

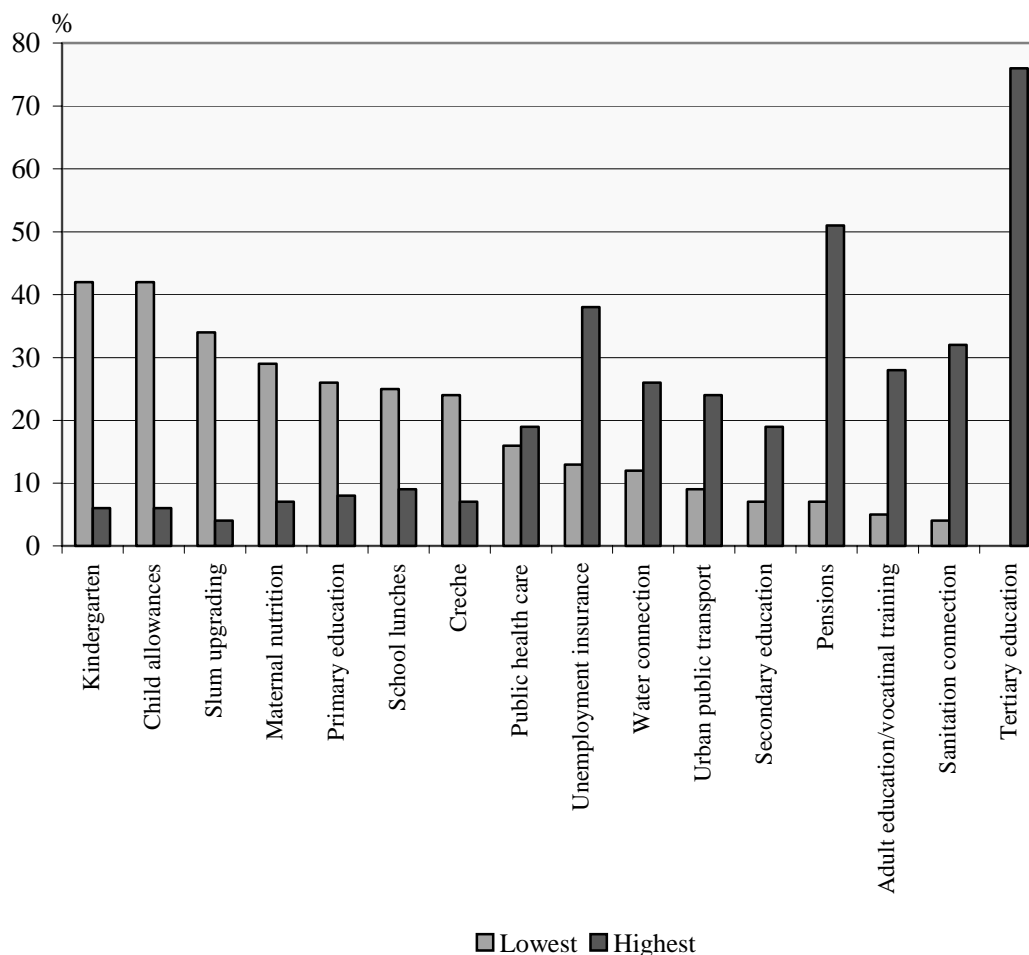
**OECD ECONOMIC SURVEY OF BRAZIL 2005:
BETTER TARGETING GOVERNMENT SOCIAL SPENDING**

This is an excerpt from Chapter 4 of the OECD Economic Survey of Brazil, 2005

Taken together, government spending on social programmes is estimated to be mildly progressive in terms of their impact on income inequality. But this masks important differences in the incidence of spending on particular programmes: public outlays on social insurance, for example, with the exception of rural pensions (discussed below),¹ as well as on tertiary education and publicly-funded private hospitals (*hospitais conveniados*),² are estimated to be regressive.³ On the other hand, public spending on programmes such as child allowances and primary education clearly benefits the poor disproportionately more than the better-off (Figure 4.6).

