DOI: 10.1590/1413-812320222711.06272022EN

Working in health and safety at work: reflections on the construction of an integrated policy

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Abstract *Interventions in work environments, processes, and situations encompass the prevention of diseases and accidents and workers' health promotion. Historically, these actions were originally the responsibility of the Ministry of Labor, being extended to the Ministry of Health, and later to the Ministry of Labor. The aim of this study was to understand and give visibility to the work of the actors working in the different sectors and institutions involved in health and safety at work in the municipality of São Paulo and gain an insight into the barriers to intersectorality and the consequences of the lack of intersectoral collaboration for this area. Work reflection groups were created between 2017 and 2019 with professionals working in the abovementioned ministries and in the Labor Prosecution Office. The data were produced and analyzed drawing on the theoretical bases of the psychodynamics of work. Despite having intrinsically linked objectives, these three bodies in São Paulo continue to encounter difficulties in consolidating intersectorality as envisioned in occupational health and safety policies. Despite sporadic partnerships, merging specific actions, recognizing and mutually respecting each other's expertise, avoiding overlaps, and building joint, cooperative, and collaborative practices remain challenges.*

Key words *Occupational Health, Public Health Policies, Intersectoral Collaboration, Work*

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Introduction

Workplace interventions have been undertaken in Brazil since the beginning of the twentieth century. The characteristics, reach, scope, origins, and affiliations of interventions have been modified over time by the reconfiguration of policies and ministries.

Workplace interventions require professionals that have specific training in the technical and ethical standards set out in the guidelines and legislation issued by the bodies where they work[1,2].

Within this context, in the 1950s, several member states of the International Labour Organization (ILO) began to standardize guidelines and approaches to the work of occupational health and safety specialists[1]. A common concern was to ensure access to decent and at the same time productive work in conditions of freedom, equity, security and dignity[3], which constitutes a fundamental condition for the reduction of poverty and social inequalities, democracy, and sustainable development.

In Brazil, "workplace inspections", originally linked to the then Ministry of Labor, Industry and Trade, have been carried out since 1930 to ensure compliance with the relevant legislation[4]. The Consolidated Labor Laws (CLL), created in 1943, regulate individual and collective employment relations and make occupational safety inspections mandatory for employees with formal employment relationships.

In 2002, the Ministry of Labor (ML) formalized its functions and responsibilities with the creation of the Federal Labor Inspection System[5] and the career of labor inspector (LI)[6], whose tasks and duties include inspection and the provision of technical advice and guidance to employers and workers.

In the realm of health, political mobilization combined with national health conferences[7] culminated in the creation of Brazil's public health system, the *Sistema Único de Saúde* (SUS) or Unified Health System, in 1990. Workers' health (WH) was enshrined as a universal right, broadening the understanding of the health-disease process to include work as one of the key determinants of health. Theoretical and methodological frameworks based on Latin American social medicine, the Italian workers' model, epidemiology[8,9], and Franco-Belgian activity-centered ergonomics played a fundamental role in this process[10].

This process reinforced the understanding that workplace intervention is fundamental for health promotion and disease and accident prevention. One of the functions of the SUS is health surveillance, which consists of sanitary, epidemiological, and workers' health surveillance, transferring certain workplace intervention functions previously performed by the Ministry of Labor to the SUS[7,11].

Several authors have researched the historical context and conceptual aspects of occupational health surveillance, highlighting advances and the challenges for consolidating actions in this area[7,12-15].

Workers' health surveillance (WHS) actions and guidelines include interventions in work processes, conditions, and environments and considerations about the complexity and new ways of becoming ill, extending beyond normative aspects addressed by traditional approaches to inspection. This set of actions and guidelines has generated several new areas of work, requiring the incorporation of different types of knowledge and an interdisciplinary approach[13,16].

In the 1980s and 1990s, the first workers' health programs and workers' health referral centers (WHRCs) were created. The focus of these municipal or regional centers is to promote workers' health through WHS and the diagnosis and monitoring of occupational diseases. These actions are inextricably linked and feedback on each other.

As a cross-cutting element underpinning the protection of workers' health, WHS aims to prevent occupational health problems and transform situations that can lead to occupational diseases and workplace accidents[7,17,18].

