Social Protection Floor in Brazil

04 August 2011

Statistics

- **Total population:** *190,732,694 (Source: IBGE/Census 2010), +1.17% p.a. (2000/2010).*
- **Formal employment:** *53.5 % of the occupied population over 10 years of age are contributors to a social security institution (Source: IBGE/PNAD 2009 Household Survey).*
- **GNI per capita (PPP $, 2009:)** *10,160 (Source: World Bank, WDI)*
- **GDP growth:** *-0.2% (2009), +7.5% (2010p) (Source: IBGE)*
- **Human Development Index Value:** *0,699 (2010) and HDI Rank: #73 (Source: UNDP)*
- **Poverty headcount ratio at national poverty line 2009:** *21.4% (Source: World Bank WDI)*
- **Recent development of poverty rate:** *headcount fell from 30.8% (2005) to 21.4% (2009), Source: WDI*
- **Gini Index:** *Income concentration falling since 2001 from 0.591-0.599 levels (1995-2000) to 0.538 (2009), according to IBGE/PNAD Household Survey, as processed by IPEA.*
- **Total public expenditures as % of GDP (2009):** *25.6% (Source: World Bank, WDI)*
- **Recent development of total public expenditures as % of GDP** *(Source: World Bank, WDI)*:

1997	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*
22.1	*22.4*	*22.2*	*21.7*	*22.8*	*22.8*	*24.9*	*22.9*	*25.6*	*25*	*24.2*	*23.8*

- **Total expenditure on health as % of GDP (2006):** 7.5% (Source: WHO, World Health Statistics 2008), of which 4.3% of GDP was public expenditure
- **Share of total health expenditure not financed by out of pocket payment (2006):** *66.7% (Source: ILO World Social Security Report 2010/11)*
- **Social assistance expenditure as % of GDP:** *1.1% (2009; Source: TCU)*
- **Unemployment rate (Dec. 2010):** *5.3% (6 Metropolitan Regions, Source: IBGE/PME)*

Coverage indicators of the SPF guarantees:

- **Health protection (Source: Min. Health/RIPSA 2009):**
  - Population which had at least one medical consultation in the year (2008): 67.7%;
  - Expecting mothers with 4 or more prenatal examinations (2008): 89.9%;
  - Children who received five key vaccines (2008): 96.3-108.4%;
  - Coverage by water, sewage and garbage collection systems (2008): 82.8%, 71.3% and 86.6% of the total population, respectively.
- **Pensions**: 67.0% among 15-59 year-olds (social insurance coverage), 81.8% among persons aged 60+ (77.3% with social insurance/assistance benefits and 4.5% still working and contributing). (Source: PNAD 2009 Household Survey, as processed by MPS/Brazil).
- **Disability:** Contributory coverage similar as for pensions, social assistance coverage income-tested.
- **Child benefits:**
  - Total Number of Families in the country 60.9 million (Source: PNAD 2009);
  - Number of families covered by Bolsa-Família in 2011 12.9 million (Source: MDS/Brazil),
  - Number of families receiving child benefit from contributory scheme in 2009 – 4.1 million (Source: MPS/Brazil).
- **Unemployment:** *Proportion of formal workers who lost their job and received an unemployment benefit – 80.0% (6.85 million workers in 2009; Source: TCU).*

1. The national social protection floor

Until the end of the 19th century, Brazilian social protection focused on charitable action, such as the religious hospitals ("Santas Casas") attending to the needs of the sick poor, and treasury-financed benefits for key groups at the service of the State, such as civil servants and the military. When the agriculture export-oriented economy triggered a growth of the urban economy based on wage work in the early 20th century, as in several other pioneer countries in Latin America, Brazil introduced contributory social security schemes for urban workers. Its set-up started with labour accident protection laws in the first two decades, and was followed by old-age and widow pension insurance starting in 1923 under the Eloy Chaves law, which is officially recognized as the foundation milestone of contributory social insurance.

During most of the 20th century, the bulk of social policy relied on the contributory principle and the payroll as the most important source of funding. An important exception was the introduction in the 1970s of rural pensions financed with a tax on rural production. As in other Latin American countries, the contributory system grew in coverage especially within the formal sector, and mainly in urban areas. The pattern of growth with high concentration of income, characteristic of import-substituting industrialization, blocked the access by most of the poor to contributory insurance. The model was challenged yet again after the crisis in the 1980s, which stopped the so-called "Brazilian miracle" of the 1970s. This decade-long crisis had a highly negative impact on the creation of formal employment and on real wages, weakening the financial pillars of the social protection regime.

The Federal Constitution of 1988, issued during the transition to democracy1, has served as the legal basis for social protection system during the last two decades. It was elaborated with important participation by social movements, trade unions among them. The Constitution contains a lengthy chapter on social security policies and rules, and introduces important orienting principles: 1) the goal of universal coverage; 2) the non-discrimination of rural populations in social protection; 3) the aim of income redistribution through social policy; 4) protection of the real value of benefits; 5) a financing basis that combines payroll-related contributions with general taxes; 6) co-participation of society in the management of social security. "Social security" was redefined as a set of social policies composed of contributory social insurance, social assistance schemes and universal health care, organized by the State and funded by society.

