

## Labor market and regulatory processes – Nursing in Brazil

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**Abstract** *The present article analyzes the job market of nursing professionals, based on data obtained through the survey “Nursing Profile in Brazil” (Cofen – Fiocruz), showing that a significant portion of these workers, mostly nursing aides and technicians, live in increasingly precarious conditions of survival, with low wages, multi-employment and insecurity in the work environment, which prevents them from performing their work activities with dignity. It also analyzes the Nursing regulation process, having as reference the sociology of professions, from the creation of the Federal Nursing Council/Regional Nursing Councils System, in the 1970s, when the category started to have self-regulation autonomy, and currently, the profession shows a robust and highly regulatory legal milestone, considering the number of resolutions issued by Cofen, which have an impact on professional practice. The article points out that it is essential for the government to develop and improve job management and regulation policies, in order to contribute to overcome the problems faced by nursing professionals.*

**Key words** *Job Market, Professional Regulation, Nursing Profile in Brazil*

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## Introduction

The modern society has increasingly become a professionalized society, making a large part of human activities developed in it seek recognition and professional status, gaining social privileges and (almost always legal) labor market monopoly. Most of our actions and activities are based on or referenced by acts, criteria and professional standards. Contemporary society is characterized by the division of labor into different activities and specialized areas. Andrew Abbott's statement<sup>1</sup> that professions dominate our world, our bodies, measure our profits and save our souls, summarizes how much we experience the myth of professionalism.

The domain and monopoly of knowledge constitute the core of the autonomy of the professions and their social prestige. They, in general, also appeal to the ideal of service in the pursuit of social credit and autonomy, which means that the patient's interest must take precedence over corporate interests. For Larson<sup>2</sup>, the ideal of service and the code of ethics, different versions of the same idea of moral obligation to society, are the main ideological response of the professions to the contradiction between socially produced knowledge on the one hand, and its private appropriation in the form of expertise, on the other. Both are the justification and assurance that this knowledge will be returned to society as qualified services; which, however, present themselves as pre-capitalist or anti-market elements, which gives them an ideological connotation. These are elements that were incorporated into the organization of the professions because they support both social credit and public belief in the ethical character of the professions<sup>3</sup>.

A phenomenon that has been increasingly growing refers to a large number of legal suits by several technical activities seeking their recognition as a profession. And this is not restricted to the Brazilian reality, as it has a universal presentation, in a movement of increasing professionalization of these occupations. This demand reflects the "social need" that the services a given technical area offers to society comprise differentiated, specialized and good quality products. These professionals need to undergo specific training, be constantly peer-reviewed, and have norms and rules that guide them in their practice. Additionally, this activity requires government regulation to ensure the monopoly and exclusivity of the labor market.

Overall, there is a consensus among theorists of the area regarding the existence of two un-

questionable attributes, namely, the existence of a specific body of knowledge and the orientation towards an ideal of services.

*Saying it more clearly, we can say that profession is an occupation of which obligations systematically create and use the accumulated overall knowledge to solve problems posed by a client, either individual or collective.*<sup>4</sup>(p.18).

According to Freidson<sup>5</sup>:

*the market design of the modern professions looks outwards to the broader market, seeking to establish a secure jurisdiction in the social division of labor, a shelter in the labor market, that is, in Max Weber's terms 'a social enclosure', that excludes potential competitors that are outside the profession.*<sup>5</sup>(p.249).

This author also shows that the:

*Reasonably firm and stable jurisdictional boundaries that minimize competition from other occupations and the rules that control competition between coworkers create sufficiently secure (although not necessarily wealthy) economic conditions to make a lasting commitment possible. (...) the market design lines permeate all this to obtain collective economic protection against external competition and from the maintenance design to preserve the solidarity between members, protecting the public image of the profession and avoiding the attempts of customers, employers and others to exercise control over their members' work.*<sup>5</sup>(p.252).

It is important to emphasize that the professionalized markets that exist today in the world emerged in the midst of the transformations arising from the Industrial Revolution and the consolidation of the capitalist system. These facts allowed the emergence of practices and new social functions, increasing the need for professionalism in all industrialized society<sup>2</sup>.

On the other hand, as it occurred with several other professions, in nursing, the regulatory aspects required complex actions involving various actors.

For Moran & Wood<sup>6</sup>, professional regulation scholars, there are three regulatory models. The first refers to *Self-regulation*, that is, the professionals themselves define the mechanisms of market entry and technical competency. The second is the *Government-sanctioned Regulation*, characterized by institutions in charge of formulating and implementing regulatory mechanisms with the government's consent and support. Finally, the *Direct Government Regulation*, exercised by specialized public institutions. For these authors, the regulatory model consists of the following elements: a) market entry mechanisms, including

licensing and certification; b) control of professional competition; c) the structure of the labor market and; d) the payment mechanism.

This is the central topic of this article: the labor market and the regulatory process of the nursing profession in the light of the empirical findings of the Nursing Profile Survey in Brazil – PPEB (2017), which makes an accurate and detailed diagnosis of the situation of nurses, nursing technicians and aides, with nearly two million workers in the country's health system. The survey listened to these professionals in more than 50% of the municipalities, in the 27 units of the Federation and in the 5 regions of the country. Therefore, we have now the radiography of this profession, allowing a more accurate and reliable understanding of the local and national realities.

### Professional regulation

The first regulatory measures of nursing were in the field of training, with the emergence of schools and vocational courses. However, even after the establishment of the National Department of Public Health in 1923, the supervision of Nursing activities was subordinated to Medicine<sup>7</sup>. Only with the creation of the Federal Council/Regional Councils of Nursing System, through Law N. 5.905/73<sup>8</sup>, the profession became self-regulating, gaining autonomy.

This “rational-legal bureaucracy structure aims an efficient division of labor, forms of supervision that can effectively control and coordinate a complex variety of specialized tasks, and channels that can freely and fully pass orders, requests, and information up and down the hierarchy. (...) The organization personnel are chosen solely based on their competency to perform a particular type of work and are required to perform this work on their own. Their rights, duties and responsibilities are very precisely defined, as is their authority over others and their subordination to them”<sup>5</sup>(p.254).

Therefore:

*the regulation on the control of entering the profession is carried out by the Regional Councils, taking into account the competencies described in the sections of article 15: I) to decide on the registration in the Council and its cancellation and VII) to issue the Employment Record Card indispensable to exercise the profession, which will be valid throughout the national territory and can be used as an ID document. The supervision of the professional activity is carried out according to the guidelines issued by the Federal Council and the*

*Regional Councils are responsible for its implementation according to the competencies related to the provisions of article 15: II) to discipline and supervise the professional practice, following the general guidelines of COFEN; IV) keep the records of professionals working in their respective jurisdiction; V) to know and decide on matters related to professional ethics, applying the appropriate penalties<sup>9</sup>.*

The inspection by the Councils is the main action to ensure the effectiveness of Law N. 7,498/1986<sup>10</sup>, which regulates the activity. In Brazil, Nursing accounts for most health care activities, totaling more than 2.2 million workers, represented by the Nurse, Nursing Technician and Nursing Aide. It is the nurse's responsibility to lead the care process, working in the management of nursing care, establishing the interrelationship between care and administering this care.

Based on the Law of professional practice, it is possible to observe that two types of Nurses are acknowledged: the generalist and the obstetric nurse, (Cofen Res. N. 581/2018<sup>11</sup>, which regulates the specialties and N. 516/2016<sup>12</sup>, which establishes the competencies for working in the field of obstetrics)<sup>10</sup>. Another measure arising from the law is the institutionalization of its activities, with the inclusion of the planning and scheduling of care in organizational structures, as well as the obligatory position of the Nursing Service Direction and Supervision as the nurse's exclusive actions. Another important regulatory element is the consultation and prescription of nursing care. In this sense, the Cofen determines the institution of the Nursing Process and Nursing Care Systematization (Cofen Res. N. 358/2009<sup>13</sup>), in all health units.

Regarding the expansion of the scope of practices, the law established prerogatives for nurses in the prescription of medications (Cofen Res. N. 195/1997), also guaranteeing the request for examinations established in the Public Health Programs and institutional routines<sup>14</sup>. Therefore, the regulation of this practice complied with the care model based on the highly relevant activity of nurses in the public health context.

In the case of Brazil, other entities are also responsible for the regulation of nursing activity, especially the Ministry of Health (MOH), which establishes the main clinical guidelines for the Brazilian Unified Health System (SUS – *Sistema Único de Saúde*), through protocols. However, David et al.<sup>15</sup> mention that “nurses perform what is allowed in the field of political negotiations between categories, according to the needs and contractualization of local interests by the power

management and micromanagement". Therefore, these practices are under constant jurisdictional disputes with other health professions. In this sense, Cofen affirms and delimits, through resolutions and opinions, the jurisdictional questions related to clinical practice. It is noteworthy that these resolutions embody, in addition to self-regulation, responses to the jurisdictional attacks of other health corporations. This responsive capacity of Cofen is analyzed by Koster<sup>9</sup>, who highlights the exponential growth in the number of resolutions following the promulgation of SUS in 1988, with the expansion of health policies of the MOH from the 1990s and continuing to the present day. (Graph 1).

Among the set of resolutions, three stand out: a) the Code of Professional Ethics; b) the inspection system operation; c) the standardization of the Technical Responsibility, as a capillarization of the supervision of the professional practice as indicated in Chart 1.

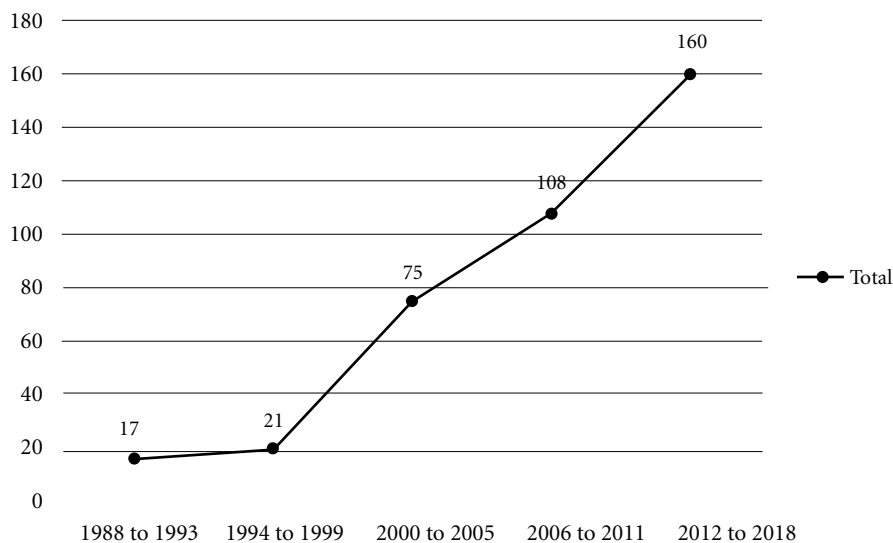
According to Koster<sup>9</sup>:

*After the first version of the Code of Ethics, there were three other reformulations. The first, in 1993, where in addition to the change of the tit-*

*le to Code of Professional Ethics of Nursing, there were structural changes with the exclusion of the preamble, considerable increase of articles, inclusion of all Nursing professionals, and inclusion of a chapter on infractions and penalties, with Cofen Resolution 51/1979 being revoked. The second, in the year 2000, with few changes, only removed the article dealing with drug advertising, indicating extensions in the professional field of nursing. And the third occurred in 2007, with a great expansion of its structure into 132 articles, divided into seven chapters, with four sections each, which concern, respectively, relationships with the person, the family and the community; with nursing workers; with professional organizations and, finally, with employers' organizations<sup>9</sup>.*

According to Koster's analysis<sup>9</sup>, the text of the current Code of Ethics, instituted by Cofen Res N. 564/2017<sup>16</sup>:

*considers in its scope a set of documents and legislations aimed at defending earned human rights, individual ones or of priority groups, involving bioethics, research with human beings, violence against women, children, adolescents and the elderly, and individuals with mental disorders.*



**Graph 1.** Distribution of the number of Resolutions per year available on the site of the Federal Nursing Council – Brazil.

Source: Koster<sup>9</sup>.

**Chart 1.** Resolutions on professional regulation of nursing – Brazil.

Resolution	Standardization	Relevance
Cofen Res. N. 564/2017 <sup>16</sup>	Code of Professional Ethics	Crucial instrument for the control and supervision of professional practice, which provides for the rights, duties, prohibitions, infractions and penalties. This version has been recreated with extensive discussion in the Regional Councils and public consultation.
Cofen Res. N. 374/2011 <sup>17</sup>	It regulates the operating of the Nursing Professional Practice Supervision System and provides other measures.	It is based on a conception of an educational process, of stimulating ethical values and valorization of the nursing work process. Establishing limits for inspection actions. Standardization of administrative and legal conducts. Permanent review of work methods and tools and standards considering technological changes and insertion of new practices. Regulates the model for selection and training of inspection professionals.
Cofen Res. N. 0509/2016 <sup>18</sup>	Updates the technical standard for Technical Term of Responsibility by the Nursing Service and defines the attributions of the Nursing Technical Manager (TM).	Inspection power granted to the TMs to act as a liaison between the institution's Nursing service and the Cofen System / Regional Councils, capillarizing the self-regulation.

Source: The authors, based on the analysis of Cofen Res. N. 564, 374 and 509<sup>16-18</sup>.

Therefore, Nursing updates one of its self-regulation instruments, establishing its standards of conduct and relationships between its peers, its competitors and its clientele<sup>9</sup>.

As for the phenomenon of specialization in nursing, the analysis points to issues related to the regulation of professional practice and the labor market. Some, involving public policies and models of health care, such as: Collective Health and hospital areas. Others meet the requirements of areas that are already regulated, such as worker's health and hemodialysis services.

As a result of technological evolution, Nursing specializes in areas of expertise. The first resolution on the subject is from 1998, regulating 8 specialties. In 2001, it increased to 37; in 2004, to 42, reaching 60 specialties in the year 2018, which represents an increase of 750% (Figure 1), as pointed out by Koster<sup>9</sup>.

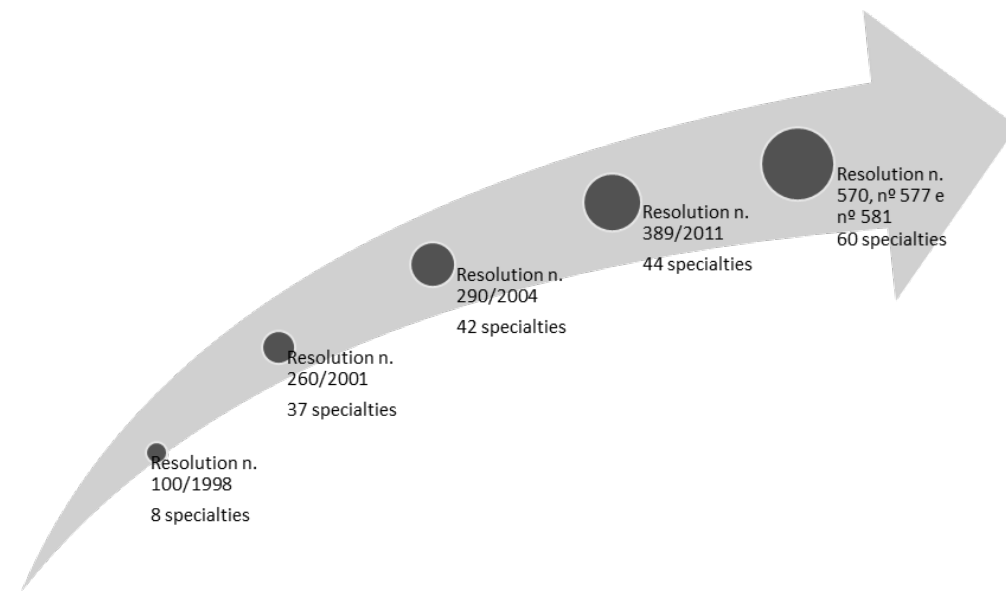
On the other hand, data from PPEB (2017) indicate that:

*Although 70% of nurses have taken a specialization course, that is not reflected when the question concerns whether or not one has a Specialist Title. In this case, 51% claim they have a title, which makes it possible to infer that a significant part of the courses offered and taken by nurses are not recognized by the category/job market, not giving them the status of specialist<sup>19</sup>(p.21).*

The authors also analyze that this “specialization” of the activity reflects something new in the nursing labor market, since “of the 211,000 nurses who reported having a title of specialist, 47% obtained the title 5 years ago or less. Adding up the group of 6-10 years, the percentage rises to 65.7%<sup>19</sup>. Similarly, and following the same process, 18 specialties have been registered for the Nursing technician, contained in Cofen Res. N. 609/2019<sup>20</sup>.

Regarding the regulation of care practice, Cofen has issued a series of norms that meets the needs and challenges in the category's daily life. The case of the autonomy for insertion of the Peripheral Intravenous Catheter (PIC); suturing/episiorrhaphy by the obstetric nurse; the collection of material for oncotic colpocytology as an exclusive activity of the nurse; authorization to perform the insertion of Intrauterine Device by nurses; the definition of the competencies of the team in the treatment of injuries, giving them the autonomy to open Nursing Offices, among others, have been defied, attained through judicial intervention by the Council, such as the recognition of the autonomy of nurses in the practice of acupuncture.

As an example, Cofen recently standardized the opening of nursing clinics and offices, through Res. N. 568/2018<sup>21</sup> and N. 606/2019<sup>22</sup>,



**Figure 1.** Distribution of the number of specializations recognized by the Federal Nursing Council according to the Resolutions.

Source: Koster<sup>9</sup>.

providing legal support to professionals for autonomous work; as well as resolutions on the regulation of the fees and the Technical Responsibility of the nurse.

Therefore, it can be observed that the profession establishes a regulatory legal framework of impact on its daily practice observed not only by the number of resolutions issued by Cofen, but also by the scope and amplitude of covered areas.

### The Job Market

The Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), established in the Brazilian Constitution in 1988, is one of the largest public health systems in the world and has produced, in its 30 years of existence, major transformations in the health system, representing

[...] *a new way of thinking, structuring, developing and producing health services and care, since the principles of universal access, comprehensive health care, equity, community participation, people autonomy and decentralization constitute the paradigms of SUS. Some trends are identified in this process: [...] 1) expansion of the established capacity; 2) municipalization of jobs; 3) ambulatory*

*care; 4) higher qualification of the team; 5) feminization of the workforce; 6) flexibility of the bonds, among others*<sup>23</sup>(p.105).

However, as stated by Machado et al.<sup>24</sup>:

*the way in which the health care model has been historically structured in Brazil has reinforced regional inequalities and the division of 'service markets' between the public and private sectors. While on the one hand there is a predominantly public outpatient network, consisting of health centers and health care units, intended for the provision of services in basic clinics, on the other, we see that the private sector has the hegemony regarding establishments with hospitalization (hospitals), being responsible for half of the existing beds in the country*<sup>24</sup>(p.54).

On the other hand, the labor market (LM) of the health sector will experience a strong expansion, which will have an impact on the dynamics of the sector. Machado and Ximenes Neto<sup>25</sup> analyze that:

*Thirty years after the implementation of SUS, Brazil has the following health reality (CNES, 2017): 200,049 health facilities; 3,594,596 health jobs. In 2017, the municipal public sector had 1,649,074 health jobs; the state had 463,720; and*

the federal had 96,491 jobs. The health team becomes multidisciplinary: nurses, dentists, doctors, pharmacists, dietitians, physical therapists, social workers, psychologists, among others; in addition to nursing technicians and aides, for the most part. The health sector now has: 1,104,340 higher level jobs; 889,630 technicians and aides; and 317,056 jobs at the elementary level<sup>26</sup>. Currently, Brazil has 453,428 doctors<sup>27</sup>, 484,530 nurses<sup>28</sup>, 300,000 dentists<sup>29</sup> and 203,600 pharmacists<sup>30</sup>.<sup>25</sup>(p.1976-1977).

The structuring of LM is one of the bases of the Nursing professional project. Over the past few decades a solid market for complex services with social credibility has been built.

*From the demographic point of view, we highlight the growth and aging of the population as the explanation for this demand. From a socioeconomic point of view, the recovery of the labor market and the social ascension of a significant part of the population, which stimulated the consumption of health care plans, generating strong pressures for the production of more diversified and qualified health goods, services and technologies. From the political point of view, the consolidation of SUS itself and the advance of public policies in this area stand out, especially the Family Health Strategy (FHS), the main responsible for decentralizing and expanding the nursing labor market and changing the focus from hospital care to outpatient, home and community care<sup>24</sup>(p.55-56).*

According to data from PPEB<sup>31</sup>, there were 1,804,535 professionals, of which 414,712 were nurses and 1,389,823 were nursing technicians and aides. In 2019, the number reached 2,169,402 professionals, of which 527,842 were nurses and 1,641,560 were mid-level professionals, of which 1,230,182 are technicians and 411,378 are nursing aides<sup>32</sup>.

Table 1 shows data from the Nursing LM, in which the public and private sectors (for-profit and nonprofit – philanthropic subsectors) are the major employers, with the public sector accounting for 55.6% of jobs and the private for 44.4% of the total.

### Public sector

This sector has continental dimensions, consisting of more than 75,000 health facilities, incorporating more than 1 million Nursing workers, which is equivalent to more than half of the employability of the category, whether at the municipal, state or federal level (Table 1).

Their insertion in the market has different types of employment bonds. The statutory

workers, ruled by the Single Legal Regime, comprise half of the workers (49.9%), while the CLT-type constitute 17.7%, service providers, 8.5% and temporary workers, 8.4%. The OSCIPs, OS and Co-ops amount to 15.6%.

Regarding the types of institutions in the sector, it has been recorded that 68.7% of the professionals work in Hospitals and Urgency/Emergency Units, amounting to more than 976,000 professionals. Basic Health Units (BHUs) and similar health services concentrate the second largest number of workers, with 18.4%, or more than 261,000. The outpatient units and polyclinics employ 6.2%, about 88,000. And the SADTs employ more than 19,000 professionals (1.4%). As for the teaching, research and management activities, they are performed by more than 75,000 professionals (mostly nurses), equivalent to 5.3%.

On the other hand, working shifts is the most often used work regime in this sector, with 57.1% (more than 593,000, with daily work showing 42.9%, which totals over 445,000 professionals.

As for the working hours in this public sector, the majority (63.8%) work between 21-40 hours a week and 34%, more than 41 hours. A total of 2.2% of workers has a “sub-number of working hours” (equal to or less than 20 hours a week), that is, almost 21,000 professionals.

In practice, the working hours of nursing professionals are not regulated by law, and a free negotiation is allowed. In general, the federal government, most states, and large municipalities adopt the 30-hour /week system, while the private sector, 40-44 hours/week.

Income distribution in this sector shows the following pattern: 1) 55.7% have a monthly income of up to 2,000 reais; 2) 39.4% receive salaries between 2,001-5,000 reais; 3) only 4.8 have income above 5,001 reais (in August/2019, 1 dollar = 3.96 reais).

### The private sector

This sector comprises more than 60,000 health facilities, with more than 840,000 professionals, which corresponds to 44.4% of the total number of workers (Table 1).

Regarding the types of employment bonds, the private for-profit sector has more than 571,000 professionals, or 29.9% of the total number. Two types of bonds predominate: CLT with almost 299,000, or 56.1% and service providers, with 30.5%. Private non-profit has 278,000 professionals, 14.5% of the total, of which 61.3% are

**Table 1.** Nursing Team according to the performance in the public and private sectors – Brazil.

Work	Public Sector		Private Sector			
	Abs. V.	%	For profit		Non profit	
			Abs. V.	%	Abs. V.	%
<b>N. Of professionals</b>	<b>1,063,694</b>	<b>55.6</b>	<b>571,099</b>	<b>29.9</b>	<b>278,283</b>	<b>14.5</b>
Employment bonds						
Statutory	562,300	49.9	0	0.0	0	0.0
Clt	198,914	17.7	298,735	56.1	152,838	61.3
Temporary	94,087	8.4	23,747	4.5	9,776	3.9
Service provider	95,425	8.5	162,411	30.5	75,688	30.3
Others	175,417	15.6	47,646	8.9	11,122	4.5
Total	1,126,142	100.0	532,539	100.0	249,424	100.0
Modalities of institutions						
Hospitals and Urgency/Emergency Units	976,242	68.7	533,566	70.1	259,812	73.6
Basic Health Units - bhus	261,682	18.4	18,904	2.5	0	0.0
Ambulatory units/polyclinics	88,122	6.2	78,643	10.3	43,007	12.2
Diagnosis and Therapy Support Units - SADT	19,486	1.4	67,212	8.8	46,751	13.3
Teaching, Research and Management	75,335	5.3	62,909	8.3	3,247	0.9
	1,420,867	100.0	761,234	100.0	352,817	100.0
Work regime						
Daily work	445,725	42.9	220,296	43.8	117,402	45.2
Work shifts	593,336	57.1	282,308	56.2	142,132	54.8
	1,039,061	100.0	502,604	100.0	259,534	100.0
Weekly hours worked						
Up to 20 hours	20,916	2.2	21,883	4.6	6,817	3.0
21 - 40 hours	607,561	63.8	240,271	50.0	120,591	52.6
> 41 hours	324,185	34.0	218,004	45.4	101,644	44.4
	952,662	100.0	480,157	100.0	229,052	100.0
Monthly income						
Up to 2,000 reais	479,532	55.7	308,507	69.4	156,613	73.0
2,001 – 5,000 reais	339,421	39.4	125,839	28.3	55,414	25.8
More than 5,001 reais	41,472	4.8	10,052	2.3	2,562	1.2
	860,425	100.0	444,397	100.0	214,589	100.0
Occupational accident in the last 12 months						
Yes	114,293	11.0	55,362	10.8	29,368	10.9
No	923,889	89.0	458,929	89.2	239,839	89.1
	1,038,182	100.0	514,291	100.0	269,207	100.0
Medical leave in the last 12 months						
Yes	230,647	22.5	87,892	17.2	37,046	13.9
No	795,316	77.5	421,949	82.8	229,073	86.1
	1,025,963	100.0	509,841	100.0	266,118	100.0
Unemployment in the last 12 months						
Yes					182,548	10,7
No					1,519,893	89,3
					1,702,441	100,0
Difficulty in finding employment						
Yes					121,697	70,0
No					52,068	30,0
					173,765	100,0

Source: Adapted from Table Summary: Machado<sup>31</sup>.



CLT workers and 30.3%, service providers. The private non-profit sector employs 278,000 professionals, 14.5% of the total, of which 61.3% are CLT workers and 30.3% are service providers.

Regarding the types of institutions where they work, the *private for-profit*, the Hospitals and Urgency/Emergency Units concentrate the absolute majority, i.e., 70.1%, which is equivalent to more than 533,000 professionals. Outpatient services comprise 10.3%; Diagnosis and Therapy Support Units – SADTs, 8.8%; BHUs only 2.5%; and in the Teaching, Research and Management activities, 8.3% (the absolute majority performed by nurses). In the *non-profit private* sector, the Hospitals and Urgency/Emergency Units also concentrate the majority, with 73.6%, almost 260,000. SADTs comprise 13.3%; Outpatient Units, 12.2% and in the Teaching, Research and Management activities, the participation is minimal, only 0.9%. There is no record of nursing activities in BHUs.

The most common work regime in the *for-profit private* sector is the shift work, used by 56.2% of the staff, whereas daily work accounts for 43.8%. As for the working hours, half of the professionals (50%) work 21-40 hours a week and 45.4% work more than 41 hours. On the other hand, 4.6% work 20 hours or less a week, that is, more than 21,000 professionals, which characterizes the existence of a “sub-number of working hours” in the sector.