Finally, the Labor Prosecution Office (LPO) was strengthened by the creation of the new federal constitution, finally consolidating its role in health and safety at work at the beginning of the twenty-first century. Staff include prosecutors and experts who defend workers' diffuse rights, enforce labor legislation, and mediate employer-employee relations. To this end, when deemed necessary, prosecutors receive advice and support for enforcement activities from expert analysts (EAs) with backgrounds in engineering, medicine, and accountancy.

Different sectors use their own terminology for intervention actions according to the theoretical framework, concepts, and rules and regulations adopted in work practices.

The role of Ministry of Labor labor inspectors (LIs) has always been to inspect whether legislation, rules and regulations are being complied with and apply sanctions for non-compliance. In 2003, "health officers" (HOs) working in WHRCs

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were given the power of police, being authorized to apply sanctions (prohibition and fines) for non-compliance with health and work standards, while EAs carry out workplace assessments to produce technical reports to inform proceedings brought by the LPO.

Barros *et al.*[15] points out that paths and proposals for the integration of the sectors and services involved in occupational health and safety were widely debated during the 8th National Health Conference, in 1986, and 1st National Workers' Health Conference, in 1989. These were transformed into policies and regulations by the 1988 Constitution and throughout the development of Brazil's public health system, the *Sistema Único de Saúde* (SUS) or Unified Health System[7].

Another important landmark during this process was the development of complementary joint actions by the then ministries of health, social welfare, and labor and employment, giving rise to the National Occupational Health and Safety Policy[19].

However, institutional processes and reshaping, the Federal Constitution, and the creation of the SUS appear to have stirred up jostles for space, leading to an overlap of roles and a lack of communication and collaboration between the sectors involved[13].

In light of the above, the aim of this study was to understand and give visibility to the work of the actors involved in the workplace inspections, surveillance, and assessments undertaken by the different sectors and institutions that make up the field of "health and safety at work" in the municipality of São Paulo. We also sought to understand the barriers to intersectorality and the consequences of the lack of intersectoral collaboration for these actions.

Methodology

This article presents the partial results of the ongoing study "Constructing intersectorality in the field of health and work: perspectives of professionals working in services in the municipality of São Paulo", initiated in 2016[7,15] and approved by the University of Sao Paulo Medical School's research ethics committee (CAAE:58418816.1.0000.0065; CEP report: 1.829.674).

Between 2017 and 2019, reflection groups were created to gain an insight into the work of LIs, HOs and EAs, work content, the challenges they face, and the know-how developed over the years. We also sought to identify differences in the scope of work and conceptions and overlaps and similarities between activities.

The empirical data were produced and analyzed drawing on the theoretical bases of the psychodynamics of work (PDW). As a "work clinic", the PDW concerns itself with subjective mobilization played out in the encounter between the subject and organization of work and the relations arising from this encounter. It is part of a group of upward methods in which understandings and theoretical constructs of concrete work situations are developed by listening to those involved. It is a qualitative interactive method that assumes that research and intervention are intrinsically linked[20]. The PDW differs from other disciplines that study work insofar as it gives preference to the reflections of workers that arise during "work reflection groups".

One of the core analytical elements of PDW, derived from activity-centered ergonomics, is the mismatch between prescribed work and the work that is actually performed. Prescribed work is the set of planned and organized tasks that the worker should perform. In this study, it is represented by the health policies, regulatory instruments, administrative procedures, and managerial tasks. Real work is the work performed in the face of the concrete conditions found in each specific situation[10,21] and takes place in the face of impositions that are apprehended and at the same time modified by the worker[22]. It is understood that prescribed work is incomplete and insufficient, or in other words fails to take into account all the situations found and modified during everyday work.

Another core element of PDW is the understanding that work takes place to bridge the gap between the prescribed and real activity. It is about what the subject does beyond the prescribed tasks, aiming to meet goals and objectives despite incidents and difficulties. By experiencing the real, the subject mobilizes his or her intelligence, acumen, body, and capacity to reflect, interpret situations and invent paths: work is acting, transforming, and finding solutions not prescribed by work organization.

Organization and development of reflection groups

The method involved the creation of three work reflection groups[20,23] (the inextricable link between workers, task content, and work organization).

Reflection groups should meet the following criteria: participation is voluntary; participants

should be at the same level in the organizational hierarchy; and the organizations' agreement should be obtained. Ideally, group discussions should take place during working hours and steps should be taken to facilitate the participation of those involved. To this end, we contacted each body (the ML, LPO, and São Paulo City Council Department of Health) to present the study, explain how reflection groups work, and identify volunteers.

