Analysis of occupation health and mental health policies: a proposal of articulation

Análise das políticas de saúde do trabalhador e saúde mental: uma proposta de articulação

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ABSTRACT This study aimed to develop an analysis concerning the Ministry of Health laws that focus on the reception of the worker-user of the Unified Health System (SUS), especially regarding mental health. Methodologically, a documentary analysis was developed, with reading, discussion and comparison of objectives and actions involving the bylalws related to mental health care and to the National Policy for Occupational Health as well as the Law No. 10.216. It could be perceived that the articulation between those documents happens in a very tenuous way, making it difficult to fully embrace the user under work-related mental distress.

KEYWORDS Occupational health. Mental health. Unified Health System.

RESUMO *Este estudo busca desenvolver uma análise a respeito de legislações do Ministério da Saúde, tendo como foco o acolhimento ao trabalhador-usuário do Sistema Único de Saúde (SUS), especialmente relativo à saúde mental. Metodologicamente, desenvolveu-se uma análise documental, com leitura, discussão e comparação de objetivos e ações envolvendo as portarias relativas à assistência em saúde mental e à Política Nacional de Saúde do Trabalhador e da Trabalhadora e ainda sobre a Lei nº 10.216. Foi possível perceber que a articulação de tais documentos acontece de um modo bastante tênue, dificultando o acolhimento integral aos usuários em sofrimento psíquico ocasionado pelo trabalho.*

PALAVRAS-CHAVE *Saúde do trabalhador. Saúde mental. Sistema Único de Saúde.*

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DOI: 10.1590/0103-11042017S224

Introduction

This article aims to analyze the bill of the Brazilian Ministry of Health (MS) regarding the reception of the worker using of the Unified Health System (SUS), seeking to articulate the occupational health and mental health legislation. The discussion will be based on bills GM/MS No. 1,823 of August 23, 2012, which establishes the National Policy for Workers Health (PNSTT), and GM/MS No. 3,088, of December 23, 2011, which establishes the Network for Psychosocial Care (Raps) for people in distress or with mental disorder and for people with needs due to the use of crack cocaine, alcohol and other drugs, within the SUS context. In addition, Law No. 10,216 of April 6, 2001, which regulates the protection and rights of persons with mental disorders and redirects the mental health care model, will be addressed.

The above documents regulate the practices proposed by SUS related to occupational health and mental health. Although those bylaws have several objectives, our proposal is to emphasize and articulate the ones regarding the reception of workers in psychological distress. Here, we aim to focus on the practice of health professionals and its relationship with the worker-user, especially the care and actions, and referrals in mental health, taking into account the hardship triggered by work. Other accessory materials considered important to support the discussion were also used in this writing, such as documents from the International Labor Organization (ILO), and national laws and decrees regulating activities related to occupational health and mental health.

After this brief presentation, important questions arise: Why is there a need to articulate existing public health policies that, at least in theory, should already meet the demands placed here? And why should we explore a subject that should have been well known to professionals and users for at least four years?

As researchers and professionals in work-related mental health, our experiences have indicated that many people with work-related suffering, experiencing diverse symptoms and even clinical mental illness have not found support for their 'pain' in the SUS health services. Their speeches, reports, and work routines have not been commonly heard by practitioners working in mental and occupational health in public health services.

To support this discussion, it is necessary to emphasize the importance of work as a constituent factor in humans, which characterizes people and makes them who they are. The role of work is fundamental to the identity and subjectivity of the contemporary human being. This also supports the interconnection between identity and mental health, for when identity is disrupted, important doubts about who one is can arise, and as a consequence mental health is negatively affected (DEJOURS, 2004).

In the current world of work, there has been a tendency for new management models to capture the subjectivity of workers, incorporating it into the values of capitalism, as never seen before. In this sense, the being, narcissistically, materializes and exists from an individualistic and consumeristic logic (BAUMAN, 2009). The identity ends up attached to what one produces and consumes: I am what I do, therefore if I have a job that provides social status, I am important, special. Another thinking that can be related to the contemporary subject says: I am what I consume, therefore if I buy expensive and rare products, I can also be considered a person of differentiated value. These are observations related to everyday life and the contemporary subject. They represents a way of placing oneself in the today world, often unconsciously.

Thus, when work defines who one is and invades the boundaries of identity, mental health, as a consequence, is often impaired. Therefore, it is evident that the line linking identity and the psychic dimension of work is

tenuous, justifying the need for an integrative approach between the policies and practices of mental health and occupational health.

