

## The history of the concept of “worker health” in the field of collective health: the case of Brazil

*Historicidad del concepto “salud del trabajador” en el ámbito de la salud colectiva: el caso de Brasil*

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### INTRODUCTION

The problems affecting the health and the quality of life of the working class are presently acquiring greater social visibility. In the academic field, a wide range of studies and practices of unquestionable value have been developed, even in the absence of adequate conceptual precision about the nature of the association between work and the health-disease process. This editorial presents a discussion of the conceptualizations of different actors looking at this question, either through the development of research studies or in the orientation of practical actions. This reflection is based on the Brazilian experience in this area.

The relationship between work and the health-disease process, although recognized since ancient times, became a focus of particular attention starting with the Industrial Revolution. The proposals for intervention in factories crystallized into several laws and regulations, culminating in the Factory Act of 1833. In the second half of the 19th century *occupational medicine* emerged, aimed at the limited space of the factory, centered on the figure of the physician, possessing an eminently biologicist and individualist perspective, and operating with a univocal and unicausal interpretation of health problems. Such an approach could be summarized in the idea that every disease has an etiological agent.

A conceptual and operational advance appeared with the concept of *occupational health*, an interdisciplinary and multicausal perspective in development since the first decades of the last century. It is based in the idea of industrial hygiene, which understands occupational diseases to arise as a consequence of the exposure to a group of risk factors – physical, chemical, biological and mechanical – present in the workplace. This concept is based on the model of the natural history of disease (1), which stems from the constant interaction between the agent, the host and the environment, without contextualizing the reasons and origin behind such relations.

In Brazil, as the concept of collective health was being constructed historically, the conceptual and practical framework of what today makes up the field of *worker health* were also being drafted. Its object, generally speaking, is the health-disease process of human groups with relation to their work, an object of great interest to the health sector as well as to workers and employers (2).

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The notion of *worker health* is rooted in the school of thought of Latin American social medicine and, more specifically, in the movement for Brazilian Sanitary Reform, which was inspired by several worldwide movements for the universalization and promotion of health. In Brazil, this wave of reformist sentiment in the health sector coincided with a political moment of organization and struggle for the redemocratization of the country – especially starting in the 1980s – in which numerous actors situated in different social spaces came together in questioning the hospital-centered model of the public policies in the sector. With the social matters affecting health as its premise, the sanitary movement focused its analysis on the role of work in the social reproduction of populations. The development of academic production in preventive and social medicine and in public health helped broaden the interpretative framework of work processes in their class dimensions, their cultural aspects of submission and resistance, and their relation to health and the possibility of workers and their families getting sick.

According to the theory in the field of worker health, workers become collective political subjects, holders of a knowledge generated by experience, and so must be regarded as essential agents of transformative actions. The incorporation of such knowledge is decisive both in the production of new knowledge and in the development of health care practices. The recognition of this knowledge/power has been the backbone of the “Italian Worker Model” (3), which arose out of the dynamism of the social movements in the late 1970s, with a particular focus on the changing of and control over work conditions in production units. Nondelegation – expressed in the refusal to transfer to technicians or union leaders the task of systematizing the knowledge acquired by groups subjected to the same work conditions (homogeneous groups) – and consensual validation – resulting from the collective discussion of the evaluations that would serve as the base for making demands – were fundamental premises of this model.

In this way, the *production of knowledge* in the field of worker health, within collective health, has as a defining framework the understanding of the many levels of complexity in the relationship between work and health, including the vision and participation of workers and, as a unifying concept, the work process (4-6). Extracted from the Marxist definition of political economy (7), the work process is understood as the primary site of exploitation and class confrontation, if adopted in its theoretical entirety. The concept offers great explanatory power regarding the genesis of health problems in different groups of workers.

Therefore, the more widely known concept of occupational health can be differentiated from the notion of workers’ health. The former, from a disciplinary and professional point view, is less complicated: it is fundamentally made up of the medical and safety engineering fields. The latter is focused on the study of the work process from the point of view of the social sciences, epidemiology and public planning, as well as, if necessary, the notions of demography, statistics, ecology, geography, anthropology, economics, sociology, history, political sciences, toxicology, production engineering, and ergonomics.

It is necessary to highlight some aspects regarding research studies that use work processes as a framework. First, it is important to point out that such studies require interdisciplinary treatment. The premise of this view is the substitution of the “principle of hierarchy” among different types of knowledge for the “principle of cooperation” among these types of knowledge, and therefore entails dialogue, interaction and mutual questioning, with a focus on philosophy and communicative action (8). Within such principles, at least two levels should be borne in mind. One contemplates the analysis of the historical, social, economic, political, and cultural context of the social relationships of production, the workplace and the conditions of reproduction of workers. The other refers to certain technical characteristics of work processes that can potentially affect workers’ health and subjectivity (6). In order to analyze these two levels, certain notions and mediatory concepts exist; the most commonly used are *risk*, *workload*, *work demands* or *obligations*. They are related to the material conditions, epidemiological dimensions, and qualitative components derived from the work organization, and should be used to identify and analyze situations that generate potential or real effects in the health of groups, categories, or sectors.

A second aspect to be highlighted is that although we know theoretically that the analysis of the effects of work processes on workers' health requires the creation of teams of researchers from different areas, in practice this rarely occurs. One of the limitations of scientific production is related to the lag between the unquestionable theoretical progress made in grasping the complexity of issues related to worker health and the level of the empirical results reached through the studies. The absence of interdisciplinary collaboration ends up producing a reductionist knowledge that contributes to understanding a dimension of these problems, but hides or ignores other dimensions of equal or greater importance. This especially occurs with the epidemiological analyses that intentionally exclude the social and political aspects implicated in health problems that are work-derived. It is necessary to reiterate that no discipline in isolation can encompass the relationship between work processes and health in its multiple and overlapping dimensions. However, it is also necessary to avoid the incorporation, without proper rigor, of concepts from other disciplines that, because of their false appearance of transitivity, hide deep differences and lead to fragmented analyses and simplifying syntheses.

A third point that must be made clear is that the concept of work process emerged in association with the conformation of the urban industrial proletariat which, in the last years, has suffered profound transformations deriving from a new logic of productivity that resulted in changes in the composition of the labor force, and in the introduction of new patterns of outsourcing, subcontracting, and employment precarization. Today the world of work is much more complex and varied. For example, research studies on service sectors constitute a challenge for those used to working with the concept of work processes, since what is at stake are different forms of "work in process." Although in the service sector some characteristics exist that are analogous to industrial work, attributes of great significance and specificity can be found in the interaction between workers and clients/users/recipients/consumers. Similarly, modifications are required for the study of sectors which are not directly determined by the law of value or are not dependent on wage labor. Similarly, some issues not previously taken into account have begun to draw the attention of the professionals who study workers, as is the case of the relationship between mental health and work. Today notions such as moral harassment, suffering and stress appear as problems in diverse economic sectors, and about which very little consensus exists. Consequently, beside the need to adjust and adapt the use of the concept of "work process," scholars are facing the challenge of finding adequate categories and concepts to comprehend the multiplicity of new points of entry of workers into the world of production.

Finally, when focusing on the field of worker health, the close interrelation between production, consumption, the use of natural resources and the impact that these human actions have on the environment and the population should not be overlooked.

## FROM A PUBLIC HEALTH PERSPECTIVE

First, it is worth mentioning some precedents that influenced the institutionalization of the worker health field in the public health system. In 1983, the Pan American Health Association (PAHO) published the document "Plan of Action for Workers' Health" with guidelines for implementing programs in the *public network* of health services. In addition, the International Labor Organization (ILO) adopted in 1985, as part of the international trend seeking to *expand the rights* of workers, the "Occupational Health Services Recommendation." The primary characteristics of the recommendation include wide worker *participation*, work in *multidisciplinary teams*, and, fundamentally, the implementation of these measures through *public policies*.

The strengthening of the workers' movement through the acquisition of basic citizenship rights and the consolidation of the right to the freedom of organization led to an increase in labor demands, the inclusion health-related issues into these demands and, more importantly, the call for health care services in the public network. As a response, several programs and centers of reference for worker health were

created in Brazil, with different levels of participation of worker representatives in the formulation and development of their actions. A significant step, at a national level, was the creation of the Federal Constitution of 1988, preceded by the 8th National Health Conference in 1986 – with wide social participation – and by the 1st National Conference on Workers' Health, which took place that same year. These events, which constitute historic milestones in the struggle to defend health as a right and to achieve a Unified Health System (SUS) [*Sistema Único de Saúde*], also brought forth the passing of the Organic Health Act, municipal organic laws, and health codes, in the context of a movement to incorporate and further rights through the *municipalization* of the health care services.

Since the 1st National Conference on Workers' Health, the entities representing workers and civil society, as well as governmental and technical agencies, have proposed the creation of a National Policy for Workers' Health in the public health arena based on SUS principles: the guaranteeing of universal and comprehensive health care access that emphasizes prevention and health promotion activities, decentralization and social participation. On this basis, the National Network for Comprehensive Worker Health Care (RENAST) [*Red Nacional de Atención Integral a la Salud del Trabajador*] was established in 2002 (9). The RENAST is charged with fomenting health care, surveillance, and promotion activities in the SUS network, thereby integrating care at the basic, ambulatory, pre-hospital and hospital levels, which must be controlled by society in the three levels of management: national, state and municipal. The network is made up of Centers of Reference in Worker Health which provide technical and scientific support and help articulate and establish agreements on health actions within or among sectors in their given territory. Therefore, the mission of these centers within the SUS is to radiate a culture dedicated to protecting workers and preventing occupational diseases, wherever they are based: in the capital city, in the metropolitan areas, and in the municipalities that serve as care centers for the health regions and microregions.

Lastly, in 2012, the National Policy for Workers' Health was officially introduced (10), which reflects in detail a recognition of the wealth of experience accumulated in the last decades by academic sectors, workers' movements and professionals working in health services. This policy defines the principles, guidelines and strategies to be observed by the three levels of management of the SUS for the development of comprehensive health care for workers, specifically health promotion and protection and the reduction in morbidity and mortality rates derived from labor-related diseases and complaints. The policy is integrated into the rest of the health policies of the SUS, which contemplate the interconnectedness of the activities of work and health as one of the determining factors of the health-disease process. The following subjects are included in this policy:

...all workers, men or women, be their location urban or rural, their insertion in the labor market formal or informal, their occupational ties public or private, as salaried, autonomous, self-employed, temporary, cooperative, apprentice, intern, domestic, retired or unemployed workers.

(10 Art. 3) [Own translation]

One of the priority objectives of the National Policy for Workers' Health is to strengthen the system of Worker Health Surveillance. The main object of intervention of this system is the work process and its relation to health, with the goal of controlling risks and decreasing labor accidents and diseases (11). The surveillance process is based in situations of risk or grievances or both, and is made stronger when integrated into the notion of territory in which diverse actors and institutions develop their actions, establishing a field of forces in relation to the work process represented by the activity and the sector in which cases and exposures are concentrated. Therefore, surveillance is regarded, in the political sphere, as a way to strengthen workers in their struggle for health, as well as an extensive and complex practice permeated by multiple, and sometimes conflictive, interests, and not merely as a neutral, standardized and strictly technical practice (12,13).

The National Policy for Workers' Health developed the following guidelines and strategies to implement surveillance actions in health care:

- a. Identification of the production activities of the working population, of situations of risk, and of the needs, demands and health problems of the workers in the territory.
- b. Intervention in work processes and environments.
- c. Production of technologies for the intervention, assessment and monitoring of surveillance activities.
- d. Control and evaluation of the quality of worker health programs and services in public and private institutions and companies.
- e. Creation of protocols, technical norms and regulations.

Among the strategies, the following proposals can be found:

- a. Intra-institutional articulation among all areas of the SUS: basic health care (Family Health Program, urgent and emergency care); medium and high complexity services; epidemiological, health and environmental surveillance and related projects; other health policies such as those related to cancer, urban violence and mental health. The lack of such intra-institutional articulation is one of the greatest obstacles to overcome in the area of workers' health.
- b. Intersectoral articulation understood as an exercise of integration in the policies of Worker Health Surveillance along with sectors of the Ministries of Labor, Social Security, Environment, and Public Affairs. Progress towards this was made in 2010 with the passing of the National Policy of Occupational Health and Security (14), incorporating the Ministry of Health, the Ministry of Labor and the Ministry of Social Security.
- c. The participation of workers or their representatives in the formulation, planning, accompaniment and evaluation of the health surveillance activities.

It must be borne in mind that society's control over government activities is conceived of in Brazilian public policy as an instrument of surveillance, action and intervention on the part of the organized segments of the civil society over the actions of the State. Since the Organic Health Law was passed (15), the health sector has prioritized, in a pioneering way, the democratic construction of decisions and has attributed the representatives of civil society with the right and the obligation to regulate and control officials in the three spheres of government. Councils and health conferences in these three spheres of government – federal, state and municipal – were created as strategic areas and instruments of that participation for the definition, elaboration, implementation and regulation of health policies. In this case in particular, the Intersectoral Worker Health Commissions were specifically defined by the SUS and linked to the health councils. The decisions of the commissions also imply facing conflicts typical of the social relations of labor and of the general conditions of reproduction of workers and their families.

## ADVANCES AND AREAS TO BE IMPROVED

It is first necessary to state that, in Brazil, the scientific production in this field has been constantly growing in the last decades, installing itself in many universities, covering diverse areas of knowledge, and even receiving contributions from the professionals working in the health care services. That growth is accompanied by the multiplication of graduate courses in the country, mainly in the field of collective health. As is seen in other areas of knowledge, the greatest number of research studies and published texts are concentrated in federal, state and religious universities.

Similarly, extensive guidelines for the National Policy for Workers' Health, as well as their and regulatory frameworks, were recently established. However, there is a long way to go in order to grasp the specificities of the world of work, which insist on being much more dynamic than all the theories built to explain or understand them. Certainly, due to the complexity of our present reality, any analysis of grievances to workers' health in Brazil, or in any other part of the world, will be partial and incomplete,

not only because of intellectual lapses but also principally because in that field the search for solutions frequently comes against powerful and deep-seated economic interests which seek short-term results.

Finally, from a Latin American perspective, it is important to indicate as auspicious Mercosur's Environmental and Worker Health measure (16), which was recently made official and has as a main objective the unification of concepts common to the member States. The measure was decided unanimously by the representatives of the states that make up the Intergovernmental Commission for Environmental and Worker Health in order to better homogenize criteria regarding health in the workplace.

## BIBLIOGRAPHIC REFERENCES

1. Leavell H, Clark EG. *Medicina Preventiva*. São Paulo: McGraw-Hill; 1976.
2. Lacaz FAC. O campo Saúde do Trabalhador: resgatando conhecimentos e práticas sobre as relações trabalho-saúde. *Cadernos de Saúde Pública*. 2007;23(4):757-766.
3. Oddone I, Marri G, Gloria S, Briante G, Chiatella M, Re A. *Ambiente de trabalho: a luta dos trabalhadores pela saúde*. São Paulo: Hucitec; 1986.
4. Laurell AC, Noriega M. *Processo de produção e saúde: trabalho e desgaste operário*. São Paulo: Hucitec; 1989.
5. Mendes R, Dias EC. Da medicina do trabalho à saúde do trabalhador. *Revista de Saúde Pública*. 1991;25(5):341-349.
6. Minayo-Gómez C, Thedim-Costa SMF. A construção do campo da saúde do trabalhador: percurso e dilemas. *Cadernos de Saúde Pública*. 1997;13(Supl. 2):S21-S32.
7. Marx K. *O Capital: Livro I, Capítulo VI (inédito)*. São Paulo: Ciências Humanas; 1978.
8. Habermas J. *Teoría de la acción comunicativa*. 2a ed. Madrid: Taurus; 1988.
9. Brasil, Ministério da Saúde. Portaria Nº 1.679/GM [Internet]. 19 Sep 2002 [cited 12 Oct 2012]. Available from: [http://www.saude.al.gov.br/sites/default/files/portaria\\_n.1679\\_de\\_18.09.2002.pdf](http://www.saude.al.gov.br/sites/default/files/portaria_n.1679_de_18.09.2002.pdf).
10. Brasil, Ministério de la Salud. Portaria Nº 1.823 [Internet]. 23 Aug 2012 [cited 12 Oct 2012]. Available from: [http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt1823\\_23\\_08\\_2012.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt1823_23_08_2012.html).
11. Machado JMH. *Alternativas e processos de Vigilância em Saúde do Trabalhador: a heterogeneidade da intervenção*. [Tese de doutorado]. Rio de Janeiro: ENSP/Fiocruz; 1996.
12. Pinheiro TMM. *A construção da vigilância em saúde do trabalhador no Sistema Único de Saúde (SUS): a vigilância do conflito e o conflito da vigilância*. [Tese de doutorado]. Campinas: UNICAMP; 1996.
13. Baker EL. Sentinel Event Notification System for Occupational Risks (SENSOR): the concept. *American Journal of Public Health*. 1989;79 (Suppl):S18-S20.
14. Brasil, Presidência da República. Decreto Nº 7.602 [Internet]. 7 Nov 2011 [cited 12 Oct 2012]. Available from: [http://www.planalto.gov.br/ccivil\\_03/\\_Ato2011-2014/2011/Decreto/D7602.htm](http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2011/Decreto/D7602.htm).
15. Brasil, Presidência da República. Lei Nº 8.080 [Internet]. 19 Sep 1990 [cited 12 Oct 2012]. Available from: [http://www.planalto.gov.br/ccivil\\_03/leis/L8080.htm](http://www.planalto.gov.br/ccivil_03/leis/L8080.htm).
16. Argentina, Ministerio de Salud. Resolución 269/2012 [Internet]. 10 Feb 2012 [cited 12 Oct 2012]. Available from: <http://www.infoleg.gov.ar/infolegInternet/anexos/190000-194999/194280/norma.htm>.



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