As for the *private non-profit* sector, the shift work is also the predominant work regimen, with 54.8%; daily work represents 45.2%. More than 50% of the workers (52.6%) work 21-40 hours a week and 44.4%, more than 41 hours. And 3% of the workers declare they work 20 hours or less a week, which characterizes a “sub-number of working hours” in the sector.

The distribution of income in the *private for-profit* sector shows that: 1) 69.4% have a monthly income of up to 2,000 reais; 2) 28.3% receive a salary between 2,001-5,000 reais; 3) and only 2.3% have incomes > 5,001 reais. In turn, the nonprofit private sector has the worst income distribution compared to the others, considering that: 1) 73% of the staff have a monthly income of up to 2,000 reais; 2) 25.8% receive a salary between 2,001-5,000 reais; 3) and only 1.2% of them have an income > 5,001 reais<sup>33</sup>.

Considering data from the PPEB it is possible to state that:

*the condition of the Brazilian nursing team in relation to the labor market reflects an economically active professional category, which represents*

*91.8% of the total workers. However, this group of workers shows signs of problems with full employability, with almost 5% of open unemployment and 1.9% declaring temporary leave from work, which corresponds to more than 100,000 workers. It is also relevant to note that more than 6,000 of these workers, or 0.4%, have definitely left the profession<sup>31</sup>(p.325).*

Still considering information from Table 1, it can be observed that 10.7% of the nursing staff experienced unemployment in the last 12 months and 70% reported difficulties in finding a new job. What is noteworthy is the team’s occupational accident rate of 11% in the public sector and 10.9% (average) in the private sector, which is equivalent to more than 199,000 injured workers in the health work environment. On the other hand, even more serious is the rate of 22.5% of sick leave among the nursing staff working in the public sector and 15.6% (average) in the private sector.

## Final considerations

Traditional professions, such as lawyers, doctors, nurses, engineers, priests, have experienced transformations regarding their technical and scientific aspects, as well as the designing of a political-ideological reordering of the “ideal of service”. Corporate interests increasingly seek to meet economic demands and respond to technological needs. It can be said that these professions undergo a process of radical changes altering their essence, with ruptures in self-perception and their professional project.

In the last two decades, nursing professionals in Brazil have experienced important changes in the world of work. The job market has shown clear signs of wage earning, with the wages being linked to several different types of work regime: by shift, by hour worked, short and temporary contracts, lack of institutional bonds, generating precariousness and multi-employment, with insecurity at the work environment becoming increasingly more frequent. The discussion about decent work has become a recurring theme among trade unions representing workers.

*The International Labor Organization (ILO) lists seven interrelated dimensions of precariousness, as opposed to decent work, namely: 1) labor market insecurity due to the absence of job opportunities; 2) job insecurity generated by inadequate protection in the event of dismissal; 3) job insecurity generated by the absence of activity delimitation.*

tations or even job qualification; 4) physical and health integrity insecurity due to the poor conditions of the premises and the work environment; 5) income insecurity, due to the low wages and lack of expectation of salary raises; 6) representation insecurity, when the worker does not feel protected and represented by a union<sup>25</sup>(p.1977-1978).

The technological advances registered in the last decades have required the nursing profession to obtain more prestige, status and a great capacity to demonstrate its resolute capacity regarding the population's health problems. However, these advances also have negative effects, generating competition, jurisdictional disputes in the field of professional regulation, jeopardizing achievements and even loss of space in the labor market.

The managerial bureaucratic control implemented in health organizations (public or private) has been pointed as a sign of new times regarding the types of health work regulation, which represents the imbalance of government regulation among the professions. It is a fact that the Brazilian health system has not responded to these new demands from both health professionals and users. Both feel dissatisfied with the results of these advances and the ways in which the state has responded to them.

If, on the one hand, the pressures of the professions on the government to achieve their autonomy and market control are definitely legitimate, on the other hand, the government should seek to promote a balance between them, to guarantee the constitutional principles and guidelines for health and develop health policies for its workers.

## Collaborations

MH Machado, I Koster, MCMW Wermelinger, W Aguiar Filho, NP Freire and EJ Pereira participated in the study conception and design, writing and review of intellectual content until the final version of the manuscript.

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