# What's new about being old

## O que há de novo em ser velho

**Monica Rebouças**
PhD in Public Health. Researcher, Department of Preventative Medicine, Universidade Federal de São Paulo.
Address: Rua Bela Cintra, 672, Sala 1004, Consolação, CEP 01415-002, São Paulo, SP, Brasil.
E-mail: monicareboucas@terra.com.br

**Marina Ruiz de Matos**
PhD in Public Health. Visiting Professor, Department of Preventative Medicine, Universidade Federal de São Paulo.
Address: Rua Borges Lagoa, 1341, Vila Clementino, CEP 04038-034, São Paulo, SP, Brasil.
E-mail: marina.matos@unifesp.br

**Luiz Roberto Ramos**
Postdoctorate in Neuro Psychogeriatrics. Full professor, Deaprtment of Preventative Medicine, Universidade Federal de São Paulo.
Address: Rua Borges Lagoa, 1341, Vila Clementino, CEP 04038-034, São Paulo, SP, Brasil.
E-mail: lrramos@unifesp.br

**Luiz Carlos de Oliveira Cecílio**
PhD in Public Health. Professor, Department of Preventative Medicine, Universidade Federal de São Paulo.
Address: Rua Borges Lagoa, 1341, Vila Clementino, CEP 04038-034, São Paulo, SP, Brasil.
E-mail: luiz.cecilio@unifesp.br

## Resumo

O texto aborda aspectos do envelhecimento e seus novos paradigmas. É bem conhecida a relação entre envelhecimento e o aumento da prevalência de doenças e, consequentemente, do consumo de fármacos, perda progressiva de funcionalidade e maior utilização dos serviços de saúde. No entanto, observam-se, a partir da segunda metade do século XX, rápidas transformações no modo de se ver e se viver a velhice. Nos últimos anos, o aumento de pessoas mais velhas ocorre de modo simultâneo à ampliação da classe média brasileira, com marcado impacto na possibilidade de acesso e consumo de determinados bens e serviços, produzindo-se novas necessidades sociais. O *tempo da velhice* e os papéis sociais a ele atribuídos sempre variaram segundo o horizonte histórico das diferentes sociedades. Mais recentemente o envelhecimento vem sendo associado à imagem positiva de se viver mais e melhor. Entretanto, os avanços não se concretizam para todos os cidadãos. As sociedades capitalistas atravessadas pela desigualdade distributiva suscitam desafios ligados às camadas mais pobres e desassistidas, assim como ao lugar a ser ocupado pelos novos e novíssimos velhos.

**Palavras-chave:** Idoso; Envelhecimento; População.

## Abstract

This paper discusses aspects of aging and its new paradigms. The relationship between aging and increased frequency of illness and consumption of drugs, progressive loss of functionality and greater reliance on health services is well known. However, from the second half of the twentieth century, rapid changes in the way of seeing and living old age have been observed. In recent years, the increase in the number of older people has occurred simultaneously with the expansion of the Brazilian middle class, with a strong impact on the accessibility and consumption of certain goods and services, producing new social needs. The time of old age and social roles assigned to it has always varied according to the historical horizon of different societies. More recently, aging has been associated with positive image of living longer and better. However, this progress has not come true for all citizens. Capitalist societies are marked by distributive inequality and in this situation there are challenges linked to the poor and underserved, as well as the place to be occupied by the young and the new old people.
**Keywords:** Aged; Aging; Population.

## The issue

From the mid-20th century onwards, an intense movement took place aimed at understanding a new phenomenon in human experience – the increasing number of individuals reaching and living through old age. Throughout history, the interval between becoming old and dying was summed up by a small number of years. The "time of old age" and the social roles assigned to it vary according to the historical horizons of the different societies and their limits to longevity, but the age-death relationship was unmistakable.

Lima (2004) indicated that humanity took various centuries to exceed a mean age of 30 years old. It was only from the 1950s onwards that there was a significant impact on life expectancy in populations benefitting from the scientific and technological advances initiated in the 20th century and accelerated during the two World Wars. Assessing the causes of this demographic transition, Minayo (1997) noted changes in the overall shape of society, alterations in the production system and the new pattern of urbanization as well as specific actions in the area of health care such as formulating programs linked to specific diseases, mass immunization and widening medical care coverage.

