



Power relations in workers' health care: a case study on the slaughterhouse and meat processing industry

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*Relações de poder na atenção à saúde do trabalhador formal:
o caso da indústria de abate e processamento de carnes*

Abstract

Introduction: production demands, as opposed to workers' needs, result in their health assistance becoming a conflict arena. Objective: to analyze the power games related to workers' sick leaves in the slaughterhouse and meat processing industry. *Method:* qualitative research with the participation of 17 workers and 14 healthcare professionals. Data collection through documentary research, semi-structured interviews and participant observation recorded in field notebook. *Results:* sick leaves certificates became the industry main control related to workers' health care. This control is exerted through restricting, refusing and reducing the number of medical sick leave certificates. On the other hand, workers try to secure the financial benefit generated by their sick leave because of the guarantee of material independence that is provided during their illness. *Conclusion:* sick leaves are central in power relations among workers, industry and healthcare professionals, resulting in significant impacts in the way health care is provided and for the implementation of workers' health policies in Brazil.

Keywords: sick leave; occupational health; slaughterhouse and meat processing industry; power relations.

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Introduction

Occupational Safety and Health (OSH) has made important progress over the last four decades in Brazil, including the introduction of new theoretical-methodological approaches that highlight the relationship between work and health-disease processes and the creation of a regulatory framework for the field of OSH. Despite these advances, a fundamental contradiction remains (which has existed since the first OSH actions in Brazil), defying the maintenance and expansion of the acquired rights. This contradiction refers to the health care developed in a scenario where growing production demands are in direct opposition to workers' needs.

Regarding formal workers' health care, this contradiction is even clearer, since it is developed within different institutional spheres, with different objectives and practices. These spheres comprise businesses (especially by their occupational safety and health service named Specialized Services in Safety Engineering and Occupational Medicine – SESMT), worker organizations (such as trade unions), private health insurance plans, and the State (through public health services)¹.

OSH actions in the aforementioned areas are permeated by issues such as: the right for injured and sick workers to remain in the State social protection (social security) system guaranteed for formal work; the roles of healthcare professionals, responsible for facilitating or restricting this stay through procedures such as emitting work exemption certificates; and the attempt by employers to avoid their liability for damages to the health of their employees and to maintain the workforce. In this context, workers' health care becomes an arena for disputes and conflicts involving different actors. This process is characterized by disputes based on individual positions and interests, a dynamic that can be defined as a basis for power relations.

Power games are understood as the integration and coordination of relationships among multiple forces, considering that the individuals upon whom the power is exercised are active and thereby allow a field of possible responses, reactions and inventions to be constructed². In this context, therapeutic practices (including the issue of sick leaves certificates) are a matter for dispute and conflict within these power games.

Therefore, this study contains reflections on power relations in the context of health care, specifically for those involved in the slaughterhouse and meat processing industry.

This industry has become one of great economic importance on a national level, as shown in the report from the Food and Agriculture Organization of the United Nations³, which highlights Brazil as the largest exporter of poultry in the world, responsible for one-third of global trade. Job creation is also a prominent factor, since the merger between two large companies in the sector (Sadia and Perdigão) resulted in the creation of one of the largest food companies in the world and the largest employer in Brazil, with over 100 thousand employees⁴.

Until 2008, the state of Santa Catarina was Brazil's leader in poultry production and export⁵. Chapecó (the city chosen to be the location for this research) is considered to be the Brazil's most important agroindustrial center in this economic sector⁵. Approximately 18% of the workforce in the city is employed in the slaughterhouse and meat processing industry⁶.

The sector is also widely recognized by its high sick leave rates, especially due to Repetitive Strain Injuries (RSI) and mental illness, as was observed in a study by Sardà et al.⁷ In addition, the results of the research that mapped out the profile of health issues affecting workers in Santa Catarina between 2005 and 2011, indicate that the number of absences due to health in the state is 48% greater than the national average, and that the slaughterhouse and meat processing industry is the economic sector with the highest sick leave rate⁸. This problem led to the establishment of the Brazilian labor regulatory standard NR 36⁹, which recognizes and proposes ways to control and eliminate various specific risks from this industry.

In view of the aforementioned difficulties, the objective of this research was to analyze the power games related to illness and sick leave within health attention for workers from the slaughterhouse and meat processing industry. In addition, we also aimed to understand how this process is comprised, what are its implications and how they overlap for the different actors involved to help deepen considerations on this subject and discussions on civil society actions and public policies in this field.

Method

Qualitative research based on a cross-sectional exploratory descriptive study, that took place in 2010 at a Primary Health Unit (PHU) located in the most populous region of Chapecó, Santa Catarina, Brazil, close to three major industrial facilities of slaughterhouse and meat processing.

