A LEGAL ANALYSIS OF VACCINE PASSPORTS AND VACCINE MANDATES IN THE PRIVATE SECTOR

[DRAFT DISCUSSION PAPER – PLEASE QUOTE AS SUCH]

Abstract

At time of writing, all Canadian provinces and territories have implemented proof of vaccination requirements for private sector businesses, allowing vaccinated individuals to congregate in non-essential settings such as restaurants, movie theatres and gyms. While these regulations provide helpful clarification for many businesses, there remain two areas of uncertainty as concern proof of vaccination requirements in the private sector. The first concerns businesses not legally required by provincial laws to check proof of vaccination: What rights or obligations do exempted businesses have to require proof of vaccination on their own initiative? Second, legal requirements for verifying proof of vaccination apply only to customers. What rights or obligations to businesses have vis-à-vis requiring proof of vaccination by employees? This paper offers an overview of the law on both fronts, explaining the applicable legal principles from human rights law, privacy law, and employment law. As explained, the legal permissibility of private sector vaccination requirements turns on contextual factors such as the health and safety risks posed by allowing non-vaccinated individuals to enter a given business location.

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[1] **Competing interests:** Kumanan Wilson is the CEO of CANImmunize Inc. CANImmunize is currently not developing an immunization passport but has been asked to provide input on proof of immunization status for COVID-19. CANImmunize has received funding from public and private sources (https://www.canimmunize.ca/en/partners). Dr. Wilson owns shares of CANImmunize and does not receive renumeration for his activities as company CEO. He is a member of the independent data safety board for the Medicago COVID-19 vaccine trial. No other competing interests were declared.

1. Introduction

Across Canada we are seeing growing support for the use vaccine passports for public gatherings (Ibbitson 2021) and the introduction of vaccination mandates in some work settings (e.g. in long-term care homes). Provincial governments have been slow to implement these measures, citing a range of legal and ethical concerns which we and others have argued are either resolvable or spurious (Thomas et al 2021). One of our contentions has been that restrictions on indoor gatherings for unvaccinated individuals are inevitable, and that a publicly administered and regulated vaccination passport scheme would be preferable to the alternative: a patchwork of vaccine checks and mandates administered by the private sector. Even in provinces that have vaccine passports and/or mandates in place, these requirements are targeted at specific contexts; for other contexts, government may explicitly state that vaccine passports are *not* required, or simply remain silent on the issue (Government of Alberta 2021; Ontario Ministry of Health 2021). This report aims to provide clarity on the use of private sector vaccine requirements *outside* the scope of explicit government requirements. There are two broad scenarios under consideration here: first, moves by private sector organizations *exempted* from government vaccine passport requirements to verify the vaccination status of customers and/or others who come and go (e.g., suppliers, contractors); and moves by private sector organizations to mandate vaccination for *employees*.

2. Scientific and Technological Considerations

We should also be clear, conceptually, as to the purpose of vaccine requirements. From a public policy perspective, the goal of mandates is to ensure that individuals who are in high-risk settings are vaccinated. In the process of requiring vaccines to gain access, the implementation of vaccine requirements has been associated with an increase in vaccination rates (CBC 2021).

COVID-19 vaccines protect through three mechanisms. They can reduce the likelihood of infection and infectivity, referred to as sterilizing immunity. They can also reduce the risk of serious illness, referred to as protective immunity.

i. Sterilizing Immunity

At the outset, the COVID-19 vaccines provided both robust sterilizing and protective immunity against the original version of the virus. With the emergence of the Delta and Omicron variants, sterilizing immunity has waned although protective immunity has remained robust. This change in type of immunity has important implications for the purposes of vaccine mandates. From a sterilizing immunity lens, vaccine mandates can increase vaccination rates to a threshold at which the virus can no longer effectively spread from individual to individual—referred to as the critical vaccine threshold or 'herd immunity'. In this scenario, increasing vaccination rates protects everyone from being infected. Thus, when individuals choose not to vaccinate, they are putting not only themselves at risk but others, by impeding the achievement of herd immunity (as vaccines are not 100% effective, the vaccinated can under rare circumstances become infected).

