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ARTICLE

Work precarization in the prison system's primary health care

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Abstract *This paper analyzes how work precariousness is expressed in the daily life of a Prison Primary Care Team in the Brazilian South. This qualitative, exploratory research applied the focus group technique and relied on the participation of ten health professionals. The results evidenced a substandard occupational relationship, objectified by the workforce's outsourcing, the poor proper management of work processes, and little provision for specific professional qualifications and actions consistent with the occupational reality.*
Key words *Occupational health, Prison, Work conditions, Primary care*

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Introduction

Brazilian society is experiencing a citizenship setback with profound consequences for the organization of the SUS and managing human resources in health with the incorporation of neoliberal thinking guidelines. In Brazil, several fields of knowledge, especially work sociology, work management, and occupational health, denounce work's precariousness as a current event. This event encourages the adoption of more flexible (from the employer's viewpoint) and more substandard (from the worker's viewpoint) work relationships.

The International Labor Organization[1] argues that the Right to Decent Work requires States to promote and ensure adequately remunerated work performed with freedom, equity, and security and capable of guaranteeing a dignified life. In practice, this translates into issues such as reducing informality, boosting education and work training, and strengthening labor rights. The Brazilian public administration defines precarious work as all work performed without the worker's social protection and a public tender[2], implemented without assuring social rights for the workers. As this is a structural problem (ideological, economic, political, social), work deterioration in the so-called health complex[3] is also reflected in specific contexts, such as PHC workers in the scope of their work in the prison system.

This is one of the results of the productive restructuring process of capital operated worldwide since the 1970s, which characterizes the transition from the Taylorist-Fordist organization of production to a Toyotist organization[4-6]. These reformist and adjustment strategies redefine the role of the State and the public-private boundaries. What remains as State property starts to work with the logic of the market. These are, therefore, state counter-reform projects[7].

Work is a strategic and fundamental pillar for overcoming inequalities, poverty, and social exclusion. In 2015, decent work became one of the central elements of the new 2030 Agenda of the United Nations General Assembly, objective n° 8[8]. Work precariousness in the health sector has been identified as a challenge for work management and the organization of work processes in the Unified Health System (SUS)[9].

In Brazil, the right to access health care, and the guidelines that guide health work in the Prison System, have legal apparatuses such as the Penal Execution Law (LEP) of 1984; the 1988 Federal Constitution; Organic Laws n° 8.080 and 8.142 of 1990, which regulate the Unified Health System (SUS); the National Health Plan in the Penitentiary System (PNSSP), 2003; and the National Comprehensive Health Care Policy for People Deprived of Liberty in the Prison System (PNAISP), of 2014, and its respective Operational and Financing Ordinance GM/MS n° 2.298/2021.

US health professionals have institutionally been part of the prison environment since 1984, from the LEP, which then included medical, pharmaceutical, and dental care for inmates. In 2003, implementing multidisciplinary health teams in prisons began with the publication of the PNSSP. The Plan was replaced in 2014 by the PNAISP to implement Prison Primary Care Teams (EABp) within the SUS[10].

The PNAISP aimed to expand the scope of health care in prisons, redirecting it to the principles and guidelines of the SUS, aligned with the PHC attributes. Through PHC teams, the PNAISP aims to ensure access to comprehensive health actions, including prevention, diagnosis, harm reduction, and treatment of the primary diseases that affect the population deprived of liberty.

Epidemiological data and systematic review studies indicate that the prison population has high levels of mental disorders, chronic, infectious diseases, and drug use, significantly above those of the general population[11]. In the specific case of female prisoners, excessive medicalization is used as a control strategy in the absence of prison policies that consider their needs and specificities in confinement placed[12].

Any environments in which people are concentrated are conducive to the aggravation of pre-existing health conditions, and the development of new health problems, such as sexually transmitted or airborne diseases[13-15]. However, studies show that the availability and access to a set of actions and services influence the health of the prison population but not enough to solve the problems demanded[16,17].

Therefore, it is not enough to increase availability and access to care; one should consider what kind of service this is. How the health service is offered enhances its resoluteness. The origin and historical course, the different conformations, and the spaces in which they are located are directly related to how work is performed; that is, with the work process orientation model.

Therefore, when talking about the work process, one necessarily refers to its objectives, the

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subjects who act, the action's object, and the means available and used in implementing the action[18]. It is essential to consider these elements to understand and transform the health service in the prison environment so that it becomes more efficient and effective. It is necessary to consider that service users are also, directly and immediately, the process subjects or agents, and their demands and needs are objects of this same process.

Therefore, the health teams responsible for prison territories must be prepared to work in an environment with several peculiarities and contradictions. How can the same institution be assigned surveillance/punishment and health care functions?

Both health professionals and the local SUS management team, in an intersectoral manner with penitentiary security, should be especially sensitive to redesigning processes and devices to generate equity, quality, and effectiveness in providing health to people deprived of liberty. Therefore, this paper aims to discuss how the precariousness of work "relationships" and "conditions" are expressed in the daily occupational life of a prison primary care team and the consequences for health care in this context.

Methods

This is exploratory and descriptive qualitative research[19]. Qualitative health research explores people's perceptions and experiences of the world around them, including those related to health, illness, social, and health services. This approach seeks to interpret practices to understand how people build the world around them, what they are doing, and what gives them meaning, always in a contextualized way[20].

Participants

Ten health professionals part of a prison primary care team implemented in a female penitentiary located in the Metropolitan Region of the State of Rio Grande do Sul participated in the study, from different training centers: four from nursing (two from higher education and two from technical education level), three from medicine (general practitioner, psychiatrist, and gynecologist), one from social work, one from psychology, and one from dentistry. This was a convenience sample[19], considering all the professionals who worked in the Basic Prison Health Unit (UBSp) during the period of empirical data collection.

Tools

Two audio-recorded focus group meetings were held[21] and were guided by three researchers: a moderator, responsible for coordinating them; an observer, in charge of observing and recording facial and body expressions; a note-taker, to record the events, the statements of the participants, the side conversations, and the complementary comments.

Data analysis and ethical measures

The material was transcribed, saved in text documents, and imported into QSR NVivo® Software, version 11 for Windows. From then on, the "corpus" was analyzed using the Thematic Analysis method, following six phases: familiarizing with the data, generating initial codes, searching for themes, reviewing the themes, defining the themes, and producing the final report/analysis[22].

We employed a constructivist, theoretical-methodological perspective in this study, supported by the critical social theory. Thus, the thematic axis entitled "Expressions of a prison primary care team's work precariousness" was previously defined per the study's objective. Their respective subthemes were constructed based on this theme through empirical data, namely: "Hybridity as an effect of the public-private mix"; "Precarious working conditions"; and "Professional qualification: between the distance from academic training and the prison working experience".

The research was submitted to and approved by the Research Ethics Committee of Escola de Saúde Pública do Rio Grande do Sul, under the CAAE 40678115.1.0000.5312, and the Research Committee of the Instituto de Psicologia da UFRGS, and followed the precepts of the Resolution of the National Council of Health n° 466/2013, which guides human research. The study was funded by Fundação de Amparo à Pesquisa do Estado do RS (FAPERGS). The research was nested in a more extensive study approved by the public notice of the Research Program for the SUS: Shared Management in Health – PPSUS/FAPERGS. The anonymity of health professionals was preserved by numbering the participants, for example, P1 (participant 1) to P10 (participant 10). The respective statements of the research participants in the item "Results and Discussion" will obey this previous coding.

Notably, regarding the limitations of the study, forty-one prison primary care teams operate in the state, and this study is contextualized in the experience of a single team, located within an exclusively female prison unit. The data described here reflect the first approximation to the precarious work of professionals and cannot be generalized. In any event, the limitation does not invalidate our study.