Two groups participated: 17 workers from the slaughterhouse and meat processing industry and 14 healthcare professionals who work in the local public health network. The number of participants was defined based on the saturation criterion, according to Strauss and Corbin¹⁰.

The criteria for selecting the workers were “working on the production lines of any of the large slaughterhouse and meat processing companies in the region during the research” and “have reported health complaints related to their professional activity”. All the respondents made sporadic or continuous use of health services, depending on their problems, and were living in the jurisdiction of the primary health unit. These individuals – 13 women and 4 men – were identified and contacted with the assistance of teams from the Family Health Strategy program. Their ages ranged from 24 to 45 years. Regarding schooling, 7 workers had finished elementary school and 10 had finished high school. Another important aspect was that 13 were on sick leave and receiving sickness benefit during the research.

Regarding the group of healthcare professionals, the selection criterion was to be linked to services that stood out in terms of use by workers. The selection of these subjects began after three months of observing the participants and carrying out five interviews with workers who used the health service. The main services used by the workers were mapped according to the health problems featured. This group of interviewees was made up by: three individuals linked to the local Reference Center for Medical Specialties (Cresme) and six from the PHU.

As states Gonzales Rey¹¹, choosing participants for a qualitative research should include individuals who can significantly contribute to the objectives proposed by the study. So, to analyze the workers’ health frame in the region, other participants linked to important services were added to the group of healthcare professionals. These participants were able to provide unique and relevant information: one from the city’s Physiotherapy and Functional Health Service; two from the Reference Center for Occupational Health (Ceresst); one member of the Labor Victims Defense Association (ADVT); and one from the Brazilian National Social Security Institute (INSS).

The research techniques and tools used for the collection of information were participant observation recorded in a field notebook,

semi-structured interviews, and documentary research. According to Minayo¹², participant observation involves the active presence of the researcher, establishing dialogues and linkages and participating in the daily events of the subjects who are being observed.

The following activities were observed: weekly meetings of two family health teams; monthly meetings in the Primary Health Unit; home visits conducted by the community health agents; medical consultations; and welcoming activities held by academics involved in a project linked to the Pró-Saúde organization^c with users who had complaints regarding mental and occupational health. Participant observation lasted for one year at the PHU. It enabled us to visualize the referral flow of workers within the health network, contributing to understand the workers’ health demands that were being met, and how they were organized on the network.

The connection created from the interaction between the researchers and the healthcare professionals, enabled to establish dialogues that would not have been possible otherwise, and also facilitated access to the workers who were using the service.

The semi-structured interviews were individually carried out with workers and healthcare professionals. The interview with the first group was organized based on the following: identification; work context in the industry; work-related health problems; and workers’ health attention in the health network. Regarding healthcare professionals, the interview scripts were drafted taking the profession and type of service into consideration. The questions were organized based on the following items: identification; healthcare service operation regarding workers’ health; and agroindustrial workers’ health.

The focus of the documentary research was the medical records of the workers (available from the primary health service) and the materials submitted by them during their interviews. These medical records allowed us to access the workers’ health histories registered at the PHU, and of the specialty services. The analysis of these documents highlighted issues such as use frequency of the primary healthcare services, the health complaints, and the actions taken by the healthcare professionals when dealing with these complaints (such as prescription of medication, issue of sick leave

c Brazilian National Program of Professional Reorientation in Health, a partnership between the Brazilian Ministries of Health and Education, with cooperation from the Pan American Health Organization (PAHO). Its central objective is to integrate training for health professionals and the SUS network, with emphasis on primary health attention. On this occasion, the first author of this research worked as a lecturer in a project from this program¹³.

certificates, diagnoses, referrals for tests and to specialty services etc.).

It is worth mentioning that, during the interviews, the workers often presented other documents not included in their basic medical records, such as laboratory tests results, medication, medical certificates, diagnoses, work accident communications, referrals sickness, among others.

The organization and analysis of the information were based on grounded theory¹⁰, a methodology that allows the researcher to combine different sources of information in the analysis. Two of the categories that emerged during the study are addressed in this article and are the basis for constructing the “Results and Discussion” item. The first category is “industry control regarding sick leaves”, divided into four subcategories: restriction on the issue of sick leave certificates; influence of companies from the agroindustrial sector on health services to avoid absences; refusal or reduction of the period of sick leaves; and wage deductions in cases of sick leave. The second category is “the pursuit of workers for health certificates”, comprising: limitation of the work capacity due to sickness; risk of unemployment; low professional qualification; and strategies to deal with precarious working conditions.

This study was submitted and approved by the Research Ethics Committee of Universidade Federal de Santa Catarina (Protocol No. 473/12), in accordance with Resolution No. 196/1996 from the National Health Council¹⁴, in force when the research was conducted.

Results and discussion

Industry control regarding sick leaves

Absence from work is one of the therapeutic measures carried out to care for workers with health problems, to give them the opportunity to rest and to interrupt exposure to work risk factors, besides providing other therapies¹⁵. It is granted by the issue of medical certificates, regulated by the Law No. 605 from 1949¹⁶, which defines a medical certificate as being a proof of temporary incapacity to work, thus justifying sick leaves.

It is worth pointing out that, for workers who contribute to social security, according to the Brazilian Provisionary Measure 664¹⁷, sick leaves lasting more than 30 days give the right to the worker to receive a monetary benefit from the

Brazilian National Institute of Social Security (INSS)^d.

The results of this research indicate that the issue of medical certificates to allow sick leaves is a common practice, a result supported by previously highlighted studies and regulations, such as Sardà et al.⁷ The high rates of absence by issue of sick leave certificates in the food industry have great economic impact on this industry.

In this sense, studies such as the one by Cardoso et al.¹⁹ indicate that the increase in turnover and absence rates, to which health issues decisively contribute, have a direct relationship with the increase in the production cost. These factors help to delineate the thesis built with the results from this research, which establishes this therapeutic practice as a center of power relations among workers, healthcare professionals and the industry that has the last control over workers' health care. There are many forms of exercising this control, such as: to restrict the issue of medical certificates; to articulate with the companies from the agroindustrial sector and the health network for purposes of avoiding absences; to refuse or reduce the absence period taken by the health network; to deduct the time of absence from the wage.

Restriction on the emission of medical certificates

Restriction to the issue of sick leave certificates happens during consultations at SESMT units, which are mandatory services regulated by Regulatory Standard NR4²⁰. Regarding the companies involved in this study, such consultations are available with occupational health physicians. According to Mendes and Dias²¹, the health care carried out at the SESMT units is based on occupational medicine and health models with practices historically guided by the interests of the employers. This analysis is in line with the study by Vasconcellos and Pignati²², which concludes that occupational medicine does not meet the ethical and scientific postulates of medicine because it is a subservient management tool supporting the interests of the production process.

Restricting the issue of medical certificates was mentioned by 17 of the workers interviewed and is illustrated by one of them as follows:

My problem has been treated at the company for ten years. As far as I can remember, I had one certificate for five days and one for 8, but this was only because I could no longer walk or move my arm. The doctor only gave me enough time to rest my arm, because they

d This Provisionary Measure amended what was provided for by Decree-Law No. 3,048¹⁸, in force when this research was conducted, increasing the period of absence from work that gives the worker the right to sickness benefit from the Brazilian social security system from 15 to 30 days.

do not like to give sick leave certificates (Industrial worker 2).

Following the context of the speech by Industrial worker 2, other data from this study indicate that, among the factories involved, sick leave certificates are only issued as a last resort, i.e., when the workers' health condition prevents them from performing industrial activities and when all other solutions have already been exhausted, such as medications and physiotherapy. In this regard, we can highlight the Vasconcellos and Pignati's view²²: occupational medicine, in the context of factories, is limited to diagnosing the workers' work capacity, and the main action is often "returning the patient to the situation that originally caused the health problem".

Different from work accidents, occupational diseases, such as mental illnesses and RSI, the most common types of injury in this sector, do not have observable signs in the early stages, facilitating restrictions on sick leaves. According to Foucault²³, after the introduction of pathological anatomy in medicine, symptoms are crucial to the diagnosis and disease therapy. The "invisibility" of the signs and, consequently, of the damage to health, facilitates its denial and dissimulation in the SESMT context through medicalization by analgesics and anti-inflammatories, widely used for pain relief²⁴.

Influence of companies from the agroindustrial sector on health services to avoid absences

The results from this research indicate that the aforementioned practices of workers' health care are only possible because of a certain control exerted on healthcare professionals. To keep their positions, many healthcare workers need to act based on the occupational health parameters that serve as a biopolitical device to govern the work force. Thus, the statements made by the respondents suggest that the care received by workers at factories focuses on avoiding or reducing the time spent by workers away from their jobs to meet production demands rather than caring for their health, what was also pointed out by Lacaz²⁵. According to Merhy²⁶, as a result of this practice, the dimension of caregiving is lost and reduced to technical and instrumental procedures.

Corroborating the statements made by workers regarding the restriction of sick leave certificates, one health agent from the PHU referred to the difference in the conduct of a physician who works at a primary care unit and at an industrial SESMT:

We have a doctor who works here at the PHU during the day and at an agroindustry at night. So, there are many patients who receive care from him at both locations. They say that he is tougher when working there; he orders patients to get back to work even

when they are very ill. He obviously behaves this way because he is instructed to do so.

Physicians being fired from the industrial medical unit for not providing care for workers based on the company's best interests was repeatedly mentioned by the workers and healthcare professionals who participated in this study, which points to the lack of autonomy of these professionals in the industrial context. Therefore, the health care provided is clearly affected by conflicts of interest that impact on the health care received by the workers. In addition, the interviewees suggest that the healthcare professionals who remain in these positions at industry are those who subject to this control of their professional practice.

According to 12 of the interviewees, to ensure control in relation to the issue of sick leave certificates, the companies join specific private health services and restrict the access to orthopedists of these health insurance plans. It is worth noting that this medical specialty is more relevant due to the high prevalence of RSI in the sector.

The control happens because the physicians who work in the industry need to authorize employees to consult with orthopedic physicians from the insurance plan. So, the companies choose the physicians who can provide care for their employees. This fact is demonstrated by the statement made by industrial worker 12: "They do not want you to go to a specialist that you have chosen; they want to send you to the doctor of their choice; they have a list of two or three orthopedists and you can only consult with them".

The information provided by the workers is borne out by a judicial agreement applied to one of the companies: "Employees are guaranteed the freedom to choose and access the physician of their preference from those provided for by the health insurance"²⁷.

According to 4 workers, the orthopedists listed by the companies behave very similar to the physicians working at the industrial health units. The care provided by them is focused on medicine prescription, and on the issue of sick leave certificates is restricted.

It is worth noting that, through public health services, such as PHUs, the referral of these workers to orthopedic surgeons due to musculoskeletal pain, despite being common, involves a long wait that could take up to three years, according to the medical health records. This delay leads workers to look for the insurance healthcare professionals controlled by the companies.

However, we observed through the interviews and the medical records that the health care provided by the physicians of the public network is very similar to those carried out by company physicians and by the private insurance, i.e., commonly restricted to medicine prescription and physiotherapy referral. This indicates a centrality in health care assistance at the expense of health promotion, protection and monitoring that characterize the proposal of comprehensive health attention for the worker, as emphasized by Dias and Hoefel²⁸. To be effective in this health attention model, the intervention regarding the sickness-inducing work process is essential, also requiring intra- and inter-sectoral actions, which, in practice, occur in an isolated and discontinuous way.

Refusal or reduction of the period of sick leave

The refusal or reduction of the absence period is favored by Law No. 2,761²⁹ that provides for an order of preference that makes certificates issued from other health services subordinate to the evaluation of the occupational physician at the company – the exception are the INSS and an industrial or commercial social service^e. Therefore, any sick leave certificate that does not observe this hierarchical order does not require the company to remunerate the absence period.

As for the reduction of the period spent absent from work, one of the criteria that proved most important in this process is to prevent or delay the workers' access to the sickness benefit. In this sense, 15 of the workers interviewed in this research reported situations that they had the time of sick leave reduced to prevent their access to the Social Security benefit, a dynamic that was also recorded during the research conducted by Santos³⁰. This situation was illustrated by one industrial worker:

I had been suffering pain for four years when they decided to refer me to the orthopedist, the doctor then did an ultrasound of my arm and the problem showed up, but then the orthopedist said to me: "I cannot do anything, you have a problem, but it will never bother you; look, the situation is that the company needs you". Then I said that I could not live with the pain anymore, and he said "I will give you a pill, the doctor at the company will give you another one, I will give you a 10-day sick leave certificate, for you not having to go to the INSS [Social Security Institution]".

The granting and the continuity of the benefit is linked to the recognition of the labor incapacity by the INSS physicians. Thus, the Social Security

physician's evaluation is responsible for defining the worker's period of absence. When this happens, the company loses the control over the worker's period of absence, which may result in labor rights provided for by the Brazilian labor laws (CLT), such as stable work for a one-year period after the cessation of the sickness benefit, as provided for in Law No. 8,213/1991³¹. In addition, the granting of sickness benefit can also generate greater social visibility in relation to the health problems that affect these workers.

Regarding SUS, care of workers' health problems can happen at three levels (basic, medium and high complexity care) and at urgent and emergency services. However, basic/primary care is highlighted as a privileged space to implement workers' health attention, because it is a priority gateway to the health system and has a wide coverage, located where the workers live and work^{32,33}. It is worth noting that the 2006 Brazilian Health Pact proposed the rearrangement of the care attention model, setting Primary Care as a guiding axis of the different SUS networks for health care¹.

In this study, primary care was confirmed as the main gateway to the health network for workers of the food industry and the PHUs to deal with work-related health problems. Sick leave certificates often are issued at this level of care. In this sense, the statements made by the interviewees indicate that the main restriction of agroindustries is in relation to these certificates issued. Contributes to the demand for medical consultations at UBS, the gratuitousness of the service provided and the perception of workers on the independence of the health professionals of these units in relation to the agroindustrial sector companies, a fact verified during the observation of participants and in the statements made by the 13 workers interviewed.

Unlike private health services and occupational physicians linked to companies, at public health services the doctors have greater autonomy to provide sick leave certificates. However, the hierarchy imposed by Law No. 2,761²⁹ limits the certificates issued by these professionals. This point can be seen in a statement made by a physician from the PHU:

We allow the patient to stay off work, sometimes until the medication becomes effective and we know that the muscle needs rest. We sometimes grant a certificate to prevent the worker from having to retire from work due to disability. However, when the patient arrives at the industry, the medical on site give one or two days, or even say that no rest is necessary (Physician 2).

^e "Sickness must be proven by a medical certificate from a social security institution that the employee is affiliated, otherwise, successively, from a physician of the industrial or commercial social services, a company physician, a physician of a federal, state or local institution responsible for public health, or in the absence of these, any physician"²⁹.

Primary health care professionals point to the fact that the companies' refusal to accept medical certificates issued by the PHUs is based on their opinion that these certificates must be emitted by specialist physicians. In this sense, one PHU physician highlight the feeling of powerlessness in relation to the control of the industry sector regarding the health care actions carried out by the service: "I feel very frustrated because I want to help the person and I am stopped from doing so because I am not a specialist, [...] It is as if we were the secretaries who refer the patients to the real doctor" (Physician 2).

Considering the same idea, it was possible to observe that it is more difficult for the occupational physician of the industry to refute certificates issued by specialists such as orthopedists, neurologists and psychiatrists. Examining the cases of the interviewed workers, it was possible to note that all medical certificates that granted sick leave benefit were signed by physicians specialized in one of the aforementioned areas: 13 workers were absent from work during the research period and two had been absent before this time, which totals 15 workers who had been given sick leave certificates by specialists.

It was possible to come to this conclusion based on the workers' statements, as well as by using documents, such as medical certificates, that the respondents showed the researchers during the interviews. It is also worth mentioning, based on the diagnoses in the emitted medical certificates, that the route taken by workers through the healthcare network shows that those who frequently access a medical specialist already had a chronic problem, making easier the acceptance of these certificates by companies.

According to the analysis performed by Mendes³⁴, the trivialization of the actions carried out in the primary care services – represented by the certificates refused – is legitimized by the difficulties that permeate fragmented health care systems. This trivialization disregards the importance of this level of health care, as well as the guidance regarding the use of complex and varied health care technologies with the purpose of meeting the health needs of the population³⁵. Thus, there is an overvaluation of practices that require "hard technologies"²⁶ and are exercised in the secondary and tertiary levels of health care, such as care given by medical specialists.

Within the health care models that focus on "specialisms" (borrowing the expression used by Pasche and Passos³⁶), care is often given individually and isolatedly from other network services. Thus,

health care provided in this perspective contrasts with the notion of comprehensive care as proposed by the guidelines set out by SUS and reaffirmed by the Brazilian National Humanization Policy³⁷, which hinders key strategies of that policy in terms of workers' health care, such as the implementation of shared healthcare networks, which highlights the role of primary health care as the main gateway of access to the health system.

Based on the cases reported, despite meeting a significant part of the demand for health care coming from the agroindustry region, we observed public health services do not have the autonomy to define therapeutic actions that somehow interfere in these industrial contexts, as is true regarding industry-changing guidelines and absence from work. Thus, the health care of the formal workers carried out by public and private services have difficulty in following the principles and guidelines of public health that have the most significant advances in the Workers' Health field, something that is corroborated by Sato et al³⁸ and Costa et al³⁹.

Wage deductions in cases of sick leave

Another form of control used by industries is to reduce sick leaves through wage deductions – this was mentioned by 10 of the interviewees. Based on the descriptions given by the workers, if the health certificate is not authorized by the occupational physician from the industry, missing one day can represent a deduction of up to 12% from the average monthly salary for the sector. The following statement clarifies this idea:

If you miss one day, they do not pay you for that day, plus Saturday, and you also lose the food allowance, this is the case if you do not miss Friday, because if you do, you will also lose Sunday. [...] They do this simply to punish people, to them not getting a certificate. And if you miss more than five days in a year they also deduct from vacations (Industrial worker 1).

Many workers are also reluctant to request the payment related to the absence period to the Social Security because of the delay to receive it. The payment only occurs after a specialized medical report is carried out, which, according to workers interviewed, usually takes a long time. Depending on the impact that absence has on the workers' wages, many remain working even when sick/injured, leading to the sickness/injury to worsen.

Despite the different control strategies used by companies to reduce or prevent absence from work, it is also through this practice that workers create important methods to resist the precariousness of the sector, as discussed below.

The pursuit of workers for sick leave certificates

Formal work is a form of social affiliation, as it gives access to a system of legal guarantees leading to the individual no longer depending exclusively on his own, as affirmed by Castel⁴⁰. Therefore the recognition of an injury or disease and receiving sickness benefit guarantees certain autonomy to sick workers by preserving their financial independence. Social security acts as a form of social property⁴⁰ that prevents the breaking of belonging and societal bonds guaranteed by the employment.

The role this medical certificate assumes within health care results stimulates employees to pursuit it. This pursuit is related to occupational illnesses and the consequent reduced working capacity, the risk of unemployment due to illness, and the low professional qualification that limits the possibility to change activity. It is also a way to deal with the precariousness of working in this sector.

Limitation of work capacity due to sickness

The restriction of sick leave certificates by the industry has an important influence on the flow of workers through the health care network, and leads them to resist this control. Some workers are able to circumvent the control that restricts the medical consultation only to orthopedists by looking for neurologists paid by private health insurance plans, what do not requires company's authorization. This strategy emerges from conversations among workers that have the same health problem and have already been on sick leave, like four of the interviewees.

When workers seek medical specialists without the company's authorization, they may suffer reprisals from the occupational physician from the industry, who is responsible for authorizing (or not) the sick leave certificate, as can be seen in the following statement:

It took me five months to get an appointment with that neurologist. He gave me a sick leave certificate for three months. When I went to the SESMT, the doctor said "forget that neurologist, I will treat you", as if I were faking my condition. Then he prescribed me some medicine and asked me to back after a while. I never went back, I would rather work with the pain (Industrial worker 7).

This type of attitudes from SESMT occupational physicians inhibits workers from seeking care models that escape the companies' control.

The previous case differs from Industrial worker 12, who, at the time of the interview, had been off

work for one month. His musculoskeletal pain started three months before that, as he states:

The company's doctor referred me to their orthopedist who wanted to give me five days of sick leave. So, I told him "but you could give me a little more time, I am going to lose my food allowance anyway, give me a little more time so I can come back well", he seemed a little hesitant, but gave me ten days off work.

Knowing that orthopedists restrict the issue of sick leave certificates, workers create a strategy to circumvent the company's control devices. According to Industrial worker 12:

There are moments you have to agree for them doing things for you, but you are still doing it your way, because, if not, it is more difficult to negotiate with the company. Then, when you need it, they will not help you.

Without directly confronting the company or the doctor, the employee benefits from the physician's confusion regarding the absence period:

When my sick leave was about to end I came back to have my follow-up consultation with the orthopedist, so I said that I was still in great pain and that I needed a few more days. He complained that I should be better, but, in the end, he put a plaster cast on my arm and said he was only giving me seven more days so I would not have to sign on with the INSS. He did not realize that the combined time of the two sick leave certificates would give me fourteen days off work. When I took my certificate to the company doctor with my arm in a cast, he had no choice, he had to refer me to INSS.

By observing how this worker is treated by the health services, we can conclude that, by bending the regulations and making veiled confrontations, he can be normative and momentarily break the industry's control.

Taking the cases of the two workers as an example, it seems that often the less sick individuals^f are those who better resist the industry's control devices. In this sense, these workers are the ones who can best deal with the adversities of this environment and establish new regulations, as affirmed by Canguilhem⁴¹. Analysis of workers' route through the health network indicates that the sickest, precisely for being more vulnerable in terms of psychological suffering as a result of injury and fear of unemployment, have more difficulty in getting proper health care and cannot create ways to escape the control exercised by the industry.

Risk of unemployment

Occupational illnesses and their limitation in labor capacity are seen as inevitable in the future

^f Healthier if we consider the chronicity of the disease, as well as the simultaneous presence of different injuries, especially those in psychological distress associated with RSI.

by the workers from this sector. The interviewed workers reported repeatedly that sick individuals who leave the factories and do not receive social security benefit often end up unemployed and, therefore, without the assistance of the Social Security system. Thus, losing the work capacity characterizes a threat to maintaining the material life of the workers and their family, as it is illustrated by Industrial worker 2, who was absent from work while the research was being conducted:

When they allow me to come back, I do not know what is going to happen, because they are going to fire me. It is only a matter of getting past the work stability period and, after this, they will fire me. Many employees have returned to work and, in the same week, have been fired. They know that the employees will not be as productive as they were before. I will have to find a way to survive. After all, which company is going to hire me knowing the health problem I have? No company will accept me (Industrial worker 2).

Low professional qualification

Due to their low educational level and lack of professional qualification, these workers only see menial jobs as a possibility for their insertion into the job market. However, RSI becomes a limiting factor for this kind of activity. Thus, receiving the social security benefit is the safest way to guarantee these workers a livelihood, and return from sick leave is avoided by them. An official from the INSS states:

When most people come here with a story of disease, they already have the idea of retirement. This is their greatest dream. They do not understand that they only have a disability, and this does not mean they are totally invalid. However, due to the lack of perspective of these workers, including them in some kind of occupational rehabilitation is difficult.

Strategies to deal with precarious working conditions

Another aspect that stimulates workers to seek for the right to be absent from work is that the sick leave becomes a strategy to deal with the precarious nature of labor. Therefore, distancing themselves momentarily from the factory is a way that some find to stay out of work, even if temporarily. Thus, due to strict and hierarchized socio-occupational relationships, and the absence of means to workers' participation in the industrial context, many of them find through health services the way to deal with their work problems. Aspects seen as motivators for workers looking for sick leave certificates are also observed by a nurse from the PHU:

You would agree that there has to be something wrong with this job. If a person came here and could easily get a certificate... but he cannot. They often have to wait here all day to be attended, but it is better to be here than there, you know. And, even though, many

doctors do not give them a certificate. So, they wait here and lose a day at work [referring to salary].

Health services and medicalization become the formal workers' main option when faced with difficulties caused by work precariousness. This only becomes visible in the labor context if it assumes the characteristic of a health complaint recognized by the biomedical model.

Thus, assuming the sick role is a worker strategy to break the control held by the management, as pointed out by Brant and Minayo-Gomez⁴². Workers also appropriate themselves of the biomedical discourse when translating their difficulties into health problems that are amenable to curative-therapeutic interventions, highlighting physical pain. In this way, the subject reproduces the socially authorized discourse and finds ways, even if they are individual ones, to deal with the alienating forms of labor, which give suffering a further dimension to the current production mode.

A health complaint without any visible sign or recognizable injury often prevents a medical certificate to authorize absence from work. When the complexity that permeates this pursuit by the worker to be absent from work and the relationships of power and domination that constitute it are disregarded, this pursuit becomes a taboo issue within the healthcare services. According to a physician from the PHU:

As people complain a lot, we often end up ignoring it [their complaints]. Then, when people come here with a really serious complaint, we tend not to believe them at first. We have a little of this bias of thinking that the patient is lying, because we have to deal with this all the time.

Sick leave certificates as a way of attaining the sickness benefit is transformed into an important crossing in the relationship between the physician and the worker who uses the health care service. This can be illustrated by a statement made by a physician from Cresme:

The workers tend to benefit themselves from the system, making the most of their symptoms and boycotting their treatment to avoid having to go back to work because they have a secondary income. There is much clientelism of the user towards SUS.

In this context of disputes and multiple crossings that span the gap between health care attention and workers' health, healthcare professionals feel powerless and often disjointed in relation to what is understood as ideal health care. As a physician from Cresme said: "it actually works like this: I pretend to give care and the patients pretend to receive it. Today, if I had a different profession, I would quit medicine".

It is also possible to see the suffering that health care professionals are subjected, due to the way workers' health care is outlined. The physicians themselves become a target for the biopolitical devices of medicalization. Thus, this offset of the health professional is a result of the function that health care services assume as mediators of the relationship between the worker and the industry.

The analyzed situations indicate that, while among workers this procedure represents an attempt to escape from the difficulties of labor and of social vulnerability⁴⁰, for health professionals it represents a method of providing cure and re-establishing work capacity. Therefore, the medical certificate, as an instrument of control over the workforce, becomes the epicenter of health attention for formal workers.

The tension caused by the differing interests and multiple meanings of the medical certificate have a negative impact on the health care practices for formal workers, giving rise to feelings of distrust and revolt in the relationship between workers and health professionals. This tension obscures fundamental therapeutic strategies of health care, considering the orientation of the Brazilian National Humanization Policy, such as patient host, bonding and co-responsibility for the treatment³⁷.

The dynamics of the power relations regarding workers' health care, as the one that involves the issue of medical certificates, ultimately strengthens the predominance of the biomedical model in public and private health services. As stated by Batistella⁴³, the actions are aimed at the individual physical body and morphological, structural and organic changes that provide evidence for illness. Among the technical procedures used by the physicians, the highlighted items are the tests that complement the clinical examinations (such as X-ray and ultrasound), which occupy a prominent position in the care provided to workers from the agroindustry.