The necessity to problematize the relationship between occupational and mental health policies is then perceived. These are inseparable issues of daily life, as work has been mentally affecting an increasing number of workers as a result of the modulations of capitalism and the current demands of the new management and production models.

Work and health in public policies

To support the discussion aimed in this text, it is important to present significant historical facts in the construction of public health policies in Brazil. Therefore, the context of the country's public health will be presented in general lines.

Historically, national health policies have proven ineffective and inefficient to meet the real needs of the population. This chronic situation led to the organization and implementation of the Sanitary Reform. This reform, which had distinct stages, social actors and social movements, culminated with the SUS proposal, established in the Federal Constitution of 1988 and, later, with Law 8,080 and Law 8,142, both of 1990 (BRASIL, 1990A; BRASIL, 1990B). However, in order to achieve the SUS as it is known today, many social fights were necessary. Its current configuration is based on a process elaborated over the years, in which diverse conceptions about health policies and different ideologies were involved.

Only at the beginning of the twentieth century some national sanitary actions took place, strategically based, however, in São Paulo, Minas Gerais and Rio de Janeiro, active zones of coffee production and ports. At the time, there was no national health policy, but rather a policy for individual medical care (ROCHA, NUNES, 1993).

In that same period, the Santas Casas de Misericórdias hospitals were responsible for individual care, and some companies provided medical service also in an individual basis and with a curative perspective (ROCHA, NUNES, 1993). It is only from the 1920s, however, that a national action emerges, with the Administrative Reform and the creation of the National Department of Public Health. This administrative body had the objective of reorganizing the country's community services, transferring to the State the responsability of promoting these services throughout the country (FIOCRUZ, 2012).

The milestone of the beginning of public policies focused on labor issues dates from the Vargas government (1930-1945). Then, an industrial period took place, with the expansion of consumption from the domestic market, especially in the 1940s (ROCHA; NUNES, 1993). Ramminger and Nardi (2007) believe that the Brazilian health system was developed focusing on health care for urban workers – for a long period in the country, the only people entitled to health care were those legally employed. This concern with the 'maintenance of the working body' was already in place since slavery.

The Consolidation of Labor Laws (CLT) was created only in 1943, and it "[...] collects the legislation regarding trade union organization, social security, worker protection and labor justice" (ROCHA, NUNES, 1993, P. 106). However, only in 1978 the Chapter V of the CLT presents the Regulating Norms for Occupational Medicine and Safety. These norms were modified with time according to pressures, but were aimed at the workers in the private sector (RAMMINGER; NARDI, 2007).

From 1945 to 1964 Brazil experiences an industrialization growth. During this period,

> [...] a large part of the unions, under populist democracy, focused on discussing a national policy, submitting specific issues, such as health problems, to a direct negotiation with the State. (ROCHA; NUNES, 1993, P. 110).

The MS was formally created in 1953 (BERTTOLI FILHO, 2008). However, it is only in the early 1960s that sanitarians actually begin to formulate proposals for health services and based on the country's reality. For Paim (2012, p. 9), the term 'health reform' appeared in the country in 1973. Before that (1950s and 1960s), the terminology used was diverse: "At that time and in some restricted circles, there used to be the term 'socialization of medicine' or 'socialized medicine'"(PAIM, 2012, P. 9).

In contrast, internationally, the ILO, created in 1919, arises to regulate work-related issues at the global level. The Convention n. 161, about occupational health services, was adopted at the LXXI General Conference of the International Labor Organization in Geneva, Switzerland, in 1985, but was applied internationally on February 17, 1988, and in Brazil on May 22, 1991. The Convention states that the protection of workers in relation to occupational diseases and accidents, and in general, is one of the tasks assigned to the ILO (ILO, 1991).

The promulgation of ILO's Convention n. 135 on the Protection of Workers' Representatives by Decree No. 131 of May 22, 1991, states that Brazil commits to carry out and comply with its provisions. The document states several measures that should be adopted by companies towards the protection of those who represent employees in different ways, which especially involves union activities. This protection must shield workers from any detrimental action, provided they act in accordance with the laws and collective agreements (BRASIL, 1991).

Even after some important milestones in the formulation of the National Health Policy, such as the III National Health Conference (CNS) in 1963, it was from the administrative reform of 1967 that the MS "[...] would be responsible for formulation and coordination of the National Health Policy, which until then was still on the ground" (BRASIL, 2012, P. 2).

