

## Long-term work disability: loss of rights, survival and tangency of primary health care

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FREE THEMES

Luiza Monteiro Barros (<https://orcid.org/0000-0002-5941-393X>)<sup>1</sup>

Mônica Angelim Gomes de Lima (<https://orcid.org/0000-0003-3364-8439>)<sup>2</sup>

Robson da Fonseca Neves (<https://orcid.org/0000-0002-3889-560X>)<sup>3</sup>

**Abstract** *This article aims to explore the experience of long-term work disability (LWD) of users-workers in primary health care (PHC), understanding the therapeutic itineraries and the search for social protection, the elements that contribute to the incapacitation process and the strategies constructed for living with this condition. LWD is a multidimensional phenomenon, with a negative impact on the lives of workers, families and society. PHC has an important role in caring for people on leave from work. This is a qualitative, descriptive-exploratory study of the daily lives of people in situations of LWD. The comprehensive perspective guides the analysis of data co-produced in interviews and field observation. Cross-cutting themes such as social lack of protection, lack of communication and co-operation between key actors that enhance or mitigate LWD were recognised. The social support network proved to be important to access health care and to avoid social decadence. The Family Health Strategy, with technical support in Occupational Health, emerges with potential in the production of care for worker-users, although the fragility of maintaining long-term care.*

**Key words** *Occupational health, Primary health care, Vulnerability, Experience*

<sup>1</sup> Instituto de Estudos em Saúde Coletiva, Universidade Federal do Rio de Janeiro. Av. Horácio Macedo s/n, Ilha do Fundão - Cidade Universitária. 21941-598 Rio de Janeiro RJ Brasil. [luimbarros@hotmail.com](mailto:luimbarros@hotmail.com)

<sup>2</sup> Departamento de Medicina Preventiva e Social, Faculdade de Medicina da Bahia, Universidade Federal da Bahia. Salvador BA Brasil.

<sup>3</sup> Programa de Pós-Graduação em Fisioterapia, Departamento de Fisioterapia, Universidade Federal da Paraíba. João Pessoa PB Brasil.

## Introduction

Long-term work disability (LWD) is one of today's main public health problems<sup>1</sup>. It is understood as the impossibility of remaining at work, or non-return to work due to a health condition whose duration exceeds six months<sup>1</sup>. It is a multi-causal, multidimensional phenomenon, resulting from the individual-context relationship, which includes interaction with the systems of health and social protection, the workplace, family and community; and demands complex interventions in the socio-cultural and politico-economic panorama<sup>2</sup>.

In Brazil, the equivalent of the term LWD is not used, and the inability to work (IT) is addressed distinctly by the following social security systems: Sistema Único de Saúde – SUS (Unified Health System), Sistema Único de Assistência Social – SUAS (Unified Social Assistance System) and Instituto Nacional do Seguro Social – INSS (National Institute of Social Security)<sup>3</sup>. The INSS defines labour disability as “the impossibility of performance of the specific functions of an insured activity, function or occupation, as a consequence of morpho-psycho-physiological changes caused by illness or accident”<sup>4</sup> (p. 26).

Thus, what prevail in this diagnosis and follow-up are the biomedical model, unidirectional and centred on medical decision<sup>3</sup>, which assesses the degree, partial or total; the duration, temporary or indefinite; and performance, when one, several or all occupational activities are adversely affected. Retirement disability is configured when it is full, for a permanent or indefinite period, with unsusceptible recovery, or impossibility of occupational rehabilitation<sup>4</sup>.

In the Social Security system, there is no time limit for determining disability retirement, but, for the civil servant, the respective benefit is granted after leave for treatment for more than 24 months, when there are no conditions to return to work<sup>5</sup>. Under SUAS, the worker, in order to be eligible for Benefício de Prestação Continuada – BPC (Benefit for Continued Service – BCS) due to disability, must present long-term (at least two years) impediments of a “physical, mental, intellectual or sensory nature, which, in interaction with one or more barriers, can obstruct his/her full, effective participation in society on equal terms with others” (p. 43); among other requirements<sup>3</sup>.

The concept of deficiency and ability/disability based on the bio-psycho-social model began to be incorporated into the BPC regulation in

2009; it is stated in the Assessment of Deficiency in Law No. 13.146, issued in 2015 (LBI), and the 2016 technical manual, Occupational Rehabilitation Procedure<sup>4</sup>. The International Classification of Functionality, Disability and Health (ICF) is a reference for the bio-psycho-social model in these Brazilian public policies. The ICF defines deficiency as alterations in body functions or structures. Regarding disability, this encompasses activity limitation and restricted social participation; it results from negative aspects of the dynamic interaction between the individual's health condition and his/her personal and environmental factors<sup>4,6</sup>.

