

## The legal precariousness of work relations in the health sector during the COVID-19 pandemic, as a factor of worker suffering

João Batista dos Santos Militão (<http://orcid.org/0009-0009-0648-3609>)<sup>1</sup>

Jorge Luiz Souto Maior (<http://orcid.org/0009-0002-0757-7710>)<sup>2</sup>

Luís Fernando Silva (<http://orcid.org/0009-0007-1181-8325>)<sup>1</sup>

Swedenberger do Nascimento Barbosa (<http://orcid.org/0000-0002-6231-2291>)<sup>3</sup>

Maria Helena Machado (<http://orcid.org/0000-0002-5209-2424>)<sup>4</sup>

Antônio Marcos Freire Gomes (<http://orcid.org/0000-0003-1724-6616>)<sup>5</sup>

José Cláudio Silva Barreto (<http://orcid.org/0009-0002-9575-6515>)<sup>1</sup>

Wilson Aguiar Filho (<http://orcid.org/0000-0003-2732-8578>)<sup>1</sup>

**Abstract** *The present article analyzed the process of precarious work relations in the health sector, demonstrating how this situation generated illness and suffering among workers. The text sought to register how the institutional adoption of neoliberal economic conceptions, of the reduction of State social policies, coupled with a history of cultural rejection of labor rights, provided the attraction of mechanisms of precarious work for the public sector, notably, the outsourcing of labor and the provision of services. In a second moment, the text points out the legal improprieties committed, presenting the consequences of the weakening of the legal bond in the working conditions of these workers, mainly regarding working hours and remuneration, also highlighting how much the dissemination of these links represented a factor of a general reduction in wages and labor and social security rights in the sector. Data from Fiocruz surveys on working conditions during the pandemic were also presented. The article concludes by showing the urgency of rescuing the legal labor institutes that were abandoned in the historical path studied in order to guide the public health policies in a new direction.*

**Key words** *Precariousness of health work, Work and health professionals, Working hours, Social Security*

<sup>1</sup> Núcleo de Estudos e Pesquisas em Recursos Humanos em Saúde (NERHUS), Escola Nacional de Saúde Pública Sergio Arouca (ENSP), Fundação Oswaldo Cruz (Fiocruz). R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. [jb.militao@yahoo.com](mailto:jb.militao@yahoo.com)

<sup>2</sup> Faculdade de Direito, Universidade de São Paulo (USP). São Paulo SP Brasil.

<sup>3</sup> Universidade de Brasília (UnB). Brasília DF Brasil.

<sup>4</sup> Centro de Estudos Estratégicos (CEE), ENSP, Fiocruz. Rio de Janeiro RJ Brasil.

<sup>5</sup> Universidade Estadual do Pará (UEPA). Belém PA Brasil.

## Introduction

During the COVID-19 pandemic, which has not yet ended, there has been no shortage of recognition regarding the essential nature of the services provided by health professionals (HP). The population has shown its gratitude to those individuals with actions and words. There were countless situations in which the HP were applauded, and even treated as heroes, since what they do in reality became clear for the public in general: they save lives. However, little or almost nothing has been said about the conditions in which they work.

The current article is dedicated to explaining how some labor and social security jurisdictional instances, which should work in favor of improving the work and living conditions of those professionals, have instead contributed to “legitimize” their suffering.

One important question to mention is that in Brazil, the formal and jurisdictional end of slavery did not represent the overcoming of the cultural, social, and economic bases which structured slavery during almost 400 years of our history. Prejudice against blacks survived the end of slavery, and in a modified form, is still alive and well even today. That was the case, at least until the mass introduction of European workers in the Center-South of Brazil, manual labor was socially despised as “something for negroes”<sup>1</sup>(p.33).

Therefore, it is important to discuss in which modality of jurisdictional-laboral contract the HP are, what labor rights they have, how much they earn, what is the workload that they are subjected to. what kind of legal insecurity may affect them, who they are, and how many hours they work.

## Methodology

This is an article of a descriptive nature based on legal references in order to support the analysis of the data from the studies “Work conditions of healthcare workers in the context of Covid-19 in Brazil”<sup>2</sup> (matrix project) and “Invisible healthcare workers: work conditions and mental health in the context of Covid-19 in Brazil”<sup>3</sup>. These are cross-sectional studies, with nationwide reach, which counted on the participation of 15,132 health professionals (HP) and 21,480 “invisible” health professionals, (IHP) who are at the technical, assistant, and support levels of healthcare, respectively, who were working during the pandemic.

A non-probabilistic sample was adopted, using the snowball model, based on the social media of the subjects of the study (HP and IHP), in such a way that the choice of the participants did not follow a random model. The data banks or the studies were built with the use of an online questionnaire with self-completion and free access, through the Research Electronic Data Capture (RedCap) platform. The answers were received and stored in the server of the Institute of Communication and Scientific and Technological Information in Health (ICICT/Fiocruz).

The data was analyzed by Microsoft Excel, cut-off by gender, kind of labor contract with the health facility, working hours, for both HP and IHP. The studies received approval from the Research Ethics Committee of the National Public Health School (*Escola Nacional de Saúde Pública - CEP/ENSP*), decision No. 4,081,914 and CAAE No. 32351620.1.0000.5240 (matrix project).

For more information regarding the methodology of the aforementioned studies, access the article: “Changes in the world of healthcare work: workers and challenges for the future”, contained in this special issue of RC&SC.

## Precarization mechanisms in public service

In the 1990s, neoliberal ideals gained space in Brazilian reality, based on the even more intense retraction of social rights, (Washington Consensus - 1989), defined as something from developing countries, in the periphery of international capital.

In that sense, the country went through constitutional reforms in 1998, establishing a ceiling for the remuneration of public workers and social security contribution by the inactive workers, as well as fundamental changes in the social security system. Constitutional Amendment 19/1998 defined the principle of efficiency in the *caput* of article 37 and established the possibility of firing stable public workers for insufficient performance and due to excessive spending by the Public Administration<sup>4</sup>.

New norms were incorporated into the legal structure, such as Law No. 9,637/1998<sup>5</sup>, with the changes introduced by Law No. 9,648/1998<sup>6</sup>, which established directives for the involvement of the State in several areas: health, education, culture, sports and leisure, science and technology, and the environment, allowing the Public Administration to have shared management with the private sector by means of formalizing, without bidding, “instruments of public private col-

laboration, through which the participation reserved for the State in the aforementioned areas was similar to “promoting”, not only by the transfer of financial resources, but also by the leasing of public goods and even public workers, given that such instruments, which are in fact agreements, were established with Non-Governmental Organizations (NGO) promoted to the status (legal title) of Social Organization (SO) through the deliberation of the public entities themselves.

In 2000, the Law of Fiscal responsibility was issued, demanding from the Administrators a strong containment of expenditure in personnel<sup>7</sup>. And on April 15th, 2015, the Federal Supreme Court (*Supremo Tribunal Federal* - STF), judging the unconstitutionality lawsuit ADI 1923, declared Law No. 9,637/1998 constitutional, opening the door to the agreements between federal entities with the SO in the areas mentioned above.

### Outsourcing services

In the ruling on ADI 1923, when deciding about the constitutionality of Law No. 9,637/1998 and its later changes (in the text established by Law No. 9,648/1998) – both edited during the Fernando Henrique Cardoso (FHC) administration, for the implementation of the neoliberal idea of minimum State – the STF decided to adopt the interpretation of those laws according to CF/88, keeping the State as a “promotion” entity, not only with the transference of financial resources, but also through the leasing of public property and even of public workers. The agreements for this were formalized with NGOs, which were promoted to the status of SO by means of deliberation by the public entity.

The decision by the STF, reproducing the spirit of the law also predicts the possibility that the SO should formalize, on their own, contracts with third parties for services, with no need for a bidding process, and even worse, that they would be able to hire workers without public tender, thereby denying them any legal guarantees of Statutory workers. It also establishes that Statutory workers must provide services to the SO and receive from those a remuneration outside the “legality” standards.

With that, many constitutional provisions were emptied, since when CF/88 prescribed that services in health (art. 199, *caput*), education (art. 209, *caput*), culture (art. 215), sport and leisure (art. 217), science and technology (art. 218), and the environment (art. 225) are public ser-

vices and that they “are the responsibility of the State and Society”, and are therefore “open to private enterprise”<sup>8</sup>, the intent was to make the point that private entities which work in those sectors should not seek only profits, and are obliged to respect the specific purpose of providing a public service, which is to first seek the satisfaction of societal interests.

It is the responsibility of the State, and even its obligation, to prevent the mere mercantilization of those services. The state should also plan and make effective public policies for the execution of those services rather than simply transferring the responsibility to the private sector, and lending to it money and public property, especially with no bidding process. What is even worse is that this deviation from the purposes defined by the Constitution also compromises the constitutional guarantee of democratic access to public services by means of public tender, all of this done in the name of a supposed efficiency, which would be ensured by controlling the results.

The vote by the rapporteur extrapolates and disconsiders the existence of the laborial-jurisdictional, legal and constitutional structures to suggest that the “employees of the SO are not public workers, but rather, employees from the private sector; therefore, their remuneration may not be based on law (CF, art. 37, X), but in work contracts established consensually”.

The concrete result of those provisions is that governments can grant a legal title of SO to companies that meet internally defined requirements, and can establish agreements with whomever they see fit, transferring money and public goods to them, as well as public workers to manage public services in several areas.

Those organizations, though controlled by the Public Ministry and by the Audit Tribunal, are managed under the jurisdictional effigy of private rights, inclusively and mainly, as far as the hiring of workers is concerned, reaching the execution of services that are part of the concept of purpose-activity of the public service, in ways which simple outsourcing cannot reach. Through the legal resource under debate here, it became possible to outsource purpose-activities in the public sector by “outsourcing” the management itself, going well beyond (and with no limits) the hypotheses already predicted in art. 175 of CF/88 (concession and permission of public services).

Thus, a given public entity may, for instance, transfer a health service to an SO. The SO that is responsible for receiving public money and inputs may provide those services by hiring profession-

als without a public tender, understanding that, for them, there will consequently be no guarantee of job stability, which is inherent to public workers, among other specific benefits. Moreover, the SO are authorized to hire service-providing companies to perform the activities required to provide the public service. In other words, it is the institutionalization of one form of outsourcing within another, which promotes and boosts the precarization of working conditions in the sector.

### Outsourcing labor

The unconstitutional practice of outsourcing the services of cleaning, maintenance, conservation, and surveillance, accepted in all spheres of public administration, is bad enough, but the privatization of public service in the health area caused the spread of subcontracting, or even the outsourcing of labor.

Outsourcing is the legitimization of the intermediation of labor, since a company can hire another, so that the second can hire workers - considering that nowadays, the reason of jurisprudence of such intermediation may inclusively reach the purpose-activity of the hiring company, with the hired company serving as an employment agent. The legal standard created detached itself from the historical function of labor rights, which is the protection of the workers. The fulfillment of immediate needs, when taken into consideration carefully in the very capitalist perspective, represents a huge dysfunction in the free market system based on fair competition.

Outsourcing is, therefore, a technique for the precarization of working conditions, because, according to Márcio Túlio Viana,

*[...] the service providing companies, in order to guarantee their conditions, since they do not have the means to automate their production, end up forced to adopt precarious labor relationships, so that, by reducing the cost of labor, they may offer their services at more accessible costs, and winning, therefore, the bidding process, defeating other service providers<sup>9</sup> (p. 27).*

### The concrete reality

Current and unreleased studies by Fiocruz point to this scenario of outsourcing and precarization, confirming the realization of this phenomenon, which worsened during the pandemic. The cases of disease increased significantly, also affecting workers' mental health, as Machado warns:

*Recent studies conducted by Fiocruz regarding working conditions and mental health of health-care workers indicate a complex and worrisome scenario. And nursing did not escape unscathed in this context, on the contrary, it was hit hard, with thousands of workers contaminated and hundreds who perished because of Covid-19 (Cofen, 2022), more precisely, 256 nurses and 617 assistants/technicians, according to Machado et al. (2022).*

*Data from our recent research at Fiocruz (2021-2022), regarding work conditions and mental health of healthcare workers show a situation in which:*

