

Psychology and the Workers' Health Movement in the State of São Paulo (Brazil)

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Abstract

This article discusses the ways in which psychology has contributed to a new range of public health services concerned with the health of working people in the State of São Paulo, Brazil. It begins by discussing the political, institutional and theoretical bases from which the Workers' Health Movement emerged in the early 1980s as a replacement for previous approaches to occupational health. It provides examples of some of the different actions and practices that were developed and which had a key role in the battle for better working conditions and for an enhanced role for workpeople in organizational change. Finally it shows how the dialogue between the field of Workers' Health and psychology was crucial for the construction of psychology's social agenda.

Keywords

health psychology, public health, São Paulo, Brazil, social psychology, Workers' Health

Introduction: the field of Workers' Health in Brazil

The political and legal context

THE SPECIFIC inclusion of the health of workers—as workers—within health services in Brazil and as part of health policy is very recent; dating from 1988. This happened as a result of the re-democratization of the country in 1984, following some 20 years of military dictatorship, and culminated in 1988 with a new Federal Constitution (Brasil, 1988). It was in the 1988 Constitution that the area of Health figured for the first time as a 'social right' and, in order for this to be guaranteed in practice, provision was made for a new Unified Health System (SUS) which would include within its responsibilities the health of workers—as workers. Hence the term Workers' Health (literally the 'health of the worker'—Saúde do Trabalhador).

Part of the reason for this choice of term lay within the various social movements involved in the fight for re-democratization. Among these, a very important role was played by the trades union movement which was involved in a number of sector wide strikes for greater democracy inside the factories and greater participation over the discussion of working conditions and the control of work. These actions were both directly related to the specific Brazilian context and influenced by events elsewhere where control over work and working conditions were also being debated (Bagnara, Biocca, & Mazzonis, 1981; Berman, 1978; Deppe, 1981; Gustavsen, 1985; Humphrey, 1982; Roustang, 1983).

The result both of an active and well-organized trades union movement with ample support in the major industrial areas and the inclusion of Health as a social right within the Constitution, brought about a very different relation between State and Society (Lacaz, 1996). The changes were also influenced by various key debates and recommendations produced in the areas of Collective Health and Social Medicine throughout Latin America, influenced by local universities and international organizations such as the International Labor Office (ILO, 1985; Laurell, 1991; Nunes, 1994; Tambellini, 1984).

Discussion was focused on the importance of specific policies to deal with Workers' Health and the creation of specific services for workers

in the public health system. These new services were conceived as integrating actions of health care, prevention and education through the use of multi-professional teams including doctors, nurses, engineers, sociologists, psychologists among others. An important step forward was the inclusion of trades unions in the management, control and evaluation of the services (Freitas, Lacaz, & Rocha, 1985). An indication of the importance of these changes and of the impact created by the workers' health centers was the increase in the notification of accidents and occupational health problems, previously hidden within the multiple forms of health service in use: public, private and charitable. The focus on the worker rather than on the occupation, drew attention to their key role within society and to the lack of focused care for work-related problems, including an effective statistical base.

Health and work in the 1970s in Brazil and Latin America: Latin American social medicine and collective health

During the 1970s, the socio-economic, political and cultural transformations occurring in a number of Latin American countries had reached what could be called late industrialization with an increasing percentage of their populations concentrated in large urban centers following widespread migration from rural areas. Already a concern of economists, anthropologists and sociologists, these processes began to become the focus of a new interdisciplinary area: Collective Health. This had come about through the growing interdependence between epidemiological research, social science studies in health and those involved in the planning and evaluation of health services (ABRASCO, 1984; Nunes, 1994).

In this same period, a new theoretical approach was developed within social medicine, focusing on the relation between health and work and proposing new approaches to health practice. The 'social' was seen as the locus for those factors that aggravated Workers' Health; a return, with a difference, to the public health movement of the 19th century (Rosen, 1958). Among those writing on this theme were Laurell (1975, 1979, 1989) and Arouca-Tambellini (1978) in relation to the situation in

Mexico and Brazil, and Garcia (1983) and Laurell (1985) in relation to the historical relationship between health and work within the region.

These studies were clearly closely linked to the process of industrialization that was taking place at the time. It was a process characterized both by its speed and by its heterogeneity. The emerging forms of work organization and production, influenced by an international division of work and the related double standard on occupational risks (Castleman, 1983), permeate the apparent 'economic miracles' of Argentina, Brazil, Chile and Mexico, producing profound changes in the class structure (Laurell, 1985; Singer, 1976). One of the key characteristics of this 'late industrialization' was its tendency to break with previous models of production and of the organization of daily life and to impose the pattern of the large multi- or transnational material goods industry with poor salaries and working conditions made possible by the large surplus and urban labor market (Singer, 1976). In the 1970s, in contrast with many places in the industrialized world, workers in Brazil were still fighting over working hours, basic salaries as well as trying to guarantee minimum working conditions and basic health rights (Rebouças, Antonaz, Lacaz, Sato et al., 1989; Ribeiro & Lacaz, 1984).

In such a context, it was not surprising to find social scientists, politicians, planners, engineers and health professionals working with workers and their representative organizations to influence work processes and technological choices and recover a libertarian, humanized and emancipated approach to work. In the perspective of Latin American Social Medicine and Collective Health, work should include both work processes and the comprehension of the social relations produced by production. The posture was that of dialectical materialism and concern was with the relation between work and the processes of health and illness seen as historically determined (Laurell & Noriega, 1989; Navarro, 1982).

This approach provided a view of work very different from that of the 'work environment', its various 'agents' and of health as a constant adaptation. Mediated through social relations, the relation between health and work came to be seen as being expressed through a wide and

varied range of problems, questions of ill health, suffering and other impacts that add to the classical occupational diseases, accidents and work-related pathologies of a more complex nature such as cardio-vascular diseases, psychosomatic disorders and problems of mental health (Breilh, 1994; Schilling, 1984). From this it was a natural step to move beyond the more visible consequences of the work-health relation to those of the mediations between work and subjectivity.

Within the various worker movements there was growing consciousness of their role as active political and social collectivities. This led the area of Collective Health and Social Medicine also to incorporate the idea of an active and collectively competent person, capable of discussing work and work processes (Laurell, Noriega, Martinez, & Villegas, 1992). As a result, the experience and local knowledge of workers began to be given a key role in discussing strategies for change, in discussing ways of interpreting illness and the organization of health services.

This theoretical approach was seen, with the environment of health reform, to have important implications for health policy; allowing for a greater political and health awareness (Berlinguer, 1978). Concern was with developing shared knowledge and with giving greater power to organized labor through a more democratic approach to health system management; placing the professional techniques at the service of the workers. The result was the growing field of theory and practice within public health services, that came to be called 'the health of the worker', or Worker's Health.

The 'Workers' Health' approach saw itself as different from either occupational health or, as it is called in Brazil, 'work medicine' (*medicina do trabalho*), arguing that these tend to place a strategic importance on 'adapting work to man and adapting man to work' and, as a result, move in the direction of those that are healthier, generating subtle mechanisms for the exclusion of those that present any divergence from normality; what Weed referred to as the 'healthy worker effect' (1986). For the 'Workers' Health' movement, the objective was not to increase productivity or control absenteeism. Its way of looking at suffering, illness and the death of classes, fractions of classes and

social groups present in the productive process, was through the recognition that these are people who work and not through their categorization as consumers of the health service (Navarro, 1982).

Public health and Workers' Health in São Paulo

The gradual implantation of the Workers' Health Programs within the ambit of the national health policy started in the mid-1980s, initially in the health centers linked to the State Secretary of Health and by the end of the decade in the municipal services of many of the important industrial towns and cities, reaching some 5 million workers. These services have the responsibility to carry out actions upon health problems at work (risks and damages) articulating health care, prevention and education. They seek to give priority to interventions over causal factors to health damage, originated from different work process, environments and conditions. In this process, the various professions being drawn in to the new integrated workers' health centers were also rethinking their practice, including the psychologists.

The State of São Paulo was not alone in this process and various other centers were being set up in other states and towns. However the discussion of the role and practice of psychologists within this movement will be focused on the experience in São Paulo, for three main reasons. First, Brazil is a country with continental dimensions and is very heterogeneous in cultural, economical, institutional and political terms. It is therefore very difficult to provide a 'general' view. Second, because São Paulo is recognized as one of the principal industrial states and occupies an important position in the economy. It occupies only 2.9 percent of the territorial area of the country, yet is responsible for 35 percent of the gross domestic product and approximately 35 percent of all exports of industrialized products. Ninety-three percent of its population is concentrated in urban areas. It is therefore not surprising to find that it is in the State of São Paulo that the industrial workers movements played an important role in the redemocratization process at the beginning of the 1980s. Third, because in relation to health and health services, São Paulo has been an import-

ant reference for public policy, serving as a natural laboratory for many different practices. It is therefore not surprising to find that it was the State of São Paulo that led the field in setting up Workers' Health Programs both in public health services and in various trades union offices.

Psychology and Workers' Health: a new dialogue

The professional training of psychologists in Brazil has traditionally been based on the model of the liberal professional. In the area of health psychology (Spink, 1993) this was based on the notion of individual clinical practice and it would take a long time for an effective health psychology to emerge. In the area of work and organizational psychology—the other half of Worker's Health—the situation was not much better. Here the focus was almost entirely on human resource practices such as selection and training. Health was hardly ever considered and at the most linked vaguely to ergonomics; itself seen as a laboratory activity. Institutionally therefore, psychology was not prepared for the Workers' Health Movement—even though a number of psychologists were individually involved.

The Workers' Health perspective requires a very different locus of activity—the public health service rather than the individual clinic—and brings also the very different focus of the intersection of work and health. The result was that those psychologists who found themselves in the movement were left with very little option than to build a new model. This, more critical, approach grew out of a process of approximation to social demands in two different spheres. The first was a very important agency that had been set up by the trades union movement, following a very successful similar experience in the area of economic data, salaries and labor trends. This was the Trades Unions Department for Research in Health and Work Environments (Departamento Intersindical de Estudos e Pesquisas de Saúde e dos Ambientes de Trabalho—DIESAT). The second was formed by the new programs and centers being set up in the public health system.

The involvement of psychologists in the DIESAT allowed direct contact with the

thematic questions being raised by the trades unions and by the various worker collectives. Research studies, advisory work in the evaluation of working conditions and training activities played a key role in formulating a wider agenda including the question of health problems linked to the organization of production processes and work design, and the theme of social cognition (Sato, 1992). At the same time in the public health system, the various centers and programs of Workers' Health were beginning to recognize the need for psychologists to be present in preventive work and also in providing care and support in a number of critical health areas such as industrial intoxication, repetitive strain injuries and psychosomatic and mental health problems.¹

The actions developed, however, have not been homogeneous, despite sharing the same principles. This heterogeneity is a result of many different factors among them the different priorities in each region and municipality, the different profiles of demand, the different trades union organizations and their priorities and degree of activity. As a result a vast range of psychological practices can be found from, on the one hand, neuropsychological evaluation to, on the other, concern in understanding the day to day lives of work-people dealing with the restrictions placed on them by a society that does not have a tradition of industrial participation nor of negotiation of work-related issues.

However despite their variety—inevitable, to some extent, given that psychologists have had to build up a good deal of their practice from scratch—it is important to recognize the common principles and concerns that hold these different practices together. The overall view of Workers' Health today is one that is the result of the concerns of the workers themselves, expressed both through their unions and through the individual demands of the health centers. Thus, independently of whether the response to these demands are based in traditional skills or highly advanced practices, they are as a set collectively innovative in the current socio-political context, for they are based on the demands of the workers themselves and their own fight for better working conditions.