The social security system — including social insurance and assistance programmes — is a powerful instrument to reduce poverty. Over 22 million people (including rural pensions) receive a pension from the National Social Insurance Institute (INSS) and about two-thirds of these pensions are equivalent to the minimum wage. For each person receiving a pension, it is estimated that 2.5 additional persons (mainly family members) benefit indirectly from the income transfer.⁴ Consistently, the incidence of poverty among the elderly in Brazil is lower than that of the average population. It is also among the lowest in Latin America.⁵ Rural pensions, which are essentially non-contributory, are considered one of the best-targeted social programmes. Several studies have stressed their role in alleviating poverty.⁶ Other non-contributory social assistance programmes include pensions paid to poor persons who are disabled, old or with per capita household income below one-quarter of the minimum wage (LOAS). These non-contributory pensions also contribute to the continued decline in poverty in the poorer regions, particularly the North-East and in the North (especially in the Amazon basin).⁷

Figure 4.6. **Brazil: incidence of selected publicly-funded programmes**
Per cent of government spending accruing to the lowest and highest income quintiles



Source: World Bank (2003a).

Despite their impact on poverty, the main social insurance programmes are poor instruments to redistribute income. This is because they are predominantly contribution-financed and reserved for formal-sector workers, who tend to have above-average incomes. Most pension benefits are proportional to previous income and can be relatively high: the ceiling on the value of pensions paid under RGPS (the regime for private-sector workers) is up to 3 times higher than the average wage in the formal sector. Because there is no minimum retirement age, high-pension earners, which are also better-off and therefore live longer, end up receiving pensions for a longer period of time, putting a drain on the budget. Spending on the social security regime for civil servants is even more regressive, because they benefit a better-off population and the regime's deficit is financed out of general taxation.⁸ But, to the extent that the on-going reforms, which are assessed in greater detail in Chapter 1, will contribute to reducing the current deficit under this regime, budget resources can be re-allocated to more progressive programmes, making overall federal social spending more pro-poor.

Comparison with the OECD experience is illustrative in this regard. The OECD experience suggests that the most systematic targeting of low-income groups is found in countries where public pension scales use lower ceilings, or are flatter and not fully proportional to previous income, as in Australia, United Kingdom, and United States. In the case of the United Kingdom, for example, the lowest income quintile

receives about one-quarter of pensions and transfers, with the top quintile receiving only less than one-tenth. If Brazil had a comparable incidence of public spending on pensions and other benefits, it is estimated that the Gini coefficient would be reduced from 0.58 to 0.54.⁹ In other countries, social insurance benefits are often proportional to previous income, as in Brazil, but low-income groups still receive much of total public spending on these programmes because they are over-represented among the disabled, the unemployed and early-retirees. This is nevertheless not the case in countries such as Mexico and Turkey, where the ratio of income transfer receipts to disposable income is low even for poor households (Table 4.6). In most European countries, by contrast, transfers account for over one-half of poor households' income, thereby bringing the Gini coefficient down by as much as 0.2 (Table 4.7).

Table 4.6. Incidence of publicly-funded income transfers

In per cent of disposable income

	Total population	By income level		
		Poorest 20 per cent	Middle 60 per cent	Richest 20 per cent
Australia	15.1	78.7	15.6	1.3
United Kingdom	16.8	72.8	19.2	2.9
France	30.1	64.6	31.6	19.3
Netherlands	19.0	63.9	19.4	5.8
Poland	26.6	58.3	37.4	9.8
Germany	25.9	57.1	28.8	14.0
Italy	28.0	48.8	33.0	18.4
Canada	14.6	48.2	15.7	5.9
Portugal	19.5	47.0	20.0	14.4
Japan	17.0	40.0	19.7	9.1
United States	9.5	38.9	9.9	4.4
Brazil	20.9	26.8	20.5	20.7
Mexico	5.6	14.7	4.7	5.7
Turkey	1.9	3.1	2.7	1.1

Source: OECD, data for 2000; calculations for Brazil in 1999 are based on Immervoll *et al.* (2003).

