GIGAPP Estudios Working Papers
ISSN 2174-9515. Año (2020), Vol. 7 Núm.184, págs. 533-554

The Brazilian Government's Inaction Policy in the face of the COVID-19 pandemic: Federative uncoordination, insufficient financial resources and political crisis

Teixeira, Marco Antonio Carvalho
Fundação Getulio Vargas (FGV), Brasil
marco.teixeira@fgv.br
ORCID ID: 0000-0003-3298-8183

Fernandes, Antonio Sérgio Aráujo
Universidade Federal da Bahia (UFBA), Brasil
antoniosaf@ufba.br
ORCID ID 0000-0002-4171-7759

Zuccolotto, Robson
Universidade Federal do Espírito Santo (UFES), Brasil
robsonzuccolotto@gmail.com
ORCID ID: 0000-0002-2629-5586

do Nascimento, Alex Bruno Ferreira Marques
Universidade Federal Campina Grande *(UFCG), Brasil*
alex.bruno@ufcg.edu.br.
ORCID ID 0000-0001-9860-7350

Documento recibido: 04 agosto enero 2020
Aprobado para publicación: 01 octubre 2020

Resumo

O objetivo deste artigo é mostrar a política pública como inação no combate ao COVID-19 no Brasil, tornando o país o segundo em número de casos e o segundo em número de mortes no mundo. Essa situação se deve a uma escolha política do Governo Federal que marcou o processo decisório de políticas públicas de combate ao COVID-19. O problema está situado no governo federal e essa afirmação é apoiada pela hipótese conceitual de política pública por inação que será demonstrada pela narrativa analítica ao longo do texto.

Palavras-chave

Política Pública por Inação; Descoordenação Federativa; Recursos Financeiros Insuficientes; Crise Política

Resumen

El objetivo de este artículo es mostrar la inacción en las políticas públicas para combatir COVID-19 en Brasil, convirtiendo al país en el segundo en número de casos y en segundo en número de muertes en el mundo. Esta situación se debe a una elección política del Gobierno Federal que marcó el proceso de toma de decisiones de las políticas públicas para combatir COVID-19. El problema está situado en el Gobierno Federal, y esta afirmación está respaldada por la hipótesis conceptual de la inacción de la política que se demostrará mediante la narrativa analítica a lo largo del texto.

Palabras clave

Políticas públicas por inacción; Descoordinación federativa; Recursos financieros insuficientes; Crisis política.

Abstract

This article aims to show the inaction in public policy to combat COVID-19 in Brazil, making the country the second in the number of cases and second in the number of deaths in the world. This situation is due to a political choice from Federal Government that marked the decision-making process of public policies to combat COVID-19. The problem is situated in Federal Governament, and this statement is supported by the conceptual hypothesis of Inaction Policy that will be demonstrated by the analytical narrative throughout the text.

Keywords

Inaction Policy; Federative Uncoordination; Insufficient Financial Resources; Political Crisis.

Introduction

This article aims to show the inaction in public policy to combat COVID-19 in Brazil, making the country the second in the number of cases and second in the number of deaths in the world. This situation is due to a political choice from Federal Government that marked the decision-making process of public policies to combat COVID-19. The problem is situated in Federal Governament, and this statement is supported by the conceptual hypothesis of Inaction Policy that will be demonstrated by the analytical narrative throughout the text.

At the time, all nations are almost exclusively concerned and dedicating all their public management efforts to combat COVID-19. This implies re-adapting all public policy structures and leading the political dispute to a level of cohesion previously only observed in times of war. Indeed, this pandemic puts the world in a viral, biological war, and the only weapon in this combat is cohesive political and social action.

The factors that mark the crisis in the fight against COVID-19 in the Brazilian case will be demonstrated here from the inaction of the Federal Government, basically on three critical points: federative uncoordination and insufficient resources to expand the health system; insufficient public expenditure to assist people and micro, small and medium businesses; and a political crisis on the part of the President with the other powers, due to his personal disagreement on how the public policy of COVID-19 should be conducted.

Based on these factors, the study uses the concept of *inaction policy*, which considers the social effects of the state's decision of not acting – for this reason Dye (2012, p.12) defines that public policies are "[...] whatever governments choose to do or not to do." In a crisis scenario, such as the current pandemic, the effects of an "emergency non-action" can directly or indirectly affect the spread of the disease. Thus, according to McConnel and Hart (2019), Inaction Policy in the face of evident needs may be considered a sign of governmental negligence, irresponsibility, or inaptitude.

The analysis adopts the narrative policy framework. According to Jones & Mcbeth (2010), narratives are forms of cognitive organization of facts; they form stories based on chains of events. Therefore, political facts connected by logical criteria form policy narratives, which, according to Roe (1994, p. 2), "underwrite and stabilize the assumptions for decision making in the face of high uncertainty, complexity, and polarization." This study, therefore, is a narrative based on documentary research. The political facts narrated were selected according to their adherence to the hypotheses of Inaction Policy.

This article is divided into five sections, starting by discussing the concept of Inaction Policy and presenting the hypotheses about its application in the case of the Brazilian federal government's response to the COVID-19 pandemic. The second discusses the lack of federal coordination between the federal government and the governments of states and municipalities regarding the management of the national health system (SUS). The third part of the article explores SUS, demonstrating the challenges of the system, such as the pre-pandemic problem of budget cuts imposed by the strong fiscal adjustment the country has gone through in recent years. The fourth section addresses the insufficient economic aid for the unemployed population and those with informal jobs, as well as the financial support for small and medium-sized enterprises in commerce and services. The political crisis unleashed by the federal government addressed in section five. The last section presents the final considerations, stressing that the decision-making process of inaction Brazil has adopted to respond to COVID-19.

Inaction Policy and Hypotheses in the Case of the Brazilian Policy to Combat the COVID-19 pandemic

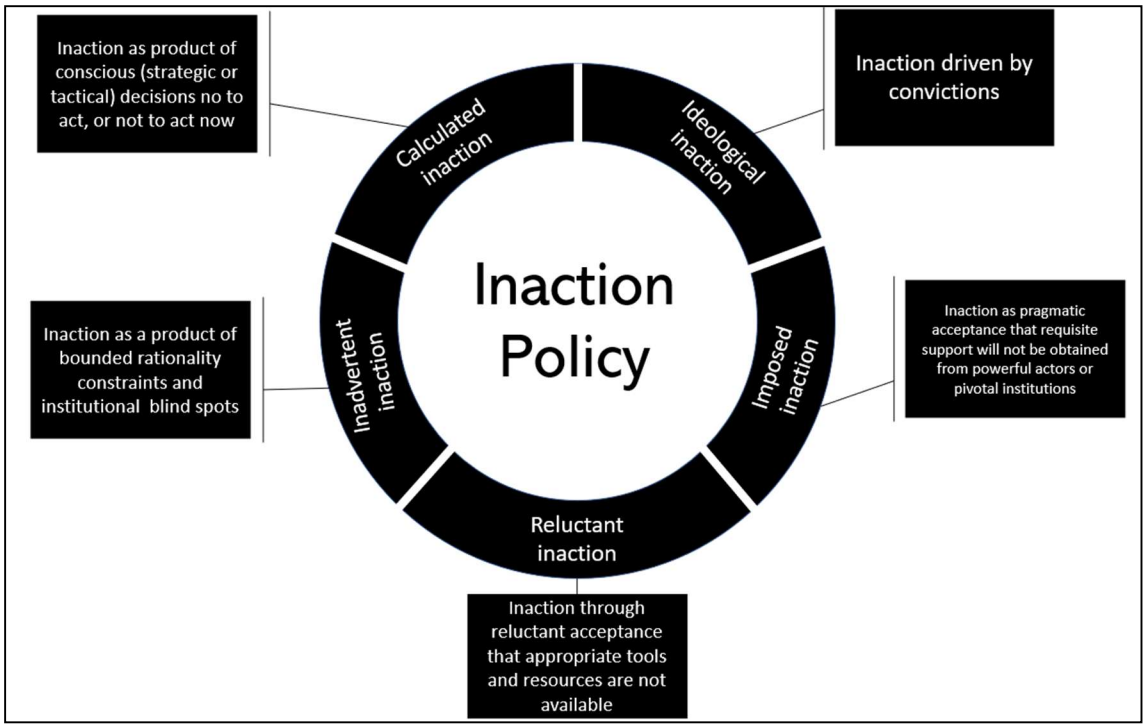
In the social structure of a democratic state, the concept of public policy covers from an isolated action of a public agent or institution to a sophisticated and planned governmental action, well implemented and evaluated. Public policies work to stabilize conflicts in an organized society, preventing the chaos and the rupture of the state.

According to Shimitter (1984), public policies are the procedures designed to peacefully address conflicts inherent to the use of public goods. Therefore, State action concerns the organization of social life to respond to citizens' needs. Thus, the concept of "public policy" is broad, interdisciplinary, and undertaken or not by governments, which, in theory, should ensure the balance of social life, providing conditions for improving the quality of life with respect for human dignity (Dias & Matos, 2012).

Even in the face of crises or conflicts, Inaction Policy can have negative results for society. Thus, policymakers should bring up ideas, avoid sudden and reckless responses, but make sure they propose some sort of intervention (Lodge & Hood, 2002; Cantekin, 2016).

McConnel and Hart (2019) discuss Inaction Policy, establishing four instances involved in this choice: policymakers, governments, organizations, and policy networks. The authors define Inaction Policy as a pattern of non-intervention by individual policymakers, public organizations, government, or policy networks. Therefore, in a scenario of possible and plausible policy interventions, these instances choose not to act. The authors listed five types of Inaction Policy, as shown in Figure 1:

Figure 1 – Types of Inaction Policy



Source: Adapted from McConnel and Hart (2019)

"Calculated inaction" entails strategic or tactical reasons. It occurs when the policymaker waits for ideas to mature in the face of a conflict or crisis, preferring to act only when there is a minimum of certainty regarding the outcomes (McConnel and Hart, 2019; Althaus 2008). Differently, "ideological

inaction" is observed objectively based on the policymaker's (or organization, government, or network) ideals. Thus, different ideologies about the role of the state or a private solution for a public problem can lead to intentional Inaction Policy (Pesch 2005, Peeters 2013).

In "imposed inaction," the institutional architecture itself creates barriers that make government action unfeasible. This occurs because of how power is divided in the state, favoring the emergence of conflicting parties and centers of political power. Thus, even if the action is rationally justified, it may be stagnant if the government is unable to articulate support from other players to carry out its implementation.

"Reluctant inaction" happens when the resources, tools, and other possible options are not available for the policymaker to take action. Thus, it tends to retreat due to the low level of operational certainty to solve the problem. Finally, "inadvertent inaction" may occur when policymakers, with their restricted capacity to process information, do not perceive a particular problem as a priority (McConnel & Hart, 2019).

The hypotheses analyzed in this article refer to the Brazilian federal government's response to the COVID-19 pandemic, which followed three types of political inaction:

1. **Imposed inaction** – discussed in section 2, this type of inaction was observed in the lack of federative coordination. The federal government did not create a crisis cabinet with governors and mayors. The central government abandoned the subnational entities when they repelled its guidelines against measures to increase social distancing. This conflict led to a lack of coordinated actions within the federation. In this case, the institutional architecture did not present barriers to coordinated actions, but the president did. He hindered the response when refraining from using constitutional provisions to gather authorities from states and local governments in a crisis cabinet.

2. **Reluctant inaction** – reflected in sections 3 and 4. Section 3 approaches the lack of structural resources – a problem inherited from previous governments – in the national health system (SUS). Section 4 presents the federal government's responses to tackle the economic consequences of measures to increase social distancing. The government response is insufficient and failing to protect the economic players, who pressure for the end of social distancing measures in order to preserve jobs and the economy, ultimately leading to the collapse of the health system. Despite having a reasonable degree of information, the federal government chose an untimely fiscal policy when the country needs immediate resources.

3. **Ideological inaction** – discussed in section 5, this type of inaction reflects the political crisis the president created when he decided to impose his ideas and challenge institutions. The president challenged the country's democracy aiming to prevent governors, mayors, the Supreme Court, and the National Congress from protecting the population from the COVID-19 pandemic. The president's ideological inaction predominated and was decisive in the sense of creating a scenario in which the other types of Inaction Policy occur.

The lack of coordination between federal and states and local governments – a crucial problem in the face of COVID-19

The Brazilian Federal Constitution of 1988 established federalism to reduce asymmetries in the distribution of resources among the subnational federated units. According to the constitution, subnational units share with the federal government the responsibility for the public administration in the country. For Arretche (2018), the definition of the federated units' roles in the constitution of 1988 established the current rules around the distribution of power among federal, state, and local governments. However, the events observed in the first months of 2020 have revealed problems in intergovernmental relations that generate vertical coordination and horizontal cooperation dilemmas among the federated units.

The reality of the Brazilian federalism is a unique case regarding combating COVID-19, with a series of uncoordinated actions involving all levels of government. This situation is a consequence of the position of the federal government, particularly of the president, who insisted on denying the pandemic. For example, the president did not support the initiatives of his own Ministry of Health designed to assist state and local governments. The lack of cooperation has been harmful and has led to severe problems for the population as, according to the Brazilian federalism, state and local governments have budgetary limitations and low capacity to implement public policies, particularly those related to health. The delivery of healthcare to the population in the municipalities depends, in large part, of intergovernmental transfers from the federal to local governments.

In addition to the low fiscal capacity of state and local governments, the different priorities and particularities of each region enhance the complexity of the health policy. These differences are the object of negotiation, generating agreements, vetoes, and conflicts in intergovernmental relations. Therefore, the implementation of the health policy occurs in a centralized manner, concentrating decision-making in states with the greatest bargaining power (Aguiar, 2011).

From an organizational point of view, the principles that guide SUS are (1) decentralization; (2) regionalization and the hierarchy of the system; and (3) participation and social accountability. The first principle addresses the distribution of responsibilities for health actions throughout the three levels of government – Union, states, and municipalities. The second concerns the adequate distribution of services among the federated units to guarantee equal access, resources optimization, the rationality of expenses, i.e., regionalization. The third principle refers to the need for each sphere of government to have collegiate instances where the population can participate, and people can offer their point of view about the health policy. These instances are the health councils and the health conference (Aguiar, 2011). Thus, the institutional design of the health system in Brazil offers the possibility for federated units to engage in decision-making, share responsibility for the implementation, and offer social accountability mechanisms, promoting participation.

In terms of combating COVID-19, this design is decisive because Brazil needed to expand ICU beds in SUS. Such expansion, however, did not occur. Instead, the measures adopted were to postpone scheduled surgeries and increase the health professionals' working hours in the ICUs available. Therefore, many people who did not have COVID-19 but had other illnesses that required treatment in the ICU of SUS, could not get assistance or did not receive a necessary or prescribed ICU procedure or intervention in time, which resulted in the deterioration of their pathological condition, and many deaths. Box 1 shows the rate of beds in ICUs and wards in the states with the most cases of Covid-19 in Brazil on June 9, 2020:

Box 1 – Occupation of ICU beds and Hospital beds

		Before		After	
		June 8, 2020, to June 9, 2020		June 23, 2020, to June 26, 2020	
State	Capital	ICU-Covid	Hospital	ICU-Covid	Hospital
Amazonas		58%	32%	58%	32%
	Manaus	70%	70%	36%	27%
São Paulo		67%	57%	65%	50%
	São Paulo	74%	71%	67%	55%
Rio de Janeiro		85%	79%	60%	57%
	Rio de Janeiro	91%	54%	71%	40%
Pernambuco		96%	63%	79%	45%
	Recife	60%	56%	83%	50%
Ceará		80%	51%	73%	47%
	Fortaleza	78%	62%	68%	59%
Maranhão		85%	46%	70%	44%
	São Luiz	93%	26%	79%	29%

Source: Health secretaries of states and municipalities; websites disseminating official data

The health systems in these states were the first to collapse in Brazil. The state of Amazonas, for example, reached a 100% bed occupancy rate in mid-April (the number of cases declined by June 2020).

Most state governments act responsibly, decreeing restrictive measures that lead to social distancing. They also monitor the number of cases to know when the pandemic reaches its peak in the states' territories, often acting in an organized and coordinated way, such as via public consortium. The states in the Northeast region formed the Northeast Consortium, where all states cooperate to face Covid-19. The initiative aims to optimize and rationalize spending and investments. In addition, the Northeast Consortium seeks to strengthen regional development and improve public services, overcoming a previous predatory culture of interstate competition (Clementino, 2019).

The federal government, on the other hand, especially the president, is totally at odds with most governors and mayors. The president appears daily in public places, provoking agglomerations, and hugging people. The Ministry of Health had three ministers since the beginning of the pandemic. The first two were led to resign after conflicts regarding social distancing measures. The president then appointed a general who has no training in health, or in public management related to health policies. The president's irresponsible and aggressive actions and narratives bring into question the possibility of coordination and cooperation among all federated units, making the federal government the greatest obstacle for federal coordination to fight the COVID-19. In view of this situation, Governors and Mayors obtained autonomy to impose measures to combat COVID-19, especially social isolation,

through a Civil Action of Unconstitutionality (ADI 6341) forwarded to the Supreme Court that decided to give autonomy of action to the states and municipalities in combating the pandemic.

The negligence of the federal government in supporting the subnational Governments requires the states to establish connections among themselves, through the National Council of Health Secretaries (Conass) and the National Council of Municipal Health Secretaries (Conasems), which is a consultative instance provided in the structure of SUS.

These councils are co-managers of the SUS, and according to Barros (2012), they have played an important role in the application of knowledge in the scope of public health. They carry out activities through sectoral technical chambers to discuss collective health actions, as well as seminars and courses. In addition, they maintain constant interaction with various areas of the Ministry of Health and with national and international organizations, such as Fiocruz and the Pan American Health Organization (Barros, 2012).

Therefore, the councils are inter-federative bodies that could strengthen intergovernmental relations between the federal government and the subnational entities. Also, such structures could originate crisis committees to increase efficiency in the implementation of national policies to combat Covid-19.

SUS – The structural crisis of the Brazilian national health system and its financial vulnerability in the face of COVID-19

The Brazilian national health system (SUS) in theory, it should guarantee universal and free access to the Brazilian population, from simple to highly complex procedures. However, the media has often reported problems in the service in recent years, such as poor assistance to the population nationwide and both from primary to medium and high complexity care. The chaos in hospitals and health units reflects the precarious conditions of infrastructure, equipment – basic and specialized –, and lack of staff, which challenge health professionals in multiple levels and attributions every day.

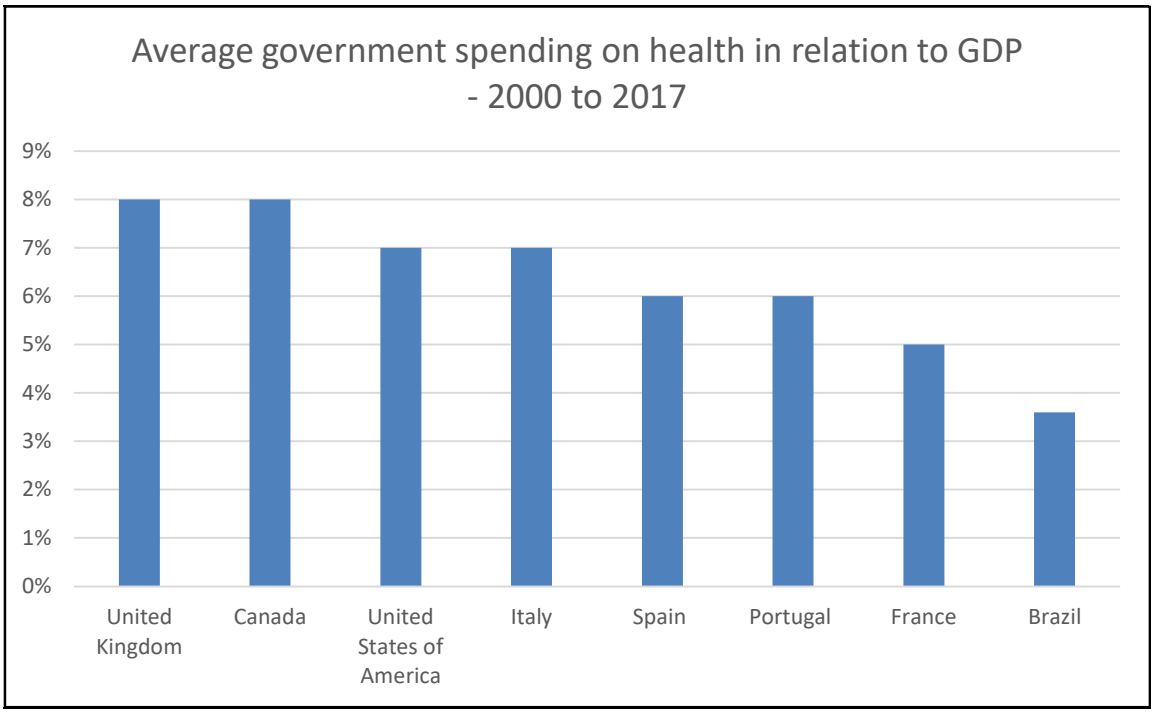
The pandemic has highlighted the role of SUS constantly featuring the system's performance in national news and uncovering the chaos in the Brazilian public health. The situation that has existed for a long time is ignored by different governments, which, not rarely, blame health professionals and managers for the lack or poor services. Although the pandemic was not predictable, the poor structure of healthcare units and services is preventable. The situation of SUS in the face of the COVID-19, therefore, has contributed to worsening the pandemics' effects. As stated in the previous section, if it was usual to face a shortage of beds in intensive care units before the pandemic, the COVID-19 drastically exposed the problem.

With the fiscal deterioration originated with the economic crisis of 2008 and felt in Brazil since 2012, a radical program of fiscal adjustment gains space in the political debate. Policies of fiscal adjustment strongly affected the health system's funding and were based on, reduced spending and fewer investments in social policies. The notion of 'minimal state' is emphasized in President Bolsonaro's administration, which uses the motto "more Brazil and less Brasilia" – suggesting a preference for decentralization. His practices show the intention to reduce the role of the central government in conducting public policies, passing on to states and municipalities almost all obligations and responsibilities. However, the central government has continuously worked to dismantle federative coordination and cooperation.

As seen in the previous section, the current context in Brazil demonstrates a huge lack of coordination and cooperation between the central government and subnational entities. The crisis made evident the inability of both governments and the market to respond quickly to the demands caused by the pandemic. There is a lack of materials, doctors, nurses, equipment, hospitals, beds, ventilators. In addition, less than 25% of the country's population has private health insurance, which means that 75% of the population depends exclusively on SUS.

The precariousness in SUS may be explained by the little investment in health (approximately 3.6% of the GDP). When compared to countries that have national health systems like the United Kingdom and Canada, Brazil is still far from investing enough money. When considering the other countries of the Organization for Economic Cooperation and Development (OECD), Brazil is also at a disadvantage, as shown in Chart 1 below:

Chart 1 – Average government spending with health compared to GDP – 2000 to 2017



Source: World Health Organization
https://apps.who.int/nha/database/Select/Indicators/en

The numbers in Chart 1 must be observed considering two essential facts. First, most of the countries that invest a higher percentage of the GDP than Brazil also have a smaller population, which means that their investment per capita is even higher. Second, the instability in the growth of the Brazilian GDP means that the volume invested is also unstable.

In addition, the resources destined to SUS, in large part, are linked to a tax system that privileges the Union. The economic characteristics of the taxes levied by local governments restrict their fiscal capacity and hinder the possibility of promoting better public policies, including those aimed at the population's health.

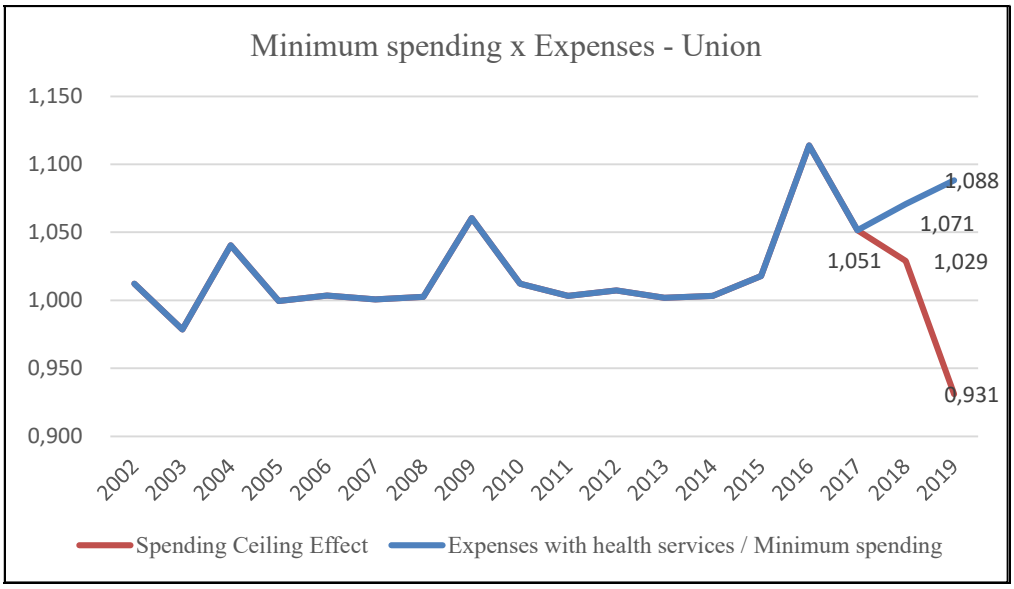
For this reason, shared management through public consortia suggests a gain in resource efficiency through collective procurements and cooperation in the implementation of policies. Therefore, economic efficiency considers cooperation as a way to save transaction costs, financial resources, and costs linked to the externalities existing between neighboring municipals (Gerber & Gibson, 2005).

Thus, territorial cooperation and coordination provide better gains in scale in the management and provision of public policies. In this sense, the economic reason is the argument that contributes most to explain the formation of consortium: rationality to save resources. Therefore, public consortia are considered as municipal actions to overcome regional inequalities that were not overcome by decentralization after the 1988 Constitution, especially on the issue of tax (Grin & Abrucio, 2017).

In this context of pandemics, emerges the argument that the recent fiscal adjustment has contributed to the crisis since it resulted in budget cuts affecting public policies. Among the fiscal austerity measures is the implementation of a 'spending ceiling,' i.e., a limit for federal spending equivalent to the expenditure of 2016, adjusted for inflation each year for 20 years. Also, there is a series of privatizations in parts of the health system, transferring resources to private entities that are not effective in offering health services. Although this argument may make sense, it still needs to be carefully studied, avoiding Manichaean views of reality that could jeopardize an adequate analysis.

However, there is evidence that recent government measures have reduced funding to SUS. Chart 2 shows the relationship between the federal government expenditures from 2002 to 2019 and the effect of the spending ceiling implemented since 2018. It is noteworthy that investments in health have long been kept at much lower limits than OECD countries.

Chart 2 – Minimum application v total spending – Union



Source: Data from the Brazilian National Treasury Secretariat - https://www.tesourotransparente.gov.br/publicacoes/despesas-da-uniao-series-historicas/2019/11.

Regarding the minimum application of resources for health, it is necessary to observe article 198 of CF/1988 and its various amendments. Until the edition of Constitutional Amendment (EC) 29/2000, the definition of a minimum application limit was conditioned to the edition of a complementary law (never enacted). After EC 29/2000, a floor was established (the amount committed in 1999 plus, at least, 5%), which was corrected by the nominal GDP variation. In 2015, with the edition of EC 86, the limit became 15% of the Union's current net revenue, effective until 2017, when there was the edition of EC 95/2016, which instituted the spending ceiling for the federal government.

Chart 2 shows that, from 2002 to 2015 (except for the years 2004 and 2009), the federal government applied the minimum provided in the constitution for health actions and services. During that period,

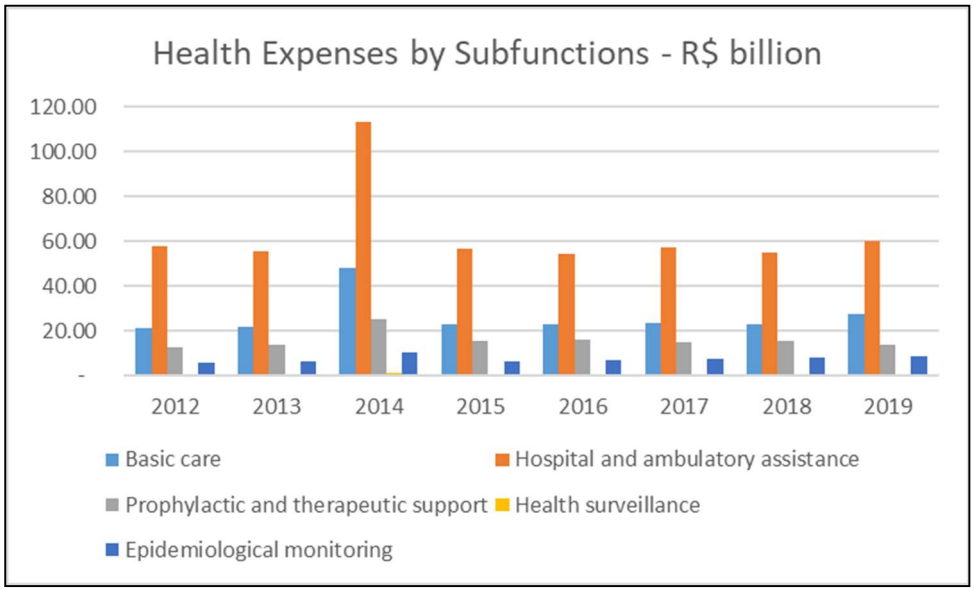
there was no significant increase in spending on SUS, leaving the Brazilian health system far behind other countries with universal systems like Canada and the United Kingdom.

The EC 86/2015 provided an average increase of 8.3% in the volume of resources invested in health in the years 2016 and 2017, while EC 95/2016, which limited public spending for 20 years, inverted this upward trend, reducing the growth to 2.9% in 2018, and reversing it in 2019. This movement caused a loss of 6.9%, compared to the amount that would be invested if EC 95/2016 had not been enacted. In the last two years (2018 and 2019), the federal government refrained from spending R$ 23.4 billion on public health actions and services due to this constitutional amendment.

The fact that Brazil spends less on health than countries such as the United Kingdom, Canada, Portugal, and Spain, affects the quality of its national health system. The structure of SUS barely meets the demands of Brazilian society, much less in the face of a pandemic. The lack of investments leading to this situation explains why tropical diseases caused by mosquito bites such as dengue and yellow fever (other endemic diseases) caused saturation in the health system.

When the health investments are divided into budget sub-functions, it is possible to see which areas of the system suffer the most with the cuts. Chart 3 shows that, except for 2014 and 2019 and the sub-function 'health surveillance,' the amounts executed had little variation in the period from 2012 to 2019.

Chart 3 – Expenditures in the main sub-functions – Union – (Billions R$)



Source: Data from the Brazilian National Treasury Secretariat (2020) - https://www.tesourotransparente.gov.br/publicacoes/despesas-da-uniao-series-historicas/2019/11.

As noted, each sub-function accounted, on average, for the following annual expenses: i) Primary care, R$ 26.2 billion; ii) Hospital and ambulatory assistance, R$ 63.8 billion; iii) Prophylactic and therapeutic support R$ 15.9 billion; iv) Health surveillance, R$ 0.45 billion; v) Epidemiological surveillance, R$ 7.4 billion.

An important point to be highlighted refers to spending (investment) on health surveillance. From 2015, this investment fell, on average, 20% to R$ 0.36 billion annually. In addition, spending by sub-functions demonstrates an 'incremental practice' in the budget, which has contributed to the

maintenance of the problems observed in the current model. Therefore, the government has not allocated a budget to address new demands in health.

Brazil has been maintaining an average standard of investment in health for years, as mentioned before, far below the standard observed in developed countries. This limits SUS' ability to invest and make the network more efficient. These investments also depend on the capacity of subnational entities to invest, making the system more unequal among the federal units. Thus, since the approval of the constitutional amendment that limited public spending, health has lost the possibility to receive over R$ 23 billion in investments. COVID-19 is revealing the state of chaos, abandonment, and inequality in SUS and public health in Brazil.

Emergency aid policies and their insufficiencies – comparing the measures in Brazil and other countries

Brazil is investing an extraordinary amount of resources to combat COVID-19, similarly to what has been observed in other countries. Observing the behavior of this spending and how Brazil compares to other nations in the implementation of economic aid to combat COVID-19 is essential to understand why the country has become the epicenter of the pandemic, with the second-highest number of cases and second highest number of deaths (data from July 2020). Therefore, it is relevant to explore how these resources are applied.

Another point of concern is the financial resources the Congress approved to support the country's economy due to the COVID-19 pandemic. The funds come from extraordinary credits created through 15 provisional measures (MPs), currently in force, and under analysis in the Congress. Congress decided that the MPs related to COVID-19 would be more quickly processed. Thus, after more than two months of issuing the first emergency MPs, it is possible to analyze the government expenditures to support the economy.

According to data from the National Treasury Secretariat, by June 26, 2020, the Government spent up R$ 177.7 billion of the foreseen R$ 404.2 billion in the fight against COVID-19 (Table 1):

Table 1 – Spending on COVID-19 – Union (on June 26, 2020) (Billions R$)

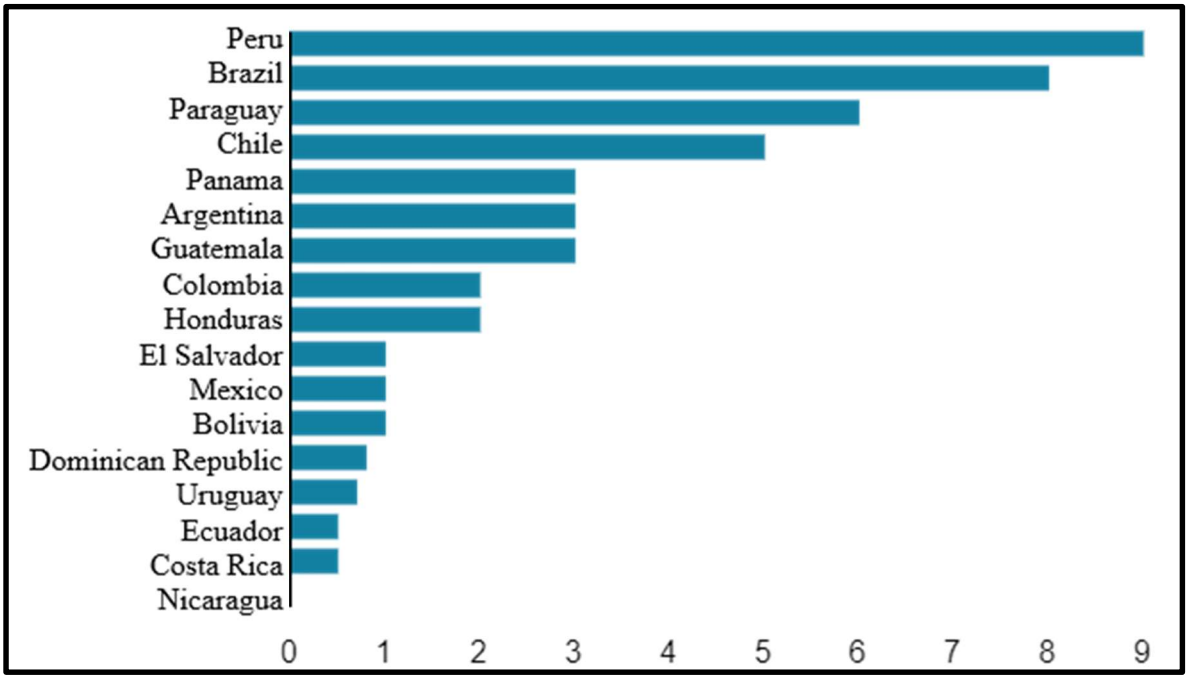
Estimated expenses to fight COVID-19	Estimated	Executed	Legislation
Transfers to the account of energy development	0.90	0.90	MP 950/2020
Credit to finance payroll	34.00	17.00	MP 943/2020
Aid for states, municipalities and the Federal District	76.19	21.64	MP 939/2020
Emergency aid to maintain jobs and income	51.64	11.72	MP 935/2020
Expansion of the conditional cash transfer program *Bolsa Família*	3.04	0.37	MP 929/2020
Emergency aid for vulnerable populations (vouchers)	152.64	95.57	MP 937/2020
Quotas of Credit and Operations Guarantee Funds	35.90	15.90	MP n° 977/2020
Additional expenses from the Ministry of Health and Other Ministries	49.88	14.55	Various ministries and agencies
Sum	404.19	177.7	

Source: Transparent National Treasury - https://www.tesourotransparente.gov.br//visualizacao/painel-de-monitoramentos-dos-gastos-com-covid-19

As noted, the largest volume of funds goes to emergency aid (vouchers), and, according to data from the state-owned bank *Caixa Econômica Federal* (CEF), 79.9 million people are registered to receive the aid. The number reveals that a large part of the population in Brazil is living in vulnerable conditions. The aid is scheduled for three months (April, May, and June 2020) and may be extended – in this case, the amount would be reduced to R$ 200.00. The government justifies the reduction in amount with the rationale that it is necessary to work to decrease informality (40% of Brazilian workers are in the informal economy) instead of including these workers in a cash transfer program. Also, the government argues that restrictive measures to increase social distancing have not lasted longer than three months in any other country. This type of argument contradicts the government's own economic policies, which have resulted in an increasing number of informal workers or the generation of micro-businesses in commerce ("necessity entrepreneurship").

Comparatively speaking, the Brazilian government's economic measures to combat COVID-19 have been inferior to those of other countries of similar economic size (G20, for example). When analyzing public spending in relative terms, considering the economic aid to deal with the pandemic, the amount Brazil has disbursed as a percentage of GDP is only 8%. This relative measure is much lower than that of rich countries, such as Japan, the country that spent the most (22% of GDP), and the United States (13% of GDP). When comparing to Latin American nations, Brazil occupies the second position, behind Peru, which spent 9% of the GDP

Chart 4 – Spending on measures to combat COVID-19 in Latin America (%GDP)



Source: BBC (2020)
https://www.bbc.com/portuguese/internacional-52721417

However, it is essential to ask questions both on the quantity and quality of emergency aid in order to understand the impacts of the economic measures in the public accounts. According to the study by

the Inter-American Development Bank (IDB)[1] "Policy and fiscal management during the pandemic and post-pandemic in Latin America and the Caribbean," Brazil occupies the seventeenth place of twenty-two countries in Latin America.

The Union already disbursed about 50% of the emergency aid to vulnerable populations, reaching about 79.9 million people (Table 1). Regarding the emergency benefit to maintain jobs and income, the government disbursed only 10% (Table 1). In addition, the government's delay in providing some income to people has also delayed the circulation of money in the economy, harming companies and resulting in dismissals.

Regarding the support for SMEs to access credit, the government enacted, with vetoes, law 13999/2020 that institutes the National Program of Support to SMEs (Pronampe) [2]. Through this program, SMEs can take out low-interest loans with repayment terms of 30 to 60 months, using a guarantee offered by the federal government covering up to 85% amount taken. The problem is that, according to data from the Ministry of Economy, only 77 thousand companies have obtained approval for this credit line, while there are 17 million SMEs.

Concerning the expenses with medical supplies, tests, ICU beds, ventilators, PPE, and other hospital costs, the last record of action by the federal government was the electronic bid 60/2020 for the purchase of 2 thousand installed ICU beds. However, the most optimistic estimates for Covid-19 in Brazil suggest that if 0.1% of the population catches the virus, beds in an intensive care unit (ICU) will be lacking in 44% of the regions. Brazil has 33 thousand adult ICU beds but considering the uneven distribution of these beds in the country, the need is greater in poorer regions such as the north and northeast. This forecasted numbers proved to be true in several states and municipalities that had to declare an emergency and went in lockdown due to the collapse of their health system.

Concerning the use of test kits, the country has not tested very much. Of the 13.9 million test kits purchased (rapid tests and RT-PCR), only 7.8 million have been delivered, and of these, 6.9 million had been distributed among the states by May 12, 2020. The lack of testing is evident, considering that although Brazil is the second country with the highest number of cases and the second in the number of deaths by covid-19, the country is only the 108th position in the number of tests per million inhabitants, behind countries like Ecuador, Iraq, and Rwanda[3].

As for the actions to aid state and local governments, the estimated Union's spending was R$ 16 billion, but only R$ 1.97 billion has been executed. This proves the weak (or non-existent) inter-federative connection, which is so necessary to face this collective problem. However, the Government sanctioned a financial aid project of R$ 60 billion to states and municipalities (with vetoes). The text was published in the "*Diário Oficial da União*" (Official Gazette) on May 28, 2020. It remains to be seen whether the execution of these fundamental resources will be carried out more rapidly.

Amid the tension among the federated units, the federal government vetoed a transfer of R$ 8.6 billion from the remaining balance of the Monetary Reserve Fund (FRM), for the states and municipalities to fight Covid-19 in their territories. In justifying the veto, the federal government stated that the items that created the transfer created mandatory expenses without indicating the budgetary and

[1] https://blogs.iadb.org/gestion-fiscal/pt-br/politica-e-gestao-fiscal-durante-a-pandemia-e-a-pos-pandemia-na-america-latina-e-caribe/

[2]https://m.sebrae.com.br/sites/PortalSebrae/artigos/saiba-tudo-sobre-o-pronampe,9030060 4aa332710VgnVCM1000004c00210aRCRD

[3] https://www.worldometers.info/coronavirus/

financial cost, which would violate the Constitutional and Transitional Provisions Act (ADCT). However, this claim is contested by legislative technicians who claim that these expenses are neither permanent nor transitional.

When comparing the federal government's estimated and the executed expenses with the COVID-19 pandemic, it is possible to observe that since February 2020, the actual spending was 35% of the estimated (by June 2020):

Table 2 – Percentage of spending on COVID-19 – Union

Until the month of	Estimated	Executed	% Executed
February/20	11,3 milhões	131, 7mil	1.17%
March/20	8.5bi	1bi	11.76%
April/20	253bi	60,4bi	23.87%
May/20	319,4bi	113,8bi	35.07%
June/20	404,2 bi	182,6 bi	45.17%

Source: Transparent National Treasury - https://www.tesourotransparente.gov.br/visualizacao/painel-de-monitoramentos-dos-gastos-com-covid-19

Therefore, government figures indicate that, in addition to delayed payments, emergency spending on the pandemic is falling short of expected execution. In addition, these expenditures are deconcentrated and uncoordinated with subnational entities. Proof of this is the fact that mayors and governors purchase hospital equipment from abroad, often with canceled purchases, caused by the federal government's own international relations policy, which caused several unnecessary conflicts with countries like China, which today is the largest exporter of hospital equipment to deal with COVID-19.

Both the quantity and quality of the emergency aid are timid and insufficient to guarantee the main objective of containing the speed of contagion and deaths by COVID-19 in Brazil. Associated with these problems is the lack of federal coordination in the fight against the pandemic, and the interference of the federal government in the state and local authorities' decision to decree restrictive measures to increase social distancing, with the president attacking governors and mayors, in flagrant collision with the federal pact. This chaotic context makes it hard to observe the evolution of the coronavirus outbreak and, consequently, jeopardizes the process of gradual relaxation of the restrictive measures and the resumption of economic activities. Without planning and with a high record of cases and deaths, the gradual exit from social distancing becomes increasingly problematic.

In Brazil, on average, 40% of the population has managed to be socially distant (less than the WHO recommendation of 70%), which has proven to be ineffective. Other countries, such as Sweden, decided to avoid restrictive measures leading to social distancing. In this case, the country was not successful in achieving the so-called "herd immunity." The capital Stockholm recorded only 7.3% of the population with antibodies to the COVID-19 pathogen, with a rate of 342.6 deaths per million inhabitants, much higher than that of Brazil, which is 62 deaths per million inhabitants. In the post-pandemic, Brazil, Sweden, and the few other countries in the world that have not undergone radical restrictive measures to increase social distancing will face higher global economic costs of recovery than countries that have declared lockdown, for example. Brazil, Sweden, and others will have to cope with both the economic costs and the high number of lives lost.

The political crisis: the president against everyone (Congress, Supreme Court, governors, and mayors)

All the factors of the crisis originate and develop unilaterally from the president, which accentuates the social division, heightens the tension of (and among) citizens, creates conflict with the governors, mayors, ministers or states secretaries who want to adopt measures recommended by international organizations (used in most countries in the world) to combat COVID-19. The political crisis caused by the President Bolsonaro further aggravates the expectation of a recession caused by the biggest health crisis in the country's history, whose deficit could be in the range of 8 to 12% of GDP.

Regarding the first factor generating the political crisis (the president's insistence on disregarding WHO protocols for social distancing), the consequences can be seen in the number of cases registered in Brazil. Despite underreporting, Brazil has become the second country with the most recorded cases since June 2020. On June 27, 2020, the number of cases went up to 1,274,974 (although it is estimated that this number can be ten to fifteen times higher). As for the number of deaths, on June 27, 2020, Brazil appeared as the second in the world, with 55,961 deaths. The percentage of the population that managed to be socially distant is of 43.4%. Despite the tragic situation, the president goes against measures to increase social distancing. Through the Ministry of Health, the president ordered a new protocol for the application of chloroquine and hydroxychloroquine to treat all patients, including those with mild symptoms.

Important recently published scientific studies refute the two elements defended by the president. Concerning social distancing, a study by Imperial College London,[4] analyzed the effect of social distancing in mitigating virus contamination. The study concluded that "rapid, decisive and collective action can prevent billions of infections and save millions of lives globally." In the Brazilian case, restrictive measures leading to social distancing managed to decrease by 54% the number of reproduction of COVID-19 (the number that indicates how many people a patient could potentially infect) in the country. Regarding the use of hydroxychloroquine, a recent study published by the University of Oxford, "Recovery," showed that there was no significant difference between patients who were treated with chloroquine and patients who received a placebo.[5]

The disagreement about the use of chloroquine and hydroxychloroquine led former minister Nelson Teich to resign on May 15, 2020, after being overruled by the president on the use of the medicine. Teich was the second Minister of Health to leave the government; the first was Luiz Henrique Mandetta, who was exonerated by the president for not agreeing with the measures against the WHO protocols that the president wanted to implement, above all the fight against restrictive measures to increase social distancing.

The second factor of the political crisis was further accentuated by the resignation of former Minister of Justice and Public Security Sérgio Moro. Moro says that his resignation occurred as a result of the direct interference by the president in the appointment of the head of the Federal Police, which may imply a crime of administrative law and coercion. There is an ongoing investigation in Supreme Court, about interference by the president in the Federal Police. Requests were sent to the Prosecutor General of the Republic (PGR) to collect the statement of the president and one of his sons, as well as to

[4] https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-Global-Impact-26-03-2020.pdf

[5] http://www.ox.ac.uk/news/2020-06-05-no-clinical-benefit-use-hydroxychloroquine-hospitalised-patients-covid-19

seize their mobile phones. This process can generate the request for the arrest of the president (as occurred with President Temer). Against this background, the president has increasingly supported small movements that call for the closure of the Supreme Court and National Congress. In addition, he sought support from groups in the Congress by offering positions in the public bureaucracy, in order to gain political strength in the legislative branch in case an impeachment process open.

The political crisis aggravated when the Supreme Court allowed the disclosure of a video recording a ministerial meeting on April 22, 2020, which is part of an investigation. During the meeting, the participants verbally attacked institutions such as the Federal Supreme Court, the state governors and mayors, and the press. In the meeting, President Bolsonaro mentioned his intention to protect private and family interests.

The third factor of the crisis is related to the massive presence of military personnel in public positions, often without the necessary qualification. The military is currently in 8 of the 22 existing ministries in Brazil and holds 1,349 executive positions. Without considering the other 881 posts occupied by members of the three forces in the Ministry of Defense. Even the current Minister of Health is military, a General with no training in medicine or related fields, or even experience in health management. In other words, Brazil's government is mostly military but democratically elected. Therefore, the president took, *de facto*, the role of the Minister of Health.

Final Considerations

The article intended to present the Brazilian federal government's Inaction Policy in the fight against the COVID-19 pandemic. Both the imposed, reluctant, and ideological inaction occurred in the case of Brazil. However, the contours that this type of political inaction took in the country conform to the reality and the Brazilian political context. The effect of Brazilian Inaction Policy in combating COVID-19 was to lead the country to unprecedented international isolation, in addition to internally creating institutional instability – observed in conflicts between the federal government with states and municipalities, as well as with the other two branches (judicial and legislative). The insufficient resources that the federal government allocated to help the poor population, unemployed or those working in the informal economy, as well as to assist small and micro enterprises and support SUS, were an indication of its reluctant Inaction Policy. As a result, players of the economic sectors and unassisted workers pressure governors and mayors to abandon the measures that increase social distancing, which could lead to a collapse of the health system.

The COVID-19 pandemic reaches the country in this context of crisis. The actions of Bolsonaro's government apparently seek to create chaos instead of finding solutions to the population's problems. The actions of the government have constantly challenged the democratic order and have led to increasing international isolation. Reproducing its incapacity for international dialogue, the government is also unable to dialogue with subnational entities. This lack of understanding is observed by the absence of coordinated public policies and cooperation among state and local governments in the face of the COVID-19 pandemic. The experiences of cooperation in the country take place through consortia formed under the leadership of the states. Notwithstanding, they are insufficient without the support of the federal government in the form of resources and capacity to expand the initiatives' scope.

As observed in this study, the federal government's attitudes have worked to aggravate the political crisis. Three major events may be pointed out as examples of this dynamic. The first refers to the president's denial of the pandemic, disregarding the recommendations of the World Health Organization (WHO). Such behavior led two Ministers of Health to resign in the first semester of 2020, and a

minister without training in health and health management currently occupies the position. The second event refers to conflicts the president created within his own cabinet. When President Bolsonaro feels threatened, either by the institutions or by the good performance of other political actors, it is common to see his inconsequent reactions, attacking ministers as if they were opponents. The president is not open to dialogue and divergent opinions. This context led the former Minister of Justice Sérgio Moro and former Ministers of Health Luiz Henrique Mandetta and Nelson Teich to leave the government. Finally, the third event refers to the excessive number of military personnel in executive positions in the government, reflecting a fixation of the president, who is a former military himself. Many of these personnel are in reserve forces and do not show much appreciation for democracy. Linked to an authoritarian past, they create, together with the president, an inadequate environment for effective political debate with a plurality of ideas.

This is the current scenario in Brazil at the time of writing (June 2020). The country has been institutionally unstable, and the pandemic hit in a particular moment in history where the incumbent government prefers to use it to cause more instability, disregarding recommendations of public health authorities such as the WHO, and an attack on democracy. The scenario is not better from an economic point of view. The absence of the federal government's leadership to propose public policies has resulted in delayed responses to the pandemic extending the time until stabilizing the coronavirus contagion, consequently damaging, even more, the country's economy.

Referencias

Aguiar, Z. (2015). SUS: Sistema Único de Saúde-Antecendentes, percurso, perspectivas e desafios. 2ª edição. São Paulo: Editora Martinari.

Althaus, C. (2013). Calculating political risk. Routledge.

Arretche, M. (2018). Democracia e redução da desigualdade econômica no Brasil: a inclusão dos outsiders. Revista Brasileira de Ciências Sociais, 33(96). https://doi.org/10.17666/339613/2018

Barros, F. P. (2012). A incorporação dos conhecimentos em saúde coletiva nas políticas e práticas municipais do SUS-a perspectiva do CONASS. BIS. Boletim do Instituto de Saúde (Impresso), 13(3), 223-229.

Cantekin, A. (2016). Ripeness and readiness theories in international conflict resolution. Journal of Mediation & Applied Conflict Analysis, 3(2), 414-428. https://doi.org/10.33232/jmaca.3.2.7917

Clementino, M. D. L. M. (2019). A atualidade e o ineditismo do Consórcio Nordeste. Instituto de Pesquisa Econômica Aplicada - IPEA, Brasília.

Dias, R., & Matos, F. (2012). Políticas públicas: princípios, propósitos e processos. São Paulo: Atlas.

Dye, T. R. (2012). Understanding public policy (12th ed.). New Jersey, NJ: Pearson Prentice Hall.

Gerber, E. R., & Gibson, C. C. (2005). Balancing competing interests in American regional governance. Program in American Democracy Speaker Series, Notre Dame University.

Jones, M. D.; Mcbeth, M. K. (2010). A narrative policy framework: Clear enough to be wrong? Policy Studies Journal, v. 38, n. 2, p. 329–353. https://doi.org/10.1111/j.1541-0072.2010.00364.x

Lodge, M., & Hood, C. (2002). Pavlovian policy responses to media feeding frenzies? Dangerous dogs regulation in comparative perspective. Journal of Contingencies and Crisis Management, 10(1), 1-13. https://doi.org/10.1111/1468-5973.00176

Grin, E. J., & Abrucio, F. L. (2017). La Cooperación Intermunicipal en Brasil frente al Espejo de la Historia: Antecedentes Críticos y la Dependencia de la Trayectoria de la Creación de la Ley de los Consorcios Públicos. Políticas Públicas, 10(2).

Peeters, R. (2013). Responsibilisation on government's terms: new welfare and the governance of responsibility and solidarity. Social Policy and Society, 12(4), 583-595. https://doi.org/10.1017/S1474746413000018

Pesch, U. (2005). The predicaments of publicness: An inquiry into the conceptual ambiguity of public administration. Eburon Uitgeverij BV.

Roe, E. (1994). Narrative policy analysis: Theory and practice. Duke University Press.

Schmitter, P. C. (1965). Reflexões sobre o conceito de política. Revista de Direito Público e Ciência Política, 8(2), 45-60..

Sobre los autores/ About the authors

Marco Antonio Carvalho Teixeira is a Ph.D. in Social Sciences at PUC-SP in Brazil. He is a professor at the School of Business Administration at FGV EAESP and Coordinator of the Public Administration course. Antonio Sérgio Aráujo Fernandes is a Ph.D. in Political Science at USP and postdoc in Public Administration at the University of Texas at Austin. Currently, he is a professor at the School of Business at the Universidade Federal da Bahia (UFBA) in Brazil. Robson Zuccolotto is a Ph.D. in Accounting and Controllership from the USP and postdoc in Public Administration and Government from FGV EAESP. Currently, he is a professor in the Postgraduate Program in Accounting at Universidade Federal do Espírito Santo (UFES) in Brazil. Alex Bruno F. M. do Nascimento is a Ph.D. in Administration at the Federal University of Rio Grande do Norte. He is also a Professor in the Postgraduate Program in Administration at the Federal University of Campina Grande in Brazil.).

URL estable documento/stable URL

http://www.gigapp.org

El Grupo de Investigación en Gobierno, Administración y Políticas Públicas (GIGAPP) es una iniciativa impulsada por académicos, investigadores y profesores Iberoamericanos, cuyo principal propósito es contribuir al debate y la generación de nuevos conceptos, enfoques y marcos de análisis en las áreas de gobierno, gestión y políticas públicas, fomentando la creación de espacio de intercambio y colaboración permanente, y facilitando la construcción de redes y proyectos conjuntos sobre la base de actividades de docencia, investigación, asistencia técnica y extensión.

Las áreas de trabajo que constituyen los ejes principales del GIGAPP son:

1. Gobierno, instituciones y comportamiento político
2. Administración Pública
3. Políticas Públicas

Información de Contacto
Asociación GIGAPP.
ewp@gigapp.org

GIGAPP
Estudios / Working Papers

ISSN 2174-9515

Número Especial: COVID19: Implicaciones para el gobierno, la gestión y las políticas públicas en Iberoamérica

Vol. 7 Año (2020) Núms. 182-189, págs. 489-642

gigapp

Grupo de Investigación en Gobierno, Administración y Políticas Públicas

GIGAPP Estudios Working Papers es una publicación de la Asociación Grupo de Investigación en Gobierno, Administración y Políticas Públicas

www.gigapp.org