In the case of Brazil, demographic censuses show that in 1950 life expectancy was 43.3 years. By 2000 it was 73.9 years and in 2010 it was 77.4 years. More specific analyses show mean life expectancy of over 80 for women in developed urban areas. This increase in life expectancy produced new aspects in ways of thinking and interacting with the meaning and the way of experiencing old age (IBGE 1956, 2001, 2013; SEADE 2008).

Of the various aspects to the investigation, two can be highlighted as apparently essential. The first is recognizing that social groups and circumstances transform a situation restricted to the individual, family, subjective sphere, with specific behavior and characteristics, into a collective issue, public and, therefore, political. The second is how those who are ageing now, as a cause and also a consequence of social changes, formulate new lifestyles, values and recognized social identities.

In the form of an essay, this work approaches ageing from its social dimension and raises possibilities of analysis. The authors start from the idea that the ageing population can also be considered in the dimension that it affects the middle class and, in turn, brings about expansion of the market, of consumption, of goods and services linked to body maintenance. The role of the media and of policies linked to promotion and prevention of so-called healthy ageing are added to this; corroborating the challenges of thinking about what's new for elderly Brazilians.

## The old elderly

Ways of keeping the body healthy, in biological terms, are well known, as are the measures necessary to prevent, control or at least monitor most diseases. The social factors which interact in different situations are also well known, resulting in multiple forms of managing health which makes it difficult to pin down the exact role played by this multi-dimensional network of interactions in the health-disease process responsible for ever greater numbers of individuals now living longer (Camarano et al., 1999).

Data for Brazil regarding individuals aged sixty and over in the 1990s, give us a picture of the job market over the last thirty years, in other words, of those live through this period marked by the end of the so-called Brazilian economic miracle, intensified by international crises and the subsequent decreases in jobs and changes in hubs of production, along with other components in the neoliberal matrix (Singer, 1975). From 1980 onwards, the macro-economic plan, the principal characteristics of which were financial globalization and the de-politicization of the economy, with significant effects local job markets.

To reduce the impact of the economic recession, hyper-inflation and financial speculation of the period, various plans were hatched to stabilize and tackle inflation. Only in the 1980s were the Cruzado I, Cruzado II, Bresser, Verão and the Cruzado Novo plans launched. As a result, poverty, inequality, exclusion and unemployment grew (Matos, 2009).

The data in Table 1 show that, in the 1990s , the Brazilian population had 15 million elderly individuals, around 10% of the inhabitants of the country, of which almost 92% were white or *pardo*. More than half of them did not live alone, either married or other family arrangement, and almost all of them (90%) reported schooling below the average level.

In Table 2, we can see the impact of the economic situation which that segment of the population faced. Approximately a quarter (23%) of the elderly were classed as poor. Pensions and work were the most common sources of income and the majority were on less than two minimum wages. It is worth remembering that the minimum wage was frozen or readjusted below the rate of inflation for long periods during the 1970s and 1980s. It should also be highlighted that, among other problems, the crisis in the job market brought with it an increased social security deficit, as the system was based on contributions dependent on formal employment, and the workforce was decreasing as the population grew older.

Together, the data in tables 1 and 2 suggest the different manifestations and adjustments in the everyday life of the elderly. These interactions are crisscrossed by different income status, different access to and consumption of various types of goods and services (Silveira et al., 2002). In this sense, the groups from the lowest social levels have the most difficulty in consumption of various items, resulting in fairly heterogeneous living conditions (Almeida et al., 2002; Barreto, 2006).

