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Workers' health policies in Brazil: historical contradictions and possibilities for development

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Abstract *The Workers' Health (WH) approach understands that it is necessary to expand the object of public policies to transform the work processes that determine the health-disease relationship. This broadening brings challenges that drive the development of the formulation and implementation of policies for the surveillance and prevention of diseases. This article aimed to analyze the development of Brazilian policies on WH from the perspective of historical contradictions. To this end, the analytical concept of contradiction from Cultural-Historical Activity Theory was used. This is a scoping review, including 64 theoretical and empirical studies and gray literature published between 1991 and 2019. The results of the analysis showed that: from the change of the object of prevention inserted by the WH approach, five new contradictions emerged that are related to the predominance of instruments of the previous activity model, normative and training instruments, division of labor for assistance and surveillance actions, intra and intersectoral articulations, and social control. These contradictions have driven some changes, but some limitations persist around a challenging object.*

Key words *Workers' health policy, Workers' health services, Workers' health surveillance*

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Introduction

The concept of Workers' Health (WH) requires the understanding of the relationships between work-health-disease, in a context of constant changes¹. Historically, this path starts with the Labor Medicine approach, which has the physician as the main actor, the workers as passive subjects, and a model which explains diseases in a unicausal manner. The growing concerns about the high cost of the health grievances and the workers' struggle for better living conditions², have demonstrated that the model is insufficient to intervene on the problems caused by the productive process.

The occupational health (OH) approach appears as an alternative, providing tools to intervene in a new object: the work environment. However, the interdisciplinary actions remain unarticulated in this approach, and its focus, although multicausal, remains mechanistic^{1,2}. In Brazil, this movement came together with the creation of regulating norms (RN) which began to mediate the relationships between the inspection agencies and companies. OH Departments were created in academic and governmental institutions, representing a significant expansion of the community.

In the context of the Brazilian Sanitary Reform Movement (MRSB, in Portuguese), the first National Conference on Workers' Health (CNST, in Portuguese) was held, with its objective switched to the determination of the work process¹. In this perspective, we began to see criticism to the scientific foundation of "tolerance limits" and "safe exposure", and mechanisms such as the Internal Committees for Accident Prevention in the Workplace, present in regulatory norms since 1978, to promote the participation of the workers² and Workers' Health Programs (WHP) to operationalize the actions³⁻⁵.

Even with improvements in the WH approach, which highlights social determination, multi-professionalism, and intersectionality, this field still operates according to compartmentalized logic, in which the actions are executed by agencies that are institutionally separated³. Furthermore, the constant technological innovations impact the appearance of new occupational hazards and new productive logic, something that is not always easy to follow².

Contributing to the studies which have discussed the progress, challenges, and possibilities of WH policies in Brazil⁶⁻¹⁰, the current review aims to contribute to the analysis with the following questions: "What was the historical develop-

ment of WH policies in Brazil? Which historical contradictions were overcome and in which way did they promote changes in the development of those policies? What contradictions still remain that limit the implementation and progress? To answer these questions, the present study adopted theoretical assumptions and concepts from the Cultural-Historical Activity Theory (CHAT).

The concept of contradiction as a source of development

The historical reference of this study begins with the premise that the implementation of public policies to prevent WH grievances is a collective activity that is determined historically and measured by social relationships. To understand these aspects, it is necessary to comprehend three principles of CHAT¹¹: the object, the historicity, and the contradictions of the system of activity (SA). The first principle determines that a system or a network of human activities is collective and guided by an object; therefore, the study of WH policies assumes the analysis of the object which guides the activity, in other words, understanding what needs to be transformed by such policies. The next principle is historicity: WH changes over time; therefore, its problems can only be understood through the study of their history. Lastly is the principle that contradictions accumulate structural tension between the elements, which are part of the activity, and when they are aggravated, they promote a questioning of the possibilities of change and, in some cases, generate a collaborative vision about possible solutions. In other words, the contradictions cause disruptions but also innovative attempts to alter the activity¹¹.

The contradictions may appear discursively through dilemmas, conflicts, and standoffs, and those manifestations are, in themselves, merely hypotheses¹². When only the public policies are analyzed, there is only a perception of what is prescribed for the implementation of the different WH models. What was found in the existing literature were the differences between what is prescribed and what is real in order to formulate the hypotheses of the possible contradictions related to those disruptions.

Methodology

The present study performed a scoping review, aiming at identifying the historical development of WH policies in Brazil. This type of review en-

ables the mapping of the key concepts that support a research field and the available sources of evidence¹³. The review followed these steps^{13,14}: 1) identification of the research question; 2) identification of the documents from databases; 3) identification of other documents based on the consultation; 4) consolidation of the sample; 5) charting the data related to the research question; 6) analysis and report of results.

This work used the simple search option in the Virtual Health Library (BVS Brasil, in Portuguese), which includes, in addition to the scientific database, sources of gray literature, such as those from the institutions responsible for the implementation of those policies. The choice of descriptors was done in phases of experimentation in order to produce two strategies of search for the title, abstract, and subject, or in the mesh: "Policy for workers' health" OR "Workers' health surveillance". Texts in Portuguese and that were fully available were included, with no time limitations. The review phases are described in Figure 1.

Our search identified 203 reports, with 73 being duplicates, which were excluded by applying the *EndNote* bibliographic reference manager. Reviewers 1 and 2 (R1 and R2) read 130 titles and abstracts obtained from the database search, identifying which ones met the inclusion criteria, eliminating 92 articles. After selecting the initial sample for the complete reading of the texts, we conducted a consultation^{13,14}, aimed at including publications which covered the study's theme and that were not indexed in the analyzed databases. To achieve this, the references of the included publications were searched, resulting in 40 new records. Of those, seven were not available online, resulting in 33 records, which were analyzed by R1 and R2, adding 29 new documents to be included in the analysis.

Six researchers did the complete reading of the 67 texts, and three texts were removed for not answering the investigation questions. Therefore, 64 texts were included, 35 from the BVS Brasil and 29 from the expanded consultation.

