

## 30 years of SUS: the beginning, the pathway and the target

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**Abstract** *In this text, we refer to the solid and historical civilizational roots of the Brazilian Unified Health System, SUS (Sistema Único de Saúde) that give it a perennial status. Data and analyses are systematized, pointing out, in parallel to the construction of SUS, the construction of another public health policy that has subverted the principles and guidelines of the Federal Constitution of 1988: a real, implicit and hegemonic policy. As for SUS, we identify and reinforce explicit advances and resistances with its principles and guidelines, over this 30 year period, but with invaluable accumulation in management, evaluation, knowledge construction, appropriate technologies, resistance strategies and politicization in defense of the constitutional directives. The knowledge that has been acquired over this time is understood to form part of a drive towards a civilizing pathway that was proposed by the 1988 Constitution. Although SUS is considered to be an unfinished work with deviations, and the need, on one hand, to be consolidated in better achievements, and on the other, to be permanently reinvented in order to accomplish its mission.*

**Key words** SUS, Health system, Public/private relation

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“Nothing can be intellectually considered a problem if it has not been ultimately a problem in practical life.”  
– Cecília Minayo

### **Introduction: The roots of SUS resilience**

In order to understand and address the great crossroads at which SUS is located, one has to go deeper into its roots in the 1970s, during the Brazilian military dictatorship, the time of a deliberate policy of massive population migration to the urban edges of medium and large cities and of intensified concentration of income, along with impoverishment of the population and an increase in social tensions. The responses of the Brazilian State to that social scenario was concentrated on the municipal administrations, with increased provision of primary social services, even though they were minimal and precarious. In the health sector, the two major training centers, the University of Public Health of the University of São Paulo and the National School of Public Health, Fiocruz, in the same period, were reshaping their traditional courses, in order to provide access to a vision of integral health care targeted at young sanitarians, who were sensitive to the public policies of social rights as well as the democratization of the State.

From the point of view of the health sector, in the late 1970s, dozens of municipalities had established primary healthcare units in their territories and accumulated experiences of comprehensive, universal and equitable care. These many initiatives anticipated, in practical terms, the principles of universality, completeness and equality that would be enshrined in the 1988 Constitution. By the end of the 1980s, ten regional and national meetings of Municipal Health Secretariats (SMS: Secretarias Municipais de Saúde) and collegiate boards or state associations that showed, at that time, rich and productive exchanges of experiences. During the 1980s, this health sector dynamic, centered on SMS initiatives, and converged towards a broader movement to formulate public policies oriented towards citizenship rights. Other frontlines were also important in the mobilization of society, such as the engagement of scholars and researchers at Fiocruz, at the Institute of Social Medicine of UERJ, and many universities such as USP, UNICAMP, the Federal University of Bahia, the Federal University of Rio Grande do Sul, the

Federal University of Minas Gerais and, not least, the contribution of professionals and technicians from the Ministry of Welfare and Health, among others. This group of actors gave form to what used to be called the “Movement of Brazilian Sanitary Reform” (MRSB: Movimento de Reforma Sanitária Brasileira).

The MRSB organization was responsible for performing along with the Health Commission of the Chamber of Deputies, in 1979 and in 1982, the 1st and 2nd National Health Policy Symposium that resonate in the mind and in the decisions of the 8th National Conference of Health in 1986. As a reflux of the dictatorship period in Brazil, the municipal health movement and the State Health Secretariats together obtained agreements with the Ministry of Social Security and Social Assistance, with the support of the Health Ministry, aiming at the expansion of integral health care and allowing the expansion of health coverage throughout many municipalities.

Several health indicators in the 1980s reflected the efficiency of the municipalization movement. For instance, the control of hypertension and its sequelae, polio, measles, prenatal and puerperal diseases, respiratory infections, infant dehydration and others. The results of this dynamic offered substance to the theses defended at the 8th National Health Conference (1986), the National Health Reform Commission (1987) and at the National Constitutional Assembly (1988). The international parameter came out of the unparalleled success of public health systems in European countries. And there was the social support, which was placed as a constitutional guideline of SUS, in the form of deliberative health councils in the three spheres of Government, as approved by law. The advances during the 1980s were ratified and driven by Laws 8080 and 8142/1990.