*\* ¼ of the healthcare workers presents comorbidities, being the five most prevalent: hypertension, obesity, pulmonary diseases, depression and diabetes;*

*\* More than 70% show strong signs of exhaustion and tiredness due to work excess or overload;*

*\* Most of the workers denounced poor working conditions, which translate into precarious and inadequate structure, causing discomfort and ergonomic problems;*

*\* Insufficient biosafety;*

*\* Wages that are too low and insufficient for supporting a home - precarious work as indicated by the International Labor Organization (ILO);*

*\* Multiplicity of work contracts, almost always precarious and temporary, in the format of informal jobs;*

*\* Physical and psychic side effects inherited from the Pandemic with severe repercussions in the daily lives of this contingent of millions of healthcare workers, in which nursing is hegemonic and essential<sup>10</sup>.*

### Legal relationships

The precarious legal relationships are an indication of the precarity in working conditions and even in the lives of workers in general. In face of a long process of precarization, which is established at several levels, since in Brazil there is a staggering of the manners of precarization, until it reaches the social segment of those who still suffer from the consequences of the background of slavery, still present structurally, culturally and economically in our society, and who are in a state of complete invisibility.

Studies prove the precariousness of working relationships among HP: 14.6% of the HP are submitted to a temporary, exceptional interest contract with public administration (Table 1), 1.8% of the occupants of commissioned jobs in the public sector do not have effective work re-

relationships, and 2.8% are in temporary contracts with private companies, adding to 19.2%. Moreover, considering the relationships with autonomous entities; 4.6% are with legal entities, 3.2% with physical individuals, and 1.9% with cooperating entities. This area alone concentrates 9.7% of all of the work relationships and in general, it contributes to a high index of precarized workers, at the level of 28.9%.

In the same way, when considering the IHP (Table 2), 10.4% have temporary contracts with the public sector, 0.8% have a commissioned job with no effective relationship, and 2.9% have contracts with private companies, adding to 14.1%. In terms of contracts with autonomous entities, the general index is 2.6%, although, when aggregate, 16.7%. Although such numbers are below those observed among HP, both figures represent high percentages of the precarization of both HP and IHP.

We can notice the adoption of a management strategy of a private nature in the hiring of HP by public entities, promoting the dissemination of unstable relationships in the sector, which is already precarized and poorly remunerated.

### Expansion of the workload in health

The work shift (WS) is one of the central questions in work relationships and working conditions, and it is more expressive when the study refers to the area of healthcare work. The Con-

stitution establishes the general regime of WS, normally lasting no more than 8 hours a day and 44 hours weekly, with the possibility of compensation of hours and the reduction of work shifts according to collective labor agreements. When the work is done in uninterrupted rotation, the work will have shifts of 6 daily hours, except in the case of collective negotiation.

There is a view in legal practice, reinforced by labor reform, in the sense of ‘legalizing’ compensatory practices in WS. This tendency seeks to turn into *tabula rasa* the historical achievement of the workers, of having WS limited to 8 daily hours or 44 weekly hours (art. 7º, XIII, of the CF<sup>8</sup> and 59, of the CLT<sup>11</sup>), naturalizing the practice of overworking as if it were legally admissible.

Note that in the Constitution, there is no prevision whatsoever regarding the possibility of doing “WS compensations”. Instead, there is the “compensation for hours”, understanding that the work shift is the time between the beginning and the end of a WS.

Therefore, CF/88 allowed for collective negotiations, seeking changes in hours without increasing or reducing WS, also in conformity with the logic established in the *caput* of the same Article 7, for the improvement of the workers social conditions and the effectiveness of a policy “aimed at full employment” (item VIII, art. 170, CF/88)<sup>8</sup>.

It is also important to note that work beyond normal shifts does not figure into the Constitu-

**Table 1.** Health professionals according to type of work relationship with the health establishment - Brazil.

Type of work relationship	V.Abs.	%
Statutory (effective position holder)	5,151	34.0
Employee (CLT of company/public foundation)	2,219	14.7
Employee (CLT of a company/private entity or philanthropic establishment)	2,554	16.9
Temporary public administration contract	2,202	14.6
Temporary contract in a company/private entity	425	2.8
Independent (individual)	485	3.2
Self-employed (legal person)	692	4.6
Cooperated self-employed	286	1.9
Occupant of a commissioned position in the public administration, without an effective bond	273	1.8
Owner/Partner	144	1.0
Resident/Specializing	312	2.1
Intern/Grant recipient	212	1.4
Retiree	4	0.03
Teacher	17	0.1
Others	49	0.3
NR	107	0.7
Total	15,132	100.0

Source: Research “Work Conditions of Healthcare Professionals in the Context of COVID-19 in Brazil” - ENSP-CEE/Fiocruz, 2020/2021.

**Table 2.** Invisible Health Workers according to the type of work relationship with the health establishment - Brazil.

Type of work relationship	V.Abs.	%
Statutory (effective position holder)	9,226	43.0
Employee (CLT of company/public foundation)	3,486	16.2
Employee (CLT of a company/private entity or philanthropic establishment)	4,228	19.7
Temporary public administration contract	2,231	10.4
Temporary contract in a company/private entity	618	2.9
Independent (individual)	298	1.4
Self-employed (legal person)	66	0.3
Cooperated self-employed	188	0.9
Occupant of a commissioned position in the public administration, without an effective bond	173	0.8
Owner/Partner	29	0.1
Resident/Specializing	12	0.1
Intern/Grant recipient	195	0.9
Retiree	3	0.01
Teacher	3	0.01
Voluntary	23	0.1
Unemployed	14	0.1
Others	95	0.4
NR	592	2.8
Total	21,480	100.0

Source: Research “Work Conditions of Healthcare Professionals in the Context of COVID-19 in Brazil” - ENSP-CEE/Fiocruz, 2020/2021.

tion as “overtime”, but rather as “extraordinary service” (item XVI, art. 7<sup>th</sup>)<sup>8</sup>, which assumes a situation of exceptionality. Overtime is not considered a legal instance and it is not in the employer’s rights, mainly because the nature of the right granted for the workers essentially refers to the limitation of the WS. However, the adoption of overtime, extrapolating even the legally established daily limit (two hours), being that in practice those extra hours are paid simply by the suppression of the annotation of hours worked, with no inspection by the Ministry of Labor.

In the context of the fragilization of unionist presence and the absence of salary policies, the practice of overtime ends up being considered by the workers as a manner of compensation for low salaries. Nonetheless, there has been acceptance towards adopting the systems of compensation for workloads that go beyond the weekly limit predicted by the FC/88 and even surpassing the maximum legal limit of working hours, which, adding the eventual overtime hours, is 10 hours a day. Therefore, there is a legitimation of the so-called “hours bank” (compensation time), which allow the worker to compensate extra hours with regular hours, along with 12-hour work shifts, practiced in the 12x36 scheme (recognized as

valid by the STF in ADI 4,842<sup>12</sup>). This case, specifically, was declared as constitutional, under the 5<sup>th</sup> article of Law No. 11,901/2009<sup>13</sup>, which establishes 12 hours for the work shifts of civilian firemen, followed by 36 hours of rest and limited to 36 hours per week

All of those legal techniques, which empower precarization of working conditions have been incorporated and disseminated in the work relationships in the health sector. As a result, precarious legal relationships, excessive WS, low salaries, moral harassment, and low resilience constitute the sad reality of the HP in Brazil, as the studies have revealed<sup>2,3</sup>.

The excessive work shift is even more impacting for the female workforce (WF), since among the HP, 77.6% are women and 22.1% are men. The same situation is present among IHP, given that 72.5% of them are women and 25.6% are men. This data characterizes work in the health area as feminine and leads us to conclude that, in general, women have a much more intense work overload than men in the health area, especially considering the domestic shift that women endure, beyond their professional life (Table 3).

The nature of the work in the different levels of healthcare services, the way in which it is orga-

nized, double shifts of public jobs (frequent), all make the analysis of the WS in this area, something very complex. The standards of time for WS depend considerably on the circumstances in which the healthcare service is performed in different health establishments, public and private, and differentiated work shifts among the professionals, regulated by specific law. For instance, we have Radiology technicians (24h weekly); Physiotherapist, Occupational Therapist, and Social Assistant (30h), all guaranteed by laws that regulate those categories.

Data from studies indicate that, among the HP, only 49% had work shifts of 21-40 weekly hours, thus conforming to the limit of 44 hours defined by the FC/88 for the country. However, it is noticeable that there is a large contingent of workers subjected to work shifts beyond that limit, indicating a concerning intensity regarding the time spent at work: 32.4% of the HP have work shifts between 41 and 60 working hours weekly, meanwhile 11% perform a workshift of 61 to 80h, and 4.3% working more than 80h a week. On the flip side, only 2.6% have work shifts below 20h a week. (Table 4).

By analyzing the data referring to IHP (Table 5), it is noticeable that 56.8% have shifts of 21-40h weekly hours. Above that level, between 41-60h, there are 25.4% and 7.1% who declared that they work between 61 and 80h hours. Extrapolating, there are 4.6% of the IHP in the level above 80 hours, and only 3.3% work less than 20h. a week.

Concluding, this data demonstrates a scenario of exhausting work shifts practiced in the health area, which indicate that policies in terms of work shifts must be reconsidered in the country.

**Table 3.** Invisible Healthcare Professionals and Workers by sex - Brazil.

Sex	Healthcare Professionals		Invisible Professionals	
	V.Abs.	%	V.Abs.	%
Male	3,350	22.1	5,508	25.6
Female	11,748	77.6	15,564	72.5
NR	34	0.2	408	1.9
Total	15,132	100.0	21,480	100.0

Source: Research "Work Conditions of Healthcare Professionals in the Context of COVID-19 in Brazil" - ENSP-CEE/Fiocruz, 2020/2021, and Research "Invisible healthcare workers: working conditions and mental health in the context of COVID-19 in Brazil" - ENSP-CEE/Fiocruz, 2021/2022.

## The social security issue

### Defining COVID-19 as a work-related disease

The social security legislation defines the professional diseases and work-related diseases, considering that COVID-19 was not included because it was not known until recently. In that sense, it is important to remember that, in March 2020, the Provisional Measure No. 927<sup>14</sup> was issued, and its art. 29 sought specifically to keep COVID-19 from becoming considered a work disease. That measure imposed on the workers the burden of proving the causal nexus between the acquired disease and the work they perform, with the purpose of achieving benefits prescribed for work-related accidents.

Fortunately that absurd legal measure had its validity canceled by the STF, with the reiteration of its previous understanding that the causal nex-

**Table 4.** Healthcare professionals according to weekly working hours - Brazil.

Work shift	V.Abs.	%
Less than 20 hours	389	2.6
21-40 hours	7,412	49.0
41-60 hours	4,906	32.4
61-80 hours	1,661	11.0
More than 80 hours	646	4.3
NR	118	0.8
Total	15,132	100.0

Source: Research "Work Conditions of Healthcare Professionals in the Context of COVID-19 in Brazil" - ENSP-CEE/Fiocruz, 2020/2021.

**Table 5.** Invisible Health Workers according to weekly working hours - Brazil.

Work shift	V.Abs.	%
Less than 20 hours	710	3.3
21-40 hours	12,192	56.8
41-60 hours	5,463	25.4
61-80 hours	1,515	7.1
More than 80 hours	991	4.6
NR	609	2.8
Total	21,480	100.0

Source: Research "Invisible healthcare workers: work conditions and mental health in the context of COVID-19 in Brazil" - ENSP-CEE/Fiocruz, 2021/2022.

us is to be presumed (releasing the HP from the burden of proving that the disease is a result of the activity), each time the nature of the activity performed is important in terms of exposure to constant, special risk, which subjects the HP to a higher burden than the remaining of the collectivity.

Moreover, we understand that it is imperative to move forward in this issue and have COVID-19 included in List B, Annex II of Decree No. 3,048/1999<sup>15</sup>, which defines the “Work-Related Infectious and Parasitic Diseases” (Group I from CID-10), and encourages the Public Powers to deepen the scientific studies related to potential after-effects of the disease, in order to decide if it is not the case to have the disease included also among those pertaining to List B, Annex II, of the Decree mentioned above, with that section being about “Work-Related Mental and Behavioral Disorders (Group V from CID-10), or even among the “Work-Related Diseases of the Nervous System” (Group VI from CID-10).

Before these legislative changes take place, it is crucial that the HP who contracted COVID-19 to inform the respective employers about the infection, making it easier for future confirmation of causal nexus between the acquired disease and the eventual after-effect resulting from it even a long after, since studies have shown that COVID-19 may provoke other health problems in the medium and long terms, which are capable of causing even future inability to work, provisory or permanent.

**The temporary suspension of work activities recurring from COVID-19, the eventual permanent inability to work and the event of death**

Social Security has the obligation to pay a security benefit to the workers who are away from work for periods of more than 15 days, due to temporary inability, which corresponds to 91% of the simple arithmetic average of 100% of the salaries in contributions made since July 1994, until the leave of absence, and such calculation is already an evidence of a decrease in family income for that worker, in comparison to the remuneration when active.

What we deem necessary, in this case, is that the law grants a more special protection for the cases of leave of absence resulting from contamination during pandemics or epidemics, with the purpose of ensuring a provisory benefit equiva-

lent to 100% of the salary, as happens, regularly, with statutory workers.

On the other hand, in cases of permanent inability to work, the social security legislation establishes two different methods to calculate the value of retirement: a) if it results from work-related accidents (including professional or work-related diseases), the benefit will be 100% of the average of all the contribution salaries since 07/1994; b) if it results from common disease or accident, it will correspond to 60% of that average, with the addition of 2% for each year of contribution exceeding 20 (men) and 15 (women). This once again proves the importance of classifying COVID-19 as a work-related disease.

Finally, in the cases of death of the beneficiary, the pension will correspond to 60% of the average of all of the contribution salaries since 07/1994, with the addition of 2% for each year of contribution exceeding 20 (men) and 15 (women). Meanwhile, if death results from a work-related disease or accident, the pension will correspond to 100% of the same average, which demonstrates that, in this instance, as well, the inclusion of COVID-19 among the work-related diseases is crucial in order to ensure social security coverage, which is more dignifying and fair.

**Special retirement as a result of exposure to agents hazardous to health or to physical integrity**

Work activities performed under proven exposure to agents harmful to health or to physical integrity grant to the workers the right to have special retirement after 25 continuous years working in these conditions, or to have a special time count for the period worked, usually adding 40% time for men and 20% for women, with the purpose of common voluntary retirement; the added time is supposed to protect workers from regular daily situations – lived by the HP as well – however, that is not the case in periods of pandemic or endemic, especially when caused by an unknown virus and there is no vaccine capable of reducing contamination and serious cases of the disease.

Therefore, we understand that in the case of those extreme hypotheses, social security legislation should establish an even more special time count for the years worked, for instance, with an increase of 75% time for men and of 50% for women, as it is the case for underground mining workers.

### **Indemnity for permanent work inability of for death caused by working exposed to COVID-19**

In 2021 the Brazilian Congress approved Law No. 14,128<sup>16</sup>, ruling on a financial compensation to be paid by the Federal Government directly to the HP who became incapacitated for work or died because of contamination when caring for COVID-19 patients. This benefit reaches: a) college level professions (recognized by the National Health Council - NHC) and professionals who work with laboratory tests and clinical analysis; b) technical level or auxiliary activities related to healthcare (those who also work with lab testing); c) community health agents and endemic prevention agents; d) those who, though they do not perform activities in the health area, help or provide support services, in person, at health facilities, including those who work in administrative services, cafeteria, laundering, cleaning, security, ambulance driving, among others, as well as morgue workers and morticians; and, e) those whose jobs or activities, being of higher education level, a secondary education, or an elementary education, are recognized by the National Council for Social Security and work in the Unified System of Social Security.

If the contamination results in the worker's death, payment should be made to the spouse or companion, or to those dependent upon the workers or who are their heirs.

Finally, the law defines the presumption that COVID-19 was the cause of permanent disability or death, even though it might not be the only, main or immediate cause, requiring only the temporal nexus between the time when the disease started and the event of permanent disability or death, if this is the case, and the diagnosis of COVID-19 by laboratory exams or medical report which states the presence of a clinical situation which is compatible with the disease, and the financial compensation is subjected to evaluation by medical examination by a Federal Medical Examiner.

### **Conclusion: to adjust the course**

#### **Ethics and bioethics in healthcare work**

In times of COVID-19, there are three ethical considerations indicated for providing health care: the responsibility to plan, thus managing any uncertainties; the responsibility to protect, providing support to workers and to vulnerable

populations; and the responsibility to provide guidance regarding levels and standards of care in crisis situations<sup>17</sup>.

In the global context, the World Health Organization (WHO) and the World Labor Organization (WLO) remind that even before the pandemic, professionals in the area already had a higher risk of infections, muscular diseases, harassment and burn-out syndrome. At the same time, they confirm: less than one in six countries has a national policy of healthcare work safety<sup>18</sup>.

Precarization of work has been taking shape for years, and resulted in a situation of difficulties for dealing with the pandemic, and it has contributed to an increase in structural precarization, since it allows for more flexibilization of working conditions and intensified the super-exploitation of workers from several sectors, such as health, food industry, fuel, transportation, among others. Such considerations are evidence of the implications caused by the neoliberal model to the working conditions of HP even before the COVID-19 pandemic, and are a reflection of how contemporary capitalism works<sup>19</sup>.

*The emergence of ethical conflicts in Brazil during the fight against the COVID-19 pandemic, was observed at different levels: some were centered around the allocation of resources to fight the pandemic and its effects, considering the need to acquire and distribute an expressive amount of material and equipment, the need to finance the acquisition or production of vaccines, in the definition of the main directives to contain the virus, in institutional or mediatic communication of measures with greater or lesser efficacy in controlling the infection - in the reallocation of health professionals, according to urgency or to regional needs, and - in prioritizing care for the population and for specific patients<sup>20</sup>(p.2).*

Based on critical observation of the Public Responsibility Ethics (by Hans Jonas), Garrafa and Amorim<sup>21</sup> stated that the Brazilian government has practiced *misthanasia*, since:

*[...] did not employ measures for the protection and strengthening of the SUS, in order to face the pandemic, and had no care towards the health and lives of those who are in the frontlines, exposed to higher risks of mental sickness, of being infected, and/or of dying. Moreover, it was negligent in the protection of vulnerable social groups and populations at risk<sup>21</sup>.*

The ethical aspects during the pandemic and post-pandemic periods, especially in relation to the social and moral obligations of the government, its relationship with society and with the

HP, must be studied deeper, focused on human dignity.

### **Political work**

The recreation of the National Board of Permanent Negotiation by SUS, which was created by the NHC and dissolved by the Bolsonaro administration in 2019, is a requirement, and constitutes the insurance that complex and often urgent issues in health work, such as precarizations and working conditions, biosafety of the workers, are matters that are debated, negotiated, and agreed upon between administrators (public and private) and workers, seeking to provide wellbeing and care to the entire Brazilian population.

### **Legal Intervention**

From the legal point of view, in terms of labor rights, it is urgent to abolish the modalities of work which go against constitutional order and

that promote precarization, pauperization, suffering and sickness among healthcare workers, who are the providers of an essential service. As highlighted in this article, among the measures which cause these results, we have outsourcing in public services, and in terms of labor, including the purpose-activity; the means-activity; the “compensation time”; the ordinary practice of overtime; and the 12x36 work shift regime.

There is a need, therefore, to provide concrete efficacy to the constitutional provisions that ensure all workers job protection against arbitrary layoffs, and protect public workers, who reach their position through public tender, with evaluations and titles; as well as protect job stability, the right to be unionized, without State intervention; and the effective right to strike. In conclusion, many steps must be taken in the opposite direction as that of the overexploitation of work, which has become institutionalized and naturalized in work relationships in Brazil.

### **Collaborations**

JBS Militão, JLS Maior, LF Silva, SN Barbosa, MH Machado, AMF Gomes, JCS Barreto and W Aguiar Filho collectively contributed to the production of the aforementioned article, from the initial phase of its conception, elaboration, development and analysis, as well as in the final draft.

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