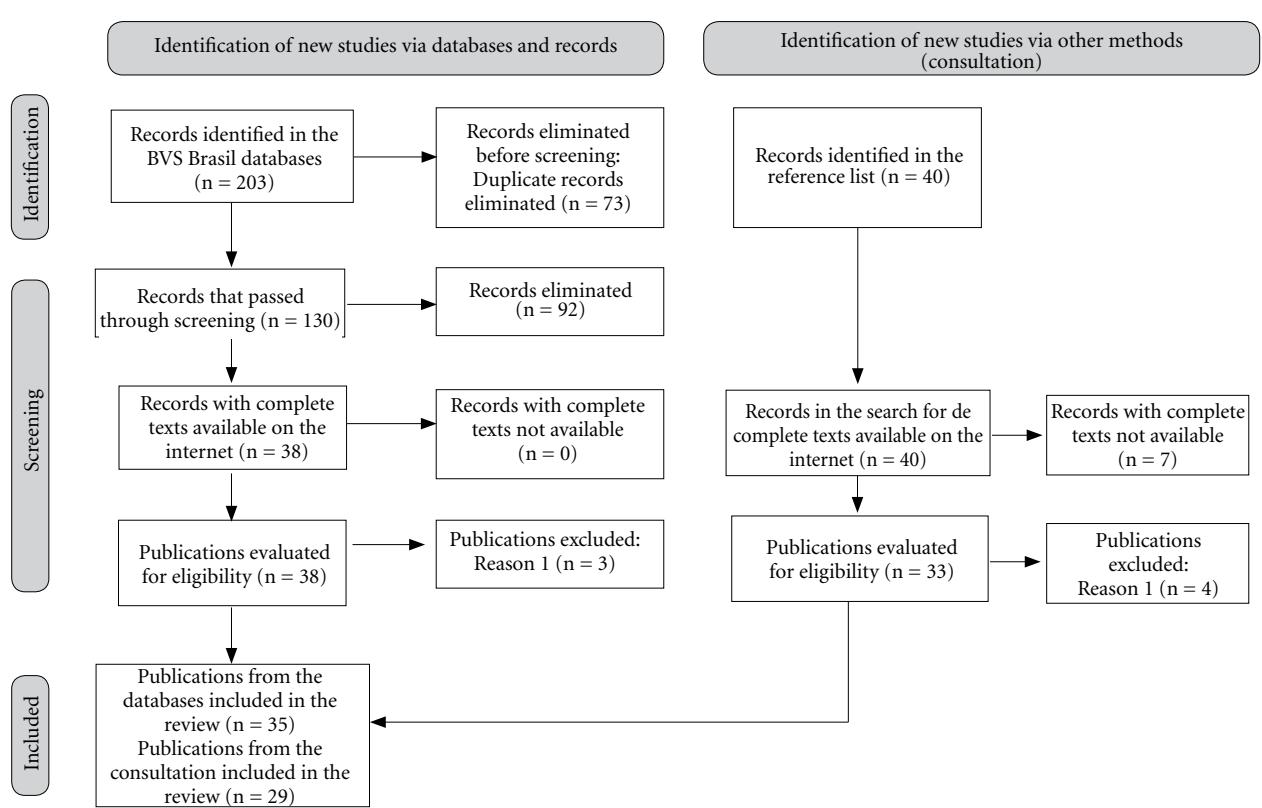


Figure 1. Scoping review flow chart.

Source: Authors, adapted from Page *et al.*¹⁵

For the data charting, we designed a matrix in an Excel worksheet with categories related to the characterization of the studies and the analysis categories, built based on the theoretical referential. A pilot test for that matrix was performed by three of the authors, using five articles selected from the BVS Brasil, to analyze the pertinence and relevance of the items, with the final version presented in Chart 1.

Link for the revision metadata set: <http://repositorio.uspdigital.usp.br/handle/item/346>

Results

The documents included in this study had the following characteristics: 22 were essays, 21 were research articles, 6 were dissertations or theses, 5 were experience reports or case studies, 5 were chapters of books, 3 were revision articles, and 2 were notebooks; 41 of the studies were theoretical and 23 were empirical; 44 were nationwide and 20 were regional. The oldest text was from 1991, and the most recent was from 2019.

The results were categorized based on the adopted theoretical reference and the research questions. The development of the WH policies in Brazil was analyzed through the difficulties and progress and, based on these findings, the hypotheses for the historical contradictions that promoted changes were formulated.

Historical development of the WH policies: changes based on the new object (contradiction 1)

In the context of the MRSB, the new approach in WH is made up of the work process as an object of transformation¹⁶. When it is adopted, there is a contradiction between the new and the old approach to prevention. In the traditional approach, the work environments have risk factors that are mostly measurable (technical dimension,

fixed, fragmented), while in the new approach, the work process socially determines the health of the population (systemic dimension, expansive, unexpected). However, many subjects involved in the activity maintain the first approach, and consequently, do not recognize the second. This contradiction is manifested by a prevention activity which favors actions upon risk factors but does not consider actions upon work processes.

The economic development model has prioritized short term and medium term results at the expense of health and the environment (for instance, no participation of the Brazilian Unified Health System (SUS, in Portuguese) in the Growth Acceleration Program)^{16,17}. The interest in the immediate creation of jobs, ignoring the sustainable development initiatives, and the lack of intervention in companies, which cause WH grievances, are evidence of the political rationale above the technical rationale^{4,6,18}. These problems can be seen in the agents' lack of autonomy to execute actions¹⁹, regardless of the political and economic interference, in the manner prescribed by the WH approach, as a political-ideological practice to overcome the power relationships¹. These are manifestations of a contradiction prior to the WH approach and inherent to the work process itself. Investments for the development of WH produce only long-term results, which clashes with the search for financial return in a very short term. Since the objective of the activity is also its true motive, the inherently double standard of the motive becomes visible²⁰.

SUS still has not incorporated "work" as a main category in the social determination of the health-disease process. On the one hand, at the level of Primary Health Care (PHC), the user is not recognized as a "worker"^{21,22}, while in other places, there are no records of the worker's occupational history²³. Many Reference Centers for Workers' Health (CERESTS, in Portuguese), where that information is partially available, do not act upon improving the records, and the pri-

Chart 1. Matrix for the extraction of data from the included studies.

| # | Author(s) | Title | Year | Type of document | Aim | Method | Population |
|------------------------|-----------------------|--|--|---|----------------------------------|--------------|------------|
| Categories of analysis | | | | | | Observations | Link |
| Contradictions | Type of contradiction | Elements of AS involved in the contradiction | Did the contradictions promote advances? Which? | Did the contradictions remain in the limitations? Which? | Was a runaway object identified? | | |

Source: Authors.

orities are not organized based on the mapping of the productive processes^{21,24,25}. All that translates into a chronic incapacity to establish the relationship between disease and the work process²⁶. However, there are some documented experiences which sought to overcome that contradiction²⁷.