Following with the historical landmarks, the content in the Federal Constitution should be highlighted, which defined that it is a responsibility of the State to guarantee the health of the population, according to article 196, "... which refers clearly to the worker health and the work environment in the chapter Right to Health" (RAMMINGER; NARDI, 2007). In article 200, the SUS competencies are defined. The SUS was consolidated when the Health Organic Law was approved (Law No. 8,080) in 1990, and a few months after, Law No. 8,142 (BRASIL, 2012). The SUS principles are universality, equity and integrality, following a decentralized hierarchical organization with the participation of the population, and provides services and actions of increasing complexity.

On the other hand, Aguiar and Vasconcellos (2015) affirm that, even though the work-related health has been regulated by the SUS through its health policies, the way in which it has been implemented demonstrates an operative purpose of little relevance, failing to transform the context of work-related illness. The authors mention that since at least 1988, with the promulgation of the Federal Constitution, the health of workers has become a concern, in theory, of those who develop public policies in the country.

The actions related to occupational health are included in the SUS legislation, and are not part of the Ministry of Labor and Employment and of the Ministry of Social Security. Even though, at the time, issues related to occupational diseases and accidents were highlighted in the actions of workers' healthcare,

> [...] we perceive that the intersection between Occupational Health and Mental Health appears incipient in the First National Conference of Occupational Health, strengthening itself from the II National Conference on Occupational Health, mainly due to the influence of professionals from universities. (RAMMINGER; NARDI, 2007, P. 11).

The National Conferences took place in 1986 and 1994. However, it was in September 2002 that the specific initiative focusing on occupational health, with guidelines and strategies, took place with the National Network of Integral Attention to Occupational Health (Renast). Its proposal of integral attention comprises the Reference Centers in Occupational Health (Cerest) (RAMMINGER; NARDI, 2007).

In order to understand the advent of the current regulation and of the IV National Conference on Occupational Health (CNST) in December 2014, it is important to look at some aspects that constitute the Occupational Health Policy as a public policy in Brazil. It is worth noting that the central theme of this conference was: 'Occupational health, the right of all and the duty of the State', which guided all the discussions and, as a central axis, the implementation of the national policy itself.

According to the final report (BRASIL, 2015), the IV CNSTT was held in Brasília from December 15 to 18, 2014. It had the participation of 991 delegates, 56 invitees, 33 speakers, 52 work group coordinators and reporters, 37 committee representatives, 12 persons accompanying persons with disabilities and 218 staff members, totaling 1,399 participants. The delegates approved 219 proposals, 63 national motions that had been presented and approved at the state level, and 56 motions presented and approved at the national level. This material was systematized and organized by integrated commissions from the participating organizations to be used as a subsidy for the XV National Health Conference in December 2015.

Thus, it is perceived the course of the social movements and initiatives to develop the Occupational Health in Brazil as a public health policy. Above, the historical timeline of the struggles that culminated in the implementation of the PNSTT is described.

Occupational health and mental health policies: can they articulate?

The PNSTT states that it must be in line with the other SUS policies and considers the transversality of actions in occupational health to be fundamental, and work as a determinant of health and illness of the subjects. Thus, one of the objectives of the policy is:

> [...] to incorporate work as a determinant of the health-disease process of individuals and the community, including it in health status analysis and health promotion actions. (BRASIL, 2012).

In addition, in line with SUS guidelines (BRASIL, 1990A), the PNSTT aims to define the principles, guidelines and strategies that should be put into practice at all three levels of government. It stresses that its proposal focuses on the integral development of occupational health, with an emphasis on awareness, to promote and protect the health of those who work. Also, it aims to reduce work-related deaths and diseases through actions that include promotion, awareness, diagnosis, treatment, recovery and rehabilitation of workers' health (BRASIL, 2012).

Therefore, mental health is implicitly included when the policy refers to the integral health of workers, even though it is not directly named. Another important observation is the reference to reducing work-related diseases, among which are the mental illnesses that, according to Social Security, have been causing more people to loose workdays than the so-called organic diseases. According to data from 2014, mental and behavioral disorders were the third main cause for granting of the sick leave pay, due to incapacity to work (BRASIL, 2016).

The proposal of the Network for Psychosocial Care (Raps) is the creation, expansion and articulation of healthcare centers for people in distress or with mental

disorder, and with needs arising from the use of crack cocaine, alcohol and other drugs, within the SUS (BRASIL, 2011B). In the last 10 years at least, with the approval of the National Policy on Drugs on October 27, 2005, the MS has been investing heavily in policies related to the use of crack, alcohol and other drugs, which explicitly indicates the importance of such issue. However, people in distress and with mental illness in general are also clearly mentioned in the Raps proposal (SÃO PAULO, 2005). Therefore, the inclusion of work-related mental suffering can be assumed. In addition, the use of psychoactive substances can be a direct result of work-related mental illness, as shown in the studies by Gavaraghi *et al.* (2016) with bankers, and by Martins and Zeitoune (2007) with nurses.

