

Social protection and public policy for vulnerable populations: an assessment of the Continuous Cash Benefit Program of Welfare in Brazil

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Abstract *This paper describes the historical development and profile of Continuous Cash Benefit (BPC) applicants, intended for poor elderly and people with disabilities, which, since 2009, uses eligibility criteria based on the International Classification of Functioning, Disability and Health (ICF) of the WHO and is aligned with the UN Convention on the Rights of Persons with Disabilities. The behavior of benefits was determined from the analysis the coefficients of the general and non-judicial grants between 1998 and 2014. The profile was established for the years 2010 and 2014 according to situation of acceptance, age, gender and ICF components. The average annual growth of the coefficient was higher from 2000 to 2010, prior to the adoption of the biopsychosocial eligibility model, and the coefficient of non-judicial grants increased until 2010, falling thereafter. The deferrals acceptance /rejections ratio was higher among children and among those facing severe or total environmental barriers, limitations, constraints and bodily changes. The implementation of the biopsychosocial evaluation model did not cause an increased rate of grants and results evidence the need for flexibility in the eligibility criteria.*

Key words *International Classification of Functioning, Functioning Disability and Health, Disability evaluation, Social protection, Social vulnerability*

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Introduction

This paper aims to describe the historical development and the profile of Continuous Cash Benefit (BPC) applicants, which integrates the Brazilian social protection policy.

The establishment of social protection systems stems from a public action aimed at protecting society from the effects of the classic risks that produce dependence and insecurity: illness, old age, disability, unemployment and exclusion. The role of social protection systems in economic development, also a stability factor for countries with improved systems¹, has also been recognized.

In Brazil, BPC is a constitutional right set forth in Article 203, which provides for “the assurance of a minimum monthly benefit wage to the disabled person and the elderly who can provide proof of their own inability to cater for their own survival or have this need met by their own family”. It is a benefit intended for a segment in a situation of dependence and social insecurity.

In the current institutional design, the BPC integrates the Basic Social Protection of the Unified Welfare System (SUAS), coordinated by the Ministry of Social Development (MDS) and geared to the population in situation of social vulnerability, understood as arising from poverty, deprivation and/or weak affective relationships².

Eligibility for the BPC implies the evaluation according to income criteria and defining characteristics of the target populations: advanced age or disability, which have been considered quite restrictive in their cutoff points and reviewed over the years in the benefit regulations, following changes in policies and regulations aimed at this target audience³. However, these changes refer only to age and the characterization of disability, since the income limit remains the same since the establishment of the benefit – monthly per capita family income less than ¼ of minimum wage.

The minimum age required for the elderly, initially set at 70 years, changed to 67 in 1998 and 65 in 2004. The characterization of disability is much more complex and controversial, especially in light of advances in the conceptualization and assurance of social rights to people with disabilities.

Regarding the design, the proposal of a new paradigm to address disability was carried out at the international level, initially with the WHO’s dissemination of the International Classification of Functioning, Disability and Health (ICF)⁴,

published in Brazil in 2003, and embodied in the enactment of the UN Convention on the Rights of Persons with Disabilities in 2006 in New York, approved and enacted in Brazil with the status of Constitutional Amendment⁵ with Legislative Decree 186/2008 and Decree 6.949/2009⁶.

In the context of BPC, the international influence has materialized in the review of the disability assessment model to access the benefit⁷. Until 1997, the grant built on the evaluation and report issued by a SUS or INSS service manned by a multi-professional team. As of August 1997, the evaluation became the sole responsibility of INSS Medical Expertise. Access to the benefit required meeting the criteria of per capita household income and characterization of disability, understood as incapacity to work and live independently. The criteria for granting and reviewing BPC remained effectively guided by the biomedical conception until 2009^{8,9}.

The new paradigm was set by Decree No. 6.214/2007, establishing new eligibility criteria. The Joint MDS/INSS Ordinance N° 1/2009¹⁰ set forth the tools and criteria for the biopsychosocial assessment of disability to access PCB, built on the biopsychosocial model of the ICF and in line with the UN Convention. Then, evaluation was carried out by Social Workers and Medical Experts of the INSS. The second version of the disability assessment tools was implemented in 2011¹¹ and the third version in 2015¹².

