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## **Brazil: Case study on working time organization and its effects in the health services sector**

Ana Luíza Matos de Oliveira

Sectoral  
Policies  
Department



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**International Labour Office**  
Geneva

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## Contents

List of Acronyms.....	v
Preface.....	vi
Acknowledgements .....	vii
1. Introduction and background .....	1
1.1. The health sector in Brazil in context.....	2
1.2. Working time in Brazil.....	8
1.3. Regulation of professions in the health sector in Brazil.....	9
1.4. Working time regulations and practices in the Brazilian health sector .....	11
1.5. Effects of working time (including literature review).....	15
2. Methodology .....	18
3. Findings.....	21
3.1. Working time arrangements in practice .....	21
3.2. Difficulties in measuring real working time in the health sector .....	23
3.2.1. Multiple jobs.....	23
3.2.2. Practice .....	24
3.2.3. Cooperatives .....	25
3.2.4. Legal persons.....	25
3.2.5. Home care.....	25
3.2.6. Household responsibilities .....	25
3.3. Factors influencing development of working time arrangements and impacts, according to workers .....	26
3.3.1. Available resources .....	26
3.3.2. Organizational culture.....	27
3.3.3. Working conditions in public and private institutions.....	27
3.3.4. Trade unions, representativeness and autonomy .....	29
3.3.5. Feedback from patients.....	31
3.3.6. Family life and housework .....	32
3.3.7. Working on weekends and holidays and at night .....	34
3.3.8. Living standards and the choice to work more .....	35
3.3.9. Leisure and working time .....	36
3.3.10. Personal security and working time .....	37
3.3.11. Adverse incidents and working time.....	37
3.3.12. Performance measures and organizational objectives .....	38
3.3.13. Working time and health of the health-care workers.....	40
3.3.14. Staff input in changes at the workplace and negotiation power .....	42
4. Discussion .....	44
4.1. Summary of findings.....	44
4.2. Good practices.....	46

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4.3. Gaps in information .....	47
5. Recommendations .....	49
Annex 1. References.....	52
Annex 2. Legislation and jurisprudence.....	58

## Figures

Figure 1. Brazilian political and administrative regions.....	2
Figure 2. Coverage rate of private health-care plans by federative units (Brazil, September 2012) .....	5
Figure 3. Proportion of health-care workers that work more than 44 hours per week, selected metropolitan regions and Federal District, 1998 to 2008 .....	12
Figure 4. Average weekly working hours per job in the health sector (public), according to federative unit (2010) .....	13

## Tables

Table 1. Number of medical consultations per inhabitant in SUS, 2010 .....	3
Table 2. Selected indicators for Brazil, by state .....	6
Table 3. Key informant interviews, by category and region .....	19
Table 4. Workers interviewed, by category and region.....	20
Table 5. Overview of working time arrangements .....	44

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## List of Acronyms

AMB	Brazilian Medical Association (Associação Médica Brasileira)
ANS	Supplementary Health Agency (Agência Nacional de Saúde Suplementar)
ANVISA	National Agency for Health Surveillance (Agência Nacional de Vigilância Sanitária)
BRL	Brazilian real
CBO	Brazilian Classification of Occupations (Classificação Brasileira de Ocupações)
CFM	Federal Council of Medicine (Conselho Federal de Medicina)
CLT	Consolidation of Labour Laws (Consolidação das Leis do Trabalho)
COFEN	Federal Council of Nursing (Conselho Federal de Enfermagem)
CONTER	National Council of Radiology Technicians (Conselho Nacional de Técnicos em Radiologia)
CRTS	Chamber of Work Regulation in the Health Sector (Câmara de Regulação do Trabalho na Saúde)
FENAM	National Federation of Physicians (Federação Nacional dos Médicos)
FGTS	Severance Indemnity Fund for Employees (Fundo de Garantia por Tempo de Serviço)
IBGE	Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística)
ILO	International Labour Organization
IPEA	Institute for Applied Economic Research (Instituto de Pesquisa Econômica Aplicada)
ISCO	International Standard Classification of Occupations
MNNP-SUS	Permanent National Negotiation Table of the SUS (Mesa Nacional de Negociação Permanente do SUS)
PSF	Family Health Programme (Programa Saúde da Família)
SiNNP-SUS	National Permanent Negotiation System of the SUS (Sistema Nacional de Negociação Permanente do SUS)
SUS	Unified Health System (Sistema Único de Saúde)
TST	Superior Labour Court (Tribunal Superior do Trabalho)

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## Preface

Working time has been a subject of central interest for the ILO since its creation in 1919. The very first standard adopted by the International Labour Conference – the Hours of Work (Industry) Convention, 1919 (No. 1) – established fundamental principles regarding the limitation of daily and weekly working hours. Since then, numerous Conventions and Recommendations have dealt with different aspects of working time, including weekly rest and annual leave with pay. In addition, sectoral standards, such as the Nursing Personnel Convention, 1977 (No.149), have addressed specific working time related issues in a number of industries, or have sought to ensure equal treatment in this area for particular categories of workers as compared to other workers.

Working time is a critical aspect of service in the health sector where work scheduling is especially complex due to the imperative need for continuous 24-hour seven-day coverage. Reconciling health workers' wellbeing, including adequate work-life balance, with organizational requirements for continuous service remains a main challenge particularly in the health services sector that involves shift work, night work and working on weekends on a regular basis.

The present working paper explores the complex issues around working time organization and their effects in the health services sector in Brazil. It is one of the products of a research initiative jointly carried out by the ILO Working Conditions and Equality Department (WORKQUALITY) and the ILO Sectoral Policies Department (SECTOR), in follow-up to the Conclusions of the Tripartite Meeting of Experts on Working Time Arrangements (2011). The research initiative aimed to develop a better understanding on how contemporary working time arrangements function in specific sectors and for different types of workers with the main objective of identifying aspects where improvements in working time arrangements and related practices can better meet both workers' needs and organizational requirements.

We hope this paper, which will also be made available in the Portuguese language, will help to stimulate discussion on working time organization and related practices in the health services sector.

Alette van Leur  
Director  
Sectoral Policies Department



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## Acknowledgements

The ILO research initiative on the organization of working time and its effects in the health services sector was conceptualized and managed by Jon Messenger, Inclusive Labour Markets, Labour Relations and Working Conditions Branch (INWORK), ILO Conditions of Work and Equality Department (WORKQUALITY), and Christiane Wiskow, Public and Private Services Unit (SERVICES), ILO Sectoral Policies Department (SECTOR).

The ILO research team would like to sincerely thank the author of this country case study for Brazil, Ms Ana Luíza Matos de Oliveira.

We would also like to thank the national tripartite participants and the managers and workers in health care institutions who participated in them, for their insights into the working conditions, including the working time arrangements and their effects. The completion of this research would not have been possible without the cooperation of the national authorities, and the health care institutions and professional associations that supported the qualitative assessment. Further, we are appreciative for the advice and support of our colleagues in the ILO Country Office Brasília.



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## 1. Introduction and background

For the International Labour Organization (ILO), regulation of working time is a crucial issue in dealing with labour relations because “it lies at the heart of the employment relationship and because of its direct and crucial impact on the protection of the health and well-being of workers” (ILO, 2011, p. 17). In this study, we will present an overview of the working time currently<sup>1</sup> implemented in the health sector in Brazil.

In a country of continental dimensions and regional inequalities such as Brazil, it is important to consider regional specificities such as availability of health-care workers, social and financial difficulties and how these affect working time for health-care workers. For example, a trade unionist in the North Region, in Belém, a metropolis in the middle of the Amazon forest, gave us the following statement:

I can fly from here to São Paulo in a direct flight of three hours, but I cannot reach places in the south of the state with less than two days travelling. I have to take a plane to Altamira,<sup>2</sup> then a boat or car to another place. ... And while you pay R\$300 in a flight from Brasília to Belém, for me to reach those places I spend a minimum R\$2000. ... I think it is very easy to travel in Rio de Janeiro, Minas Gerais, São Paulo.<sup>3</sup>

This situation described by the trade unionist is representative of the diversity of realities inside the same country. These realities must be considered and integrated into planning of the health-care system. Travassos et al. (2000) analysed some differences in access to health-care services depending on the region of the country.<sup>4</sup>

In this study, the Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística, IBGE) division of the country has been used, as shown in figure 1. The Brazilian states and districts composing the regions are:

- South Region: Rio Grande do Sul, Santa Catarina, Paraná
- Southeast Region: Minas Gerais, São Paulo, Rio de Janeiro, Espírito Santo
- Midwest Region: Mato Grosso, Mato Grosso do Sul, Goiás, Distrito Federal

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<sup>1</sup> Study delivered in November 2013.

<sup>2</sup> A city 800 km from Belém.

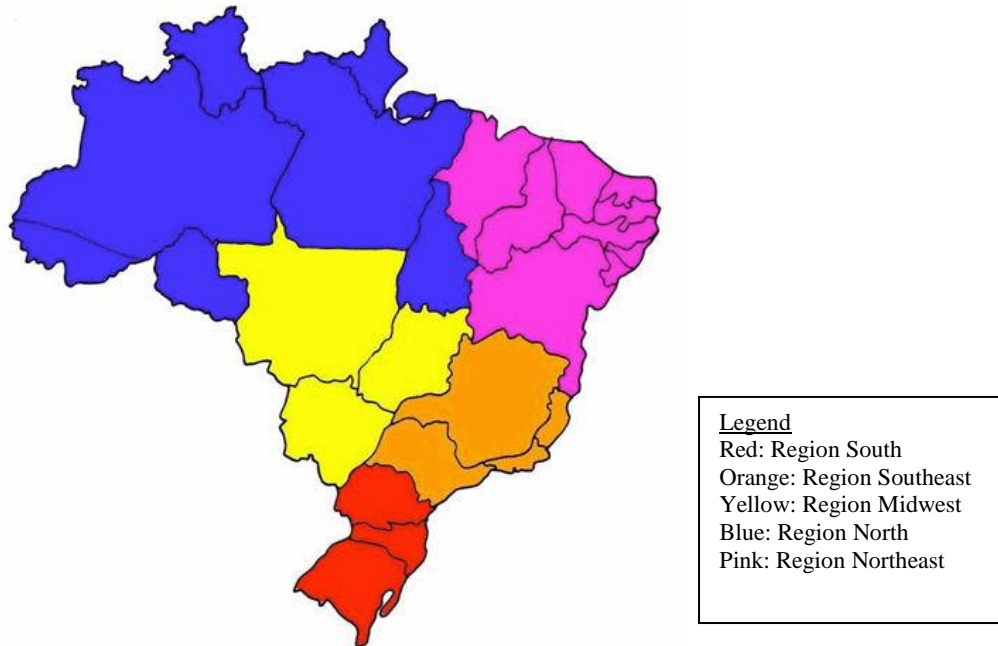
<sup>3</sup> All states in the Southeast.

<sup>4</sup> Throughout June and July 2013, Brazil faced unprecedented protests (Harvey et al., 2013). Demonstrators in the streets focused explicitly on the need to increase public investments in health, education and transportation. The federal Government reaffirmed proposals to extend investments, particularly in health, and to contract foreign physicians (Mais Médicos programme) despite opposition from the Brazilian medical class (AMB, 2013a). In July and August 2013, the so-called “Ato Médico” (Medical Act, Bill 7703/2006) was also discussed. This measure aims to regulate and standardize the attributions of health professionals. Another measure under discussion is the demand from nursing professionals to reduce the working week to a maximum of 30 hours. Many regulations in the health sector were changed while this study was being written. Additional changes that will alter regulations and working time in the health sector may develop in the near future (status October 2013).

- North Region: Acre, Amapá, Amazonas, Pará, Rondônia, Roraima, Tocantins
- Northeast Region: Alagoas, Bahia, Ceará, Maranhão, Paraíba, Piauí, Pernambuco, Rio Grande do Norte, Sergipe.

Each region has similarities in terms of social and geographical characteristics and this division is the background for our sampling process, as will be discussed.

**Figure 1. Brazilian political and administrative regions**



This country case study aims at identifying existing working time arrangements in place in the health service sector in Brazil and studying their influence on workers' well-being, including their work–life balance and organizational performance. Therefore, we will present the legislation regarding working time in Brazil; organizational needs of health-care establishments; patterns of shift scheduling adopted in the country; and mechanisms for consultation with staff (exact procedures). We will also identify key working time-related factors affecting staff morale and performance, and describe staff and managerial perceptions and preferences of working time arrangements.

The study comprises a literature review, with a description of the health-care system in Brazil and the regulation of working time, as well as previous studies done on the subject, followed by a qualitative study that involved interviewing specialists, class representatives, trade unionists, managers and workers from the five regions of the country and their districts (figure 1).

### 1.1. The health sector in Brazil in context

Article 196 of the Brazilian Constitution (1988) states: “Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal

access to actions and services for its promotion, protection and recovery.”<sup>5</sup> The Brazilian health system is composed of both public and private institutions, as legislated in the Constitution (section II, articles 198 and 199) and Law 8080/1990. Both public and private (profit and non-profit) health actors are dedicated to delivering, financing and managing services; researching, producing and distributing health products and technologies; and building human resource capacity. The regulatory function in this sector is performed by two distinct bodies: (a) the National Agency for Health Surveillance (Agência Nacional de Vigilância Sanitária, ANVISA), dedicated to regulating health products, food, ports, airports and borders; and (b) the Supplementary Health Agency (Agência Nacional de Saúde Suplementar, ANS), dedicated to regulating private health care (PAHO, 2007, p. 21)

The public health system, termed the Unified Health System (Sistema Único de Saúde, SUS), is structurally decentralized between the federal, state and county governments. The breadth of coverage of the public health system in 2010 (using the number of medical consultations with the SUS in the national territory as a proxy) can be seen in table 1. Unfortunately, there is no mechanism that allows us to know with certainty how many people used those 517 million consultations.

**Table 1. Number of medical consultations per inhabitant in SUS, 2010**

National/region	No.
Brazil	2.71
North	2.22
Northeast	2.39
Southeast	3.03
South	2.75
Midwest	2.58

Source: Ministério da Saúde/SE/Datasus – SIA/SUS.

The coverage of the SUS expanded slightly throughout the 1990s. The small expansion was caused by on-going decentralization to municipal authorities and expansion of the private sector. Many private establishments in Brazil sell services to the SUS. This includes highly complex services (Silva, 2006, p. 43). According to Law 8080/1990, the funds for the SUS come from federal, state/district and municipal resources.

The SUS has been at the centre of unrelenting political debate and has never attained its main goal of universal access. The SUS emerged as the antithesis of the policies of privatization that had been adopted by the military dictatorship (1964–1985). However, the various democratically elected governments that have held power since dictatorship ended in 1981 have so far failed in the task of reversing a situation of private sector dominance in the absence of public services.

Macroeconomic adjustments and liberalizing reforms adopted since 1990 have undermined its funding bases and restricted investments necessary to expand the public offering. ... A

<sup>5</sup> Constitution of Brazil (1988). <http://www.v-brazil.com/government/laws/titleVIII.html>.

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consequence of this is the deep social and regional inequality, perceived by queues and delays in care consultations, examinations and admissions (Fagnani, 2013).<sup>6</sup>

Private delivery of health care – or the “supplementary health system”, as it is known – is also allowed by the Constitution: “Private institutions may participate in a supplementary manner in the unified health system, in accordance with the directives established by the latter, by means of public law contracts or agreements, preference being given to philanthropic and non-profit entities” (article 199, paragraph 1).<sup>7</sup>

Bahia (2005) affirms that there is an identifiable tension between the public and private health-care systems. She claims that public resources finance demand for private health-care plans, private institutions profit from both public infrastructure and human resources developed with public money, and openings are created for managers of private health companies to take over public posts (Bahia, 2005, p. 11).

Inequality in Brazil remains persistently high. Brazil consistently records a high Gini coefficient as inequalities also exist between regions and between urban and rural environments, and the health system reproduces these inequalities in terms of access to health care. Higher-income citizens typically have access to private health plans. They access health services mainly through private entities that vary from less expensive to luxury health plans. Ability to buy a private health plan is considered as an indicator of being part of the middle- or high-income groups (Bahia, 2013). Meanwhile, lower-income citizens rely almost solely on the public system.

The private health sector in Brazil is large and growing, rising from coverage of 17.9 per cent of the population in 2003 to 25.1 per cent in 2013 (ANS, 2013). Nonetheless, the regional factor has to be considered, as Brazil is a large country with considerable differences between regions, as illustrated in both figure 2 and table 2.