It is relevant to say that the Raps is composed of several actions and health services of the SUS: basic care, specialized psychosocial care, urgent and emergency care, temporary residential care, hospital care, deinstitutionalization strategies and psychosocial rehabilitation. This means that all axes of the health network must be involved in mental health (and work) care (BRASIL, 2011B).

The 1st paragraph of article 6 of the bill that established Raps, says that the Basic Health Unit (UBS), which is inserted in primary care,

> [...] is responsible for developing actions to promote mental health, and for prevention and care of mental disorders, harm reduction actions and care for people with needs arising from the use of crack, alcohol and other drugs, whenever needed and with the other points of the network. (BRASIL, 2011A).

This demonstrates the essential character of the UBS as the 'gateway' of the SUS with regard to health promotion, prevention and care. It also includes mental issues, since it refers to the initial health care services to SUS users, as indicated in Decree nº 7.508, of June 28, 2011 (BRASIL, 2011A).

The Psychosocial Care Centers (Caps) are specialized services that act in an interdisciplinary way serving people with severe and persistent mental disorders, as well as people with needs due to crack, alcohol and other drugs (BRASIL, 2011B). Thus, people with intense and persistent work-related mental suffering who often present with disorders such as depression, anxiety, burnout , and not rarely suicidal ideation and attempts, are included, which is in accordance to the Raps guidelines.

The sole paragraph of article 2 of Law No. 10,216, which lists the rights of people with mental disorders, states that they have the right "to have access to the best treatment of the health system, according to their needs" (BRASIL, 2001), that is, the reception from the mental health care field must be adequate to the one who is in distress.

In this sense, it can be understood that when a person is mentally ill as a function of his or her work, this condition must be known and emphasized in the treatment course. This often concerns an articulation of networks, not only of the health system, but also of social assistance and judicial systems, as well as other possible service referrals to an extended network. For example, in a case of moral harassment, trade unions and the Public Ministry of Employment, among other bodies, can be activated to guarantee of rights and protection of the subject.

The PNSTT is inclusive as it addresses all workers, whether men or women, from the urban or rural areas, formal or informal, from the public or private sectors. People on contracts, self-employed, unionized or not, apprentices, temporary, trainees, domestic workers, retired or unemployed are subject to the same policy (BRASIL, 2012). Likewise, Law No. 10,216 ensures the rights of persons with mental disorders irrespective of race, skin color, sex, sexual orientation, religion, political orientation, age, family, social class, and degree of severity and / or illness stage (BRASIL, 2001). Thus, it follows the SUS principles

(BRASIL, 1990A), in agreement with the other documents mentioned above.

The PNSTT also emphasizes that, like other health policies, it supports the transversality of occupational health actions, viewing work as an important determinant in the health-illness process. The recognition of work as a key factor in the illness of workers by the MS represents an important landmark in occupational health. It clearly supports that work-related questions should be included in the initial assessment of the SUS users, regardless of the health service being sought. Accordingly, one of the basic rules of the Raps is the recognition of social determinants in health promotion, of which work is a fundamental factor (BRASIL, 2011B).

This is in accordance with one of the objectives of the PNSTT which is to:

> [...] ensure that the work situation of the users is considered in the health actions and services of the SUS and that the work activity of people, with its possible health consequences, is accounted for at the time of each intervention. (BRASIL, 2012).

The PNSTT advises that there should be an articulation between

> [...] the technical knowledge and the background, experiences and subjectivity of the workers, and between these and the respective institutional practices. (BRASIL, 2012).

Thus, in order to make this and other articulations mentioned in the policy possible, crucial changes in occupational health processes, as well as in the network organization and in its respective professionals are necessary, so that the complex relationship between health and work can be properly addressed.

In agreement with the above, one of the objectives of the PNSTT is:

> [...] to broaden the understanding that occupational health should be conceived as a transversal action, and the health-work relationship must be identified in all points and instances of the healthcare network. (BRASIL, 2012).

The perception, however, in the daily processes involving actions in occupational health is that this policy is still being implemented, especially in relation to mental health care.

Also in accordance with this proposal, one of the guidelines that ensures the proper functioning of the Raps affirms the importance of providing access to quality services, with comprehensive and interdisciplinary care, in which the different health fields are complementary in the health-disease dynamics. In addition, both the Raps objectives and guidelines emphasize the importance of continuing education in health, for updates and continuous training of health professionals (BRASIL, 2011B).

