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Street-level Bureaucracy and Social Policy in Brazil

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Nilson do Rosário Costa [1]

Abstract *This paper describes the Brazilian central government bureaucracy and people with disabilities' access to the Continuous Cash Benefit (BPC). This access depends on the Ministry of Social Security bureaucracy's evaluation of the condition of vulnerability. We performed a literature review, analysis of secondary data from time series and cross-sectional data to describe street-level federal bureaucracy. Legal documents and indicators describe the expert evaluation regimen of the Ministry of Social Security (MPS). This paper shows the uneven growth of the number of career public servants of the central government in the last two decades. The Brazilian central government has adopted the international concept of person with disabilities in the evaluation of BPC applicants. Despite this decision, it is shown that the Brazilian central government expanded selectively the career bureaucracy to work in the social area. It was found that the result of the evaluation process was quite strict, favoring applicants in conditions of extreme biomedical vulnerability. Despite adopting the social model, BPC eligibility is tied to medical diagnosis.*

Key words *Social policy, People with disabilities, Street-level-bureaucracy, Medical diagnosis, Access*

[1] Departamento de Ciências Sociais, Escola Nacional de Saúde Pública, Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041- 210 Rio de Janeiro RJ Brasil. nilsondorosario@terra.com.br

Introduction

This paper analyzes the decision-making model to assess the eligibility of persons with disabilities to the Continuous Cash Benefit (BPC). BPC was formalized in the Federal Constitution of 1988 (FC-88) and regulated by the Social Welfare Organic Law (LOAS) in December 1993. Access to BPC is tied to the evaluation of street-level bureaucracy. If disabled persons are assessed in a situation of vulnerability, a continuous government income is provided to them to cater for basic needs. This work analyzes the effects of the guidelines of the International Convention on the Rights of Persons with Disabilities, ratified by Federal Decree Nº 6.949 dated August 25, 2009, within Brazilian social protection[1].

As highlighted by Silva & Diniz, the Convention adopted a comprehensive conceptualization for the disabled person that influenced the decisions of the Brazilian government. Thus, Brazilian legislation defines that persons with disabilities have long-term physical, mental, intellectual or sensorial impediments that may obstruct their total and effective participation in society in equal conditions with other people[2].

This expanded conceptualization favored the deconstruction of the narrative of the decrees and regulations that defined disability at the individual level as a bodily phenomenon associated with the lack of functional parts or limitations[3]. According to Silva & Diniz, after formal ratification at the governmental level, there was a need to fit what is known as the "expert and social regime for the assessment of disability" to the supra-national principles of the Convention ratified by Brazil[2]. Authors said that the new BPC granting regulations set forth in the LOAS incorporate the broad set of principles for the protection of persons with disabilities contained in the Convention, but return the discursive authority on the disabled body to the biomedical field[2].

Worth noting in this paper is that the discursive authority in the evaluation of disabled persons is exercised by specialized bureaucracies firmly established in the state apparatus. BPC access mechanisms are thus not constrained by the widespread practice of patronage, typical of clientelist exchanges identified in other areas, but suffer the consequences of the application of standardized routines of technical assessment of the vulnerability of individuals who declare or are declared by a third party as persons with a disability. Thus, this self-assessment of applicants' disability status is subject to judgment by a specialized career bureaucracy of the Executive power. The effects of the international guidelines on the BPC implantation and development standard are not so obvious and linear as most domestic studies tend to reiterate in a surprisingly uncritical way.

Cavalcante & Lotta have correctly pointed out the lack of empirical studies on the professional bureaucracies that holding positions within the Brazilian federal government. Authors argue that the intervention of the professional street-level bureaucracy in the administration and regulation of allocative decisions of social policies is one of the areas of extreme relevance of the national governmental action that needs to be studied[4]. In the book *Bureaucracy and Health Policy Implementation*[5] (English free translation from the Portuguese title), Lotta provides a specific contribution to the field of collective health by analyzing the processes of final delivery of policies through a street-level sectoral bureaucracy, focusing on the Family Health Strategy. Following this perspective, this papers aims to situate the organizational mechanisms that influence the implementation of public policies within the scope of Brazilian social security, which includes health, as a special attention to the intervention of the medical professional bureaucracy.