Table 4.7. Impact of transfers and taxation on income distribution

Measured by the Gini coefficient

	Initial income (A)	Gross income (B) (initial income plus transfers)	Disposable income (C) (gross income minus direct taxes)	Overall impact (A-C)
Belgium	0.53	0.35	0.29	0.24
Sweden	0.55	0.34	0.32	0.23
Germany	0.55	0.39	0.32	0.23
Denmark	0.55	0.37	0.33	0.22
Spain	0.51	0.38	0.33	0.18
Canada	0.51	0.38	0.34	0.17
United Kingdom	0.53	0.38	0.35	0.18
Australia	0.49	0.40	0.35	0.14
United States	0.53	0.43	0.38	0.15
Brazil	0.64	0.58	0.56	0.08

Source: de Beer, Vrooman, and Schut (2001); Lakin (2001); and Immervoll *et al.* (2003).

The role of taxation

Neither does the tax system contribute to improving the distribution of income. While the distribution of before- and after-tax incomes differ by significant amounts in most OECD countries, this is not the case in Brazil. This is because the impact of direct taxes on the distribution of income is almost entirely offset by that of indirect taxes, particularly in the top income bracket (Table 4.8). Significant progress was made in the second half of the 1990s to improve the efficiency of direct taxation, but the exemption threshold for the income tax remains relatively high in relation to those in OECD countries, severely reducing the number of taxpayers (Figure 4.7).¹⁰ Extending the direct tax net to those currently below the exemption threshold -- while recognizing that administrative costs also tend to increase as a result -- would pave the way for reducing the share in government revenue of indirect taxes. It is nevertheless important to note that the impact of these measures on the progressiveness of the tax system is uncertain: a move from indirect to direct taxes would make the tax system more progressive but a reduction of the exemption threshold would make it less progressive.

Table 4.8. **Brazil: impact of transfers and taxation on income distribution**

Measured by income shares (by income decile)

