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Return-to-Work challenges from workers' perspective after work-related sick leave

Desafios do Retorno ao Trabalho na perspectiva dos trabalhadores após afastamento por agravos do trabalho

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ABSTRACT Return to Work (RTW) involves several social stakeholders to build collective and integrated strategies based on shared objectives that facilitate employees' reintegration and retention at work. This process must consider the biopsychosocial aspects of workers and workplace conditions. This qualitative research aimed to identify RTW challenges from workers' perspectives after work-related sick leave. We interviewed eight workers who were victims of occupational diseases or accidents and were treated by a Brazilian Public Occupational Health Service. We analyzed the statements considering theoretical and methodological approaches of RTW, Psychodynamics of Work, and Discourse Analysis. The results showed that RTW persists as a problematic experience and workers do not receive adequate support from stakeholders. Services are unprepared and incipient in case management, emerging and escalating negative feelings throughout the RTW process. We believe that Public Occupational Health Services should lead the RTW process with the involvement of stakeholders and focus on disease-affected workers' needs.

KEYWORDS Occupational health. Return to Work. Accidents, occupational. Occupational diseases.

RESUMO *O Retorno ao Trabalho (RT) envolve diversos atores sociais na construção de estratégias baseadas em objetivos comuns que facilitam a reintegração e manutenção dos trabalhadores no trabalho. Este processo deve considerar os aspectos biopsicossociais dos trabalhadores, bem como as condições do local de trabalho. Buscou-se identificar os desafios do RT na perspectiva dos trabalhadores após afastamento por agravos do trabalho. Trata-se de uma pesquisa qualitativa. Foram entrevistados oito trabalhadores vítimas de doenças ou acidentes ocupacionais atendidos por um Centro de Referência em Saúde do Trabalhador. Os discursos foram analisados considerando abordagens teórico-metodológicas do RT, da Psicodinâmica do Trabalho e da Análise do Discurso. Os resultados mostraram que o RT continua a ser uma experiência difícil e os trabalhadores não recebem apoio eficaz dos diferentes atores sociais; há despreparo e incipiência dos serviços na gestão dos casos, surgindo e intensificando sentimentos negativos ao longo do processo de RT. Acredita-se que os Centros de Referência em Saúde do Trabalhador devem liderar o processo de RT com o envolvimento dos atores sociais e centrar-se nas necessidades dos trabalhadores vítimas de agravos do trabalho.*

PALAVRAS-CHAVE *Saúde do trabalhador. Retorno ao Trabalho. Acidentes de trabalho. Doenças profissionais.*

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Introduction

Work is a relevant determinant of health. It can positively affect workers and provide social status, personal development, social relationships, and improved self-esteem, household income, and economic aspects[1]. Moreover, work is not an external environment but something internal that triggers satisfaction and recognition[2]. On the other hand, work can also cause distress and alienation, forcing workers to struggle to protect themselves from the impositions of labor organization[3] and the accident and disease risks.

Over the years, workers' distress has increased due to substandard working conditions from poor public policies that accentuated control over work-related social movements, particularly the unions[4].

Workplace organization imposes rules for conducting work that affects workers' health and elevates work absenteeism[5,6], escalating individual distress. On this matter, the International Labor Organization (ILO) estimates approximately 2.78 million annual deaths due to work-related injuries, 2.4 million of which refer to illnesses, besides 374 million non-fatal work accidents[7].

The Brazilian National Social Security Institute (INSS) is a governmental insurance/compensation system for regular jobs, paid by employees and employers, which includes employees hired by the Consolidated Labor Laws (CLT), domestic workers, self-employed, and independent workers. The INSS grants benefits for work disability from the 16th day of sick leave conditioned to a physician medical examination report[8]. Notably, informal work represents almost 50% of the Brazilian workforce, and any compensation system does not cover workers in this condition. However, they can access and receive assistance from the Brazilian Unified Health System (SUS) – a universal public system.

SUS financial support is essential for funding public health actions and services, leading to improvements in people's quality of life and health indicators, especially for the low-income population in the several healthcare lines[9], which include workers' care. The SUS offers universal access to all healthcare services, regardless of employment condition, which includes the Public Occupational Health Services – POHS (Centro de Referência em Saúde do Trabalhador – Cerest), a strategy to ensure workplace and workers' health promotion. Some 215[10] POHS are spread across Brazil, and each has a multi-professional team that works together in prevention and the promotion of occupational health through inspections in work environments, workers' assistance, and technical support to Primary Healthcare (PHC).

To ensure the success of Return to Work (RTW), rehabilitation of work-related injuries or illnesses must address workers' physical and psychological aspects by a multidisciplinary team, considering their skills to adapt to work[11]. Different stakeholders' collaboration and commitment are needed to reestablish workers' biopsychosocial health and capacities and then provide workplace accommodations and support to enable their reintegration.

Stakeholders and workers must interact through a multi and transdisciplinary action to identify the factors influencing RTW and design strategies based on different contexts[12]. This process is based on communication, negotiation, and personal perspectives to reach decisions that address workers' and employers' needs[13]. Strategies must focus on workers' active participation considering the new health conditions, professional requirements, the workplace[14], and perceived self-efficacy[15].