However, as we move to the protective immunity lens, this no longer holds. Evidence from the Delta variant suggests that individuals can become infected and minimally symptomatic and thereby spread the virus (Steenhuysen 2021), albeit at a lower transmission rate than unvaccinated individuals. This is, even more apparent with the Omicron variant. Emerging data is suggesting that two doses of an mRNA vaccine provides comparatively minimal protection against infection, although continuing to provide protection against serious illness (Buchan et or, 2022). Booster vaccines are needed to provide protection against infection and strengthen protection against serious illness. This evolution in the science of the pandemic makes achieving herd immunity much more challenging.

ii. Protective Immunity

Fortunately, the vaccines (with boosters as needed) still prevent individuals from becoming seriously ill, thus providing protective immunity. In this scenario, vaccine mandates protect the unvaccinated or sub-optimally vaccinated. An unvaccinated person who goes into a poorly ventilated warehouse is at risk of contracting the virus from an asymptomatic or minimally symptomatic vaccinated worker. Since they do not have the protective immunity from the vaccine, they are at substantially increased risk of getting seriously ill in comparison to vaccinated individuals who are infected. Furthermore, they can then transmit the virus to other intentionally unvaccinated individuals, as these individuals often cluster together (Lieu et al 2015). They can also spread the virus to children under the age of 12 who may not yet be fully vaccinated and

individuals in for whom vaccine effectiveness may be reduced (this is true also for vaccinated individuals but their likelihood of becoming seriously ill from the virus is reduced). Mandating vaccines in this scenario is a basic protective measure, just as we mandate seat belt use in cars and hard hats on construction sites.

Finally, we note a secondary purpose of the vaccine mandates is societal. As unvaccinated or sub-optimally vaccinated individuals get sick, they become admitted to hospitals and ICUs. As these exceed capacity, the decisions of the unvaccinated impact the broader population by restricting access to medical care. Eventually, this can potentially lead to lockdowns and the ensuing social and economic consequences.

We've just laid out the core justification for vaccination requirements, but as explained, our understanding of how vaccines protect and their effectiveness is evolving. Policies need to adjust to address this changing evidence. For example, data is emerging on waning immunity, particularly in older populations. This data will inform how 'being vaccinated' will be defined as, for example, Israel is now requiring receipt of a booster shot for this designation and is already exploring the need for a fourth shot.

Which, if any, of our laws circumscribe private sector vaccine requirements? The analysis that follows canvasses the possibilities. First, there is the possibility that vaccine requirements might be deemed *discriminatory* under provincial human rights legislation (section 1). Next, there is the possibility that requiring disclosure of vaccination status might be deemed an unreasonable intrusion on privacy, under federal or provincial privacy laws (section 2). In the workplace, there is the possibility that vaccination requirements might be challenged as infringing employees' rights under applicable employment laws (section 3).

3. Human Rights Legislation

Some have raised concerns as to whether vaccine requirements impinge upon civil and human rights. As a preliminary point, it is worth untangling how rights-based concerns apply to public (governmental) actors as opposed to private actors. The Canadian *Charter of Rights and Freedoms* empowers individuals to challenge government interferences with various protected interests—(e.g.) the s.7 right to "life, liberty and security of the person," the s.2(b) right to freedom of peaceful assembly, and so on. The line between public and private actors is not always clear cut, of course,

and there is a body of *Charter* jurisprudence outlining, for example, the conditions under which actions by publicly-funded hospitals or universities are subject to *Charter* scrutiny. Where an actor or organization is acting *purely* in a private capacity—e.g., a private employer mandating, on its own initiative, that employees be vaccinated as a condition of service—the *Charter* does not apply. Insofar as purely private actors impose vaccination requirements, the applicable rights protections will draw from provincial human rights legislation, such as the *Ontario Human Rights Code*.

Human rights legislation is narrower in scope than the *Charter,* and generally focuses on freedom from *discrimination*. Under human rights legislation there is not, for example, any counterpart to the *Charter's* protection of "life, liberty and security of the person". Concerns raised regarding proof of vaccination has focused heavily on the *coerciveness* of such measures, and specifically whether such requirements impinge upon the fundamental right to autonomy over medical decision-making. While such concerns can perhaps find some footing, under s.7 of the *Charter,* as a legal objection to government-imposed vaccination requirements, there are no analogous generic liberty protections in the private sector.

Broadly speaking, then, private sector vaccine requirements are open to challenge only insofar as they result in people being refused goods and services, employment or housing on the basis of some protected characteristics. The language varies by province, but for example Quebec's *Charter of Human Right and Freedoms* protects against discrimination on the basis of "race, colour, sex, gender identity or expression, pregnancy, sexual orientation, civil status, age except as provided by law, religion, political convictions, language, ethnic or national origin, social condition, a handicap or the use of any means to palliate a handicap." Attempts to challenge private sector vaccination requirements under human rights legislation will need to rest on an allegation of discrimination on the basis of one or more of these protected characteristics; some jurisdictions also extend protection to characteristics deemed analogous to those enumerated (Manitoba Human Rights Commission 2002). In what follows, we consider how these protections might apply to private sector vaccination requirements.

i. Do vaccination requirements discriminate on the basis of 'creed'?

It is sometimes alleged that vaccination requirements effectively discriminate against individuals on the basis of their religious or conscientious beliefs. As all of the major religious traditions and denominations support COVID-19 vaccination (Graham 2021), the vast majority of unvaccinated

people are best described as 'vaccine hesitant'—individuals who have non-religious misgivings about the safety of the specific vaccines, and/or who mistrust pharmaceutical companies and government regulators. Do beliefs of this sort attract the protection of human rights legislation?

