


### Worker's health and primary health care: dialogues and perspectives of integrated care in the health-work-disease process

Saúde do trabalhador e Atenção Básica à Saúde: interlocuções e perspectivas de cuidado integrado no processo saúde-trabalho-doença (resumo: p. 17)

Salud del trabajador y atención básica de la salud: interlocutores y perspectivas de cuidado integrado en el proceso salud-trabajo-enfermedad (resumen: p. 17)

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The article presents and discusses the scope of Worker's Health (WH) actions in PHC in São Paulo. Within the context of a thematic project, an interview and two focus groups were carried out with professionals working in a Basic Unit in the northern region of the city in 2019. The resulting material was assessed using thematic content analysis. The private outsourcing of part of the public services management, the decay of labor rights and agendas related to worker's health, the overload of the PHC teams that started to develop actions of different lines of care, in addition to the quantitative issue and the territorial scope of the WH Reference Center (CEREST) are obstacles to the conformation and consolidation of WH practices in PHC. There is a challenge in resizing services and requalifying actions, considering the interfaces production-work-health.

**Keywords:** Occupational health. Public health policies. Health care networks. Primary Health Care. Intrasectorality.



## Introduction

The National Primary Care Policy (PNAB) proposes the offer of health actions at the individual, family, and collective levels aiming at health promotion, protection, and maintenance, prevention of diseases, diagnosis, treatment, rehabilitation, and health surveillance. It is developed by multidisciplinary teams working in a given territory<sup>1</sup>.

Within the PNAB, the primary health care (APS), through the Basic Health Units (UBS), is the preferred gateway, coordinator, and organizer of the actions and services available in the Brazilian National Health System (SUS). It is also the level for the articulation of the Health Care Network (RAS)<sup>2</sup> and of intersectoral, community, and social networks<sup>3</sup>. The RAS and the guidelines for its organization<sup>2</sup> in the SUS seek to overcome the fragmentation of the different levels of care and lines of care, promoting the integration and articulation of vertical and horizontal actions, that is, of the APS network and also with the specialized care networks.

Workers' Health (WH), on the other hand, is a field of strategic and inter-institutional practices and knowledge (health, labor, social security, and justice) that takes as a reference the determination of work in the health-disease process of individuals and collectivity<sup>3</sup>. WH has undergone important advances since the promulgation of the 1988 Federal Constitution and the implementation of the SUS in 1989, such as the construction of the National Network for Integral Attention to Worker's Health (RENAST)<sup>4</sup> and the promulgation of the National Policy for Worker's and Worker's Health (PNSTT)<sup>5</sup>, which foresaw greater integration with APS.

The Workers' Health Reference Centers (CEREST), specialized public services in this field, develop actions to promote health, prevent diseases, and Surveillance of the Workers Health (VISAT), in addition to training the RAS health professionals to identify and monitor work situations and/or production processes that favor diseases and/or represent situations of risk to health<sup>5</sup>.

It is expected that the high degree of decentralization and capillarity of the APS, together with the proximity of the UBS to homes and workplaces, will favor the access to health care for workers<sup>3,4,6-8</sup>. This would also allow, as provided in the PNSTT<sup>5,6</sup> that the relations between the health-disease-work process can be identified at all points of the RAS aiming to establish the link between complaints and/or illnesses and the occupation and/or work situation of the user, whether he/she is a formal, informal, or unemployed worker<sup>9</sup>. This would also favor a greater identification and notification in the Notifiable Diseases Information System (SINAN) of the Ministry of Health.

The Matrix Support is one of the planned actions and presupposes a continuous monitoring and articulation between the teams of APS and CEREST. It is characterized by a frequent proximity to form links between professionals from different teams in order to reorganize health care, co-responsibility of cases, and improvement of the identification of the health-work-disease relationship, integrating assistance and surveillance actions<sup>4,10,11</sup>.