Subsequently, the project, its objectives, the principles of the PDW, and group dynamics were explained to the participants and any questions were answered. The participants signed an informed consent form.

Specific strategies are used to stimulate discussion. For example, it is suggested that participants tell the group how they started their career, why they chose the profession, what they do and how they do it. These suggestions are generally enough to start and continue a discussion. Thereafter the researchers act as facilitators, ensuring that everyone has their voices heard, clarifying unclear points, and maintaining the focus on the topic at hand, etc.

Each group process involved around 16 hours of discussion, organized according to the availability of the service and participants. The discussions were recorded to help in the preparation of the reflection group reports. At the end of each group process, a one-month pause was taken to prepare the report, which was subsequently validated by the participants. Much more than a synthesis of the encounters, the report presents a comprehensive interpretative analysis of the subjective aspects of work that emerged from the groups as captured by the researchers through clinical listening[20,23].

The three groups were conducted by two researchers who held weekly meetings throughout the process with a third member of the research team (supervisor) who did not participate directly in the sessions. The aim of the supervision was to discuss and analyze the material that emerged during the sessions with the support of an external agent, thus facilitating the comprehensive analysis of the process by the researchers and helping reduce potential biases in interpretation in the clinical listening process[20,23].

The report validation process, which lasted around eight hours, is a participatory process in which feedback is given to the participants to improve the researchers' understanding, clarify issues, remove fragments that may identify or be awkward for specific participants, and verify the accuracy of the researchers' analyses. The group characteristics are shown in Chart 1.

This article is based on the validated group reports. The reports were analyzed to identify common issues across the groups. Aspects related to intersectorality were added to the PDW categories (work carried out, know-how, difficulties and solutions found, suffering and pleasure in work, visibility and intelligence in work, mechanisms of recognition and cooperation, etc.), highlighting common and diverging points among the three groups.

Results

The work of labor inspectors

LIs historically inspect work sites to establish whether labor legislation and occupational protection, safety, and medicine standards are being complied with[24] and to assess working conditions.

They propose changes in working conditions and the work environment and prepare reports, infringement notices, terms of prohibition, etc. When serious imminent risks are identified, they have the authority to stop work and shut down sectors and premises.

In the past, LIs were predominantly doctors and engineers; however, recent selection processes have prioritized fiscal knowledge (accountancy and business administration), altering the profile of auditors and tasks. While younger professionals are expected to focus on document analysis and issuing notices, older inspectors conduct on-site actions and workplace inspections. Different understandings and approaches to work result in communication difficulties.

Another important change was the increasing focus on productivity, meaning that staff to spend more time on document analysis to the detriment of on-site work:

It causes discomfort that since 2010 the ML has increased pressure [to issue] infringement notices, understood to be productivity indicators.

However, the participants mentioned that the main expertise required to verify infringement is precisely analysis and inspection of work situations. In other words, the work of LIs loses its meaning when on-site analysis is not prioritized.

Work is generally initiated by a request forwarded by the LPO, courts, police, or chiefly by unions.

The participants believe their work to be important. They are sometimes able to immediate-

Chart 1. Characteristics of the work reflection groups.

	Body	Professional background	Reflection groups	Period
Labor inspectors	ML (1988)	Occupational medicine and engineering, with specialist training in accountancy, law, ergonomics, environmental management, and business management	4 participants in 4 sessions	2017
Health officers	WHRCs (2003)	Nursing, speech therapy, occupational therapy, and social services	4 participants in 3 sessions	2017
Expert analysts	LPO (2003 to 2005)	Medicine, engineering	8 participants in 4 sessions	2019

Source: Authors.

ly see the positive impact of interventions and achieve good results. However, the results are not always immediate, as transforming workplaces is a challenge that requires time. The awareness of the importance of safety at work is essential for meaningful transformations to take place:

You can sell the idea of safety and the person becoming aware. He'll let the bad situation go on for as long as he can, but from the moment you point it out, issue a notice, and stop the works, you manage to change the culture.

The participants mentioned that it would be important to have a space for knowledge sharing with other professionals. However, this is difficult because training and meetings are occasional and ineffective:

We are "dying", and I prefer to use this expression than we are retiring, and we are not leaving heirs.

The younger [labor inspectors] don't participate, they don't get involved. They don't attend meetings and training. We always thought about improving, training, bringing specialists for talks.