A literature review pointed out that interventions with positive results for RTW included several components, including health, service management, and workplace accommodations, considering individual and social factors. Multifactorial and multidisciplinary interventions reflect in the final results and decrease time away from work and expenses with disabilities[16]. Meanwhile, in Brazil, interventions for RTW that can include different

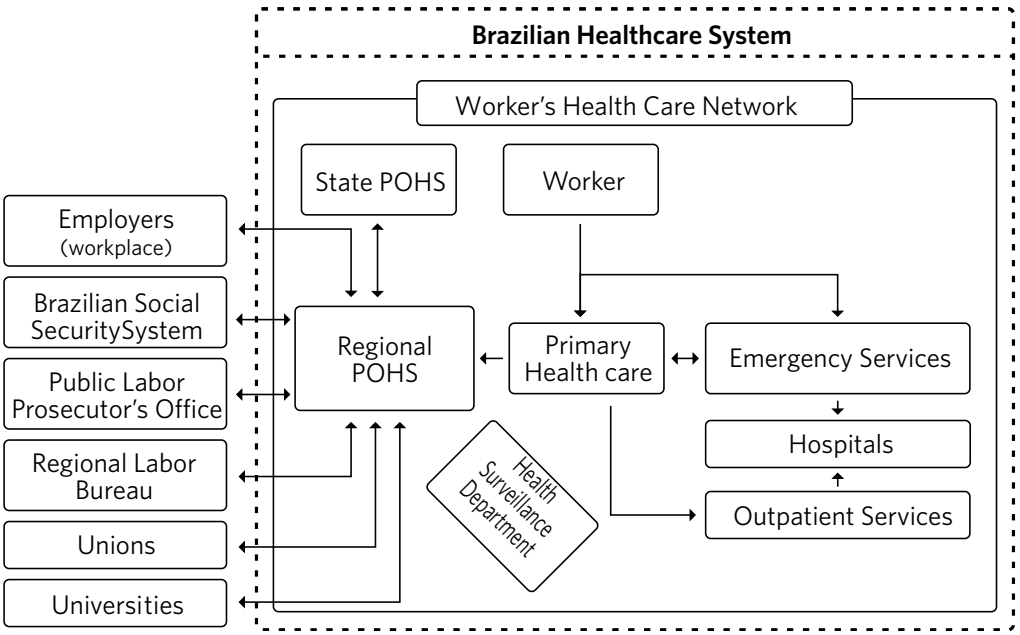
stakeholders and workers' biopsychosocial aspects are still embryonic, such as a few examples implemented by some POHS[17-19].

Considering the above, this study aimed to identify RTW challenges from workers' perspectives after work-related sick leave.

Material and methods

This qualitative and descriptive-exploratory study was based on the French Discourse Analysis (DA), which identifies the senses and meanings of situations experienced by individuals[20]. It was conducted in a regional POHS in the countryside of the state of Sao Paulo, Brazil. This service relies on a multiprofessional team involving nurses, doctors, social workers, physiotherapists, psychologists, engineers, occupational safety technicians, administrative assistants, cleaning assistants, drivers, and occupational health surveillance inspectors. POHS communication with different stakeholders can be seen in *figure 1*.

Figure 1. POHS communication with Brazilian different stakeholders



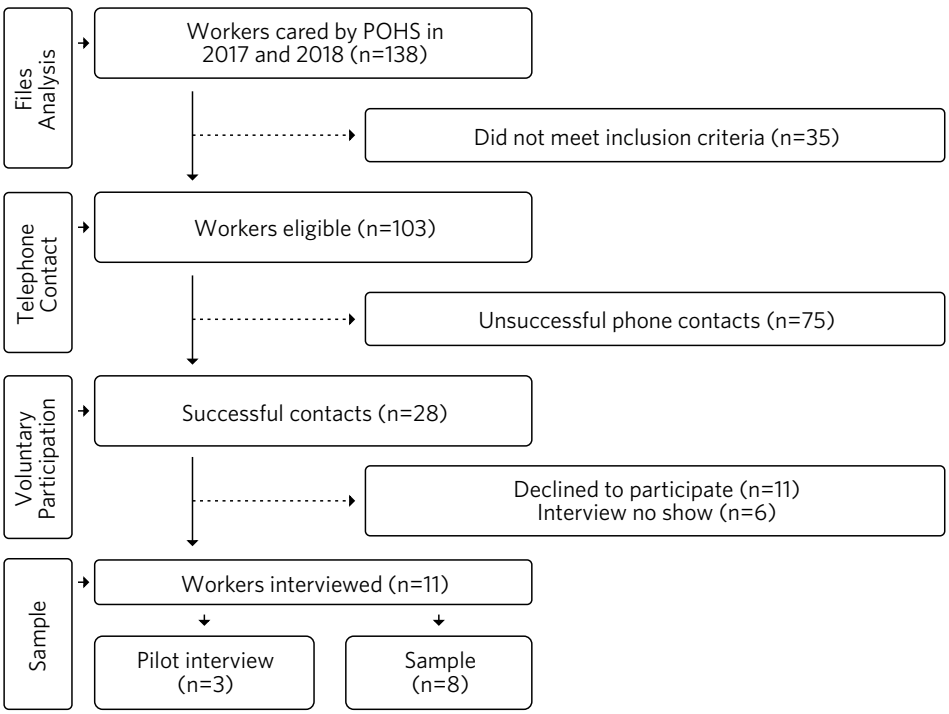
Source: Created by the authors (2023).

Inclusion criteria were to be a worker of legal age who had been away from work for at least fifteen days due to work-related injuries or illnesses, who had been assisted by POHS in 2017 and 2018, and who had already returned to work at the time of contact. Despite recognizing the differences between the nature of work-related injuries and illnesses, we opted to include the different situations that motivated work leave once the object of investigation is RTW and the role of POHS in this process, regardless of the factor that triggered the leave.