However, until today, WH actions have been challenged to compose the actions in the APS and also in other points of the RAS in an integrated/articulated way<sup>3,6</sup>. Lacaz et al.<sup>12</sup> point out that the implementation of CEREST has allowed sectoral advances, accumulation of experiences and technical knowledge, but still does not result in intersectoral articulation in APS, in other specialized services and in surveillance instances.

When analyzing the work of Community Health Workers (CHWs) in a medium-sized city in Minas Gerais, researchers concluded that these professionals incorporated aspects of WH in their practice (identification of occupation, home work, and health risk factors), without having undergone specific training<sup>13</sup>. However, there is a need for greater qualification of CHWs, because work-related issues, even when identified, do not generate interventions, nor are they referred as specific WH demands.

Lacerda and Silva et al.<sup>14</sup> highlight difficulties in consolidating a WH approach in the APS, from lack of knowledge about the topic to little or no structure and institutional support to ensure conditions for the effectiveness of public health policies.

An additional challenge in several regions, including São Paulo, is the management of UBSs by Social Health Organizations (OSS), regulated in 1998<sup>15</sup>. According to the São Paulo City Hall (PMSP)<sup>16</sup> in 2022, the set of health units in this municipality were managed by 10 different OSS.

Considering this context, the objective of this article is to present and discuss the permeability and reach of WH actions in APS, based on the work developed by teams linked to UBSs in a microregion of the city of São Paulo/SP.

## Methodological configuration and data analysis<sup>17</sup>

This article will present the results of one of the phases of the research: Construction of intersectorality in the field of health and work: perspective of professionals inserted in the network of services in the municipality of São Paulo<sup>18</sup> developed from 2016 to 2022. One of the last stages of the study aimed to understand the intersectoral dialogue in the municipality, especially the dialogue between the WH and the APS, from the perspective of the workers involved.

The research was cleared by the Research Ethics Committee of the University of São Paulo Medical School (CAAE:58418816.1.0000.0065). All participants signed the Informed Consent Form (ICF).

## Context of study development

São Paulo was the most populous and largest city in the country in 2021<sup>19</sup>, with 12.4 million inhabitants and an area of 1,521 km<sup>2</sup>. It had 470 UBS, more than 1,574 Family Health Strategy (FHS) teams, 151 Family Health Support Nucleus (NASF in the Portuguese acronym) teams<sup>20</sup>, 87 medium complexity services, the Ambulatory Medical Assistance (AMA)<sup>21</sup>. It also has six CEREST with regional coverage, responsible for 13 million inhabitants.



These CERESTs refer to macro-regions, linked to the respective Regional Technical Supervisions of Health - Central, West, East, North, Southeast, and South. Each one of them is responsible for the integration and matrix support of UBSs and AMA/UBSs, besides the other services of the RAS, as illustrated in the chart below.

