Aim: In the last three decades, the segment of population aged 60 years and older has more than doubled in Brazil. People aged 80 years and older are expected to be the fastest-growing segment in the near future. This aim of this study was to analyze the legal structures currently in place in Brazil and to provide a framework for care policies and practices towards older-adults.

Methods: This article focuses on past and present major socioeconomic burdens on this segment of the Brazilian population as well as on public achievements to overcome inequities.

Results: Both the public health and the social security systems have been directed to provide preferential assistance to the aged. Nonetheless, the elderly remain the most impoverished segment of Brazil and carry the burden of an overall lack of specialized services. Moreover, socioeconomic inequalities and population diversity in Brazil affects elderly care, adding complexity to this unique scenario.

Conclusion: Brazil has adopted legal hallmarks that substantially shifted public practices towards the elderly segment from a philanthropic status to a legitimate right for care and assistance. The demographic transition that took place provides an opportunity for innovative solutions in public policies for older adults in a developing economic environment.

Keywords: Brazil, demographic aging, health care, public policy, social assistance.
converge to increase the burden on the aged segment of Brazilian society and exert a great deal of pressure on the government to ensure outcomes for problems of the elderly population. Moreover, geographic, political and population diversities in Brazil also create a unique scenario that affects elderly care. In 2005, Garcez-Leme et al. provided a valuable, provocative contribution in understanding the Brazilian aging scenario. The present study has the purpose of updating aspects considered therein and to analyze the legal structures currently in place in Brazil that aim to provide the framework for care policies and practices towards older adults. To perform this task, this article provides a description of past and present major socioeconomic burdens on this segment of the population as well as on public achievements to overcome inequities.

Social and cultural aspects of Brazil

As stated before, the ethnic distribution in Brazil is diverse and, according to official statistics, encompasses 51.4% whites, 5.9% blacks and 42.1% of mixed race originating from the interracial admixture that has been taking place since the 16th century. Nonetheless, these frequencies are highly debatable and somewhat misleading because the governmental census relies solely on the color of skin, and any intense admixture process (such as that observed in Brazil) can result in segregation between the skin color phenotype and the overall genetic background. Another 0.6% of the population is composed of ethnic minorities such as Italian-German Europeans and Japanese that emigrated to Brazil in the 19th and early 20th centuries. Nowadays, Amerindians account minimally to the country’s contingent, being nonetheless incorporated in the genetic composition of the Brazilian population. This great miscegenation between different cultures has created a complex and heterogeneous social structure, and causes special difficulties in the care of older patients. The image of the geriatrician, for instance, is habitually associated with a skilled physician not only due to the ability of dealing with multiple health conditions in one patient but also due to communication skills necessary to deal with unequal levels of literacy and older, first-generation immigrants. Literacy rates have increased among older people. Among those aged 60–74 years, the proportion of individuals with less than 1 year of formal education has dropped from 40.8% in 1993 to 31.2% in 2003. Nonetheless, Brazil still has more than 6.1 million illiterate older adults.

The elderly are the most impoverished segment of the Brazilian population. According to the 2003 National Household Survey, only 8.4% of elderly Brazilians lived in families with per capita monthly gains of more than 5 minimum wages (1 wage = US$80.00 in that year). The elderly distribution and poverty level varies by region. The largest contingents are in the southeast (8.0 million) and northeast (4.5 million) regions. The Brazilian northeast has an elderly poverty level of 65.5%, whereas the south and southeast regions stand at 33.9% and 33.0%, respectively.

For almost the last three decades, the segment of the population aged 60 years and older has more than doubled in absolute terms, from 7.2 million in 1980 to 16 million in 2007. On the other hand, the infant segment (0–12 years old) has increased from 45.3 million to 52.1 million, a 15% increase in the same period. By 2050, the estimates are that the elderly population will constitute 64 million individuals whereas children will add up to 46.3 million, that is 25.0% and 17.8% of the general population, respectively. This is as a result of decreasing family sizes and fewer births. As observed elsewhere, people aged 80 years and older are expected to be the fastest growing segment, up to 13.7 million. Currently, women constitute the majority of the elderly population. Brazilian women live, on average, 8 years longer than men. In 1980, women constituted 52.7% of the elderly population whereas in 2007 this proportion reached 55.4%. In 2050, projections estimate that women aged 80 years or older will correspond to 62.4% of all Brazilians in this age strata. The above scenario allows us to present a poor, solitary very old lady as the typical elderly Brazilian of the near future.