The participants highlighted that work would be more effective if it was preventive, inspecting works to eliminate the risk of workplace accidents. However, they still receive requests for corrective actions, such as issuing infringement notices:

When work is focused on a reactive attitude towards a worker who is sick or has had an accident, public civil actions, if the incident has already happened, our work is lost.

The work of health officers

Actions developed by WHRCs include assistance for workers with occupational health problems and training in WH for staff from other health services. HOs carry out inspections and interventions in work environments in accordance with the municipal health code[25] and other specialist legislation and documents[26,27]. They also prepare technical reports, analyze cases, and highlight irregularities that pose a health risk to workers, issuing corrective action orders and prioritizing collective measures.

They have autonomy over and are responsible for their actions and the sanctions they apply. However, they encounter difficulties meeting deadlines due to the characteristics of the work, the volume of cases, staff shortages, and level of stringency, and technical requirements. The shortage of resources leads to frustration and demotivation:

It's all left for us to do, there's a bomb on one side, an inquiry on the other, form the team, superiors chasing, patients/users. It's tough.

You're the spokesperson in situations of conflict with users and with shortages of everything, which reflects the precariousness of policy. Before there was funding from RENAST [National Network for Comprehensive Workers' Health Care], a maintenance team; not anymore.

We are not going to meet most of the targets because most of the professionals have left.

WHS actions encompass working conditions, work situations, and production processes. With the expansion of the AS's roles and responsibilities, performance expectations and other related duties have become more complex. However, the increase in work demands has not been accompanied with increased time and resources.

According to the HOs, a gap has opened between their work some of the precepts of WHS. Four factors have caused this gap: the fact that they have been assigned the power of police and the corresponding administrative procedures;

HOs are now responsible for investigating all serious and fatal workplace accidents, and accidents involving underage workers; the technical cooperation agreement with the LPO and staff reductions has increased work demands:

We'd go to a company and if it was an accident involving machinery we'd do an intervention. Questions were sent saying that the press wasn't so bad, but the one next to it was worse. So we'd look at everything, not just the one machine, but all of them. This caused an intensification of work; you have to look at the electrical installations, bathroom, canteen.

We became health officers. We didn't get paid any more for it, we took it on because we were militant. We don't receive support. I'd like to see [what would happen] if we all gave up our qualifications and said, "we're not going to do inspections anymore, do it yourself".

The participants are frustrated by the lack of recognition of WH despite the importance they attach to their work. It is as if WHS actions were not important and could even be suspended. They feel they are losing ground, for example when they see the shortage of professionals and lack of reach of their actions.

Work is draining. "I'm doing my best", "I'm trying in fits and starts, despite the difficulties"...when you need support, which is the management's obligation, you don't have it: "So am I a clown?".

The participants are concerned with the future of WHRCs, as they think they are going to be extinct. Many HOs have retired without being replaced. They also mentioned worsening working terms and conditions:

In the country of unemployment, the cheapest raw material is labor. Apart from sad, you feel a bit frustrated.

It's accumulated knowledge that is leaving and the people that replace them don't have the same training or experience.

The consolidation of work also depends on intrasectoral actions, including: greater engagement with other areas of health surveillance; the incorporation of health-work into other areas of work; increased health worker and user awareness of the importance of areas other than assistance; development of suitable methodologies and approaches, etc.

The work of expert analysts

The work of EAs is linked to the work of prosecutors who, when they deem necessary, request technical reports of the working environment and work. These reports address situations ranging from small incidents to major problems in different sized companies. Activities include requesting and analyzing documents[24], conducting workplace assessments for technical analysis and preparation of reports, and taking part in hearings with prosecutors and company representatives.

Although EAs play a critical role in investigations, they do not have any control over the referral criteria for the cases they receive or the fate of the reports and/or recommendations. Neither do they have the autonomy to broaden or limit the focus of analyses, and the guidance they receive from different prosecutors varies: "some request specific actions restricted to the original theme of the complaint, others ask you to broaden the focus to include other irregularities in the company". Sometimes EAs encounter situations that require specific knowledge outside their area of professional expertise, thus requiring additional research.

The participants recognize that the number of EAs is small in relation to the volume of work and tight deadlines, and that the lack of standardization, scope, and prioritization of demands often takes up time that could be used in more complex analyses:

You pluck the feather and get the whole chicken, but we need time... what should I spend my time on in this case? And the others? That's an important [cause of] suffering.

Lack of autonomy over work and the fate of cases are seen as an underestimation of abilities and lack of recognition. EAs tend to believe that despite their importance, "they have no strength of their own, depend exclusively on the prosecutor to be effective". They are advisors, but often feel like "accessories" or "attachments":

We work hard to produce a report and a decision is made that ignores it. That's demotivating, frustrating.

EAs often investigate "peripheral" situations identified during inspection that are not directly related to the prosecutor's request. In such cases, the EA's considerations may often go ignored by the prosecutor. For example, the inspection of a specific item of machinery can reveal various other unsafe conditions that are not the target of the investigation and are therefore disregarded.

This type of situation generates ethical and moral suffering, due to the potential consequences of unsafe situations and because the professional may be left with a feeling that his or her work lacks quality:

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Sometimes the prosecutor places all the responsibility on us. Setting a deadline knowing that the machinery is dangerous, or laying off 500 staff? Safety versus employability... I won't sleep if someone has an accident.

We want to do good job, effective, we don't want to play at working. I won't be able to do a good job, but I'll do my best... that is suffering.

Work at the health-work interface and the dilemma of intersectorality

The work of each body can sometimes be confused and overlapping, given that the same complaint can be presented to more than one body, for example when prosecutors make use of cooperation agreements and deploy external partnerships (WHRCs and/or the ML) and/or the technical advice of their own EAs. This can lead to gaps in advice, requirements, deadlines, and sanctions.

With regard to autonomy, it is important to highlight that LIs and HOs enjoy independence when conducting actions and applying sanctions, while EAs have no control over the fate of the case, thus hampering their participation in intersectoral actions.

Chart 2 presents a summary of the roles and responsibilities, origin of work demands, and partnerships of each type of surveillance officer.

In this context, although the LPO engages with both institutions, this is not enough to ensure joint working. The LPO is often seen more as a requestor of collaboration than a partner, while staff from the ministries of labor and health believe that their working practices have conceptual differences:

If you say WHRCs here they'll be down on you like a ton of bricks due to remit (ML).

The scope of the ML is broader than the inspection that the health [ministry] does in working environments (ML).

[...] we have almost antagonistic roles; we have nothing to do with each other. Our theoretical and methodological framework is different. That's what creates rivalry. We locate ourselves in the field of public health, the social determinants of the health-disease process. The ML works using the logic of occupational medicine, of hygiene (WHRC).

Workers from the ministries of labor and health believe that cooperation with the LPO is not always two way. They act as technical assistants, meeting deadlines set by the prosecutors, while the requests they make to the LPO are not always met. Collaborations often seem to be more linked to interpersonal relationships than institutional guidelines.

The findings show that, although all participants feel overworked and none of the bodies are able to meet the volume of demand, there is little willingness to join forces and contribute to each other's work.

Discussion

To avoid situations that create suffering and damage to health, demand requires systematic and careful planning[13]. However, the accounts show that the bodies involved in occupational health surveillance do not have the level of complexity and effectiveness that the field demands.

Inspection actions resulting from complaints and specific demands have momentary effectiveness and are based on outdated models such as the occupational medicine and occupational health approaches[9].

The limited time available to carry out the actions has made it practically impossible to count on the participation, practical knowledge, and consensual validation of workers to promote transformations in their work[9].

Partnerships bolster actions and resources, avoiding overlapping interventions that duplicate efforts and waste scarce resources, lack of communication, and even lack of recognition of the contribution of each body[15].

Lack of institutional recognition of staff skills and competencies, experience and expertise, and disregard for their intelligence in work is common across the three sectors. For the participants, this is a sign of obsolescence and the dismantling of their work[14]. Hence, they feel that their know-how and accumulated knowledge will be lost when they retire, given the impossibility of transmitting this experience to those who will replace them.

There is a consensus among the participants that acquired experience is a unique attribute in the identification of demands and assessment of situations. All the participants have developed know-how, strategies, and assessment instruments that cannot be learned from the literature or in education and training.

The burden of responsibility, uncertainty, and lack of institutional support[13] are a source of concern. Signing off reports under the pressure of deadlines in the face of the high number and diversity of cases exacerbates anxiety, fear, ethi-

Chart 2. Roles and responsibilities, demands, and partnerships of each type of surveillance officer.

Roles and responsibilities	Labor inspectors (ML)	Health officers (WHRCs)	Expert analysts (LPO)
Verify compliance with legal responsibilities related to work and employment	X		
Provide technical guidance to workers and persons subject to inspection	X	X	X
Articulation with different levels of health care		X	
Provide specialist technical advice to prosecutors at various stages of investigative procedures	X	X	X
Carry out inspections of work sites	X	X	X
Prepare reports	X	X	X
Apply sanctions; shut down works, machinery, sectors, or companies	X	X	
Analyze documents and health programs set out in the legislation	X	X	X
Origin of demands			
LPO	X	X	X
Police stations	X		
Unions	X	X	
Residents of nearby regions	X		
Own initiative	X	X	
Other national and state bodies	X		
Other municipal bodies		X	
Health service users		X	
Partnerships			
Unions	X	X	
LPO	X	X	
Other national and state bodies	X		
Social movements and health organizations		X	
Health movements		X	

Source: Authors.

cal and moral suffering, and the feeling of being alone.

Feeling a lack of recognition and that their work is invisible was common among LIs, HOs and EAs inside and outside work. This appears when they highlight the dismantling of their work, poor working conditions, lack of recruitment of new staff, and lack of structures capable of ensuring the transmission of know-how.

Despite conflicting pressures, each group of surveillance officers showed social concern, seeking to adopt corrective measures over issuing infringement notices. They were also concerned about ensuring good working conditions, keeping people employed, and company survival, always seeking to avoid shutting down establishments that provide important social services (hospitals for example) or employ a lot of staff. They need to create ways of ensuring compatibility with often rigid and inflexible laws within deadlines based on the capacity of the company and applying affordable measures.

Finally, crisis management and changes in the legislation have reduced the participants' political force to confront companies. Inspecting and transforming workplaces is a challenge that requires time, knowledge, and institutional support.

The feeling of being alone in the fight against the dismantling of the institutions tasked to promote health and safety at work and to fulfill the ideal of ensuring decent working conditions was common among all participants. The infeasibility of occupational health surveillance, be it due to overwork and understaffing, underfunding, or the lack of political priority, results a feeling that

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efforts are not enough in the face of the reality that they would like to change.

The conflict between working well and working quickly, implementing piecemeal interventions versus having the time to broaden the scope of actions and promote change rather than just imposing penalties is something that afflicts all the participants, generating suffering and despair.

In addition to the issues relating to know-how, staff reduction, lack of meaning at work, and the abolishment of government bodies and ministries, there is strong evidence of the dismantling of occupational health and safety policies and the worsening of working terms and conditions[15].

Participants working in the ML, which became a department of the Ministry of the Economy and was later recreated, are concerned with the future of labor inspection, believing that there will be a reduction in the efficiency of their work. In addition, they mentioned that labor inspection will also be negatively affected by using remote checklist inspection systems.

The HOs feel they are losing ground, due to staff shortages and the lack of reach of their actions. As a result, they fear that the service is not prepared to meet changing demands and are concerned about the future of the service itself, believing that WHRCs could be abolished.

The EAs raise the question of the symbolic demise of their work amid the weakening of labor protection legislation and the lack of investment in professional staff and accumulated knowledge. They believe in the importance of the LPO, especially given the limitations and deficiencies of the government bodies involved in enforcement and workers' health surveillance.

The group reports show just how unaware each body is of the work conducted by the other bodies, despite their common goals, and the amount of dismantling that these organizations are simultaneously subjected to. This unawareness and lack of interaction weakens all the organizations. Alliances could strengthen these bodies and lead to mutual resistance, confrontation, and protection[4,15].

One of the barriers to intersectorality is lack of clarity regarding funding sources to consolidate the actions proposed by the National Occupational Health and Safety Policy[19]. WHS actions developed by the Ministry of Health are funded by the SUS, while the origin of specific funding for the actions developed by the other bodies is unclear. While on the one hand this uncertainty suggests that resource management is centralized in the SUS, on the other it isolates and hinders other proposals, discouraging intersectorality and shared responsibility.

It would be expected that synergy between sectors with such similar goals could enhance joint actions. For example, in São Paulo, there is a total lack of integration between the ML and WHRCs. These organizations are unaware of each other's work and criticize each other's competencies and supposed conceptual, theoretical, and technical differences. This demonstrates jostling for space, which is probably related to the origins of the two bodies. We believe that the actions developed by these bodies should be complementary and in tune with each other; however, the professionals appear to be reticent to developing partnerships, with cooperation arising more from individual or specific initiatives.

