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Worker's Health in Rio de Janeiro: A Literature Review

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ABSTARCT

The present work carried out a literature review on the submission of data from Bireme, Lilacs and Official Documents of the Ministry of Health since the emergence and evolution of the National Health Policy of the Worker and its interface with an industrial revolution, as well as his own. arrived in Brazil, intertwined with national policies. The proposal also expanded the addition of the medical walls, including: legal aspects; ergonomics and worker safety, creating an Occupational Health practice. The access of the Brazilians to oral health was extremely difficult and limited, but with a Brazilian policy and a proof of the diseases caused by microorganisms of the oral cavity, the odontological medical clinic favors the action as a whole, in order to understand the multidimensional nature of health, its cultural, environmental and psychosocial influences, aiming the fulfillment of the same by the children through the better quality of life. Existence of studies to understand the relationship between National Policies and their implementations.

Keywords: Collective health, Worker health, Dentistry.

INTRODUCTION

The term Occupational Health refers to a field of knowledge that aims to understand the relationship between work and the worker's health/disease process, which is like a work tool that generates profits and services. [1]

Health care organization aimed at workers emerged in the 18th century, in England, with the Industrial Revolution. Pressured by the economic losses resulting from the high rates of accidents and illness determined by the poor living and working conditions and by workers' demands for change, industrialists at the time began to hire doctors, assigning them the responsibility of "taking care" of workers' health. .[2]

Baker, considered the father of occupational medicine, proclaimed in 1883 that his own doctor be placed inside the factories to serve as an intermediary between the entrepreneur and his workers, where he would visit the factory, room by room, so that he could check whether any of the workers is suffering the influence of causes that can be prevented, it will be up to him to carry out such prevention.

In the first half of the 20th century, changes in production processes resulted from the two great world wars and post-war reconstruction efforts. Worker's health began to have a multidisciplinary action and expand the focus of health actions creating the practice of Occupational Health, addressing legal, hygiene, ergonomics and work safety aspects and improving quality of life. In Brazil, the history of workers' health intertwined with national health policies begins, in fact, in the First Republic with the emergence of the figure of Oswaldo Cruz. Through his, the health issue became a political issue.[3] Another milestone was the Eloy Chaves Law, which, in addition to social security, provided medical assistance and medication to "insured" [4]

The organization of health services in Brazil before the SUS (Sistema Único de Saúde) lived in separate worlds: on the one hand, actions aimed at prevention, the environment and the community, known as public health; on the other hand, workers' health, included in the Ministry of Labor; and, also, curative and individual actions, integrating social security medicine and liberal, philanthropic and, progressively, business medical assistance modalities [5]. The objective of the present work was to propose a critical thought regarding health policies in the country, describing the National Network for Integral Attention to Worker's Health (RENAST) and the Reference Center for Worker's Health (CEREST) to serve workers in the state of Rio de Janeiro, based on a literature review on workers' health in Brazil.

METHODOLOGY

The present work is a critical literature review using the Bireme, Lilacs, Ministry of Health and PUBMED databases to select scientific articles, books and legal files related to social public health policies. Approaching the policies, through the health and disease models that have influenced it since its creation until the present moment, whose performance is based on Public Health in Brazil .

LITERATURE REVIEW

In Brazil from the turn of the 19th to the 20th century, the concern with health was linked to the economic interests of the elites in keeping the worker healthy to maintain production, mainly in the agrarian context of the time."(...) With the abolition of slavery in 1888, the process of replacing slave labor with salaried labor of European origin was consolidated (...). for Brazil, the government at the time was obliged to adopt some measures to improve this situation" [6]. Creating and implementing public health services and programs at the national (central) level. "At the head of the General Directorate of Public Health, Oswaldo Cruz progressively implemented public hygiene and health policies in Brazil. At the same time, it adopted the model of 'sanitary campaigns', designed to combat urban epidemics and, later, rural endemics."[7] In 1923, the Eloy Chaves law was enacted, a milestone in the beginning of Social Security in Brazil. In the period between 1923 and 1930, Caps. (Retirement and Pension Funds).