Therefore, regardless of the sector or specific area of the SUS service, the care must be interdisciplinary, with professionals able to act towards the demands of psychological work-related distress. However, this goal is far from being achieved, as the subject it a complex one, in which a set of forces play a part. Among other aspects, the capitalist system (which also rules the public sector, since it works in a logic of goals, even if not-for-profit), the structure of the service, the training and view of the health professional and the configuration of the institution to which the service belongs interfere in the success of the program.

One of the main strategies created to organize public actions in favor of occupational health was the Cerest proposition that emerged in the 1990s, in line with the SUS proposal (BRASIL, 1990A). Another important action was the creation of the National Network of Occupational Health, which includes the state and regional Cerests and aims to disseminate actions in this field,

articulated to the other SUS networks (BRASIL, 2002). Currently, there are 210 Cerests in the country, of which 26 are statal, and 184 are regional. The PNSTT emphasizes that the priority is to strengthen Occupational Health Surveillance and, in order to do so, it seeks to expand the work of the Cerest and suggests actions related to the promotion of health and of healthy and productive environments (VASCONCELLOS; GOMEZ; MACHADO, 2014).

A survey of the current situation of the Cerest in Brazil was developed by Bittencourt, Belomé and Merlo (2014) to mainly assess the actions focused on the mental health care of workers. Its methodology consisted of mailing 173 questionnaires to the Cerests, of which 37 were answered and returned. It is worth noting that of the 25 units that have psychologists/psychiatrists in their team, 19 provide some clinical care to workers. This study also showed the lack of uniformity in the provided care, especially in actions focused on mental health. This can result from the difficulty in recognizing the relationship between mental health and productive processes.

In accordance with the above study, Bottega (2015) states that the Cerests urgently need to develop new strategies while improving the ones in place, to promote advances in health, quality of life and working conditions.

It is thus perceived that legislations concerning occupational health and those concerning mental health have similarities regarding social determinants, but there is no explicit articulation between policies, since one does not refer to other. The result, irrespective of legal documents, is the difficulty of connecting practices of mental health with the work aspect, so that workers in distress are holistically understood and attended.

Conclusions

Although the PNSTT is an important milestone in occupational health, it has not yet been able to establish a meaningful proposal to meet the demands of the workers, especially those related to mental health. Likewise, the mental health legislations addressed in this text do not explicitly present the aspect of work as a decisive factor in the mental health-disease process. However, both cite the importance of taking into account social determinants, in which the productive factor is included.

Historically, it seems that there has been an attempt to link occupational health to mental health issues. However, both in the legal documentation and in clinical practice, this connection is not part of the daily routine of most health professionals, even of those who are in work-related distress and need to be attended in the health services.

Therefore, the proposal of integrality in occupational health represents articulating actions in the most diverse areas that permeate the relationship between people and their work activities, including mental health actions. In addition, this discussion aimed to highlight the need for lines of mental health care to address the work element.

Healthcare lines are cited in occupation health legislation, but in general guidelines only. Other health policies, such as mental health, and women, children and adolescents health, for example, have already established lines of care that are integrated with care practices. A line of mental health care for the worker can be inserted in the existing network, articulating the different policies related to this field (BOTTEGA, 2015).

When addressing the term ‘occupational health’, mental health should be implicitly included, since health involves at least physical, psychological and social aspects. When dealing with mental health, it is implicit that social factors that may cause mental dysfunction are included. In the social context, there is the work element, which should be taken into account in the creation of policies and practices in the field of mental health. However, there is no clear mention

of the terms in the policies analyzed here. Therefore, the development and updating of public policies on mental health and occupational health in which these two themes are concretely connected is suggested, making clear the importance and inseparability of both elements, as it happens in real life.

In order to build an occupational healthcare system that addresses the most diverse and complex demands of the contemporary worker, the involvement of various social actors is necessary. The participation of social movements, trade unions, and the responsible public authorities is essential if a practice is to focus on the interests of those who need it, in this case, the worker-users who experience situations of work-related psychological distress.

Contributions

Authors Karine Vanessa Perez, Carla Garcia Bottega and Álvaro Roberto Crespo Merlo contributed substantially to the conception, planning and analysis of this article, collaborating both in the draft and in the final version of this manuscript. ■

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Received for publication: August 2016
Final version: December 2016
Conflict of interests: non-existent
Financial support: Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes)