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Worker's Health in Rio de Janeiro: A View of Dentistry

Caroline Gonzalez* and Sonia Groisman

Department of Pediatric and Preventive Dentistry, "Ss Cyril and Methodius" University, Skopje, Republic of Macedonia

***Corresponding author:** Caroline Gonzalez, Department of Pediatric and Preventive Dentistry, "Ss Cyril and Methodius" University, Skopje, Republic of Macedonia, E-mail: carolinegonzalez.ufrj@gmail.com

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Abstract

The present work aimed to carry out a literature review based on a database of Bireme, Lilacs and Official Documents of the Ministry of Health, since the emergence and evolution of the National Worker Health Policy and its interface with the industrial revolution, as well as its arrival in Brazil, intertwined with national policies. The access of Brazilians to oral health was extremely difficult and limited, but with the Smiling Brazil Policy and proof of systemic diseases caused by microorganisms in the oral cavity, the dental medical union favours the individual as a whole, to understand the complex multidimensional nature of health, its cultural, environmental and psychosocial influences, aiming to provide well-being to workers through better quality of life. There is a need for further studies to understand the gap between National Policies and their implementations.

Keywords: Collective health; Worker health; Dentistry

Introduction

The term Worker's Health refers to a field of knowledge that aims to understand the relationships between work and the worker's health/disease process, which is like a work tool that generates profits and services [1].

The organization of health care for workers emerged in the 18th century, in England, with the Industrial Revolution. Pressured by the economic losses, resulting from the high accident and illness rates are determined by the terrible conditions of life and work and also by the workers demands for changes, industrialists of the time started to hire doctors, assigning them the responsibility of taking care of the workers' health [2].

Baker, considered the father of occupational medicine, proclaimed in 1883 that his own doctor should be placed inside the factories to act as an intermediary between the businessman and his workers, where he would visit the factory, room by room, so that he could to check if any of the workers is suffering from the influence of preventable causes, it will be up to him to do such prevention.

In the first half of the 20th century, changes in production processes stemming from the two major world wars and post-war reconstruction efforts. Workers' health started to have a multidisciplinary action and expanding the focus of health actions creating the practice of Occupational Health, addressing the legal, hygiene, ergonomics and work safety aspects and improvements in quality of life. In Brazil, the history of workers' health intertwined with national health policies begins, in fact, in the First Republic with the appearance of Oswaldo Cruz. Through his, the health issue became a political issue [3].

Another milestone was the Eloy Chaves Law, which, in addition to social security, granted medical assistance and medicines to the "Insured" [4]. The organization of health services in Brazil before SUS (Unified Health System) lived in separate worlds: on the one hand, actions aimed at prevention, the environment and the community, known as public health; on the other, workers' health, inserted in the Ministry of Labor; and, still, curative and individual actions, integrating social security medicine and liberal, philanthropic and, progressively, business care modalities [5]. The objective of the present work was to propose a critical thinking about health policies in the country describing the RENAST and CEREST to assist workers in the state of Rio de Janeiro, based on a literature review on occupational health in Brazil.

Methodology

The present work is a review of critical literature using the Bireme, Lilás, Ministry of Health and PUBMED database to select scientific articles, books and legal files related to public health social policies. Approaching policies through the models of health and disease are influenced since its creation until the present moment whose performance is based on Public Health in Brazil.

Literature Review

In Brazil from the turn of the 19th to the 20th century, the concern with health was linked to the economic interests of the elites in keeping the worker healthy to maintain production, especially in the agrarian context of the time. With the abolition slavery in 1888, the process of substituting slave labor for salaried workers of European origin was consolidated. Since epidemics continued to kill this scarce population, reducing the number of people willing to come for Brazil, the government of the time was obliged to adopt some measures to improve this situation. Creating and implementing public health services and programs at the national (central) level. At the head of the General Directorate of Public Health, Oswaldo Cruz progressively implemented public hygiene and health policies in Brazil. In parallel, it adopted the 'health campaigns' model, designed to combat urban epidemics and, later, rural endemic diseases. In 1923, the Eloy Chaves law was enacted, a milestone in the beginning of Social Security in Brazil. In the period between 1923 and 1930 the Caps appeared (Retirement and Pensions Funds).

In the Vargas era, the Ministry of Health favored health actions, based on the American model, favoring workers, since they were an

important factor of productivity; development and economic investment. At this time INAMPS (National Institute of Medical Assistance for Social Security) was created to provide medical assistance to those who contributed to social security and self-employed, however, most of the assistance was provided by the private sector, with which they established agreements providing for remuneration per procedure, consolidating the logic of caring only for the disease and not for health promotion, as was already the case in England and other countries.

With the mass movements originating in the mid-1970s and during the 1980s, which led the country to democratization, the Sanitary Reform movement emerged, which proposed a new conception of public health. The universal right to health was achieved through the 1988 National Constitution, which states that health becomes a duty of the State and the competence of the Unified Health System.

Unified Health System; Article Art.196 of the Brazilian Constitution describes that: Health is the right of all and the duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other diseases and universal and equal access to actions and services for its promotion, protection and recovery. From the publication of the constitution, the country legally assumes responsibility to society regarding the health of Brazilian citizens, initiating a new era in Brazilian public health, where health is recognized , as a social right, inherent to each and every citizen [6].

The Organic Health Law (No. 8,080/90) regulated, and implemented, the Unified Health System (UHS) in Brazil. The definition of competences and attributions for each governmental sphere sought to make the implementation and execution of UHS viable, facilitating the functioning of this new public health guideline. Through this Organic Law and the 1988 Constitution, it is the duty of the State to formulate, develop, implement, and evaluate economic and social policies aimed at reducing the risks of diseases and other diseases, creating conditions that ensure universal and equal access to actions from health to services for their promotion, protection and recovery. Within this quote from Article 2 of the Organic Law, the concept of health and the provision of services by governmental spheres are diversified and broadened, such as: health surveillance, epidemiological surveillance, health of the worker; comprehensive therapeutic assistance, including pharmaceutical. Thus, inserting worker health is one of the fields of action of UHS [7].

Discussion

With the work process increasingly fragmented, specialized, it requires, besides qualification, a series of personal factors demanded of the worker, which generate tension; fatigue; anxiety and somatic diseases, usually occurring in work environments with high psychological demands on the part of the entrepreneur and low decision-making power by the worker. The charge for leadership attitudes and behaviors; of efficiency and effectiveness, it can generate signs and symptoms of insecurity, frustration and even introspection, or in more severe cases of a psychosomatic pathology, which ends up harming the worker's potential to contribute to the company's growth.

For Paim care models are technological combinations structured to face individual and collective health problems in certain spaces destined for this purpose for the population. For the author, one cannot speak of a RENAST care model, since this is the SUS care model itself, organized according to Universality access standards and principles; integrality of care with equity and social control in a given territory, privileging the strategy of Primary Health Care and the focus on Health Promotion.

Workers have always been users of the health system, however not all Family Health Clinics work at reasonable hours for workers. RENAST's proposal is to qualify this attention, making the system, as a whole, enabling workers' health. These actions have been constituted, over the last 30 years, in a policy that is against the predominance of the developmental and financial logic. CERESTS (Reference Centers in Occupational Health) are responsible for direct surveillance actions, of a complementary or supplementary nature for situations in which the Municipality does not have technical and operational conditions, or for those defined as of greater complexity. The current public policy of Occupational Health in the dental field still contains incipient actions, not observing the presence of the dentist in his Health and Safety team and, therefore, not addressing the principle of integrality.

Toothache is the third place among the causes of absence from work, second only to stomach pain and headache. The health policy in Occupational Dentistry is new and begins with the recognition of the specialty by the Federal Council of Dentistry in 2002 and its inclusion in the Occupation Code of the Brazilian Ministry of Labor, where it is transcribed that maintaining good dental health enables good results and greater productivity on the part of the workers, acting based on the 1988 constitution, in obedience to the principle of integration proposed by SUS, in a multiprofessional way, and it fills the gap of SUS, in relation to the workers regarding the Occupational Health Policy.

Conclusion

Toothache is the third major cause of absenteeism at work, as well as the interconnection of oral and general diseases, justified the creation of RENAST and CEREST, however there is no attention registered with Occupational Dentistry itself. It would be necessary to conduct a practical experience survey within CERESTs to detail the services provided in the area of Dentistry, since the same area is not explained in the scope of services offered. Urging a need for pressure by the organs of the dental class, educational institutions and Associations representing Dentistry to comply with the law, offering the job market to the oral health team, as well as complying with the constitution are offering comprehensive health to the worker.

Conflicts of Interest

The authors declare no conflict of interest.

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