The appearance of the primary contradiction in the new object (in this context, the WH model) leads to other contradictions which are described here below.

Contradictions between the new WH object and the old elements of occupational health (contradiction 2)

The new object (work processes) is supported by the theoretical approach of WH, however the actions are still mediated predominantly by instruments created to deal with the old subject of occupational health (work environment). The publication of protocols, norms, and manuals to guide the actions of WH through the network of public services²⁸ do promote progress in instrumentalization. However, the heritage of instruments to interpret productive industrial work, with a strong predominance of the concept of "risks"²⁹, limits the understanding and the dynamic transformation of the work processes.

At the same time, the current WH policies define a minimum number of people for the CERESTS teams, but the hiring and transferring processes do not require a degree or experience in the field³⁰. This results in the aggravation of the contradiction between the use of outdated conceptual instruments (from the old model) to deal with the object of the work process (proposed by the new model). The CERESTS which face that difficulty seek to invest in ongoing education or to encourage people to acquire Master's degrees in the profession, thereby accumulating experience and knowledge^{28,30-32}. However, there are still many services that do not have specialized professionals who are technically capable or do not include the thematic of WH in the ongoing education actions^{19,26,28,29,33-35}.

Even in face of a State policy for the education and training of those human resources³⁶, it is possible to notice an increase in post-graduate programs related to WH, with a resulting boost in academic production and incorporation of new concepts that allow for professional practices guided by WH policies⁸. However, there is a mismatch between the scientific production and the

level of empirical results, and the production of knowledge is too fragmented to offer subsidies for the elaboration of public policies^{25,29,37,38,39}.

Between assistance and surveillance – in the division of labor (contradiction 3)

Several authors indicate difficulties for the implementation of WH practices based on the principle of integrality. The initial strategy of the National Network for Workers' Health (RENAST in Portuguese) allowed for the financing and the expansion of the network with new CERESTS. However, it emphasized individual care actions, at the expense of surveillance actions and of the recognition of those services as instances for specialized occupational health care^{18,21,26,28,30-32,40-43}. On the other hand, the regionalization strategy resulted in a high number of regional services, with limited access to the more remote municipalities^{39,43}. In addition, regardless of the financing that was promoted, some resources were earmarked to cover other needs of the health system^{28,30,31}.

Since 2009, Decision no. 2728 determines the municipalization and the inclusion of articulated actions of Workers' Health Surveillance (VISAT, in Portuguese) at the PHC level, as well as at other levels of the Health Care Network (RAS, in Portuguese). Some of those CERESTS have invested in strategies for the creation of Family Health Teams (FHT), thus achieving improvements in the use of the Notifiable Diseases Information System (SINAN, in Portuguese), with advancements in terms of surveillance, although there were inconsistencies in the data banks^{44,45}. Even with that initiative, the technical support by the CERESTS to the FHT is limited to punctual qualification and is seldom used as a support strategy, such as the discussion of cases. The FHT works in a scenario of overload, high staff turnover, precarious connections, and insufficient use of the surveillance instruments. There is a clear need for intervention, not only to institutionalize the support offered by the CERESTS, but also to improve the working conditions within them^{21,40}.

Although assessment indicators were created in the CERESTS, many are still following the healthcare line of work, and there are no qualitative indicators for the evaluation of the impact of the actions and the results of the formulation of the network, which encompasses the different work processes and the needs of each service^{36,41}.

Between the ability of articulation and the results of surveillance and prevention (contradiction 4)

The authors included in this review, refer to VISAT's limited capacity of intrasectoral and intersectoral articulation, with no conceptual basis for cross-sectional actions^{25,26,34,41}. Regardless of some attempts, such as the ABRASCO Congress in 2003, which promoted integrated discussions in different thematic groups among the surveillances, it is still difficult to create an intrasectoral connection between the VISAT actions and the environmental, epidemiological, and sanitary surveillance^{6,26,28,30,40,46,47}. The 2005 decision sought to strengthen RENAST through the organization of services and "sentinel-municipalities"; however, the notification of diseases was restricted to those municipalities⁴⁴. Even with the expansion of notifications to all the municipalities, some CERESTS still face difficulties to develop capacitation in the sentinel-municipalities supported by those CERESTS⁴⁵.

Three examples of successful actions can be highlighted among the coordinated surveillance: the control of the exposure to benzene at gas stations, the actions of VISAT in the sugarcane sector^{19,48,31}, and the insertion of WH actions in the SUS municipal plan by CEREST from the town of São Bernardo do Campo, SP, Brazil³².

In the organizational plan, since 2007, the General Coordination of Environmental Health Surveillance and the General Coordination of WH form the Environmental and Workers' Health Department at the Ministry of Health, seeking to move forward into intrasectorial realm²⁴. However, the authors included in this review did not mention the specific results achieved by this new department.

Regarding the intersectoral dimension, the WHPs are referred to as relevant antecedents, since they have already connected WH care with surveillance at the workplaces, with the workers' unions participating in the management of those programs²⁵. In addition, one can see progress in the announcement of the Intersectoral Commission for the Workers' Health (CISTT, in Portuguese) in the Organic Health Law⁴⁹, set forth by representatives of eight ministries with the aim of supporting the National Health Council in matters related to WH.

Even before the publication of the Organic Law, there was a fragmentation of responsibilities with the Regional Labor Agencies, with the extinct National Institute of Medical Care from Social Security, overseeing medical care, and the

National Institute of Medical Care for Social Welfare, performing cause recognition^{3,6}. Hence, when the VISAT was created, historical conflicts of competence among the Ministries (Health, Labor, Work) arose^{4,50,51}. In an attempt to overcome such conflicts, the National Policy on Safety and Health in the Workplace (PNSST, in Portuguese)⁵² was created, reaffirming attributions already present for each Ministry^{23,31} without proposing intersectoral actions and maintaining the Ministry of Labor at the core of the surveillance actions in the workplace⁴⁸.