Responding to demands in the Workers' Health Program

The variety of the contributions that have been made can be illustrated by a number of different examples. Neuropsychological evaluation played a very important role during the earlier years of the service, in the mid-1980s, when problems of exposure to chemical products in the workplace made national headlines.

One of the cases involved mercury intoxication in a chemical plant situated in a heavily industrialized region. Working backwards from symptoms and workers complaints, health staff was able to link the causal strand together. This had the result not only of drawing attention to the appalling working conditions in the plant and showing that the workers complaints were legitimate, but also led to the development of federal legislation which established criteria for the diagnosis, treatment and early retirement for health reasons for workers exposed to mercury. This historical event showed all those working in the field that even a very traditional and classic set of psychological tools can help workers exercise greater control over working conditions.

A second example concerns the work done both in therapy and training with workers with repetitive strain injuries. From an epidemiological point of view, repetitive strain injuries are a major problem of public health and while there are no general data available for the country as a whole, they are currently the principal single cause of health-related notified sick leave and in some of the São Paulo State Workers' Health Programs reach around 80 percent of the demand. In addition to the physical symptoms, workers with repetitive strain injuries suffer considerable psychological discomfort. How to deal with this was a major question for the psychologists and this concern led, at the beginning of the 1990s, to the creation of a different form of group treatment.

The group meetings took place in the health centers and were referred to as 'quality of life groups'. The idea was that everyone could improve their quality of life, even though they had a physical injury that could be incapacitating. The objective of the groups was to enable the workers to learn from one another, gather information about possibilities, discuss the working conditions that lead to the injuries and,

as a result, re-signify their working possibilities and the process of illness (Sato, Araújo, Udihara, Franco, Daldon, Settini, & Silvestre, 1993). Concern was with developing an activity that could have at the same time a therapeutic effect and promote health. Social cognition questions of identity, ideologies about work, about capacity and illness were brought together with discussions about alternative practices.

The result was highly positive, allowing the workers to empower themselves as social actors and in some cases led to the organization of social movements to press for recognition of the problems of repetitive strain injuries. The approach was gradually adopted and adapted by other centers and other regions of the State and is today recognized as a key reference for working with this type of injury.

Workers' knowledge and prevention action in Workers' Health

While some areas of demand could be dealt with through relatively traditional or normal tools of psychological practice, it was probably in the area of prevention that most rethinking took place and which required a more critical stance. Prevention is one of the major pillars of the Workers' Health Programs with specific attention to controlling and eliminating risks in the workplace. In this work, there is no alternative to making public the working conditions and forms of organization of work that create health problems for the worker and, through effective evaluation, suggest changes or improvements. The need for action can come as a result of a number of activities, from epidemiological data, individual case descriptions and the trades unions all of which can use very straightforward methods of analysis. However the action itself is very different and like the work on repetitive strain injuries, it represents a moment when many themes and people come together.

In general, prevention is carried out by multi-professional teams (doctors, engineers, psychologists, nurses, etc.) who assume the responsibilities of the local health authority. They are a privileged opportunity for workers to express their opinions about working conditions, to gain greater political control over health and working conditions and to take part

in dialogue with other bases of knowledge. The psychologists take part in the multi-disciplinary teams as social researchers rather than as specific advisors on individual psychological themes. Their aim is to provide support in what are processes of participative action-research, helping with questions of social cognition, of organizational processes and questions of asymmetric power and control relations.

In Brazil, as—in different ways—elsewhere, workplace democracy has still a very long way to go and, as a result effective joint workplace and work organization design is still out of reach of the Workers' Health Programs. Even though São Paulo is in many ways highly advanced industrially, with many different branches of international companies and an active trades union movement, it is still rare to find cases of negotiation of working conditions, or cases in which the obligatory Internal Accident and Health Prevention Committees (CIPA) are given a relatively free range of action. Thus one of the principal difficulties in prevention occurs early on: that of access. While direct access is possible in cases where there are clearly major problems and very hard data available, as for example in the mercury case that has already been mentioned, this is of very little use in avoiding their occurrence in the first place. The alternative approach is to use what openings are available through the trades union movement and at the various centers in the Workers' Health Program.

However even in such difficult circumstances it is possible to observe that workers are attempting, in their day to day lives, to react against the limitations imposed. Examples of this have come through an investigation that took place in a food factory situated in city of São Paulo (Sato, 2002). In the factory, the manufacturing process used was the very simple and basic fordist production line and the local obligatory CIPA was not very active, nor was the local chapter of the union. Throughout the company the dominant managerial discourse was focused on total quality. The workers were in general non-skilled but through what could be called 'common sense epidemiology', they were well able to connect the high levels of repetitive strain injury to the prevailing practices of work organization—even if nobody else could or would.

With very little or no space for action, the workers had to resort to subtle tactics that enabled them to get their interests heard. For example, they would adopt the managers' own discourse of quality control but using its polissemic possibilities. Thus, if for the management, working with 'quality' meant adopting a series of control procedures during the production process (such as statistical process control), for the workers on the factory floor, working with quality meant reducing the speed of the machine paced work and having more workers on the production line. Thus in one example observed when the manager was discussing the importance of increasing the speed of the production line, a machine operator replied: 'yes, I could increase the rhythm of the machine, but it will prejudice the quality'. Through the apparent logic of this reply the operator was able to avoid changing the machine speed; negotiating possibilities in a situation in which the power relation is very asymmetric but, nevertheless still able to make space for the workers' own interests.

Another example in this same factory shows how once more it is through tactical moves that workers are able to negotiate possibilities and avoid having to assume 're-work', reduce the volume and rhythm of work, avoid tasks that they consider bad and reduce suffering (Sato, 2002). This was a case involving two production lines: the first that dealt with the preparation of the food containers (plastic bottles with over-stamped labels) and the second a number of lines that dealt with the bottling of the product. The first line fed into the second but spatially the two sets of lines were in different places and on different floors. The line that prepared the containers was in the basement and known as the 'line below' and the second was on the ground floor and known as the 'line above'. The containers when they are ready, are transported by elevator and then distributed among the various bottling lines, where the product gains its finished appearance. The transportation and delivery is done by the workers from the 'line below'.

The case concerns the ways in which the day-to-day negotiation takes place by the workers from the 'line below' who question the roles and the boundaries between them and the 'line above'. The 'line above' and the 'line below' are terms that indicate the hierarchical values on

the factory floor and have important implications for the organizational choices made by managers. The 'line below' is run by the 'boys' (meninos) who are unskilled workers and who have the responsibility of date stamping the product shelf-life on the bottles. On the 'line above' or 'lines above' there is a mix of different skill levels. Qualified machine operators control the machine speed, the quality of the product and coordinate a number of unskilled operators (usually women) who fill, label and pack the product. The 'lines above' are situated in a place where visitors are taken around the factory, for it is there that the product gains its identity, its label and logotype. It is there that the visitors can recognize the products that the firm makes, as also can members of the firm.

For reasons of security and product control, the information date stamped on the empty bottles (hour, date, batch number and factory unit) must coincide with the hour, date and batch when the bottle is filled. When these actions are not synchronized, the bottles have to be returned, the date stamp cleaned and redone. This is a manual activity that has to be done bottle by bottle. This 're-work' is carried out by the 'boys' from the 'line below'. One of the 'boys', Josildo, who dislikes this process as it gives more work and is considered disagreeable, comments: 'I am contracted to stamp and not to rub out'.

Josildo and his colleagues then began to search for ways of solving this problem, looking for other 'organizational choices' (Kelly, 1978). The first step was very practical, they carried out their own research. They found that when the date stamp and the bottling time were not synchronized, the machine operators on the 'lines above' should, as a control measure, fill out a report. However, they also found out that filling out a report could bring the management against them, for the report was in some way an admission that the lines were not working well. In addition, they found that when the machines of the 'lines above' were stopped (through breakdown or problems with the product specification) the packagers, the women, had nothing to do. To the 'boys', the 'women sat with their arms crossed'. They also observed that when the product was excessively handled, stamped, rubbed out re-stamped, there was greater possibility of product loss.

Bit by bit and based on their own research, the 'boys' began to build arguments and show that the situation created by the need to re-stamp the bottles was bad for everybody. They would at times refuse to rub out the date stamps or when it was inevitable, suggest that the 'women' who sat with their 'arms folded' should also help out. They complained to the production supervisor that their work should be more highly respected and suggested that he should develop some rules to help control the flux of bottles between the two areas. The procedure they suggested was really quite simple: that they should be advised when the machines on the 'lines above' were stopped. A simple action that could be carried out by a telephone call or a shout down the elevator shaft, but one that carried a host of meanings, for it changed the status of the two areas in relation to one another and recognized their interdependence rather than the previous dependence.

The 'line below' was not a mere appendix to the 'line above' but a separate work area with responsibilities. The 'boys' gained some control over their work and began to calculate, given the knowledge they had developed about the interdependence of the areas, on their own personal calculators how many bottles/hour were needed by the 'lines above'. As a result, they were able to program their own work, planning what was needed, organizing breaks and setting the rhythm in order to maintain the two areas in balance. The need for 're-work' was virtually eliminated and, when necessary they would also appeal to the arguments about quality.

As the case demonstrates, the practical everyday knowledge (Garfinkel, 1990) of people as workers is part of the front-line in the effort to improve health and working conditions. The health professionals of the Workers' Health Program centers may still be struggling to gain effective access to the practical debate on factory and office working conditions, but this does not mean that the debate has not already begun. Unbalanced the power structure may be, there are nevertheless possibilities that are being explored and as the case shows, workers too are able to think in epidemiological terms.

With such actions, workers will not be able to undo their repetitive strain injuries, nor will

they replace the need for effective public health actions, but Josildo in evaluating the changes that he and the other 'boys' brought about—using their own indicators—points to improvements. These included: longer pauses, getting the day's work finished before the end of the work period and avoiding the rush or the pressure, eliminating a task that was highly disagreeable, less tiredness and less suffering.

Conclusions

One of the most important characteristics of the psychology that has emerged in the Workers' Health Movement has been the fact that by and large, the practices and knowledge developed about Workers' Health problems and the ways of intervening, have happened in the field; in the day to day of multi-disciplinary dialogue and multi-professional action. This involvement has enabled psychology to progress both as science and as a profession and has shown the possibilities of its contribution to the field of Workers' Health. Even though only a recent venture, this interaction has produced important results, including drawing the University closer to the problems of the field. Social psychologists, for example, have been involved in studying discursive practices in relation to work accidents, the social representations about chemical risks, social consciousness of workers with repetitive strain injuries, the social representations of heavy work and a number of other topics. In the opposite direction, the involvement in the Workers' Health Movement has brought the concerns about working conditions and Workers' Health into the classrooms, influencing the content of the traditional personnel-oriented work psychology programs and providing support for a different approach to health.

At the level of the society as a whole and certainly within the State of São Paulo, the movement has been responsible for a number of partial successes and some quite significant gains, as in the previously mentioned case of mercury intoxication. Equally, it is possible to argue that the theme of Workers' Health is a very real one to many workers and their trades unions. But there are the inevitable gaps and difficulties both in multi-disciplinary dialogue, in academic production and in public health

practices. Brazil continues to remain a country with extreme levels of inequality in economic, social and political terms; in such a situation, a purely technical response will never be enough.

Note

1. In both cases, psychologists became to be formally employed in order to take part in multi-professional teams. This fact opened a new and large field of work for psychologists in Brazil.

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