In view of this, absence from work usually begins with a health condition, and, in Brazil, extension of disability is largely related to barriers imposed on workers by the social security systems<sup>1,7</sup>. Absence from work greater than 12 weeks and delay in health interventions are regarded as negative prognoses for a return to work<sup>8,9</sup>. Lack of communication, unco-ordinated and contradictory performance of the key actors and decision-makers involved, confuse the worker who, even wishing to resume work, feels insecure and even incapable of doing so<sup>2,9</sup>.

Consequently, LWD leads to material deprivation, compromising the subsistence and daily life of both worker and family<sup>2,10,11</sup>. The loss of rights and social participation in the work triggers a process of social decadence, identity deconstruction, occupational and health deterioration, marking a biographical rupture for the individual and family<sup>7,10,11</sup>.

The growth of IT worldwide, its negative impacts on the worker, family and society, along with the burden on countries' economies, have aroused the interest of public and private institutions/organisations and society<sup>2,12</sup>. In Brazil, based on estimated data regarding social security, the expenditure on disability retirement from 2012 to 2021 was 545.7 billion reals (107.57 billion US dollars on 10/10/ 2023). In 2021 alone, 22.3 thousand days of work were lost, and 1.8 billion reals were paid as assistance for work accidents. These data are limited to salaried workers with a formal contract, thus excluding informal workers, the latter representing 40.1% of the occupied population<sup>13</sup>.

Changes in the world of work are based on competitiveness, individualisation and flexibility that require the worker to develop new skills to respond to the demands of, for example, the financial market and technological advance. Research has been conducted on how much the

worker, who cannot keep up with this pace, is led to a process of social disruption, exclusion and illness configured in the LWD condition<sup>14</sup>.

Setbacks in the area of social rights impinge on labour by increasing informality and social vulnerability<sup>14</sup>. This “informalisation” manifests itself in the growth of home-based productive and peridomicial activities, which mostly lack security, favouring “domiciliation of the occupational risk of damage to health and IT<sup>14-16</sup>”.

Given the consequent economic and social impact of illness and work leave, studies have focused mainly on the challenges of disease certification by the medical profession and the difficulty in assessing the occupational and psycho-social aspects. Ignorance of the environment, the process and the organisation of work limits the multidimensional assessment of the individual-context relationship, and hinder vocational rehabilitation policies<sup>17,18</sup>.

Regarding SUS and the National Network of Integral Occupational Health Care (RENAST), worker care is situated in the context of Primary Health Care (PHC), whose preferential model is the Family Health Strategy (FHS). This is characterised by the delimitation and understanding of the adjacent area in its diverse aspects, and linking of the users to Family Health teams (FHS). It is intended that the role of the FHS in worker health will provide cover ranging from disease prevention to the management of cases of removal from work in order to prevent LWD<sup>19</sup>.

Despite the efforts and advances in the field of Worker Health, its institutionalisation in PHC is still inconsistent<sup>19</sup>. There is little visibility of the user as a worker, and the influence of work in the health-disease process, producing a rather ineffective approach in cases of removal from work due to illness, in addition to consequent subnotification of cases<sup>20</sup>.

This article explores the LWD experience by seeking understanding of the disabling process, indications from therapeutic itineraries and the search for social protection. Furthermore, it discusses the strategies adopted by the user(s) to cope with this condition within the PHC. This information will be important to support discussion among technical teams engaged in Worker Health Care and FHS under the health-disability condition for work, with a view to preventing LWD.

## Theoretical methodological path

It constitutes a qualitative study of a descriptive, exploratory nature, inspired by the social phenomenology of Alfred Schutz<sup>21</sup>, for understanding the experiences in the quotidian of worker-users with LWD in the ambit of a Family Health Unit (FHU). The first author, a physiotherapist, a Family Health specialist, acting at the Extended Centre for Family Health Support (NASF-AB), participates in the Worker Health Project at PHC in close liaison with the Worker Health centres of reference, CEREST/CESAT.

According to Social Phenomenology, everyday life lies within the world of life that, albeit placed on a stage with a full range of meanings, in which social action is produced in intersubjective interactions, in a continuous flow of communications, acts and reactions composing the experiences. Each individual modifies these, producing his/her own world, according to motivations, inventory of knowledge from personal and prior experience of others, and his/her biographical situation. Two types of motives drive the individual to act, “the reason for”, the intention for which the process of the action will be taken and the “reason why”, which refers to the causes that determined the act after being performed<sup>21</sup>.

The research participants are workers with LWD resident in an area close to an FHU in a district of Salvador, Bahia, with a population of 12,095. The FHU is organised in five family health teams, each with a total of six community health agents (ACS), who receive support from NASF-AB.