In this context, some studies indicate the fragility of the CISTT and the limitations of the PNSST, which do not show practical lines for the sectors involved^{53,54}. Oliveira and Vasconcellos⁵⁵ proposed that the CISTT should also include unions, the Labor Courts, and the Labor Prosecution Office (MPT, in Portuguese), as well as called attention to the fact that the work environments were left out of the sphere of intervention of the National Health Surveillance Agency, following the recommendations of the International Labor Organization (ILO). The historical emphasis of the work on such products as medicine and food has hampered the incorporation of work processes in its sphere of action⁵⁶.

In 2012, considering the need for a definition of principles, directives and strategies in the three spheres of SUS, the Ministry of Health published the National Policy on Occupational Health (PNSTT, in Portuguese)⁵⁷, which became one more contradictory element, since the clashes between the PNSST and the PNSTT result in two systems of surveillance and no actual policy⁴².

By contrast, with the massive loss of Labor Inspection Agents, some actions by the Ministry of Labor were substituted by actions of the MPT. In this sense, the uses of the Conduct Adjustment Agreements (TAC, in Portuguese) have been widely used as important instruments for action^{17,54}, since most of the CERESTS do not have the status of a sanitation authority. Some Regional Labor Agencies use the TAC as a tool to confer the power of action to the Centers^{48,58}. This is also the product of progress produced by contradiction 2, since the instruments that VISAT has, such as prosecuting and fining, have limited efficiency in terms of intervening in work processes. The connection with the MPT otherwise favors the use of more adequate instruments for that purpose.

As mentioned above, RENAST enabled the transference of resources and the expansion of the network. However, there have been few advancements in terms of "coherence" (cooper-

tion between actors) and “connectivity” – intra and intersectoral (fluid communication between the components of the network)⁴¹ (p. 89). Interactions with other sectors, such as companies and organizations, are mentioned in the texts as theoretical proposals, but there are no reports of experiments in this sense.

Between social control and the incorporation of the workers as subjects (contradiction 5)

WH emerged in a favorable context of strong MRSB participation. Initiatives, such as the creation of the Intersyndicate Department for Study and Research on Health the Workplace and the first CNST would bring several sectors of the society to the discussion about the basis for future policies in WH. The PNSTT and the PNSTT themselves were placed under society's scrutiny. However, with neoliberal policies in place in the country and the subsequent precarious nature of working conditions, unemployment, and growth of informal work, the connections between workers and unions weakened^{1,24,25}. Mostly focused on salary issues, job maintenance, welfare benefits, and health plans, the workers' unions are likely to defend the WH agenda less^{28,48,59} and to demand increasingly technical and short-term proposals from the CERESTS.

The CISTT presupposes the participation of civil society as an element of technical-political handling for the development of planning and evaluation actions⁴⁹. However, the population has minimal participation in the elaboration of WH policies and in the control of governmental actions^{56,58}. The Legal Decision for the expansion and strengthening of RENAST establishes that the social control of the services that are part of the network must take place through the Health Conferences, the Health Councils, and the CISTTs⁶⁰. However, the local CISTTs, in general, are non-existent or do not participate in the Municipal Health Councils; therefore, there is an absence of municipal WH policies structured and supported by social control³⁶.

The expansion of health care to the working population takes place, in some areas, as a product of discussions between public managers, union organizations, and social control instances, as well as of the incorporation of actions in Municipal Health Plans, in a perspective of both universality and the inclusion of the workers from the informal economy¹⁸.

In 2013, the city of São Paulo recognized that there was a problem of “sparse participation of

organizations, social entities, and workers in the creation of WH policies, as well as in social control”⁴⁷ (p.3). In the Municipal Pluriannual Plan for the WH, there are two specific objectives established: a) to strengthen public participation in the creation of WH policies and b) to make public administration more transparent in the area of health, solving the indicated problems through the participation of the beneficiaries⁴⁷. However, the literature included in this review does not make reference to the realization of those objectives.

Figure 2 summarizes the results, highlighting the main events, publications, and moments in which the literature began to identify the challenges that are interpreted here as manifestations of contradictions in the development of the WH policies.

Discussion

In the implementation of WH policies, what persists is a contradiction that emerges with the expansion of the object of interest: the social determination inserted in the organization of the work processes¹⁶ as a determining factor of the WH problems⁶⁰. Before discussing this effect specifically, a conceptual difference must be defined.

The Social Determinants of Health (SDH) are defined as the social, economic, and cultural factors which influence the development of health problems⁶³. The concept appears in Brazil “devoid of its theoretical and political weight” when one tries to “understand it in the Marxist light” of social thought⁶² (p. 7). This model reinforces the positivist approach of traditional epidemiology, since, when methods of the natural sciences are used in the natural world, they provide a static picture of reality, clouding the dynamic nature of the social determination theory^{62,64}. In addition, the model maintains a limited view regarding factors and makes it impossible to analyze the historic nexus of the dimensions of life.

The social determination model proposes the comprehension of the events based on the dynamic mediations between the levels in which the social processes are produced⁶⁵. In the field of WH, the preference for the SDH-based approach favors the implementation and maintenance of the “ailing work process”, since the social determination of the productive system, which is evidenced in its structure, organization, targets, and deadlines, is not contested nor even altered.

The actions by the State are aimed mainly at the interests of the market, so the lack of articu-

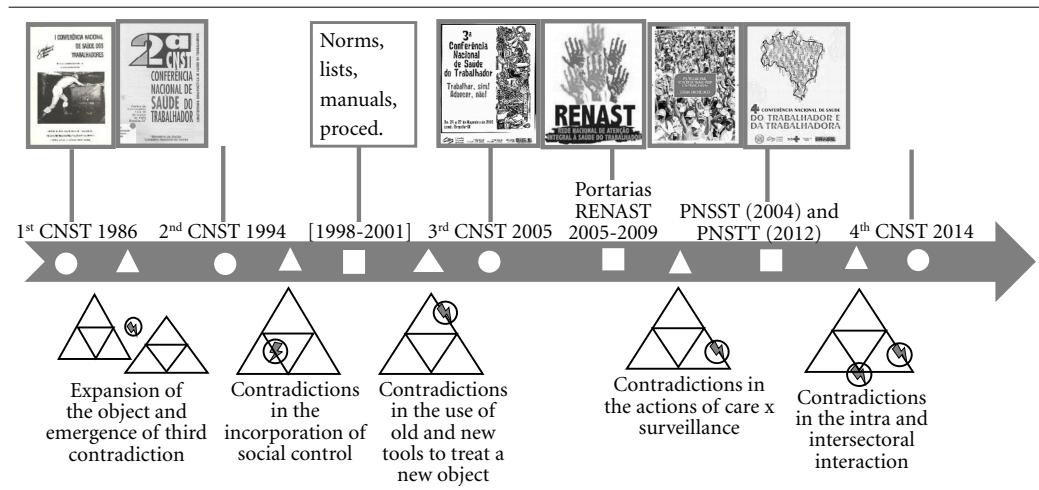


Figure 2. Timeline of the historical contradictions in the development of WH policies in Brazil.

Source: Authors.

lation between the Ministries in the field of WH weakens the main intervention actions⁶⁶. Therefore, the relationships between workers and the owners of the means of production, in fact do not change. The third CNST, from 2005, also warns of the disconnection of the industrial and economic policies, which creates risks to workers' health.

The reviewers of the present study noticed that only two publications highlight the insufficient staff for the development of WH actions^{19,48}, which was interpreted as a contradiction between subjects and object. The well-known situation of working groups which are dismantled, or have witnessed a high staff turnover in recent years is a fact which has most likely been indicated in more recent publications, or there have simply been too few studies regarding this issue.

Studies which were published after the data collection for this review indicate a persistence of the contradictions mentioned here. For instance, in the integrality dimension (contradiction 3: assistance and surveillance), Faria et al.⁶⁷ indicated that the insertion of the line of WH care in the Family Health Strategy is still weak. The authors also warn that important transformations are happening in the field of national PHC policies and in the ability of the State to guarantee the workers' social security, which is necessary to fight for the right to have public policies for the working class.

In the fourth contradiction, of intra and intersectoral interaction, Lancman et al.⁶⁸ mentioned the lack of guidelines that support the operationalization of clear and effective intersectoral actions between managers and workers.

Concerning contradiction 5, on social participation, Lacaz et al.⁶⁹ stated that the unionist experiences opened the possibility of reverting the medical model of health care by means of controlling technical performance. However, the authors show that the focus of the unions on negotiations with healthcare companies has proven to be a persistent contradiction. Finally, the authors mentioned that there is a separation between the MRSB and the Union Movement concerning WH, since the reform did not consider the political relevance of the work of the unions towards WH.

The texts included in this review highlight the difficulties for the implementation of policies due to undernotification, to the process of outsourcing, and to precarious nature of work and informal work^{17,36,48,53,70}. Moreover, fast changes in productive processes and work relationships, through new technologies and labor reforms, bring consequences that take time to be understood and recognized, with a consequent delay in the implementation of strategies to face the problems^{2,16,24,29,35,37,71,72}.

Therefore, social determination of the WH health problems, located in the organization of the work processes, is a complex object which is multi-determined and goes beyond the control of the different activity systems. It seems to be a hard-to-grasp object⁷³, which, in the context of globalization, changes rapidly and avoids isolated actions by the systems which gravitate around it, attempting to transform it (Figure 3). It is an object which may go unnoticed for long periods of time, apparently showing that it overcomes

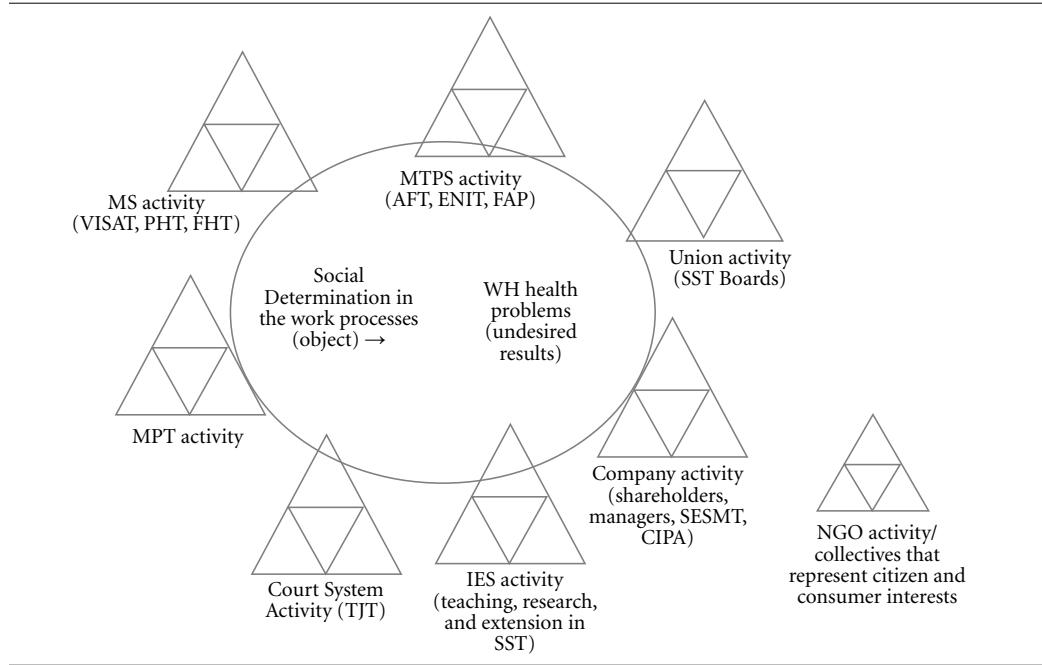


Figure 3. Multiple activities which attempt to control the social determination of the WH problems, seen as a runaway object.

Source: Authors, adapted from Engeström⁷³.

the contradictions it produces, until it explodes in severe crises. Controlling this object depends on intention and action, but such initiatives are dispersed and have little result⁴².

With the development and implementation of WH policies, some contradictions have promoted or still promote punctual or local efforts to overcome them, with a strong potential to transform the field over time. Some of these advances were mentioned in each contradiction, for instance: the Service of Surveillance in Environments and Workplaces at the regional CEREST from Palmas (TO) in contradiction 1; the instrumentalization brought by RENAST in contradiction 2; the creation of FHTs, notification of diseases via SINAN, and improvements in surveillance in contradiction 3; attempts to articulate a dialogue between surveillances and successful examples of coordinated actions in contradiction 4; and proposals to improve social participation in contradiction 5. Other advancements promoted, based on these contradictions, such as the Digital Observatory on WH and Safety and the PHC notebooks for WH, were not found in the reviewed texts, but they are nonetheless an effort to overcome the lack of information regarding WH problems.

Final considerations

Some of the historical contradictions which arose from the development of the WH policies do persist, limiting the progress of the actions by VISAT, while at the same time others promote innovation and local transformations in prevention practices. A detailed comprehension of those contradictions would promote a review of WH policies, especially at the level of instrumentality, in order to act upon the work processes, integrality, intra and intersectoral interaction, and social control.

This scoping review limited the search into health data, leaving out possible publications from other areas, which are influenced by WH policies. Moreover, it was necessary to exclude texts which were not available on the Internet, especially chapters that are only available in printed books, since the SARS-CoV-2 pandemic kept libraries closed for consultation. The search in the databases was conducted in the first semester of 2020; therefore, the publications related to the pandemic and WH had not yet been indexed. The discussions about the new ways of labor organization and the advancement of neoliberal policies did appear in some more recent publications, al-

though terms such as “uberization of labor” were not yet used.

The influences of the institutional scenario on Brazilian policies did not appear in the included publications. There is a need for new studies that may contribute to reflections on how the WH models, which are predominant throughout the world, produce contradictions or progress in Brazil.

The formulation and implementation of WH policies calls for studies on participative and formative intervention with agents who produce

and apply these policies at different levels and in different activity systems. Such efforts must keep their sights on the formulation and validation of the hypotheses of the contradictions indicated herein order to curb them through stable and long-lasting coalitions, so as to contemplate scenarios of decent work. The object dealt with in this study is highly liberating and may give impetus to initiatives that are common to all the parties involved, as well as open up new possibilities of development, welfare, and protection for those who produce social wealth.

Collaborations

SLB Hurtado: conception and planning; data analysis and interpretation, write-up of the article, approval of the version to be published. AP Simonelli: conception and planning; data analysis and interpretation, critical review of the article, and approval of the version to be published. VA Mininel: conception and planning; data analysis and interpretation, critical review of the article and approval of the version to be published. TV Esteves: data analysis and interpretation, write-up of the article, and approval of the version to be published. RAG Vilela: conception and planning, critical review of the article and approval of the version to be published. A Nascimento: conception and planning; data analysis and interpretation, critical review of the article and approval of the version to be published.

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References

1. Lacaz FAC. O campo Saúde do Trabalhador: resgatando conhecimentos e práticas sobre as relações trabalho-saúde. *Cad Saude Publica* 2007; 23(4):757-766.
2. Mendes R, Dias EC. Da medicina do trabalho à saúde do trabalhador. *Rev Saude Publica* 1991; 25:341-349.
3. Oliveira MH, Vasconcellos LC. Política de saúde do trabalhador no Brasil: muitas questões sem respostas. *Cad Saude Publica* 1992; 8(2):150-156.
4. Machado JM. Processo de vigilância em saúde do trabalhador. *Cad Saude Publica* 1997; 13(Supl. 2):S33-S45.
5. Leão LHC, Castro AC. Políticas públicas de saúde do trabalhador: análise da implantação de dispositivos de institucionalização em uma cidade brasileira. *Cien Saude Colet* 2013; 18(3):769-778.
6. Santana VS, Silva JM. Os 20 anos da saúde do trabalhador no Sistema Único de Saúde do Brasil: limites, avanços e desafios. In: Brasil. Ministério da Saúde (MS). *Saúde Brasil 2008: 20 anos de Sistema Único de Saúde (SUS) no Brasil*. Brasília: MS; 2009. p. 175-204.
7. Jackson Filho JM, Lacaz FA, Costa D, Vilela RAG. Resposta dos autores. Dossiê temático. atenção integral em Saúde do Trabalhador: desafios e perspectivas de uma política pública – III. *Rev Bras Saude Ocup* 2013; 38(128):197-198.
8. Silveira AL, Merlo AR. Políticas Públicas em Saúde do Trabalhador: campo prático e de disputa simbólica. *Estud Pesqui Psicol* 2017; 17(3):877-894.
9. Gomez CM, Vasconcellos LC, Machado JM. Saúde do trabalhador: aspectos históricos, avanços e desafios no Sistema Único de Saúde. *Cien Saude Colet* 2018; 23(6):1963-1970.
10. Jackson Filho JM, Assunção AA, Algranti E, Garcia EG, Saito CA, Maeno M. A saúde do trabalhador e o enfrentamento da COVID-19. *Rev Bras Saude Ocup* 2020; 45:e14.
11. Engeström Y. Expansive Learning at Work: Toward an activity theoretical reconceptualization. *J Educ Work* 2001; 14(1):133-156.