In the Vargas Era, the Ministry of Health favored health actions, based on the American model, favoring workers, since they were an important productivity factor; of development and economic investment.[8] At that time, INAMPS (National Institute of Medical Assistance of Social Security) was created to provide medical assistance to those who contributed to social security and self-employed, however, most of the care was provided by the private sector, with which they estab-

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lished agreements providing for remuneration per procedure, consolidating the logic of caring only for the disease and not for health promotion, as was already the case in England and in other countries. With the mass movements that originated in the mid-1970s and during the 1980s, which led the country to democratization, the Sanitary Reform movement emerged, which proposed a new conception of public health. The universal right to health was conquered through the National Constitution of 1988, which defines that health becomes the duty of the State and the responsibility of the Unified Health System.

Health Unic System

Article 196 of the Brazilian Constitution describes that: Health is everyone's right and the State's duty, guaranteed through social and economic policies aimed at reducing the risk of disease and other harms and universal and equal access to actions and services for its promotion, protection and recovery.[9] From the publication of the constitution, the country legally assumes the responsibility with society regarding the health of Brazilian citizens, starting a new era in Brazilian public health, where health starts to be recognized , as a social right, inherent to each and every citizen.

The Organic Law of Health (No. 8.080/90) regulated and implemented Brazil's Unified Health System (SUS). The definition of competences and attributions for each governmental sphere sought to facilitate the implementation and execution of the SUS, facilitating the operation of this new public health guideline. Through this Organic Law and the 1988 Constitution, it becomes the duty of the State to formulate, develop, implement, and evaluate economic and social policies aimed at reducing the risk of diseases and other injuries, creating conditions that ensure universal and equal access to actions from health to services for their promotion, protection and recovery.[1] This citation of article 2 of the Organic Law diversifies and expands the concept of health and service provision by government spheres, such as: health surveillance, epidemiological surveillance, health of the worker; comprehensive therapeutic assistance, including pharmaceuticals. Thus, inserting, in fact, the worker's health as one of the fields of action of the SUS.

Insertion of the dental surgeon in public health policies

Changes in health practices brought about changes in the way of serving the population, and currently the Family Health Strategy, based on primary care, in an ascribed territory, also sought to change the perception of the profile of diseases; their determinants, to be able to cause impact, reducing the epidemiological conditions of diseases in a population way.

In 1978, from the ordinance 3214 of the Ministry of Labor, with support in the Federal Law n° 6514, it regulated the norms in health and security of the work, whose fulfillment became obligatory. The performance of union movements is decisive for the transformations in the field of workers' health in favor of guaranteeing and applying workers' rights in improving health and work conditions, despite the fact that the process of building public policies in Occupational Health is historical and arising from the constant struggles of the population of workers and their legal representatives, the unions. [10]

In history, Dentistry has been distant from public health policies. Brazilians' access to oral health was extremely difficult, limited and expensive. Because of this history, the main service offered has almost always been tooth extraction, perpetuating a vision of mutilating dentistry in Brazilian dentistry. Brasil Sorridente was a project that marked the history of dentistry in public health, constituting a series of measures aimed at guaranteeing actions for the promotion, prevention and recovery of the oral health of Brazilians.

PNSB - National Oral Health Policy

The main differential in its creation was the reorganization of the practice and the qualification of the actions and services offered to citizens of all ages, with increased access to free dental treatment for Brazilians through the SUS. The main lines of action of the program are: the implementation of Oral Health teams in the Family Health Strategy - ESF, the expansion and qualification of Dental Specialty Centers CEO and Regional Dental Prosthesis Laboratories and the feasibility of adding fluoride in public supply water treatment. [11]

Primary Care constitutes "a set of health actions, at the individual or collective level, which covers the promotion and protection of health, the prevention of injuries, diagnosis, treatment, rehabilitation and maintenance of health, located at the first level care of the health system. It is developed through the exercise of democratic and participatory management and health practices, in the form of teamwork, directed at populations in well-defined territories, for which it assumes health responsibility. [12]

Brasil Sorridente - National Policy for Oral Health is the federal government program that aims to guarantee actions to promote, prevent and recover the oral health of the Brazilian population, Brasil Sorridente brings together a series of actions to expand access to dental treatment free, through the SUS.

Worker's health

Based on the aforementioned history, the health care model for workers in the SUS and adopted in the construction of the Integral Care Network for Workers' Health (RENAST), it is licit that health services for workers, based on organized social movements both in Dentistry and in other branches of Medicine, they offered little impact of oral disorders on the general health and quality of daily life of the worker. In an attempt to reverse this situation, Reference Centers for Worker's Health (Cerest) were created, which promote actions to improve working conditions and workers' quality of life through prevention and surveillance. There are two types of Cerest: state and regional.