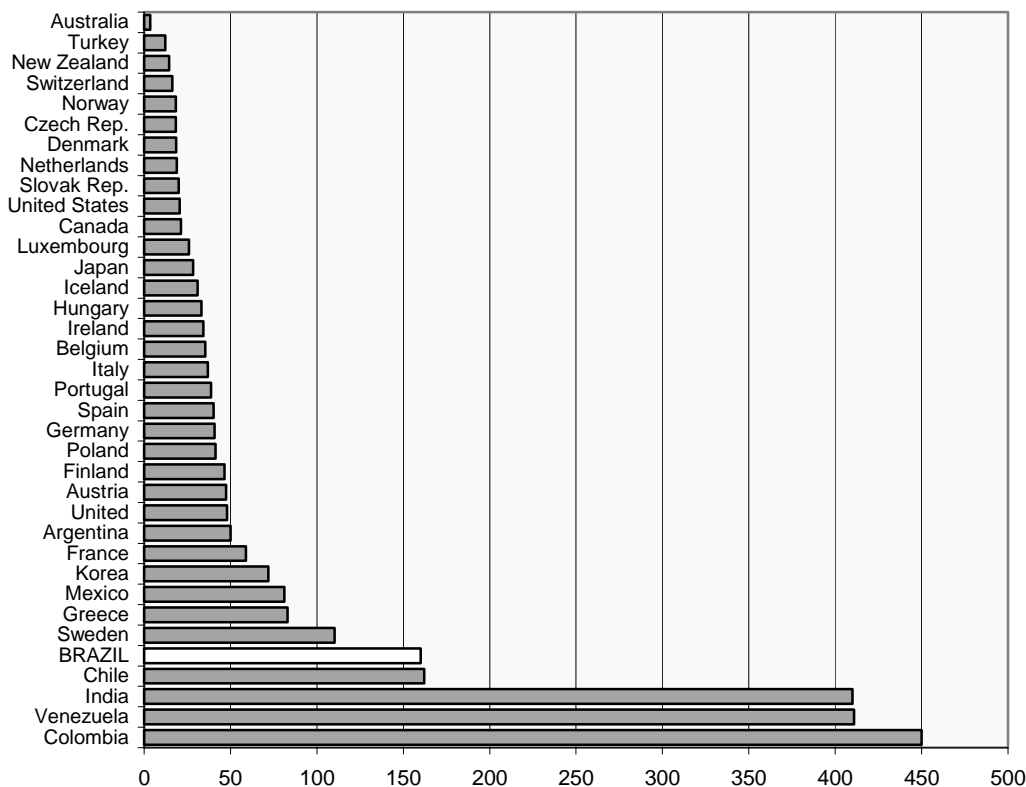
	Initial income (A)	Gross income (B) (initial income plus transfers)	Disposable income - direct taxes ^a (C) (gross income minus direct taxes)	Disposable income - indirect taxes (D) (gross income minus direct and indirect taxes)	Overall impact	
					Direct taxes ^a (C-A)	Direct and indirect taxes (D-A)
1 st (lowest) decile	0.7	0.8	1.0	0.9	0.3	0.2
2 nd decile	1.5	1.7	1.9	1.8	0.4	0.3
3 rd decile	2.3	2.5	2.7	2.5	0.4	0.2
4 th decile	3.2	3.4	3.6	3.4	0.4	0.2
5 th decile	4.2	4.5	4.6	4.4	0.4	0.2
6 th decile	6.0	5.9	6.0	5.6	-0.0	-0.4
7 th decile	8.2	8.1	8.1	7.7	-0.1	-0.5
8 th decile	11.3	10.9	10.9	10.5	-0.4	-0.8
9 th decile	16.7	16.5	16.5	16.5	-0.2	-0.2
10 th (highest) decile	45.9	45.7	44.8	46.6	-1.1	0.7
<i>Memorandum item:</i>						
Gini coefficient	0.64	0.58	0.56	0.58	0.08	0.06

a. Includes social security contributions.

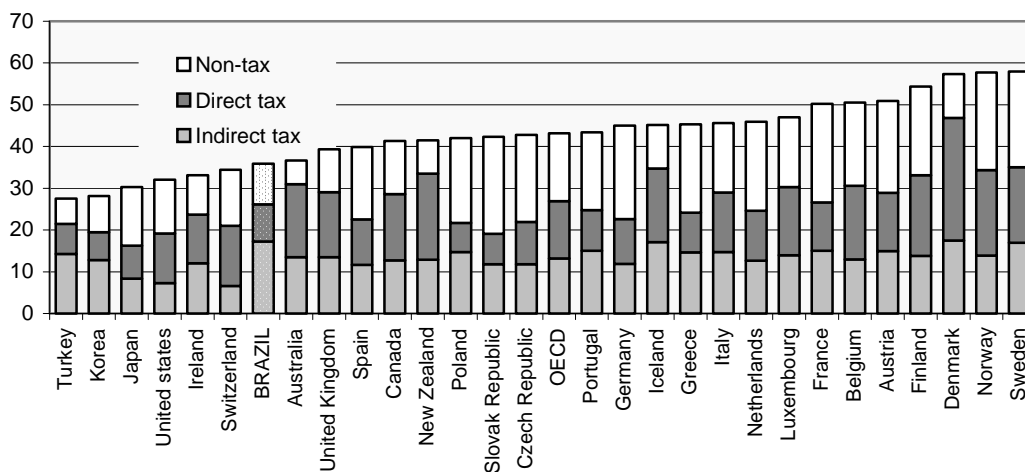
Source: Immervoll *et al.* (2003).