This district has a socio-demographic and geographical heterogeneity; it is characterised by a contrast between luxurious condominiums and shantytown agglomerations, comprising upper middle class and poor populations, as well as by having social and public facilities of the health care network<sup>22</sup>.

The participants in the research were presented by ACS and NASF-AB physiotherapists, considering the inclusion criteria: workers resident in the USF area, engaged in the formal/informal economy; both sexes; age range 18 - 65; with LWD; at least six months after suspension from work due to illness or interlocutory appeal, whether related to work or not.

In-depth interviews were conducted with eight worker-users, guided by the initial question: “Tell me about your life/tell me your story.” The interviews were conducted in the users’ neighbourhood at a meeting place, from October

to December 2019, recorded in audio, duration 25-65 minutes. For this article, the interviews of six of the eight users were used.

The interviews were transcribed and reviewed, followed by successive readings, producing an initial synthesis of each interaction. The thematic analysis proposed by Braun and Clarke<sup>23</sup> was adopted and developed in six stages: familiarisation with their data, generation of initial codes, search for themes, theme review and suggestion of themes, report production; presentation of results: Working Life, Past and Present and the Process of Becoming Ill and Disabled in relation to Work, Configuration of the Disability for Work, Trajectories between the Therapeutic Itinerary and the Bureaucratic Itineraries.

This final theme formed the theoretical foundation for this article, in which the following categories emerged: Health treatment and lack thereof; Uncertainties in meetings with Social Security and Assistance; Occupational rehabilitation; and Non-return to work.

The research project was approved in Opinion no. 3.463.410, dated 21/05/2019, issued by the Research Ethics Committee of the UFBA Faculty of Medicine.

The consent form was presented, clarified and signed, observing the bioethical principles of the research presented in the Resolutions of the National Health Council no. 466/2012 and 510/2016. Names were replaced by pseudonyms.

## Results and discussion

Table 1 shows the participants in this study, presenting their different LWD experiences in which intersectional oppression and socio-economic inequalities permeated both their bodies and their everyday lives. There were four women and two men, white and black, age range 41-53, with incomes of one to two minimum salaries. In all cases, discontinuous schooling predominated: only three had completed secondary school, and two had not been educated beyond the primary level. Two men were single, one was married, and three women were separated single mothers. Four had their own homes and two lived rentfree in houses provided by their families.

The group was composed of unemployed and informal workers in various activities. Their working lives had started in childhood, and they had entered the labour market in the informal economy with fragile links to the formal market. Their predominant health conditions were

musculoskeletal disorders (MSD), one was in a typical work accident situation, and one was in a post-cerebral vascular condition due to a stroke.

The granting of social security sickness benefits ranged from four months to ten years. Discontinuous social security contributions justified non-granting of benefits. Social assistance was received through the Bolsa Familia (Family Assistance) scheme, and the bureaucratic process for granting the BPC, in the most severe case, was dragging on with no end in sight.

Faced with restricted social participation in work, and limitations due to their health conditions, the worker-users sought subsistence by engaging in odd jobs, such as selling popsicles or rendering domestic services. Among those restricted to their homes, one sold cosmetics, clothes and shoes online using WhatsApp, and another provided advice to people nearby on how to maintain their clientele.

The previous and recent experiences of these workers range from the family life arrangement, child labour, the difficulty of schooling, the intermittent engagement in precarious work, form part of the biographical situations of these persons, and these are stored in their stocks of knowledge<sup>21</sup>. Individual psycho-social and socio-demographic aspects were identified as possible predictors of LWD<sup>1</sup>, as a barrier to the return to work, and portray the social disadvantage that subalternised groups face to be able to stay in the world of post-illness/accident employment<sup>24,25</sup>.

Aggravation of health and imminent work removal constitute a moment of rupture; It interferes with the representation of the disease, exerts an important impact on the worker's life and imposes reorientation to prepare for other activities to mitigate the problem<sup>1,7</sup>. The process of recognition and legitimation of disease, and its interpretation, in the logic of Social Security, as an inability to work, is widely described as the first significant challenge to workers<sup>7,26</sup>.

The legitimation of illness plays a role in permission to unveil this suffering and its repercussions on individual behaviour, opening up possibilities to initiate a therapeutic itinerary, which is conceived in a non-linear movement of decisions, actions and interactions between individuals and services<sup>27</sup>. It is considered that two orders of explanation influence the decision-making: one a cognitive order, related to values, emotions, representations, and the other the socio-economic order regarding social inequalities and their relationship with social class, gender, race, family and community matters<sup>27</sup>.