**Frame I.** Coverage areas of the macro-regions and the 6 CERESTs, São Paulo<sup>22</sup>.

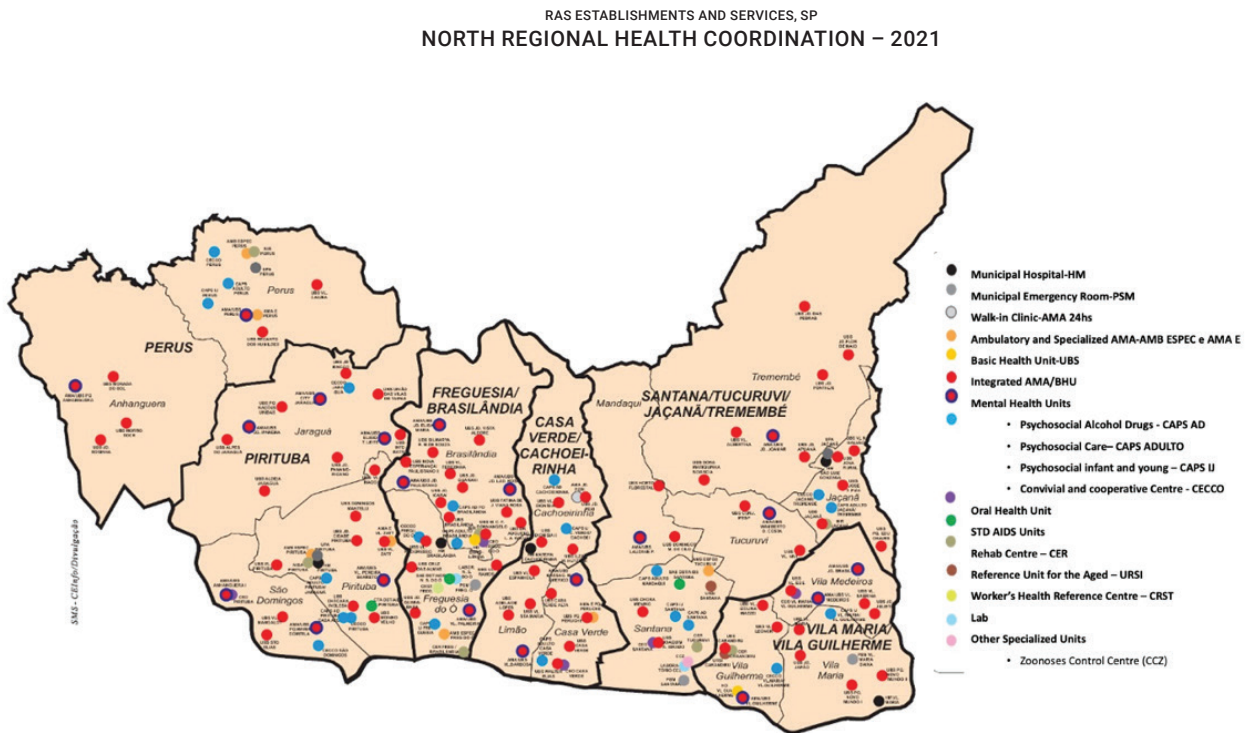
Region	Coverage Area	Health Units Encompassed
Sé (Downtown)	Centro; Bom Retiro; Santa Cecília; Consolação; República; Sé; Bela Vista; Liberdade e Cambuci.	9 UBS and no integrated AMA/UBS
West (Lapa)	Butantã; Lapa/ Pinheiros e Sé e parte da região central da cidade. Lapa, Perdizes, Sumaré, Jaguaré, Pinheiros, Butantã, Itaim, Brooklin, Morumbi, Alto de Pinheiros, Raposo Tavares, Vila Sonia, Rio Pequeno, Vila Leopoldina.	17 UBS and 8 integrated AMA/UBS
East	Cidade Tiradentes, Ermelino Matarazzo, Guaianases, Itaim Paulista, Itaquera, São Mateus, São Miguel.	42 UBS and 12 integrated AMA/UBS
Southeast (Mooca),	Aricanduva/Formosa/Carrão, Ipiranga, Jabaquara, Mooca, Penha, Vila Mariana, Vila Prudente, Sapopemba.	38 UBS and 10 integrated AMA/UBS

## Place, population, and period of the study

The study sought to contact the responsible persons for the various Health Surveillance Supervisions (SUVIS) of the municipality in October 2019, for subsequent access to the UBSs and respective teams.

Due to greater availability and readiness, we started the fieldwork in one of the UBSs of the region attached to the Technical Health Supervision (THS) of Santana/Jaçanã, linked to the Regional Health Coordination North of São Paulo. The Santana/Jaçanã THS includes units of the Santana/Tucuruvi and Jaçanã/Tremembé sub districts. The reference CEREST is in Freguesia do Ó.

This THS had 17 UBSs and 3 integrated AMA/UBS<sup>22</sup> and was responsible for the care of approximately 616,000 people<sup>23</sup>, represented in the map below. It is noteworthy that the map represents, simultaneously, the total area covered by CEREST Freguesia do Ó, which transcends the Santana/Jaçanã WHS.



**Figure 1.** Establishments and services of the RAS - SP - North Regional Health Coordination – October 2021.

Aided by the support of the manager of one of the SUVISs in the northern region, we reached the coordinator of a UBS who was willing to participate and facilitate the contact with workers in the unit. It is noteworthy that this unit is managed in a mixed form through a management contract between the municipality and an OSS. We hoped to access one UBS in each region of the city, but due to the epidemic of Covid-19 and the deadlines for completion of the research, the work could not be extended.

## Procedures adopted for data collection and analysis

A semi-structured interview<sup>24</sup> was conducted with the UBS coordinator during 75 minutes. The dialog was based on the following guiding questions: How long have you worked in the APS? How do you perceive the interlocution between APS and WH and, more specifically, in the region where you work? Do you develop specific WH actions with the population served by the UBS? Are there any specific care actions for the workers who work at the unit?

As suggested by the coordination of the studied UBS, among the 87 professionals linked to the unit, those who had more direct contact with users with some work-related health condition and who had a more attentive look at this aspect of health were the Community Health Workers (CHWs) and those from the multiprofessional team, made up of nursing assistants and pharmacy workers, which in that unit made up different teams.



In this way the study proceeded to gather two focus groups<sup>25</sup>, one with the CHWs and the other with members of the multiprofessional team (nursing and pharmacy assistants). There was a single session for each group, at an agreed time, according to the convenience of the participants. Participation was voluntary. Six CHWs and seven multiprofessional team workers participated. The other members of the multiprofessional team refused to participate, claiming overwork.

The groups were held in the UBS, in a private room, lasting approximately 150 minutes each. Both took place with the presence of a main moderator, an assistant, and a graduate student, all without previous contact with the participants. The questions were proposed: in your daily professional life, do you identify cases with work-related health problems? How do you deal with this in your practice? In a second moment the following question was proposed: as health workers, do you identify aspects of work that can affect your health?

The interviews and focus groups were recorded, transcribed, and analyzed using the Thematic Content Analysis technique<sup>24</sup>.

## Results

In the presentation of results, the statements were identified with the letters “E”, representing the individual interview, G1, portraying the focus group held with CHWs, and G2, for the multiprofessional team.

### The identification of work as a determinant of the health-disease process

A first aspect that appears transversely in the participants' reports is related to the perception they have developed over the years in the care in APS, stating that work (or lack of it) is one of the determinants of the health-disease process.

[...] there are patients who have back problems, because of their profession, like masons, they have developed varicose veins; some women who work as maids, have arm, knee and emotional problems. Everything has a little bit of this WH issue. (G1)

I found a lot lately, maybe because of unemployment, problems related to the mind, psychiatric. Many depressed people, because of the situation Brazil has been facing. (G1)

If, on the one hand, identifying work-related diseases and illnesses can be positive for the proper referral, on the other hand, it becomes distressing to be faced with problems in which their intervention has little reach and resoluteness, given the social reality experienced by users, since they transcend the scope of actions provided by SUS, but are a strong source of illnesses. Examples are situations of job insecurity, vulnerability, night work hours involving minors, exhausting workload, among others.



There are patients who need to take pressure medicine, and we know that the exhausting heat alters the pressure. They fry snacks at dawn to earn some money and can't even buy the medicine. (G2)

These little markets are popping up, hiring young apprentices, working 8 to 10 hours a day! They get overworked, their performance at school gets worse. There is that law, 'work so many hours', but here it is unassisted, we have no supervision, it's a 'God will have mercy', 'today you work three hours more, nobody will notice, or you will be fired'. (G2)

The other day I saw a man... He had mouth cancer from work, he was a carpenter, tinsmith, something like that. It triggered this cancer. His mouth was not normal, but he was cured. I said, 'did you stop working?', and he said 'I can't stop, it's my livelihood', 'but if it comes back and gets worse? (G2)

The participants shared situations in which they carry out guidance/interventions that are considered feasible, given that the resolution of many of them depends on actors with whom they have no direct articulation or governability.