We collected data in two stages; first, we analyzed 2017 and 2018 files from POHS to identify workers meeting the inclusion criteria. Then, we performed face-to-face semi-structured individual interviews following a pre-conceived roadmap with characterization data and six questions

regarding RTW experience. Three pilot interviews were conducted to validate the roadmap, and they did not compose the sample. *Figure 2* shows a flowchart of data collection procedures.

Figure 2. Sampling design for data collection



Source: Created by the authors (2023).

All interviews were held in a private room and were audio and video recorded, an indispensable strategy for the theoretical and methodological framework adopted in the study, which considers verbal and non-verbal discourses. Data were analyzed based on the French DA, evolving to three-stage analysis without pre-established interpretation: desuperficialization was used for the passage from the linguistic surface (stage 1: text) to the discursive object (stage 2: discursive formation), and interpretation gestures were included for reaching the discursive process (stage 3: ideological formation)[21].

We aimed to achieve the senses and meanings in each worker's statement. Therefore, it was necessary to understand concepts pointed out in DA as a production condition, which refers to circumstances in which discourses are produced; corpus, which includes material for analysis, selecting discursive fragments; forgetting n.1 related to enunciation, an unconscious and ideological process in which subjects have the illusion of being the origin of their statement; forgetting n.2 linked to subjectivity, in which subjects select the words and discursive sequences from others to use in their statement; and metaphor and metaphorical effect, which represents a slip in the discourse, referring to some discursive formation, promoting a change of meaning[21].

This research was approved by the Research Ethical Committee of the Federal University of Sao Carlos, Brazil, under the Certificate of Presentation for Ethical Appreciation Nº 08627819.6.0000.5504 and approval Nº 3.291.225. All participants signed the consent form for participation. All ethical human research principles, as outlined in the Resolutions of the National Health Council (CNS) Nº 466[22], dated December 12, 2012, and Nº 510[23], dated April 7, 2016, were respected.

Results

We interviewed eight participants, five men and three women aged between 26-66 years, working in these professions: clerk, production assistant, smelter, logistics assistant, engine rectifier, cleaning assistant, driver, and nursing technician. Concerning education level, four did not complete elementary education, three completed high school/vocational training, and one completed higher education.

Sick leave occurred from 2014 to 2018, with a minimum duration of one month and a maximum of two years. Five of them left due to work-related illnesses (spondylolisthesis, painful shoulder syndrome, adaptation disorder, low back pain, and tendinopathy in the right shoulder), and three due to work-related injuries (falling at the same level, falling to a lower level, and fracture of the left ankle due to a motorcycle accident). At that time, all workers received compensation from INSS, but only five reported that their conditions were recognized as work-related.

All workers reported returning to the same employer after rehabilitation. However, two returned to different activities. Most workers had their work positions changed after a specific RTW time. At the interview, two workers were unemployed, two retired (but they did informal side jobs to supplement their income), and four were employed – only two in formal employment; the other two became Uber driver and painter. Moreover, all workers reported health impairment resulting from the injury that triggered their work leave; however, only six did rehabilitation at the POHS.

Through DA, we found that all respondents assumed predominantly the discursive formation of workers in a subordinate relationship, resulting from hierarchical power relationships in their work experiences. As a result of de-superficialization, workers were characterized as hired workers with formal jobs and pre-established working hours without holding higher or hierarchical positions in the companies.

Concerning non-verbal discourse, some workers showed anxiety during the interview; some more intensely expressed by holding and shaking hands, hitting keys on the chair, and having difficulty finding words to explain how they felt. Sometimes they laughed ironically and sarcastically, paused throughout statements, expressed pain, showed indignation, breathed deeply, emphasized some words, and simply gazed. However, some statements were clear and objective, with expressions of satisfaction and joy when discussing work, implying its meaning. These behaviors expressed in non-verbal discourse show work's marks on workers and the RTW experience.

Workers' statements were separated into discursive fragments (*corpus*) and were shown in *tables 1 to 3*. To protect their identities, they received the letter 'W' referring to the first letter of 'Worker' followed by a cardinal number. Each table contains a segment corresponding to the guiding question and some discursive fragments that define that segment. *Table 1* presents the RTW process corpus as per the participants.

Table 1. Discursive fragments about the RTW process

"Ah! It was very smooth, I started coming back little by little, I went back to the same job and in the same position, but I went back slowly, you know?! [...] I did the same thing but not in the same place [...] I worked with people I used to work before, so I got back much more slowly, without intense demand... that's it". W.1 (anxious behavior, squeezing fingers on legs).
"[silence] no, for me it was normal... I came back normally as if nothing had happened [...] I didn't show that I was suffering [...] my work there is [...] it was a lot for one person, but I was there, steady and strong, you know?! We need to work, we depend on it, you know... you have to do it... [laughs] It is not a job you say 'wow' but it is your job... you must do everything there yourself". W.3 (anxious behavior).
"*At first, it was a little hard, I had a hard time to get back to my activities, because the pain still bothered me a little so much [...] so, I did not stay long in the company afterward, I was no longer able to develop my work as before, understand?!".* W.4 (anxious behavior).
"Ah it was difficult, right, because the INSS [National Social Security Institute] discharged me without me being properly able to go back to work... I suffered a lot [...] if you went to court, sometimes you won, sometimes you didn't; so that you lost time and you didn't receive any compensation from the employer [...] you were obliged to sacrifice yourself [...] the INSS is complicated... sometimes you have a medical certificate proving everything [...] and sometimes doctors don't consider it, I don't know why". W.5 (objective speech, suggesting indignation).
"Look, the process was very hard, because I stayed... how long it took... [company] didn't have a place yet to place me [...] I mean... I wanted to go back to work, but they didn't have a place to place me yet, right, so I was waiting at home [...] so, this is a concern when we come back from leave for rehabilitation, it was kind of complicated, I had to fight [laughs irony]". W.8 (looks up, contemplative, seeming to look for words to explain).