There is a profound change in the disability concept represented by the biopsychosocial model proposed by the ICF and the UN Convention and its incorporation into the benefit eligibility model was an unprecedented advance in the history of social protection and public policy aimed at people with disabilities in a social vulnerability situation in the country.

However, discrimination, invisibility and inequality still persist^{6,13}. Take, for example, differences in the situation of poverty and social exclusion that mark persons with some type of disability identified in the 2010 census¹⁴ in relation to the general population. Among those over 15 years of age, 61% had no schooling or complete elementary education. The more serious the deficiencies, the more important the exclusion. Among people with total or severe disabilities over 10 years of occupation, 14% had no income and 42% earned up to one minimum wage, while for non-disabled persons, these figures were 6% and 31%, respectively.

The poverty and exclusion situation evidenced by national data underscores the impor-

tance of non-contributory welfare benefits such as BPC, associated with social inclusion policies. Despite the relevance of the benefit as a Brazilian basic protection component, the eligibility criteria have been repeatedly questioned, since the adoption of such a narrow income limit hinders access by a significant portion of the population in a situation of poverty³.

The growing phenomenon of the benefit's grant judicialization^{3,15-17} has evidenced the need to revise the criteria for the characterization of dependency and vulnerability, especially considering the impacts of aging and disability on the household budget. These expenditures, called "catastrophic expenditures" in the literature increase or deepen the risk of poverty for the whole family group³. In 2015, 30% of benefits were granted in court, according to data reported by the National Welfare Office (MDS)¹⁸.

In fact, two movements were decisive for the levels of access to BPC since its inception: the trend of age and disability criteria regulation and action of the judiciary, identifying protective gaps in the poor assurance of access to BPC for the elderly and people with disabilities³.

Taking into account the adoption of the biopsychosocial eligibility model as of 2009, the results of this paper discussed in light of the literature produced on the topic are shown in three sections. In the first, the disabled person evaluation model for the access to the BPC is examined; in the second, we sought to identify possible changes in the pace of granting new benefits, evaluating the trend between 1998 and 2014; and, in the final part, the profile of disabled persons applying for BPC in the validity of the new evaluation model is described.

Methods

This is a descriptive, observational study based on secondary data. Considering that the evaluation for the granting of BPC became the exclusive responsibility of the INSS in August 1997, the behavior of benefits was determined for the period from 1998 to 2014, based on the analysis of the coefficient of benefits granted to persons with disabilities (PwD) in the population aged 0-64 years (per 10,000 inhabitants), corresponding to the entry of new benefits into the social security system (http://www1.previdencia.gov.br/aeps2006/15_01_01_02_01.asp).

In the numerator of the coefficient, the number of benefits granted to people with disabilities

provided by DATAPREV in the Social Security Historical Database, known as the "People with Disability Support" was used¹⁹. The population from zero to 64 years, estimated by the IBGE Foundation (<http://tabnet.datasus.gov.br/cgi/deftohtm.exe?ibge/cnv/poptbr.def>) was considered as denominator. Using the same formula and excluding from the numerator the judicially granted benefits²⁰, the coefficient of non-judicial grants for the period from 2004 to 2014 was also calculated. The population older than 65 years was disregarded since it was eligible for BPC for the elderly, and the number of grants to people with disabilities in this age group was nonexistent or residual.

Initially, a descriptive analysis of the behavior of the grant coefficients was performed during the study period. The trend analysis was then performed through the Join Point Regression free access program of the National Cancer Institute²¹, version 4.4.0.0, dated January 4, 2017.

The joinpoint analysis was developed according to the segmented linear regression method, with estimated inflection points, in order to determine whether these and the estimated trends are statistically significant. The joinpoint analysis identifies the timing of trend changes (inflection points) and calculates the Annual Percentage Change (APC) in each trend segment, with a 95% confidence interval (CI). APC values can range from minus to plus infinity (negative numbers reflecting a decreasing trend, and positive, an increasing trend), with zero being equivalent to lack of trend.

The deferral profile was analyzed during the validity of the new model for the evaluation of the disabled person for 2010 and 2014, entirely under the validity of a single version of the evaluation tool, considering the ratio of deferrals according to age, ICF components and gender, the latter being analyzed only for 2014 due to the large proportion of ignored records in 2010.

The ICF components – Environmental Factors barriers, Bodily Functions change and limited and restricted Activities and Participation – were considered according to the results of social and medical evaluation, expressed through qualifiers ranging from none to total, according to the measurement proposed by the classification.

The deferral ratio was calculated by dividing the number of benefits granted by the number of denied benefits and multiplying the result by 100.

Information on the deferrals profile was obtained on a structured basis within the research project "Improved Public Policy for People with re-

duced functionality - People with Disabilities and the Elderly”, based on data provided by the MDS. In this case, only the benefits with full medical and social assessment were included in the analysis. Some differences are observed in the number of registrations of benefits granted (in the Historical Database of Social Security) and deferred (on the basis structured by said research project). They are probably due to differences in the update of existing databases in the two sources. From 2010 to 2014, the lowest difference (0.8%) was observed in 2010 and the highest (4.9%) in 2012.

A Brazilian Ethics in Research Committee approved the study.

The biopsychosocial disability assessment model for access to BPC

In terms of its regulation, the BPC was implemented by the Welfare Organic Law (LOAS), Law N° 8.742, of December 7, 1993, with significant amendments made by Laws N° 12.435, dated July 6, 2011 and N° 12.470, dated August 31, 2011. Regulation was enacted by Decree N° 6.214/2007 and subsequent amendments, and the most recent is Decree N° 8.805, dated July 2016.

The biopsychosocial evaluation model for eligibility to BPC came into force in August 2009 as a result of the work of a multi-professional and multi-sectoral group, established to align the eligibility criteria adopted at the time to the concept of disability proposed by international frameworks²². It was developed based on the ICF and in line with the UN Convention on the Rights of Persons with Disabilities.

The biopsychosocial model submitted by the ICF/WHO transcends bodily changes, focusing on the interaction between the various realms of health (biological, individual and social)^{4,23}. Different grades of functionality and disability stem from the interaction between a health condition (disease, trauma and injury) and context factors (environmental and personal factors). Total disability and functionality are two extremes of a continuum, in which individuals are positioned dynamically – which changes due to age, or to specific events that occur throughout life, producing permanent or temporary situations, according to the concrete result of the interaction between their physical and psychological conditions and their surrounding environment.

According to the biopsychosocial perspective, disability is born from specific social contexts and is defined by the barriers faced by individuals

in performing basic or more complex daily tasks required for independent living. It is important to emphasize that this is an approach applicable to a wide range of acute and chronic health situations and conditions, in interaction with the environment, not restricted to structural losses or functions traditionally considered as disabilities.

The UN Convention, which is the result of the participation of governments, civil institutions and people with disabilities around the world, recognizes that disability is an evolving concept and conceptualizes “people with disabilities”, formalizing the term. In the Brazilian Portuguese version, people with disabilities include those with “physical, mental, intellectual or long-term sensory impairments, which in interaction with the various barriers obstruct their full and effective participation in society, in equal conditions with other people”²⁴.

In Brazil, the concept established by the Convention is explicitly adopted in the BPC regulatory framework and, since 2009, the benefits eligibility evaluation model includes two steps: 1) assessment of household income declared, from registration, by technician or social security analyst, in a specific registration system; 2) assessment of disability performed by social worker and medical expert.

The disability assessment is based on the Medical-Expert and Social Disability Assessment Tool for Access to BPC, organized into components, domains and classification units selected from the ICF, in two modalities: for people under 16 years and those aged 16 years and over. Expert Doctors evaluate 18 domains, related to changes in the bodily functions and medical aspects-related limitations and restrictions. Social workers evaluate nine domains related to environmental barriers and limitations and restrictions related to the social context.

The result of the evaluation produces a final qualifier for each of the three tool components, quantifying the intensity of environmental barriers, the limitations and restrictions on activities and participation and changes in bodily functions/structures, in five levels: none, light, moderate, severe or total.

The outcome of the evaluation and the resulting indication for deferral builds on the combination of the final qualifiers of the three components. Environmental factors, provided that they qualify as severe or total barriers, are decisive for granting only in one situation, when Bodily Functions and Activities and Participation are borderline, that is, are qualified as moderate.

The remaining combinations, with the respective deferral results are systematized in Chart 1.

Considering the above, it is worth emphasizing two aspects regarding the current disability assessment model for access to BPC: 1) only applicants with bodily changes and moderate or severe long-term limitations and restrictions are eligible for benefit; 2) despite the introduction of social assessment in the model, the result of the medical-expert evaluation has greater weight in the final result.

Model controversies point to the preponderance of medical evaluation and to the grant restriction due to long-term impediments. Silva and Diniz⁹ draw the attention to the current LOAS wording that excluded the requirement of lack of capacity for independent living and work that existed in the original wording of the device, aligning it with the contemporary language of the Convention, but reversed the positive meaning of change by qualifying the long-term impediment with the requirement to produce effects for two years. They rightly argue that the text of the Convention and therefore of the Federal Constitution does not reduce fundamental rights to the duration of bodily impediments.

In fact, socially vulnerable individuals who, because of a temporary change in their health status cannot cater for their basic needs²⁵, may be qualified with temporary impairments, it should be noted, in the expanded ICF conception. Once they are not covered by (contributory) social insurance, they are not covered by the BPC and remain without social protection.

Expanded access to this segment can be achieved by replacing the two-year fixation by an

evaluation of the duration of the impediment by medical experts and social workers, based on the individual needs of applicants, with reassessment forecast according to the deadline stipulated in each case, or automatic cessation of the benefit in situations with foreseeable terms.

It is worth noting that, as underlined by the World Disability Report, in addition to temporary welfare benefits, greater flexibility in payments and options to keep benefits on hold while people enter the labor market can have positive effects on the employability of people with disabilities by making them, at the same time, feel encouraged to work and safe because they know that they can still use the benefit²⁶ if they do not succeed.

The biopsychosocial model and the granting of benefits: the 1998-2014 trend

The grant coefficient ranged from 8.7 to 11.4 in the period 1998-2010. From 2010 to 2014, the coefficient declined to 9.8 in 2014 after a small increase in 2013 (Table 1).

The new disability evaluation model came into effect in the second half of 2009. The joint-point method (Figure 1) analysis revealed a significant increased trend of the grant coefficient from 1998 to 2004, at a yearly rate of 2.84%. An alternative model, which takes the years of 2000 and 2010 as inflection points, revealed that, when the medical disability assessment model was in place under the exclusive responsibility of INSS medical experts, a non-significant yearly decline of 14.67 % was reported in the first two years of the series – which may have been due to the elim-

Chart 1. Matrix of combinations between the results of social and medical-expert evaluation of disabled person, according to biopsychosocial model of assessment to the BPC.

Changes in body functions / structures *	Limited activities and restricted participation				
	None	Light	Moderate	Severe	Total
None	No	No	No	No	No
Light	No	No	No	No	No
Moderate	No	No	No Yes (only if environmental hurdles are severe or total)	Yes	Yes
Severe	No	No	Yes	Yes	Yes
Total	No	No	Yes	Yes	Yes

NOTE: The Yes or No categories correspond to the condition of deferral in relation to the combination of the final qualifiers, in compliance with the requirements set forth in article 20 of Law 8.742/93, which defines a person with a disability.

* Terminology introduced from the 3rd version of the tools in 2015 (used here for the correct understanding of what is effectively evaluated in the component).

ination of the grant based on a report issued by a SUS service – followed by a significant yearly increase of 5.26% up to 2010. The upward trend seems to have reversed in the last four years of the series, after, therefore, the adoption of the new model, since the coefficient showed a slight (not significant) yearly decline of 1.53% compared to the maximum peak of 2010, but remained stable at levels similar to 2008, the last year of the exclusively medical evaluation.

Judicially granted benefits (Table 1) increased steadily between 2004 and 2014, when the proportion of court grants exceeded 24%. The trend towards policy judicialization has a strong impact on the grant levels, which is evident from the coefficient of non-judicial grants, which showed inverse but not significant trends before and after 2010: annual increase of 4.21% from 2004 to 2010 and annual decrease of 3.58% from 2010 to 2014, a relatively greater decrease than that shown by the general grants (Figure 2).

The results indicate that the benefits granting rate did not increase with the incorporation of social eligibility criteria. On the contrary, the implementation of the new model was followed by stabilization and slight decline in the coefficient

of beneficiaries. However, a few more years of observation of the series are required to confirm whether 2010 was a significant turning point in the granting of benefits or not.

No studies were found on the effects of the new evaluation model on BPC grants for people with disabilities. However, Santos²⁷ draws the attention to the milestone of adopting a biopsychosocial perspective in the assessment of BPC, one of the first policies to adopt in its entirety the concept of disabled persons in the 2006 Convention.