Figure 4.7. Personal income taxation and composition of government revenue

A. Personal income tax threshold, 2003¹
in per cent of per capita income



B. General government revenue, 2002
in % of GDP



1. 1998 for Chile, India, Venezuela, and Colombia.

Source: OECD, Special Features: Thresholds for Paying Income Tax and Social Security Contributions, Paris; OECD Economic Outlook 75 database; and OECD calculations.

At the same time, a heavy tax burden on labour income, more than the rigidity of Employment Protection Legislation (EPL), appears to be the main determinant of labour informality. Duality in the labour market contributes to income inequality, as evidenced by household survey data showing that earnings tend to be higher in the formal sector. Brazil does not appear to have overly rigid EPL, at least as gauged by the indicator constructed by the OECD (Annex 4.1), although legislation is complex and partly outdated.¹¹ The main instrument is the 1943 labour code (*Consolidação das Leis do Trabalho*, CLT) with amendments, of which some were included in the 1988 Constitution. On the other hand, the total rate of mandatory payroll contributions to social insurance is about 45 per cent, of which employers pay around 35 percentage points (including FGTS and other programmes).¹² Empirical evidence is scarce but policies aimed at reducing the tax burden on payroll in small and medium enterprises are believed to have contributed to job creation in that market segment. The creation of SIMPLES in 1999, a simplified federal tax regime for small enterprises, reduced the tax burden on labour, encouraging the creation of formal jobs in those enterprises. Discussions are under way to include regional government taxes in SIMPLES, therefore extending the programme beyond the federal government.

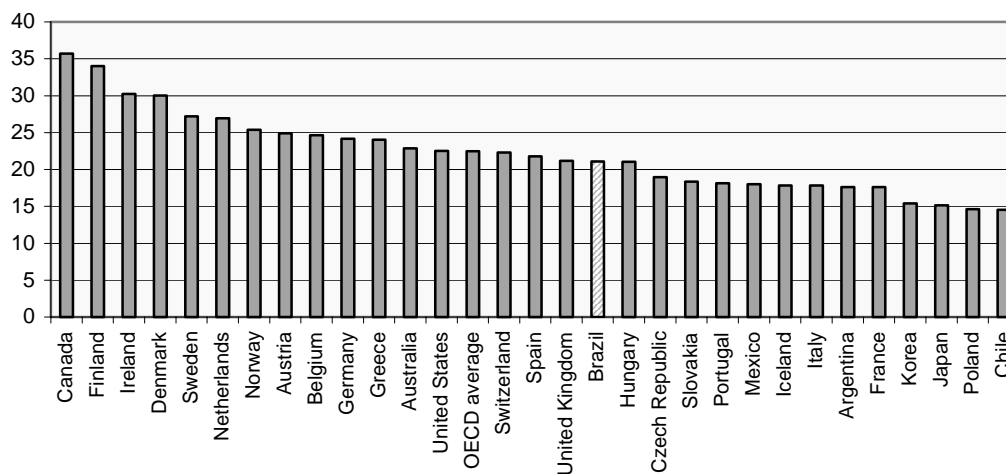
Education and health care

There is considerable heterogeneity in incidence rates in education and health care. In the case of education, the composition of government spending is skewed towards higher education, the benefits of which accruing predominantly to the non-poor. Nearly 60 per cent of students attending public higher education belong to the top income quintile. Tertiary education accounts for about one-fifth of government spending on education, close to the OECD average (Figure 4.8). But the average cost to the budget of higher education per student is about 150 per cent of GDP per capita, almost four times as high as the OECD average.