In the case of the elderly, we need to add the important role of physical health as a strategic indicator in this interaction (Rebouças and Pereira, 2008). Reinforcing this aspect, the fact that the majority of them suffer from at least one chronic disease should be highlighted (Ramos and Goihman, 1989, Ramos et al., 2001, Lima-Costa et al., 2003). Their expenditure is naturally overloaded by the costs of medicines and care and this is increased when they are socially disadvantaged (Barros et al., 1999; Marin et al., 2008). The higher frequency of chronic disease among the elderly is also associated with the severity of the manifestations of acute diseases.

Situations such as flu epidemics record more serious cases among the elderly (Luna, 2002).

The ideas of Papaléo Netto (2007) on awareness of old age which, according to the author, is linked to historically established patterns, corroborate the contents of the previous paragraph. One of these can be summed up as proving finiteness and another in the fact that disease is more commonly found in older individuals, both confirming the inexorable action of time, irrespective of technology. Ageing is characterized, therefore, by physical alteration associated with decline in the performance of various organs. On this topic, Ramos (1993, 2003) discusses the fact that even ageing free from disease involves some degree of functional loss, expressed by discrete, albeit continuous, decreases in vigor, strength, alertness and reaction speed. These findings lead to thinking of the ageing process through paradigms in which biological alterations progressively change the body, making it susceptible to health problems and finally leading to death (Papaléo Netto, 2007).

Reflecting on the high frequency of disease among the elderly leads to other reflections on the use of health care institutions to meet these demands. And the data presented in table 3 indicates the budget commitment of elderly Brazilians on health care at the end of the 20th century. The majority spent almost half their resources on costs connected with disease, especially on medicine. Of a population estimated at some 15 million individuals aged 60 and over, around 10,200,000 earned two minimum wages or less (table 2) and, at least in those aged 65 and over (data for item 2 in table 3), spent almost half of this figure on health care.

In view of this situation, the impact which drove the establishing of broad actions, with free access to medicine, becomes clear. For some segments of the elderly population, due to their multiple diseases and subsequent use of polypharmacy over long periods of time, the provision of free medicines frees up part of their income to be spent on other goods, such as food, housing, leisure or other needs.

**Table 1 - Profile of the elderly in Brazil in the 1990s**

| Indicators | Percentage (%) |
|---|---|
| 1 - Number of elderly individuals | 15 million |
| 2 - Proportion of elderly individuals in the population | 98.56 there are two percentages |
| 3 - Racial and ethnic composition: | |
| white | 61.0 |
| *parda* | 31.0 |
| black | 7.0 |
| Asiatic | 1.0 |
| indigenous | 0.4 |
| 4 - Marital status: | |
| married | 52.0 |
| separated/divorced | 4.0 |
| widowed | 28.0 |
| single | 16.0 |
| 5 - Level of schooling (completed): | |
| Higher Education | 4.0 |
| High school | 6.0 |
| other | 90.0 |
| 6 - Household arrangements | |
| Couple with or without children | 56.0 |
| Elderly individual with children | 21.0 |
| Elderly individual alone | 23.0 |
| Living in a shared residence | 0.7 |

Source: IBGE Demographic Census 2000

**Table 2 - Economic profile of the Brazilian elderly population in Brazil in the 1990s**

| Indicators | Percentage (%) |
|---|---|
| 1 - Poverty | 23.0 |
| 2 - Main source of income | |
| Social security | 59.0 |
| work | 28.0 |
| pension | 5.0 |
| rent | 8.0 |
| other | 0.3 |
| 3 - Monthly income | |
| Less than 2 MW (minimum wage) | 68.0 |
| 2 to 5 MW | 19.0 |
| over 5 MW | 13.0 |
| 4 - Participation in the work force | |
| 60 - 64 years | 41.0 |
| 65 - 69 years | 27.0 |
| 70 and over | 2.0 |

Sources: Item 1 — National Survey by Household Sample (Pesquisa Nacional por Amostra de Domicílios), 1997 and Household Budget Survey (Pesquisa de Orçamento Familiar) 1995. Adapted by Barros et al, 1999 and Camarano, 2005. Items 2; 3 and 4 National Survey by Household Sample, 1983, 1991, 2003, 2005.