12. Engeström Y, Sannino A. Discursive manifestations of contradictions in organizational change efforts: a methodological framework. *J Organ Chang Manag* 2011; 24(3):368-387.
13. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Social Research Methodology* 2005; 8(1):19-32.
14. Colquhoun HL, Levac D, O'Brien KK, Straus S, Tricco AC, Perrier L, Kastner M, Moher D. Scoping reviews: time for clarity in definition, methods, and reporting. *J Clin Epidemiol* 2014; 67(12):1291-1294.
15. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, Shamseer L, Tetzlaff JM, Akl EA, Brennan SE, Chou R, Glanville J, Grimshaw JM, Hróbjartsson A, Lalu MM, Li T, Loder EW, Mayo-Wilson E, McDonald S, McGuinness LA, Stewart LA, Thomas J, Tricco AC, Welch VA, Whiting P, Moher D. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021; 372:n71.
16. Vasconcellos LC, Machado JM. Política Nacional de Saúde do Trabalhador: ampliação do objeto em direção a uma política de Estado. In: Minayo-Gomez C, Machado JMH, Pena PGL, organizadores. *Saúde do trabalhador na sociedade brasileira contemporânea*. Rio de Janeiro: Fiocruz; 2011. p. 37-65.
17. Lacaz FAC. Continuam a adoecer e morrer os trabalhadores: as relações, entraves e desafios para o campo Saúde do Trabalhador. *Rev Bras Saude Ocup* 2016; 41:e13.
18. Albuquerque MD, Costa AM, Lima LP, Melo Filho DA. Equidade e inclusão de grupos sociais na política de saúde: o caso do Recife, Brasil. *Rev Bras Saude Mater Infant* 2011; 11(1):73-82.
19. Lourenço EA, Lacaz FA. Os desafios para a implantação da política de Saúde do Trabalhador no SUS: o caso da região de Franca-SP. *Rev Bras Saude Ocup* 2013; 38:44-56.
20. Engeström Y. *Aprendizagem expansiva*. Campinas: Pontes; 2016.
21. Amorim LA. *Vigilância em Saúde do Trabalhador na Atenção Básica: contribuições para o aprimoramento das ações de saúde no município de João Pessoa, PB* [dissertação]. Rio de Janeiro: ENSP, Fiocruz; 2016.
22. Silva A, Ferraz L, Rodrigues-Junior SA. Ações em Saúde do Trabalhador desenvolvidas na atenção primária no município de Chapecó, Santa Catarina. *Rev Bras Saude Ocup* 2016; 41:e16.
23. Dias EC, Silva TL. Contribuições da Atenção Primária em Saúde para a implementação da Política Nacional de Saúde e Segurança no Trabalho (PNSST). *Rev Bras Saude Ocup* 2013; 38:31-43.
24. Dias EC, Silva TL, Almeida MH. Desafios para a construção cotidiana da Vigilância em Saúde Ambiental e em Saúde do Trabalhador na Atenção Primária à Saúde. *Cad Saude Colet* 2012; 20(1):15-24.
25. Dias EC, Chiavegatto CV, Silva TL, Reis JC, Silva JM. Construção da RENAST em Minas Gerais: a contribuição dos Centros de Referência em Saúde do Trabalhador (CEREST), 2002-2007. *Rev Med Minas Gerais* 2010; 20(Supl. 2):S66-S74.
26. Lacaz FAC, Santos APL. Saúde do Trabalhador, hoje: re-visitando atores sociais. *Rev Med Minas Gerais* 2010; 20(Supl.2):13-23.
27. Silva RF, Fonseca BMC. A Vigilância nos Ambientes e Processos de Trabalho em Palmas – Tocantins: diagnóstico situacional e contribuições ao setor. *Tempus* 2021; 11(2):199-217.
28. Dias EC, Hoefel MD. O desafio de implementar as ações de saúde do trabalhador no SUS: a estratégia da RENAST. *Cien Saude Colet* 2005; 10:817-827.
29. Gomez CM, Lacaz FA. Saúde do trabalhador: novas-velhas questões. *Cien Saude Colet* 2005; 10(4):797-807.
30. Dias EC, Silva TL, Chiavegatto CV, Reis JC, Campos AS. Desenvolvimento de ações de Saúde do Trabalhador no SUS: a estratégia da Rede Nacional de Saúde do Trabalhador (RENAST). In: Minayo C, Machado JMH, Pena PGL, organizadores. *Saúde do trabalhador na sociedade brasileira contemporânea*. Rio de Janeiro: Fiocruz; 2011. p. 107-22.
31. Ribeiro FS, Leão LHC, Coutinho SR. Saúde do Trabalhador no Brasil nos anos 1990 e 2000, do período da audácia ao desbrío. *Revista em Pauta* 2013; 11(32):39-63.
32. Garbin AD, Pintor EA. Estratégias de intra e intersetorialidade para transversalizar a saúde do trabalhador em todos os níveis de atenção à saúde. *Rev Bras Saude Ocup* 2019; 44:e18.
33. Facchini LA, Nobre LCC, Faria NMX, Fassa AG, Thummé E, Tomasi E, Santana V. Sistema de Informação em Saúde do Trabalhador: desafios e perspectivas para o SUS. *Cien Saude Colet* 2005; 10(4):857-867.
34. Machado JMH. A propósito da Vigilância em Saúde do Trabalhador. *Cien Saude Colet* 2005; 10(4):987-992.
35. Dias MD, Bertolini GC, Pimenta AL. Saúde do trabalhador na atenção básica: análise a partir de uma experiência municipal. *Trab Educ Saude* 2011; 9(1):137-148.
36. Daldon MT, Lancman S. Vigilância em Saúde do Trabalhador: rumos e incertezas. *Rev Bras Saude Ocup* 2013; 38:92-106.
37. Gomez CM. Introdução – Campo da saúde do trabalhador: trajetória, configuração e transformações. In: Gomez CM, Machado JMH, Pena PGL, organizadores. *Saúde do trabalhador na sociedade brasileira contemporânea*. Rio de Janeiro: Fiocruz; 2011. p. 23-34.
38. Moisés M, Machado JM, Peres F, Hennington E, Beltrami AC, Beltrami Neto AC. Reflexões e contribuições para o Plano Integrado de Ações de Vigilância em Saúde do Ministério da Saúde (MS) de Populações Expostas a Agrotóxicos. *Cien Saude Colet* 2011; 16(8):3453-3460.
39. Santos AP, Lacaz FA. Saúde do trabalhador no SUS: contexto, estratégias e desafios. In: Minayo-Gomez C, Machado JMH, Pena PGL, organizadores. *Saúde do trabalhador na sociedade brasileira contemporânea*. Rio de Janeiro: Fiocruz; 2011. p. 87-105.
40. Evangelista AI, Pontes AG, Vale J, Saraiva AKM. A saúde do trabalhador na atenção primária à saúde: o olhar do enfermeiro. *Rev Rene* 2011; 12(n. esp):1011-1020.
41. Leão LH, Vasconcellos LC. Rede Nacional de Atenção Integral à Saúde do Trabalhador (RENAST): reflexões sobre a estrutura de rede. *Epidemiol Serv Saúde* 2011; 20(1):85-100.
42. Vasconcellos LC. Duas políticas, duas vigilâncias, duas caras. *Rev Bras Saúde Ocup* 2013; 38(128):179-98.
43. Rosa LS, Cardoso LS, Costa VZ, Camponogara S, Bisanello J, Cesar-Vaz MR. Rede de saúde do trabalhador: planejamento e execução do processo de trabalho. *J Nurs Health* 2016; 6(1):103-115.

44. Cardoso EM. *Análise conjuntural da vigilância em saúde do trabalhador no estado do Amazonas* [tese]. Rio de Janeiro: ENSP, Fiocruz; 2014.
45. Costa FSM. Política nacional de saúde do trabalhador: a estratégia RENAST no município de Castanhal/PA. *Pegada Eletrônica* 2014; 15(1):16-32.
46. Leão LHC. *Nas trilhas das cadeias produtivas: subsídios para uma política integradora de vigilância em saúde* [dissertação]. Rio de Janeiro: ENSP, Fiocruz; 2011.
47. São Paulo. *Política municipal de saúde do trabalhador e da trabalhadora: plano plurianual*. São Paulo: Secretaria Municipal de Saúde; 2013.
48. Costa D, Lacaz FA, Jackson Filho JM, Vilela RAG. Saúde do trabalhador no SUS: desafios para uma política pública. *Rev Bras Saude Ocup* 2013; 38:11-21.
49. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 20 set.
50. Alves RB. Vigilância em saúde do trabalhador e promoção da saúde: aproximações possíveis e desafios. *Cad Saude Publica* 2003; 19(1):319-322.
51. Servo LMS, Salim CA, Chagas AMR. Saúde e segurança no trabalho no Brasil: os desafios e as possibilidades para atuação do executivo federal. In: Chagas AMR, Salim CA, Servo LMS, organizadores. *Saúde e segurança no trabalho no Brasil: aspectos institucionais, sistemas de informação e indicadores*. São Paulo: IPEA; Fundacentro; 2012, p. 113-32.
52. Brasil. Decreto nº 7.602, de 7 de novembro de 2011. Dispõe sobre a Política Nacional de Segurança e Saúde no Trabalho – PNSST. *Diário Oficial da União* 2011; 7 nov.
53. Chiavegatto CV, Algranti E. Políticas públicas de saúde do trabalhador no Brasil: oportunidades e desafios. *Rev Bras Saude Ocup* 2013; 38:25-7.
54. Gomez CM. Avanços e entraves na implementação da Política Nacional de Saúde do Trabalhador. *Rev Bras Saude Ocup* 2013; 38:21-5.
55. Oliveira MH, Vasconcellos LC. As políticas públicas brasileiras de saúde do trabalhador tempos de avaliação. *Saúde Debate* 2000; 24(55):92-103.
56. Porto MFS, Lacaz FAC, Machado JHM. Promoção da saúde e intersetorialidade: contribuições e limites da Vigilância em Saúde do Trabalhador no Sistema Único de Saúde (SUS). *Saúde Debate* 2003; 27(65):192-206.
57. Brasil. Ministério da Saúde (MS). Portaria nº 1.823, de 23 de agosto de 2012. Institui a Política Nacional de Saúde do Trabalhador e da Trabalhadora. *Diário Oficial da União* 2012; 23 ago.
58. Machado JMH, Porto MFS. Promoção da saúde e intersetorialidade: a experiência da vigilância em saúde do trabalhador na construção de redes. *Epidemiol Serv Saude* 2003; 12(3):121-130.
59. Pina JA, Castro HA, Andreazzi MFA. Sindicalismo, SUS e planos de saúde. *Cien Saude Colet* 2006; 11(3):837-846.
60. Brasil. Ministério da Saúde (MS). Portaria nº 2.437, de 7 de dezembro de 2005. Dispõe sobre a ampliação e o fortalecimento da Rede Nacional de Atenção Integral à Saúde do Trabalhador – RENAST no Sistema Único de Saúde – SUS e dá outras providências. *Diário Oficial da União* 2005; 7 dez.
61. Vilela RAG, Jackson Filho JM, Querol MAP, Gemma SFB, Takahashi MAC, Gomes MHP, Duracenko SRC, Almeida IM. A expansão do objeto da vigilância em acidente do trabalho: história e desafios de um centro de referência em busca da prevenção. *Cien Saude Colet* 2018; 23(9):3055-3066.
62. Nogueira RP. *Determinação social da saúde e reforma sanitária*. Rio de Janeiro: Cebes; 2010.
63. Buss PM, Pellegrini Filho A. A saúde e seus determinantes sociais. *Physis* 2007; 17(1):77-93.
64. Soares CB, Campos CMS, Yonekura T. Marxismo como referencial teórico-metodológico em saúde coletiva: implicações para a revisão sistemática e síntese de evidências. *Rev Esc Enferm USP* 2013; 47(6):1403-1409.
65. Breilh J. Las tres 'S' de la determinación de la vida: 10 tesis hacia una visión crítica de la determinación social de la vida y la salud. In: Nogueira RP, organizador. *Determinação social da saúde e reforma sanitária*. Rio de Janeiro: Cebes; 2010, p. 87-125.
66. Rafagnin MS, Rafagnin TR. Política Nacional da Saúde do Trabalhador e da Trabalhadora: uma reflexão sobre a gestão da saúde e doença da classe-que-vive-do-trabalho. *Barbaró* 2020; 5(57):88-102.
67. Faria MG, Silveira EA, Cabral GR, Silva RO, Daher DV, David HM. Saúde do trabalhador no contexto da estratégia de saúde da família: revisão integrativa de literatura. *Esc Anna Nery* 2020; 24(4):e20200027.
68. Lancman S, Daldon MT, Jardim TD, Rocha TD, Barros JD. Intersetorialidade na saúde do trabalhador: velhas questões, novas perspectivas? *Cien Saude Colet* 2020; 25(10):4033-4044.
69. Lacaz FA, Reis AA, Lourenço EA, Goulart PM, Trapé CA. Movimento da Reforma Sanitária e Movimento Sindical da Saúde do Trabalhador: um desencontro indesejado. *Saúde Debate* 2020; 43:120-132.
70. Minayo-Gomez C, Thedim-Costa SM. A construção do campo da saúde do trabalhador: percurso e dilemas. *Cad Saude Publica* 1997; 13(Supl. 2):S21-S32.
71. Lourenço EA, Bertani IF. Saúde do trabalhador no SUS: desafios e perspectivas frente à precarização do trabalho. *Rev Bras Saude Ocup* 2007; 32:121-134.
72. Vilela RAG, Almeida IM, Mendes RWB. Da vigilância para prevenção de acidentes de trabalho: contribuição da ergonomia da atividade. *Cien Saude Colet* 2012; 17(10):2817-2830.
73. Engeström Y. The future of activity theory: a rough draft. In: Sannino A, Daniels H, Gutierrez KD, editors. *Learning and expanding with activity theory*. New York: Cambridge University Press; 2009, p. 303-328.

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