To prevent the detrimental outcomes of Brazilian inequalities for the elderly segment of the population, Brazil has adopted legal hallmarks that substantially shifted public practices towards the aged from a philanthropic status to a legitimate right for care and assistance. The current Federal Constitution issued in 1988 demands that assistance to older adults be provided by the family, the society and the State, so that fundamental rights related to community participation, dignity and well-being are met. Efforts to fulfill these aspects are recent in Brazil. Only in 1994, Federal Law no. 8842 was passed to stand as the first National Policy on Aging, that created the National Council for the Rights of the Older Person (CNDPI) and proposed the first model for integration of public practices on health, education, laborite, social security and recreation for the aged. This law unfolded from the National Policy on Social Welfare (Federal Law no. 8842) issued in 1993 that created the so-called Unified System of Social Assistance (Sistema Único de Assistência Social, SUAS) from which the elderly were entitled to special protection and care actions on issues regarding access to permanent shelter, to user embracement, to functional independence and to violence prevention.

Despite those legal standards, it was not until 2003 that a federal legislation was passed to provide an actual hallmark for care policies and practices for older adults. For over 8 years, the National Congress debated this document, which was approved as Federal Law no.
10 741 on 1 October 2003, named The Elderly Statement. It creates preferences for older people in all public health assistance programs and priority for the aged in the restitution of taxes and law suits whilst assuring free medication benefit for those with chronic diseases. Moreover, the statement foresees free public metropolitan and interstate transportation and harsher criminal penalties for elder abuse and neglect. The Brazilian Elderly Statement also determines that all individuals aged 65 years or more who are unable to provide their own maintenance are eligible to be granted a lifelong, minimum federal pension of 1 minimum wage per month (currently = US$210.00 due to a devaluation of the US currency), despite never having contributed to the Welfare Ministry. Even though all this represents a critical step towards improving quality of life and providing dignity for Brazilian older people, it is recognized countrywide that much effort is still needed to turn policy into practice due to developmental constraints inherent in the country, mostly related to economic limitations and insufficient cultural evolution akin to developed countries. To illustrate that, one might remember that 1 wage is insufficient to assure the cast of individual rights presented as mandatory for all by the 6th article of the Brazilian Federal Constitution. Such rights encompass house holding, transportation, nourishment and health, to list a few.

**Living arrangements**

In Brazil, the lack of governmental assistance to older individuals tend to be replaced by familial efforts, which helps buffer the effects of poverty. In rural areas, expanded families see the care of grandparents as of an essential cultural value. Nonetheless, in metropolitan areas, the ongoing phenomenon of lower fertility rates coupled to increased divorce rates has led to an augmented number of single-parent families, imposing a burden on the middle-aged. This burden ends up being extended to the aged, who find themselves compelled to continue contributing to the family gains. In 2003, 65% of older Brazilians were financially responsible for their family, and approximately one-third of older people were still working. Frequently, elderly pensions are the only household income, further defining the critical role of the older person in overall family support and dramatically changing traditional family roles. For many poor families, living with an elderly parent is pivotal to overall family support and taxation. All of the above translates into only 12% of older people living alone. Moreover, the Brazilian economic heterogeneity gives rise to migration episodes that occasionally occur throughout the country and that add complexity to the scenario. A recent case of internal massive migration, for instance, took place at the time the capital city was built. Located in Central West Brazil, Brasilia was constructed in the late 1950s and early 1960s and conceived to hold the ultimate administrative organizations of the Brazilian Federation. At that time, most of the inhabitants of Brasília were single working males who settled alone in the city. As an outcome, nowadays the city shows an elevated rate of male older adults residing in long-term facilities.

**Health-care system**

The first health-care system in Brazil was based on a series of altruistic or philanthropic institutions founded in the beginning of 16th century. It was not until Getúlio Vargas’ administration (1920s) that a governmental office (Welfare Ministry) was established to ensure retirement and health-care benefits. Nonetheless, those benefits were offered solely for selected Brazilian formal workers. Only after 1930, a series of labor laws were passed to expand retirement and health benefits to a larger working population. Meanwhile, the poor continued to receive care through the model of charity hospitals. In the 1950s, a Health Ministry was implemented to hold a separate governmental health-care branch to address collective, public health issues, mostly for management of chronic conditions and infectious diseases. In 1988, to replace both pre-existing structures, an integrated model for orientation and administration of health-care resources was founded, the so-called Unified Health System (Sistema Único de Saúde, SUS). Based on the goal of providing universal and equal access to multiple levels of health services and actions, primary care was substantially strengthened through the creation of programs such as the Family Health Program (PSF) and Community Health Agents Program (PACS), under guidelines established by the Health Ministry. The SUS budget accounts for 3.6% of Brazilian gross national product, being the Latin American country with the highest annual health-care expenditure (roughly $20 billion/year).

The SUS is responsible for paying for the healthcare of 70% of the elderly Brazilian population. Even though older adults represented 14.3% of the Brazilian adult population in 2001, this segment was responsible for 33.5% of adult hospitalization that year. In 2006, of the 11.3 million acute care admissions in SUS hospitals, 2.2 million were of people aged 60 years or older, accounting for 26% (over $800 million) of all expenditure related to hospital admissions. Despite shortcomings of the pharmaceutical assistance funded by the public system, the SUS is also responsible for providing most of the drugs consumed by older adults.

Formal geriatrics training can be considered quite recent in Brazil, because it was not introduced in medical schools until the late 1970s. It was not until 1979 that the Brazilian Education Ministry recognized the first geriatric medicine residency program.
2007, Brazil registered approximately 250 000 active physicians, of whom 468 have geriatric credentials. This translates into one geriatrician per approximately 34 000 elderly citizens and less than 1 to each 5560 Brazilian municipalities. Other inconsistencies in the distribution of health-care professionals can also be noticed. The southeast region (Esperito Santo, Minas Gerais, Rio de Janeiro and São Paulo states) is the most developed and populated part of the country, accounting for more than half of the total available health-care providers.

Cardiovascular, respiratory and gastrointestinal conditions are responsible for 60% of all hospitalizations of older adults in Brazilian SUS. Nominally, the three leading causes of hospital admission regardless of sex are heart failure, bronchitis/emphysema and pneumonia. Despite remaining the leading cause of death among the aged, a remarkable decrease of the mortality rate due to cardiovascular diseases took place in the last decade (38.0% and 29.1% of all deaths in 1996 and 2006, respectively). Unfortunately, this trend has not been paralleled to the same extent by mortality rates due to cancers (13.3% and 10.0% of all deaths in 1996 and 2006, respectively) and have even increased on what concerns respiratory causes (12.3% and 21.9% of all deaths in 1996 and 2006, respectively). In the same period, mortality due to endocrine/metabolic disorders increased more than twofold (original data).

Specialized assistance for older adults in Brazil is not well developed. Residential care and nursing homes are scarce and exist almost exclusively in major metropolitan areas. Long-term care institutions supported by the government are not available nationwide, and take only the poorest and most disabled older people. Despite efforts to standardize Brazilian nursing home services, most institutions do not comply due to lack of law enforcement. In São Paulo State, for instance, the State Law no. 12.552 (8 March 2007) was passed to oblige nursing homes to possess at least one physician with geriatric training on-site, but few have complied since then. Most elderly Brazilians lack the resources necessary to afford private institutional long-term care and health-care insurance. Currently, only one out of four older adults are holders of either an individual or a collective private health insurance policy. Nonetheless, this proportion might be considered an achievement based on the proportion of 1 out of 10 in 1996. The administrative Act no. 2528/2006 issued by the Health Ministry may be considered another achievement because it establishes a status of priority for the aged in all public health services. Moreover, besides the attempt to provide long-term care for older people by the home-based Family Health Program, introduced in most areas of the country by the SUS, the subsequent Act (no. 2529/2006) brought about the initiative for home-based hospitalizations of older adults. Both measures respond to demands of the Brazilian Elderly Statement, but their effectiveness remains to be assessed.

In 1999, Brazil started an annual elderly vaccination program whose goal was to increase elderly immunization rates against influenza. Known as the annual influenza vaccination campaign, these vaccinations are free for older people and their caregivers. This program began by administering 4 million influenza doses and, by 2007, these had increased to more than 13.8 million doses. Presently, 88.7% of the Brazilian elderly population are fully vaccinated.

**Perspectives**

Most of the scenarios described highlight that substantial political and ideological achievements have been made in the relatively few years since which Brazil was acknowledged as an aging country. Concerning public policies towards the elderly, our study and others demonstrate that the focus has already been moved away from the unassisted/neglected paradigm to aim for compensatory/management actions. It is important to consider that most of the Brazilian efforts for improving the socioeconomic condition of older adults are essentially related to governmental goals for implementing an operational Social Security apparatus. For now, this apparatus is mostly represented by the nation’s public health system (SUS) and public welfare system (SUAS), from which come most of the benefits for the poorest aged individuals. Despite much improvement in elderly care, the inequities of the Brazilian scenario, inherent in all aspects of the country, prevent those systems from being available and effective countrywide, and this tends to burden the elderly in the poorest regions and in the frailest conditions. Therefore, it becomes evident that strengthening the status and the role of older adults in Brazil is achieved by improving the effectiveness and the breadth of actions currently aimed at this segment. Moreover, specific public programs should also be created to ensure a policy-to-practice shift on issues such as pharmaceutical assistance, nutritional support, mental health, tobacco use cessation, continuing and competency-based education, supported employment, homes for the aged and protection from abuse, among others. The need for specialized health services and social support for the growing population of older people in Brazil is also noteworthy. With all these structures in place, it would be reasonable to expect further, future accomplishments from the shift from the current compensatory/management paradigm to the emancipatory/empowering strategies that could lead this segment to a concrete possibility of a state of citizenship and well-being.

It is needless to emphasize the magnitude of the efforts to come. Nonetheless, Brazil is widely acknowledged for facing and solving problems through
unorthodox, innovative approaches. Therefore, the population aging in Brazil may provide an opportunity for such innovative solutions to flourish into both another design/illustration/role of the older person, as advocated by Leibing,31 and another model of care and assistance, similar to the AIDS program, in a continent swept by marked cultural and regional inequities.

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