There was a 20-week pregnant woman who came for prenatal care, a gas station attendant. Her boss didn't want to change her sector. She wanted to leave. What can we do? We send a letter, a report, telling the damage that the work can cause to the mother and the child. We wrote to reassign her to a less harmful sector and this was done. (G2)

He worked as a bricklayer, in a heavy construction job. The boss gave the workers a packed lunch, rice and beans. Then I said, 'but do you eat everything? In the morning, he gets a bread roll, eats 2 or 3. Then, 'I'm hungry. You tell him to eat more salad. What are you going to say? 'What if you bring a lunch box?', 'I live alone, I can't bring a lunch box. Eating on the job is an economy. (G2)

The mission of CEREST is to provide WH training to workers of the RAS, for a better understanding of the link between work and illness, actions, and conduct guidance. However, it is observed that this training does not reach them and that their actions are guided by common sense, discussions in the units and, sometimes, by improvisation. Unlike other networks, such as mental health or rehabilitation, the worker's health, in cities like São Paulo, does not reach most of the UBS.



We are not qualified to identify the health problem as work-related, we bring them to the unit, and try to solve it the best way possible. They count on the intimacy they have with us, they use the CAPS, for mental issues, the NIR (Patients' referral center), other networks, but we do not know CEREST, I have never heard of it. (G2).

### **The intrasectoral relationship between UBS and CEREST**

Regarding the dialogue between the APS and WH networks, it is unanimous among the participants the finding that there is a fragility and often ignorance of the existence of specific services that empower the network, welcoming workers and intervening in potentially pathogenic work situations. There is also difficulty in accessing the scarce existing services due to the extension of the municipality.

There was a CEREST in Itaquera, the referrals took a long time to access it, both, for the professionals working in the UBS and for the patients, maybe even due to a lack of knowledge, I think WH in São Paulo is precarious, in this region we have CEREST in Freguesia do Ó, it is far away and inaccessible, we use the one in the Center more and we receive many counter-references ... it wasn't solved there and comes back to us. (E)

The participants also pointed out two other aspects that indicate the little and equally necessary interlocution between the networks: training related to WH topics, including the identification of work-related diseases and the opening of Work Accident Record (CAT), as well as conduct orientations facing relevant and frequent problems in the population and that could be incorporated into APS practices.

There is no training or teaching to identify work-related problems, we identify them naturally. We know the family, they bring the demand, and with the intimacy we have with them and them with us, they end up reporting it, we bring it to the unit and try to solve it the best way possible. SUS works, but it takes time, and depending on the specialty, it ends up not giving the necessary feedback. (G1)

There is a higher turnover of these doctors, it is hard to do it this way, it is usually through the nurses. The nurse identifies it, discusses it in the team meeting: "I think it is related to the occupation", there are many cases in the sewing workshops, there are immigrants, Bolivians, there were families with respiratory issues and the CHW had visited them, we already knew about them, then she brings them to the team", it is related to sewing machines", they sew and sleep in the same place, "it is an informal occupation, what can we do, besides follow up? "We fill out the CAT, but they don't go to CEREST, because it is informal work and we work "slowly", otherwise they don't even open the door, they are afraid. (E)





In the situations in which they tried to formalize a partnership with the CERESTs to follow up on specific cases, there was no resonance.

We didn't know how to act when we had a patient contaminated by metal during a period that worked in an industry and he already came with this diagnosis. He was being treated, had received compensation, but had sequelae. The doctor sent him to CEREST, so that they could give him some information, asking for orientation and guidance for the monitoring of this patient; she felt insecure about how to handle the situation. They sent it back to us, it is a chronic case of outpatient follow-up. (E)

Even though they identify the relationship between illness and/or accident and work and this is a cross-cutting aspect to the damages observed, the other health services with other specialties are more accessible for worker care, as well as the NASF, which has a multidisciplinary team that integrates and supports the FHS.