Source: Prepared by the authors.

RTW was considered a complicated process, and workers highlighted the challenge of performing activities with a newly impaired condition, facing the lack of assistance and disregard of stakeholders such as the INSS and employers. Even when workers shared positive experiences (as cited by W.1), in a slip in the discourse, we can see him mentioning that the workplace still requires adjustment. W.3 mentioned obligations and overload imposed by the workplace and the need to remain strong and look perfectly able to perform job tasks; distress is aggravated when workers do not feel capable of carrying out a task, as pointed out by W.4. *Table 2* shows the workers' feelings during the RTW.

Table 2. Discursive fragments about the workers' feelings during the RTW

"*Ah, I felt a little insecure at first with the movement... and not being able to go back to work, but then I felt confident and it was smooth, I had no issues".* W.1 (objective speech).
"Look, I felt humiliated [...] before I had the accident, my superior and everyone used to talk to me, and when I returned they started chit-chatting about me in the corner [...] looking at me from head to toe". W.2 (responds quickly and directly).
"[...]it is as if you already feel like a person who has not already fit, being no longer useful [...] it interferes a lot with the psychological [...] people charge you [...] they will not assess in-depth if you are really able to do that again [...] in fact, they [employers] want results, they want a performance from you [...] then you feel like... it's not right like this, but kind of invalid because... you want to do it, but you can't do it anymore... and people look at you with that kind of demand, you know? They think 'he is dragging his feet about work', get it?!" W.4 (anxious behavior, keeps rolling paper with hands).
"*Ah, a feeling of revolt... [facial expression of lamentation] because you have no right attendance... because there is all evidence proving that you had an accident, injury, and all. I went through medical examination [...] and you have to work and sometimes with pain".* W.5
"*Look... [slight smile of irony] summing up... like a trash, nothing, dog without owner [...] I felt like crap myself, a human beggar, a parasite. I was totally dependent on everyone. Today I am still dependent, but at least I can walk; I lie down on the days I have pain [...] so I didn't fall because I wanted to, I didn't throw myself... it was an accident, and the company I work for did not provide any assistance [...] so I was nothing more than a crumpled paper to be thrown in the trash. And today I was left out".* W.6

Source: Prepared by the authors.

Workers pointed out negative feelings about the RTW process, such as humiliation, revolt (indicated by W.2 and W.5), and profound distress manifested by guilt, uselessness, and incompatibility with productivity and multifunctionality expected by the labor market (as said by W.4 and W.6). Workers' distress deteriorates due to sustained need to prove the (dis)ability and their new health conditions (as stated by W.5). W.6 expressed through a metaphorical effect that he feels like 'dog without his owner', 'trash', 'parasite', i.e., helpless by all, fighting for their recognition and acceptance. *Table 3* shows additional RTW considerations made by the participants.

Table 3. Discursive fragments about the additional RTW considerations

"It was not respected [referring to the medical letter for job accommodation]. I was in the same role, they just made me change machines, my machine was an average machine, he [employer] put me to work with a bigger machine [ironic laughs]". W.2
"We always wait, because you give yourself so much to someone or a company and then you think it was not what you thought it was. So it's just a matter of employers looking a little more closely at employees [...] you cannot treat a human being as if he or she were a machine, an instrument you put there, click on the button and go... you end up carrying out your task until you feel burned out but it's not like that, get it?! It's a life and a life is priceless". W.4 (anxious behavior).
"The INSS does not provide rehabilitation, the person goes back to work even worse, then the person has to be absent again... there is no validity, the treatment does not coincide with the date, it seems that the insurer and healthcare systems do not speak the same language. There must be a follow-up by both with the right treatment and person". W.5.
"[...]everywhere I go, this work is not done with employees. For instance, when an employee is having a problem, they keep replacing... they do not assess why it is happening, what is happening [...] and the big problem I see is the poorly prepared leadership". W.8 (objective speech).

Source: Prepared by the authors.

At the end of each interview, we provided workers with the opportunity to make their final considerations. All of them reinforced the invisibility of the working class associated with its historical disrespect, mostly with punitive measures (as experienced by W.2). Historically, workers have been marked by exploitation, lack of trust, and hierarchical imposition, suffering punishments from different areas.

Discussion

In many situations, workers hide their distress in a defensive strategy to circumvent it[3] and for fear of supervisors' and peers' retaliation and stigmatization. On the other hand, many workers leave the company because they can not meet the job demands. Workers experience hardships and feelings of embarrassment due to fear of judgment and labeling by peers, caused by employers' unpreparedness to offer a compatible job with the new condition[24].

Beyond physical impairment and distress, workers also faced the limitation of healthcare services and professionals in handling cases. They needed to present evidence that proves their disability in several situations. However, not always employers and supervisors recognized it, so they had to submit to tasks unsuited for their abilities, as experienced by W.5. Lack of communication about worker disabilities also happened between health providers and the compensation system. Sometimes, workers are judged as pretending their situation by doctors, who deny the link of injury or illness with work, suggesting a "disqualification of the social recognition of illness due to work"[25(9)].

The new health conditions of workers on RTW are often invisible to employers, who, therefore, do not offer possibilities of accommodations or work position changes. Workers must fight to be respected in their needs and reach appropriate readaptation (as said by W.8), which is not always possible due to the unbalanced power between them and the employers. Practicing a collaborative model aimed at disability management involving different stakeholders, including the worker, has a satisfactory impact on RTW[26], resulting in environments modified per the workers' needs and health conditions. Invisibility is found in many musculoskeletal or mental disabilities. If, on the one hand, the pathology itself carries this trait, on the other, peers and supervisors also tend to struggle in recognizing the issue. In this aspect, peers and supervisors should not be blamed, as they are frequently unaware of the disease's nature and evolution and they reflect the organizational culture.

Workers' invisibility can be explained by contradictions in the country's worker health development models. Although advances have been made in those models, the social determination of the health-disease process is still secondary, keeping actions focused on instruments and standards limited to the workplace[27].

Brazilian public health policies consider work a determinant of health, and SUS must provide unrestricted services and actions aimed at all workers. In this sense, the Health Care Network (RAS) plays an important role in identifying and monitoring the impacts of work-related distress on the population's health through its relationship with society and holistic view of healthcare. It also promotes occupational health, strengthening such policies and workers' rights[28].

However, a study pointed out that the RAS actions in this area are unstructured and fragmented despite occupational health having a considerable legal framework. Gaps are identified as the lack of recognition of work-related injuries through the SUS entry points, fragmented care actions, lack of knowledge regarding the surveillance of working bodies in occupational health, conducting actions with a curative rather than preventive nature, and the lack of the worker's leadership[29], point to challenges in implementing networking and, consequently, comprehensive health care[30].

Even so, the SUS stands out as an important stakeholder in the RTW process, where the worker seeks healthcare, disease diagnosis, and its connection with labor, treatment, rehabilitation, and guidance. The POHS acts and provides technical support to all SUS services in the aforementioned occupational health actions.

The SUS role does not exempt workers from seeking proof of the connection between their illness and work through examinations, expert opinions, or the registration of occupational accident communication, which, even so, may lead to non-recognition by the INSS[31].

At the INSS, the challenges faced by the workers in the RTW process are enhanced due to the resumed assessment based on the biomedical model for admission to rehabilitation and subsequent RTW, which cancels the assessment by the multi-professional team and emphasizes the physical aspect to be admitted to such program[32].

Social relationships in the workplace were adversely modified after reintegration and made workers feel excluded and victims of prejudice and stigma, which also happened in other places, such as the compensation system, showing the exclusion of workers if there is no proof of their disability. The participants affirmed that they are neglected and ignored even when workers have some evidence. A study suggests that compensation systems should use a framework to recognize the relationship between injuries or illnesses and work because, in some cases, medical experts' distrust of workers' psychosocial aspects generates anger, humiliation, embarrassment, and impotence[31].

In this context, the workers' experiences emerged in verbal and non-verbal discourses,

bringing impacts of the disarticulation of stakeholders and the approaches, with stances that may suggest feelings and behaviors resulting from the experiences during the process of sick leave and RTW, such as distress, stress, tension, feelings of depreciation and disbelief. However, by placing themselves objectively, they may also express their convictions and viewpoints on the situation experienced.

Workers feel guilty about these feelings. It is a common practice to blame workers for mistakes and point them out as replaceable, not considering how workplace organization and conditions can contribute to injuries and illnesses[33]. When workers workability and productivity are affected by occupational problems, they are replaced and abandoned.

Disability appraisal and INSS benefits are granted upon assessment by a federal medical expert to workers with a formal employment contract or social security contributors[34]. This fact attributes the recognition of the work-related injury to the analysis of documentation provided by the worker, the employer accident's recording, and the crossing of data relating to the illness, occupation, and economic activity of the company to which the worker is linked and is subjected to the expert physician's judgment.

It is up to other stakeholders, especially the public health sector, to incorporate excluded workers and implement care and surveillance actions in occupational health in unarticulated fashion. This group comprises workers who are not insured by Social Security or who are ineligible for this organization's Rehabilitation Program for subsequent RTW, given the reduction of its objective to professional guidance and the exclusion of "attention in physical and psychosocial rehabilitation for workers with disabilities"[35](4).

Work is so meaningful and central in individuals' live[36] that health problems that compromise workers' performance cause loss of identity, as evidenced by W.4. Societies are still marked by capitalist market logic and are based on consumerism. Power is concentrated in the hands of the few, who remain with an individualistic, unequal, hierarchical behavior. They do not show concrete social policies based on equity, access, and fair opportunities for each worker[37], considering individuals' conditions and needs.

Capitalism's impulse continues to deteriorate workers' health in favor of profits in a historic way, currently reaching reductions and simplifications of occupational safety standards[38], with contract flexibility, new recruitment forms, and substandard work. Capitalist and neoliberal logic shapes work precariousness since it requires heavy burdens and exploits workers. Profits are at the expense of health, with physical and psychological impacts on workers. W.4 expresses this claim, calling for a human and holistic perspective from employers to workers who are still ignored as human beings and treated subordinately. The increasing demand for productivity makes workers the victims of capital and its alienating manipulation, which enslaves workers to its logic of maintaining enrichment and social position to those who hold power. We should not disregard that organizations exploit workers to the limit,

> imposing on them the deeper meaning of their commercialization: the abbreviation of their time of use as a result of their deepened characteristic of highly disposable merchandise due to illness[39](423).

Workers also pointed out that institutional unpreparedness in occupational health management compromises their constant relocation between jobs. There is no dialogue between workers and employers to invest in improvements based on workers' considerations. This disarticulation extends to the insurer/compensation and healthcare systems (as cited by W.5), promoting disastrous effects on workers' lives and health, such as RTW impairment and loss of compensation benefits, besides psychological, economic, and social impacts on workers.

This also reinforces the relevance and need for work disability management and the implementation of RTW programs with a biopsychosocial approach for workers, considering their feelings and meanings triggered by work, besides the work environment[40]. Different stakeholders must be involved in this process, such as representations from the workplace, the health system, and social security. Furthermore, partnership must be promoted and co-responsibility for RTW must be highlighted, in addition to the active participation of workers throughout the entire process[17].

Concerning insurer/compensation and healthcare systems interaction, there are no cooperation movements, communication, or even crossing information systems that allow understanding of workers' health conditions, with failures in the performance of both sectors[41]. Difficulty in interaction and collaboration is also seen worldwide due to service fragmentation and the restriction of professionals' time, which leads to insufficient use of information and consequently to the same approaches by different stakeholders[42], although public policies have disseminated the development of intersectoral actions over time.

> The lack of clear guidelines for their implementation in the daily practice of services has been recurrent, and their effective exercise brings challenges to the sectors involved[43](4040).

Due to the transfer of responsibility for implementing occupational health actions to the professionals who perform them and lack of funding, actions are centralized on the healthcare system[43].

In this way, the intersectorality remains a challenge for occupational health actions. Different stakeholders, with specific responsibilities for the same public, perform fragmented actions or sometimes implement confused and overlapping actions caused by poor coordination. This backdrop also reflects high work demands and an insufficient number of professionals to perform occupational health actions[44], contributing to the lack of partnership.

Finally, workers' participation in decision-making is a point of singular importance to consider in the RTW process. This should make actions consistent since workers know all their job specifications, identifying and analyzing expectations and strategies incompatible with their health condition[45]. Therefore, shared and participative leadership is crucial in promoting dialogue, listening, and valuing everyone involved.

This study has limitations: We had to interrupt data collection due to the COVID-19 pandemic restrictions, which limited the number of interviews. Nevertheless, we believe this did not compromise the findings and their importance to the research field.

Final considerations

Most workers still experience a difficult RTW, aggravated by the lack of coordination of all stakeholders. They also mentioned the unpreparedness, disrespect, and institutional neglect by lack of assistance from the compensation/insurance system, which disregarded workers' health conditions, discharging them early, resulting in worse disability and increased distress. It also perpetuates incipiency among the sectors concerning the workers' health, bringing out negative feelings and escalating the worker's distress in the RTW process.

Given these workers' challenges, the POHS stands out in providing assistance and orientation to all workers and monitoring work-related illness cases. It also provides technical support to SUS services for occupational health actions and can establish partnerships with stakeholders. However, its RTW actions are still incipient, emphasizing the individual aspect and actions with a curative nature.

Notably, in the Brazilian context, there are no specific policies aimed at RTW, which contributes to weak actions, lack of

partnership among stakeholders, and no active worker participation to ensure a safe and sustained RTW.

Therefore, stakeholders need to move toward establishing interaction, discussions, collaboration, and active participation of workers to seek a sustained RTW, focusing mainly on workplace adjustments and negotiation to their new health condition. For the Brazilian context, it means strength in the intra (i.e., with different services and professionals from SUS) and intersectoral coordination (i.e., INSS, POHS, Ministry of Labor regionals, and occupational safety and health inside companies).

Strengthening PHC and occupational health services is crucial to ensuring proper occupational health prevention and promotion strategies because those sectors are linked and care for workers' health. Also, PHC could map the workers' health profile in its area and work together with other sectors, like workplace surveillance, to look for safe and healthy work environments.

Surveys covering operational and stakeholder interaction difficulties contribute to the design of strategies to address obstacles, adapt the approach, and increase the worker's involvement in the RTW process.

Collaborators

Freitas KG (0000-0003-1282-4894)* contributed to the conception and design of the work; data acquisition, analysis, and interpretation for the work; writing of the manuscript and critical review of the intellectual content; final approval of the version to be published. Baptista PCP (0000-0003-1433-6456)*, Camarotto JA (0000-0003-2578-609X)*, Silva JAM (0000-0002-8307-8609)* and Miranda FM (0000-0003-2198-2827)* contributed to analysis and interpretation for the work; writing of the manuscript and critical review of the intellectual content; final approval of the version to be published. Mininel VA (0000-0001-9985-5575)* contributed to the conception and design of the work; data analysis and interpretation for the work; writing of the manuscript and critical review of the intellectual content; final approval of the version to be published. ■

References

1. World Health Organization. Protecting workes' health [Internet]. Geneva: WHO; 2017. [accessed 2023 Nov 2]. Available from: https://www.who.int/es/news-room/fact-sheets/detail/protecting-workers'-health

2. Amaral GA, Mendes AMB, Chatelard DS, et al. Siting the Concept of Sublimation within the Psychodynamics of Work. Revista Polis e Psique [Internet]. 2017 [accessed 2024 Dec 20];7(3):200-23. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S2238-152X2017000300012&lng=pt&tlng=

3. Dejours C. Trabajar hoy: Nuevas formas del sufrimiento y de acción colectiva. In: Wlosko M, Ros C, coordinación general y compilación. El trabajo entre el placer y el sufrimiento. Provincia de Buenos Aires: Edunla Cooperativa; 2019. p. 51-69.

*Orcid (Open Researcher and Contributor ID).