With SUS enshrined in law, half of the population that had been excluded from any health system was then included in the public health system during this decade. A survey carried out over the period from 1990 to 2005 showed that municipalities turned out to represent 93% of new facilities and 69% of public health workers in the country. The average percentage of municipality taxes aimed at public health was raised, reaching 14.4% in 2000 and 23.3% in 2015. And the interdepartmental context, which has been the government sphere of health, breaks with the anti-public and anti-social political culture of treating the legal minimum threshold of financial investment stipulated in EC-29 as a top limit.

### **The advances of SUS, celebrating its 30 years**

The unquestionable advances of SUS in favor of the needs and rights of the population constitute an unprecedented level of achievement, knowledge and practices. Within the framework of Primary Health Care (PHC), integration of activities aimed at promoting, protecting and recovering health increased, and this was supported in epidemiological and social diagnostics, training and teamwork processes. In practice, it has been noted that the resolution can reach 80%/90% of health needs being met. There are dozens of areas or microregions in the national territory, with favorable and even exceptional circumstances and characteristics for managers, health workers, family health teams, and matrix support groups actions. Many of these areas have excellent physical and funding infrastructure, the support of specialized references, and are often integrated with academic activities. However, these areas tend to be exceptions, because there is no material condition and strategy to expand their experiences today, turning them into niches or trenches or even system standards.

It is not just in primary care that there are areas of excellence. Showing the same features, there are similar niches in the networks of Centers of Psychosocial Care (CAPS), Regional Centers of Workers' Health (CEREST), Pre-Hospital Emergency-Urgency Services (SAMU) and Hemocenters. The area of Health Surveillance earned international recognition for its competency, despite the modest infrastructure it has both within the Ministry and at the regional level. In addition, specialized care and the supply of materials have developed significantly in relation to the inclusion of people with disabilities and chronic diseases. For example, the control of AIDS, which still has the best rating among developing countries, as well as the services of organ and tissue transplants are among the most productive worldwide.

Throughout the 30 years of SUS, the feedback between resistance to deviations and the assumption of the health care model based on the needs and rights of citizenship has been remarkable. This ideology is only feasible with a universalist public policy encompassing the socioeconomic conditions of health and the primary care network in residential and workplaces settings, with 80% to 90% resolution and timely access to specialized care to the remaining 10% to 20% (SUS model). This ideology matters more in terms of social cost/efficacy than cost/effectiveness.

The combination of human practices and values generated a position of positive militancy behavior that was taken up on a daily basis by hundreds of thousands of health workers, managers, counselors and movements for social rights and democratization of the State. It is worth mentioning that the advances achieved led to the development of an inter-federative pact: the intermanagement through the intermanager committees at national, state and regional authorities, which are recognized in practice since 1993 and were legalized only in 2012. The system remains pending the implementation of the constitutional guideline "hierarchization/regionalization", which is a structural, strategic and decisive challenge for the development of the SUS care model as there is an accumulation of municipal experience of four decades. There is also constitutional and legal support: the single command within the federal spheres and interagency agreements in full implementation. The system still lacks the challenge of building the single command based on the smallest cell in the SUS system, the Health Region, to be set and agreed among the intermanager committees and at the health councils.

Hence the question: how and why has SUS militancy, which has been operating with great productivity and monumental output of actions and services, not managed to transform the exception of processes of excellence into the rule? Why, after 30 years, has the SUS management adopted the successful program "Mais Médicos" ("More Doctors") as an example of its advances? This will be addressed in the sections that follow.

### **30 years of the intricate relationship between funding and model of care**

One cannot deny that there is a federal shortfall of funding to SUS, generating distortions and deviations in its implementation. There are some central factors in this issue, as follows:

(1) Disregard of the constitutional commitment to a minimum of 30% of the Social Security Budget (OSS) as the basis for the budget calculation, which, since 1963, does not include the Social Security Fund. Federal funding has remained since then between a third and half of the amounts initially determined in the Constitution. Federal spending with SUS is maintained at around 1.7% of GDP which, together with the municipalities and states, adds to between 3.6 and 3.9 percent of GDP, well below the 7% to 8% applied by good public health systems around the world.

(2) Undue deviation of significant resources from SUS to other government priorities. This has occurred since 1997, when new resources were approved to SUS through the CPMF; and worsened in 1994 with the Emergency Social Fund which in 2000 went to the DRU (Unlinking of Union Revenues), taking away 30% of OSS. Not by chance, in 1997 the huge National Council of Social Security was extinguished by presidential decree.

(3) Approval in 2000 of Constitutional Amendment 29 which binds the funding of SUS to tax revenues for states and municipalities only; the law of Fiscal Responsibility that is a replica of the public sector framework for personnel, with penalties for municipalities that can be ruinous; and the law that created the National Health Agency for development and regulation of private healthcare insurance plans.

(4) The growth and systematization of three forms of federal public subsidies to the private insurance and health care plans in the years 1990: (a) The tax waivers for companies of private healthcare, extended to the pharmaceutical market; (b) public co-financing of private healthcare insurances for civil servants and employees of the Executive, Legislative and Judicial powers; and (c) non-reimbursement by companies of private healthcare insurances to SUS - which is mandatory by Law - for the public services provided to their consumers.

5. In 2004, the PL-01/2003 (a draft bill) was put aside, after improvements and approval arduously achieved by SUS militancy in the three obligatory commissions in the Chamber of Deputies during 2003 and 2004. The PL increased federal funding to a minimum of 10% of the Union's Gross Current Income, and that meant an increase of 0.7% of GDP for the SUS, going from 3.6 to 3.9% to 4.3 to 4.7%, with a legal obligation to apply equitable transfers for Regionalization.

6. In 2007, the Congress put aside the PL-121/2007, similar to the PL-01/2003.

7. By the year 2005, large, heavily subsidized and facilitated public financing from BNDES and BID for building large private hospitals with agreements for SUS use and accredited by major private healthcare insurance companies, as well as the installation of hospitals owned by these companies.

8. The government of Article PL-141/2012 that previewed a minimum of 10% of the GDP

for SUS (the third proposal to be 'put aside'), maintaining the remaining articles of PL-01/2003 that address the expenses.

9. The government veto to an open debate and to voting on the draft bill of popular initiative (PLIP-321/2013) requested by two million signatures of voters. This PLIP had been articulated by the National Health Council, by the National Conference of Brazilian Bishops and a further 100 entities. This was the fourth proposal to be 'put aside' in attempts to rescue PL-01/2003, 121/2007 and the original 141/2012.

10. Without debate with the National Health Council, nor with SUS managers, militants or society at large, the inclement PEC-358/2013, (which is now EC-86/2015), was approved very quickly, which provides for the application of 13.2% to 15% of the Net Current Revenue from 2016 to 2020, which requires the Health Ministry to execute parliamentary tax amendments (0.65 of RCL), excludes the five-year constitutional revaluation, with values below those set by the EC-29 and constitutionalises the federal underfunding of SUS.

11. Approval of Provisional Measure MP-619/2013 granting a tax waiver for the COFINS and PIS social contributions to private healthcare insurance companies.

12. Approval of MP-656/2014, which extends the entry of foreign capital into the domestic market of the private outpatient, hospital and laboratorial network, as well as supports the private healthcare market already contemplated by Law 9656/1998.

13. Submission of PEC 87/2015 by the Government to the Chamber of Deputies that raised DRU from 20% to 30%, creating the DRE (untying of income) to the state and municipal levels (DRM) also by 30% by extending it from four to eight years, and preserving the basis of calculation of SUS funding within the three spheres.

14. Presidential veto to Article LDO/2016, allowing for a reduction in the SUS budget from 2015 to 2016, estimated between R\$8 and R\$14 billion.

15. Approval in Congress of the EC 95/2016, which reduced the annual correction of federal funding in the social area, including SUS, putting real growth at zero by substituting a calculation for the lowest limit of funding, based on the evolution of public revenue, with capping the top level of funding based on inflation from the previous year.

### The implicit building of another model for health care

The distortions listed above were borne from decisions made in the Ministries of Finance, Civil Affairs and Planning. But their approval depended and depends on the docile political group of the sitting party in Congress. Such restrictions and constraints have disfigured the strategic points of SUS, leaving it with insufficient funding and human and material resources. This in turn opens up opportunities for private services which should be complementary or should burden market risks.

The 15 best structured public health systems in the world are defined by society and the State, although they are strongly impacted by the neoliberal health market<sup>1-3</sup>. It is possible to conclude that the strategy of underfunding of SUS is not isolated: it is tied not only to the flow of public resources and other priorities, but also to the building of another model of understated health care, as following 11 findings suggest:

1. Drastic federal underfunding since the 1990s has limited the expansion and quality of installed capacity, which would be fundamental to investment in the physical structure of the public network aiming at universalization. (a) As for the system setting: the underfunding led to the free expansion of the private sector, which should be legally complementary, but it has been replaced by State responsibility. The private sector now produces 65% of hospitalizations and over 90% of SUS diagnostic and therapeutic services, concentrating the majority of average specialist care, payment for production and market services, as well as drugs and equipment. The same modalities of subsidized loans from BNDES and BID for the construction of private hospitals, if they were channeled to SUS, would in eight years allow for the expansion of the public network in 200 regional hospitals, 500 specialist clinics with diagnostic and therapeutic support and 600 emergency room units<sup>4</sup>. (b) Human resources: SUS staff development acting at all levels, after the first decade of its deployment, already accounted for 35% of total health workers as public servants and employees. However, this workforce was complemented by more than 65% of personnel who were outsourced, alongside worsening work conditions, allocated by private entities providing human resources at lower costs, in opposition to what is provided for under Law 8142/1990. (c)

Care Model: the development of primary care has become focal and compensatory, without conditions to reorient the model proposed by SUS. As a catch-phrase, the municipal managers at SUS started to repeat the following sentence: “the humanitarian and legal obligation to emergency relief and assistance to the most severe cases consumes almost all resources, inhibiting the initiatives of protection and early diagnosis”. In 2003, the SUS militancy was left only with the viability of the program “More Doctors”, a timely demonstration and accumulation of powers in favor of human rights, awaiting a less restrictive future. (d) The profile of boards managers: the representation of small municipalities (an absolute majority of Brazilian towns) in management commissions remains little more than symbolic.

2. In November 1995, foreseeing the serious misdirection in the construction of SUS, the National Council of State Health Secretaries sponsored a productive workshop with 67 leaders and national, state, municipal experts and representatives from the Pan-American Health Organization. During that workshop, a report was prepared that strategically prioritized the implementation of the constitutional guideline of Regionalization and Human Resource Management. At that time, those decentralized managers already conceived the Health Region as the smallest systemic cell in the network, a condition for the full realization of the guidelines of integrality, equity and universality, based on primary care. There has been a concern regarding inter-federal agreements for the full offer of services and enough funding. Such a workshop did not give rise to repercussions in national policy. Senior leaders from the Health Ministry in their positions proved to be deeply dependent on the economic ministries in the government. For the same reason, Decree 7508/2011 and Law 141/2012 which provide for the implementation of the Regionalization/Planning-Fair Ascendant Budgeting/Transfers barely got off the statute books.

3. As for federal grants for private health plans and insurance, in 2003, the tax waiver alone corresponded to 23% of Health Ministry expenses and 158% of declared net profit all together. That is, the State was and still is responsible for the profitability of the business sector<sup>5</sup>. It is estimated that those three forms of subsidies mentioned represent at least 30% of Health Ministry expenses. The ministry’s budget should be between double and triple what it currently is. In

summary, the major savings in federal spending on the health sector works in favor of SUS internal privatization through the private sector hired as a substitute; and externally, through public subsidies to the market.

4. The National Health Agency, a federal agency with five government-appointed directors, has all its members coming from the health market. That is, the public agency which regulates the market is captured by this same market.

5. The critical and cautious engagement that occurred in the 1980s by the central and federation unions, participants of the MRSB, was reversed in the 1990s, by the provision of subsidized private health plans that were more accessible and sensitive to the annual agreements of categories, and also by the slowness in accessing and lack of efficacy of the underfunded public network. It is clear that the working class that was historically at the forefront of social struggles gave way to corporatism, against the universal rights of citizenship in the health arena. This was not the case in those 15 countries that implemented universal public health systems and have full State support<sup>3</sup>.

6. In 2004, after the PL-01/2003 was put aside, and after the Health Ministry crisis and other frustrations related to SUS and MRSB struggles, leaders from these militant groups, in partnership with the Social Security and Family Committee of the Chamber of Deputies, conducted in June 2005, the 8th Symposium on National Health Policy, bringing together 800 participants who approved the so-called "Letter of Brasilia". This event was a breather and stimulus for the MRSB allowing appropriate tripartite debate and led to a pact named "For life, in defense of SUS and management".

7. In practical terms, 25% to 30% of the population consume private healthcare insurance whose access to services, opportunity of use, quality and results are segmented according to their prices. The monthly fees range from R\$80 to R\$10,000. However, this same population depends on SUS for the supply of expensive medicines, sanitary and epidemiological surveillance, the control of endemic diseases, immunizations, as well as costly and emergency services. The sum of their health expenditure per capita amounts to between four and six times the expenditure of the 70% to 75% of the population that only use SUS, including sophisticated medical services and materials and sometimes litigation. Lawyers' offices falsely reinterpret the constitutional principles of SUS as an "all for all" where, implicitly, the "every-

thing" remains more defined by the market than by the law and the rules of the National Council of Justice and the Ministry of Health. Among the population who are insured privately, there are upper middle class, middle class and a small fraction of lower middle class people, where most of the structure of union workers in the private and public sector can be found. The 70% to 75% of the population who only use SUS are mostly from the lower middle class, consisting of the majority of workers in the formal and informal sectors and the impoverished. There is in fact a hybrid public-private system, with promiscuous relations between them, without regulation of public interest and reflecting a market-creating State at the costs of the rights of citizenship<sup>6</sup>. Hence, the jargon "Poor SUS for the poor and an additional segment for private healthcare insurance users".

8. There is a striking level of social inclusion under the SUS: every year, billions of primary and specialized ambulatory actions; many hundreds of millions of laboratory and imaging diagnostic exams; and more than 10 million hospitalizations. However, this inclusion is being held up simultaneously by both the actions and services linked to the advances of SUS (exception), as well as to the advances of the market-dependent model, with uncontrollable distortions (rule). Over the last 30 years, the increase of SUS public and private installed capacity and the offer of "SUS" services have been orienting the use of services more focused on specialized care<sup>7</sup>. SUS is affected by another furtive model which is increasingly wrapped in insidious propaganda of "public-private arrangements with lesser public costs". This argument has been laid bare by national and international studies and researches. Scientific evidence points out that such arrangements contribute to inequity in funding, access and use of the services; there is no proof that they relieve the public system; nor diminish the pressure of demand for services; and fit into the logic of articulation between three complexes: the medical-industrial (drugs and equipment), the medical-financing (private insurance companies) and the expansion and support services (advice, information, export, and other)<sup>1</sup>.

9. The resurgence in the HM management in order to make market and government economic area marketing pressures viable for cheap private healthcare insurances (increasing the number of consumers) will certainly worsen the quality of care, as it will restrict the types of diseases and their severity to be cared, increasing the pilgrim-

age of the citizens and the payment outside the system. As a business, this will be a good choice for investors in private health care companies, but this will also be the official double door of entrance in hospitals and laboratories that provide services for SUS, as well as the rupture with the proposal of equality and integrality in health care.

10. The EC-95/2016 aims to constitutionalize the end of SUS (based on which social pact?). This EC restricts the federal primary expenditure calculation, exclusively to the inflation correction of the previous year. That is, it disregards the population growth, the incorporation of technologies in the quality of services, increasing the number of seniors and the underfunding that has crept in over the last 30 years. Not by chance, the National Health Agency acts on the legalization of the market offer of private plans with deductibles: low monthly payments with high deductibles and vice-versa, in view of the accession of the poorest social segments, under the slogan “the consumer needs to feel it in his pocket”<sup>8,9</sup>.

11. Comparing the SUS with advanced universal public health systems, one notes that while also hampered by neoliberal globalization, they: (a) prioritize feedback between quality-equity, aiming at maintaining the adhesion of the middle and elite sectors, without which public services deteriorate; (b) reconcile efficiencies at macro and micro levels; and (c) maintain public health spending above 70% of total expenditure in the sector<sup>1</sup>.

### **In search of what to do**

The numerous distortions already mentioned and the findings presented here point to the validity of hegemonic goals of the State that are contrary to the public health sector. Underfunding is part of the construction, at an advanced stage, of a public-private arrangement with the Brazilian neoliberal policies called “universal coverage” with social segmentation and public financing<sup>2</sup>. Possibly, several political segments in the progressive and popular fields underestimated the organic and shaping power of neoliberal and hegemonic forces over the last 30 years<sup>10</sup>. In addition, the health boards committees have been minimized by State power in decisions that affect the SUS, thereby undermining the social movement. This power creates and stimulates false disputes between management boards and social

control: treating the first with the false notion of realism and prospects for federal transfers, and treating the second waving illusory aspirations, options and pressures of the represented social groups, for private health plans. This ultimately weakens the representation and performance in these important collegiate bodies, and strengthens private health plan operators.

The promising debates in the election campaign in 2002, rescued the flags of the massive mobilizations of the 1980s for the State democratization in the direction of a national project with unstoppable structural reforms (fiscal, political, land, social security, industrial, health, educational and in other areas)<sup>11-13</sup>. From 2003, a remarkable social inclusion of tens of millions of Brazilians into the consumer market reactivated the internal market. But the new governments shared the same reproduction of very serious distortions during the 1990s, such as de-industrialization, the omission of the flags of structural reforms, the diversion of most public resources for financial speculation, for tax havens, tax evasion, tax waivers, political support and funding of election campaigns. Today the country has one of the highest concentrations of income and wealth in the world: out of our current national 43 billionaires, 5 hold the same amount of income as the poorest half of the population (105 million Brazilians)<sup>14</sup>. All this has been done with the worsening of the collusion between speculative financial capital and companies and the high political representatives of the Executive, Legislative and the Judiciary tentacular powers<sup>15</sup>.

This strong neoliberal hegemony has apparently been developed with relative certainty in the face of counter-hegemonic developmentalist, progressive and popular reactions since the 1990s. The structural reforms of the State were, as a rule, omitted or deemed unsuitable, radical, secondary, outdated and out of context. Also in the light of a political and historical analysis, the militants and counter-hegemonic leaders are challenged to make a critical assessment of their positions. We need urgently to preserve the achievements of universalism and social rights, without which the counter-hegemony lacks legitimacy and becomes weaker in relation to citizenship. It is no dream: the resilience and advances of SUS referred to at the beginning of this article attest, if in part and sectorially, that they can serve as another example of the civilizing process.

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