**Table 3 - Percentage (%) of the elderly population according to indicators of access to health care services and associated costs, Brazil, 2000**

| Indicators | Percentage (%) |
|---|---|
| 1 - Spending on health care | |
| Monthly income spent on health by income levels, by number of minimum wages (MW) received | |
| 0 to 2 MW | 36.0 |
| 2 to 5 MW | 41.0 |
| 5 and over MW | 24.0 |
| 2 - Composition of health expenditures | |
| Net monthly income spent on pharmacy items | 51.0 |
| Net revenue spent on other items of assistance | 49.0 |
| 3 - Access to health care services | |
| Elderly individuals who sought health services and were not treated | 0.6 |
| Elderly individuals who did not seek health care because they had no money | 3.0 |
| 4 - Utilization of health care services | |
| Number of elderly inpatients in the SUS in 2003 | 2,301,763 pessoas |
| Average length of hospitalization of the elderly population (in days) | 8 dias |
| Proportion of elderly individuals who had at least one medical visit in the last twelve months | 71.0 |
| 5 - Proportion of elderly individuals who received home care | 2.0 |

Sources: Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística) — IBGE and Brazilian Ministry of Health (Ministério da Saúde). Item 1. Household Budget Survey (Pesquisa de Orçamento Familiar) - POF 1995. Adapted by Almeida, 2002. Item 2. National Survey by Household Sample (Pesquisa Nacional por Amostra de Domicílios) - PNAD 1998. Adapted by Lima and Costa, 2003 for individuals aged 65 and over. Item 3. National Survey by Household Sample (Pesquisa Nacional por Amostra de Domicílios) - Pnad 1998. Item 4. Ministry of Health (Ministério da Saúde) — SIH/SUS for 2000 and 2003. National Survey by Household Sample (Pesquisa Nacional por Amostra de Domicílios) - Pnad 1998. Adapted by Camarano, 2005. Item 5. Demographic Census 2000. Adapted by Camarano, 2005.

## The new old

Despite the socio-economic difficulties through which the country passed, many changes in the last 30 years of the 20th century can be identified. The rapid increase in the number of individuals entering their 60s at the end of the millennium can be understood as a period of "transition", in other words, changes in the standard of health care and an archetype which together serve to extend the "state of old age" (a figure of speech referring to living past 60, which denotes old age).

This change requires changes in the "traditional" care models and production of input to face the new challenges of health care issues in the Brazilian population through alternative proposals, with original formats, even including the idea of commitment to defending life (Cecílio, 2000).

The changes in living standards were comprehensive, involving managing care beyond the family sphere, creating alternatives with the potential to increase the network of community contacts and engage social groups more, which has repercussions on the meaning of being old.

Establishing programs aimed at the 60 and over age group, by both public and private institutions, increased resources which, in turn, encouraged a new way of preventing disease which was more effective and involved more exchange between different age groups (Faleiros and Rebouças, 2005).

From this perspective, we can identify many actions aimed at the elderly, established by various organization aiming to create a better fit between everyday needs and possible responses for this segment of the population (Serapioni, 2005; Busse et al., 2010). Policies have been established up, albeit in a fragmented way, trying to respond to differences in ethnicity, gender, age group, economic situation, psychological and cultural and other aspects. The meanings of the expressions functionality and functional capacity, in particular, have been widely discussed, as have indicators of independence with autonomy, terms which signal participation with self-governance in everyday activities, for those who have lived for six or more decades (Ramos, 2003; Ruger, 2010; Rebouças and Pereira, 2008).

The steps taken by the government were basi-

cally divided into two groups: healthy ageing (the expression used for policies aimed at promoting health and preventing disease) and recognizing the rights and citizenship of the elderly (Guimarães, 1987; Brasil, 2003, 2006a, 2006b). At the end of the 1970s, proposals for health care, resulting from proposals which had already been consolidated in other countries, started to make their presence felt in Brazil, due to the demands of social groups and, in the political sphere, because of the appearance of certain actions aimed at specific population groups on the public agenda (Brasil, 2003, 2006a, 2006b).