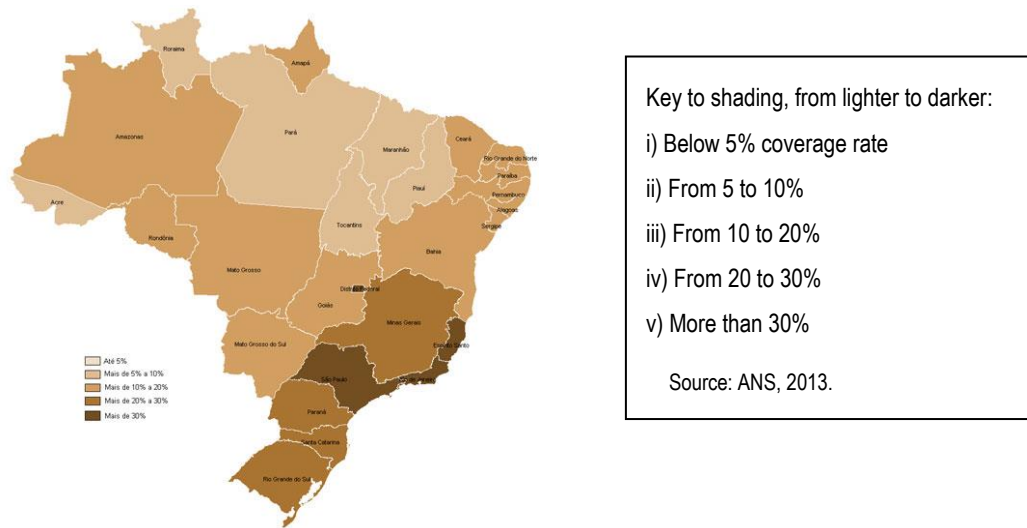
The rate of coverage of private health-care plans in June 2013 was 43.8 per cent for populations living in state capitals, while 25.1 per cent of the total Brazilian population had coverage. The South and Southeast Regions, as well as the Distrito Federal, show higher levels of health-care plan coverage than the North, Northeast and the rest of the Midwest Region. The Human Development Index distribution shows the same regional patterns. There is a significant regional diversity in the presence of private health-care services in Brazil. The South and Southeast Regions (those with the highest Human Development Index) show significantly greater coverage.

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<sup>6</sup> Free translation by author

<sup>7</sup> Constitution of Brazil (1988). <http://www.v-brazil.com/government/laws/titleVIII.html>.

**Figure 2. Coverage rate of private health-care plans by federative units (Brazil, September 2012)**



Distribution of human resources in health-care services is an on-going challenge in Brazil. The majority of nursing and medical schools are concentrated in the South and Southeast Regions, with a higher Human Development Index. This distribution generates clusters of specialization, high technology, attractive wages and access to the facilities of big cities (Seixas and Stella, 2002). These areas also have higher coverage of health-care plans. According to CFM/CREMESP (2011, p. 8), there are more physicians available for private health care than for the SUS. Table 2 presents data on density of nurses and physicians, Human Development Index, health coverage and other indicators for Brazilian states.

**Table 2. Selected indicators for Brazil, by state**

	State of the Federation	Nurses per 1000 inhabitants, 2008 (a)	Physicians per 1000 inhabitants, 2009 (a)	Human Development Index, 2010 (b)	Rate (%) of coverage of health-care plans: Medical assistance per state, 2013 (capitals) (c)	Rate (%) of coverage of health-care plans: Medical assistance per state, 2013 (total per state) (c)	Gini coefficient, 2011 (d)	GDP per capita, 2010 (e)
North	Rondônia	0.48	1.11	0.690	27.4	13.4	0.465	15 098
	Acre	1.02	1.03	0.663	10.9	5.7	0.492	11 567
	Amazonas	1.82	1.12	0.674	29.1	15.6	0.469	17 173
	Roraima	0.95	1.45	0.707	10.1	6.6	0.503	14 051
	Pará	0.54	0.83	0.646	26.9	9.8	0.507	10 259
	Amapá	0.71	0.99	0.708	14.2	10.5	0.468	12 361
	Tocantins	1.01	1.35	0.699	21.9	7.1	0.507	12 461
Northeast	Maranhão	0.50	0.64	0.639	29.9	6.6	0.545	6 888
	Piauí	0.75	0.92	0.646	21.9	7.6	0.550	7 072
	Ceará	0.77	1.05	0.682	35.3	13.3	0.523	9 216
	Rio Grande do Norte	0.74	1.32	0.684	37.3	15.4	0.528	10 207
	Paraíba	1.07	1.27	0.658	29.6	10.6	0.532	8 481
	Pernambuco	0.61	1.41	0.673	44.9	17.4	0.464	10 821
	Alagoas	0.55	1.18	0.631	28.0	13.1	0.467	7 874
	Sergipe	0.80	1.36	0.665	37.2	14.3	0.530	11 572
	Bahia	0.59	1.10	0.660	28.1	10.9	0.534	11 007
Southeast	Minas Gerais	0.74	1.84	0.731	55.8	26.8	0.476	17 931
	Espírito Santo	0.83	2.03	0.740	70.7	32.3	0.487	23 378
	Rio de Janeiro	1.20	2.71	0.761	53.2	36.6	0.492	25 455
	São Paulo	1.06	2.52	0.783	59.9	44.3	0.468	30 243
South	Paraná	0.76	2.00	0.749	52.6	24.4	0.459	20 813



	Santa Catarina	0.98	1.89	0.774	43.5	22.2	0.436	24 398
	Rio Grande do Sul	1.28	2.31	0.746	47.5	24.1	0.476	23 606
Midwest	Mato Grosso do Sul	0.66	1.63	0.729	25.4	18.5	0.499	17 765
	Mato Grosso	3.97	1.24	0.725	33.0	14.2	0.476	19 644
	Goiás	0.66	1.64	0.735	30.3	15.9	0.465	16 251
	Distrito Federal	1.66	3.80	0.824	31.2	31.2	0.584	58 489

Sources:

- (a) Brazilian Health Ministry, Secretary of Work Management and Health Education (Secretaria de Gestão do Trabalho e Educação em Saúde): Information System for Human Resources at SUS (from administrative records of professional councils) and demographic base of IBGE.
- (b) Human Development Index 2010 – Atlas do Desenvolvimento Humano.
- (c) Rate of coverage SIB/ANS/MS – 06/2013, and Population – IBGE/DATASUS/2012.
- (d) Base de dados do Estado de Pernambuco from IBGE:  
[http://www.bde.pe.gov.br/visualizacao/Visualizacao\\_formato2.aspx?CodInformacao=918&Cod=3](http://www.bde.pe.gov.br/visualizacao/Visualizacao_formato2.aspx?CodInformacao=918&Cod=3)
- (e) IBGE – Contas Nacionais 2010, in Brazilian reals.

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## 1.2. Working time in Brazil

The labour legislation that applies to private sector workers and some public sector workers in Brazil is the Consolidation of Labour Laws (Consolidação das Leis do Trabalho, CLT), which was created by President Getúlio Vargas in 1940. Workers covered by these are often referred to as the *carteira assinada* (signed card), meaning that these workers, who have their *carteira de trabalho* (labour card) signed by their employers, are entitled to various rights, such as the Severance Indemnity Fund for Employees (Fundo de Garantia por Tempo de Serviço, FGTS), to which employers contribute, and unemployment insurance. Other public service workers – public servants – have a different status and are regulated by a specific statutory instrument – Law 8112/1990 – which establishes a different legal framework. Workers with formal contracts (*carteira assinada* or public servants) have access to the system of social security and the labour rights included in the legal framework.

Unregistered employment is illegal but very common in Brazil. In addition to a high level of informality, other forms of employment relationships that have received legal status have become more common as the flexibility of labour laws was increased in the 1990s. These employment forms include work as an external service provider, outsourced employee, employee on a temporary contract, autonomous worker, intern or apprentice (Fornazier and Oliveira, 2011; Baltar et al., 2010; Oliveira, 2013).

The maximum weekly working time in Brazil is 44 hours according to the Brazilian Constitution of 1988, article 7, paragraph XIII, which stipulates that the duration of working time should not be more than eight hours a day and 44 hours a week. A 44-hour working week was only possible due to pressure from organized workers in the 1980s, who demanded a reduction in weekly working time from 48 to 44 hours. Ironically, the successful decrease of maximum working time in Brazil coincided with an increase in overtime work, intensification of work and other more flexible arrangements on the part of employers (DIEESE, 2010, p. 3). Organizational and technological innovations in the last 25 years have made it possible to enhance productive capacity and the intensity of labour. Workers produce much more in the same number of hours, while there are no laws to regulate the intensity of labour (DIEESE, 2010, p. 7). There have not been any reductions in maximum working time since 1988, when it was reduced from 48 hours to 44 hours with a maximum of eight hours per day. A very important observation is that the weekly limit of 44 hours refers to *each* job a worker has, i.e., a worker can have two formal jobs of 30 hours a week without that being illegal, and in this study there are many examples of this practice in the health sector.

The daily overtime limit is two hours. Article 59 of the CLT reads: “The normal duration of working time can be increased by supplementary hours, by not more than two hours, via written agreement between employer and employee, or via collective contract.”<sup>8</sup> Part-time workers, i.e., those that work less than 25 hours a week, are prohibited from doing overtime work. However, it is very common that overtime is requested by employers and constitutes a way to complement income, particularly for health-care workers. Statistics from 2009 show that 36.1 per cent of Brazilian wage earners worked more than the legal working time of 44 hours a week (DIEESE, 2010, p. 5).

In the 1990s, the Federal Labour Court showed greater resistance to strikes and allowed for greater private negotiations between employers and workers. The Ministry of Labour also weakened its regulatory functions, decreasing fines and inspections, giving

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<sup>8</sup> Free translation by author.

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consistent preference to “negotiated over legislated”. Some of the more flexible measures adopted in the 1990s were time banking (Law 9601/1998); allowing work on Sundays (MP<sup>9</sup> 1878-64/1999); flexible remuneration, with the introduction of profit sharing and the end of wage policy (MP 1029/1994); ending wage indexation (MP 1053/1994); allowing greater flexibility for professional cooperatives in providing services (Law 8949/1994); and, later, allowing for workers to perform “intellectual work” under the form of legal persons, with no employment relationship recognized (article 129, Law 1196/2005).

In the context of rapid and consistent economic growth throughout the 2000s, public institutions and unions both worked to reduce fraud and push companies to hire according to current legislation, which improves the situation of workers. The labour movement has contributed to the acquiring of rights despite being fragmented. “There is also an increase in the unionization rate, from 16.7 per cent in 2001 to 18.2 per cent of total occupied in 2008, including the informal (self, unregistered etc.)” (Baltar et al., 2010, p. 30).<sup>10</sup> Since 2004, collective bargaining has started to show more promising results for workers.

### 1.3. Regulation of professions in the health sector in Brazil

According to the Brazilian Classification of Occupations (Classificação Brasileira de Ocupações, CBO), core workers of the health sector are physicians, dentists, nurses (with university degree), auxiliaries in practical nursing (non-graduates) and laboratory assistants, psychologists, therapists (physical therapists and phonoaudiologists) and similar occupations with university degree and acupuncturists, orthopaedic technicians, physical therapy, prosthetics and similar. In Brazil, there are three types of nursing professionals: a nurse, who has a university diploma and deals with assistance to patients and coordination; a technician in nursing, who has completed high school and has a technical degree; and an auxiliary in nursing, who goes through a shorter training period, but whose foundation course no longer exists.

In 2006, those core workers reached a total of 1,469,626 workers (Dedecca, 2008). By the end of 2011, according to DIEESE (2011a, p. 5), there were around 1.4 million active posts in health in the public sector in Brazil. Of those posts, 846,000 were nursing professionals; 174,000 were nurses; and 671,000 were technicians and auxiliaries in nursing. For the purpose of this work, we will concentrate on the following professions:<sup>11</sup>

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<sup>9</sup> *Medida Provisória* (Provisional Measure), enacted by the Federal Executive.

<sup>10</sup> Free translation by author.

<sup>11</sup> Midwives are considered by the CBO to be auxiliaries in practical nursing. Traditional midwives exist in Brazil in rural areas or in small villages and receive a course from the Ministry of Health, though the profession is not yet regulated. Bills 7531/2006 and 2145/2007 on this topic have not yet been voted. As we concentrated in urban regions and capitals in Brazil, we were not able to meet with traditional midwives. Another option for a professional who, together with a physician specialized in obstetrics, wishes to assist in pregnancy, births and newborns is either to study nursing and specialize in obstetrics or directly study obstetrics. Such a professional always works integrated into a multiprofessional team. Although the profession of obstetrics has been recognized by the government since 1986 with Law 7498/1986, it was not until 25 April 2013 that the Federal Council of Nursing (Conselho Federal de Enfermagem, COFEN) decided to accept the profession as affiliated to the council (COFEN, 2013). The obstetrics professional is still very rare in the labour market, as in Brazil there is only one course at the University of São Paulo (Universidade de São Paulo) that trains these professionals, which opened in 2005. Obstetric

1. physicians
2. nurses (university degree)
3. technicians and auxiliaries in nursing
4. medical and pathology laboratory technicians
5. pharmacists and biomedics (performing laboratory analysis)
6. technicians and technologists in radiology.

These professions correspond to the following, according to the International Standard Classification of Occupations (ISCO, 2008):

221	medical doctors
222	nursing and midwifery professionals
226	other health professionals
226	pharmacists
321	medical and pharmaceutical technicians
3211	medical imaging and therapeutic equipment technicians
3212	medical and pathology laboratory technicians
3213	pharmaceutical technicians and assistants
322	nursing and midwifery associate professionals
325	other health associate professionals. <sup>12</sup>

The practice of the profession of a physician, nurse, technician in nursing, radiologist, or laboratory assistant requires a qualification recognized by a public institution (Dedecca et al., 2005, p. 125).<sup>13</sup> Thus, for a group of professions in the health sector, characteristics of the job are not defined by particular characteristics of the health establishment (public or private) where work is taking place, but rather: “The main determinant of the regulation of the function, which characterizes the consolidation as a profession, is the irreversible character of the inherent risk as to the services offered by the sector – that, in this case, includes the client and the service provider” (Dedecca et al., 2005, p. 125). In Brazil, there are some specific norms that need to be observed. Nursing professionals, physicians and radiology professionals each have a specific national council, the Federal Council (Conselho Federal), which regulates those categories. Those entities are legal entities under public law – called *autarquias* – and have considerable autonomy.

The radiology technicians are regulated by the National Council of Radiology Technicians (Conselho Nacional de Técnicos em Radiologia, CONTER), created by Law 7394/1985. The Federal Council of Medicine (Conselho Federal de Medicina, CFM), created by Law 3268/1957, regulates the exercise of medicine in Brazil. Every physician has to be affiliated to a regional entity and have specific qualifications, according to the state where they exercise their duties. The Federal Council of Nursing (Conselho Federal de Enfermagem, COFEN), created by Law 5905/1973, regulates the exercise of nursing professions in Brazil. The nursing profession is the largest category providing health services in Brazil and is mostly female (DIEESE, 2006): according to Barreto, Krempel

nurses are more common in assistance, and in some health establishments we were able to interview some of them. Their views were added to the category of nurses. Other than that, there are courses for *doulas* (also a midwife, from the Greek for “servant”) all over the country with no recognized certification, and this degree is not yet regulated by the government.

<sup>12</sup> Considering receptionists that took part in focus groups.

<sup>13</sup> Some of the laws pertaining to those professions are Law 6684/1979, Biomedicine; Law 7498/1986, Nursing; Decree 85.878/1981, Pharmacy; Law 3268/1957, Medicine; and Law 7394/1985, Radiology.

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and Humerez (2011), in 2011, 87.24 per cent of nursing professionals were women in Brazil, while for physicians the proportion was 41.26 per cent (CFM/CREMESP, 2011). There is not a specific council for workers performing laboratory or clinical tests, as they usually form part of a multiprofessional team, and those workers have specific legislation or regulations to comply with. There are also regional councils (*conselhos regionais*), responsible for regional regulation of those professions and to which workers should be affiliated. Additionally, professional associations and trade unions defend workers' rights and articulate their views. The nursing professionals and physicians are the most organized category in terms of representations, councils, associations and trade unions.

#### **1.4. Working time regulations and practices in the Brazilian health sector**

In terms of direct trade union activity related to the working hours of these professionals, we can highlight the mobilization of the nursing professionals (nurses, technicians and auxiliaries in nursing) to reduce maximum working time at the national level to 30 hours a week via Bill 2295/2000. Radiology technologists and technicians already have a clear working time limit of 24 hours a week, due to their exposure to radiation, as stipulated by Law 7394/1985 and Law 1234/1950. Nonetheless, there is a legal understanding that they can have more than one job, if in each job the limit of 24 hours a week is respected and working hours are compatible (according to Regimental Appeal of Extraordinary Appeal 633.298 STF). In fact they are allowed to have two or even three jobs, working 48 or 72 hours a week or more, if in each job the limit of 24 hours is respected and there is not a conflict in working hours. Other than radiology workers, there is no specific legislation for the other categories studied to limit the amount of weekly working time regarding one job. In this case, the general laws for Brazilian workers are applied to each job (maximum of 44 hours a week).

The difficulty in measuring the precise number of health-care workers arises from the specific characteristics of this sector. Many workers have more than one job and some statistics for this sector present the number of existing jobs, not the number of workers employed. An additional problem is that in some cases, workers do not have a formal contract if they are part of a cooperative or similar organization, so they are thus not taken into account in formal employment statistics.

Productivity gains in the health sector would benefit the population. However, an increase in productivity in terms of reduction of time to assist patients or to undertake tests and examinations can actually diminish the quality of care given to each patient, whether in the private or the public sector, as some of the interviewed workers stated.

Thus, while it is important to focus on the need to expand the health-care network in Brazil, this must be done without increasing the precariousness of work (Junqueira et al., 2010), as that would have negative effects for patients and workers. Efforts to limit uncertainty in labour relations in the SUS include improved working time arrangements (Nogueira, Baraldi and Rodrigues, 2004). State reforms in the health sector have also modified the employment relationships that regulate human resources. Reforms have been focused on increasing flexibility, efficiency and deregulation (Pierantoni, 2000). Following the trend of the broader Brazilian labour market, the tendency towards insecurity of labour contracts in this sector is clear (Dedecca, 2008). This trend began with the increased outsourcing of activities considered non-core to health services, such as cleaning services or transportation, and was completed with the hiring of services via cooperatives and non-governmental organizations. Most measures of flexibility adopted after the 1990s enable the hiring of workers with less structural access to basic rights.

It can be said that although the wage has not been reduced, the increase of the occupation has been accompanied by greater precariousness in employment contracts, increasing the

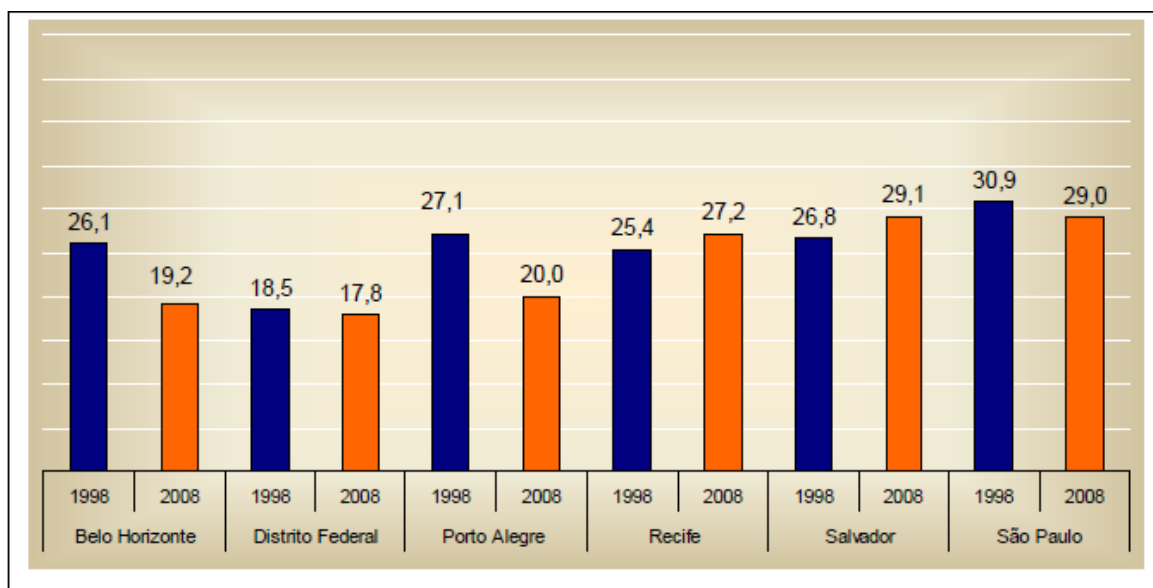
fragility of working conditions in the various segments of the occupational health sector. Even if some of these are distinct, in terms of conditions of employment, from the general labour market, it is observed that they have not escaped the trend towards the greater instability and fragmentation of the 1990s (Dedecca, 2008, p. 101).<sup>14</sup>

Research in the Distrito Federal from 2000 to 2002 came to the conclusion that the health sector was following the same trends as other sectors in the Brazilian economy, showing an increase and intensification of working time, job sharing, versatility, etc. (Dal Rosso, 2008, p. 71). According to DIEESE (2011b, p. 11), if working time is more intense due to technological and organizational changes to such a degree that workers are extremely tired, sick or suffer incidents at work, they will not have the disposition or health to work, which is economically negative for employers and disadvantageous to the personal life of employees.

This has increased pre-existing insecurity in the health sector due to the necessity for some workers to hold multiple jobs. According to the 2006 National Household Sample Survey (Pesquisa Nacional por Amostra de Domicílios), 47 per cent of physicians and 23 per cent of nurses reported having more than one job (Dedecca, 2008). This has implications for both performance and for the personal lives of workers. Albuquerque et al. (2006) draw the same conclusions for professionals of the Family Health Programme (Programa Saúde da Família, PSF).

Figure 3 shows a similar phenomenon. Over time, health sector workers are working more hours, with many working more than the maximum 44 hours per week allowed. It is important to note that according to the ILO (2011), working longer than 48 hours a week is considered a long working week.

**Figure 3. Proportion of health-care workers that work more than 44 hours per week, selected metropolitan regions and Federal District, 1998 to 2008.**



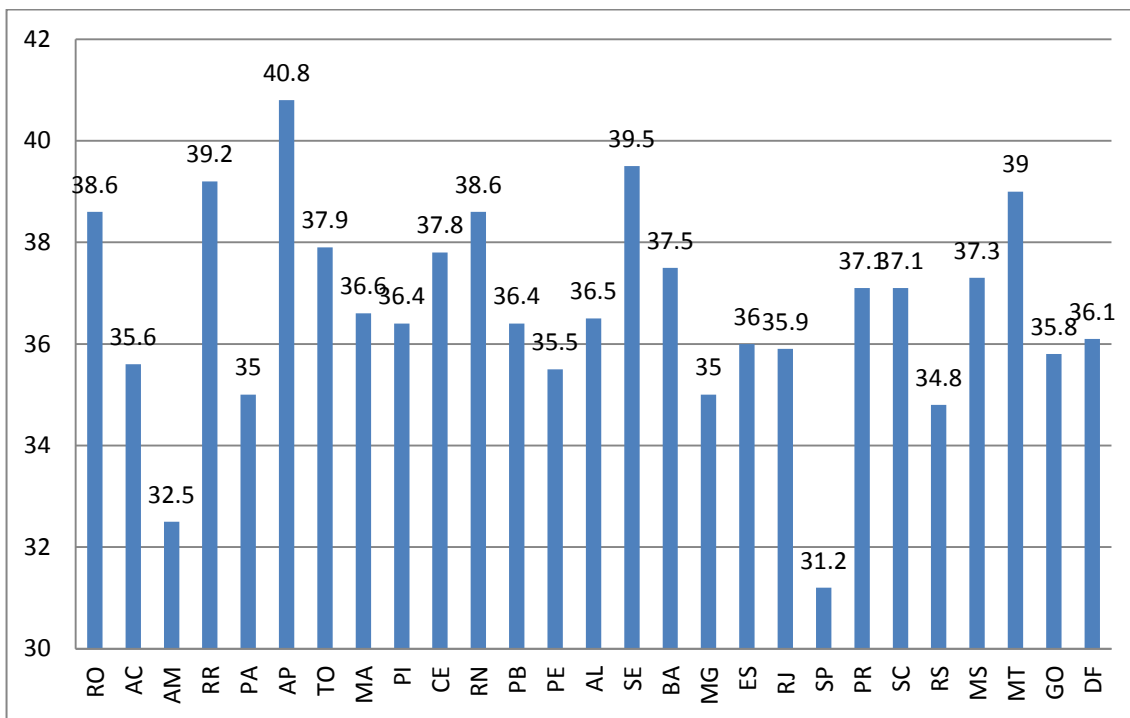
Source: DIEESE, 2009.

Figure 3 clearly shows that a significant number of workers in the health sector work more than 44 hours per week. Considering that workers in the health sector usually

<sup>14</sup> Free translation by author.

have multiple jobs, and figure 4 refers to working time per job, the conclusion can be drawn that average weekly working hours are high.

**Figure 4. Average weekly working hours per job in the health sector (public), according to federative unit (2010)**



Source: RAIS/MTE, elaborated by DIEESE, 2011a.

A multivariate ranking for university degrees and the labour market, authored by the Institute for Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, IPEA), presented data showing that physicians have the best median wages in Brazil (8,459.45 Brazilian reais (BRL), proportional to 44 hours worked in a week), but are also one of the three categories that work the most hours in a week, with an average of 41.94 hours. Nurses have an average wage of 3,495.07 BRL and work 41.27 hours a week. They are one of the 15 professions that work the most hours (IPEA, 2013).

DIEESE (2006) shows that many workers in the health sector hold multiple jobs and this proportion is 3 times greater than for the rest of the population in the regions studied. More than 10 per cent of health-care workers accumulated a mean of 58 hours a week in the region of Recife. These hours of work do not vary significantly from other metropolitan regions studied.

Such professionals, when they experience labour intensity much beyond the limits indicated by legislation designed to protect the worker in Brazil, undoubtedly become even more vulnerable to illnesses. In this case in particular, the interpretation given to information becomes essential, because it is known that health workers, by the nature of their work, are among the groups most exposed to suffering at work. Thus, not only do they put themselves at risk, which is already severe, but they also submit the population they assist to these effects (DIEESE, 2006, p. 10).<sup>15</sup>

<sup>15</sup> Free translation by author.

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According to DIEESE (2011a), 43 per cent of workers in the health sector are employed by the private sector, while 57 per cent are employed by the public sector. Furthermore, there has been a deepening of the existing inequalities among those employed in the health sector. The difference in the wages of employees in the public and private sectors has increased. This was the case for all cities studied by DIEESE (2009). Wages were consistently higher in the public sector and that difference showed an increase.

In terms of working hours, DIEESE (2011c, p. 25) showed that 87.5 per cent of private sector health-care workers in the state of São Paulo and 89.5 per cent of health-care workers in Brazil worked more than 30 hours a week per job. Of nursing professionals, 93.6 per cent in the state of São Paulo and 95.3 per cent in Brazil as a whole worked more than 30 hours a week per job. Physicians maintained a 39-hour main job and an additional job of 13 hours per week, while nurses worked 45 hours per week. Thus, the situation of the nursing professionals regarding working time is relatively more insecure (DIEESE, 2011c).

As to collective bargaining and other labour regulations specific to this sector, on 4 June 2003 the National Negotiation Table (Mesa Nacional de Negociação) was installed on a permanent basis as the Permanent National Negotiation Table of the SUS (Mesa Nacional de Negociação Permanente do SUS, MNNP-SUS). The Ministry of Health has had an important role at this table, as part of the National Permanent Negotiation System of the SUS (Sistema Nacional de Negociação Permanente do SUS, SiNNP-SUS) via Resolutions CNS 52/1993, 229/1997 and 331/2003 (Ministério da Saúde, 2003). The MNNP-SUS is a joint forum that brings together managers and workers in order to address inherent labour relation conflicts (Ministério da Saúde, 2013a). These are formal spaces for collective bargaining on labour relations and working conditions that are attended by representatives of government, private service providers and trade unionists or workers' representatives. The Ministry of Health has done an important job in training workers and supporting them in the implementation of local (state and municipal) negotiating tables (*mesas de negociação permanente do SUS*) (Ministério da Saúde, 2013b). Following negotiation, the protocols from the *mesas de negociação* need to be transformed into bills, decrees or internal normative acts so that they can have juridical legitimacy (Militão, 2011, p. 66). The *mesa* has played an important role in stimulating the reduction of insecurity of labour at SUS, both in defining what it is and in monitoring its substitution in order to guarantee that health workers of the SUS have their rights respected, including in the area of regulation of working hours. In some places, particularly in rural areas or smaller cities and villages, workers do not have a formal contract even if they are employed by the local government. The absence of a formal contract obviously impacts capacity to regulate working time. Municipal government employment without a contract has increased since the 1990s, when those governments faced increasing financial constraints with regard to the employment of workers (Ministério da Saúde, 2013b).

ILO Labour Relations (Public Service) Convention, 1978 (No. 151), was signed by former President Lula in May 2010. Convention No. 151 ensures new rights to public (municipal, state and federal) employees, including freedom of association and inclusion of these professionals in negotiations about working conditions, via Legislative Decree 206 (DIEESE, 2012a). Private sector workers have the right to collective bargaining. Other instruments for collective bargaining and discussion at the public level are (a) the Chamber of Work Regulation in the Health Sector (Câmara de Regulação do Trabalho na Saúde, CRTS), a permanent consultative body also established under Law 8080/1990; and (b) the National Interinstitutional Committee for Protection of Employment Relationships of the SUS (Comitê Nacional Interinstitucional de Desprecarização do Trabalho no SUS), created in December 2013, which seeks to address problems affecting



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labour relations of workers in the SUS who have unconventional contracts (PAHO, 2013).

### 1.5. Effects of working time (including literature review)

There is a wide variety of working time arrangements in Brazil for health-care workers, according to (a) the private or public sector; (b) municipal, state or federal level; (c) those that have a contract (even in the public sector), those that excelled at an entrance examination and thus have more job security in the public sector (*concurados*), and those that have no formal contract and are service providers; (d) those that work on their own for cooperatives and health plans; and (e) those that are outsourced to a private or public establishment. Thus, the total number and organization of working hours vary according to the contract and type of labour relations that govern the employment relationship that workers have with the health establishments where they work. We found workers performing the exact same function but with very different working time arrangements within the same health establishment.

Efforts to reduce the diversity of workers' contracts in the health sector are being made in order to meet social needs in a more efficient manner. The Ministry of Health has opened discussions on a new regulation for workers in both the sectors included in this study and those that are not. These discussions were advanced at the International Seminar on Labour Regulation of Health Professions that took place in Brasília in August 2013, but implementation will require time and political power and will.

Much of the emergency room and intensive care unit work is organized on a shift basis. Workers in these areas are most likely to be under a shift structure organization, including time banking schemes and shift structures such as a clockwise shift. Others work from 9 a.m. to 6 p.m. from Monday to Friday and are subject to more flexible working time arrangements, including time banking, overtime, and working on weekends and holidays (Fares and Oliveira, 2011; Oliveira, 2013). There is also the possibility that workers combine a 9 a.m. to 5 p.m. job with another at night or on weekends.

It is necessary to have shift, night or weekend work in this sector, given that health services are required 24 hours a day, seven days a week. However, we should note that increasing flexibility beyond what is actually needed to secure health-care assistance at all times may actually be hazardous and inefficient for both health workers and society. Risks include increased workload and diminished leisure and rest time, which may affect work and even have irreversible consequences for patients (Dedecca, 2008). A further risk is that workers' lives and the lives of their families become completely subordinated to the economic sphere (Krein, 2007).

Working time arrangements in the sector evolve in the same context of unequal power that exists in all labour relations. Particularly in the private sector, the employer has more power to impose conditions of work than the employee, given that employers are free to choose whom to hire and fire while workers need employment to fulfil their livelihood needs. Extreme flexibility can contribute to precarious work. In the public sector, however, workers, especially physicians, have more autonomy.

Numerous publications have described the negative effects on sleep and performance in shift workers, non-diurnal workers, and those with irregular work schedules, including in Brazil (Fischer, 2004). Shen et al. (2006) found shift workers with chronic fatigue. A broad and recent literature review on the topic of excessive working hours in the health sector in Brazil (Robazzi et al., 2012) found that overwork-related health problems included job stress, burnout, violence, musculoskeletal disorders, absenteeism, accidents, medication errors, and other mental or physical illnesses.

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Studies in Brazil have shown accumulated sleep deficits, excessive sleepiness during and after work, biological disorders, difficulties in performing work, increased rates of accidents and other consequences of unsafe or unhealthy working conditions (occupational and environmental stressors, including shift work organization), unhealthy lifestyles (such as smoking, alcohol consumption, sedentary habits, and poor nutrition), lack of social support, and other negative psychosocial factors (Fischer, 2004). Health-care workers are in a particularly difficult situation due to the nature of their job, which requires high degrees of emotional involvement. The emotional component of care work differentiates it from other professions that do not deal directly with care (Dal Rosso, 2008, p. 198). Papadopoulos et al. (2010) suggest a link between the disruption of circadian rhythms caused by rotating shifts and night work with carcinogenesis and peptic ulcers, metabolic diseases, coronary diseases, disturbances of the menstrual cycle, preterm births, low birthweight, sleep disorders, stress, burnout, depression, excessive alcohol use, smoking, chronic fatigue, etc. There is a growing body of scientific literature demonstrating the effects of long and non-standard working hours on health and well-being, including stress, fatigue, sleep disorders, adverse health behaviour such as smoking and sedentary lifestyle, as well as cardiovascular disease, gastrointestinal disorders, and musculoskeletal and mental disorders (Johnson and Lipscomb, 2006, p. 924). Medical residents and truck drivers have basically similar sources of fatigue and are likely to react the same way because of sleep debt and disturbed circadian rhythms (Johnson and Lipscomb, 2006, p. 928). Matejovic et al. (2011) evaluated health consequences for physicians after working a 24-hour shift and found alterations in the blood coagulation mechanism before and after work. All of those conditions can affect the level of safety for workers and patients. Cordova et al. (2012) show that patient outcomes on weekends and at night are worse than during the day, possibly due to long working hours and less rest as well as lower staffing levels, differing from weekly day shifts.

Pires et al. (2010) argue that witnessing pain, suffering and disease, as well as shift working on weekends and holidays, added to poor working conditions and undervaluation, lead to dissatisfaction, diseases and increase in professional changes among nursing professionals. Portela, Rotenberg and Waissmann (2005) indicate that both professional and home environments are relevant in the evaluation of the effect of work overload on nurses' health and their family and social life. According to Martins et al. (2009, p. 2), health professionals in Brazil form a group of mostly female workers with a rigid hierarchical structure and almost always have an insufficient number of workers.

According to Martins et al. (2009), working conditions are worse for nursing professionals as they have fewer possibilities to alter the organization of work and working time. Silva et al. (2006) show that there is a deficit in assistance by nurses due to a long and heavy working time. Johnson and Lipscomb (2006, p. 925) say nurses are a particularly important population to study because the effects of their exhaustion and fatigue are also likely to have an adverse impact on the safety of their patients. Silva, Rotenberg and Fischer (2011) found that many workers in the health-care system reported having little time for rest and leisure and that current working time arrangements combined with multiple jobs could provoke psychological and musculoskeletal disorders, exhaustion, fatigue, lack of sleep, insomnia, complaints of little family time, etc.

Another risk for health-care workers is the daily exposure to unhealthy conditions, including radiation and toxic chemicals in addition to many diseases. Prüss-Üstün, Rapiti and Hutin (2003) report that health-care workers worldwide suffer about 3 million accidents a year with needles, with serious effects: 37 per cent of hepatitis B, 39 per cent of hepatitis C and 4.4 per cent of HIV infections in health-care workers are due to occupational needle-stick injuries.

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Working time arrangements found in health-care establishments visited and those depicted by workers' representatives are described in the results section below. Many of the testimonies corroborate the scientific studies quoted in this section.

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## 2. Methodology

The first part of this study consisted of a literature review, with a short overview of the health-care system and regulation of working time, as well as previous studies done on this matter in Brazil and worldwide. The exploratory nature of this investigation also favoured a qualitative approach. This involved gathering insights, opinions and recommendations from target groups and a qualitative research element consisting of focus group discussions with managers and workers in selected health-care organizations and establishments and interviews with key informants aimed at (a) identifying the actual working time arrangements in the national health service sector and their practical application to the sector; (b) acquiring in-depth information about the types of working time arrangements in place, including specific variations within the same type of arrangement; and (c) obtaining informed opinions and insights as to the impact of these existing working time arrangements on both worker well-being and organizational performance.

Regional diversity and specificities combined with the sheer size of Brazil make for a complex case study. For representational purposes, it was important to visit health establishments from the five different regions of the country according to the IBGE division previously mentioned (see section 1 and figure 1). This meant travelling over 14,000 kilometres in order to perform interviews from June to August 2013. At least one capital of each of the five regions was visited. The choice of health establishments was made considering their size, availability to contribute to this study and variety of representation (private and public, small and large establishments).

For this study, we visited:

- three university hospitals<sup>16</sup> in the North, Midwest and Northeast Regions;
- one *casa de saúde* (health centre)<sup>17</sup> in a metropolitan area in the Southeast Region;
- two private elite hospitals in the South and Southeast Regions;
- one small private<sup>18</sup> orthopaedic hospital in the Midwest Region.

Out of 18 health-care establishments contacted, seven were visited, including at least one in each region of the country, while 11 refused authorization to perform focus group discussions and interviews with workers of the establishment. Additionally, we interviewed individual workers not associated with the establishments visited. Those workers have different working experiences and added to our study in terms of variety (urban and rural experiences; private and public; regional and income variations). Individual workers interviewed worked in a public trauma hospital in the Southeast Region, in a general public hospital in the Midwest Region, in other private hospitals and private clinics in the Southeast Region, at health centres in metropolitan areas of the Midwest Region and at federal government buildings in the Midwest. We interviewed (individually or in focus groups) a total of 164 health-care workers (physicians, nurses,

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<sup>16</sup> A university hospital is connected directly to a university and is used as a centre for the teaching of professionals (Ministério da Saúde, 1977).

<sup>17</sup> A health centre is a complex sanitary unit, with ambulatory services (Ministério da Saúde, 1977).

<sup>18</sup> A private hospital integrates the patrimony of a juridic or natural person of private law (Ministério da Saúde, 1977).

auxiliaries and technicians in nursing, laboratory workers, radiology workers and receptionists). Managers of these establishments and health-care workers with managing experience were also interviewed.

Key informants included representatives of trade unions,<sup>19</sup> members of professional associations,<sup>20</sup> patients' organizations, government officials, and national experts in the fields of working time and occupational safety and health. Of 10 patients' associations contacted, eight refused interviews. Also, more than four trade unions and seven professional associations of the health sector refused to be interviewed. The main objective of meeting with specialists in the health sector and on labour relations was to collect new data so as to identify the working time arrangements in place in the health service sector and to examine their impact on workers' work-life balance and organizational performance. In total, 30 key informants were interviewed.

We contacted seven members of employers' organizations or the organizations directly, including owners of private health service organizations and establishments as well as administrators of private health plans. In several cases we did not receive a response. In other cases, employer contacts were not interested in being interviewed. This represents a limit to our study, as we only interviewed seven health-care establishment managers and no members of employers' organizations or health-care plan representatives. Most interviews and all focus group discussions were conducted in person. One was made by telephone and six by email. Tables 3 and 4 show key informants and workers interviewed, by category and region.

**Table 3. Key informant interviews, by category and region**

Categories	Southeast	North	Midwest	South	Northeast	National	
Professional associations	1	0	0	1	1	3	
Trade unionists	3	1	0	1	3	0	
Patients' associations	0	0	0	0	0	2	
Managers of health-care establishments	2	1	2	1	1	0	
Specialists (universities, government, organizations)	0	0	0	0	0	7	
Key informants interviewed by region	6	2	2	3	5	12	
Total key informants interviewed							30

<sup>19</sup> We included five trade unions in our interviews: two were of workers in public institutions (state level), two were of physicians (state level) and one of nurses (state level).

<sup>20</sup> Two nursing class associations at state level, two nursing class associations at national level and one doctors' association at national level.

**Table 4. Workers interviewed, by category and region**

Categories	Southeast	North	Midwest	South	Northeast
Nurses	2	3	4	4	7
Technicians and auxiliaries in nursing	6	6	4	12	5
Physicians	10	6	10	6	7
Radiology technicians and technologists	5	3	7	5	6
Laboratory technicians and other analysis workers	0	2	5	4	6
Managers and health professionals with managing position	2	3	7	3	1
Receptionists	0	0	1	1	0
Technicians and auxiliaries in nursing working in laboratories	5	4	0	2	0
Professionals interviewed by region	30	27	38	37	32
Total professionals interviewed	164				

In the following section, we will comment on results obtained from our focus groups and interviews, including what working arrangements we encountered. For confidentiality reasons, each worker was labelled according to the categories in table 4. For example, nurse Southeast 1 is a nurse that works in a health-care establishment in the Southeast Region, and trade union (physician) Northeast 1 is a trade unionist of the physician category working in the Northeast Region. In cases where there is no reference to a region, informants interviewed represent organizations at the national level. All interviews were conducted in Portuguese and excerpts were translated to English. Extracts of interviews and focus groups are available throughout the text.

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## 3. Findings

### 3.1. Working time arrangements in practice

While visiting the health establishments and interviewing specialists, we found the subsequent time arrangements for the selected health professional categories. Some advantages and disadvantages of each of these arrangements for workers, employers and patients are suggested. These suggestions are based on ILO, 2011, Fares and Oliveira, 2011, and Oliveira, 2013. Additionally, the suggestions are complemented in the subsequent sections by workers' impressions.

- **“12x36”**, meaning that workers have a shift of 12 hours and rest for 36 hours. This can be considered a compressed working week arrangement. Example: On Monday, work from 7 p.m. to 7 a.m., then rest until Wednesday 7 p.m., when a new shift starts. Then work on Friday night and again on Sunday night, Tuesday night and so on. This arrangement applies most commonly for nurses and laboratory technicians and, among those workers, those that work night shifts. This system provides more continuous care for patients in specific sectors. Those doing shifts within a 12x36 regime work 180 hours a month. This arrangement was recognized as valid by Docket 444 (Resolution 185/2012) from the Superior Labour Court (Tribunal Superior do Trabalho, TST). Workers are entitled to double payment in case of working on holidays. This arrangement results in less commuting time and transportation costs for workers and employers, and for workers it means fewer workdays combined with longer working hours. Regarding organizational performance, this guarantees workers will be available on weekends and nights, ensuring assistance at all times. A negative consequence is the disruption of circadian rhythm mechanisms when working at nights. This impacts workers' health negatively and is connected to other adverse conditions. “The long uninterrupted days observed in this kind of scale, such as the ‘12x36’, exposes the worker to long hours of continuous activity and may harm his/her health or even cause accidents at work due to fatigue and lack of concentration” (Fares and Oliveira, 2011, p. 12).
- **“6x1”**, meaning that workers work six days and have one day off, usually working six hours a day. The number of days off in a month depends on the quantity of Sundays and holidays in the specific month. The days off are previously defined by the employer or manager and could fall on any day of the week. Workers interviewed affirmed that they usually did not work more than ten days in a row. This arrangement was most applied for nurses and laboratory technicians, the majority of whom worked in private hospitals. Those that work this arrangement typically work 42 hours a week. Regarding organizational performance, this guarantees workers will be available on the weekends, ensuring assistance at all times. Workers, on the other hand, complain about very rarely having a free Saturday or Sunday. Workers may also trade their shifts with other workers practising the same arrangement for personal reasons. Some establishments limit the number of changes a worker can make in a month.
- **Shift working arrangements of 12/24 hours**, meaning that the worker has a compressed working time of 12 or 24 hours. Shifts of 12 hours are regulated in the university hospitals visited by Decree 7186/10, and other cases rely mostly on resolutions of regional councils. This arrangement is most applied to night shifts for radiology technicians and technologists, nurses and laboratory staff, physicians in night or weekend shifts, and specific areas such as an intensive care unit. This is useful for health establishments, given the need for more continuous care for some patients and some specific areas. For workers, this

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arrangement means fewer workdays, but longer working hours. For organizational objectives, it reduces time in passing on cases and patients to another worker. In some cases, workers choose to work shifts to avoid traffic and transportation costs. Workers may also trade their shifts with other workers practising the same arrangement, but some establishments limit the number of changes a worker can make in a month, depending on the profession of the worker. Physicians typically have more flexibility for changing shifts than technicians. In some health establishments, workers receive a specific amount of money for a 12-hour shift, counting all hours worked equally. In others, workers receive a normal wage per hour until the eight hours worked. The four hours that exceed normal working hours according to Brazilian legislation are paid as overtime and thus are remunerated at a higher level. This arrangement results in less commuting time and transportation costs for workers and employers, and a 12-hour shift is the best option for employers to guarantee assistance in the overnight hours. A negative consequence for workers is the disruption of circadian rhythm mechanisms when working at night, which is connected to other adverse conditions.

- **Fixed working arrangements** of daily work of four, six or eight hours a day, usually on weekdays and sometimes on one of the days of the weekend. Workers that have this kind of arrangement usually work on a fixed schedule every day (five or six days a week) and usually have a contract for hours worked in a week. If they work six days, the day off is usually decided in a scale previously defined by the managers, but usually falls at the weekend. This arrangement is most applied to physicians, radiology technicians, nurses and laboratory staff, and can be of 20, 24, 30, 40 or 44 hours a week, depending on the category, workplace and terms of contract or entrance examination (for public employees and servants). Socially, a 20 hours per week job for a physician is not considered a part-time job, and this working time is still followed most commonly in public establishments, depending on the contract.<sup>21</sup>
- **60 hours a week for resident.** Residents have a special “training” weekly working time of 60 hours during the period of the residency, which is considered a “high-level internship”. Residents are not entitled to labour protection as a regular worker (Lima, 2010). This is regulated by Law 6932/1981. Residents are not prohibited from working in other establishments.
- **24 hours a week.** Radiology professionals (technicians and technologists) have a maximum workload per week of 24 hours, due to their exposure to radiation. This is regulated by Laws 7394/1985 and 1234/1950.
- **Combined extended work and leave periods,** characterized by a number of weeks working in remote areas of the country and a number of weeks off work. Mostly applied for physicians and nurses, this arrangement results in less commuting time and transportation costs for workers and employers.
- **On-call work, zero hours or “as and when required” arrangements,** characterized by a requirement that physicians or coordinators of sectors or departments be available to work when called. Many reported working this arrangement, combined with others.

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<sup>21</sup> In fact, the National Federation of Physicians (Federação Nacional dos Médicos, FENAM) (2013) argues that the minimum wage for a physician should be 10,412 BRL for 20 hours.



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- **Working time banking arrangements**, characterized by the possibility of accumulating hours that can then be taken off as extended leave in a subsequent period or used to reduce the total overall lifespan of work. This is more common in private hospitals with the electronic control of beginning and end of working time. Workers can choose to use hours accumulated to have free time to spend with family and in social events or receive monetary compensation for the hours worked. Some workers report that this system allows them to better plan ahead time for social and family events and that it facilitates the combining of multiple jobs. This was found to increase workers' motivation and productivity. This arrangement is more complex to manage, but employers can save on paying overtime and are able to adapt more easily to variations in demand.
  - **Regular overtime hours arrangements**, characterized by hours worked in addition to the contractual hours usually worked, compensated by the employer at a premium. Overwork is sometimes necessary for organizational needs and to complement income. Workers at times complain they feel forced to work overtime because the size of the team is not adequate. Workers indicate that if colleagues are on leave or absent, there are not enough workers, so the remaining feel obliged to substitute. Overtime can damage worker's mental and physical health and adversely affect patient safety. Workers claim it increases fatigue. It is sometimes used not as a sporadic instrument, but as the answer to systematic incorrect proportioning of the professional staff needed, making professionals more tired and allowing employers to avoid hiring more workers. Radiology technicians/technologists North 1, 2 and 3 claimed that they preferred that health establishments did not hire more workers, because the overtime hours they worked complemented their income. Where there is not a control of overtime in place (for example, the time spent passing on information of the shift to the next worker on charge, which usually takes place after normal working hours), workers are regularly disadvantaged.

## **3.2. Difficulties in measuring real working time in the health sector**

### **3.2.1. Multiple jobs**

As discussed in previous sections, most health-care workers have multiple “full-time” jobs and non-conventional working hours, both of which are allowed by current legislation. Some statistics that measure working time via declaration of the employer consider working time in a specific workplace, thus not capturing the real situation of health-care workers that hold multiple jobs.

According to manager South 1, health-care workers were aware that when they chose that career they also chose to have multiple jobs, and in the beginning they enjoyed having a second income. For manager South 3, most absences were for osteomuscular diseases and psychiatric disorders, and those absences were more frequent in those professionals that had two jobs. “Of course they are not going to come to us and say ‘I am sick because I am working too much,’ but we can infer. Because there is always the question that the professional says ‘I need to have two jobs, I have a living standard to maintain’.” Manager South 2 said she saw an interesting study made with health professionals wherein a researcher delivered cameras to health-care workers with instructions for them to photograph things related to their working environment and then discussed the photos with them. One of them took a picture of a bank that advertised being available 30 hours a day. The worker said he felt the same, as if he worked 30 hours a day. This was not only a characteristic of the South Region, but can be

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generalized to the entire country. The data in section 1 show that health-care workers work more hours in a week on average and are more likely to have multiple jobs.

Most of the physicians interviewed were working more than 44 hours a week, due to multiple jobs, with at least one of those jobs usually in a public health-care facility. Class representative (physician) National 1 claimed there were physicians working 24 hours and resting 36 hours on a constant basis. Usually, residents showed a greater number of hours worked, reaching even 108–120 hours a week to complement income. Physician Northeast 7 said:

As a resident, I work 60 hours a week in this hospital. Until one month ago I worked between 84 and 120 hours a week, but now I have decreased it. I work a maximum of 112 hours a week. It is because I work in other places: in another place I work 36 hours more a week and I'm on call in other places 12 hours a week. ... A friend of mine, who is also a resident, worked 72 hours in other places, i.e., she worked around 132 hours a week. Then she acquired celiac disease. Now she only works 120 hours a week. Now the problem is "taken care of" [laughter].

Considering that there are 168 hours in a week, a person that works 132 hours a week has 36 hours a week for sleep, eat, rest, study, family, social life and leisure, i.e., approximately five hours a day. Physicians that work less than 44 hours say that they work too little and they usually choose to do so if they are studying or, if female, have small children (none of the male workers pointed to children as a reason for working fewer hours).

Nurses interviewed also usually worked more than 44 hours. This was a category mostly composed of women who were also responsible for domestic work. Laboratory technicians and nursing technicians also usually had two jobs, working each day 12 hours (not 12x36 but 12x12). Manager Midwest 1 claimed that the arrangement 12x36 made it easier for 99 per cent of the employees of the hospital to have two or three jobs, but that they were always tired. Professional association representative nursing 1 said that weekly working hours were more than 44 hours. Nurse Midwest 2 claimed she worked from seven to 19 hours every day in two different jobs, while technician/auxiliary in nursing Northeast 5 worked 48 to 60 hours a week between two jobs. Technicians/auxiliaries in nursing Northeast 1 and 2 worked 64 hours and 70 hours a week each, having two jobs. According to professional association (nursing) Southeast 1, due to having two or three jobs, nursing professionals were getting sick and were chronically exhausted, with heart and blood diseases or mental disorders. Professional association (nursing) Northeast 1 and trade unionist Southeast 3 both reported that many workers used licit and illicit drugs to keep standing up.

Although radiology workers had a limited working time of 24 hours a week, most of the professionals interviewed had two or three jobs, and thus worked up to 72 hours a week. Some of them claimed that the number of hours they worked impacted performance at work (radiology technician/technologist Midwest 3). Others reported working from six hours to 20 hours at three different places every day (radiology technician/technologist Southeast 1).

In general, the health-care workers interviewed chose to work multiple jobs to maintain a certain living standard and preferred to accept jobs that allowed them to be combined with another one.

### **3.2.2. Practice**

Some physicians chose to open a practice to complement working hours and income, and for other interests. Physicians could either accept private consultations (in which the patient paid when receiving a service) or via a health plan. We are not aware

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of available data on the exact number of hours a physician works in a practice. There is also not a limit for hours worked in this manner.

### **3.2.3. Cooperatives**

It is very common that physicians are associated to medical cooperatives that either offer services to a health plan or directly sell health plans themselves. Physicians can either offer care in practices (as stated above) and be paid directly by the health plan or work directly and regularly at a health-care establishment (private or public, but more commonly in private establishments) and be paid through the cooperative, without formal contract with the health establishment (trade union (physician) Northeast 1 and physician Southeast 9). We found that there were also nurses and nursing technicians that worked in the same manner. Thus, the number of hours worked depended on the availability of the worker, which was extremely difficult to measure (trade union (physician) Northeast 1). Payment depended directly on the number of hours worked, and the value of each hour could depend on productivity indexes (physician Southeast 9), on the state of health of patients assisted or on procedures performed, even in an intensive care unit, as physician Southeast 10 reported. In some cases, cooperatives functioned like a company, having major partners that received a considerable share of profits (class representative (physician) South 1).

### **3.2.4. Legal persons**

Some health establishments (mostly private) do not hire physicians as employees, but as “legal persons”, which in practice functions like a contract between two enterprises. This allows the physician to pay less tax on income and property and also presents advantages for the health establishment in that it does not have to recognize an employment relationship between the physician and the organization (class representative (physician) South 1). This also allows the physician to work longer shifts than those allowed by law. This arrangement usually allows health establishments to meet organizational objectives. As this relation is formally via enterprises, working hours are not regulated as in other sectors.

The physician contracted as an enterprise accepts full risks, is more vulnerable. In case of an accident with a patient, they are responsible for mistakes, or in case of bankruptcy of the health establishment, they have less guarantees to get paid (trade unionist (physician) South 1).

This type of contract is expanding in many parts of the country. According to Girardi and Carvalho (2002), only 6 per cent of the private hospitals in São Paulo and 2 per cent of the private hospitals in Minas Gerais choose to pay wages to physicians. Most are contracted through cooperatives or outsourced completely. This practice is expanding to the public sector, where it is estimated that more than 40 per cent of the contracts for health services are compensated in forms other than wages (Girardi and Carvalho, 2002).

### **3.2.5. Home care**

There are enterprises that offer home care and have a formal contract with the professional that provides the care, but in some cases home care is an informal activity and very difficult to measure.

### **3.2.6. Household responsibilities**

Female workers usually stated that they were also responsible for domestic work. This generated an increase in working hours in an uneven, gendered manner. Rotenberg

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et al. (2008) consider the domestic sphere in evaluating working time, which is a very interesting approach considering the predominantly female gender of health-care workers in Brazil.

### **3.3. Factors influencing development of working time arrangements and impacts, according to workers**

In organizing working time, factors that need to be taken into account include current legislation, pressure of trade unions and professional associations, will of employers and broader government policies. Working hours or the type of working arrangement are usually defined at the time of the contract or entrance examination for a public position.

#### **3.3.1. Available resources**

At SUS, there are financial restraints (Fagnani, 2013; Bahia, 2013) that compromise care for the population and working conditions for workers in public establishments.

Since its inception, SUS has been the object of political resistance that constantly undermines its chances of completion. SUS could never be universal and public, as stated in the Constitution. It emerged as the antithesis of the policy adopted by the privatizing military dictatorship, but inherited 21 years of wild expansion of commodification of the sector. Democratic governments have failed the task of reversing the predominance of private supply and absences of public supply. Macroeconomic adjustments and liberalizing reforms adopted since 1990 have undermined its funding bases and restricted investments necessary to expand public supply, especially in average and high-complexity systems. A consequence of this is the deep social and regional inequality in public supply at this time, perceived by queues and delays in care consultations, examinations and admissions (Fagnani, 2013).<sup>22</sup>

Solving the financing of this system would augment investment in the sector, thus improving working conditions, hiring more workers and hence diminishing stress at the workplace, as well as enhancing access to quality public health care.

At the private level there are more available resources and the constraints usually come from the conflict between the objectives of quality assistance to patients and other institutional objectives such as reducing costs or increasing profits. If in the public sector there are financial restraints, in the private sector there are restraints due to the commodification of health-care assistance, submitting assistance to market laws and to the objective of maximization of profits (Bahia, 2013).

As for available health-care workers, there is a shortage of qualified personnel (Rede Brasil Atual, 2013). Demand on existing workers to increase working time is the most common method used in attempts to alleviate the shortage of qualified workers. AMB (2013b) showed that the number of physicians in the private sector is greater than the number available for the public sector, despite the fact that only 25 per cent of the Brazilian population has access to the private sector. The Mais Médicos programme also seeks to attract physicians (national or foreign) to more remote areas of the country, but this programme focuses exclusively on physicians.

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<sup>22</sup> Free translation by author.

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### **3.3.2. Organizational culture**

For the majority of workers, working in the health-care sector means having a life of sacrifice in terms of working time. It was difficult for health-care workers to see possibilities in changing working time. When asked, “What would be the ideal working time arrangement?” or, “If you could change something about your working hours, what would that be?”, it seemed very difficult for health-care workers to imagine very different working hours from what they had today. Most of them said that “it comes with the profession”, “if you work in the health sector, you choose to work like this”, “if you do not like these working hours, you have to find another career”, “what can we do, this is our reality”. Workers offered those responses with reference to night shifts, working on weekends and excessive working hours. For some of the workers, it seemed natural to have unconventional working hours.

Although health services have to be available 24 hours a day, seven days a week, institutional modifications could be made to increase workers’ motivation, leisure and family time, enhance patients’ security and thus achieve better institutional results. Some working arrangements are historically defined, such as the length of shifts or the 12x36 shift, and these practices become difficult for workers, managers and government agents to change. Possible changes seen by the health-care workers were on who defined schedules (if managers or workers), how soon changes had to be reported to managers or to workers, and how many changes workers were entitled to make.

### **3.3.3. Working conditions in public and private institutions**

Public employees or servants in Brazil are selected through an entrance examination (*concurso*) with usually many contestants, and after passing this examination they enjoy certain job stability. These jobs are regulated either by the CLT or the Public Service Regulations (*Estatuto do Servidor*), which differs. The government can also contract workers directly via emergency contracts, commissioned positions, etc. In the case of commissioned positions, workers complained that their jobs were at risk when the political party in power changed:

In this working place there is also a political problem: when the government changes, as I only have a contract, I never know if they will continue it. In this place where I work there are not public employees or servants, everyone there was appointed (physician Midwest 2).

The government can also outsource, offering a service formerly offered directly by the State directly to the private sector. Outsourcing impacts everything from cleaning services to radiology and laboratory services. Outsourced employees have a contract with an enterprise and not directly with the health establishment, and so do not have the same rights as an employee of the establishment. For example, the orthopaedic hospital visited in the Midwest Region outsourced radiology services; the private hospital visited in the South Region outsourced laboratory services; and the public hospital visited in the North Region outsourced radiology and laboratory services. Laboratory technician/other analysis worker North 2 complained that she could not park inside the hospital like other workers, although she worked at the same hospital every day. Working hours were also very different for outsourced workers. In a public hospital in the North Region, nursing technicians hired directly by the state via entrance examination worked 30 hours a week (from Monday to Friday), while outsourced nursing technicians working on laboratory examinations worked six hours a day with around four to five days off per month (not necessarily a Saturday or Sunday), working around 36 hours a week.

Many physicians reported working 20 hours a week in a public establishment, while working more weekly hours in private institutions. In the case of physicians, there were

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complaints that they did not fulfil the whole working time they were paid to do in the public sector. This practice was highlighted in the media and literature<sup>23</sup> as well as by trade unionist North 1.

Nursing professionals working at many public establishments had a limit of 30 hours working time, but as state nurse North 2 indicated, no law guaranteed 30 hours per week at the national level. Radiology professionals usually had a working week of 24 hours, as established by law in both public and private institutions. For laboratory technicians, working hours at public institutions were also usually less than in the private sector. In all hospitals visited, most workers reported having more free time (weekends and nights) in public establishments.<sup>24</sup>

Working in a public hospital is being in heaven, there is no comparison with a private hospital. I worked in a private hospital, those who have worked there know, it is poison, you do not stop, have little time off (technicians/auxiliaries in nursing North 2, 3, 4, 5 and 6).

Public sector is better, you have more stability, wages are better. And in the private sector you are pressured to work 12x36 (technicians/auxiliaries in nursing Northeast 1, 2, 3 and 4).

My co-workers that also work in the private sector say here it is better, in terms of wages and working time. But some public places administered by private companies have a worse pay (technician/auxiliary in nursing Northeast 5).

Private sector and contracts in the public sector are inhumane, wages are low, most workers have two jobs. Contracts are usually 12x36 (professional association (nursing) Northeast 1).

The private sector is slavery, there you work every other day. You can work up to 44 hours a week. It is not stable (nurse Midwest 1 and manager Midwest 3).

Although working hours were usually less in the public sector, there were some factors that contributed to make working time more stressful. Stressors included (a) a larger number of patients to assist (physician Northeast 2 was interviewed inside the examination room while his resident was attending a patient, because he did not have any free time; or physician Midwest 2, who complained of having only eight minutes to assist each patient, due to performance standards she needed to fulfil); (b) lack of structure and necessary material (many professionals claimed that sometimes they did not have basic instruments such as needles, gauzes, alcohol, etc., as well as sufficient beds or breathing machines, as reported by trade union (physician) Northeast 1, who developed a back problem after resuscitating a patient on the floor because there were no beds available, and said that working conditions in public hospitals were bad); and (c) workers also complained about the insufficient number of professionals, having to replace them in case of absence, leaves, etc., and thus being overloaded in terms of excessive working time and intensity. Trade unionist Southeast 1 said professionals were overloaded and there were not enough co-workers, which generated stress and other diseases.

Even if I have a health attestation, I feel obliged to come to work, I do not want to leave an opening in the team (physician North 2).

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<sup>23</sup> Folha de São Paulo, 2013; Pragmatismo Político, 2013; Bolsão MS, 2013; Gazeta Online, 2013; Estadão, 2013; Bom Dia Brasil, 2011.

<sup>24</sup> In the following, and elsewhere in the document, the quotations given are in some cases representative samples drawn from a focus group discussion involving the participants listed.

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Nurse Southeast 1 said many workers were on leave and those that had to cover for their colleagues' leave were workers themselves. This led to overload and new medical leaves. Radiology technician/technologist Midwest 3 also complained that there were not enough co-workers.

In public hospitals many complaints focused on structures. These complaints referred to the equipment necessary for work and the structures for rest and time to eat meals. Laboratory technicians/other analysis workers Northeast 2, 3, 4, 5 and 6 said the workplace was unhealthy and lacking ventilation. They complained of pests that included rats and cats, and one complained of a ceiling that often fell. Others complained that the water at work was not potable. "Sometimes the water we drink here is filled with larvae, but they say it is harmless, how can that be? We have to bring water from home. When it rains, it floods and the sewer enters the sector. There are too many mosquitoes also. And you have to buy your own individual protection equipment." Physician Midwest 3 also stated that the physical structure for workers was not adequate. Technicians/auxiliaries in nursing working in laboratories North 1 and 2 also complained of a lack of infrastructure for workers to rest and to store personal belongings. Even managers said that the work environment would benefit from better structure.

The workload in a health-care establishment could vary within certain limits, but workers usually reported that staff and equipment were not enough for the work that was needed. Workers in both private and public institutions made complaints about staffing levels and basic infrastructure, but there were clearly more complaints from workers in public institutions. Some workers, such as nurse Southeast 1, who had worked in the same establishments for years, confirmed the findings of Dal Rosso (2008) when describing the intensification of work and increase in workload due to the growth of cities and greater complexity of wounds in emergency sectors (due to increase in violence and more developed weapons), adding that the structure of health-care establishments (equipment and staff) did not meet with that increased and changed demand. Lengthening of working time was easier to measure than intensification of working time. Despite the difficulty of measuring changes in intensity, it remained an important factor to analyse (Fares and Oliveira, 2011).

The situation described suggests that working time in the public sector is stressful due to structural constraints, while in private establishments the pressure is to work a greater number of hours and to strictly follow the organizational needs of the establishment.

### **3.3.4. Trade unions, representativeness and autonomy**

Technician/auxiliary in nursing Midwest 4 indicated that it was better to work in a public hospital in terms of autonomy at work and in terms of wages. Nurse North 1 also reported that professionals had more autonomy in the public sector. The notion of autonomy was interesting when we analysed union presence and participation in the public and private sector. Trade union density was higher in the public sector although workers' participation in union meetings or other activities was low. Public sector unionized workers were more aware of the political demands of the categories they belonged to. In the private sector, most workers did not even know which trade unions corresponded to them and what the status of political demands or recommendations were. One example was the demand of nursing professionals for a maximum weekly working time of 30 hours. In the public sector, most workers were aware of this demand and supported it. In the private sector, very few workers could report that they followed what was happening and they did not participate in any discussions. Some workers in private hospitals, when asked, seemed to be afraid to answer, as if being a part of a trade union carried risks to their jobs.

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Here we don't even deal with trade unions, you know. When there are elections we participate and everything, but for example this question of the 30 hours no one moves (technicians/auxiliaries in nursing Southeast 4, 5 and 6).

I don't know anything about trade unions here (technician/auxiliary in nursing working in a laboratory Southeast 1).

Low participation of workers in either the public or private sector made it more difficult for trade unions to be aware of irregularities or violations of agreed (or legislated) rules regarding working time. "Working time in the public sector is better than in the private, because in the private the worker is sucked, is forced to work 12 to 14 hours non-stop and it is more difficult for us to keep an eye on that", said trade unionist North 1. The lower density and involvement of trade unions exacerbated this problem.

Trade unions and professional associations were seen as distant by workers in general. Almost all workers interviewed indicated that they were distant from a union and they perceived that the union was absent at the workplace. Only one of the interviewed workers (laboratory technician/other analysis worker South 1) said that she felt a distance from the trade union because *she* was not present in the union. Workers showed a consistently passive approach when it came to unions. Workers waited for the union to come to them instead of taking any initiative towards participation. Technician/auxiliary in nursing Midwest 4 stated that the trade union did not do much and that "with the amount of time we work, no one has time to protest".

Workers in general were not aware of collective bargaining with the government or health establishments (employers). This contrasted starkly with the trade unions' presence in collective bargaining (although mostly in the public sector), particularly as regard the nursing professionals' demand to reduce working time to 30 hours a week. Many trade unionists said that in municipalities and at state level they were able to reduce working time from 40 to 30 hours a week. In contrast to this, a worker from an outsourced laboratory in the hospital visited in the North Region described an agreement that was said to have occurred between the enterprise she worked for and the trade union. We could not obtain confirmation from the trade union that the worker's description of the agreement was accurate. When asked, workers indicated that they had not demanded explanations from the trade union.

Before we used to work 12x36 and I think it was better, but it was embargoed not by our company, it was interrupted by the trade union. Now we have to be here every day. It was a bit demanding, but we had gotten used to it (laboratory technician/other analysis worker North 2).

But this wasn't discussed with you? (interviewer).

Our company came to us and said that for them we would stay the same. In other places where the company functions it is 12x36, but here the trade union didn't accept, so there was no way. ... But the trade union itself did not talk to us, because we preferred to work 12x36, there were weekends that we had free. ... It was much better (laboratory technician/other analysis worker North 2).

We can see from this quote that the discourse of the worker showed more proximity with the views of the company than those of the trade union.<sup>25</sup>

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<sup>25</sup> And the worker went on:

But here the hospital is very demanding with the company, doesn't give in, only thinks on what is better for them, doesn't think about the company, so we have to work with miracles, because the amount SUS



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### 3.3.5. Feedback from patients

One aspect of the relationship with patients that caught our attention when interviewing health-care workers was that in many health establishments we visited, workers consistently referred to patients as “clients”. This was the case even in public facilities (nurse Southeast 1, technicians/auxiliaries in nursing Southeast 4, 5 and 6 and physician Southeast 8 all referred to patients as “clients”). This might indicate that a vision of the patient as client – representing a market orientation also in assistance to patients – was present at the discourse and maybe also in the practice.

Procedures and working hours varied by hospital<sup>26</sup> and could thus be more or less stressful. In private high-class establishments like those that we visited, workers felt that patients were more demanding, and they wanted to know all the details and at times even wanted to interfere with how workers performed their job. For technician/auxiliary in nursing working in a laboratory Southeast 4, there were calm patients and there were stressed patients “that want to tell us how to do our job. That wants us to pinch them here or there, not to pinch them here etc. It is a differentiated public. In a public hospital the patient doesn’t question, but here they are more demanding.”

The client here sucks the most out of you. [The client] is very demanding. And the hospital is also very demanding. We cannot hold a patient too much, it affects our salary (technicians/auxiliaries in nursing Southeast 4, 5 and 6).

Physician Southeast 8, working at the same high-class hospital as technicians/auxiliaries in nursing working in laboratories Southeast 4, 5 and 6, said she always needed to be helpful, smiling, with nails done, “almost like a stewardess”. She said patients noticed everything and that not all physicians had the profile to work there. This worker said she stopped getting annoyed over those things and got used to it.

In public hospitals, where workers faced constraints in terms of infrastructure and materials, as well as overload, they had to deal with complaints of patients that wished to be assisted. Professionals working in other non-elite establishments also complained of structural and material restraints to assist patients.

Physicians suffer with stress. They personify the health structure, be it when they assist via a private health plan or via SUS. They have to manage the dissatisfaction of the user.

The patient doesn’t understand that it is the system’s problem, not the physician’s. We swim against the tide (trade unionist (physician) South 1).

pays for examinations is too little, so they want us to work miracles (laboratory technician/other analysis worker North 2).

But the amount SUS pays for examinations affects your pay directly? (interviewer).

No, our wage, the cost the company has with us, is fixed, it depends on what we do here in the hospital, the one that really suffers with it is the company. The company does not profit from the examinations made here, although they are many, but they do not profit here, the prices paid are too low (laboratory technician/other analysis worker North 2).

<sup>26</sup> For example, in the obstetric ward of a hospital in the North Region, there were more normal births. This is also a question that depends on financing. In public hospitals there is a campaign to “humanize birth” and make the least interventions possible, for the sake of mother–baby health and well-being, but also to reduce costs, so caesareans reach 37 per cent (Ministério da Saúde, 2011). In private hospitals, where physicians are paid to do interventions and are stimulated to do caesareans (and women usually think caesareans are less painful), the number of caesareans is very high (up to 82 per cent of births according to Ministério da Saúde, 2011).

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Most professionals complained about having to deal with situations that went beyond their responsibilities and capacities to intervene. Workers reported being blamed for situations they were not responsible for and even suffering from verbal and physical violence from patients. Those kinds of situations made working time more stressful. However, the health-care workers interviewed claimed to have good relations with their patients.

Relationship with patients is generally good, but sometimes they come, see that they have to wait or that things are late and then they think we are guilty of it. Then they say they pay taxes and that they want assistance as high as the taxes they pay (radiology technician/technologist Midwest 6).

One example of how demanding patients were in private (and mostly elite) establishments in Brazil was shown by the following extract of an interview with physician South 3, who worked in a high-class establishment in the South Region:

I like working at SUS because there I can do research, but here I have more possibilities to make contacts (physician South 3).

What do you mean by “there I can do research”, is there more structure for you to research there? (interviewer).

Well, here patients have a higher educational degree, I can explain things better to them, but at SUS I can do research. Here the population is different. Here a patient would never accept being part of a medical research, but at SUS they accept it (physician South 3).

The symbolic power of the physician also counted (Carapinheiro, 1991; Bourdieu, 1979). At an elite private hospital patients treated physicians as “just one more person” that had a university diploma and a high level of specialization in their area. Patients at those hospitals were more aware of the risks that could come with participation in medical research, whereas in a public hospital patients respected the physician for possessing knowledge and a formal and institutional education very different from the education they themselves possessed. From the viewpoint of patients in a public hospital, the medical diploma granted the physician a more legitimized and socially valued cultural capital,<sup>27</sup> much greater than the one the patients in a public hospital possessed. If the physician suggested that patients in a public hospital participated in medical research, workers reported that it was much more likely that they would accept it.

### **3.3.6. Family life and housework**

We were able to confirm that most female workers interviewed felt and expressed that there was an unequal balance when it came to unpaid housework because both paid and unpaid caring work was associated with women. In most cases, the availability of care services was not sufficient to meet the needs of workers (ILO, 2009a). Recent studies (ILO, 2009a) have shown that it is no longer true that women are responsible for housework because they do not work outside their homes. Rather, women are nowadays responsible for unpaid housework whether they work outside the home or not.

Many workers complained of the difficulty of reconciling work and family or personal life. Those included workers on night shifts, working on weekends or simply working too many hours in a week and for multiple employers. Trade unionist North 1

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<sup>27</sup> “The title, product of the economic capital converted into cultural capital, sets the value of the cultural capital of a title holder, in relation to the other holders of titles and also, inseparably, sets the monetary value for which it can be exchanged in the labour market” (Bourdieu, 1979, p. 3, free translation by author).

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said the health-care professionals could be away from the family for 16 to 17 hours a day, due to multiple jobs and transportation. “When they get home, it is to sleep. And sometimes on Saturday or Sunday, they are working, so they are more distant from the family.” Manager South 1 said it was difficult for workers to miss family celebrations and other personal events as the family usually questioned workers. Some workers chose to work less than their co-workers in order to be with their family or to study, as did physician South 5 and physician Midwest 3.

A male worker (trade unionist (nursing) Northeast 1) stated that most nurses were women, and that after working in one or two jobs they still had to work at home, taking care of their husbands and children, and he understood that to be an overload. Professional association (nursing) Northeast 1 said 90 per cent of nursing professionals were women, and although society had progressed a great deal and more women were participating in the labour market, domestic work was not shared with the men in their families, whether they were husbands or sons.

Housework, when it is not directly done by me, is my responsibility to administer, my husband is not worried if the maid didn't come today, that is the woman's problem. Especially here in the Northeast, it is a machos' region (professional association (nursing) Northeast 1).

Trade unionist Southeast 2, also male, said most health-care workers were women; some were single mothers that worked in two or three jobs because of low wages and were also housewives. Nurse North 2, working on weekdays and on weekends, said she did not have time for anything: neither family nor health. She also reported that “at home, the woman is the centre of everything, she has to administer the home. She has to think of her performance at work, of her son or daughter, of the other job, so you feel at a deficit in your current job. And you stay longer at the hospital than at home.” Technician/auxiliary in nursing North 1 indicated that women could adapt more to working and family life. However, according to her, it was difficult that women also worked at home. “When she gets home, she has to take care of the house, of the children, do things at home, it's more difficult.” Technician/auxiliary in nursing working in a laboratory South 1, a woman, claimed that it was difficult to find a day care centre that accepted children very early in the morning, when she started working. She tried to reconcile working with the hours of the day care centre:

For women it is harder to reconcile life at work with family. The house is my responsibility, as well as the kids (physician South 5).

Technicians/auxiliaries in nursing Northeast 1, 2, 3 and 4 also agreed that for women it was harder, because at home women tutor the children and take care of the house. Physician Midwest 3 had grown-up children, and stated it was only possible for her to work because *she* (not her family) had nannies and maids (other women) to help her. Nurse Midwest 2 also reported that it was more difficult for her as a woman to be able to handle everything and that she had three jobs. This worker indicated that she had two jobs outside her home and the domestic work at home was her third. She also made clear that she did not have time for herself, but that she was “lucky” because her husband “helps me, buys groceries. He is very supportive. If he didn't help me, it would be worse.” This shows that she (and most of the female workers interviewed) felt socially responsible for domestic work and that the role of the husband or partner was to “help”. Those social roles and responsibilities were equally present for technicians and for professional with university degrees. Due to the fact that the workforce in the health sector in Brazil is mostly female (Martins et al., 2009; Pires et al., 2010), it is possible to extrapolate that most health-care workers maintain major responsibility for domestic work in their homes. Thus, it is extremely important to consider time spent on domestic work when studying working time in the health sector (Rotenberg et al., 2008; Pires et al., 2010; Portela, Rotenberg and Waissmann, 2005).

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### **3.3.7. Working on weekends and holidays and at night**

Laboratory technicians/other analysis workers Northeast 2, 3, 4, 5 and 6 stated that working at night was terrible. Laboratory technician/other analysis worker South 4 said she wished to work only on weekdays: “I always tell the joke that I’m going to find a Monday to Friday job! [laughter].” According to her, she had a whole weekend free every three or four months. Radiology technician/technologist Southeast 2 argued that if you did not want to work weekends, you had to find another career. Physician North 1 usually worked 24 hours on weekends and believed that was a characteristic of her profession, and she knew she would have to miss holidays and family celebrations. For some of the workers, it appeared natural to have unconventional working hours and they connected it to having chosen that profession. We found that workers believed this to be the case with reference to the number of hours they worked or for working at nights and on weekends.

Technician/auxiliary in nursing South 9 told us that it was difficult never having a free weekend, but that the family had adapted to it. Technician/auxiliary in nursing Southeast 4 claimed she only had one Sunday off a month and that was a problem if you had children. Laboratory technician/other analysis worker North 1 said that it was difficult not having free weekends, especially due to judicial constraints whereby she could only see her son at weekends. Physician North 2 also complained about never having a free weekend. Physician Northeast 1 said he was used to working Christmas and New Year’s Eve, because he was an obstetrician and births could not be scheduled. Most workers felt that not having free weekends came with the job.

Many workers indicated that they spent too much time (and especially nights) at work. Physician Southeast 2 disclosed that some physicians had trouble sleeping in their own beds. “They sleep so many days a week outside their home that when they get home they have trouble sleeping.” Physician North 3, also a resident, said that he lived at the hospital and took “shifts” at home, and that he had difficulty explaining to his family why he had to work in that way. Physician Northeast 7, a resident, shared that she slept at home only one night a week. Technician/auxiliary in nursing North 1 also claimed that she lived at the hospital and visited her home. Her son and husband demanded more time, but she claimed that for her to have a free weekend she had to work 15 days in a row.

To work more hours on weekends and at nights generated conflicts with the family. Radiology technician/technologist Midwest 6 said it was hard managing work and family; he had a daughter, and was getting a divorce. Trade unionist (physician) Northeast 1 shared the observation that divorce rates were high among physicians. Physician Northeast 3 said that for her it was not very complicated to reconcile family and social life, as she was single and lived with her mother, with whom she shared the housework. Nurse Midwest 2 said that her husband complained about her spending a lot of time outside, but that it seemed he was more used to it now. Nurse Midwest 3 said her job affected her family, and she ended up putting her son and his school to the side due to work. In cases where partners were both health-care workers, there was more understanding. For example, physician Midwest 7 admitted working too much, but said his wife understood, as she was also a physician.

Working nights and weekends did not favour family life and rest (Krein, 2007), and most workers interviewed reported it was difficult to manage everything, which could increase risks of social and psychological problems (Fischer, 2004). Cordova et al. (2012) also showed that patients’ outcomes on weekends and nights were worse than on weekdays.

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### 3.3.8. Living standards and the choice to work more

Some workers reported that they chose to work more in order to have a better living standard for them or for their children. Social pressure for higher living standards was reported to be greater for physicians. Physician Southeast 3 argued that physicians in Brazil were “workaholics” and wanted to “sell” every possible moment, being rich but alone, with destroyed relationships. “No one has time to check the children’s grades, help with homework.” Physician Midwest 3 said most of her colleagues wanted to have high living standards, but that a physician did not have to be rich.

They die from working, live a sacrificed life. Sacrifice the family to do overtime. ... I see that most of my female colleagues are single. So are most of the nurses. Those that have children “outsource” them: they are raised by maids, nannies (physician Midwest 3).

Physician Midwest 9, who was a resident, claimed to be stressed more due to the work she did beyond the 60 hours she worked as a resident. This clearly left her little time for family or sleep. Residents that worked beyond 60 hours claimed to do so because the grant they received was not sufficient to pay their bills. Physician Southeast 7 said medicine did not have the “glamour” it had before, when the physician was admired. “Now it is better to work at [a worldwide-known technology and electronics company] or in the financial market.”

In such an unequal society as the Brazilian, being called a “doctor” – as only lawyers and physicians are – represents inclusion into a very privileged class. Those that belong to this class feel a social obligation to have middle or high living standards.

Physicians don’t think they are God, they are sure of it (Manager Midwest 1).

Socially, physicians in Brazil have a higher status than workers in other professions. Physicians typically come from the middle- or upper-class families (Ristoff, 2013), while technicians typically come from lower-income families (Frias and Takahashi, 2000). In Brazil, there also remains segregation based on race. Afro-Brazilians and native Indians have lower incomes and work in less specialized jobs (Beltrão and Teixeira, 2005). In all of the regions we visited we were unable to find any black or native Brazilian physician to interview. This is despite the fact that the black and *pardo* population accounts for 50.7 per cent of the total population of the country (IBGE, 2010). In contrast, many of the technicians interviewed were Afro-Brazilian descendants.

This pressure for high living standards might also come from the fact that, socially, physicians have high symbolic power (Carapineiro, 1991; Bourdieu, 1979) and are considered to be an important profession that deals with life issues. Workers in the profession receive social recognition that allows them to have more power in decision-making and inputs at the workplace in addition to high monetary remuneration. One group of physicians connected “being a competent professional” with “high living standards”:

Today we are evaluated not only by our competence, but by our looks, the clothes you wear (physician Northeast 3).

By the car we drive (complements physician Northeast 4).

If you ride a bus it means you are a bad professional, that you are not successful in medicine (physician Northeast 3).

Many physicians reported there was social pressure to have a high living standard, which compelled them to work more. This may be connected to the social origins and symbolic power they possess (Carapineiro, 1991; Bourdieu, 1979). To “fit in”,

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physicians are expected to have high wages and high living standards, as well as a continuous education that allows them to maintain the economic and cultural capital they have acquired (Bourdieu, 1979). This pressure to work more, have higher living standards and be a part of the consumer society also makes it more difficult for physicians in Brazil to leave the big metropolis to assist the population in more remote areas of the country. Access to the facilities of a big city, higher quality of life, attractive wages and poles of high medical technology present in large cities remain highly attractive (Seixas and Stella, 2002).

Throughout our interviews, the social pressure to have a higher living standard was reported to be greater among physicians, but other workers did report working more hours in order to maintain a higher living standard. Technician/auxiliary in nursing Northeast 5, for example, argued that it was not the profession that obliged her to work, but rather it was the living standard she wanted to have and give to her children. Working unconventional hours in the health sector offered workers the chance to sell their nights and weekends in order to achieve a higher wage and commensurate living standards.

### **3.3.9. Leisure and working time**

The workload is not easy. I live during the breaks (physician North 6).

Health-care workers work a higher number of hours per week than most other workers and usually work weekends. Therefore, the available time they have for leisure is not only reduced, but is also different from that usually available to other workers, i.e., Saturday and Sunday off. Physician Southeast 8 shared that she had not had a free weekend in two years and that her leisure time was during the week. That is rarely the pattern for workers in other sectors in Brazil, particularly those with university degrees.

Trade unionist North 1 indicated that the amount of leisure or family time health-care workers had was very little. Technician/auxiliary in nursing North 1 reported that she did not have leisure time, as she worked weekends. Technician/auxiliary in nursing working in laboratories North 2 said that she usually did not have free time at weekends, and she usually did not indulge in leisure. Nurse Southeast 2 said health-care workers did not have time for leisure and that the situation was even worse for those that worked the 12x36 regime.

Trade unionist (nursing) Northeast 1 claimed that reducing working time to 30 hours a week would be a gain for all of society, as nurses would be entitled to time for leisure, study and other personal pursuits. "Today people do not have time to live, to be trained. They only go out of their homes to work, from work back home, going back to the times of the industrial revolution."

Due to the excess of unconventional working hours, workers reported having little time for leisure, which confirmed Silva, Rotenberg and Fischer (2011), who showed that many health-care workers can develop physical, mental and emotional disorders that can obviously affect their capacity to care for others (Silva et al., 2006).

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### **3.3.10. Personal security and working time**

According to ILO et al. (2002):

Recent studies confirm that workplace violence in the health sector is universal, although local characteristics may vary, and that it affects the health of both women and men, though some are more at risk than others. Altogether it may affect more than half of health-care workers (p. 2).

Workers in specific facilities, particularly those working in public health facilities, complained of a lack of security. Trade unionist North 1 claimed that violence was sometimes the reason that professionals did not show up for work. Physician Southeast 2 indicated that the first thing they did when they received a patient with a gunshot wound was to call the police, because in many cases those that tried to kill the person showed up to finish the job, and might in addition kill the health professionals attending the wounded. Physician Midwest 3 told of hospitals where the police had to stay on guard outside the building to act quickly in case of an incident. Trade unionist Southeast 2 claimed that nursing professionals were sometimes threatened or even assaulted by the same patients. Class representative (physician) South 1 said that in some cases physicians were threatened by patients that wanted their diagnoses modified in order to be excused from work or school. Others faced threats from patients procuring specific medications. Workers might face a very real risk of being kidnapped or robbed in these cases. One professional had a jaw dislocated, while another was bitten and had a piece of flesh ripped out of her arm. Nurse Southeast 1, working in a trauma hospital, said:

Our patients are dangerous, sometimes you have in the same place the victim and the aggressor. We once had a nurse who had to change her shift, dye her hair, everything, because she was threatened. Sometimes you have patients that have an escort. It is difficult to manage risks in health-care provision. These situations increase the chance of mistakes.

Verbal and physical violence is a risk at some health establishments. This risk increases workplace stress, confirming a study done by ILO et al. (2002).

Violence is also a problem outside the workplace. Manager South 1, from a private institution, said one obstacle in changing working arrangements was workers' lack of security when returning to their homes late at night. Personal security inside and outside the workplace thus develops into a restraint when defining working hours.

### **3.3.11. Adverse incidents and working time**

Professional association (nursing) 2 said that care work outcomes involved a combination of working conditions, worker's performance, disposition, concentration, competence and ability. Nurses needed time to coordinate and reason clinically. They could not do all of that in situations of stress, lack of materials and excess numbers of patients. "It is inhumane for workers and for the population." Workers reported that working conditions and stress increased the possibility of mistakes. Working time could also impact workers' attention and capacity to respond.

Professional association (nursing) 1 said that after six hours working, attention levels fell to half, leaving more room for mistakes. Similarly, a number of workers

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interviewed in different regions<sup>28</sup> reported that fatigue influenced work and increased risk of mistakes.

In health care, professionals cannot work under pressure. They make mistakes. And a mistake can be lethal (trade unionist Southeast 2).

Professional association (nursing) 2 reported that workers were sometimes asked to double-shift to substitute for absent colleagues. “That makes things more complicated; induction to error is much bigger.” Manager Northeast 1 and laboratory technician/other analysis worker Northeast 1 argued that a satisfied worker worked more effectively and made fewer mistakes.

Professionals interviewed claimed that stress and excessive working time negatively affected organizational performance, while job satisfaction had the opposite effect. Unconventional working hours have also been linked to a decrease in patients’ and workers’ safety (Johnson and Lipscomb, 2006; Silva, Rotenberg and Fischer, 2011; Cordova et al., 2012).

### **3.3.12. Performance measures and organizational objectives**

In most health facilities that we visited, performance was measured according to protocols and specific procedures to be followed by workers according to their functions across various indicators and standards, including (a) hygiene, mortality, infections, maximum time to assist a patient according to severity of problem, etc.; (b) occupation of beds, severity of conditions of patients; (c) patients’ satisfaction; (d) number of procedures or examinations, for example in the radiology or clinical examination sectors; and (e) punctuality and attendance. It is important to observe that organizational objectives are not always equivalent to good quality in care or curing patients. Sometimes institutional strategies are aimed solely at cost reduction.

The way performance is defined and measured has direct implications for workers. For example, radiology technicians/technologists Midwest 1 and 2 articulated that there was pressure to produce and to meet standards, leaving quality to the side. Technician/auxiliary in nursing Southeast 1 explained that at their private hospital, workers received a bonus for seniority at the hospital, qualifications and attendance, which motivated them to work according to the establishment’s organizational objectives. Workers said this motivated them to follow the hospital’s rules. Technicians/auxiliaries in nursing Southeast 4, 5 and 6, working at the same hospital, reported that they were afraid to get sick. “Sometimes you have your health attestation, but you hide it because you lose your bonus if you do not come to work.” They indicated that they came to work sick for fear of losing the bonus, a part of their income.

Other professionals were paid according to productivity at work. While they received a base pay that was linked to the number of hours worked, a portion of their pay was based on the number of procedures performed and the severity of patients that they treated. “We are paid by our productivity in the intensive care unit, thus you can say our productivity is measured by the number of procedures we perform. We always have that in our minds: the amount of money we receive for hours worked depends on the procedures we perform” (physician Southeast 10). Physician Southeast 9 complained

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<sup>28</sup> Laboratory technician/other analysis worker North 1, laboratory technicians/other analysis workers Midwest 3 and 4, technician/auxiliary in nursing Midwest 4 and technician/auxiliary in nursing North 1.



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about being paid according to productivity, indicating that she also had to follow an index of *decreases* in productivity:

There is no absolute value, I am not sure how much I will earn. There is a minimum value for determined shifts, let's say those that are more difficult to cover, such as emergencies that require an experienced professional and with a lot of patience. Others have a fixed minimum value and productivity increases. Others also have decreases in productivity. Well, I guarantee you there are more negative indexes than positive ones. There are evaluation indexes, I mean, in theory, not talking about the final performance [the patient being cured or not], I mean what is paid by the health plan: you have more to lose considering what is paid for productivity than to win, i.e., your productivity levels will fall. And productivity also varies from the type of health plan the patient has, the level of gravity, etc. This works even in an intensive care unit (physician Southeast 9).

One of the members of the multiprofessional team (usually the physician) being paid according to performance can compel all workers to work more intensely. Nogueira (2010) analysed this practice and highlighted the pressure that is applied to workers whose pay is not connected to the same productivity measures as the physicians:

In enterprises in which the physician is paid by service unit [productivity], ... the physician works with more intensity and to a longer duration than usual, in the quest to be more productive. The subordinate personnel are obliged to keep up with this rhythm, for they depend on the technical command of the physician. But their remuneration is fixed, being that, although they work with more intensity, this does not alter their wage (Nogueira, 2010, p. 66).<sup>29</sup>

Trade unionist (nursing) Northeast 1 says that in some places in the private sector the organizational focus is clearly on profit and not on the patient's well-being: "You have to empty a bed for another person to come." These kinds of performance measures can actually pervert health-care provision from the perspective of caregivers and patients.

Organizational objectives also affect the level of attention physicians can offer patients in the public sector. Physician Midwest 2, working in the public sector, complained about only having eight minutes to assist each patient as prescribed by the performance standards she was required to fulfil. "I like hearing what the patients have to say, their complaints, to make a complete assistance, but with eight minutes I have no time."

Performance measures also affect working time, pushing workers to work with greater intensity (Fares and Oliveira, 2011; Nogueira, 2010) and work more hours (mostly in the case where workers get paid by the hour), even if they are physically exhausted. This could obviously generate unnecessary risks for both workers and patients. Some measures can indicate that a greater number of patients were moved through the system due to an intensification of working time. This can indicate positive results for managers and employers. However, those same numbers may be directly connected to an increase in adverse incidents at the workplace and may have impacts on the health and safety of both workers and patients.

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<sup>29</sup> Free translation by author.

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### 3.3.13. Working time and health of the health-care workers

Who will take care of health-care workers? (nurse Southeast 1).<sup>30</sup>

Workers were asked the following question: “Do you see any effects in your health that might be caused or related to your working time?” Some of the responses received are reported below.

Technician/auxiliary in nursing North 1 reported that she started getting sick more often after taking on her second job. “I did not have asthma and I started having crises. I developed an allergy, have pains, now I think I get sick more often.” Radiology technician/technologist Midwest 7 indicated that colleagues with health attestations were usually those with two jobs. Professional association (nursing) Southeast 1 argued that nursing professionals were getting sick (heart, blood pressure and stress problems, even cancer) due to having multiple jobs. “It’s chronic fatigue syndrome.” He also told us of workers that used drugs to be able to work.

Manager South 3 and physician South 1 revealed that sick leaves for musculoskeletal diseases and psychiatric disorders were most frequently for workers that had multiple jobs. Professional association (nursing) 2 shared that a hospital in the Southeast had 25 per cent of its workers on leave due to health problems. “It is sickening!” Trade unionist Southeast 2 said that between 10 and 15 per cent of the workers from a state network in the Southeast Region were on leave due to psychological or musculoskeletal diseases.

Nurse Midwest 2 complained that she suffered health consequences from her work: “I work with cancer treatment! My hair falls out all the time and I always have the flu.” Physician Northeast 6 revealed that they were sometimes exposed to X-rays in the operating room, as well as contamination by blood and toxic gases. Physician North 1 claimed to have had tuberculosis acquired at a hospital. Receptionist South 1 complained that management did not allow her to wear a mask or gloves and that sometimes she had direct contact with patients that came in to test for H1N1.<sup>31</sup> She also had to manipulate cups with faeces and urine and was not provided with any nearby facility to properly clean her hands.

Trade unionist (physician) Northeast 1 reported that most workers complained of “avoidable” diseases, including back problems, hypertension and arrhythmia. Some workers complained of burnout. Technicians/auxiliaries in nursing North 2, 3, 4, 5 and 6 complained of back problems from carrying patients. Technicians/auxiliaries in nursing Northeast 1, 2, 3 and 4 also suffered with back problems and varicose veins and had to walk up the stairs all the time because the building’s elevator did not work. Manager North 3 disclosed that professionals complained of repetitive strain injuries, back problems, allergies – “all problems related to work”. Technician/auxiliary in nursing Northeast 5 complained of fatigue, stress and back problems. Laboratory technician/other analysis worker South 4 complained about the long hours working with a computer. Physician Midwest 9 shared feelings about the impact of working a 12-hour shift: “I have headaches, back pains. You are tensed the whole day.” Physician Midwest 6 said many workers suffered from depression, insomnia and pains.

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<sup>30</sup> “*Quem cuidará dos cuidadores?*”

<sup>31</sup> H1N1, a subtype of influenza A virus, was declared by WHO as a pandemic in June 2009.

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Physician Midwest 8, a resident, reported that she had tension headaches and that she was exhausted, “but that is the life of a physician. All I wanted was to have 30 minutes to have lunch.” Other professionals also reported eating problems. Physician South 5 said she gained weight, especially after working the night shift; physician Southeast 6 complained of gaining 24 kilograms since starting residence; physician South 3 complained of eating a poor diet. A friend of physician Northeast 7, working 132 hours a week, developed a celiac disease.

Professional association (nursing) Northeast 1 stated that nursing professionals were psychologically disturbed and that after 35 years all of them had hypertension, diabetes and heart problems due to being sedentary and eating poorly.

A wide variety of health problems were reported by workers. They clearly linked those health problems to their work. Most of the complaints were confirmed by other studies (Fischer, 2004; Shen et al., 2006; Robazzi et al., 2012; Papadopoulos et al., 2010; Johnson and Lipscomb, 2006; Pires et al., 2010; Silva, Rotenberg and Fischer, 2011).

When asked if his job was stressful, physician Northeast 2 offered a non-verbal answer. He used his hands to show the practice around us, with a resident assisting a patient at our side. He then asked me if I had seen the number of people waiting outside (around ten patients). Nurse Southeast 1 described the work environment as heavy and stressful, especially because it was an urgent care and emergency area. The nurse argued that working there certainly affected the mental health of workers. Physician Midwest 6 agreed that working in an emergency area was very stressful. Trade unionist (nursing) Northeast 1 and 2 stated that nurses had psychiatric disorders linked to dealing with human suffering. Professional association (nursing) Northeast 1 thought that workers absorbed patient’s problems and doubts. Nurse Southeast 2 said her job was demanding and required a lot of emotional work. The workers testimonies confirm Dal Rosso (2008) and Pires et al. (2010), in the sense that health-care workers deal with human suffering, sometimes bond with patients, and absorb their problems, requiring a high level of emotional involvement.

Trade unionists (nursing) Northeast 1 and 2 also argued that working hours hindered workers from family and social activities, thus generating social problems. They claimed that nursing professionals had a high suicide and divorce rate as well as a high rate of usage of psychotropic drugs. Trade unionist Southeast 3 shared that many nursing technicians were depressed, alcoholic or used drugs. He told us that:

Not long ago, a technician was found in the bathroom of the hospital, after making a mistake on the dose of the drug she used in order to be able to work. She had an overdose and died (trade unionist Southeast 3).

There is a high tendency to use alcohol and drugs, professionals have many children, a heavy working time, but have no way of taking care of their families with dignity. We see a lot of mental disorders (trade unionist North 1).

Trying to manage and balance work and family generates stress and many of the workers interviewed complained of this specific aspect (Silva, Rotenberg and Fischer, 2011; Martins at al., 2009). Manager South 1 indicated that the hospital had created a programme to assist workers with psychologists and social workers and that it had been reporting good results, as professionals were able to deal with personal questions and to decrease sick leaves.

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### **3.3.14. Staff input in changes at the workplace and negotiation power**

In all establishments we visited, we asked workers about the relationship with management. We asked specifically if they felt that their inputs were considered when there was the need to change working time, schedules or other arrangements, or if changes were only communicated to them after being decided. The relationship with management differed from workplace to workplace and depended on many factors, including the constraints of the health establishment; personalities of workers and managers; social and emotional characteristics of individuals involved in the process; the social and cultural context; and the professional categories workers belonged to. Opinions on that matter varied considerably, but most of them said they were satisfied with regard to the relationship. Interestingly, this could be due either to a feeling that their inputs were considered or because they believed it to be normal that their inputs were not considered. Trade unionists and class representatives complained that workers' inputs were not taken into account. Trade unionist North 1 disclosed that managers were very authoritarian and that they rarely consulted staff to define anything. "They think that as they reached this managing position they are the owners of it." Professional association (nursing) Northeast 1 reported that nursing professionals were not regularly consulted if there was the need to make changes, and that management usually made decisions without any discussion. That worker also complained of a lack of flexibility to understand the situation of the worker: "Many times I heard management say 'that is your problem if you work in two places'."

In most workplaces, workers claimed that management considered physicians' inputs more than those coming from other categories of workers, and that physicians typically had more power to negotiate with managers. This difference might also be due to the fact that physicians maintain more symbolic power (Carapinheiro, 1991; Bourdieu, 1979), as we discussed above (subsection 3.3.8, Living standards and the choice to work more).

Physicians were said to have more flexibility to negotiate working hours than other workers. They were also consulted more when it came to inputs for changes at the workplace. For example, physician Midwest 2 suggested that she worked fewer hours (20 hours) than the number established in her contract (40 hours). Technician/auxiliary in nursing Midwest 4 argued that: "It is 'evil' that the physician is entitled to work less. Our dream is to work four hours a day, like a physician [laughter]!" (technicians and auxiliaries in nursing North 2, 3, 4, 5 and 6). Technician and auxiliary in nursing North 1 also shared her dream of working four hours a day "like a physician". Others reported similar desires:

I believe there is a big difference here between the levels in the hospital. Sometimes I even think they have prejudice. University, high school and elementary school. ... The institution itself treats people differently. This causes lower motivation, awkwardness. ... It is demoralizing. Wage difference is too high. For example: nurses and physicians have a more flexible schedule, vacations and leaves we can never have, but they can. But if we are all under the same juridical regime, everyone should be entitled (technician/auxiliary in nursing North 1).

There are rules that are not imposed on everyone, only on workers with elementary and high school education, such as working hours. If working hours are six hours daily, this has to be for everyone, it is not because you are a physician and I'm a cleaning person that you can have perks. The difference between both has to be via a different wage, a different position, not in working time. This causes terrible dissatisfaction. In some cases, if workers are 15 minutes late, they are considered to be absent, but this is only for some categories. Physicians arrive hours late, leave way before the end of the workday and they do not pay for it. There is a great imbalance, people with university education treat very differently those that have elementary and high school education, in our state that is very acute. It is not

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all of them, but there is a considerable number of professionals that treat others differently (trade unionist North 1).

Physicians come to basic assistance, sign in, stay for two hours and leave, while they should stay eight hours. But they have a scheduled patient, that arrives, and who will assist them? The nurse (professional association (nursing) 1).

According to professional association (nursing) 1, the job of the nurse was never appreciated or valued. Professional association (nursing) 1 stated that workers were undervalued and their dedication was not recognized. Professional association (nursing) 2 also reported that nursing professionals faced disrespect at work and from other health professional categories, particularly the medical team. Trade unionist 2 said that nursing technicians did not have a voice and that nothing was ever discussed with them. "They come and say, 'This is how it will be done.' No one takes the views and opinions [of nursing technicians] into account." Professional association (nursing) 1 conveyed that physicians were usually consulted, not nursing professionals.

Most approaches and public policies still focused on physicians at national and international level. The Brazilian Government recently presented the Mais Médicos (more physicians) programme, aimed at attracting more physicians to remote areas of the country. The World Bank has also historically focused on physicians when promoting health programmes, rather than other professionals (Dal Paz et al., 2002).

Professional association (nursing) 1 indicated that other workers (physicians) had more negotiating power over their working time due to the continuous, 24-hour nature of the nursing job. "A health centre cannot function without nursing professionals." Nurse Southeast 1 said nursing professionals were not recognized by society or by the medical team:

There is no use in the physician making the prescription and putting it inside the patient's chart if the nursing team does not execute it. ... There is no motivation to become a nurse today, you can see it by the number of nursing schools closing. But when there is a lack of this professional in the market, it will get better (nurse Southeast 1).

In the physicians' category, residents Midwest 8 and 9 felt their opinions were not heard, that they were not consulted and that sometimes they needed to do the job of other people. Radiology technician/technologist Midwest 3 argued that the category of professionals with high school education doing contract work in the public sector felt that they suffered prejudice and were treated as inferior by both co-workers and managers.

The relationship with management differed from workplace to workplace and depended on many factors. Most workers were said to be satisfied in that aspect. Again, that could be because they felt their inputs were considered or because they thought it was normal that their inputs were ignored. Trade unionists and class representatives complained that workers' inputs were not taken into account. In most workplaces, workers claimed that management considered physicians' inputs to be of greater value (Carapineiro, 1991; Bourdieu, 1979) than inputs coming from other categories of workers. Most approaches and public policies also still focused exclusively on physicians at national and international level. Nursing workers consistently complained about being undervalued.

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## 4. Discussion

### 4.1. Summary of findings

In visiting the health establishments and interviewing specialists, we found a range of working time arrangements, as summarized in table 5.

**Table 5. Overview of working time arrangements**

Arrangement	Characteristics
12x36	Workers have a shift of 12 hours and rest 36 hours
6x1	Workers work six days and have one day off, while usually working six hours a day
Shift working arrangements of 12 hours/24 hours	The worker compresses his/her working time in intense periods of 12 or 24 hours
Fixed working arrangements	Daily work of four, six or eight hours a day, usually on weekdays, sometimes working on one weekend day
60 hours a week	For residents
24 hours a week	Radiology professionals (technicians and technologists) have a maximum workload per week of 24 hours
Combined extended work and leave periods	Characterized by a number of weeks working in remote areas of the country and a number of weeks off work
On-call work, zero hours or “as and when required” arrangements	Characterized by a requirement that physicians or coordinators of sectors or departments be available to work when called
Working time banking arrangements	Characterized by the possibility of accumulating hours, which can be taken off as extended leave in a subsequent period
Regular overtime hours arrangements	Characterized by hours worked in addition to the contractual or hours usually worked, compensated at a higher rate by the employer

The difficulties in measuring real working time for health-care workers include:

- **Multiple jobs.** In the health sector, most workers have multiple jobs. Some statistics that measure working time via declaration of the employer consider working time in a specific working place and thus do not capture the real situation of the health-care worker.
- **Practice.** Some physicians choose to open a private practice, working unlimited hours per week.
- **Cooperatives.** It is very common that physicians are associated to medical cooperatives. Payment depends directly on the number of hours worked, and the value of those hours can depend on productivity indexes.
- **Legal persons.** Some health establishments do not hire physicians as employees but as “legal persons”, and this allows the physician to work longer hours than allowed by law.

- **Home care.** There are enterprises that offer home care and have a formal contract with the professional that provides the care, but in some cases home care is an informal activity and very difficult to measure.
- **Domestic work.** Female workers usually state that they are also responsible for unpaid domestic work, which generates an increase in working hours in an uneven gendered manner.

Key factors underlying the developing of existing working time arrangements in the health service organizations and establishments studied include current legislation, pressure of trade unions and professional associations, will of employees and government policies. Working hours and the structure of hours is usually defined at the time of the contract or entrance examination. Other influencing factors and effects of working time arrangements include:

- **Available resources.** In the public sector there are financial constraints; in the private sector there are constraints due to commodification of the care work (Bahia, 2013). As for available health-care workers, there is a shortage of qualified health-care personnel. This tends to increase pressure on existing qualified workers to increase working time.
- **Organizational culture.** For some workers, it seems natural to have unconventional working hours.
- **Workload and working in public and private institutions.** Working time in the public sector can be stressful due to structural constraints, while in private establishments the pressure is to work a greater number of hours and to strictly follow the organizational needs of the establishment.
- **Autonomy and trade unions.** Trade unions and professional associations and organizations are seen as distant by workers in general.
- **Feedback from patients.** In private high-class establishments, including some of the institutions visited, workers feel patients are very demanding. In public hospitals where workers face more constraints in terms of infrastructure and materials and often work in conditions of overcapacity, they also have to deal with complaints of patients that wish to be helped. Professionals working at other non-elite establishments made similar complaints about structural and material constraints on their ability to provide care for patients.
- **Family life and domestic work.** Most female workers interviewed are responsible for domestic work and described the role of the husband or partner as “help”. Given that the workforce in the Brazilian health sector is mostly female (Martins et al., 2009; Pires et al., 2010), most health-care workers are also responsible for unpaid domestic work.
- **Working on weekends and holidays and at night.** Working nights and weekends does not favour family life or rest, and most workers interviewed reported difficulties managing a balance between work and family life. The resultant stress increases chances of social and psychological problems (Fischer, 2004). Cordova et al. (2012) shows patient outcomes on weekends and nights to be worse than on weekdays.
- **Living standards and the choice to work more.** Many physicians reported social pressure for a high living standard, which resulted in pressure to work more (Carapinheiro, 1991; Bourdieu, 1979). Other workers also reported

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working more to maintain their living standards. Working unconventional hours gives workers the chance to offer their nights and weekends in order to achieve higher living standards.

- **Leisure and working time.** Due to unconventional working hours, workers reported that they had little time for leisure.
- **Security and working time.** Verbal and physical violence is a risk at some health establishments. This clearly increases stress at that workplace (ILO et al., 2002). Security reasons inside and outside the workplace are constraints when defining working hours.
- **Adverse incidents and working time.** Professionals interviewed claimed that stress and excessive working time reduced organizational performance while job satisfaction had the opposite effect. Unconventional working hours, according to many studies, can also compromise patients' and workers' safety (Johnson and Lipscomb, 2006; Silva, Rotenberg and Fischer, 2011; Cordova et al., 2012).
- **Performance measures and organizational objectives.** While some measures may indicate a greater number of patients move through the system (possibly due to an intensification of working time), those same measures may provide evidence of a decrease in health and safety in the workplace, which has clear impacts on workers' well-being (Nogueira, 2010; Fares and Oliveira, 2011).
- **Working time and workers' health.** Various health problems were sourced directly to the workplace. The majority of the complaints we heard are confirmed by other studies on this matter (Fischer, 2004; Shen et al., 2006; Robazzi et al., 2012; Papadopoulos et al., 2010; Johnson and Lipscomb, 2006; Pires et al., 2010; Silva, Rotenberg and Fischer, 2011).
- **Emotional and psychiatric disorders.** The workers' testimonies confirmed Dal Rosso (2008) and Pires et al. (2010), in that health-care workers deal with human suffering and that requires emotional involvement. Trying to manage work and family in this context generates stress (Silva, Rotenberg and Fischer, 2011; Martins et al., 2009).
- **Staff input in design mechanism.** Regarding inputs into changes at the workplace and negotiating power, trade unionists and class representatives complained that workers' inputs were not taken into account. In most workplaces, workers claim that physicians' inputs are considered more than others (Carapinheiro, 1991; Bourdieu, 1979).

## 4.2. Good practices

Some of the successful experiences found in our fieldwork and in the literature were:

- **Implementation of the MNNP-SUS at the local level.** The Ministry of Health is trying to expand this initiative to local levels by offering training and aiding the establishment of structures to promote and facilitate collective bargaining. Implementation would also help to deal with local specificities regarding working time.
- **Collective bargaining for reducing working time and changing working time arrangements.** Trade unionists in many regions reported successfully negotiating reductions in working time with municipal and state governments.



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- **Psychological support for workers.** The human resources department at a private hospital in the South Region was aware of the difficulties workers faced at a personal level due to their working time. For this reason, they developed a programme with psychologists and social assistants to help workers deal with emotional and family problems. This programme was also aimed at diminishing absences and leaves.
  - **Ability to change shifts.** Workers seemed more satisfied when they were able to arrange their monthly schedules themselves or change shifts with colleagues to respond to personal needs. This should be done while respecting the existing legislation and contracts.
  - **Management training.** Health-care workers in management positions are more confident and prepared for managing after being trained.
  - **Mais Médicos (more physicians) programme.** This federal programme brings physicians (national or foreign) to remote areas of the country where access to health care is poor, thus increasing supply of medical professionals in the region and having a preventive role. This might help decrease working time for physicians in remote areas and diminish demand for health-care assistance in metropolitan hospitals, thus reducing stress caused by working time for professionals. Potential improvements to this programme include (a) increasing investment in infrastructure in those remote areas; and (b) bringing other health professionals to those areas, such as nurses, dentists, pharmacists and technicians.
  - **Investment in infrastructure.** Investments in structure show positive effects on worker satisfaction. This is true for investment directly related to completion of tasks (equipment and materials for working, elevators, repairing structural problems) or communal places (including kitchens, cafeteria, dormitory or lockers). These investments also reduced health and safety risks for workers and patients.

### 4.3. Gaps in information

- **Number of hours worked per worker.** Capacity to gather and compile accurate statistics on working hours in the sector is limited. Accurate statistics would require a focus on the number of hours actually worked by workers, rather than counting the number of hours by jobs. This modification in practice requires investigating multiple jobs, the informal economy, cooperatives, private practices and domestic work (especially considering that the workforce in the health sector is mostly female). Compilation of these kinds of data would require a quantitative approach similar to that used by the gender and time use studies (IATUR, 2013). Resources would need to be allocated in order to include a more significant sample at national level. There are some databases at local levels and some recent initiatives from the Brazilian Medical Association (Associação Médica Brasileira, AMB), who are applying a census that will estimate the number of hours per week a physician spends working in direct care, teaching or research, administration and other activities (AMB, 2013b). That could be an interesting database for physicians. The Nursing Professionals Profile (Perfil da Enfermagem), developed by the Centre for Studies and Research in Human Resources for Health at the National School of Public Health (Núcleo de Estudos e Pesquisas em Recursos Humanos em Saúde da Escola Nacional de Saúde Pública) and the Oswaldo Cruz Foundation (Fiocruz, 2013), will give more accurate information on working time at national level for these workers.

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- **Researches in Brazil regarding adverse incidents and health and safety issues** that result from fatigue, stress or excessive working time.
  - **Causes of absenteeism and work-related health diseases and complaints.** Some trade unionists indicated that it would be an interesting idea to compile data they had on leaves and absenteeism and work-related diseases. Although they could highlight the most frequent diseases workers complain of, there is little systematic analysis of those causes using the data they have available. Brotto and Dalbello-Araujo (2012) confirm that municipal managers in the state of Espírito Santo do not have an understanding of the reasons for leaves in the health sector, thus confirming the need for further studies and compilation of data on occupational diseases in the health sector.
  - **Research on other categories of health-care workers.** We found that there was more research on working time for nursing professionals and physicians than for the other health-care worker categories studied. Data on radiology and laboratory professionals are lacking.

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## 5. Recommendations

Decent working conditions for health workers are absolutely essential to the provision of quality health services and to ensure that all members of society have access to health protection.

### *Guarantee necessary public financing for SUS*

The public health-care system has never received the necessary funding to fulfil its core objective of universal access. Sufficient public funding for this system has to be respected in order for it to achieve its goal (Fagnani, 2013; Bahia, 2013). Fulfilment of this core objective would make possible structural improvements, the hiring of more workers and reductions of the stressful conditions in the health-care service sector.

### *Increase the number of health professionals*

In order to fill gaps and reduce the overloaded expectations on existing workers in the sector it is necessary to increase the number of health professionals that graduate each year. The number of workers could also be supplemented through the attraction of foreign professionals as recently done with the Mais Médicos (more physicians) programme. The shortage of trained health workers, particularly in more remote areas of the country, coincides with a population increase, longer life expectancies, rising use of specialized medical technology and the rise of new and drug-resistant diseases. As the demand for health services grows and the shortage of qualified health personnel becomes even more severe, working conditions will deteriorate and the quality of health care may be jeopardized. It is also necessary to promote decentralization of schools and universities, and residency programmes that train health-care workers. Decentralization would assist in the challenge of providing equal access to health care for the population while also creating more equal working conditions for workers.

### *Extend and support discussion of a maximum working time of 30 hours per week for nursing workers*

Establishing and enforcing maximum working hours can be important social and economic strategies. There is currently a proposal to limit nursing professionals' working week to 30 hours. One very important aspect to be discussed in society is the maximum working week of 30 hours or, as it is proposed today, that at each job the nursing professional would be permitted to work a maximum of 30 hours. According to DIEESE (2012b, p. 16), if a 30-hour working week was implemented gradually over three years, the percentage increase in monthly remuneration in the health sector would only be 1.75 per cent, including payroll and taxes for public administration (distributed over those three years). A technical study about the possibility of establishing limits on working time for nursing professionals was coordinated by the Department of Management and Regulation of Health Work (Departamento de Gestão e da Regulação do Trabalho em Saúde) of the Ministry of Health. The study included participants from workers and employers in Brazil. Participants calculated the costs of implementing a 30-hour working week, and the published results showed an even lower financial impact than the previous study by DIEESE.<sup>32</sup> In addition to the financial costs, professional association (nursing) Southeast 1 claimed that reducing nurses' working time to 30 hours per week would give workers more time for education and would generate 300,000 new jobs.

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<sup>32</sup> Nota Técnica No. 56/2012/DESID/SE/MS, 25 September 2012.

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### ***Recognize overtime***

In some establishments visited, electronic timecard machines were installed and set up only to control entrance time, but they did not control exit time. Consequently, if workers exceeded their scheduled, contractual working time their hours were not counted as overtime. In some cases, machines did not provide a paper receipt for workers. They were thus unable to keep control of their working time and maintained less structural capacity to question possible mistakes than management. In most hospitals visited, the time that workers spent passing on information to workers on the next shift was not considered to be overtime. This unpaid work took place after normal working hours, and workers stayed up to one hour after their shift had ended.

### ***Introduce more flexibility for workers to organize their schedule***

In most health establishments, the possibility to change shifts (when necessary) with colleagues does exist. In one hospital we visited, workers were limited to a maximum of three shift changes per month. In order for this flexibility to work, professionals must respect national legislation and not work beyond permitted hours. Manager South 2 indicated that many nursing professionals that worked a six-hour day changed shifts with colleagues in order to work 12 hours in a row, or even combined a night shift of 12 hours with a six-hour shift, working 18 hours without rest. Workers did this in order to have a “free” day. However, the practice clearly violates labour regulations and puts the workers themselves, patients and the health establishment in danger.

Health establishments could gain from increasing staff input into design mechanisms and allowing workers to choose from a range of possible working times that best suit them, where this is possible. For example, a nursing technician working 30 hours a week could be offered the possibility to choose working six hours a day (Monday–Friday), either in the morning or afternoon shift; or working longer shifts at nights or weekends, then complementing working time in a weekday. If workers are able to choose the working time that best suits them, and meets their personal needs, they work in a more satisfied manner and help achieve institutional objectives.

### ***Reduce working hours***

Health care needs to be available 24 hours per day. It is necessary to have workers available to provide this care. It is also necessary to reduce overall working time and to reduce incidences of schedules that require work that contradicts our circadian rhythms. Reductions in this area would improve patient and worker safety. Brazilian labour legislation refers to maximum working time per job, but not per worker. This creates a gap that needs to be addressed. Addressing this issue would have immediate effects in the health sector due to the prevalence of multiple jobs. The need to perform overtime should also be communicated to workers with sufficient advance notice. According to Brazilian legislation, overtime should only be used in special cases and increasing the number of workers hired should be used to substitute workers on leave or absent.

### ***Diminish gap between private health-care workers and unions or professional associations***

Communication should be facilitated between health-care workers in the private sector and trade unions, professional associations or labour ministry entities in order to oversee and monitor working hours in different establishments. Coordinated efforts could also be made to orient workers on their rights and responsibilities regarding working time and contracts via cooperative and legal entities. Public sector workers that had more contact with trade unions were more aware of their rights, compared to workers in the private health sector. Additionally, public sector workers can also participate in the negotiating tables (*mesas de negociação*) at national and local levels, an initiative that should receive

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incentives, whereas private sector workers rely on other types of collective bargaining. The Ministry of Labour and the Supplementary Health Agency (ANS) should pay special attention to labour relations between physicians and health-care plans, health-care establishments and cooperatives.

### ***Consider workers with family responsibilities***

Organizing time in a way that favours the reconciliation of family responsibilities and work would be beneficial for the well-being of workers and could promote equality between men and women by stimulating a more equal division of unpaid domestic work between genders. Public policies and gender education can also help.

Policies and laws oriented towards the reduction of excessively long working hours for men and women would help balance work and personal life (ILO Workers with Family Responsibilities Recommendation, 1981 (No. 165), paragraph 18). ILO (2009b) points out that policies allowing workers to better combine work and family life – such as some flexible working time measures, care services for children and elderly, more leaves to accompany sick relatives – lead to greater overall well-being and better productivity. These types of policies can facilitate the retention of the best workers in the job, diminish rotation and churning, reduce absenteeism, and reduce delays in patient care. Men typically have fewer chances to participate in family life because most programmes to better balance work and family life focus on women.

### ***Increase management training***

Physician Midwest 5 and Manager 5 said they did not feel prepared to manage and that “to be a manager you have to be trained”. Many coordinators and chiefs of staff in health-care establishments are health professionals and do not have any training in managing. Investing in training for those professionals could reduce stress and managing problems related to working time.

### ***Offer psychological support for workers***

Health-care establishments could gain from offering psychological support to workers. Many of the workers interviewed reported that they commonly observed psychological disorders among colleagues. This was also reported as a common cause of unplanned leaves and absenteeism.

### ***Guarantee a safe working environment***

Workers need to have the guarantee of a safe working environment, in terms of moral, sexual, verbal and physical violence. The ILO et al. (2002) recommendations could be implemented in order to achieve this objective.

### ***Address gaps in information***

Further research should focus on:

- the number of hours worked per professional, with a broader sample, at national level, and should also include time spent on unpaid domestic work;
- workplace accidents that are the result of fatigue, stress or excessive working time;
- partnership with specific trade unions, professional associations or governments to create a database to monitor leaves from work and why they were taken;
- extend research agendas to include health-care workers that are not nursing professionals or physicians.

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