4. Dejours C. Psychodynamique du travail et politique: quels enjeux ?. Travailler. 2016;36(2):75-90. DOI: https://doi.org/10.3917/trav.036.0075

5. Rudbeck M, Johansen JP, Omland Ø. A Follow-Up Study on Return to Work in the Year After Reporting an Occupational Injury Stratified by Outcome of the Workers' Compensation System. JOEM. 2018;60(6):542-7. DOI: https://doi.org/10.1097/JOM.0000000000001274

6. Bubonya M, Cobb-Clark DA, Wooden M. Mental health and productivity at work: Does what you do matter? Labour Economics. 2017;46:150-65. DOI: https://doi.org/10.1016/j.labeco.2017.05.001

7. Internacional Labour Organization. Safety and Health at the Heart of the Future of Work - Building on 100 years of experience [Internet]. Geneva: ILO; 2019 [accessed 2023 Nov 3]. Available from: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_687610.pdf

8. Coelho RM, Nunes MAP, Gomes CVC, et al. Time trends and social security burden of temporary work disability due to chronic venous disease in Brazil. BMC Public Health. 2020;20(477). DOI: https://doi.org/10.1186/s12889-020-08563-2

9. Castro MC, Massuda A, Almeida G, et al. Brazil's unified health system: the first 30 years and prospects for the future. The Lancet. 2019;394:345-56. DOI: https://doi.org/10.1016/S0140-6736(19)31243-7

10. Ministério da Saúde (BR), Vigilância em Saúde e Ambiente, Saúde do Trabalhador. Rede Nacional de Atenção Integral à Saúde do Trabalhador [Internet]. [accessed 2024 Dec 20]. Available from: https://www.gov.br/saude/pt-br/composicao/svsa/saude-do-trabalhador/renast

11. Vargas AC, Santos ACT, Souza RM, et al. Users' perception of a professional rehabilitation service. Rev Bras Saude Ocup. 2017;42:e11. DOI: https://doi.org/10.1590/2317-636900011716

12. Bilodeau K, Tremblay D, Durand MJ. Exploration of the contexts surrounding the implementation of an intervention supporting return-to-work after breast cancer in a primary care setting: starting point for an intervention development. J Multidiscip Healthc. 2018;11:75-83. DOI: https://doi.org/10.2147/JMDH.S152947

13. Ansoleaga E, Garrido P, Domínguez C, et al. Return to work enablers for workers with work-related mental illness. Rev Med Chile. 2015;143:85-95. DOI: http://dx.doi.org/10.4067/S0034-98872015000100011

14. Pardo JMV, García AL-G. Psychosocial Factors as Predictors for Difficult Labor Return after Incapacity. Med Segur Trab [Internet]. 2018 [accessed 2024 Dec 20];64(250):50-74. Available from: http://scielo.isciii.es/pdf/mesetra/v64n250/0465-546X-mesetra-64-250-00050.pdf

15. Corbière M, Negrini A, Durand M-J, et al. Validation of the Return-to-Work Obstacles and Self-Efficacy Scale (ROSES) with Workers Suffering from a Common Mental Disorder or Musculoskeletal Disorder. R-982 Studies and Research Projects. Montréal: IRSST; 2017. DOI: http://doi.org/10.13140/RG.2.2.14662.93762

16. Cullen KL, Irvin E, Collie A, et al. Effectiveness of Workplace Interventions in Return-to-Work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners. J Occup Rehabil. 2018;28:1-15. DOI: https://doi.org/10.1007/s10926-016-9690-x

17. Lima MAG, Carvalho RCP, Andrade AGM, et al. Logical model of a return to work program: guiding tool to prevent disability. Rev Bras Saúde Ocup. 2019;44:e29. DOI: https://doi.org/10.1590/2317-6369000018318

18. Takahashi MABC, Simonelli AP, Sousa HP, et al. Rehabilitation program for of workers with RSI/WRMD at Cerest-Piracicaba, São Paulo, Brazil. Rev bras Saúde ocup. 2010;35(121):100-11. DOI: https://doi.org/10.1590/S0303-76572010000100011

19. Bartilotti CB, Andrade PR, Varandas JM, et al. Extended rehabilitation program: a multidimensional

approach to the occupational rehabilitation process. ACTA FISIATR [Internet]. 2009 [accessed 2024 Dec 20];16(2):66-75. Available from: https://www.revistas.usp.br/actafisiatrica/article/view/103169/101558

20. Pêcheux M. Língua, linguagens, discurso. In: Piovezani C, Sargentini V, organizers. Legados de Michel Pêcheux: inéditos em análise de discurso. São Paulo: Contexto, 2011. p. 63-76.

21. Orlandi EP. Análise de Discurso: Princípios e Procedimentos. Campinas: Pontes; 2015. 100 p.

22. Conselho Nacional de Saúde (BR). Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União [Internet], Brasília, DF. 2013 jun 13 [accessed 2024 Dec 11]; Seção I:59. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

23. Conselho Nacional de Saúde (BR). Resolução nº 510, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais cujos procedimentos metodológicos envolvam a utilização de dados diretamente obtidos com os participantes ou de informações identificáveis ou que possam acarretar riscos maiores do que os existentes na vida cotidiana, na forma definida nesta Resolução. Diário Oficial da União [Internet], Brasília, DF. 2016 maio 24 [accessed 2024 Dec 11]; Seção I:44-46. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html

24. Pina JA, Stotz EN, Jackson Filho JM. "Compatible" Workers, a Compound Fracture in the Automobile Industry: Intensification of Labor and the Health Implications. Cad Saúde Pública. 2018;34(7). DOI: https://doi.org/10.1590/0102-311X00114017