The gradual introduction of these principles during the 1990s, along with the ensuing institutional reforms, shaped the country's social protection system. Health care was transferred from social insurance to the Ministry of Health and health facilities mostly decentralised to states and municipalities, giving rise to the "Sistema Único de Saúde" (SUS). Social insurance was restructured and administratively modernised throughout the 1990s and 2000s. Modern social assistance benefits, such as the BPC social assistance pension, were introduced in the mid-1990s. The low inflation environment in the aftermath of the successful Plano Real of 1994 enabled the devaluation of monetary benefits and the minimum wage to be controlled, the real value of which had been on the rise since 1995. A minimum level of funding for basic public education had been guaranteed by the minimum education expenditure standards set by Congress already in the 1980s. The funding structure for the other two universal tax-financed policies – health and social assistance – were developed starting in the 1990s. The contribution shares of the Federal, State and Municipal levels were defined, and a tax on financial transactions was applied between 1996 and 2007 to supplement other sources of funding foreseen by the Constitution. The administrations' division of roles and the

[1] The country was ruled by military governments from 1964 to 1984.

coordination of their actions were developed in both health and social assistance, giving rise to sophisticated levels of coordination and steering within the Federation. The principle of social dialogue was introduced and strengthened by establishing participatory councils attached to each policy sector, as well as sectoral policy conferences and social dialogue processes, especially in the 2000s. Another highlight is the 2009 ratification of ILO Convention No. 102 (1952, Social Security Minimum Standards) by Brazil.

Despite the introduction of the concept of "social security" and several organisational details, the 1988 Constitution did not foresee the birth of conditional cash transfer programmes in the 1990s. These programmes, unlike short-term social safety nets created in response to the crisis of the 1980s, combine poverty-alleviating cash injections with health and education conditionalities that recipients must abide by, that aim at longer-term human capital development. The predecessor of conditional cash transfers was pioneered by three municipalities (Brasília, Campinas, Ribeirão Preto) in 1995, and soon the basic idea spread around the country. In 2001, the federal government expanded the programme Bolsa Escola to nation-wide coverage, and in 2003 it was merged with other conditional cash transfer programmes and renamed Programme Bolsa Família. Its funding is based on taxes2. Since its inception in 2003, the coverage of Bolsa Familia has expanded to almost 13 million families, and thus it boasts a scale unforeseen in Brazilian social assistance.

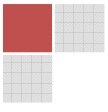
The implementation of public policies described above has led to an increase in social security spending. The spending on social security and health rose from 12.6% of GDP (1990) – the year the new laws on health and social security were passed – to 18.4% of GDP in 2008, according to Cepalstat. Expenditure on education and housing grew during the same period, from respectively 4.0% and 1.1% of GDP (1990) to 4.9% and 2.1% (2008). The total federal, state and municipal spending on social security, health, education and housing reached 26.1% of GDP in 2008 (Cepalstat). This figure also includes nutrition programmes, labour market policies and the expansion of water and sanitation services. The latest national data (TCU Annual Report 2009) show that the federal-level social security expenditure was R$ 427.4 billion in 2009. Most of this was funded by workers' and employers' contributions (R$ 360.7 billion), whereas the Treasury covered the remainder (R$ 66.6 billion) out of general taxes. Figures recently published by IPEA show that federal social spending has increased significantly between 1995 and 2009, from 11.28% to 15.80% of GDP. Importantly, out of this total, 7.28% are directed towards social security, 2.37% to benefits for civil servants, 1.85% to health and 1.09% to social assistance. Social security is the area of spending that has grown most in absolute terms (+2.30 percentage points of GDP), while the highest relative growth has occurred in social assistance spending (from 0.08% of GDP in 1995 to 1.08% of GDP in 2009, largely due to the extension of non-contributory pensions and Bolsa Familia)3. Due to the funding needs resulting from this development, the fiscal pressure in relation to GDP rose from 26.4% in 1988 to 36.5% in 2008, according to OECD figures. This is comparable with levels observed in some Western European countries.

Brazilian income inequality has systematically fallen in the 2000s according to data from the PNAD/IBGE household surveys. The Gini index has dropped from 0.592 (2001) to 0.538 (2009), largely due to three factors4: 1) improvements in the labour market, 2) the increase of the minimum wage and 3) the cash transfer programmes. Firstly, the period of strong economic growth has

[2] Until 2007, the Programme Bolsa Familia obtained a share of the revenue from a tax on financial transactions linked to the financing of poverty reduction.

[3] See IPEA (2011). 15 Anos de Gasto Social Federal. Notas sobre o Período 1995 a 2009. Brasília: 8 de Julio de 2011. Comunicados IPEA N° 98.

[4] See: IPEA (2010). PNAD 2009 – Primeiras Análises: Distribuição de Renda entre 1995 e 2009. Brasília: 5 de Octubre 2010. Comunicados IPEA N°. 63, especially graph 4.



created 15.3 million formal jobs since 20035 and raised the level of real wages, including the incomes of low-wage workers in both the formal and the informal economy. Secondly, the rise of the minimum wage has had multiple positive repercussions in the labour market and it also functions as a reference for the level of social pensions (BPC), as well as the minimum benefit guarantee for social insurance benefits. Thus, as the minimum wage has been raised at a rate higher than inflation, minimum benefits have also increased at a rate higher than that of other benefits, raising the incomes of the lower economic strata. Thirdly, cash transfers, especially Bolsa Família, have reduced income inequality. The impact of this is of similar magnitude to that of the minimum wage increase.
During the same period, general and extreme poverty also fell rapidly, regardless of the poverty line applied6. If measured by a poverty line at an income of half a minimum wage per person7, the reduction between 2003 and 2009 was of 36%. If measured using to the income references of Bolsa Família programme, the decrease registered was even higher: 50% (R$ 100 per capita) and 56% (R$ 50 per capita – extreme poverty). It has also been shown that the poverty gap was reduced: whereas in 2003 the gap corresponded to 10.7% of the total income of families (for a poverty line at the level of half a minimum wage per person), the gap was reduced to 4.7% in 2009. This is a consequence of the systematically higher growth of the income of the poor throughout the period. Hence, the combination of pro-poor growth and cash transfers (part of the social protection floor) has helped the country to reduce the incidence of extreme poverty by more than half, thus reaching the first target of the Millennium Development Goal 1 six years in advance.

It is important to mention that social policies have played an important role in Brazil's response to the global financial crisis of 2008/2009[8]. For the first time, in 2009, the development of federal social spending happened at a rate different from that of GDP. While in 1995-2008, federal social spending grew at a pace similar to that of GDP, a series of anti-cyclical policies divorced the two indicators: while the GDP fell 0.19%, social spending increased by 11.67%. The decision to maintain and anticipate the real positive adjustments of the minimum salary (affecting two-thirds of the social security benefits, the social pensions and the unemployment insurance), an expansion of coverage of Bolsa Família and the extension of the period during which unemployment benefits are paid to workers in sectors most seriously affected by the crisis are among the factors explaining this development. Innovations in the financing of the popular housing policy (e.g. programme Minha Casa, Minha Vida) have sought to activate the construction sector.

2. Initiatives already in place linked to the SPF approach

The Social Protection Floor (SPF) Initiative can be seen as both a tool for better policy coherence, as well as an instrument for the extension of social protection to those excluded from basic transfers and services, improving the general level of social protection. Firstly, as the SPF focuses on establishing coordination between social programmes ranging from income transfers to social services, it can increase the synergy and coherence between policies. Secondly, the SPF is an instrument to expand access to social programmes and services, and harmonising them with existing social insurance and other social programmes. By providing a basic set of services and transfers to all, the socioeconomic position of those previously excluded is greatly improved. For significant segments of the population, this new coverage can facilitate future access to better levels of protection and ease their incorporation or return to the formal labour market, among other things. Nevertheless, the availability of basic income and basic services increases the demand for products and services that generate employment, often with largely local employment. Therefore, the SPF is,

[5] According to: Relação Anual de Informações Sociais (RAIS) 2003-2010.
[6] See also: IPEA (2010)
[7] This is one of the lines foreseen in the Organic Law of Social Assistance of 1993.
[8] See: IPEA (2011)

ultimately, a route to higher levels of social protection for all. This process is visualised by the "social protection staircase" metaphor.

In other words, the building of a SPF in any country requires a vision of the development strategy and social protection system where SPF policies are embedded. In the Brazilian case, a vision of universal social protection and health is clearly present in the Constitution of 1988. In practice, the programmes that form part of the SPF were introduced in the 1990s. The SPF focus, by proposing improvements in coordination and encouraging the closing of coverage gaps, can facilitate the efforts to reach the objectives stated in the Constitution.

For example, coordination mechanisms have been developed, notably within the universal health and social assistance systems, but also increasingly by providing the Bolsa Família beneficiary families a set of social and employment services. Policies targeted at families with children have been implemented on both contributory (Salário Família, maternity benefits) and non-contributory basis (Bolsa Família) and their coverage expanded. Policies to support the socially vulnerable working-age population form part of the labour market policies, and include unemployment insurance, training and employment services. Finally, the coverage of the elderly and the disabled has been expanded through social insurance (Previdência Social, for private sector workers and public servants), semi-contributory (rural pensions and schemes for small urban entrepreneurs) and social assistance policies (social assistance pension BPC). Regarding access to essential services, in addition to the universal tax-financed Health System SUS, this document will describe the programme Luz para Todos, aimed at universalising access to electricity.

The Coordination of Social Policy: SUAS[9]

Modern Brazilian social assistance policies are the outcome of a progressive institutional development built around the framework of the Organic Social Assistance Law of 1993 and the gradual administrative and budgetary institutionalization, which resulted in the creation of the Ministry of Social Development (MDS) in 2003. Since the passing of the National Social Assistance Law in 2004, by the National Social Assistance Council, in 2005 the Sistema Único de Assistência Social (SUAS) was established. SUAS has an important role in systemic coordination. In order to operationalise SUAS, the Norma Operacional Básica, or basic operational norm (NOB), was created in 2005. It establishes, for example, the mechanisms of coordination and service models. In 2011, through the law 12.435, the Organic Social Assistance Law was thoroughly revised and included the definition of the SUAS, hence raising the level of the legal protection of access to social assistance services. The states and municipalities have undergone a process of qualification to locally administer and run, at least on a basic level, many of the schemes. By 2009, 99% of the Brazilian municipalities had qualified at least for the basic management of social assistance programs under SUAS minimum standards. The SUAS also counts on national, regional and a local social assistance councils that monitor policy implementation.

The federal government, in addition to being responsible for the general coordination of social assistance through MDS, also plays an important role in financing the SUAS: the 2009 social assistance expenditure amounted to R$ 32.9 billion, equalling 1.1% of GDP. This budget comprised Bolsa Família, the BPC social pensions, as well as a share of the other social assistance programmes and social services, which are delivered by States and Municipalities. Additionally, the federal government granted tax exemptions allocated to social assistance functions worth 0.1% of GDP,

[9] See: http://www.mds.gov.br/assistenciasocial. See also: on the history of social policy since the 1988 Constitution: IPEA (2009). Boletim de Políticas Sociais, N° 17, and, on recent developments, see: IPEA (2010). Boletim de Políticas Sociais, N° 18 y N° 19..

mostly tax relief for non-profit social assistance organizations or private charity donations, as well as some tax exemptions for aged persons.

Social transfers: to families with children

The Bolsa Família programme, the largest cash transfer scheme in the country, supplements the income of the families with the lowest incomes[10]. Since June 2011, the value of the transfer is between R$ 32 and R$ 306 per month (approximately US$20 and US$190), depending on the socio-economic condition of the family. The income criteria state that the programme targets families with a monthly income per person of less than R$140 (US$88). The cash is preferably paid out to women. The cash injection immediately alleviates the beneficiaries' poverty, and the conditionalities and support services improve access to health and education. This combination is designed to create the conditions for long-term poverty reduction. The programme establishes three principal conditionalities: 1) for the children between the ages 6-17, a proof of school attendance is required (of at least 85% for 6-15 year-olds and 75% for 16-17 year-olds), 2) women aged 14-44, especially pregnant women, and small children must follow a health schedule comprised of regular health and maternal health check-ups and vaccinations; also some social assistance services need to be used by the respective families; 3) there must be no child labour in the family, in order to encourage schooling. The families that have no children receive the basic benefit worth R$70, or US$44, of Bolsa Família. Families with children receive additional shares on top of the basic benefit. The value of these depends on the number of children.[11]

Bolsa Família currently covers 12.9 million families (March 2011). Its budget in 2009 was R$11.8 billion, equivalent to only 0.4% of GDP. Evaluations show that the programme has reduces extreme poverty and inequality with a modest administrative cost. 4.3 million families moved out of extreme poverty and the programme explains 21% of the registered reduction in income inequality (data from 2004-2006). The average family income among the beneficiaries increased by 48.7% in 2010 (in the north-east this figure was as high as 60%). It has also been highlighted that school attendance rates have risen and beneficiary families' nutrition levels have improved. Interestingly, inclusion in Bolsa Família often leads to improved labour market participation by the beneficiary families. This can be explained by the positive impact of the cash injections and access to services on beneficiary families' ability to compete for job opportunities.[12]

The programme is operated with the help of a single national database, the information of which can be contrasted with information from other social programmes. This allows for a more precise targeting of the benefits. Municipalities provide social services and have an important role in the identification of potential beneficiaries. The programme also includes an interesting rule that creates financial incentives so that the municipalities would regularly feed the database with up-to-date information on the current and potential beneficiaries. The Municipal Social Assistance Councils supervise the implementation of the programme, and the local health and school authorities were able to provide information on how well 90% of school age children and 66% of expecting mothers and young children abided by the conditionalities.[13]

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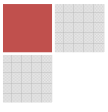
[10] See: http://www.mds.gov.br/bolsafamilia.

[11] In June 2011, the maximum number of children per family used to calculate the level of benefits has been increased from three to five, raising the maximum benefit from R$242 (US$150) to R$306 (US$ 190). The value of additional benefits is different for children and adolescents.

[12] Bolsa Família evaluations abound. The above mentioned figures have been obtained from MDS. See also: Soares, Sergei & Sátyro (2009). O Programa Bolsa Família: Desenho Institucional, Impactos e Possibilidades Futuras. Brasília: IPEA/Texto para Discussão N°1424.

[13] Failing to abide by a conditionality can be due to a cause external to the beneficiary family, for example due to a situation that increases the family's vulnerability. Simply seizing to deliver the benefit to the family would



The contributory social insurance scheme Previdência Social offers a family benefit to the insured (Salário Família). It is given to those insured earning R$862/month or less (2011, equivalent to approximately US$540) with children aged 0-14. The transfer per child is either R$29.41 (approx. US$19) or R$20.73 (Approx. US$13), depending on the income of the insured. In the case of wage workers, the benefit is paid by the employer (who deducts it from the due contributions), and by the social insurance institution in all other cases. The parents need to document yearly their compliance with a vaccination calendar and their children's school attendance. According to official data, the expenditure on the scheme was R$2.0 billion in 2009. 5.8 million insured persons received the family benefit, covering 4.1 million families (6.7% of Brazilian families). In the case of 1.7 million families both parents qualified. Estimates by the Ministry of Social Security (MPS) show that 85% of the beneficiaries came from the poorest 50% of the population.[14]

Social transfers: old-age and disability

The transfers to the elderly and disabled are an important component of a social protection floor. The SUAS system includes a social assistance pension (Benefício de Prestação Continuada, BPC) set at one minimum wage per month. It is offered to persons with a family income below ¼ of the official minimum wage per person who are 65 or older, and disabled persons who are unable to work and live independently. The benefit is provided only if no member of the family receives an income-replacing benefit (e.g. unemployment insurance or social insurance benefit). This social pension was introduced by the 1988 Constitution and implemented in 1996 to replace the preceding benefit Renda Mensal Vitalícia, which had a prerequisite of at least 12 social insurance contributions. In 2009, 3.5 million persons (1.9 million disabled and 1.6 million elderly) benefited from the BPC pension, with an annual expenditure of R$ 18.7 billion, 0.6 % of GDP. The programme is operated by the social insurance institution (Instituto Nacional do Seguro Social, INSS), which performs the required medical disability evaluations and pays the monthly benefits through its payment system, mostly a deposit on a bank account of the beneficiary.

There is also an interesting effort to link different policy areas under the Programa BPC na Escola, which was established in 2007 and targets the 435 000 BPC beneficiaries aged 18 or under. This programme is based on cooperation between different health, education, social assistance and human rights programmes at federal, state and municipal level. The programme has raised the share of young disabled BPC beneficiaries that attend school from 29.5% in 2007 to 52.6% in 2010.[15]

The country's social insurance schemes offer contributory coverage to private sector workers, public servants and the military. According to the 2009 national household survey PNAD, social insurance covered 67% of the occupied population. Since 2001, coverage increased by more than 5% thanks to the vigorous generation of formal jobs and the changes made in coverage policies for self-employed workers and small and medium enterprises. The strengthening of the tax, social security, and labour inspection systems also helped increase the coverage of the schemes. Another explanation for the coverage rate is that approximately 8% of the occupied population corresponds to rural workers, who are covered by the Previdência Rural. Among those aged 60 or more, 81.7% were covered by social insurance schemes or received social assistance benefits. The higher the coverage of contributory schemes, the lower is the demand for non-contributory programmes.

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put in jeopardy the goal of long-term poverty reduction. Therefore, there are a series of actions that the administration of Bolsa Familia adopts to prevent discontinuing the delivery of the benefit. The first option is to send a social worker to study the causes behind the failure to meet the conditionality.

[14] See: Guimarães, Leonardo R. (2011). Análise do Alcance e da Implementação do Programa Salário-Família. Informe de Previdência Social. MPS: Janeiro 2011.

[15] Source: Ministry of Health/Secretariat of Assistance in Health, personal correspondence, 24 June 2011.

The federal-level INSS-administered General Scheme spent a total of R$254.9 billion in 2010 (6.9% of GDP). It granted 23.5 million benefits, mostly old-age, survivor and invalidity pensions, sickness and maternity benefits and labour accident benefits. The schemes for federal public servant and the armed forces spent in 2010 R$73.3 billion (2.0% of GDP), providing approximately 949 000 pensions.

The rural semi-contributory scheme focuses on self-employed workers in small-scale agriculture and fishing. It is an innovation of the Brazilian pension system, a first version of which was introduced under military rule in the 1970s. It expanded in the 1990s, backed by the 1988 Constitution. The innovation resides in the fact that the contributions are not collected from the payroll, which rarely exists in the rural family economy, but charged based on the value of production. The purchaser of rural produce has to pay 2.1-2.5% of the transaction value as a contribution to social security. This amount is nevertheless too low to fund the rural benefits. Since there is no individual contribution, the benefits are flat-rate, set at one minimum wage. Almost 8 million benefits were paid monthly to rural workers in 2010, mostly old-age and widow pensions. That year, the scheme required a contribution from the Treasury worth 1.4% of GDP.

The poverty impact of these transfers is significant. According to 2009 PNAD household survey data, analysed by the Ministry of Social Security (MPS), 23 million persons would have fallen below the threshold of half an official minimum wage per person had no social security or BPC benefits been paid out that year. This represents 12.5% of the Brazilian population. [16]

Access to essential services: health

The Unified Health System (Sistema Único de Saúde, SUS), created in 1990 offers universal access to its services, without requiring previous contributions. It is financed by taxes earmarked for social security by the Constitution of 1988, in addition to general tax revenue at federal, state and municipal level. Its introduction transformed the system from a contributory[17] to a universal one. Its administration requires close coordination between the federal, State and municipal administrations. In addition to the public system, there are different private optional health care modalities that cover close to 40 million people, mostly from the middle and higher classes. These are regulated by the National Supplementary Health Agency (Agência Nacional de Saúde Suplementária).

Public health expenditure in Brazil was 4.9% of GDP, with the federal authorities as the main source of funding. States and municipalities also contribute to the costs, and arrange the provision of health services. In 2009, federal authorities alone spent R$69.1 billion or 2.2% of GDP on health.[18] 0.3% of these 2.2% came from a tax break applied to private expenditure, social assistance and charity action in the field of health and the price of key pharmaceutical products. The remaining 1.9% of federal spending were distributed to States (27%), municipalities (45%) or spent directly by the federal government (28%) in a number of federal health policies and institutions. Also, in Brazil, health expenditure has been concentrated on medium and high complexity level attention (86%), representing one of problems the system faces. Even so, the SUS performs annually 2.3 billion normal and ambulatory consultations, 11 thousand transplants, 215 thousand surgeries, 9 million

[16] See: MPS (2010). Evolução Recente da Proteção Previdenciária e seus Impactos sobre o Nível de Pobreza.Informe de Previdência Social, October 2010.
[17] The administration of the previous health system was responsibility of the National Medical Assistance Institute of Social Security (INAMPS), which has been transferred to the Ministry of Health and states and municipalities.
[18] TCU (2010). Relatório e Parecer Prévio sobre as Contas do Governo da República 2009. See: www.tcu.gov.br.

chemotherapy and radiotherapy sessions, and 11.3 million hospitalisations. The 2008 PNAD household survey[19] data reveal that 67.7% of the population had at least a medical consultation in the 12 previous months and that 15.1 million (56.6%) out of a total of 26.7 million medical attention processes had been performed by SUS.[20]

Several innovative health programmes deserve to be highlighted: the Family Health Programme (Programa Saúde da Família, PSF), the National Immunization Program, the Programme to Control Sexually Transmitted Diseases and HIV/AIDS, the Emergency Health Attention Programme (Serviço de Atendimento Móvel de Urgência, SAMU), and the Dental Health Programme (Programa de Saúde Bucal). The Family Health Programme was introduced in the 1990s and operates with multidisciplinary teams and local health agents, and each team is responsible for covering an area, usually with around 1 thousand families. The programme aims at prevention, diagnosis, treatment and monitoring of health problems and their pro-active treatment, and it has an impact on reducing the demand for hospitalisations and other health services. The programme has gradually expanded. It started by having 328 teams in 1.1% of the Brazilian municipalities in 1994. Currently, it has 31 981 teams in 93.8% of the municipalities. According to the 2008 PNAD household survey, 27.5 million households (47.7% of households) with 96.5 million members (50.9% of the population) were covered by PSF. The Dental Health Program, on the other hand, covered 4,857 municipalities with 20 640 dentist teams reaching an estimated 44.0% of the population. STD/AIDS, an internationally acclaimed programme, increased the access to retroviral treatment. It helped to control the spread of and mortality related to AIDS among Brazilians. Policies to provide access to medication (generic drugs, Farmácias Populares, public production of medicines and vaccines) increased the proportion of population with effective access to prescription drugs.[21]

Indicators show several advances in the health of the Brazilian population. The number of health consultations per inhabitant grew from 1.9 (1995) to 2.7 (2007); infant mortality was more than halved over the last two decades (47.5/1,000 in 1990 to 22.5 in 2009); and life expectancy at birth increased from 68.5 years (1995) to 73.9 (2009). Vaccination programs have been increased and a number of diseases eradicated. However, besides the aforementioned focus on providing higher complexity level services, with higher cost, redesigning the financing of the system is a looming challenge. Also, the health system needs to be better equipped to face the challenges related to demographic transition and several tropical diseases, such as dengue fever and malaria, which have yet to be controlled and eradicated.[22]

Access to essential services: food/nutrition

Brazil has a National Policy of Food and Nutritional Security, coordinated by the Ministry of Social Development and Fight against Poverty (MDS)[23], the objective of which is to improve the population's access to food. The Fome Zero ("zero hunger") programme, launched in 2003, strengthens the supply of and access to food through schemes, such as school feeding, popular restaurants and food banks. There have also been efforts to improve the supply of food through agricultural development policies. An important set of policies targeted at family agriculture, mostly small farmers and responsible for 2/3 of the production of food, has been implemented by the Ministries of Agriculture, Agricultural Development and the official banks. This policy has dramatically increased the supply of credit to small farmers through the National Programme for the

[19] PNAD/IBGE 2008 household survey has a supplement with specific questions on health care.
[20] See the supplement to PNAD/2008 on: www.ibge.gov.br.
[21] IPEA (2010 y 2011). Boletim de Política Social. N° 17-19. The figures regarding the PSF and the Dental Health Programme were supplied by the Ministry of Health (SIAB, figures of April 2011).
[22] See also: IPEADATA at: www.ipeadata.gov.br.
[23] See: http://www.mds.gov.br/segurancaalimentar.

Strengthening of Family Agriculture (PRONAF), with credit rising from R$1.1 billion (1998/1999) to R$10.8 billion (2008/2009). Also, a law in 2009 declared that at least 30% of the federal transfers to municipalities for school feeding shall be spent by purchasing local family agriculture production. In this manner, the impact of public spending on the generation of local employment and incomes is enhanced. In 2009, federal public purchases of food from small farmers amounted to R$ 624 million. Among the programmes administered by MDS are initiatives that seek to universalize the access to clean water, promotion of food fairs, cooperation with the private sector through Corporate Social Responsibility and programmes focused on food nutritional education. Interestingly, also Bolsa Família can be considered part of the nutrition strategy, since it benefits the poorest, reducing the risk of hunger. The food security policy is based on the Organic Law on Food and Nutritional Security and is supported by an important process of social dialogue, consisting of, for example, National Conferences on Food and Nutritional Security and the National Council on Food and Nutritional Security (CONSEA).

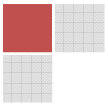
Access to essential services: education

Brazil has an education system with obligatory schooling for nine years, which will increase to 14 years of schooling between the ages 4-17 by 2016.[24] On the other hand, the Constitution prescribes that public education be offered for free from pre-school (age 4) until completion of secondary school. Each level of the Federation has a specific role in the education system, as prescribed in the Constitution and legislation. Pre-school, as well as basic and intermediary school are administered by States and municipalities, except for secondary vocational schools (Escolas Técnicas, which are run by the Federal administration). The federal government establishes the minimum curricula and standards that apply in the entire national territory, finances school books and school feeding, and transfers resources to States and Municipalities to co-finance local educational activities. The federal government also runs a group of public universities. Another interesting federal initiative is the Prouni Program, created 2004, which provides stipends for low-income students (maximum family income of 3 minimum wages per month). Beneficiaries are selected based on a national examination, giving preference to afro-descendent, indigenous/native and handicapped students so as to reverse traditional exclusion patterns. Since the inception of the programme, 750,000 students have gained access to university.

The National Education Plan (2001-2010) aimed at increasing public expenditure on education to 7% of GDP. In 2008, public education spending reached 5.6 % of GDP according to Cepalstat. At the federal level, funding comes from the Ministry of Education (R$36.7 billion, 1.2% of GDP, largely transfers to States and Municipalities), tax exemptions (R$3.5 billion, 0.1% of GDP) and from funds (FUNDEB – Basic Education Fund). The latter had been created by a constitutional amendment in 2006 that aimed to replace a previous fund arrangement. FUNDEB is funded by earmarked taxes and by the Treasury, and it had R$72.2 billion, 2.3 % GDP, in funds in 2009. One of the major purposes of FUNDEB is to ensure a minimum remuneration for all Brazilian teachers as well as their qualification, and guarantee the universalisation of coverage of basic and intermediary schooling in the whole country. Its existence has been foreseen by the constitutional amendment until 2021. Also other minor funds and resources from States and Municipalities are used to finance education activities.

Huge progress has been accomplished in universalizing access to schooling over the last decades. 97.6% of children aged 6-14 were enrolled in school in 2007, according to the PNAD survey. This figure is quite homogenously distributed throughout the country and regions: Even in rural areas, enrolments were 96.6%, 97.2% among non-white children, 96.1% in the Northern region, and 97.8%

[24] According to National Education Plan and Constitutional Amendment No 59/2009



among girls. Also, 82.1% of youth between ages 15 and 17 were studying. Even at the pre-school level, ages 4-5, the enrolment rate was already found to be 77.6%.[25]

Access to essential services: electricity

It is not surprising that exclusion from access to electricity in developing countries is the most pervasive in rural areas, among low income families, and in regions with lower development indicators. According to the 2009 PNAD household survey, Brazil has 58.6 million households and 58.3 million residential units consuming electricity registered by the sectoral supervision agency ANEEL (October 2010). Therefore, the country now seems to be close to universalizing access to electricity. This is a notable achievement, as electricity is crucial for improving quality of life.[26] It is also necessary for participating in other social and economic programs and boosts productivity and incomes. The main policies for extending access to energy are Luz para Todos (LpT, "Energy for All") and Tarifa Social de Baixa Renda (Social Energy Prices for Low-Income Population).

The programme Luz para Todos was launched in November 2003. Its goal was to connect 10 million, mostly rural, people to the electrical power network. The first deadline had been set for 2008, but the programme was extended to 2011, due to changes in its scope. Of the total expenditure of R$20 billion (approximately US$ 11 billion) over the whole period of operation, 70% was funded by the federal government, using energy development funds[27], and 30% by States and electrical energy companies. An important regional and sub-regional coordination structure has been created under the Ministry of Mines and Energy, the electricity company Eletrobrás and regional energy companies. Between 2003 and 2007, LPT has strongly contributed to expanding access to electricity to 13 million persons, especially in the states of Bahia, Minas Gerais and Pará. The energy research company suggests that the rapid expansion of coverage in the Northeast between 2005 and 2008 was due to three factors: real wage increases, the cash transfer programs (notably Bolsa Família), and the Luz para Todos program.

Brazilian energy legislation prescribes that all households with an energy consumption of less than 80 kWh/month, or those between 80 and 220 kWh/month if accepted by the Unified Social Programme Roster (the same as used by Bolsa Família), should benefit from a subsidized electrical energy price. According to the Supervision Agency ANEEL, the price reduction compared to standard residential energy prices corresponds to 65% for the first 30 kWh/month, 40% for the next 70 kWh/month, and finally 10% for the remaining kWh/month. Households with a BPC pension beneficiary are entitled to receive a complete subsidy for energy prices up to a consumption level of 50 kWh per month. The subsidy is designed as a cross-subsidy, i.e. the higher income residential consumers cover the cost of the low-income consumers.[28]

Access to essential services: labour market policies

In the field of policies for the unemployed and low-income workers, a significant unemployment insurance scheme covers approximately 80% of formal workers who lose their jobs, but their access rules do not cover informal sector workers. Vocational training programs, microcredit policies, as well as support for social economy and employment services have been extended significantly.

[25] See: IPEA (2010). Boletim de Políticas Sociais. N° 17. Statistical Appendix.
[26] According to PNAD 2009, 93.4% of households owned a refrigerator and 95.7% a television.
[27] The fund in question is the Reserva Geral de Reversão electricity fund, created in 1957 to finance construction and purchase of electricity plans. It is funded by a 2.7% charge on electricity bills. 35% of the revenue has been directed towards Luz para Todos.
[28] See: statistics and reports of the programme on: www.mme.gov.br and www.epe.gov.br.

Formal low-income workers receive a 14th wage (Abono Salarial) from the same fund that finances unemployment insurance (Fundo de Amparo ao Trabalhador, FAT). In addition, workers in both formal and informal sectors have benefited from the policy of positive annual adjustments of the minimum wage. The spending on labour market policies was 0.8% of GDP in 2010. Increasingly the link between policies geared towards the labor market and income transfers of the Bolsa Família is being strengthened, in the spirit of the concept of a SPF. It is a major challenge to deepen the connection between transfers and these services.

Concerted combat against extreme poverty: the Brasil sem Miséria plan (2011-2014)

In June 2011, Brazil officially unveiled the plan Brasil sem Miséria ("Brazil without Misery") which recognizes that, despite progress in implementing social protection programs mentioned in this brief, according to preliminary data from the Demographic Census of 2010, there still are around 16.2 million people under the extreme poverty line of a monthly household income of R$70 per household member.[29] It was politically established that the goal is the eradication of extreme poverty, which is possible with the resources of a medium-high income country. For them to be reached, the state must seek to cover the extremely poor actively, because the fact that they have not been covered by existing programmes means that these segments of the population suffer the most resilient barriers to inclusion, which they by themselves have not been able to overcome.