A national plan aiming to legally consolidate the rights of the elderly was established in 1996, following great efforts, reaffirming the relationship between democracy and the legal and judicial basis. Although the existence of this law does not mean it will be complied with, its absence impedes vindicatory legal actions.

However, no matter what changes have taken place, some institutions still retain their conservative attitudes. In the case of the Residential Institutions for the Aged - Instituições de Longa Permanência para Idosos (ILPI), it is not often that functions beyond the role of residence and care for the vulnerable elderly interact without encouraging the residents' citizenship, increasing their participation in the community (Maia et al., 2008).

There is, however, a noticeable positive balance from the point of view of advances made in the early years of the 21st century, the repercussions of which can be identified in the form health care takes and in the vision which society as a whole has come to have of this stage of life. On this latter point, it is impossible to ignore the presence of many intellectuals, politicians and other groups, attracting the media to this age group, which results not only in politicization of the issue (treated in various ways, even as politicking) but also in the possibility of a more positive image of ageing.

The elements which enable this wider picture to be consolidated can be sought within the social structure, as, on a historical level, all age groups come to play a part and make sense. In the capitalist production mode, dividing society into segments is basically linked to income levels and consumption of goods and services. The mid-levels, between the elite and the poorest levels, known in the Marxist tradition as bourgeois and proletariat, are becoming more and more numerous, with various internal subdivisions homogenized by the aspiration to consume, by values and specific social representations. This amalgamation enables the participants to refer to themselves in relation to others and, in turn, reflects behavior, aspirations and ways of life which includes numerous groups. Weber (Thiry-Cherquer, 1997) identified this role of the middle class as the herald of patterns of analyzing reality through its strategic space in the social structure, creating a market-aimed rationality which generalizes the practices and aspirations of consumption. It is in this context that the transformation of the old takes place: from being of little use and a responsibility for the families, they came to have a more and more positive image, a metaphor which assisted the effective lengthening of life.

The so-called lower middle class have the identities and aspirations similar to those of the traditional middle class, considering the subdivisions which exist in urban societies and the possible breaking up of meaning by the different internal groups of which they are composed, according to Nery (2008). On this topic, the recent entry of a large contingent of individuals into the so-called "class C" led not only to them seeking to own property, a car, a computer, new forms of leisure and other goods indicating mobility but also a new social identity, driven together with representations which marked the sensation of belonging to this group. "Middle class thinking" allows its members to explain both their own actions and those of others, through a strong symbolic system which "stitches together" the subject, the social structure and the place they occupy. The research coordinated by Nery (2008) indicates that there was no impoverishment of the mid-levels due to the entry of the new groups. The findings indicate a 22.8% increase in mean income between 2004 and 2008, with those new entrants into the mid and 33.6% for the richest levels. However, it should be remembered that, in terms of inequality, 50% of the population exists below the mean. Aiming to quantify these segments, the authors define "class C" as a group with a mean household income between R$ 1,064.00 and R$ 4,561.00. In the general calculation, these

values correspond to mean income of the group of Brazilians, the statistical middle class, despite being within the median value.

The social mobility noted in the first decade of the 21st century has distinctive contributing factors which produce new questions. However, the concern here is to highlight both the impacts of ageing on society in general and on health care needs in particular, such as the broadened meaning within the traditional middle class levels, produced by the culture of consuming goods and services and the political expressions of demand.

Another relatively recent phenomenon, affecting individuals regardless of their different income classes, but especially the most numerous, the middle, are change in the way of referring to old age such as using the expression "third age", which became popular at the end of the last century. The term was used in France at the end of the 1970s and in England in the 1980s, in courses aimed at discussing issues connected with old age, at the same time as creating its own academic area. The term "third age" is associated with concepts such as that of "elderly"; "active retirement" as well as the controversial "best age", lexical examples which seem to seek to construct a more positive image of ageing, irrespective of the reality being supported.

For Nery (2008), the increasing dominance of this affirmative discourse in the symbolic sphere produces and reproduces values which are constituted in the current system of identifying the elderly, in which the media play an important part.