**Chart 1.** Characterisation of the participants in the research.

Name	Age	Education	Work record and occupation	Marital status and children (M/F)	Health condition	Monthly family income	Situation in relation to social security/ social assistance
Mércia	54	secondary (complete)	Worked in childhood  Manicure and hairdresser for 33 years (initially as formal employee and self-employed later)	single	DME* involving arms, and cervical and lumbar region	Less than minimum salary	No benefit, intermittent social security contribution, denied sickness benefit
Célia	41	secondary (complete)	Events decorator (self-employed)	Separated 1 child (F)	Polytrauma** (after fall on workplace stairs)	Less than minimum salary	No benefit, intermittent social security contribution, denied sickness benefit
Janete	41	secondary (complete)	Cosmetics demonstrator (formally employed)  Manicure and hairdresser (self-employed)	Separated 2 children (M)	DME mainly involving lumbar region	No income	Received sickness benefit for 4 months,
Solon	52	secondary (incomplete)	Worked in childhood  Formally employed and self-employed in different occupations  Shop Shelf Loader	Separated 2 children (M)	DME involving shoulder	Up to one minimum salary	No benefit  Contributed to social security for 22 years, received sickness benefit for 4 months, denied renewal  Received family benefit
César	56	primary (complete)	Worked in childhood in the family  Self-employed painter in civil construction. Formally employed in a hotel.	Married 2 children (M)	DME involving cervical and lumbar regions, and shoulder	Up to 2 minimum salaries	No benefit Suspended from work for 10 years, attempts to return, received sickness benefit in this period.
Sueli	43	primary (complete)	Formally employed as a domestic servant for a short time.  Self-employed hairdresser (megahair application)	Single 3 children (M)	AVC*** with main sequel in upper right arm	Less than minimum salary	No benefit Awaiting BPC Received family benefit

\*MSD – musculoskeletal disorder, \*\* foot and right arm fractures due to work accident, \*\*\*AVC – cerebral vascular accident (stroke).

The therapeutic itinerary of people in socially vulnerable situations, such as these users, is initially marked by self-medication, such as the use of teas and repetition of previously prescribed medicines, followed by searching for informal services, such as traditional care and/or formal health services, depending on results<sup>28,29</sup>. In the case of symptoms that interfere with work activity and a need for them to be covered up, the main resource was self-medication<sup>25,30</sup>. For Janete, working while in pain was usual; when exacerbated, she would take analgesics without a prescription, and teas: [...] fellow churchgoers used to bring me herbal teas, and used to say: "Take this. Take that", but nothing worked. They thought no medicine would solve the problem (Janete).

Although indiscriminate self-medication and the absence of long-term monitoring can cause damage to the individual's health, there are also access barriers imposed so that informal and unemployed workers use health services less, even when presenting more serious health conditions<sup>29</sup>.

#### Health treatment and lack of it

Mércia used to be attended at a Basic Health Unit (UBS) in another district to deal with part of her health problems; when they worsened and adversely affected her work, she went to the Emergency Care Unit (UPA). Upon reaching the limit of this search for official confirmation of her pain, she decided it was necessary to resort to the private sector, within a narrow margin of possibility to bear the cost of this "medical consultation". For Mércia, confronting this situation was embarrassing:

[...] when I got there, shamelessly, as I knew it was a private service, I spoke to the security guards [...] "The cost of the consultation will be 80 reais, and if I paid by card, it'd be 150", [...] I had 100 in my handbag [...] I said: "so I'll make an appointment here". Then I had to pay for a rheumatologist, who arranged for me to undergo a series of exams. As a result, I found out the diagnosis was carpal tunnel syndrome (Mércia).

The construction of social support networks involving help from family members, neighbours and social institutions, such as churches and associations, comprise the therapeutic itineraries to confront the vulnerabilities<sup>27,30</sup>. Some studies point to access barriers erected by the service organisation, expressed in the form of difficulty making an appointment or finding a vacancy during the health unit's opening hours; as well as

geographical barriers to users who work in another district and are not considered registered FSU patients, or in the absence of a Basic Health Unit near the workplace. The extension of opening hours to include a night shift is an attempt to minimise access barriers to the worker<sup>20,32,33</sup>.

The choice of individuals in search of care also stems from previous experiences in social relations and health services. Mércia, ended up moving away from SFU after an uncomfortable situation, as can be understood from the following:

[...] I couldn't take it any more [waiting]. Then, when it was about five and a bit, I started saying to myself: "My God, I'll leave. I no longer have any condition to be attended by this woman [doctor], because, if she comes out of that door and calls me, this appointment will be terrible". So I left, annoyed, and never went back. I always kept on going to Chame-Chame, the clinic at Santa Terezinha church; There it was good (Mércia).