They do what is within their reach, they have several specialties (psychologist, nutritionist, therapist, etc.) and direct what they can do. What is out of reach, depending on the demand, there are several places in the network to refer. (G2)

It can be observed, with the exception of the interviewee (UBS coordinator with a nursing degree) who sometimes tried to call the CERESTs without success, that the participants of the groups were unaware of the WH care line in the municipality, the specific services, the public policies in the area and especially the existence of this theoretical/practical field.

Some of the explanatory hypotheses are: the disproportion between the primary care network, the number of CERESTs, the municipality's population density and its territorial extension, which make it difficult to access these few services. An example of this is the distance between the researched health unit and the reference CEREST, which is 27 km, requiring more than 1 hour of travel within the city. This makes the reach and capillarity of the WH not reach the various regions.

Another relevant factor is that with the implementation of the OSS, the turnover of professionals in the APS has increased in contrast to the CEREST workers who are civil service workers.

It is noteworthy that it is more usual for these UBS professionals, when facing work-related issues, to seek medical specialists or the NASF team, which, despite having a greater diversity of professionals, does not have WH specialists.



## Health promotion actions with users, even not prioritizing the intrinsic aspects of worker's health

According to the participants, the health of people who work can and should be looked beyond the WH as a specialty. Added to the absence of specific actions aimed at workers based on the roles they occupy and the places where they are, they manage to develop some care actions, even if they are more individualized and punctual in the territories and with the people they work with.

We do actions in local companies, supermarkets, smaller factories, usually focused on some other line of care, I do actions in the market, it is basically to identify people with hypertension, diabetes or some vascular disease, to detect them early. We go to those places where there are people to work on this promotion, where the workers will be. (E)

We offer the services we have. There is a physiotherapy group, a physical education teacher, they teach how to lift weight in a less harmful way. That's the most we can do. (E)

Company X came to us to do some physical activity, I thought it was interesting to promote these actions in the market space and talk about the importance of this and nutrition to the workers, it was their initiative. (E)

It may be observed through these examples, that these actions are more focused on people than on productive processes. They understand workplaces as spaces of concentration of people that favor the development of health prevention activities (hypertension, diabetes measures, others), but they disregard work situations that are harmful to health, which could even trigger surveillance actions. This occurs mainly due to the distancing from the line of attention in worker's health.

## The care of those who care - worker's health actions for the health worker

During the groups, in several moments it was necessary to alert the participants and divide the discussions into two parts: one addressing issues related to service users and the other focused on their care as workers. The complaints about their own working conditions and the reflection of what they experience at work in their own health and in the clinical manifestations that seem to be unwelcome. There is no structure that guarantees the care of those who care. They realize that as workers they are exposed to situations similar to the users of the UBS they attend and end up with no one to seek help.

When I am overloaded, I start to have insomnia... when many patient problems start to come or there is no professional doctor in the team. It is not only related to work, but to mental loads, "I leave work, I have to pick up the children,



I don't rest, I also work at home, my husband is not a partner, he doesn't help, when I see it is already midnight, I couldn't rest and I have to wake up early to work. (E)

We tried to access the CEREST to talk about care in relation to lesions by repetitive efforts, even for us, they couldn't afford it, they had no capacity, because it is a center for the entire northern zone. In the region where they work, they manage to do this work, because it is closer and we could look for the UVIS (Health Surveillance Units), which do this more regional work. (E)

They feel neglected as workers in the care of their health needs, despite it being mandatory that the contracting OSS perform periodical exams, offer follow-up by an occupational physician and monitor working conditions.

We feel helpless as workers, we lack a psychologist, we are also workers, we wanted to spend time with other professionals, we also get sick... we lack specialists, mental health care... many situations that we live here impact our health, this affects us. (G2)

The occupational health team never came here to look at our environment, ergonomics. The CIPA (Internal Commission for Accident Prevention) team came and talked about safety at work, and WH. (G1)

We never had periodical exams and I don't know if there is any legislation. In other companies we did annual periodical health exams, blood tests, posture evaluation. (E)

The initiatives to listen to the demands of these workers are developed by the local managers, in the UBS where they work, a situation that creates embarrassment for them.

