaned frequently and patient equipment cleaned between each use.[12] Considering the significant risk of transmission from surfaces, all contacted surfaces should be cleaned between every patient and frequently touched surfaces should be cleaned as often as is practicable.

In a recent Victorian Supreme Court case, *Rowson v Department of Justice and Community Safety*,[13] a prison inmate sought an injunction to be temporarily released from prison on grounds of the risk of harm or death to him if COVID-19 arose in prison, due to current medical conditions. His case was advanced primarily in negligence, but was also grounded in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) in that the prison acted incompatibly with his human rights, specifically to recognition and equity before the law, right to life and right to humane treatment when deprived of liberty. The judge found that there was a *prime facie* case that the prison authorities breached their duty to take reasonable care for the man's health, based on absence of risk assessment performance by the prison and evidence of poor hygiene practices. This case is significant in the potential extrapolation to the hospital, residential care and aged care contexts, serving as an important reminder that policy implementation in response to COVID-19 may be insufficient to satisfy common law duties of care or meet obligations imposed by OHS law.

Similar to PPE, policies and guidelines providing for the frequency of cleaning may not be sufficient to fulfil employers' obligations alone. The obligations would likely extend to include access to cleaning supplies for staff or residents, such as disinfectant and cleaning supplies, as well as inbuilt quality

assurance practices. Staffing shortages are emerging in roles such as cleaning services, with employers required to ensure that staff employed in these roles have adequate experience and training to be able to satisfactorily perform these tasks. The Victorian 'hotel quarantine outbreak'[14] highlighted this issue, with inadequate training of security staff considered as a contributing factor to virus transmission.

Psychological risks

OHS law applies to both physical and psychological hazards. Psychological hazards particularly relevant to employers at this time include remote and isolated working environments, job uncertainty, fluctuating workloads, poor clinical outcomes and increased family and domestic violence. These hazards may precipitate anxiety, depression and post-traumatic stress disorder. Employers should take steps to mitigate these hazards, including sharing relevant information as it becomes available, while also being cautious of the potential for worker stress secondary to information overload. Where possible, employers should offer flexibility, prioritising staff breaks, rostering to mitigate fatigue risks and ensuring time off to mitigate burnout risk. Processes to aid in identifying at-risk staff and responding in a timely and effective manner to their needs are required, including the availability of a contact person to respond to, and appropriately escalate, issues of staff well-being. Staff should also be made aware of, and assisted to access, domestic violence leave entitlements.

Exposure response

Clear health service guidelines are required to ensure efficient responses to potential and confirmed staff exposures. Notification requirements around COVID-19 infection to work health and safety regulators vary between states and territories, reflecting discrepant levels of COVID-19 transmission across Australia. Some areas with limited COVID-19 transmission, such as the Northern Territory and Australian Capital Territory, only require notification in limited circumstances (e.g. requiring both the person to be hospitalised and the infection to have arisen in the context of the business' conduct).[15] Comparatively, Victoria, which has seen high levels of community transmission, introduced a new notification requirement on 28 July 2020 (*Occupational Health and Safety (COVID-19 Incident Notification) Regulations 2020* (Vic), No. 78), prescribing a confirmed positive diagnosis of COVID-19 as an incident for the purpose of Part 5 of the OHS Act for 12 months. Under section 38 of the *Occupational Health and Safety (COVID-19 Incident Notification) Regulations 2020* (Vic), employers are required to notify the Victorian WorkCover authority immediately on becoming aware of the positive COVID-19 test result of an employee, independent contractor or an employee of that contractor where that person has attended the workplace during the infectious period. The infectious period is defined in the regulations as the 14 days before symptom onset or a confirmed diagnosis (whichever comes first) until the day that the person receives a clearance from isolation from the Department of Health and Human Services (*Occupational Health and Safety (COVID-19 Incident Notification) Regulations* 2020 (Vic) s. 3). As with all reportable incidents, the employer must provide written documentation of the positive diagnosis within 48 h, and a copy must be kept by the employer for a minimum of 5 years (*Occupational Health and Safety Act 2004* (Vic), s. 38). Employers should update OHS policies and guidelines to ensure that a positive COVID-19 diagnosis in staff, independent contractors or employees of independent contractors is now a reportable incident. Failure to notify WorkSafe or maintain written records detailing the incident attracts 240 penalty units for an individual (A$39 652) or 1200 penalty units for a body corporate (currently A$198 264).