These users' reports bring to light the difficulties of access to health services, the lack of assistance and fragmented care. The FHS catchment area is no guarantee of access to care. The organisational and attitudinal barriers and dissatisfaction with assistance lead users to seek health services in other districts, where they feel more welcome<sup>20,32,33</sup>. On the other hand, there were workers' experiences in which they had managed to obtain access to PHC and received full treatment, although there were gaps in worker health care<sup>34</sup>.

In this study, contact between the ACS and an NASF-AB professional is registered as social support in facing the situations, given the scarcity of material resources, such as in Célia's case:

ACS helped me, brought someone [physiotherapist] here. So, I'm doing these exercises she taught me at home. For Janete, this relationship with the medical specialist is in contrast to that of the Family Health Service (FHS) team and NASF-AB:

The doctor in the Family Health team asked me to see the expert, but it was very far; when I managed to go, an appointment was made [...], but when I got there, the doctor didn't even look at me. They would say: "You have to have treatment," but they did not refer me, did nothing. Who was doing something for me was the clinic, which had mobilised the physiotherapist who comes to do the physiotherapy, and the FHS doctor who accompanies me (Janete).

In the therapeutic itinerary of informal worker-users, intermittent social security contributors and a health condition that restricts social partic-

ipation at work, NASF-AB care has been a central point in the face of the difficulty in accessing SUS secondary treatment, and the impossibility of paying even the low-cost clinics and transport.

At the meeting with the FHS there was also a record of care provision, as in the case of Sueli, a new arrival in the community, who, with the support of family members, restarted her life after suffering a stroke and becoming unemployed. She began to receive treatment for her various health needs, including support from NASF-AB's occupational therapist in identifying new occupational openings for her, especially in view of her need to take care of her children and earn an income.

In the Sólón case, who used to access UPA and doctors in distant districts to treat diabetes and shoulder pain, the FHS with CESAT/CEREST support, in integrated worker health support (ST), welcomed him and issued proper referrals within the health care network and follow-up with the NASF-AB physiotherapist. Intersectoral articulation with the INSS was attempted, but it was frustrated by the rejection of the report issued by CEREST/Salvador.

Despite the important advances, the difficulties in ensuring integral care of the worker involve all levels of health care and background technical centres. ST care under PHC, with some exceptions, portrays the double invisibility<sup>20,21</sup>. On the one hand, the worker-user does not recognise the USF as a place to go to solve health problems<sup>20</sup>, as observed in César's comment:

*I knew, but I always used to go there for something for my son, vaccine, these matters; but I myself seeking service, never, because, at this clinic, for this problem of mine, usually you can't find an orthopaedist or neurologist (César).*

On the other hand, USF does not see these users as workers or the influence of work on the health-illness process, as observed in the evolution of the medical records. There was almost an absence of information about occupation, and, even when present, no association with the complaints presented by the user was observed, although work was recognised as a cause of their health problems, except for the user who had suffered a stroke.

At meetings between professionals and users, this invisibility can manifest itself in three ways: a) the work is not mentioned; b) the user associates his health problem with work, but this information is ignored by the professional; c) the professional notes the occupation, but without its deepening or specific developments. Thus,

it is imperative to understand the complexity involved in the invisibility of work, not only to blame the professionals' biomedical approach, but also to consider working conditions, the problems of the local area, the public administration model, the politico-economic context, besides the gaps in the background specialised worker health services<sup>19</sup>.

Inefficient, fragmented performance of the health system, along with inconsistent diagnoses and opinions, and ineffective treatments, reinforce the worker's misunderstanding and insecurity. An approach that disregards psycho-social, personal and work aspects, and guides user behaviour change in relation to work, is deficient and contributes to LWD by delaying user recovery<sup>35,36</sup>.

#### **Uncertainties in the meetings with the social security and assistance**

Parallel to the therapeutic itineraries, worker-users are motivated to seek social security rights and social protection, subject to the bureaucracy of the administrative processes. The experiences of salaried, self-employed and informal workers, each category with its own peculiarities and different trajectories, are considered a true '*via crucis*'<sup>30,35,36</sup>. Janete, who was once a formal worker, and then switched to informality as a manicure and hairdresser at home, narrated:

*[...] In March, when I had another crisis, I applied for social security benefit (INSS). I was in a bad state, in a wheelchair [...] They told me I was outside the grace period, and so I was rejected; But, in fact, I was eligible, because I had received treatment a whole year ago, in 2018. Even so ... (Janete).*

Informal workers often do not manage to maintain their social security contributions, especially as these are expensive. The situation of being without health cover or not fulfilling the grace period as a consequence of intermittent contributions, prevents recognition of the IT, thus forming a socially unprotected condition. It is urgent to rethink the social protection strategies for informal workers in poverty, as well as preventive measures to minimise risks in the workplace<sup>36</sup>.

Three of the users who had worked formally, at some point, received sickness benefit. The tortuous trajectories of these workers included legal action, several appointments with lawyers, difficulties in arranging diagnostic examinations, and consultations with health professionals and

a medical expert<sup>26,30</sup>. According to Sólon's experience:

*[...] As I had undergone the ultrasound, they gave me four months' leave, [...] but my arm did not improve; [...] When I returned, I was attended by another expert, and he thought of suspending the benefit; Then, I gathered other documents, [...] I went to have resonance [...] and went to the INSS, but I was rejected again; The magnetic resonance imaging is to see if it proves whether the person has a problem or not. As I had been rejected, I resorted to making an appeal last April (Sólon).*

Sólon underwent more sophisticated exams, confident of their relevance to the legitimation of the IT, albeit in an unfair process that ignores clinical and occupational history, working conditions, and places more value on high-tech examination to gauge the disease. Thus, the condition of chronic pain was neglected, despite its "imponderable" and "immeasurable" character, to say nothing of the functional performance of the individual. Legal action is taken in the last resort for the few who can afford to bear the legal costs.

In the face of failures on the part of INSS, SUAS is the only alternative left open to the informal worker. However, in the interaction with SUAS, it is required to demonstrate and measure the eligibility against the prerequisites established to obtain the BPC. On this theme, a study crossed the INSS data on 4,000 sicknesses benefits with BPC applications for social assistance. It was found that only 1.5% of these workers resorted to BPC, and only 32% of these were successful<sup>3</sup>.

Among the users, three received Bolsa Família (family assistance), and one was awaiting assessment of eligibility for BPC by a medical expert. Sólon, unemployed, surviving on odd jobs, commented on the challenge to keep the family assistance benefit:

*I was receiving Bolsa Família, but then it was cut; This ruined me; I even commented this to the staff there. I don't know if they had done something; I just know that, after another appeal, I started to receive it again, but it took ages.*

Successive failures in the worker-user interaction with social security and SUAS demonstrated a blatant attitude of invisibility towards these workers, denying their rights and not recognising their vulnerabilities, causing a sense of humiliation. Beyond this humiliation, other authors identified emotional wear and tear, and worsening of health, consequences of the attitudinal barriers at the social security reception, lack of hospitality, disregard for the information presented<sup>30,35</sup>.

Considering the biographical situation of the users, studies show inequalities in the scope of social security, related to race/colour, gender and education. The black population, the majority in precarious jobs in the informal market, has even greater difficulty in accessing benefits, often partly due to lacking understanding of the bureaucracy involved<sup>3,35</sup>.

### **Occupational rehabilitation and non-return to work**

In the formal worker's trajectory, occupational rehabilitation (OR) is a critical process for a sustainable return to work, considering individual bio-psycho-social barriers and environmental aspects. The needs and preferences of workers influence the success or failure of this process<sup>2</sup>. In Brazil, the implementation of a bio-psycho-social approach by a multi-professional team, as provided for in the 2016 OR technical procedure manual and the 2015 LBI, was harmed by publication of the 2018 version of the technical manual, as it centralised assessment of the work potential on the medical experts, and accentuated the biomedical perspective, insufficient for the PR process<sup>37</sup>.

César, although a formal worker, did not make the OR application for social security, and had to seek alternative physical rehabilitation via physiotherapy, in associated clinics and treatment by SUS after losing his private health insurance. His report below, from around September 2006 till 2010, provides an insight:

*I had physiotherapy there in C., [...] I always had it there, but then it became H., I had already received physiotherapy at H. in Garibaldi. Then it became A., another health plan. It was 2017 when I began to improve a little. Then I had it there in Ar (clinic) (César).*

Access to PR was under the responsibility of the worker himself, who underwent physiotherapy care intermittently and was disarticulated from social security and the workplace. César spoke of his attempts to return to work. These were unsuccessful as they involved lifting transport of heavy cargoes that worsened his symptoms:

*The function they put me in there, [...] was in the warehouse first, but then [...] I had to carry watermelons, and that's when the crisis began [...] It didn't work out. They transferred me to other floors [...] in the workplace. In one sector there was a car [...] Female employees would throw wet towels for me to catch and later move them to a larger vehi-*



*cle [...] At certain moments I had to go downstairs to collect those heavy wet towels; I did this during the day. By the afternoon, my back was already painful. As I had to do certain types of postures, I was suspended again, and remained so until 2017; When I was cured, I had an appointment with the company doctor. He declared I was fit for work, so I returned to the company, but then I was dismissed (César).*

César's non-participation and that of a health-care professional to discuss the most appropriate work activity for his health, made it difficult to return and remain at work. OR inefficiency also occurs by not offering work alternatives that consider functional limitation, while valuing the worker's potential, and does not consider the participation of everyone involved<sup>25</sup>. Policies focused on disability for work act as "traps" for the LWD, a paradoxical action that perpetuates disability instead of a return to the workforce, as has also been analysed in other contexts<sup>2,36</sup>.

## **Final considerations**

The LWD process is not linear, and it is being configured as worker-users are vulnerabilised in the face of the lack of assistance, mismatches and discoordination in health, and social and work protection. Under these conditions, the construction of a family and community social support network has been important in averting social decadence.

Despite the weaknesses and limitations, the FHS presented some successful experiences in this study, thus reinforcing the need for the NASF-AB and CEREST safeguards, and articulation with other services and sectors, such as the Social Assistance Reference Centre (CRAS), for the care of the worker-user with LWD, and for the planning of preventive action, health promotion in the local area, with strategies to address situations that accentuate social inequalities.

Considering the condition of informal workers, those in precarious employment, and unemployed LWD workers, there is an imperative need to identify and uphold their rights, to strengthen the PHC, improve workers' health care in this context, and reformulate the insurance model, in order to adapt to the reality of the Brazilian workforce.

## **Collaborations**

LM Barros carried out the fieldwork, data analysis and interpretation; worked on the conception, design, writing and critical revision of the article and approved the version to be published. MAG Lima collaborated with the analysis and interpretation of the data, worked on the conception, design, writing and critical revision of the article and approved the version to be published. RF Neves collaborated with the writing and critical revision of the article and approved the version to be published.

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## References

1. Organization for Economic Co-Operation and Development (OECD). *Sickness, disability and work: breaking the barriers a synthesis of findings across OECD countries*. Paris: OECD; 2010.
2. Ståhl C, De Wispelaere J, MacEachen E. The work disability trap: manifestations, causes and consequences of a policy paradox. *Disabil Rehabil* 2022; 45(11):1916-1922.
3. Wünsch DS, Mendes JMR, Martins JMR. Trabalho e previdência social: as lacunas de proteção social na seguridade social. *Argumentum* 2017; 9(3):37-51.
4. Instituto Nacional do Seguro Social INSS. Manual Técnico de Perícia Médica Previdenciária [Internet]. 2018. [acessado 2023 out 13]. Disponível em: <https://www.saudeocupacional.org/v2/wp-content/uploads/2018/03/Manual-Técnico-de-Perícia-Médica-2018.pdf>
5. Brasil. Presidência da República. Lei nº 8.112, de 11 de dezembro de 1990. Dispõe sobre o Regime Jurídico dos Servidores Públicos Civis da União, das autarquias e das fundações públicas federais. *Diário Oficial da União* 1998; 18 mar.
6. Organização Mundial da Saúde OMS. *Classificação internacional de funcionalidade incapacidade e saúde*. São Paulo: EDUSP; 2003.
7. Souza MEL, Faiman CJS. Trabalho, saúde e identidade: repercussões do retorno ao trabalho, após afastamento por doença ou acidente, na identidade profissional. *Saude Etica Justiça* 2007; 12(1-2):22-23.
8. Hoefsmit N, Houkes I, Nijhuis FJN. Intervention characteristics that facilitate return to work after sickness absence: a systematic literature review. *J Occup Rehabil* 2012; 22(4):462-477.
9. Young AE, Roessler RT, Wasiak R, McPherson KM, van Poppel MNM, Anema JR. A developmental conceptualization of return to work. *J Occup Rehabil* 2005;15(4):557-568.
10. Coutu MF, Côté D, Baril R. The Work-Disable Patient. In: Loisel P, Anema, JR, editor. *Handbook of work disability: prevention and management*. New York: Springer Science+Business Media 2013. p. 15-29.
11. Bury M. Chronic illness as biographical disruption. *Sociol Heal Illn* 1982; 4(2):167-182.
12. Ståhl C, Costa-Black K, Loisel P. Applying theories to better understand socio-political challenges in implementing evidence-based work disability prevention strategies. *Disabil Rehabil* 2018; 40(8):952-959.
13. Ministério Público do Trabalho. Observatório de segurança e saúde no trabalho [Internet]. 2022. [acessado 2022 jan 15]. Disponível em: <https://observatoriosst.mpt.mp.br>
14. Antunes R, Praun L. A sociedade dos adoecimentos no trabalho. *Serviço Soc* 2015; 123:407-427.
15. Brasil. Ministério da Saúde (MS). *Saúde do trabalhador e da trabalhadora*. Brasília: MS; 2018.
16. Santos AL, Rigotto RM. Território e territorialização: incorporando as relações produção, trabalho, ambiente e saúde na atenção básica à saúde. *Trab Educ Saude* 2011; 8(3):387-406.

17. Aamland A, Werner EL, Malterud K. Sickness absence, marginality, and medically unexplained physical symptoms: a focus-group study of patients' experiences. *Scand J Prim Health Care* 2013; 31(2):95-100.
18. Krohne K, Brage S. How GPs in Norway conceptualise functional ability: a focus group study. *Br J Gen Pract* 2008; 58(557):850-855.
19. Andrade AGM, Neves RF, Carvalho RCP, Dias EC, Lima MAG. (In)Visibilidade do usuário-trabalhador na interação com profissionais de saúde no contexto de uma Unidade de Saúde da Família. *Interface (Botucatu)* 2021; 25:e200700.
20. Silva TL, Dias EC, Pessoa VM, Fernandes LMM, Gomes EM. Saúde do trabalhador na Atenção Primária: percepções e práticas de equipes de Saúde da Família. *Interface Commun Heal Educ* 2014; 18(49):273-287.
21. Schutz A. A linha de base fenomenológica. In: Wagnier HTR. *Sobre fenomenologia e relações sociais*. Petrópolis: Vozes; 2012. p. 65-83.
22. Companhia de Desenvolvimento Urbano do Estado da Bahia (CONDER). *Painel de informações: dados socioeconômicos do município de Salvador por bairros e prefeituras-bairro*. Salvador: CONDER/INFORMS; 2016.
23. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2008; 3(2):77-101.
24. Toldrá RC, Daldon MTB, Santos MC, Lacman S. Facilitadores e barreiras para o retorno ao trabalho: a experiência de trabalhadores atendidos em um Centro de Referência em Saúde do Trabalhador – SP, Brasil. *Rev Bras Saude Ocup* 2010; 35:10-22.
25. Waddell G, Burton K, Kendall N. *Vocational rehabilitation what works, for whom, and when?* London: Vocational Rehabilitation Association; 2008.
26. Neves RF, Nunes MO. Da legitimação a (res)significação: o itinerário terapêutico de trabalhadores com LER/DORT. *Cien Saude Colet* 2010; 15(1):211-220.
27. Alves PC. Itinerário terapêutico, cuidados à saúde e a experiência de adoecimento. In: Gehardt TE, Pinheiro R, Ruiz ENF, Silva Junior, AG, organizadores. *Itinerários terapêuticos: integralidade no cuidado, avaliação e formação em saúde*. Rio de Janeiro: CEPESC/IMS/UERJ – ABRASCO; 2016. p. 125-146.
28. Gerhardt TE. Itinerários terapêuticos em situações de pobreza: diversidade e pluralidade. *Cad Saude Publica* 2006; 22(11):2449-2463.
29. Demétrio F, Santana ER, Pereira-Santos M. O itinerário terapêutico no Brasil: revisão sistemática e metassíntese a partir das concepções negativa e positiva de saúde. *Saude Debate* 2019; 43(Esp. 7):204-221.
30. Zavarizzi CP, Alencar MCB de. Afastamento do trabalho e os percursos terapêuticos de trabalhadores acometidos por LER/Dort. *Saude Debate* 2018; 42(116):113-124.
31. Cockell FF, Peticarrari D. Retratos da informalidade: A fragilidade dos sistemas de proteção social em momentos de infortúnio. *Cien Saude Colet* 2011; 16(3):1709-1718.
32. Nehmy RM, Dias E. Os caminhos da saúde do trabalhador: para onde apontam os sinais? *Rev Med Minas Gerais* 2010; 20(Supl. 2):13-23.
33. Silva DP, Freitas RF, Souza LF, Teixeira NA, Dias EC, Rocha JSB. Professional practices in occupational health in Primary Care: challenges for the implementation of public policies. *Cien Saude Colet* 2021; 26(12):6005-6016.
34. Pedroso HC, Gonçalves CGO, Areosa J. Trajetória de trabalhadores com perda auditiva induzida por ruído na rede de assistência à saúde do Sul do país. *Res Soc Dev* 2021; 10(2): e4610212187.
35. Severiano EMO, Macêdo AC. Previdência Social: a saga entre trabalho e adoecimento. *Rev Katalysis* 2015; 18(2):172-181.
36. Souza NSS, Santana VS. Posição socioeconômica e duração do benefício por incapacidade devido a doenças musculoesqueléticas relacionadas ao trabalho. *Cad Saude Publica* 2012; 28(2):324-234.
37. Miranda CB. Aspects of the current workers' rehabilitation scenario in Brazil: Strides and setbacks. *Cad Saude Publica* 2018; 34(8):e00218717.

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