On the other hand, one of the objectives of BPC is to address poverty in the segment served²⁸⁻³⁰ and, for some years, studies have been pointing to its effects on inequality. Soares *et al.*³⁰ evaluated the 2004 PNAD and concluded that the benefit is high enough to remove a significant number of families from poverty. Viana and Teixeira²⁹, on the other hand, in a study on the role of non-contributory benefits in the fight against poverty in 2005 argues that, while the number of benefits grew annually, they still fell short of what seemed necessary to cope with poverty. The problem would therefore lie in the coverage achieved by the policy.

Table 1. Development of the coefficient of total and non-judicial (per 10.000 inhabitants) of the Continued Cash Benefit Programme of Social Assistance (BPC) in Brazil, from 1998 to 2014.

Year	Number of benefits granted to PwD for the year (1)	Population from 0 to 64 years (2)	Coefficient of grants to PwD per 10 thousand inhab. (3)	Benefits granted judicially to PwD (4)	Percentage of judicial grants (%)	Coefficient of non-judicial grants to PwD per 10 thousand inhab. (3)
1998	138,528	159,408,459	8.7	---	---	---
1999	109,847	161,574,034	6.8	---	---	---
2000	107,915	163,726,137	6.6	---	---	---
2001	88,387	165,888,577	5.3	---	---	---
2002	144,301	167,976,072	8.6	---	---	---
2003	119,096	169,994,582	7.0	---	---	---
2004	141,198	171,952,349	8.2	9,497	6.7	7.7
2005	132,578	173,852,503	7.6	16,069	12.1	6.7
2006	131,774	175,688,292	7.5	19,423	14.7	6.4
2007	145,245	177,456,142	8.2	25,321	17.4	6.8
2008	178,900	179,146,245	10.0	28,545	16.0	8.4
2009	166,924	180,744,946	9.2	31,340	18.8	7.5
2010	207,396	182,244,390	11.4	31,530	15.2	9.7
2011	185,935	183,647,517	10.1	33,088	17.8	8.3
2012	174,013	184,953,422	9.4	35,205	20.2	7.5
2013	186,027	186,162,628	10.0	41,060	22.1	7.8
2014	183,465	187,279,396	9.8	44,525	24.3	7.4

Sources: (1) Historical Database of Social Security. Available at: <http://www3.dataprev.gov.br/infologo/>; (2) IBGE – Population Estimates, available at: <http://tabnet.datasus.gov.br/cgi/defohtm.exe?ibge/cnv/poptuf.def>; (3) Own elaboration; (4) MDS. 2015 BPC Bulletin, available at: <http://www.mds.gov.br/>.

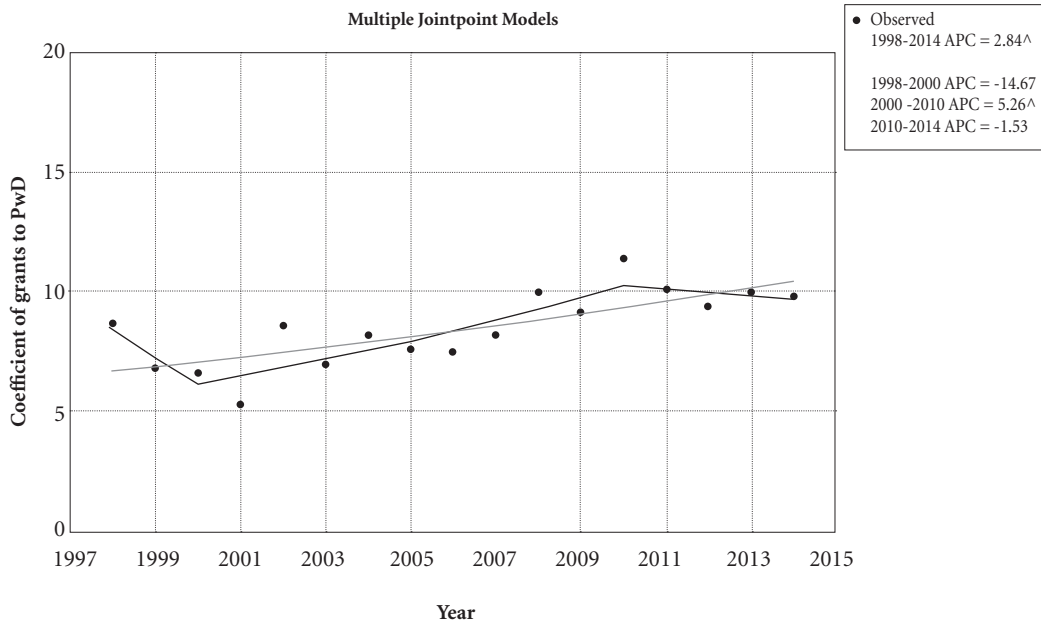


Figure 1. Coefficient of grants per 10,000 inhabitants observed and expected through the join point method and annual rate of change, by time segment. Brazil, 1998 to 2014.

^ Indicates annual percentage change (APC) other than zero ($\alpha = 0.05$).

Source: Own elaboration based on data collected in the Historical Database of Social Security (available at: <http://www3.dataprev.gov.br/infologo/>) and IBGE – Population Estimates (available at: <http://tabnet.datasus.gov.br/cgi/defohtm.exe?ibge/cnv/poptuf.def>).

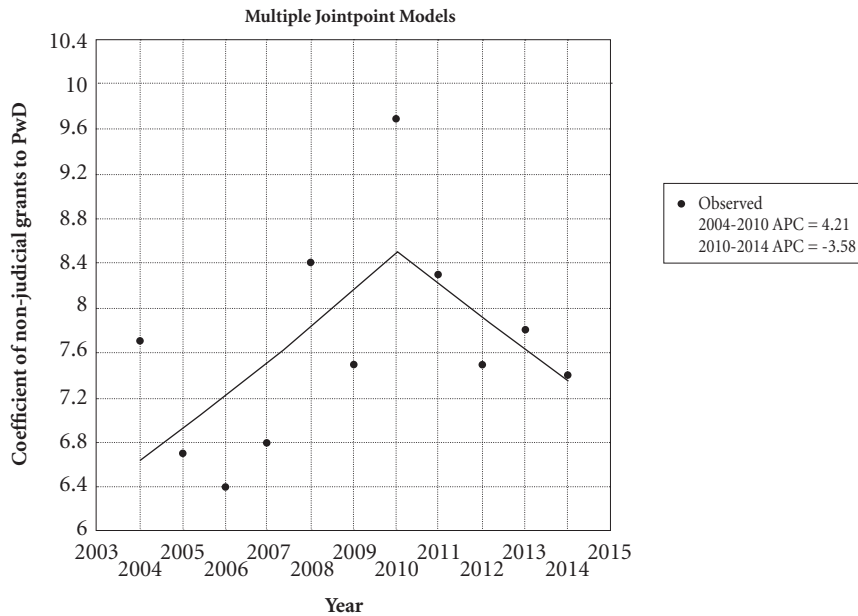


Figure 2. Coefficient of non-judicial grants per 10,000 inhabitants observed and expected through the join point method and annual rate of change, by time segment. Brazil, 1998 to 2014.

^ Indicates annual percentage change (APC) other than zero ($\alpha = 0.05$).

Source: Own elaboration based on data collected in the 2015 BPC Bulletin published by the Ministry of Social Development (available at: <http://www.mds.gov.br>) and IBGE – Population Estimates (available at: <http://tabnet.datasus.gov.br/cgi/defohtm.exe?ibge/cnv/poptuf.def>).

Although results of this study show annual growth of the benefit coefficient, they still do not authorize a review of author's observations. Despite the developing design of the disability concept and the eligibility criteria, BPC may not be able to reach sufficient coverage of the target population. However, the lack of population data on the number of people with disabilities belonging to families with a household per capita income lower than $\frac{1}{4}$ minimum wage – the target population of the program – makes a conclusive evaluation impossible. Notwithstanding, the impact of the BPC is far from negligible. In 2015, 4.2 million Brazilians received from the public coffers a monthly minimum wage, representing a total of R\$ 39.6 billion injected into the market²⁰, which have effectively contributed to a reduced inequality over the years^{28,29,31}.

The expanded judicial grants corroborate the assessment that the BPC has not fulfilled its role in basic social protection, excluding significant portions of the population in a situation of poverty from basic social rights. Silveira *et al.*³ argue that the progressive judicialization imposes a normative deliberation on the easing of the benefits granting conditions, because it further expands the inequity gap in the access to rights, since its implementation depends on the applicants' access to justice and the individual understanding of each judge or court on the specific situations of the applicants.

Authors point out that the decision handed down in 2013 by the Federal Supreme Court, regarding the insufficient income criterion to gauge the vulnerability of BPC applicants is still awaiting decision. Despite raising a discussion about new criteria among benefit managing agencies, based on concepts of dependency and autonomy and considering a wider range of socioeconomic vulnerabilities, the most recent legal tool – Decree N° 8.805/2016 – did not accept the access flexibility rule for claimants with income higher than $\frac{1}{4}$ of the minimum wage, which keeps legal uncertainty for these cases.

The pattern of BPC deferral in the validity of the medical-social evaluation model

The general pattern of deferrals (Table 2) reveals a higher proportion among men – ratio of deferrals is 1.5 times higher than among women – and among the youngest people, especially those under 1 year of age.

It is important to highlight the change in the pattern observed in children under 1 year: the de-

ferral ratio increased 1.5 times in 2014 compared to 2010. While the possibility of this significant increase is due to modifications in the second version of the form, which increased the odds of deferrals, these findings indicate the need for further study, especially considering possible sequelae due to the Zika virus³, before the change of the microcephaly pattern in Brazil was characterized by the Ministry of Health, which occurred from 2015³².

The analysis of the profile of BPC applicant, considering ICF components, contributes to unraveling how the broader social and cultural dynamics, in connection with individual aspects, define a situation of vulnerability in the field of health, in an approach that seeks to overcome risk-anchored practices and capture interference between the multiple realms involved in the health-disease process³³. In addition, it reveals difficulties faced by both those whose benefit has been deferred and those with rejected ones, and it is fundamental, in the case of the latter, to guide policies directed at a segment not covered by the BPC.

The main defining factors of deferral are the limited and restricted activities and participation and bodily functions changes. Among those deferred, severe or total classifications prevail, and in the case of dismissals, limitations and restrictions are of lower intensity and bodily changes are light or moderate. Ninety to one hundred percent of applicants with serious or total impairments had their benefit granted. In 2014, the deferral ratio decreased for those with more severe limitations and restrictions. On the other hand, the deferral ratio increased for individuals with greater bodily functions changes.

A large proportion of evaluated people faces significant environmental barriers. While there are differences in the profile of the deferred and rejected, this is the component in which discrepancies are smaller: if moderate barriers are taken into account, almost all applicants experienced moderate or severe environmental barriers in the two years of the series – about 99% of those deferred and 96 to 97% of those rejected.

According to the ICF, environmental factors are external to individuals and have a positive or negative influence on other components: on performance as member of society (Participation), on the ability to perform actions or tasks (Activities) or on the function or body structure. Environmental barriers are characterized by difficulties in accessing products and technologies, untailored environments, lack of support net-

Table 2. Proportionate distribution of the requirements of the Continued Cash Benefit Programme of Welfare (BPC), by age range, status and deferral ratio - Brazil, 2010 and 2014.

	2010					2014				
	Deferrals		Rejections		Deferrals ratio (1)	Deferrals		Rejections		Deferrals ratio (1)
	N	%	N	%		N	%	N	%	
Age group										
Less than 1 year	6,102	3.0	2,083	1.0	293	7,928	4.2	1,752	0.9	453
from 1 to 6 years	25,871	12.6	12,674	6.2	204	28,240	15.0	11,503	6.0	246
from 7 to 14 years	23,609	11.5	18,342	9.0	129	22,625	12.0	18,849	9.8	120
from 15 to 19 years	11,802	5.8	8,992	4.4	131	10,931	5.8	9,879	5.2	111
from 20 to 49 years	84,656	41.3	92,814	45.4	91	67,704	36.0	81,410	42.5	83
from 50 to 59 years	36,371	17.7	47,688	23.3	76	34,638	18.4	46,083	24.0	75
from 60 to 64 years	16,598	8.1	21,799	10.7	76	15,999	8.5	22,131	11.5	72
from 65 to 69 years	3	0.0	3	0.0	100	0	0.0	0	0.0	---
Ignored						182	0.1	89	0.0	
Gender										
Male	---	---	---	---	---	102,596	54.5	84,962	44.3	121
Female	---	---	---	---	---	85,461	45.4	106,651	55.6	80
Ignored	---	---	---	---	---	190	0.1	83	0.0	218
ICF components										
Environmental barriers										
None	62	0.0	425	0.2	15	115	0.1	360	0.2	32
Light	1,967	1.0	7,855	3.8	25	1,774	0.9	5,332	2.8	33
Moderate	39,913	19.5	88,857	43.5	45	33,139	17.6	75,308	39.3	44
Severe	161,208	78.6	106,326	52.0	152	152,577	81.1	110,331	57.6	138
Total	1,862	0.9	932	0.5	200	642	0.3	365	0.2	176
Limitations and restrictions in activities and participation										
None	0	0.0	3,510	1.7	0	0	0.0	918	0.5	0
Light	0	0.0	110,952	54.3	0	0	0.0	81,669	42.6	0
Moderate	101,777	49.6	87,699	42.9	116	90,985	48.3	105,054	54.8	87
Severe	99,988	48.8	2,234	1.1	4,476	92,139	48.9	3,511	1.8	2,624
Total	3,247	1.6	0	0.0		5,123	2.7	544	0.3	942
Body functions changes										
None	0	0.0	38,682	18.9	0	0	0.0	27,512	14.4	0
Light	0	0.0	108,008	52.8	0	0	0.0	113,842	59.4	0
Moderate	61,988	30.2	47,143	23.1	131	65,004	34.5	43,661	22.8	149
Severe	101,786	49.6	8,264	4.0	1,232	72,378	38.4	4,945	2.6	1,464
Total	41,238	20.1	2,298	1.1	1,795	50,865	27.0	1,736	0.9	2,930
Total	205,012	100.0	204,395	100.0	100	188,247	100.0	191,696	100.0	98

(1) Deferral ratio for every 100 Rejections. Calculated through the relation: number of deferred / number of rejected x 100.

Source: Elaborated within the scope of the "Improvement of the Public Policy for People with Reduced Functionality - People with Disabilities and the Elderly" research project (LIS / ICICT / FIOCRUZ, FMP-FASE / FOG). Database provided by the Department of Welfare Benefits of the Ministry of Social Development (DBA/SNAS/MDS).

works and relationships, attitudinal barriers and difficulties in accessing services and policies. The more important the barriers, the greater the dependency and vulnerability, pushed to the limit by poverty.

The association between poverty, disability and social exclusion is recognized in international literature³⁴. In Brazil, the National Health Survey, whose data were collected in 2013, provides some important clues about the vulnerability to

which people with chronic diseases or disabilities are subjected, in the traditional conception of the term. The prevalence of higher intensity limitations of regular activities is higher among the poorer, elder, less educated and women³⁵. As Cavalcante and Goldson³⁶ emphasize, people with disabilities are the poorest of the poor and will remain at risk of worsening poverty and subject to worse impairments unless they are the subject of public protection and social inclusion policies. Thus, it is fundamental to mobilize governmental and non-governmental agencies, activist groups and empowered and organized families and disabled people.

Final considerations

The implementation of the biopsychosocial model for the assessment of disability was a step forward from the biological concept in force until 2009. Its adoption did not inflate the BPC grants coefficient, as the trend analysis showed. Conversely, from the viewpoint of social protection, the reduced pace of grants after its adoption, more exacerbated when considering only non-judicial grants, evidences, as argued, the need to relax the dependency and vulnerability

assessment criteria, especially those directed to those who earn more than $\frac{1}{4}$ of minimum wage, under penalty of the policy reinforcing inequities instead of minimizing them.

The profile of applicants highlighted the vulnerability they are subjected to, especially considering the large proportion of those facing the most severe environmental barriers, underscoring, as discussed, the need to establish public policies aimed at segments not served by the BPC.

Consistent with the design of the model implemented in 2009, the highest deferral ratio was found among those who experienced environmental barriers, limitations, restrictions and severe or complete bodily changes. All those who were considered with limitations and restrictions and non-existent or minor bodily changes had their benefit denied.

The lack of population data on the target segment of the policy is a study constraint. During the validity of the new model, changes in the pattern of deferral among applicants with severe or total limitations and restrictions, with severe or total bodily changes and among those under one year of age, as well as the highest deferral ratio observed in males are aspects to be further analyzed in specific studies.

Collaborations

CMR Duarte participated in all stages; MA Marcelino participated in the design, analysis and interpretation of the data, critical review and approval of the version to be published; CS Boccolini and PMM Boccolini participated in the design, methodology and approval of the version to be published.

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