Results and discussion

Hybridity as an effect of the public-private mix

According to the health professionals participating in the research, the recruitment and implementation process of the prison primary care service assumed work flexibility and deregulation characteristics, with profound consequences for developing prison health care.

In March 2011, the prison primary care team started its activities in the penitentiary focus of the research. Since then, a "hybrid team" was established with workers outsourced by the municipal health management and public servants, involving seven outsourced health professionals (four doctors, two nurses, and a nursing technician) and four other state public servants (a social worker, a psychologist, a dentist, and a nursing technician) linked to the Superintendence of Penitentiary Services (SUSEPE).

Outsourced professionals were recruited under a public-private partnership through the Municipal Health Secretariat to compose the team. One of the best-known and most perverse forms of precarious work in the health field is workforce outsourcing. Although this system is highly controversial, there is a consensus on the concept that defines it: *[...] the entire process of hiring workers by an intermediary company, whose ultimate objective is to reduce costs with the workforce and (or) the externalization of labor conflicts*[23]. In short, with greater or lesser intentionality, companies seek to reduce the resistance of the workforce and limitations exogenous to the accumulation process.

The professionals mentioned that outsourcing the employment relationship produced uncertainty, unpredictability, and instability "about tomorrow" (P5), mainly because the employment risks were generally assumed by themselves and not by their employer. As they informed, the insecurity regarding keeping jobs increased with each government/political party change. Reiterating: *Nobody knows what will happen with each change of municipal and state government. We don't have a career plan. We don't know whether we're going to stay here for ten years, one, twenty, right?* (P5).

Associated with the employment issue, professionals were highly concerned about the lack of recognition and permanent exposure to occupational risk situations to which they were subject. They reported that the nursing technicians had recently "achieved" (P3) the right to receive unhealthy and hazardous work financial benefits, although they worked under the same conditions as other health professionals and SUSEPE staff. It should be noted that Bill n° 6007/13 guarantees outsourced workers the right to receive unhealthy and hazardous work financial benefits.

We observed that the unstable employment relationship could be exacerbated in the face of non-replacement of the workforce. Reports realized that, as the vacancies of retired public examination-appointed professionals were no longer filled. Arguments such as increased functional overload, poor quality of care, and risk to service maintenance were considered by health professionals, as can be seen in the excerpt:

[...] people leave and don't renew themselves. [Professional's name deleted] retired, and no one replaced her. [...] they are retiring and eliminating vacancies. [...] Sometime soon, there won't be any. So, how is the service going to be offered here? We have to discuss this because it's not just our reality (P5).

The team had been incomplete for approximately two years. *Only the nurse and the technicians were left* (P6) to perform daily care at the UBSp. Two servants linked to SUSEPE, from the social service and psychology center, confirmed that they had deviated from their role, working in other penitentiary sectors. They returned to the UBSp during the period in which the research data collection began.

Furthermore, it was found that there was not an equitable division of work activities, which produced work overload among professionals in the nursing center. At that time, the availability of doctors at the UBSp was reduced, both in terms of the days they attended and the time they remained there, given that they shared the workload and care in other prisons.

The only objective of the public-private mix also does not meet the interests and demands of the public served, nor does it guarantee favorable conditions for developing the work of health

professionals. Outsourcing the employment relationship brings insecurity in the face of fear of losing the job and the lack of workers' social protection. The composition of a hybrid team revealed inadequate staffing, deviation from the role of public servants, and conflicts between sectors of the prison unit.

We perceived a clear return to the neoliberal policies of the 1990s[24]. The objective, then and now, with the outsourcing of primary care, is to dismantle the SUS, which has become a highly profitable commodity for the private sector. Defending these ideas stems from a neoliberal conception that the State does not have the political-economic conditions to administer the social security system. To that end, it needs to disperse its managerial power, since the 1988 Federal Constitution does not fit the Brazilian public budget. This "managerial state" model[25] provides ideological and organizational coherence, materialized in the public equipment's reform and modernization projects.

Precarious working conditions

Another obstacle to the teams' work was reported as the "lack of supplies and material" to perform some dental procedures at the UBSp. By way of example, the lack of material for adequate treatments was mentioned. Professionals argue that this condition restricted both the care and the supply of preventive and oral rehabilitation services so that, many times, they were limited to urgent care (extractions). However, the incarcerated women often needed dental prostheses due to their poor oral condition and significant commitments in this area:

[...] this is quality of life; it is oral health, and we have been struggling for years. Many don't have teeth to eat, [professional's name deleted] who manages sometimes doing something there [...] but we can't get a denture service; I know we don't have it for the community, but sometimes she stays here, two, three years without teeth, eating poorly (P1).

Given this situation, the work focused on "eliminating or relieving pain" (P4) due to dental problems. In this and other situations, it is interesting to note that some procedures were only performed when judicially demanded due to the scarce health care resources, usually by family members or lawyers of women deprived of their liberty.

This same worker stated that ensuring the *right to health in the Prison System is surrounded by bureaucracy*" since *I write a report, and they come over and over again; the judge ordering and I answering* [...] (P4). The judge's participation means that the service will be conducted, sometimes, through the "legal determination to perform" (P4). The big issue is how to legally promote the right to health of people deprived of liberty, given the State's duty to provide such care.

From the above, it is evident that care actions for comprehensive care and care coordination work by PHC largely deviate from the SUS principles when these care teams are obliged to produce excessive reports instead of promoting care and comprehensive care.

The dual burden of meeting the demands of the Judiciary and securing promotion, prevention, and treatment actions deteriorates the daily work conditions. Thus, the precariousness prevailing in the reality of health professionals working in the Brazilian Prison System[16,26] disadvantages health care for the population deprived of liberty. Consequently, the action of professionals is limited, the repressed demand increases, and the health situation of the population served deteriorates.

Professional qualification: between the distance from academic training and the prison working experience

In this case, besides the substandard employment relationship and the lack of material resources to preserve and offer some procedures, "few actions aimed at training, qualification and permanent education" of health professionals working in the prison system were in place, especially in prison psychosocial care. Notably, part of the team came from the hospital care model, and another part from the penal treatment context (social service and psychology), requiring all these workers to comply with the guidelines of municipal primary care to meet the health needs of a specific population fully, all this in a work environment (prison) structured by own rules and laws, foreign to those of health.

Paradoxically, the professionals reported not having received introductory training to work in PHC services in the prison system. The general guidelines were limited to safety issues in the workplace and, more specifically, to care in the relationship with the population served, provided by other professionals in the penitentiary or the local administration, which coincides with the findings of another research[27]. However, professionals from the nursing center had participated in the training and qualification to work

in the prevention, detection, and management of cases of infectious diseases (rapid tests for HIV, syphilis, and hepatitis B and C) offered by the Municipal Health Secretariat. Notwithstanding this, they felt the need for training spaces that addressed topics such as mental health, psychosocial care, and the rights of women deprived of liberty, which they believed should be equally favored.

It was a dilemma between the distance between academic training and the prison work experience. Moreover, the previous work experiences, differing in skills and health care resources in a prison environment, would justify the need for adequate training to work in this new setting. This finding is consistent with the results found in studies that address the issue of health work in the brazilian prison system[17,26,28,29].

Furthermore, professionals considered it extremely necessary to offer training spaces that could contribute to qualifying mental health care in the prison system and greater knowledge of the Psychosocial Care Network (RAPS). They believed this topic was not in the basket of priorities of the Municipal and Penitentiary Management, with a significant gap between what is regulated in the legislation and what can be done in that work environment. Bringing to the fore that any training process aimed at prison health workers in psychosocial care will only bring results if associated with changes in the prioritization of political and management agendas.