Whereas the Canadian *Charter* refers to 'freedom of conscience and religion,' Ontario's *Human Rights Code* bundles these protected categories under the term 'creed'.[2] While the *Code* offers no definition for the term, 'creed' has been interpreted by courts and tribunals as referring to religious beliefs and practices, as well as non-religious beliefs and practices. In its *Policy on Preventing Discrimination Based on Creed,* the Ontario Human Rights Commission (2015) explains that a legally protected 'creed' must meet the following criteria:

- Sincerely, freely and deeply held
- Integrally linked to a person's identity, self-definition, and fulfilment
- A particular and comprehensive, overarching system of belief that governs one's conduct and practices
- Addresses ultimate questions of human existence, including ideas about life, purpose, death, and the existence or non-existence of a Creator and/or a higher or different order of existence
- Has some 'nexus' or connection to an organization or community that professes a shared system of belief.

These criteria follow, in part, those set out by the Supreme Court of Canada, in its interpretation of the *Charter* right to freedom of religions and conscience (*Syndicat Northcrest v Amselem* 2004, *R v Edwards Books* 1986).

In challenging private sector vaccine requirements under human rights legislation, the initial onus will be on claimants to demonstrate that they meet the criteria above; it is unlikely that vaccine hesitancy—or even strident vaccine rejection as an 'anti-vaxxer'—would qualify (*Ataellahi v Lambton County (EMS)* 2011, *Sharma v Toronto (City)* 2020). By analogy, consider the 2004 *Charter* ruling, *R v Locke*, where the plaintiff, skeptical of the science behind seatbelts, claimed that mandatory

[2] The relevant terminology varies by province. British Columbia, Quebec, PEI, Newfoundland and Labrador, and Alberta legislation lists only religion as a protected category, with no mention of creed or conscience; legislation in Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Nunavut, Yukon, and the Northwest Territories mentions both 'religion' and 'creed'.

seatbelt laws infringed his freedom of conscience. The court rejected the claim on grounds that beliefs about seatbelt safety are not integral to a person's sense of identity, or comprehensive system of belief, or grand philosophy about the meaning of life. In a recent policy statement, the Ontario Human Rights Commission takes the position that:

> "a person who chooses not to be vaccinated based on personal preference does not have the right to accommodation under the *Code*. Even if a person could show they were denied a service or employment because of a creed-based belief against vaccinations, the duty to accommodate does not necessarily require they be exempted from vaccine mandates, certification or COVID testing requirements. The duty to accommodate can be limited if it would significantly compromise health and safety amounting to undue hardship—such as during a pandemic (OHRC 2021)."

Similar statements have been issued by human rights commissions in other provinces (Saskatchewan Human Rights Commission 2021; Nova Scotia Human Rights Commission 2021). It should come as no surprise that courts and tribunals have limited the scope of accommodation for beliefs in this way: a pluralistic community like ours is rife with political disagreements on (e.g.) matters of public health, and a commitment to exempt or accommodate every dissenter would render society ungovernable (*R v Malmo-Levine, R v Caine* 2003).

For better or worse, the criteria set out above effectively treat *religious* belief systems as paradigmatic (Thomas 2008). While we have noted above that all major religious denominations have endorsed COVID-19 vaccines, there is perhaps a concern that some individuals, or members of marginal denominations, may reject vaccines on *bona fide* religious grounds, and allege discrimination when confronted by private sector vaccine requirements. In previous analyses of *public* (i.e., government-mandated) vaccine passport systems, we have taken this possibility seriously, emphasizing that the Supreme Court of Canada interprets the *Charter* right to religious freedom *very* generously: under the leading precedent, the right is triggered wherever "a claimant demonstrates that he or she sincerely believes in a practice or belief that has a nexus with religion" (*Syndicat Northcrest v Amselem* 2004). Under the *Charter,* in other words, there is no burden on claimants to show that their beliefs are grounded in relevant scriptures, or endorsed by religious leaders, or widely shared among members of the faith. All that is required is a sincere *subjective* belief, having some nexus with religion, that prohibits or discourages compliance with the impugned law. Notice, however, that the *Ontario Human Rights Act* is more demanding this regard (per the Commission's policy

statement): claimants are required to show not merely a subjective nexus with their faith, but also a more objective "connection to an *organization or community that professes a shared system of belief*" (emphasis added). This imposes a considerably more demanding onus on claimants—particularly when it comes to COVID-19 vaccines, which all major religions have embraced. Religious protections in other provinces can be somewhat ambiguous on this point. For example, the guidance from Nova Scotia's Human Rights Commission states that "[o]nly religious beliefs that are sincerely held and connected to a faith must be accommodated." Here, it is unclear whether the 'connected to a faith' criterion can be satisfied by private and idiosyncratic commitments. Quebec has formally legislated limits on religious accommodation, requiring decision-making bodies to ensure that the accommodation is consistent with equality norms, and does not impose undue hardship to (among other things) public health and safety (*An Act to foster adherence to State religious neutrality and to provide a framework for religious accommodation requests in certain bodies* 2017).