It is up to Cerest to promote the integration of the SUS health service network, as well as its surveillance and management, in the incorporation of Occupational Health in its routine activities. Its attributions include supporting more complex investigations, advising on the implementation of technical cooperation agreements, subsidizing the formulation of public policies, strengthening the articulation between basic, medium and high complexity care to identify and respond to accidents and work-related injuries, in especially, but not exclusively, those contained in the list of work-related or compulsory notifiable diseases.[13]

DISCUSSION

With the work process increasingly fragmented, specialized, it requires, in addition to qualification, a series of personal factors charged from the worker, which generate tension; fatigue; anxiety and somatic illnesses, usually occurring in work environments with high psychological demands on the part of the entrepreneur and low decision-making power on the part of the worker. Demanding leadership attitudes and behaviors; of efficiency and effectiveness, can generate signs and symptoms of insecurity, frustration and even introspection, or in more severe cases of a psychosomatic pathology, which ends up harming the worker's potential to contribute to the company'growth. [14]

For Paim5 care models are structured technological combinations to face Individual and Collective health problems in certain spaces destined for this purpose for the population. For the author, one cannot speak of a RENAST care model, since this is the SUS care model

itself, organized according to standards and principles of Universality of access; integrality of care with equity and social control in a given territory, favoring the Primary Health Care strategy and the focus on Health Promotion.

Workers have always been users of the health system, however not all Family Health Clinics work at plausible hours for workers. RENAST's proposal is to qualify this care, making the system, as a whole, viable for workers' health.

According to Vilela et al, there are many challenges for services in the face of the new National Occupational Health Policy. Over the last 30 years, these actions have constituted a policy that is against the predominance of developmental and financial logic. Despite the enormous difficulties in prioritizing Worker's Health Promotion within the SUS.

The CERESTS (Reference Centers for Worker's Health) are responsible for direct surveillance actions, of a complementary or supplementary nature, for situations "in which the Municipality does not have the technical and operational conditions, or for those defined as of greater complexity". [15]

The current public policy of Occupational Health in the dental area still contains incipient actions, not observing the presence of the dentist in its Health and Safety team and, therefore, not addressing the principle of comprehensiveness.

Toothache ranks third among causes of absence from work, second only to stomach pain and headache. The health policy in Occupational Dentistry is new and begins with the recognition of the specialty by the Federal Council of Dentistry in 2002 and its inclusion in the Occupation Code of the Brazilian Ministry of Labor, where it is transcribed that maintaining good dental health enables good results and greater productivity on the part of workers, acting based on the 1988 constitution, in obedience to the principle of integration proposed by the SUS, in a multidisciplinary way, and fills the gap in the SUS, in relation to workers in terms of the Occupational Health Policy. [16]

Rio de Janeiro

According to the official website of RENAST there are 18 CEREST points in the state of Rio de Janeiro allocated in the cities: Cabo Frio, Duque de Caxias, Maricá, Nova Friburgo, Petropolis, Três Rios, Angra dos Reis, Campos dos Goytacazes, Itaperuna, Niterói, Nova Iguaçu, Resende, Volta Redonda and Rio de Janeiro.The CERESTs must develop actions that include structuring protocols, lines of care, training network professionals, recording, analyzing and disseminating information and other instruments that favor the integrality of workers' health actions and social control. Yet, in practice, these policies are not so active in the city of Rio de Janeiro.

Dentistry in the Worker's Comprehensive Health Care Network

During the research, there was no mention of dentistry in any of the official sources of RENAST and/or CEREST, only other areas such as Physiotherapy and Medicine. In the view of health, where the human being must be understood as a whole, it makes no sense and goes against the very concept of well-being stated by the World Health Organization in 1996.

CONCLUSION

Toothache is the third major cause of absenteeism at work, as well as the interconnection of oral and general diseases, which justified the creation of RENAST and CEREST, however there is no registered attention with Occupational Dentistry itself. A survey of practical experience within the CERESTs would be necessary to detail the services provided in the area of Dentistry, since this area is not explained in the scope of services offered. There is an urgent need for pressure by dental professional bodies, educational institutions and associations representing dentistry to comply with the law, offering the oral health team a job market, as well as complying with the constitution offering integral health to the worker.

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