Several professionals who have psychological suffering, physical problems, are CHWs from our territory, their reference unit is ours, but not all of them feel at ease to be cared for by colleagues from the same team, they have to have distance, for example, a psychotherapy. There is this void, I realize that I am a woman, a CHW, I have to do the Pap smear, with my coworker, I wouldn't do it. When I needed it, I went to a neighboring unit, there should be an exchange, I see the professionals from the neighboring unit, they see mine. (E)

We offer integrative and complementary practices: tai chi, shiatsu, dance, and labor gymnastics. (E)

## Discussion

The RENAST network, particularly the CERESTs, may be considered a technical reference for health actions in the APS. However, for this to occur, it is necessary to consider the historical and current role of the CERESTs in the context of the RAS and their attributions in network integration. Recent studies on the development of RENAST show that sometimes the articulation with the APS, mediated by the qualification of teams, has increased the demand for CERESTs without effectively incorporating the APS as the gateway to the system<sup>7</sup>.

Reports of successful experiences deal with small and medium-sized municipalities, which at the end are not reflecting the complexity of cities like São Paulo. In this capital, as demonstrated, the quantitative relationship and territorial coverage between CEREST and APS makes it impossible to have reference and counter-reference actions and the harmony and integration of forms, objectives and working hours among services<sup>14</sup>.

WH is developed according to the precepts of RENAST<sup>4</sup> and PNSTT<sup>5</sup>. Among the PNSTT's strategies, the "integration of the VISAT with the other components of Health Surveillance and with the APS" is recommended; the analysis and identification of the productive profile of the working population and the health situation of these workers in the territory must be carried out together; the guarantee, in the identification of the worker, of the registration of his/her occupation, branch of economic activity, and type of labor bond" in the diverse systems and sources of health information, "taking advantage of all the worker's contacts with the health system" as well as the "articulation and systematization of information" from different "databases of interest to the WH"<sup>5</sup>.

However, there is a gap between the strategies proposed by the PNSTT and the conditions to operationalize them in the RAS, aggravated by the territorial and population extension of the municipality that generates a demand incompatible with the installed capacity of the RAS.

The capillarity of the APS includes residents from the regions and not always the place where they work<sup>12,13</sup>. In this study, we found that the initiative to address key topics for the WH occurs more by the movement of some primary care workers than as a result of public policies that involve information collection, data analysis, and actions based on common guidelines. The consequence of the "spontaneity" of these approaches is reflected in the impotence of the APS workers to integrate, solve or refer the detected aspects to other points of the RAS.

The complaints of illnesses and suffering at work that are evident in the statements of the group participants deserve our attention. The presence of harmful factors related to the organization and precariousness of the work of these agents has been widely discussed in the literature, but in practice, it is evident the lack of advances in the care and recognition of such situations<sup>26,27</sup>. We also highlight the overload of the APS teams when including the development of WH actions in their agenda<sup>7</sup>.

The interrelation between WH and APS is studied by several authors who address historical, political, and conceptual aspects and analyze some integration experiences. Although relevant, these productions do not discuss municipalities that have gone through privatization of health service management. The OSS, through agreements with the state

and/or municipalities, are responsible for managing health services. They are alternatives that substitute the direct public administration in the provision of human resources and respective management, equipment, and facilities.

This outsourcing of management, understood by some authors as a form of privatization of the SUS<sup>28</sup>, hinders the integration and articulation among the units of the RAS, and can make them unstable, incomplete, disintegrated, and fragile. The OSS do not support the principles of articulation and integration between the WH and the APS, a factor evidenced in the groups and interviews carried out<sup>29</sup>. It should be noted that in the city of São Paulo, 67% of the units are managed this way<sup>30</sup>.