Isolated courses and training are insufficient. In this sense, actions aimed at professional training and qualification cannot depend primarily on the initiative of the very health workers. Self-organization capacity is insufficient, and the management's role is crucial to ensure this prerogative.

Like any health professional working in the SUS network, those who work in the prison system are covered in official training proposals[30]. The Ministry of Health and the State and Municipal Secretariats, in turn, are responsible for proposing technical mechanisms and organizational strategies for training and continuing education to develop the skills required for the work of health professionals in this occupational context, guided by the national guidelines and the workplace's reality.

In the absence of this work management prerogative, the professionals mentioned that daily strategies were created to adapt to the new occupational environment, while others that did not adapt to the context were changed to adjust to the situations. Feelings of not being valued, such as solitary work and powerlessness, were reported:

[...] when we started here, nobody showed us anything. We were groping and pushing on alone, without much training or experience in this reality. [...] I feel helpless sometimes because we do what we can with what we have (P1).

It is clear, therefore, that the more complex the work process and the less systematized it is, the more difficult it will be to reflect on it[31]. Creating spaces for teams to ponder and analyze their practices should be an integral part of their work. Therefore, PHC professionals in the SUS working in the prison system should develop skills and attitudes to reflect critically and transform their work process.

One of the possibilities to solve this issue would be the incentive by the prison system management, the SUS, and the Universities, to program actions or establish strategies for developing continuing education spaces targeting the health and safety professionals of prison units. Continuing Health Education, as an instrument of in-service training, should not be undervalued by managers and professionals. Otherwise, there is a risk that the right to health of people deprived of liberty will be confused only with the availability of a medical or hospital apparatus when the SUS and the PNAISP reiterate the need for work focused on health care equity and comprehensiveness.

Final considerations

This study showed that the substandard health work process in the prison system is directly related to complex structural and managerial factors in the field of health and the different purposes and demands of penal security health. This reality adversely affects the work of professionals in PHC aimed at the population deprived of liberty.

Outsourcing the occupational relationship of professionals brings a feeling of insecurity and uncertainty, given the lack of social protection for employees sharing the same work environment with different salaries and unequal rights, advantages, and duties. This context enhances occupational dissatisfaction and sometimes undermines interpersonal relationships and performance dynamics.

Professionals sometimes find themselves in a dilemma between the necessary care and what can be offered. Regarding qualification, we un-

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derscore managerial obstacles expressed in the lack of training spaces (qualification and training) and knowledge sharing (continuing education). We highlight the relevance and need for continuing health education, proposing actions sensitive to the daily work of these professionals and action strategies anchored in the PHC attributes, with its macro and micromanagement tools of the clinic, to change the institutional and health practices.

Besides this training process is the indispensable opening and establishment of penitentiary policies committed to health in the prison system, in the sense of providing the offer of internship vacancies specifically in the health area and as a practice setting for the medical and multidisciplinary residency programs. It could trigger a potential market for the inclusion of these professionals, making them closer to a field of work limited to the SUS and PHC, which still lacks human resources with a qualified profile to work in this context.

Health professionals play a significant role in defending citizenship, offering PHC in prisons, and influencing the development of policies aimed at this very vulnerable segment of the population, which, in turn, can lead to improving health work conditions and processes and, above all, effective prison services. Therefore, this research's contributions can supply theoretical and methodological information to professionals in this area who work in the Prison System, academics, and other segments interested in the topic. They can also contribute to informing and influencing managers and policymakers on the contextual issues affecting PHC work in the Prison System and, consequently, the health of the population deprived of liberty.

Collaborations

ALV Schultz participated in the paper's conception, writing, and analysis, and approved the final version to be published. RM Dotta and BS Stock participated in the paper's conception and writing, the relevant critical review of the intellectual content, and approved the final version to be published. MTG Dias participated in the paper's conception, the relevant critical review of the intellectual content, and approved the final version to be published.

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