This form of intervention shows an overlap between the concepts of regulation and health⁴¹, meaning that there is a pursuit of empirical and measurable evidence that objectively reflects the illness and put away the subjectivity of the physicians in the health assessment. In other words, it is mainly the existence of sickness and injury that allows absence from work.

When the complementary examinations identify anatomophysiological changes in the worker's body, it can prove the existence of the health problem and

can give veracity to the reported pain and suffering. However, this does not guarantee that the causal link between the injury and the work is established. Assunção and Vilela⁴⁴ consider that diagnosis related to RSI/WMSDs^g is eminently clinical and, especially during their early stages, require sensitivity from the physician, who also needs to analyze the work activity.

The need to visualize the health problem along with complementary examinations often leads workers to long paths through the health network, where procedures are repeated until the injury is revealed. Meanwhile, the workers are put on a course of medication that worsens the occupational sickness, since they remain exposed to the occupational hazards. However, at a certain point, these procedures enable forms of resistance and contestations by the workers through the refusal to work. When these tests have positive results they also become important tools for workers regarding legal disputes with the employer and the INSS itself, to prove their work incapacity^h.

The need to "prove" the existence of a health problem often means that health care for workers is restricted to technical procedures, becoming an end in itself, as states Galimberti⁴⁶. The technique becomes an objectification of human intelligence, established as greater than the ability of the individual and turns into an expression of the "power over life" exerted by the industry through medical power.

Final considerations

Workers' health actions from the slaughterhouse and meat processing industry are part of a complex reality, which is traversed by multiple aspects such as the health conditions of this population, the economic interests of the companies, the regulations referring to formal work and the health sector, among others. The large number of sick leaves and their economic impacts on the agroindustrial sector make the issue of medical certificates the main control of workers' health attention. This occurs within the factories and within other services that provide healthcare for workers. In this context, the companies' SESMT units are important management devices to exercise this control.

The way workers' health attention is configured also generates great demand for medical consultations in the public and private health network, due to the centrality of procedures that

^g RSI/WMSDs refer to occupational injuries, as indicated by the Brazilian Ministry of Health Protocol⁴⁵.

^h It is possible to discuss how labor capacity assessment is carried out by the INSS, an institution that gives greater importance to the complementary tests rather than the workers' health. However, this discussion is outside the scope of this article and can be a matter for future research.

only these professionals can carry out, such as requesting complementary tests and emitting sick leave certificates. From this perspective, medical care that focuses on the physician and on the procedure is highlighted. This care model and its low resolutivity increases the flow of workers through the health services, thereby creating a vicious circle that is difficult to break, in addition to intensifying the power game among industry, health services and workers.

The possibility of obtaining the social security benefit by sick leaves is one of the resistance mechanisms available to agroindustrial workers in precarious working conditions. Thus, the set of benefits reached through formal work supports rights guaranteed by the social protection provided by the State. However, if on the one hand, the worker can somehow avoid precarious work in the interstices of the OSH regulations, on the other, this weakens workers' health care in public network. This is because healthcare professionals have difficulty to understand their role and also to create escape lines from the established power games. So, the principles and guidelines that drive worker's health actions, and that represent indisputable advances to the field, are jeopardized.

It is worth highlighting that the issues presented by this study indicate difficulties for implementing recent worker's healthcare policies^{35,47}, especially regarding formal workers' health. Therefore, it is our consensus that the

main barrier to improving workers' health in Brazil is the prioritization of economic growth over social policies, what creates contradictions that are difficult to overcome in this economic model, as mentioned by Costa et al³⁹.

It is important that these contradictions are recognized and discussed by the different players involved and interested in the new advances in the field of workers' health. It is also necessary that healthcare professionals working in the workers' health network recognize the dynamic that involves the process of being absent from work and what this means for the different subjects involved in the process. By doing this, it would be possible to map the limits and possibilities of the healthcare professional practices, as well as to plan actions in this field.

The results of this research can give rise to questions that can serve as object of future research, especially about the power games that involve worker's health and the impact of returning to work after the sick leave as well as rehabilitation. Another issue raised is the importance of analyzing how these power relations work in the field of OSH when referring to small organizations that do not have the same economic power as the companies analyzed in this article. Finally, studies that address the role of labor courts regarding workers' health care are also worth investigating.

Authors' Contribution

The authors contributed equally to the project and its design, to data collection, its analysis and interpretation, as well as to the writing of the manuscript.

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