One of the principles of "Brasil sem Miséria" is geographically locate the population in extreme poverty and extend, with means appropriate for each local reality, the existing programmes and services. By comparing the extreme poverty map with a "map of services and opportunities" can reveal geographical and institutional efforts that are required of the state to bring transfers and services to the extremely poor. In rural areas, there will also be efforts to increase productive opportunities and the state guarantee to purchase food for food security programmes. Also, access to drinking water has not yet been universalized and existing programs to build cisterns will be expanded. In the cities the focus will be on public vocational training, job placement, support for microenterprise and activities suitable for people employed in the collection and recycling of waste.

Additionally, it has been recognized that despite the favourable impact of the Bolsa Família, families with several children are still highly vulnerable. Therefore, the Bolsa Família benefits will be extended to cover a maximum of 5 children per family in lieu of the previous maximum of 3, starting in June 2011. Correspondingly, the value of the benefit will be raised. The families that could receive the benefit but do not request it will be sought out by social workers to inform them of their rights and to support them in the requirements for inclusion in the programme. The same procedure applies to older adults not covered by a pension and that would be entitled to access the BPC benefit but do not apply for it. In conclusion, the efforts to eradicate poverty require a different approach of the State which will have to actively seek to remove the social, economic, cultural and geographic barriers that prevent the full use of transfers and essential social protection services.

3. Challenges and the way forward

The Brazilian social protection system has greatly evolved since the Constitution of 1988 was issued, and the expansion of coverage of transfers and services has had an undeniably positive impact on many social and economic indicators.

[29] See the webpage of the programme: http://www.brasilsemmiseria.gov.br/

Social insurance coverage has expanded thanks to, among other factors, the rural pensions programme, and the pro-poor economic growth of recent years, which has generated formal jobs, raising social insurance affiliation by more than 5 percentage points since 2002. The extension of coverage has also benefited from the changes made to affiliation rules for the self-employed and employees of small and medium enterprises. An interesting social security education programme has been in place since the end of the 1990s, informing people of their social security rights and obligations.

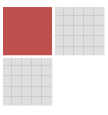
In the field of social assistance, the state has sought to move away from the charitable model of social provisioning to gradually implement an approach focused on professionally produced transfers and services based on rights enshrined in law. In this way, the main social programmes have been maintained and they have been continuously developed over recent years, despite the change of governments. A modern social assistance pension, the BPC, has been introduced, focusing on the elderly and disabled poor, with a total of 3.5 million monthly benefits paid in a timely fashion. The administration of social assistance has benefited from lessons learned in the various social programmes over the past two decades, including in the administration of contributory social security. New information, communication and management technologies have been progressively introduced, and, therefore, the efficiency of programmes has increased.

A very important development in social assistance has been the appearance, starting in the mid 1990s, of the massive programme to combat poverty with education and health conditionalities aimed at breaking the intergenerational transmission of poverty. This programme, Bolsa Família, uses an efficient and sophisticated targeting mechanism, and requires a complex coordination between states and municipalities. Bolsa Família has become an internationally recognized success story of the extension of social protection and rights to people previously excluded from the traditional social insurance schemes.

Significant progress has been made in extending coverage of the health system through the creation of the SUS. The programme Saúde da Família is one of the main reasons behind the cost-effective expansion of coverage, in addition to a number of programs of a collective nature, focusing on prevention and public health. However, there remain challenges with regards to the rising cost of health care, with a greater weight of secondary and tertiary care spending. Also, the challenges of quality and accessibility, as well as some tropical diseases, require further attention.

The challenge of coordinating between different policies and different levels of federal administration is notable. Significant advances have been achieved with the introduction of instruments of coordination in the health system through the SUS and in social assistance through the SUAS, as well as through the consolidation of the principle of social dialogue in the different areas of social policy. However, there is potential for more synergy between different sectors. Related to this issue, the plan Brasil sem Miséria, aimed at eradicating extreme poverty by 2014, will require a higher level of policy coordination, transfers and services, both conceptually and geographically, in the search of universal horizontal coverage.

In addition, the long-term financing of health schemes and social security is a challenge that will need significant attention in the future. Brazil has witnessed an accelerated process of demographic and social change that presents new challenges for the social policy agenda. Therefore, the current success in the implementation of a number of policies related to the SPF will require continued efforts in the future to ensure that the coverage achieved is maintained and extended, deepening their poverty reducing impact.



Brazil has also ratified the ILO Social Security Convention No. 102 (Minimum Standards), which is a sign of its support for a strong system of social benefits and services. At the same time, this ratification serves as an example that countries can develop a social protection floor, expanding horizontal coverage, while also ratifying the Convention No. 102 to support the expansion of coverage in the vertical dimension.

Higher levels of social protection have led to a gradual growth in social spending (26.0% of GDP in 2008 according to Cepalstat, 15.8 % of GDP as federal social spending according to IPEA). However, much of this spending can be seen as an investment that gives Brazil a competitive advantage, as reflected in the lesser impact of the international financial crisis on the country. The existence of a social transfer system and an anti-cyclical reaction that combined financial instruments and extension of social transfers and services, reducing the impact of the crisis on poverty as well as damage to the labour market and consumption. The existence of policies that conceptually form components of a social protection floor has contributed, therefore, to protecting the significant socio-economic progress and higher levels of well being achieved in the last two decades.