Figure 4.8. Spending on tertiary education, 2000

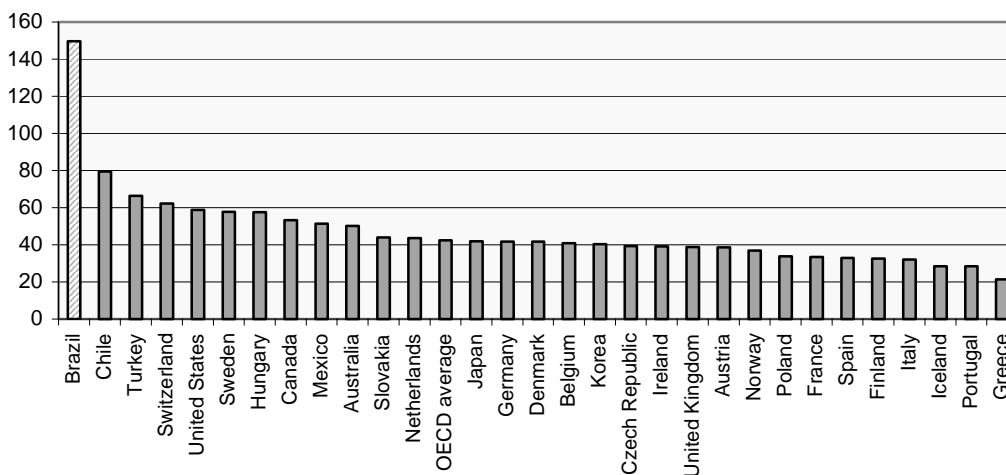
A. Public expenditure on tertiary education

% of total public expenditure on education



B. Expenditure per student on tertiary education institutions

% of GDP per capita



Source: OECD, *Education at a Glance*.

In the case of health care, while government spending on public hospitals is estimated to be progressive, this is not the case for the private hospitals funded by SUS (*hospitais conveniados*). This is because access to SUS is universal, even for holders of private health insurance, which are typically middle- and higher-income individuals. As a result, insurance companies are discouraged from covering complex and costly procedures, which would result in higher premia.¹³ Provision costs are therefore shifted to the government and insurance companies do not face strong incentives to broaden the array of procedures eligible for reimbursement. At the same time, income tax deduction for expenditure on private

health insurance and medical care tends to benefit higher-income individuals, making overall public spending on health care less progressive than desirable.

The targeting of public spending on health care also depends on the distribution of outlets throughout the country. This is because health care budgets remain predominantly input-oriented, making federal transfers to states and municipalities dependent on existing infrastructure, which is relatively more developed in the richer states. Federal transfers therefore tend to favour states with relatively higher per capita income despite the more pressing health care needs in the relatively poorer states. But, since the end of the 1990s, differences in federal health spending per capita have been reduced as the government has replaced part of these input-cost transfers by block grants based on estimated primary and preventive care needs (Box 4.2).

Box 4.2. Preventive care programmes

Spending on primary and preventive care accounts for about one-third of primary public outlays on health care. The main programmes are PAB (*Piso Assistencial Básico*), PSF (*Programa Saúde da Família*) and PACS (*Programa Agentes Comunitários de Saúde*).

- PAB, set up in 1998, is a block grant from the federal government to the municipalities based on estimated per capita spending needs. State governments provide the remaining services and are, in principle, responsible for planning, coordinating, monitoring, and evaluating the implementation of national health policies at the local level. Health Councils oversee the use of funds and resources allocation.
- PSF, set up in 1994, provides every 1 000 families with a team comprising a physician, a nurse, one or two nurse assistants, and six community agents. The programme was originally implemented in poorer regions, especially in areas not covered by the SUS network. About 45 million people are now served by family health teams.
- PACS is also sponsored by the Ministry of Health and managed by local governments. The programme focuses on maternal and child care. By 2003, 94 million people had been served by these community agents and 93 per cent of all municipalities are now covered by PACS.

In the case of PSF, there is evidence that infant mortality has been reduced in areas where the programme is in operation, in particular in the poorer regions. Improvements in health indicators, as an increase in pre-natal assistance or health prevention and monitoring of diabetes, hypertension, tuberculosis, and other common diseases in the communities have also been observed (Box Table 4.1).

Table Box 4.1. Community care programmes PSF/PACS, 2002

	Coverage (per cent population)	Share of pre-natal care	Children under 1 year of age	
			Immunisation rate	Malnutrition rate
Brazil	58.8	82.5	87.4	6.1
North	98.7	72.3	82.7	6.1
Rondônia	89.2	83.6	93.9	4.0
Acre	88.4	73.4	77.9	9.1
Amazonas	100.0	68.9	84.8	6.0
Roraima	90.7	83.1	91.7	3.8
Pará	93.9	69.5	78.0	7.1
Amapá	100.0	67.5	85.9	3.4
Tocantins	100.0	81.5	91.8	4.5
North-East	90.0	78.4	84.1	7.8
Maranhão	100.0	63.5	73.0	10.1
Piauí	100.0	77.9	85.3	8.2
Ceará	78.9	89.4	90.6	6.4
Rio Grande do Norte	97.7	85.7	85.3	5.5
Paraíba	98.8	85.9	86.7	6.5
Pernambuco	83.3	83.6	89.6	8.1
Alagoas	86.2	78.7	86.7	10.9
Sergipe	91.9	83.6	88.6	5.6
Bahia	84.2	72.4	79.7	7.6
South-East	33.1	91.9	95.3	3.7
Minas Gerais	53.4	90.9	95.1	5.8
Espírito Santo	75.1	89.6	95.7	2.8
Rio de Janeiro	25.5	92.2	94.7	3.0
São Paulo	22.7	93.6	95.6	2.0
South	50.4	92.5	93.0	3.4
Paraná	56.0	93.6	93.2	3.4
Santa Catarina	79.6	92.8	95.5	2.7
Rio Grande do Sul	29.8	90.0	90.1	4.2
Centre-West	64.7	90.1	91.9	3.4
Mato Grosso do Sul	75.0	90.9	89.7	2.9
Mato Grosso	74.5	90.3	93.1	3.3
Goiás	74.7	89.8	93.4	3.8
Distrito Federal	18.0	86.5	90.4	2.0

Source : Ministry of Health.

NOTES

- 1 . Social insurance coverage was extended in the 1990s to rural workers of both genders even if they have not paid social security contributions. Claimants are only required to provide evidence of 15 years of work in farms or other rural activities to be eligible for a minimum pension at age 60 (men) or 55 (women), as well as for other benefits (e.g., disability, maternity, and work accident). Such pensions are now paid to nearly 7 million rural workers.
- 2 . Together with public hospitals and clinics, these publicly-funded private hospitals make up the National Health System (*Sistema Único de Saúde*, SUS). Funded through general and earmarked taxes, SUS provides universal access to primary, secondary, and complex care to all residents. SUS was created by the 1988 Constitution, which consolidated the existing publicly-funded health care programmes and extended coverage to the entire population. The system is managed in a decentralised manner. SUS accounts for about one-half of total public spending on health care. See OECD (2001), for more information.
- 3 . These aggregate incidence rates mask regional discrepancies. Empirical evidence is scarce but, for example, Soares (1999) shows that nearly one-third of public pensions accrue to the lowest income quintile in the metropolitan region of São Paulo, against nearly one-fifth to the highest quintile.
- 4 . Based on the 2001 National Household Survey (PNAD).
- 5 . See Gill, Packard, and Yermo (2004), for more information. Also, according to Barros, Mendonça, and Santos (1999), pensions and social security benefits account for almost 60 per cent of per capita household income in the case of poor individuals in the over-60 age group, against nearly 47 per cent for the non-poor in the same age group.
- 6 . See World Bank (2000*b*) and Schwarzer and Querino (2002), for more information.
- 7 . See Morley (2003) and Carvalho (2001), for more information.
- 8 . Private sector pensions averaged less than two minimum wages in the second half of the 1990s, while public sector pensions in the executive branch of the federal government were, on average, seven times higher. See de Mello (2000*b*), for more information.
- 9 . See Ministry of Finance (2003), for further discussion.
- 10 . See Federal Revenue Service (2001), for more information.
- 11 . Much of labour legislation appears to be widely observed in the formal and informal sectors: most formal and informal employees work around 44 hours per week and administrative procedures are often similar in both sectors. Minimum wage legislation may even have a stronger impact on wage setting and unemployment in the informal sector, where wages are lower.
- 12 . The employers' contribution rate includes 20 per cent to social insurance, 8.5 per cent to FGTS (including the 0.5 percentage-point surcharge introduced in 2001), and charges to finance several specialised institutions (e.g., the so-called "S" system to finance labour training, education, small-business support, and agricultural development). Other social charges are based on turnover, notably for unemployment insurance and employment services. The employees' contribution rate for social insurance is 7.65 per cent for earnings of up to 3 minimum wages, 9 per cent for earnings between 3 and 5 minimum wages, and 11 per cent for earnings between 5 and 10 minimum wages.

- 13 . The coverage of private health insurance is relatively low in Brazil, at nearly 25 per cent of the population, against about one-third on average in the OECD area. Access to private health insurance is skewed towards the better-off, with 75 per cent of policy-holders having household income over five minimum wages, and 95 per cent of them living in urban areas, mainly in the South and South-East of the country.

BIBLIOGRAPHY

- Barros, R.P., R. Mendonça, and D. Santos (1999), “Incidência e Natureza da Pobreza entre Idosos no Brasil”, *Working Paper*, No. 686, IPEA, Brasília.
- Carvalho, V.P. (2001), “Amazônia Cidadã: A Previdência Social na Região Norte do Brasil”, *Informe de Previdência Social*, Vol. 13, Ministry of Social Security, Brasília.
- de Mello, L.R. (2000b), “Social Spending in Brazil: Recent Trends in Social Assistance”, *Brazil: Selected Issues and Statistical Appendix*, International Monetary Fund, Washington, DC.
- Federal Revenue Service (2001), “Considerações sobre o Imposto de Renda da Pessoa Física no Brasil”, *Discussion Paper*, No. 14, Federal Revenue Service, Brasília.
- Gill, I.S., T. Packard, and J. Yermo (eds.) (2004), *Keeping the Promise of Old Age Income Security in Latin America*, World Bank, Washington, DC. www.worldbank.org/lacpensionsconf
- Immervoll, H., H. Levy, J.R. Nogueira, C. O’Donoghue and R.B. de Siqueira (2003), “Simulating Brazil’s Tax-Benefit System Using BRAHMS, the Brazilian Household Micro-simulation Model”, *Annals of the XXXI Encontro Nacional de Economia (ANPEC)*, Porto Seguro.
- Ministry of Finance (2003), “Gasto Social do Governo Central, 2001 e 2002”, Ministry of Finance, Brasília.
- Morley, S. (2003), *Reducing Poverty in Brazil: Lessons Learned and Challenges for the Future*, Boston Institute for Developing Economies, Boston, MA.
- OECD (2001), *Economic Survey of Brazil*, OECD, Paris.
- Schwarzer, H., and A.C. Querino (2002), “Benefícios Sociais e Pobreza: Programas Não-contributivos da Seguridade Social Brasileira” *IPEA Discussion Paper*, No. 929, IPEA, Brasília.
- Soares, M.C. (1999), “A Mensuração do Impacto Distributivo do Gasto Social: Um Estudo para a Região Metropolitana de São Paulo,” *IPEA Discussion Paper*, No. 643, IPEA, Brasília.
- World Bank (2000b), *Attacking Brazil’s Poverty: A Framework for Sustainable Poverty Reduction—With a Focus on Urban Areas*, World Bank Report 20475-BR, World Bank, Washington, DC.