There is also a duty to preserve an incident site under section 39 of the *Occupational Health and Safety Act 2004* (Vic). Employers are required to ensure the site of a reportable incident is not disturbed, without reasonable excuse, until a WorkSafe inspector arrives at the site or such other time as directed by the inspector (*Occupational Health and Safety Act 2004* (Vic), s. 39). It is unclear how section 39 would apply in the healthcare setting. If strictly interpreted, an application of this provision could be the immediate closure of an entire medical ward or clinic with potential adverse impacts to patient care. In this setting, the exception under subsection 2(a) may apply, enabling incident site disturbance in order to protect 'the health and safety of a person'. However, this would be unlikely to apply to a hospital tearoom exposure, with a penalty for breach of section 39 of 1200 penalty units for a body corporate (A$19 8264.00). Further clarification on this point by WorkSafe, or a clear exception, would be helpful in promoting compliance without adversely impacting patient care.

Beyond regulatory notification obligations, worker exposure constitutes a significant risk to other staff and patients. Employer obligations would include implementing appropriate policies and guidelines allowing for immediate isolation of the positive staff member, supporting effective contact tracing (whether this is performed internally or externally) and clear, consistent return-to-work procedures. Ensuring compliance with health department guidelines, and responding in a timely manner to changes, is therefore of the upmost importance.

If contact tracing is occurring within the health service, as in many public hospitals, the employer's obligations are significant due to the high potential for harm associated with delay or error. Contact tracing should therefore occur as soon as possible following a positive test result due to the high likelihood that close contacts pose an immediate and substantial risk to other staff and patients. If this standard is not being met, investment in resources to achieve this is warranted.

Consequences for breach

Potential offences under work health and safety law may be prosecuted in the court of the relevant jurisdiction, with penalties specific to the provision breached.

It is possible that the recently introduced criminal offence of workplace manslaughter (under work health and safety legislation in the Northern Territory (*Work Health and Safety (National Uniform Legislation) Act 2011* (NT), s. 34B), Victoria (*Occupational Health and Safety Act 2004* (Vic), ss. 39A–G) and Queensland (*Work Health and Safety Act 2011* (Qld), s. 34C) may be applied to a death of a staff member who contracts COVID-19 from a workplace exposure. The type of conduct that this encompasses includes negligent conduct by individuals,

including a failure to act, accumulation of conduct by different individuals and accumulation of conduct based on unwritten rules, policies or work practices of the organisation.

Conclusion

Australia's OHS laws were drafted at a time when a global pandemic (such as COVID-19) may not have been foreseen. As such, employers of healthcare workers have found themselves in the unenviable position of being beholden to these laws and required to satisfy standards of care while, at the same time, attempting to adapt in response to a rapidly evolving crisis under substantial public and media scrutiny. The COVID-19 pandemic has continued to accelerate with the number of cases worldwide as of January 2021 now numbering over 81 000 000 (https://covid19.who.int/), with more than 30 000 infections and 2500 deaths among healthcare workers.[16] COVID-19 deaths among healthcare workers are not concentrated in older age groups, with the median age at death being 41 years in the US.[17] COVID-19 infections in staff will remain a substantial area of emerging risk for health services, at least until mass vaccination is achieved, with an associated increase in the potential liabilities for health services in achieving necessary standards of care.

Health services have a range of obligations to protect healthcare workers from the consequences of the COVID-19 pandemic. These obligations can be discharged through appropriately adapting employment, including using telehealth, making changes in work practices and protecting susceptible groups. Employers have obligations to uphold the appropriate use of PPE and rostering commensurate with employee risk, given physical distancing is often impractical and certain procedures increase exposure risk. Failure by an employee to comply with PPE, isolation or testing policy without exemption may result in liability in negligence, breach of contract or dismissal. Where such employees have exemptions, redeployment, special leave or 'standing down' may be appropriate. Employers have obligations to provide adequate cleaning, protect employees' psychological well-being and ensure efficient exposure management. Whether employers have met requisite obligations and duties may be assessed upon a 'reasonable practicability' basis.

Competing interests

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