The intellectual production of the Brazilian professional street-level bureaucracy can be classified into three main currents: the first results from the explanation of the role of the bureaucratic apparatus of developmentalist bias in authoritarianism (1964-1985)[6,7]; the second is the result of the reflection on the agenda of the unfinished administrative reform of the first years of democratic government (1995-2002)[8,9] and the third is dedicated to the description of the recent growth of the federal government bureaucracy influenced by the service delivery requirements of the social and budgetary and fiscal coordination areas (1995-2016)[10-13].

In convergence with the third article, it is interesting to argue in this article that the constitutionalization of social rights can be strongly associated with the expanded state apparatus, strengthening what Pereira has called the "universalist and meritocratic" feature of the high federal bureaucracy in recent years[14]. The constitutionalization included the insertion the idea of social citizenship in the FC-88, with important effects on access to benefits and services in the areas of education, social welfare, health and social security. The eligibility of the disabled person to BPC has thus been directly influenced by the

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combination of the process of bureaucratic modernization vis-à-vis expanded social citizenship.

The BPC was formulated and implemented as a public policy highly focused on the elderly population and people with disabilities in extreme poverty, integrating Basic Social Protection within the scope of the Unified Social Welfare System (SUAS)[1]. Currently, people who are 65 years of age or older and people with disabilities who are unable to cater for their own livelihood or whose families cannot afford to do it for them are eligible for a minimum wage.

The condition of inability to provide survival conditions is measured by the bureaucracy of the Ministry of Social Security through the quantification of social risks by the National Institute of Social Security (INSS). A crucial variable in eligibility is the applicant's family situation. The family is incapable of providing subsistence when the household per capita income is less than ¼ of the minimum wage.

The family group includes those who live under the same roof – the applicant, the spouse, the companion, the non-emancipated child, in any condition, under the age of 21 or disabled, the parents, and the non-emancipated brother, in any condition, under 21 or disabled. The household income is calculated by considering the sum of gross income earned monthly by the members and composed of wages, salaries, pensions, private pension benefits, commissions, per-job compensation, other income from self-employment, income from the informal or autonomous market and income earned from equity[1].

Bureaucracy and Medical Diagnosis

Within the scope of the Brazilian central government, the evaluation of the eligibility condition of the person with disability is the responsibility of individuals of professions recognized by law and holding monopolies of competence. It is worth highlighting the role of the paradigmatic profession of physicians, which holds the monopoly of competence to diagnose the condition of functional vulnerability of BPC applicants. The intervention of the medical profession is a central reference in the functioning of the expert and social system to evaluate disabled persons. Doctors compose a state career with high decision-making autonomy with the technical scope in the operational structure of the MPS/INSS.

The influence of professional bureaucracy on government decision-making is widely recognized in the field of social sciences, while little studied in collective health. Lipsky was one of the first to identify that value, opinion, preference of professions influence the development of public policies. Professionals working in government organizations are categorized by the author as street-level bureaucracy. This state bureaucracy has discretionary power in the exercise of authority[15]. Discretionary power stems from the relative autonomy that they have when policies are implemented. They are the ones that decode the rules that affect the users or demanding parties. As Lipsky points out, the discretion exercised by bureaucrats is also the result of the interaction between their values, the values of other stakeholders involved, procedures, incentives, structures and prohibitions at the organizational level[15].

The analysis of the position of the public bureaucracy is thus justified by the impact it has on the life of the average citizen in determining eligibility for social benefits, mediating the institutional relationship with the State apparatus. This may be a radically new realm in understanding the place of Brazilian street-level bureaucracy. We are before street-level bureaucracy linked to the social protection structure consolidated in the last decades in the country[16] and that interacts directly with the citizen.

Most of the times, Brazilian public service users cannot choose the services to which they are linked. They must accept the schools, health or social services of their municipality or region. If they are poor, as Keizer[17] points out in another context, they must accept government arrangements for health care, income transfers, housing programs, or other social programs.

It is important to note that the criteria for evaluating BPC applicants were explicitly subject to biomedical guidance in Brazil until the end of the 1990s. In that period, disability assessment was the sole responsibility of INSS Medical Experts. Persons with disabilities' access to the BPC required, essentially, complying with the per capita household income criteria and the characterization of disability in purely biomedical terms, as inability to work and have an independent life.

The evaluation performed by INSS medical experts verified the ability to work, the level of visual, hearing, motor and speech difficulties; the level of difficulty to perform daily life activities, such as personal hygiene, food and clothing; the evacuation control level; the dependence of permanent care of health professionals or others, and diagnosed schizophrenia[18].

In 2009, Joint Ordinance MDS/INSS No. 1, through international commitments, established

new procedures for social and medical evaluation of people with disabilities applying for BPC[1]. The evaluation started to be performed by the two professional communities – INSS Social Workers and Medical Experts – with functional attributions of evaluating social and environmental barriers, bodily functions change, limited activities and restricted social participation[1].

Article 2 of Joint Ordinance MDS/INSS N° 1/2009 detailed the division of labor of social workers and medical experts and formal procedures for the assessment of the disabled and the "level of incapacity". The social evaluation proposes to qualify: 1) the so-called "environmental factors" through "realms": products, living conditions and environmental changes; support and relationships; attitudes; services, systems and policies; 2) activities and social participation for those over and under 16 years of age through analysis of the "realms" interpersonal relationship and interaction and community, social and civic life. The evaluation of the social service is carried out through a face-to-face interview with the applicant at the headquarters of an MPS agency.

The medical evaluation checks the bodily functions via anamnesis, considering the following "realms": mental, vision, hearing, voice and speech sensory functions, skin, genitourinary, neuromusculoskeletal and movement-related functions and the cardiovascular, hematological, immunological, respiratory, digestive, metabolic and endocrine systems.

The evaluation of the medical expert should also qualify the activity and participation through the "realms" of learning and application of knowledge, tasks, communication, mobility and personal care. In any case, it should be noted that the diagnosis of changes in bodily functions is exclusively assigned by medical experts and prevails over the social evaluation of social workers. Intensity of functional limitations and constraints is defined in five (5) levels: none, mild, moderate, severe, and total.

The new international guidelines supported by the World Health Organization (WHO) have forced national states to broaden their understanding of disability mainly through the dissemination of the International Classification of Functioning, Disability and Health (ICF)[19]. In ICF, human functionality problems are categorized into three areas: changes in bodily structures and functions; limitations to perform activities such as walking or eating, and restricted participation in multiple aspects of life, such as discrimination in employment or transportation. However, WHO recognizes the autonomy of national states to set limits on the severity of disability, limitations to perform activities or restricted participation[20].

In the Brazilian experience, due to the adoption of an extremely low household income limit and the biomedical risk categories, the MPS/INNS decision-making process was not immune to the challenge – although ICF guidelines were the normative reference. It is worth mentioning the influential revisionist intervention of the BPC eligibility decisions exercised in recent years by the Judiciary[1]. The establishment of the limit of a basic income by the BPC has also been subject of debate in the specialized literature. Silva & Diniz reiterate that the reduced social minimum needs pose a threat to universal social welfare in Brazil[2].

It is especially important to highlight the crucial role played by medical diagnosis based on the conception of specific diseases that exist regardless of the individual[21]. As Rose points out, medicine is associated with the scheme of values where individuals are described in terms of health and disease and patterns of normality and pathology. The truth of the diagnosis is not based on "subjective narrative" or the description of "symptoms" – considered as sources of error. The exercise of diagnosis consolidates a system of expert knowledge and increases the power of the medical sphere[22]. This power is increased when such diagnoses condition access to social rights[23]. Therefore, this paper considers that a complete shift from the expert medical scheme to the social ICF-based model is not identifiable in the organizational process of evaluation of BPC applicants, but rather a conflict between normative principles on the conceptualization of persons with disabilities.

Methodology

This paper describes the scope, position and functions of public bureaucracy in mediating access to social policy for the disabled under the management of the Brazilian central government. It aims to contribute to the reflection on the condition of access to the BPC of persons with disability and the role of professional bureaucracy. Different secondary sources of information were used to answer the proposed objectives. Public administrative data from the Ministry of Planning and Budget (MPOG) – from 1997 to 2016 –

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were used to demonstrate the trend and scope of bureaucracy of the Brazilian central government. The main descriptive variables of the historical series are: 1) Number of active central government servants; 2) Number of active MPS, Ministry of Health, Ministry of Education and Ministry of Budget and Management servants. The relative participation of INSS medical experts in this structure is shown with data from the 2006 and 2015 Statistical Yearbook of Social Security.

The Statistical Bulletin of Social Security was used to describe the number of beneficiaries of the General Social Security Regime and BPC beneficiaries. This information is shown according to the different national governments and the different areas of administration of public policies of the period: government Fernando Henrique Cardoso (FHC) (1997-2002); Luís Inácio Lula da Silva (2003-2010) and Dilma Rousseff (2011-2016). Following Souza's analysis[24], for descriptive purposes, we consider that different coalitions of government and different public policies faced the task of modernizing the State-society relationship and State-State in Brazil in the last decades.

This paper uses the log-linear model described by the equation $ln\ Y_t = \beta_1 + \beta_2 t + \mu_t$ to analyze the mean variation of the overall number of bureaucracy in central government and of selected ministries. The log-linear model is like any other linear regression, in which parameters β_1 and β_2 are linear. The difference here is that the regressand is the logarithm of Y and the independent variable is time, represented by "t", which will assume values of 1,2,3, +...+ n, [...]", corresponding to the analyzed period[25].

The source used in the analysis of the MPS medical professional bureaucracy decision-making pattern is the balance of deferrals and denials according to the intensity of medical diagnosis on the bodily functions limitations and restrictions of the Continuous Cash Benefit Assessment System for Persons with Disabilities (SIAVBPC). These data were produced in the Research Project "Improvement of Public Policy for Persons with Disabilities and Elderly Persons", a partnership between the Oswaldo Cruz Foundation and the Petrópolis Medical School, based on a collaboration agreement with the Ministry of Social Development and Fight against Hunger – 2015-2017.

Results

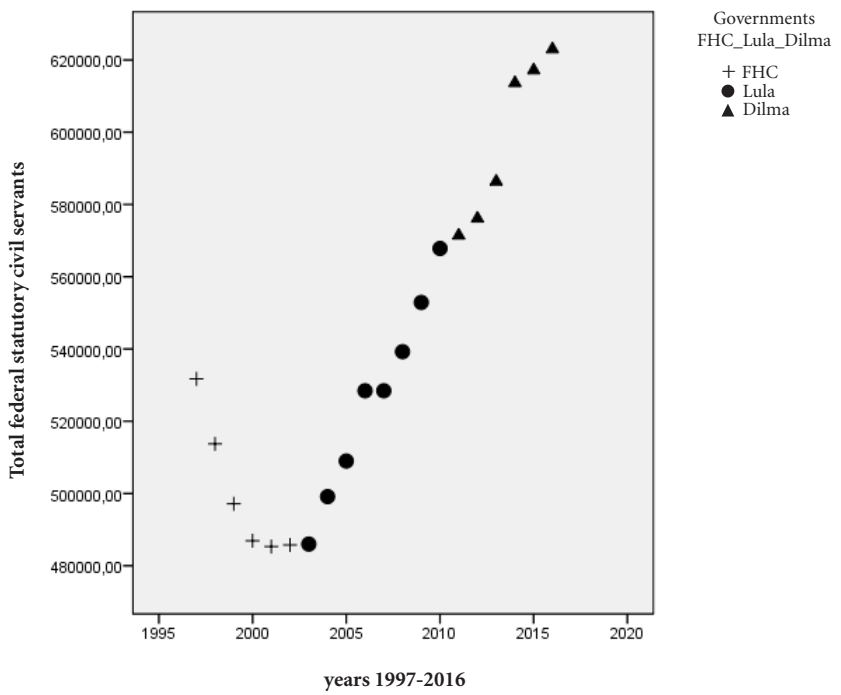
The recent expanded federal bureaucracy was well described in the works of Cavalcante & Carvalho[11], Nunberg & Pacheco[13] and Souza[24]. Graphic 1 allows us to identify two distinct moments of this trend in the last decades: the first, of decline (1997-2002) during the FHC government, and the second, of reversion or rearrangement of the active staff in subsequent governments (2003-16). The decentralization processes in the health area, the acceleration of pensions and reduced frequency of public tenders, besides the privatizations of federal companies influenced the expressive decrease of the federal bureaucracy of the first moment; in the second period, the federal government began to significantly expand the number of public tenders, which elevated the annual number of new servants[11,24].

Table 1 also shows that the mean annual variation in the number of public servants was quite uneven among the different areas of activity of the central government (Table 1). For comparison purposes, Table 1 shows the trend of the statutory bureaucracy of the Ministries of Social Security, Health, Education and Planning and Budget, and the federal government as a whole.

Surprising in Table 1 is the increased number of servants of the Ministry of Education, driven by the massive entry of teachers and technicians in federal universities, as also observed by Nunberg & Pacheco[13] and Souza[24]. The area of education grew on average at a rate of 3% in the period, with great expansion of the last 5 years of the historical series. The same growth can be observed in relation to MPOG, which had similar average expansion of 2.1% per year in the period 1997-2016, with a significant hike in the 2015-2016 biennium. Health and social security sectors were the most affected by the reduced number of servant over 20 years, with an annual average fall of 0.66 and 0.72 in the period, respectively.

Graphic 2 further shows the variation in the number of MPS servants in the federal bureaucracy structure in the period 1997-2016. Graphic 2 evidences that the decline in the MPS statutory workforce has become more pronounced since 2006.

The decline of MPS statutory staff was followed in the period by the significant increase in the number of benefits issued by the General Social Security System and the BPC from 2006, as shown in Graphic 3. We can observe that the number of benefits granted-servants ratio increased substantially from 481 to 915 per servant



Graphic 1. Variation of the statutory workforce of the Brazilian federal government - 1997-2016.

Source: Brasil. Ministério do Planejamento, Desenvolvimento e Gestão. Estatística de Pessoal e Informações Organizacionais. Brasília. Outubro, 2016.

Table 1. Annual mean variation of the number of statutory civil servants in the central government and selected ministries - 1997-2016.

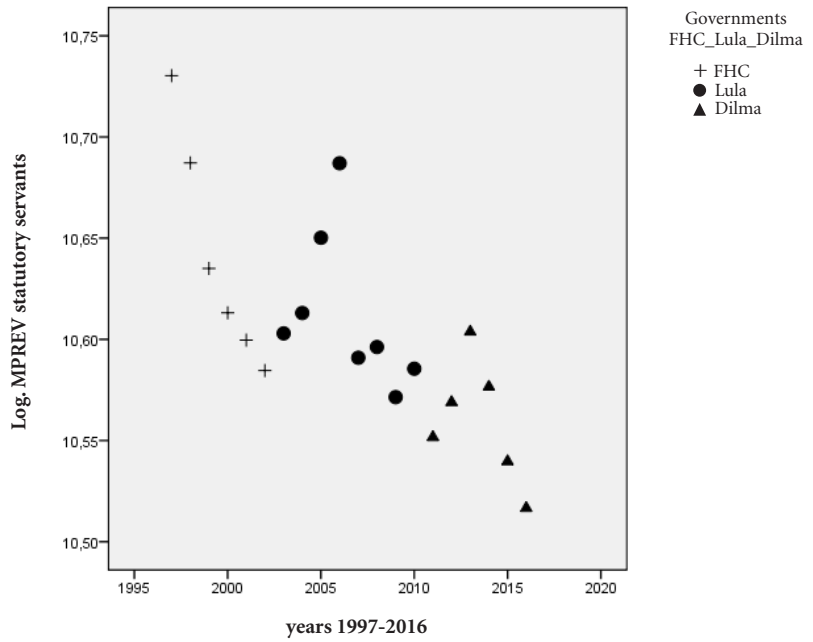
Central Government and Ministries	Annual Mean Variation
Brazilian Central Government	1.3
Ministry of Education	3.0
Ministry of Health	(0.72)
Ministry of Planning, Development and Management	2.1
Ministry of Social Security	(0.66)

Source: Brasil. Ministério do Planejamento, Desenvolvimento e Gestão. Estatística de Pessoal e Informações Organizacionais. Brasília. Outubro, 2016.

between 2000 and 2016. This robust elevation indicates that the dissemination of managerial routines aimed at increasing workforce's productivity was certainly intense in the MPS/INSS structure.

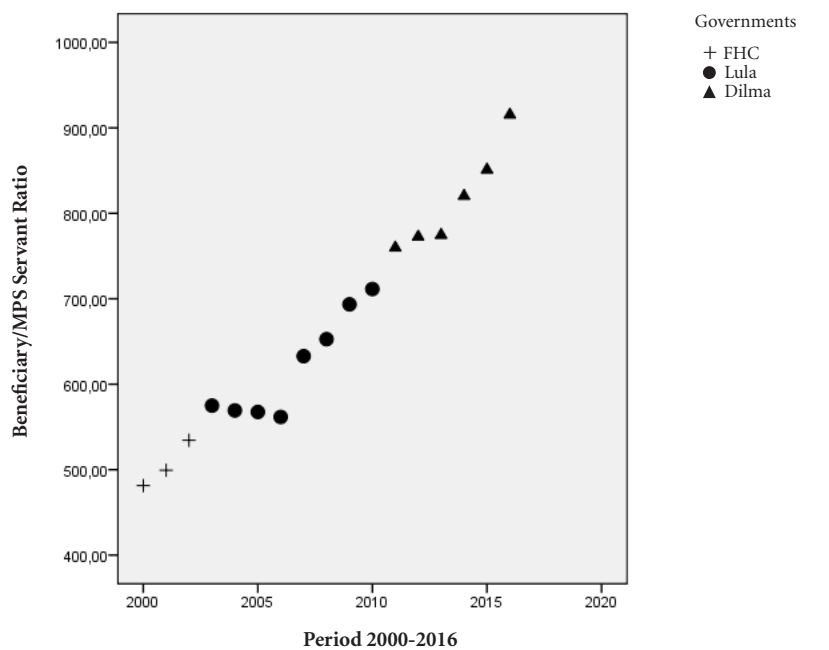
In the general context of reducing MPS/ INSS staff and growing productivity, it is also worth noting the insignificant decline of the proportional participation of medical experts in the INSS statutory human resources structure between 2006 and 2015, as shown in Table 2. The reduced number of medical experts by a mere 3.3% in the period reveals that the supposed shift of the evaluation model centered on medical expertise has marginally affected the position of the profession in the MPS/INSS structure.

The authority suffered a flattening of 12.6% in the statutory staff in the 2006-2015 period, following the framework observed for the MPS between the two decades. Table 2 also shows a monumental reduced participation of social welfare in the composition of the INSS professional bureaucracy, at 25% of the workforce between 2006 and 2015. This reveals an unexpected contradiction between the adoption of the guideline for expanding the evaluation criteria and decreasing, in absolute terms, the share of the street-level bureaucracy with a greater propensity to accept the normative guidelines of the expanded evaluation inspired by the ICF.



Graphic 2. Variation of the number of statutory servants of the ministry of social security (MPrev) – Brazil – 1997-2016.

Source: Brasil. Ministério do Planejamento, Desenvolvimento e Gestão. Estatística de Pessoal e Informações Organizacionais. Brasília. Outubro, 2016.



Graphic 3. Beneficiary/MPS statutory servant ratio.

Source: Brasil. Ministério do Planejamento, Desenvolvimento e Gestão. Estatística de Pessoal e Informações Organizacionais. Brasília. Outubro, 2016.

Given this setting, the analysis of the results of medical expertise performance in 2010 reveals a severe final decision-making process – only 50.5% of the 414,000 BPC application were approved. In the same year, the approval rate of disability allowance applications to the General Social Security Scheme (RGPS) was 61%[26]. If the same standard of decision-making for the diagnosis of medical experts for the RGPS applicant were observed for the disabled persons demand to the federal government, 39,000 BPC applicants would be included in the public policy in 2010.

Table 3 also shows the remarkable preference for deferral of applicants when diagnosed on the scale of changes in bodily functions in the condition of extreme disability (severe (98%) or total (100%)). There are clear indications of medical diagnostic prevalence in the eligibility decision, despite the introduction of the social assessment model in 2009. Thus, Table 3 also demonstrates that all the requirements of persons assessed as having no change or slight alteration in bodily functions were denied. It is quite plausible that a non-irrelevant portion of the applicants diagnosed in biomedical terms as having no alteration or slight alteration in bodily functions has been evaluated by the social service in the situation of severe or total vulnerability according to the "environmental factors" and was consequently rejected.

Table 4 shows the medical diagnosis of a sample of 772,641 active BPC beneficiaries in December 2015, according to the International Statistical Classification of Diseases and Related Health Problems (ICD). This year, the total number of BPC beneficiaries as persons with a disabilities totaled 2,323,797 individuals[27].

In Table 4, particular attention is drawn to the fact that 43% of sample beneficiaries were diagnosed with "mental retardation" according to the ICD (ICD F70-F79). The medical diagnostic category "mental retardation" is similar to what, for example, in the 2013 National Health Survey (PNS) is categorized as "intellectual disability". It is worth noting that, in the PNS, the estimated prevalence of "intellectual disability" is only 0.8% in the Brazilian population, without regional variation[28].