ii. Medically Justified Vaccine Refusal and Disability Discrimination

Apart from religious- or conscience-based objections to vaccination, there is a small subset of the population for whom COVID-19 vaccination is medically contraindicated. This likely constitutes a 'disability' under human rights acts, and thus requires reasonable accommodation. The National Advisory Committee on Immunization (NACI) has identified a handful of scenarios where COVID-19 vaccination is contraindicated: individuals with a history of severe allergic reactions to COVID-19 vaccine using a similar platform (mRNA or viral vector); patients who have experiences venous or arterial thrombosis with thrombocytopenia with the first does of a viral vector COVID-19 vaccine should not receive a second dose of a viral vector vaccine; patients with a history of capillary leak syndrome should not receive the AstraZeneca vaccine (NACI 2021). In some cases, these contraindications do not suggest categorically that a patient should not be vaccinated, but that the precautions should be taken (e.g., a patient who experienced mild to moderate allergic reaction on at first dosage might receive a second dose, but with the period of observation extended to 30 minutes). The decision whether to vaccinate under these circumstances must be made on a case-by-case basis, and Ministries of Health in some provinces have provided detailed guidance as to when medical exemptions will be granted (see e.g., British Columbia Ministry of Health 2021).

A further question is whether private actors can *require* a physician-issued medical exemption as a precondition to making disability accommodations. There is some legal ambiguity here: for example, as a general rule, the Ontario Human Rights Commission (OHRC) urges employers to "accept the person's request for accommodation in good faith, unless there are legitimate reasons for acting otherwise" (OHRC 2016). It does not seem to us that the Commission's reasons for urging employers to rely on good faith declarations is applicable to the context of is COVID-19 vaccination. One distinguishing factor is that accommodating an unvaccinated person may entail an increased risk to others in the workspace, in a way that (e.g.) accommodating an individual's mobility issues does not (OHRC 2016). Moreover, the Commission's rationale for accepting disability accommodation requests on good faith is partly to avoid "overburden[ing] the health care system with requests for medical notes" (OHRC 2016). This consideration carries less weight in the context of the current pandemic, where a person's decision not to be vaccinated—potentially out of unfounded beliefs about medical contraindications—may itself contribute to overburdening the health care system.

iii. Reasonable Accommodation and Its Limits

To this point, we have attempted to delineate the isolated scenarios where individuals could make a *prima facie* case that vaccine requirements are discriminatory, pointing to hypothetical scenarios where a marginal religious denomination rejects vaccination, and rare scenarios where vaccination is medically contraindicated. To be clear, these hypotheticals in no way foreclose the option of private sector vaccine requirements. For example, private employers have the option of carving out exemptions to accommodate those rare individuals who are unvaccinated for valid religious or medical reasons. Alternatively, there is the option of defending a vaccine requirement as a *bona fide* requirement—for which there cannot be accommodation "without undue hardship on the person responsible for accommodating those needs, considering the cost, outside sources of funding, if any, and health and safety requirements, if any" (Ontario *Human Rights Code* 2006).

It is difficult to generalize as to what constitutes 'undue hardship' across private sector contexts. There is the basic question of whether and to what degree universal vaccination is necessary within a specific organization: from a health and safety perspective, the hardship of exemptions may vary depending on the risk profile of employees and clientele, the nature of the workplace environs (e.g., workers exerting themselves in close proximity in a meat-packing plant, versus working outdoors or in separate well-ventilated offices). In settings that see a constant churn of different

customers, such as hair salons, an attempt to vet religious exemption requests on an ad hoc basis may simply be impractical and ineffective—particularly as government has provided no guidelines for doing do—and thus constitute an undue hardship. The recent policy statement from the Ontario and Saskatchewan Human Rights Commissions suggests that exempting religious objectors is not required as a matter of reasonable accommodation.