25. Silveira AL, Merlo ARC. Work and Disease: Temporalization of Agro-Industry Workers. Rev Subjet. 2019;19(3):1-14. DOI: http://dx.doi.org/10.5020/23590777.rs.v19i3.e9131

26. Mustard CA, Skivington K, Lay M, et al. Implementation of a disability management policy in a large healthcare employer: a quasi-experimental, mixed-methods evaluation. BMJ Open. 2017;7:e014734. DOI: http://dx.doi.org/10.1136/bmjopen-2016-014734

27. Hurtado SLB, Simonelli AP, Mininel VA, et al. Workers' health policies in Brazil: historical contradictions and possibilities for development. Ciênc saúde coletiva. 2022;27(08):3091-102. DOI: https://doi.org/10.1590/1413-81232022278.04942022

28. Nascimento MM, Silva Júnior VB. The importance of occupational health in primary care. Braz J Health Rev. 2024;7(2):1-13. DOI: https://doi.org/10.34119/bjhrv7n2-033

29. Silva MF da, Mieiro DB, Camarotto JA, et al. Workers' Health Surveillance from managers' and decision-makers' perspectives. Rev bras saúde ocup. 2023;48:e1. DOI: https://doi.org/10.1590/2317-6369/05221pt2023v48e1

30. Barros LM, Lima MAG, Neves RF. Long-Term Work Disability: Loss of Rights, Survival and Tangency of Primary Health Care. Ciênc saúde coletiva. 2023;29(9):1-11. DOI: https://doi.org/10.1590/1413-81232024299.01422023

31. Zavarizzi CP, Alencar MCB. Work leave and therapeutic pathways of workers affected by RSI/WRMSD. Saúde debate. 2018;42(116):113-24. DOI: https://doi.org/10.1590/0103-1104201811609

32. Kulaitis F, Silva KC. Recent changes in the Brazilian Social Security Institute's professional rehabilitation program. Trab educ saúde. 2022;20:e00335165. DOI: https://doi.org/10.1590/1981-7746-sol00335

33. Araújo MRM, Morais KRS. Labor precariousness and the worker's overthrow process. Cad Psicol Soc Trab. 2017;20(1):1-13. DOI: https://doi.org/10.11606/issn.1981-0490.v20i1p1-13

34. Ferreira LP, Mello MCMB, Souza FNF, et al. Work-Related Voice Disorder: Achievements and Challenges in Latin America. São Paulo: Sintropia; 2022. 402 p.

35. Tessarro MTV, Querol MAP, Almeida IM. Challenges of the vocational rehabilitation developed by the Brazilian Social Security Institute (INSS): a cultural-historical approach. Rev Bras Saude Ocup. 2022;47:e12. DOI: https://doi.org/10.1590/2317-6369/26320pt2022v47e12

36. Dejours C, Deranty J-P, Renault E, et al. The Return of Work in Critical Theory: Self, Society, Politics. New York: Columbia University Press; 2018. 248 p.

37. Drolet M-J, Désormeaux-Moreau M, Soubeyran M, et al. Intergenerational occupational justice: Ethically reflecting on climate crisis. J Occup Sci. 2020;27(3):417-31. DOI: https://doi.org/10.1080/14427591.2020.1776148

38. Alcantara AC. Worker's health in times of social insecurity. SER Soc. 2020;22(47). DOI: https://doi.org/10.26512/sersocial.v22i47.25515

39. Antunes R, Praun L. The society of illness at work. Serv Soc Soc. 2015;123:407-27. DOI: https://doi.org/10.1590/0101-6628.030

40. Loisel P, Durand MJ. Applying transdisciplinary to the complexity of work disability prevention [Internet]. Québec: Université de Sherbrooke; 2005 [accessed 2024 Dec 11]. Available from: https://www.researchgate.net/profile/Patrick-Loisel/publication/267956389_Applying_transdisciplinarity_to_the_complexity_of_work_disability_prevention/links/550f06a70cf2ac2905adfd47/Applying-transdisciplinarity-to-the-complexity-of-work-disability-prevention.pdf

41. Vaitsman J, Lobato LVC. Continuous Cash Benefit (BCP) for disabled individuals: access barriers and intersectoral gaps. Ciênc saúde coletiva. 2017;22(11):3527-36. DOI: https://doi.org/10.1590/1413-812320172211.20042017

42. Lammerts L, Schaafsma FG, Mechelen WV, et al. Execution of a participatory supportive return to work program within the Dutch social security sector: a qualitative evaluation of stakeholders' perceptions. BMC Public Health. 2016;16(323). DOI: https://doi.org/10.1186/s12889-016-2997-x

43. Lancman S, Daldon MTB, Jardim TA, et al. Workers' health intersectoriality: old questions, new perspectives? Ciênc saúde coletiva. 2020;25(10):4033-44. DOI: https://doi.org/10.1590/1413-8123202025510.27572018

44. Lancman S, Bruni MT, Giannini R, et al. Working in health and safety at work: reflections on the construction of an integrated policy. Ciênc saúde coletiva. 2022;27(11):4265-76. DOI: https://doi.org/10.1590/1413-812320222711.06272022

45. Gray P, Senabe S, Naicker N, et al. Workplace-Based Organizational Interventions Promoting Mental Health and Happiness among Healthcare Workers: A Realist Review. Int J Environ Res Public Health. 2019;16(22):4396. DOI: https://doi.org/10.3390/ijerph16224396

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