Conclusions

Historically, enforcement and occupational health and safety actions were originally the responsibility of the ML. They were subsequently extended under different theoretical and methodological frameworks to the Ministry of Health and later to the LPO. Despite having intrinsically linked objectives, these three bodies in São Paulo continue to encounter difficulties in consolidating intersectorality as envisioned in occupational health and safety policies. The integration of objectives and practices could help ease workloads, combine expertise and, above all, join forces to resist the dismantling of occupational health and safety in the country.

Despite sporadic partnerships, some of which institutionalized, several barriers remain to merging specific actions, recognizing and mutually respecting the expertise of each body, avoiding overlaps, and building joint, cooperative, and collaborative practices.

At this sociopolitical moment, it is evident that workers' health and rights are not a government priority. Despite sailing the same "sea" and facing the imminent risk of sinking, the bodies involved in occupational health and safety refuse to realize that they could be much stronger if they pooled together their resources in one a single "boat".

Overwork, be it due to understaffing and underfunding or high work demands, hampers communication and cooperation between these bodies. This, combined with the lack of autonomy of frontline surveillance officers, who are subjected to hierarchies with different degrees of

rigidity, hinders progress towards effective intersectoral collaboration.

The future of inspections, surveillance actions, and work analysis in the country therefore remains cloudy, and intersectorality, at least in São Paulo, still appears to be a utopian dream.

One of the limitations of this study is the fact that the reflection groups were created in different years (2017 to 2019) and there were already signs that workplace interventions would be diminished, of shifts in leadership within the federal government, ministerial changes, and labor reforms, coupled with the weakening of labor legislation, flexibilization of employment relationships, and an increase in informal work[15,26,27]. Despite its importance, this process was not captured in the findings as data collection took place before this process.

We believe that the findings of this study can help foster dialogue and overcome the fragmentation and overlap of actions, reinforcing common elements and promoting increased synergy between the different bodies. It is also hoped that this study will contribute to advancing intervention activities, which are fundamental to occupational health and safety. Finally, it is worth noting that the originality of this article resides in the fact that the data are derived from listening to groups of workers employed in different bodies with singular yet converging actions.

Collaborations

S Lancman: coordinator of the thematic project, responsible for this stage of the research and one of the protagonists in the elaboration of the article. VS Barreto: scholarship holder of scientific initiation of the thematic project and participant of several phases of the study and also, of the elaboration of the article. MT Bruni, R Giannini: researchers participating in the project and co-authors of the article. JO Barros: co-author of the project and co-responsible for this phase of the research. The article counted on the role of all authors in writing and revising the text.

Acknowledgements

To Fapesp, process number 2014/25985-2. To the Laboratório de Ciências da Reabilitação (LIM 34) of the Hospital das Clínicas, Faculdade de Medicina, Universidade de São Paulo-SP for the financial support for the translation of the manuscript.