4. Privacy Rights

Private sector vaccine requirements may also engage privacy rights. Canada has a notoriously complex patchwork of privacy legislation at the federal and provincial levels, variously addressing the collection, use and disclosure of personal information by governments (the federal *Privacy Act*, Ontario *Freedom of Information and Protection of Privacy Act* (*FIPPA*), Alberta *Freedom of Information and Protection of Privacy* Act (*FOIP*)), the private sector (the federal *Personal Information Protection and Electronic Documents Act* (*PIPEDA*), BC *Personal Information Protection Act* (*PIPA*), Alberta *Personal Information Protection Act* (*PIPA*), and Quebec P-39.1) and health care providers (*Personal Health Information Protection Act* (*PHIPA*) (Ontario), *Personal Health Information Act (PHIA)* (Nova Scotia)). Health information is singled out for special protection, in recognition of its sensitive nature, and the fact that control over one's health information is a key element of patient autonomy. To be sure, one's vaccination status *is* personal health information, although the provinces' bespoke health information privacy laws will not apply in the context of most private sector vaccine requirements. For example, Nova Scotia's *Personal Health Information Act* (*PHIA*) concerns the collection, use and disclosure of personal health information by health information 'custodians', such as a doctor or hospital, typically in the delivery of care. It does not apply to scenarios where (e.g.) an employee or patron is asked to verify their vaccination status to an employer or restaurant. In such scenarios, the privacy legislation that is most likely to apply is the federal *Personal Information Protection and Electronic Documents Act* (*PIPEDA*), which broadly governs the collection, use and disclosure of personal information in the course of 'commercial activities.' In British Columbia, Alberta, and Quebec, provincial private-sector privacy laws that have been deemed 'substantially similar' by the federal Privacy Commissioner will govern the privacy-related aspects of

private sector vaccine requirements within those provinces. For simplicity's sake, the analysis that follows will draw primarily on *PIPEDA*.

i. Employee Privacy Rights

Protections for employee privacy are an especially patchy area of Canadian privacy law. *PIPEDA*'s protections for employees extend only to federally regulated industries (e.g., banking, airlines), and so does not protect employee privacy rights broadly across the private sector (*Canada Labour Code* 2006). Many provinces, including Ontario, have *no* legislation addressing private sector employees' privacy rights (Raymer 2019); there are protections in place for private sector employees in British Columbia (*PIPA*), Alberta *(PIPA*) and Quebec (*Act Respecting the Protection of Personal Information in the Private Sector)*.

Discussions around privacy rights often highlight the importance of individual *consent* to the collection, use and disclosure of personal information. Consent requirements are certainly an important element of privacy, but employees will doubtless feel strong pressure to consent to their employers' demands for personal information—particularly when, as in the case of vaccine requirements—a refusal may result in consequences such as suspension or dismissal. In those sectors and jurisdictions where employee privacy is protected by statute—again, federally regulated industries and select provinces—the truly crucial legal test is one of *reasonableness.* Thus, for example, s.5(3) of *PIPEDA* states that, "An organization may collect, use or disclose personal information only for purposes that a *reasonable person* would consider are appropriate in the circumstances."[3] There is also an obligation to clearly communicate *why* the information is being collected (i.e., health and safety), and to collect as little information as necessary to that purpose (data minimization), and use the information *solely* for the stated purpose.

The courts have acknowledged that privacy is a 'protean concept', noting particularly that, "the difficult issue is where the 'reasonableness' line should be drawn" (*R v Tessling*). The courts have specified that the following factors inform the application of *PIPEDA*'s reasonableness standard:

- The degree of *sensitivity* associated with the personal information

[3] Emphasis added. Note that Quebec's legislation requires that "collection of that information is necessary for the conclusion or performance of a contract," and that, "[i]n case of doubt, personal information is deemed to be non-necessary."

- Whether the purpose of collection represents a *legitimate business need*
- The *effectiveness* of collecting that information in achieving that legitimate business need
- The availability of *less intrusive means* to achieve the stated business needs, with comparable costs and benefits
- The *proportionality* of the loss of privacy as against the costs and operational benefits (*Turner v Telus Communications Inc.* 2005)

The Federal Privacy Commissioner has explained that sensitive information includes, "health and financial data, ethnic and racial origins, political opinions, genetic and biometric data, an individual's sex life or sexual orientation, and religious/philosophical beliefs" (Office of the Privacy Commissioner 2011). Judgments about the sensitivity of a given information type are a matter of degree, but as a species of health information, vaccination status would appear *prima facie* to qualify as sensitive. It is debatable, however, whether vaccination status is as sensitive as other kinds of health information. Certain kinds of health information are more sensitive than vaccination information because they: (1) are highly revealing of our intimate characteristics; (2) give rise to the possibility of unlawful discrimination by employers or others; or (3) are stigmatizing.

It's not clear that these considerations are germane to requests for the disclosure of COVID-19 vaccination status. Apart from very isolated medical contraindications, outlined above, the decision to be vaccinated for COVID-19 is a matter of choice—and as explained, our legal and ethical concerns about discrimination typically extend only to traits that are unchangeable or changeable only at great personal cost. As a matter of public policy, we are not committed to fully shielding individuals from the societal consequences of a decision to be unvaccinated, in the way that we are committed (e.g.) to maintaining a zone of privacy around people's medical conditions and treatments. These considerations should inform the courts' thinking about the sensitivity of COVID-19 vaccination status.

Next is the question of whether there is a *legitimate business need* to collect employee information on vaccination status. Above, we mentioned the broad public policy aim of increased vaccination rates, but for present purposes, the relevant concern is the health and safety of employees and clients within a specific workplace. This includes, importantly, the health and safety of unvaccinated employees themselves—who may put themselves at serious risk, even in entering a workplace where all or most other employees are vaccinated. The fact that vaccination mandates are, in this regard, paternalistic is not necessarily problematic: courts have recognized, for example,

that hard hat mandates are a *bona fide* occupational requirement in hazardous workplaces—the paternalism of such policies notwithstanding (*Singh c Montréal Gateway Terminals Partnership* 2016).

Of course, the *need* and *effectiveness* of confirming vaccination will vary by workplace: it would seem very important in settings like meat packing plants (CBC 2021), where employees exert themselves in close proximity to each other, and less imperative in settings where employees work in physical isolation and/or outdoors. Likewise, the availability of *less intrusive means* will vary by workplace.

ii. Consumer Privacy Rights

Outside of the employer/employee relationship, statutory privacy protections apply to all commercial activities—whether under relevant provincial laws or, by default, *PIPEDA*. The question therefore arises of whether private businesses can demand proof of vaccination from their patrons, as a condition of entry and service. By now, every province has enacted regulations mandating that specific commercial sectors (e.g., restaurants, theatres, gyms) begin checking vaccine passports, while remaining silent on other categories (e.g., essential services like grocery stores, along with more arbitrary categories like barber shops and hair salons). These regulations specify that businesses may verify a patron's proof of vaccination, but that they may not retain that information or use it for any other purpose—under the face of severe penalties (*Reopening Ontario (A Flexible Response to COVID-19* 2020)).

It is obvious that businesses that are required by law to check vaccination status must do so. But can businesses who are not subject to such regulations ask patrons to provide proof of vaccination? Assuming that customers consent to disclosing their vaccination status, the legality of such requests by businesses will hinge on their reasonableness. In the context of an ongoing pandemic caused by a highly transmissible airborne virus, in businesses where close physical proximity to the customer is required for the provision of services (e.g., personal care services) can make a strong case regarding the legitimacy of their need to verify vaccination status. By contrast, it may seem less reasonable for businesses that provide services from a distance to require their customers to provide proof of vaccination. In all cases, retention of vaccine status information by such businesses is likely to be deemed unreasonable, without the express and informed consent of the individual in question.

5. Employment Law

A final and critical issue is whether workplace vaccination requirements may violate employees' rights under applicable employment law. This is especially complex terrain, particularly in workplaces governed by collective agreements, where the unilateral imposition of vaccination requirements might be grieved an unreasonable exercise of managerial rights (*Association of Justice Counsel v Canada (Attorney General)* 2017). It comes as no surprise that provincial governments have been circumspect about mandating vaccination requirements for employees. Media commentary on this topic, from labour lawyers, has only heightened confusion, as experts have come down on opposing sides on the legality of private sector vaccine mandates (Smith 2021). The reality is that, as with the application of privacy rights, this is a question that requires contextual nuance—not one-size-fits-all answers.

As a general argument that employers have a right—indeed an obligation—to impose vaccine mandates, some have cited employers' general duty, under occupational health and safety laws, to "take every precaution reasonable in the circumstances for the protection of a worker" (*Occupational Health and Safety Act* 1990). This is not as dispositive as some take it to be. First, there is a *reasonableness* standard at play here, meaning that employers cannot impose vaccination requirements on employees with no consideration of their necessity. We have already seen the reasonableness standard at play in the privacy context and discussed some of the relevant factors: the probability and severity of risk, the effectiveness of the precaution in addressing that risk, and the effectiveness of alternative precautionary measures. Vaccine requirements are unlike other workplace safety measures inasmuch as they impose an obligation on employees: nobody will scrutinize an abundance of caution when it comes to (e.g.) the installation of guardrails on a building site, whereas they may complain if vaccination mandates are perceived to be unnecessary.

A second point is that, in some provinces at least, Occupational Health and Safety legislation contains provisions specifically addressing the medical surveillance of workers. For example, Quebec's *Act respecting occupational health and safety* requires "medical supervision of workers for the prevention and early detection of harm to their health"; Ontario's *Occupational Health and Safety Act,* similarly requires that employers "establish a medical surveillance program for the benefit of workers as prescribed" and "provide for safety-related medical examinations and tests for workers as prescribed." One might interpret these provisions as hiving off medical surveillance and testing—i.e., vaccination or testing requirements—from the general obligation to take reasonable safety

precautions. What separates the two categories, on this interpretation, is that medical surveillance and testing are required only when prescribed by government regulation. Provinces' prescribed vaccination policies are typically only directed at high-risk settings such as long-term care homes, hospitals, and community care centres (CBC 2021c).