According to Table 4, the neuropsychiatric diagnosis, when grouped, accounts for 86.9% of the sample of 772,641 active BPC beneficiaries of people with disabilities in 2015. This paradoxical result allows us to enquire about the scope of the repertoire of diagnoses of INSS medical experts within the BPC. In what way does this restricted repertoire differ from the perception of common

Table 2. Variation in the number of medical experts and social workers in the INSS organizational structure – 2006-2015.

Descritors	2006	2015	Variation
Total Statutory Servants	43,623	38,130	(12.6)
Medical Experts	4,866	4,704	(3.3)
Social Workers	563	420	(25.4)

Source: Brasil. Ministério da Previdência Social Anuário Estatístico da Previdência Social – 2008 e 2015.

Table 3. Results of the evaluation of the applicants by the INSS medical experts according to the bodily functions change criteria – Brazil – 2010.

Bodily Functions Change	Applicants (A)	Granted (B)	Grant Ratio (B/A*100)
None	39,214	0	0.0
Mild	108,538	0	0.0
Moderate	110,081	63,002	57.2
Severe	111,597	103,258	92.5
Total	44,720	42,369	94.7
Total	414,150	208,629	50.4

Source: Research Project "Enhancement of the Public Policy for People with Reduced Functioning - People with Disabilities and the Elderly" – 2017.

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Table 4. Active Beneficiaries for the Person with Disabilities according to the International Statistical Classification of Diseases and Related Health Problems ICD 10 – Brazil – December – 2015.

ICD	Total	%	% accumulated
F70, F71, F72, F73, F79 Mental Retardation	350,412	44.7	-
F20, F29 Schizophrenia and Unspecified nonorganic psychosis	131,096	18.4	63.1
G80 Cerebral Palsy	82,619	10.7	73.8
Q90 Down's Syndrome	43,980	5.7	79.5
I64, I69 Cerebrovascular Diseases	39,488	5.0	84.5
G40 Epilepsy and Recurrent Seizures	25,796	2.4	86.9
H90.3, H91.3 Sensorineural hearing loss, bilateral / Deaf mutism, not elsewhere classified	37,961	5.0	91.9
H54 Blindness and low vision	28,526	4.1	96.0
B91 Sequelae of poliomyelitis	14,178	2.0	98
B24 Unspecified human immunodeficiency virus [HIV] disease	18,585	2.0	100
Total	772,641	100	-

Source: Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Boletim - BPC 2015. Benefício de Prestação Continuada. Brasília: Secretaria Nacional de Assistência Social, 2015, p. 20-21.

sense regarding persons with disabilities? Does overrepresentation of the neuropsychiatric diagnosis mean that the other diagnostic categories listed or missing in Table 4 are being routinely rejected?

Discussion

This paper shows that the Brazilian central government has a specialized bureaucracy that acts with high autonomy in the decisions of eligibility to social benefits. This bureaucracy makes BPC eligibility decisions via evaluation procedures influenced by professional values. While this decision-making process distances itself from the patrimonial practices attributed to Brazilian social welfare as a whole[29], it is necessary to reflect on whether the preferences of this bureaucracy fit the objectives of the public policy.

This paper shows that the introduction of the new BPC social evaluation model at the end of the last decade occurred in a context of effective decline in the relative participation of the workforce with stability in the bureaucratic careers of Brazilian social security. The systematic decreased number of social welfare professionals was an unexpected result of the reduced statutory workforce of MPS/INSS in the last two decades. This paper also shows that the reduced share of medical experts was negligible in the period. Given this evidence, the thesis of a detachment of the decision-making role of the biomedical field in the evaluation of BPC applicants in the scope of MPS/INSS can hardly be sustained.

The critical point of the Brazilian experience can be attributed to the ongoing normative conflict between the biomedical model and the social model in the BPC eligibility process. This paper demonstrates that, despite mediation of the social model through the influence of international guidelines and domestic legislation, BPC eligibility is subjected to clinical diagnosis, which favors limitations defined in biomedical terms by a specialized bureaucracy.

There is no doubt that the country needs to broaden the reflection on the condition of access of disabled persons to the BPC and the reliability of the diagnosis-based final decision. This process will facilitate the access of more vulnerable individuals to established rights and, in the face of refusal, such individuals could have more elements for legitimate political action and even judicial demand.

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