The coexistence of different models of management of services and teams in the municipality (direct administration, OSS, and mixed) hinders the implementation and continuity of programs that presuppose the integration between the APS and the WH. The high turnover and lack of stability of health professionals hired by the OSS<sup>30</sup> contrasts with the public career and long tenure of municipal civil servants. This may justify the difficulty for the development of a Permanent Education Policy<sup>28</sup>, matrix support actions, and professional training, attributed to CEREST.

## Final considerations

We tried to give visibility to the WH actions carried out in the APS and the importance of its increment, as well as to favor the integration between services that make up a network with consonant objectives.

There are issues that need to be valued and discussed in the performance of technicians, managers, and social control of the SUS, when proposing the development of WH actions in the APS. The WH policies, and the SUS itself, did not foresee the private management of part of the services, nor the decay of labor rights and of the agenda related to WH.

On the other hand, the necessary integration of the WH within APS did not consider the workload of the teams, which were in charge of working on multiple themes.

It is observed that the professionals of the APS already develop activities in the field of WH, although punctually and without the expected support. Thus, the challenge would be the dimensioning and requalification of these actions, from the perspective of production/work and health relations. For this, it is essential to prepare them to recognize the productive processes that occur in their territory and their repercussions on people's living and getting sick<sup>4</sup>. We also highlight the need to resize the CERESTs, so that they can play their role as technical support and backup for the APS.

One of the study's limitations is related to the number of UBSs surveyed, which occurred due to the difficulty of dialogue with the network because of the Covid-19 pandemic. Another limitation occurred in the UBS studied, which was restricted to the multiprofessional team, which included only nursing and pharmacy assistants, the number of CHWs available, and the number of coordinators interviewed. We can affirm, as a result of this experience, that the distancing of the WH from the UBS was also evidenced in our research, because when we contacted the RAS and presented our objectives, we had difficulties in accessing the units.



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### **Conflict of interest**

The authors have no conflict of interest to declare.

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Objetivou-se apresentar e discutir o alcance das ações de Saúde do Trabalhador na Atenção Básica à Saúde (ABS) em São Paulo. Em 2019, no contexto de um projeto temático, realizaram-se uma entrevista e dois grupos focais com profissionais inseridos em uma Unidade Básica da região norte da cidade. O material produzido foi apreciado à luz da análise temática de conteúdo. A gestão privada de parte dos serviços públicos; o esvaziamento dos direitos trabalhistas e da pauta relacionada à saúde do trabalhador; a sobrecarga das equipes da ABS que passaram a desenvolver ações de diversas linhas de cuidado; e a questão quantitativa e de abrangência territorial dos Centros de Referência em Saúde do Trabalhador (Cerest) são obstáculos para a conformação e a consolidação das práticas de Saúde do Trabalhador (ST) na ABS. Tem-se como desafio o redimensionamento dos serviços e a requalificação das ações, considerando a interface produção, trabalho e saúde.

**Palavras-chave:** Saúde do Trabalhador. Atenção Básica em Saúde. Políticas públicas. Rede de atenção à saúde. Intra-setorialidade.

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El objetivo fue presentar y discutir el alcance de las acciones de Salud del Trabajador en la Atención Básica de la Salud en São Paulo. En 2019, en el contexto de un proyecto temático, se realizó la entrevista y dos grupos focales con profesionales inseridos en una Unidad Básica de la región norte de la ciudad. El material producido fue considerado a la luz del análisis temático de contenido. La gestión privada de parte de los servicios públicos, el vaciado de los derechos laborales y de la pauta relacionada a la salud del trabajador, la sobrecarga de los equipos de la ABS que pasaron a desarrollar acciones de diversas líneas de cuidado, además de la cuestión cuantitativa y del alcance territorial de los CERESTs son obstáculos para la conformación y la consolidación de las prácticas de ST en la ABS. Se presenta como desafío el redimensionamiento de los servicios y la recalificación de las acciones, considerando la interfaz producción, trabajo y salud.

**Palabras clave:** Salud del trabajador. Atención básica de salud. Políticas públicas. Red de atención de la salud. Intra-sectorialidad.