To be clear, the takeaway here is simply that for employers for whom vaccination policies are *not* prescribed by regulation (e.g., hair salons), vaccine requirements are *neither categorically required* nor *categorically forbidden* under occupational health and safety legislation. The legalities are a more nuanced question, turning in part on the risks posed within a given workplace, and also whether employees are under a collective agreement, where the imposition of vaccination requirements may be construed as managerial overreach.

i. Vaccination Mandates for Non-Unionized Employees

From an equity and public policy perspective, vaccination policies affecting low-socioeconomic status workers are, or ought to be, a top concern. This segment of society has borne the brunt of the pandemic, thanks to factors like cramped work and living conditions, and has faced unique challenges in accessing the vaccine, due to factors like the cost of travel and missed work to be vaccinated, language barriers in accessing information about vaccination, and so on. Though it may not be a legal requirement, this is an area where fairness clearly demands that employers help workers overcome access issues before wielding the stick of vaccination mandates. At a minimum, this should include an offer of paid time to seek vaccination and sick pay in the event of vaccine side effects. Note however that a government program exists which provides compensation for serious and permanent vaccine injuries, including income-replacement and medical expenses, calculated on a case-by-case basis. (Vaccine Injury Support Program, 2020).

In non-unionized contexts, workers have a little protection against dismissal for failure to comply with vaccination mandates. The salient question is whether the courts will view the refusal to be vaccinated as wilful misconduct, giving employers just cause for termination, and obviating severance pay requirements. There does not appear to be any case law on this matter, no doubt owing to the novelty of mandatory vaccinations outside of unionized settings like hospitals. It is possible that the courts will find just cause in some workplaces and not in others—again this may turn on the specific risks within a workplace: to echo previous examples, it will be easier to establish just cause in a meat packing plant than in a spread-out office. Absent a finding of just

cause, termination for non-vaccination can still proceed, but the employer will owe termination or severance pay to the employee; calculation of these payments may vary by jurisdiction and turns on a handful of factors, including the employee's length of service, salary, length of notice, and so on (*Employment Standards Act* 2000).

ii. Vaccination Mandates for Unionized Employees

As it concerns unionized workplaces, the issue is whether the unilateral (i.e., non-negotiated) imposition of vaccine mandates might be successfully grieved in labour arbitration, as an unreasonable exercise of managerial rights. The applicable test here is the '*KVP* test,' drawn from a 1965 labour arbitration case (*Re Lumber & Sawmill Workers' Union, Local 2537, and KVP Co.*1965), which requires that unilateral management policies be:

- Not inconsistent with the collective agreement
- Not unreasonable
- Clear and unequivocal
- Brought to the employees' attention before the employer acts on it
- Where the rule is invoked as grounds for discharge, the employee was notified that a breach of could have this result
- The employer has enforced this rule consistently

The Supreme Court of Canada has stated that, "heart of the '*KVP*' test…is that any rule unilaterally imposed by an employer and not subsequently agreed to the union, must be consistent with the collective agreement and be reasonable" (*Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper, Ltd.* 2013). The reasonableness standard set out by the Court is reminiscent of the reasonableness standard used in other contexts—including the privacy law context discussed above:

> "Determining reasonableness requires labour arbitrators to apply their labour relations expertise, consider all of the surrounding circumstances, and determine whether the employer's policy strikes a reasonable balance. Assessing the reasonableness of an employer's policy can include assessing such things as the nature of the employer's interests, any less intrusive means available to address the employer's concerns, and the policy's impact on the employees."

Unlike the non-unionized context, there is some relevant case law here, notably from health care workers challenging influenza vaccination mandates in labour arbitration. The mandates at issue in these cases vary, sometimes requiring vaccination as a brute condition of service, sometimes requiring that unvaccinated health care workers take unpaid leave during flu outbreaks, and sometimes giving workers the choice to vaccinate or mask. For the most part, arbitrators have upheld influenza vaccine mandates as a reasonable policy in these health care contexts (Flood, Thomas and Wilson 2020; Gruben 2015). There have been isolated cases where vaccination policies have been overturned by arbitrators. In *St. Peter's Health System v Canadian Union of Public Employees Local 778*, the employer categorically required vaccination as a condition of service during an influenza outbreak, requiring employees who refused vaccination to stay home without pay, and the arbitrator found that the policy infringed upon the right to security of the person—"forced medical treatment … is an assault if there is not consent"—and deemed the policy unenforceable. Likewise, in *St. Michael's Hospital & The Ontario Hospital Assoc. v the Ontario Nurses' Association*, the arbitrator found a broad requirement to vaccinate or mask (outside of the context of an outbreak) to be an unreasonable exercise of management power—the arbitrator deeming the evidence for masking against flu influenza "insufficient, inadequate and completely unpersuasive." Clearly, it is likely that this finding would not translate to the question of COVID-19 vaccinations, given the evidence that has emerged over the course of the COVID-19 pandemic regarding the benefits of masking and transmission via aerosolization.

As indicated, these instances where arbitrators have overturned vaccination mandates are the exception to the rule. More importantly, these cases concerned seasonal influenza vaccination—the reasonableness test would require that arbitrators account for the high morbidity and mortality rates associated with COVID-19, and the effectiveness of vaccination in preventing both transmission and serious illness. Other things being equal, these factors should push arbitrators even further in the direction of upholding workplace vaccine mandates. There has been at least one arbitral ruling that bears this out: in *Caressant Care Nursing & Retirement Homes v Christian Labour Association of Canada* (2020), the union grieved the reasonableness of a unilaterally imposed policy requiring that all staff at the home be tested for COVID-19 every two weeks. The arbitrator in the case dismissed the grievance, explaining among other things that,

> "COVID is novel, thus its name. Public health authorities are still learning about its symptoms, its transmission and its long-term effects… In my view, when one weighs the intrusiveness of the test: a swab up your nose every fourteen days, against the problem to be addressed—preventing the spread of COVID in the Home, the policy is a reasonable one."

The difficulty, from the standpoint of gaining clarity on the law here, is that all the available precedents concern the reasonableness of vaccination mandates in uniquely high-risk setting like hospitals and nursing homes. We are in uncharted waters when speculating about lower risk workplaces, with only the reasonableness standard, outline above, as our guide. This brings us back to considerations that are by now familiar: what are the risks of infection within a given workplace?; are there less intrusive measures by which those risks can be effectively mitigated?; if so, are those alternative measures feasible from a logistical and cost standpoint?

One alternative was just mentioned, namely, requiring that unvaccinated workers submit to regular testing. Indeed, a testing requirement may appear to offer a solution to other concerns canvassed above as well, such as workers or patrons who demand a religious exemption to vaccination requirements. The problem is that testing does not achieve the key objective of protecting unvaccinated individuals themselves. An unvaccinated individual who provides a negative test result will be at risk of infection from vaccinated co-workers, who after all can carry and transmit the virus, sometimes asymptomatically.

6. Conclusion

Private sector organizations are, quite understandably, eager for clear guidance as to their legal rights and obligations when it comes to imposing vaccine checks on workers and patrons. The governments' targeted implementation of vaccine passport systems and vaccine mandates has provided both obligations but clarity too for specific sectors, such as restaurants and long-term care providers. But many businesses have been left to sort these legalities out for themselves, making educated guesses as to whether a proposed vaccine requirement, in a given context, will meet the law's open-ended standards of reasonableness. Thankfully, some human rights bodies in some provinces (Ontario, Saskatchewan) have issued policy statements clarifying that vaccine hesitancy is likely not protected under the rubric of religious freedom. However, beyond this much remains uncertain.

Even as we come to grips with basic question around the legality of vaccination requirements that individual businesses can impose, the emerging science may present us with new challenges. Consider the question of *what information* is transferred when confirming vaccination. Under current vaccine passport implementations, the aim for is for *no* data to be transferred: vaccination status is either visually verified or verified with a QR code scanning app, meaning that businesses

do not store information about what vaccine you received and when, your age, and so on. This simple approach has much to recommend it from the privacy law perspective of minimizing data collection, but it will soon be insufficient from a public health perspective. We know that people's immunity will gradually wear off—the timing is a function of what vaccines were received and at what intervals. In the long run, then, employers who wish to track their employees' vaccination status may need to request the employee to submit their vaccination records. They may also require other personal health information along with this which may inform occupational health decision-making, for example age of the employee or immunocompromised status, to determine if a booster is needed. It's possible the employee could provide a one-time attestation and then delete the record but given the data on changing immunity this would likely be problematic and vaccination data would eventually need to be re-requested.

The legalities surrounding private sector vaccine requirements are a complex and require attention to contextual nuances. The information and analysis in this report provides a broad overview but is no substitute for the specific legal advice likely needed. One option would be for trade associations made up of business in similar industries/workplaces to establish vaccination requirements and jointly seek the legal advice needed to support how best to implement this. Broadly speaking, any business contemplating the implementation of vaccine requirements should ensure that the policy, and its justification, are clearly and fully explained and communicated to those affected—including the type of documentation required, the penalties for non-compliance, and the name of a designated person within the organization responsible for answering questions and adjudicating requests for accommodation (Vijaykumar 2021). What would be better for all businesses concerned would be governmental regulation, providing the footing from which employers are permitted to require proof-of-vaccination, both from employees and customers.

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