References

1. Hale A. From national to European frameworks for understanding the role of occupational health and safety (OHS) specialists. *Saf Sci* 2019; 115:435-445.
2. Los FS, Hulshof CTJ, Sluiter JK. The view and policy of management of occupational health services on the performance of workers' health surveillance: a qualitative exploration. *BMC Health Serv Res* 2019; 19:473.
3. Organização Internacional do Trabalho (OIT). *Trabalho Decente* [Internet]. [acessado 2020 jul 6]. Disponível em: https://www.ilo.org/brasilia/temas/trabalho-decente/lang--pt/index.htm.
4. Sindicato Nacional dos Auditores Fiscais do Trabalho. *Auditoria Fiscal do Trabalho - Conheça a Auditoria* [Internet]. [acessado 2020 jun 10]. Disponível em: https://sinaitsp.org.br/conheca-a-auditoria.
5. Brasil. Decreto nº 4.552, de 27 de dezembro de 2002. Aprova o Regulamento da Inspeção do Trabalho. *Diário Oficial da União* 2002; 30 dez.
6. Brasil. Lei nº 10.593, de 6 de dezembro de 2002. Dispõe sobre a reestruturação da Carreira Auditoria do Tesouro Nacional. *Diário Oficial da União* 2002; 9 dez.
7. Lancman S, Daldon MTB, Jardim TA, Rocha TO, Barros JO. Intersetorialidade na saúde do trabalhador: velhas questões, novas perspectivas? *Cien Saude Colet* 2019; 25(10):4033-4044.
8. Laurell AC, Noriega M. *Processo de produção e saúde: trabalho e desgaste operário*. São Paulo: Ed. Cebes-Hucitec; 1989.
9. Machado JMH. Processo de vigilância em saúde do trabalhador. *Cad Saude Publica* 1997; 13(Supl. 2):33-45.
10. Güérin F, Kerguelen A, Laville A, Daniellou F, Duraffourg J. *Compreender o trabalho para transformá-lo: a prática da ergonomia*. São Paulo: Edgard Blucher; 2001.
11. 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. *Diário Oficial da União* 1990; 20 set.
12. Minayo-Gomes C, Thedim-Costa SM. A construção do campo da Saúde do Trabalhador: percurso e dilemas. *Cad Saude Publica* 1997; 13(Supl. 2):21-32.
13. Daldon MTB, Lancman S. Vigilância em Saúde do Trabalhador: rumos e incertezas. *Rev Bras. Saude Ocup* 2013; 38:92-106.
14. Vasconcellos LCF, Gomez CM, Machado JMH. Entre o definido e o por fazer na Vigilância em Saúde do Trabalhador. *Cien Saude Colet* 2014; 19(12):4617-4626.
15. Barros JO, Daldon MTB, Rocha TO, Lancman S, Sznelwar L. Intersetorialidade em saúde e trabalho no contexto atual brasileiro: utopia da realidade? *Interface (Botucatu)* 2020; 24:e190303.
16. Brasil. Portaria nº 1.378, de 9 de julho de 2013. Regulamenta as responsabilidades e define diretrizes para execução e financiamento das ações de Vigilância em Saúde pela União, Estados, Distrito Federal e Municípios, relativos ao Sistema Nacional de Vigilância em Saúde e Sistema Nacional de Vigilância Sanitária. *Diário Oficial da União*; 2013.

17. Brasil. 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; 24 ago.
18. Araújo TM, Palma TDF, Araújo NDC. Work-related mental health surveillance in Brazil: Characteristics, difficulties, and challenges. *Cien Saude Colet* 2017; 22(10):3235-3246.
19. Brasil. Decreto nº 7.602, de 7 de novembro de 2011. Dispõe sobre a Política Nacional de Segurança e Saúde no Trabalho. *Diário Oficial da União* 2011; 8 nov.
20. Lancman S, Sznelwar LI, organizadores. *Christophe Dejours: da psicopatologia à psicodinâmica do trabalho*. Brasília: Paralelo15, Rio de Janeiro: Fiocruz; 2004.
21. Daniellou F, Laville A, Teiger C. Ficção e realidade do trabalho operário. *Rev Bras Saude Ocup* 1989; 17:7-13.
22. Brito J. Trabalho Prescrito. In: Pereira I, Lima J. Dicionário da Educação Profissional em Saúde. 2ª ed. Rio de Janeiro: EPSJV; 2008. p. 478.
23. Dejours C. *Observations cliniques en psychopathologie du travail*. Paris: Presses Universitaires de France; 2010.
24. Brasil. Portaria nº 3.214, de 8 de junho de 1978. Aprova as Normas Regulamentadoras - NR relativas à Segurança e Medicina do Trabalho. Ministério do Trabalho. *Diário Oficial da União*; 1978.
25. São Paulo. Lei Municipal nº 13.725, de 9 de janeiro de 2004. Institui o Código Sanitário do Município de São Paulo. *Diário Oficial da Cidade de São Paulo*; 2004.
26. Krein JD. O desmonte dos direitos, as novas configurações do trabalho e o esvaziamento da ação coletiva: consequências da reforma trabalhista. *Tempo Soc* 2018; 30(1):77-104.
27. Brasil. Lei nº 13.467, de 13 de julho de 2017. Altera a Consolidação das Leis do Trabalho (CLT), aprovada pelo Decreto-Lei nº 5.452, de 1 de maio de 1943, e as Leis nº 6.019, de 3 de janeiro de 1974, 8.036, de 11 de maio de 1990, e 8.212, de 24/07/1991, a fim de adequar a legislação às novas relações de trabalho. *Diário Oficial da União* 2017; 14 jul.

Article submitted 01/12/2021
Approved 30/06/2022
Final version submitted 02/07/2022

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva