social protection floor initiative

Brazil in Search of Universal Social Protection

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lead agencies

ILO
WHO

cooperating agencies

FAO, IMF, OHCHR, PAHO
UN Regional Commissions,
UNAIDS, UNDP, UNDESA,
UNESCO, UNFPA, UNICEF,
UNHABITAT, UNHCR,
UNODC, UNRWA, WFP,
World Bank

The universalization of social security is a mandate of Brazil's 1988 Federal Constitution, whose proclamation was an important mark of the return to democracy. The goal of the Constitution is the construction of a broad social protection system that would harmoniously coordinate contributory, non-contributory and targeted policies. According to the Constitution, the financing of this model should be diversified, combining pay-roll taxes with social contributions on firms' net profit and turnover, as well as general taxes.

Over two decades of the Federal Constitution's gradual implementation, an extensive social protection system was created, achieving a high degree of coverage in each of its components. The health care system is non-contributory and universal. The social welfare system manages the *Programa Bolsa Família*, a conditional cash-transfer programme that targets low-income families with children and adolescents. Additionally, there is a basic social pension for the elderly and handicapped: the *Benefício de Prestação Continuada*, *BPC* (a social pension), besides a wide range of social services. The contributory Social Security system currently covers 66% of the active population and pays 23.5 million benefits each month between pensions, family allocations and retirement, health, and maternity benefits. In the field of job-creation, unemployment insurance pays more than 600,000 benefits monthly and the Ministry of Labour and Employment manages a system that provides support and services to workers in search of employment and professional requalification.

This social protection system demonstrated a great capacity to absorb and mitigate the social impact of the recent international economic and financial crisis. Moreover, its role as an income-stabiliser was confirmed, given that the income it distributed was one of the important sources of demand for the strengthening of the domestic market and for Brazil's rapid economic recovery. Today, in Brazil, there is widespread consensus on the need for this new Welfare State. This Welfare State will face new challenges as it gradually evolves and as Brazilian society undergoes transformations. Among these complex challenges is the need to achieve a coordinated management of the rather diverse range of policies with varied operating principles, administrations and sources of funding. In addition, the Welfare State must be transformed such that it can adapt to the aging of the Brazilian population.

Some of the Brazilian programmes conceptually linked to the social protection floor (SPF)[1]

The *Programa Bolsa-Família (PBF)* is a programme designed to supplement family income that targets low-income families with children and adolescents. The transfer ranges between R$ 22 and R$ 200[2], depending on the socio-economic characteristics of families, and is preferentially directed toward women. The conditions that families must meet in order to participate in the programme are: 1) school-aged children and adolescents under 17 years of age have a high attendance rate at school, 2) pregnant women and small children comply with a given health care schedule (health exams, immunization), and 3) there is no child labour in the family. In May 2010, 12.5 million families were eligible and covered by the programme, with an expenditure of only 0.4% of GDP in 2009. The *PBF* developed a unique social register in order to increase the precision of the programme and to avoid targeting errors. The programme is also linked to public social assistance, health, education, employment and housing services, and it partners with states and municipalities. The evaluation of the programme is largely favourable as it lifts 4.3 out of 12.5 million families out of extreme poverty and was considered responsible for 21% of the reduction in inequality registered in Brazil (as measured between 2004 and 2006). In total, income concentration has fallen over the last decade, with the Gini coefficient decreasing from 0.600 (1998) to 0.548 (2008). Among the future challenges for *Bolsa Família* are: the deepening of its relationship with other social programmes, especially public universal services; the establishment of rules on the institutional readjustment of benefits; and the elaboration of a specific strategy for the metropolitan areas.

The *Benefício de Prestação Continuada, BPC* (social pension) is a social assistance benefit equivalent to the official minimum wage (R$ 510) that is given to individuals 65 or older and to individuals with handicaps. To qualify for the programme, candidates must have an income of 25% the minimum wage or less per member of the family and they must not already benefit from another income-replacement programme (social security benefit or unemployment insurance). The programme is operated by the *Instituto Nacional do Seguro Social* (the National Institute for Social Insurance), whose social workers provide socio-economic evaluations of potential beneficiaries and which makes the regular payments directly to beneficiaries through bank accounts. In May 2010, 3.4 million *BPC*s were being paid: 1.6 million were old-age pensions and 1.8 million were benefits paid to handicapped persons. The cost of the programme was R$ 15.5 billion in 2008, corresponding to 0.5% of GDP.

The *Sistema Único de Saúde, SUS* (Universal Health Care System) is public. It does not require out-of-pocket payments and is financed through taxes. It was created in 1990 when the Federal Constitution's provisions in the area of health care were implemented. Until then, health care in Brazil was provided by the social security

[1] Data used in this section was extracted from the pertinent Brazilian Ministries and IPEA (Boletim de Políticas Sociais, n. 17, 2009).
[2] Exchange rate: USD 1.00 = R$ 1.81 (June 2010).

system on a contributory basis. The coordination, financing, production of services, etc. of the health care system are shared with states and municipalities.

In addition to hospital-based and ambulatory services, programmes that stand out are the *Programa de Saúde da Família, PSF* (family health programme), the *Programa Nacional de Imunização, PNI* (national immunization programme), the *Programa de Controle das Doenças Sexualmente Transmissíveis e da Síndroma da Imunideficiência Adquirida, DST/AIDS* (programme for the control of sexually transmitted diseases and of HIV/AIDS), the *Serviço de Atendimento Móvel de Urgência, SAMU* (ambulance services) and the *Program de Saúde Bucal* (oral health programme). The system annually gives 2.3 billion ambulatory consultations, performs 11 thousand transplants, 215 thousand cardiovascular surgeries, 9 million chemotherapy and radiotherapy treatments, and makes 11.3 million internments.

Created in the 1990s, the *PSF* uses community agents and interdisciplinary teams to carry out a two-fold action: prevention of sickness in the family and avoidance of people's immediate use of the secondary health attention level. Each team assists approximately one thousand families in its respective area. The *PSF* was gradually expanded from 328 teams assisting 1.1% of Brazilian municipalities in 1994, to 28,865 teams assisting 93.8% of municipalities in 2008. It is estimated that 48.6% of the population, particularly the poorest, is covered by the *PSF*. Using a comparable approach, the *Programa de Saúde Bucal*, in 2008, had 17,124 oral health teams placed in 4,857 municipalities, covering approximately 44% of Brazilians. Another programme of international prominence in the *Sistema Único de Saúde (SUS)* is the *DST/AIDS.* In addition to cooperating with civil society in an effort to prevent sexually-transmitted infections, it has universalized access to retroviral treatment, curbing the expansion of AIDS and significantly diminishing the lethality of the disease among the Brazilian population. In the pharmaceutical domain, evaluations conducted within the last decade show that the policies improving access (generic pharmaceuticals, "Popular Pharmacies," public production) have allowed the majority of the population to buy prescription medicine (depending on the disease, 80-90% of the population).

The *SUS* indicators demonstrate that many advances have been achieved. The average number of medical consultations per inhabitant increased from 1.9 in 1995 to 2.7 in 2007. Child mortality fell 44% between 1996 and 2006 and life expectancy at birth rose from 68.5 years in 1995 to 72.4 years in 2006. The immunization programmes were universalized and various diseases were eradicated in Brazil. Many challenges must certainly be surpassed in the coming years. Among these are the strengthening of the financing basis for the *SUS* or, in the area of epidemiology, the fight against some tropical diseases for which there are no existing vaccinations (such as dengue fever and malaria). The total public health care expenditure in Brazil reached R$ 84 billion in 2006, which corresponded to 3.5% of GDP.

The *Previdência Social Rural* (rural social security) exists since 1971 but was enhanced in 1988 with the new Federal Constitution. The programme focuses on

the small family farmer, who utilizes his/her own work and that of his/her family. The *Previdência Rural* represents an innovation when compared to the traditional social security systems that are based on individual contributions. This is due to the fact that the farmer's contribution is collected based on the production that was commercialized. Furthermore, the contribution is collected by the buyer (in this manner, taxes are not directly collected from the millions of small rural properties but from the few thousand commercial establishments). At the same time, the value of the benefit is flat rate, equalling the minimum wage, unless the farmer decides to voluntarily contribute under the same rules as urban workers do. In May 2010, of a total of 27.3 million benefits paid by Social Security, 8.2 million were *Previdência Rural* benefits (5.4 million were old-age pensions, 2.1 million were widow pensions, and the rest were invalidity, maternity and work-related accident benefits); 8.1 million rural benefits were equivalent to the minimum wage. The impact of these benefits on the reduction of poverty and inequality in rural areas is very favourable. They redistribute income regionally and strengthen food security by stimulating the production of food (carried out by family agriculture). According to household surveys, the differentiation in the contribution rules allows for the expansion of coverage to 8.8% of Brazilian workers—small farmers and their families who do not have a regular monthly income—enabling them to contribute in the same way urban workers do. The necessary subsidy, transferred from the National Treasury to the *Previdência Rural*, amounted to R$ 40.9 billion in 2009, which was equivalent to 1.3% of GDP. Using household surveys, it is estimated that the income transferred by *Previdência Social* and by *BPC* lifts 22.6 million people out of poverty, or 12.3% of Brazil's population.