This image is linked to the idea of preserving youthfulness, an old ideal. To facilitate consumption, there are countless different technological resources which create the possibility of individuals not appearing to be their true age. This possibility, in a way which is not entirely clear, became part of so-called "quality of life" or other middle class metaphors, discussed in works without definitive conclusions for those analyzing the times we live in (Debert e Simões, 1994).

Debert (2010) states that contemporary experience of ageing relativized the traditional vision that age groups are accompanied by specific, rigid behaviors. According to the author, there is a lifestyle which involves a set of recipes and techniques for maintaining the body, such as healthy eating, exercise and medicines, as well as including various forms of socializing, such as dance, attending courses and leisure, showing how those who do not feel old should behave, irrespective of age. This attitude is spreading through different social groups (some with programmed public activities, such as the Reference Centers for the Elderly - Centros de Referência ao Idoso, others within the middle class area of access to consumption).

Consequently, it seems appropriate for those who aim to define what Brazilians aged 60 and over are like, based on their historic and social definition, to recognize the clear change in the rigid demarcation of roles and behavior. The appearance of increased fluidity and nuance makes it difficult to identify age, the element which, up until now, guided relations between individuals.

In Brazil, the elite have always had access to products and services connected with the aesthetic mode of each era and to maintaining the body, thus they are able to put off the image of old age for longer. For the rich, situated at the top of the economic pyramid, when national resources are exhausted they have access to rejuvenating clinics abroad, especially in Europe. The results can be seen in magazines which, while attracting admiration, do not achieve collective expression due to their distance from the reality of the majority of society. More recently, what stands out is the middle class entering this world, paying in installments to preserve their appearance. Thus we have the increasing proliferation of popular clinics, always full and financing aesthetic treatments paid for in the long term. Limiting or delaying the effects of ageing and, simultaneously, a new meaning for this stage of life is, therefore, becoming a population issue when access to part of these goods is available on a large scale, according to market logic, to consumers.

However, the exacerbation of inequalities among older Brazilians should also be highlighted. For example, the appearance of the market for goods and services aimed at segments of the population with acquisitive power. And for the new arrivals in classes with disposable income, the appearance of the distance between the icons of the new market and the ability to acquire. This inequality is struc-

tural, it being in the power of those from whom it is composed, including the media, to increase or minimize it. But issues relating to inequalities are not related to acquisitive power. Among the most elderly there are also those without spending power. They are elderly individuals without income, sick and vulnerable, occupying the opposite end of the scale to those vying for new markets and products, in contrast to those more economically favored. Therefore, at the same time, as well as the images of types of ageing growing closer to each other, the same centuries-old inequality in Brazil perpetuates.

## Taking up the issue

Experiencing individual processes associated with ageing, sharing values and positive ideas in the collective context, is connected to the intricate web of relationships that give meaning to various stages of life. Concentrated efforts are made to develop alternatives to preserve the appearance and control risk factors for illness – the deleterious effects of ageing. However, in the everyday life of the subjects, phenomena such as illness and physical and mental decline are experienced as heterogeneous experiences.

At the start of the 21st century the positive metaphor for the third age appeared and was fulfilled for the population in the mid-levels of society. Important advances affected the space between adulthood and old age, which moved further and further from its traditional limits. The course of life was altered and demarcations of behavior considered appropriate, even in the recent past, blurred and weakened.

However, these possibilities did not manifest themselves for all citizens. Capitalist societies, crisscrossed by inequalities in distribution, make a distinction between body, health and longevity, thus the importance of recent social mobility in the country. With this mobility, new identities pose challenges far beyond the ageing of social groups.

The bias attached to the poorest levels of society, including the elderly, is still present and is growing; as is the role of ill elderly household members; the collective incorporation of health care policies, among others.

Therefore, in the 21st century, broad horizons appear in discussions of real changes in the young and in the new old.

## References


ALMEIDA, M. F. et al. Prevalência de doenças crônicas auto-referidas e utilização de serviços de saúde, PNAD/1998, Brasil. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 7, n. 4, p. 743-756, 2002.

BARRETO, S. M.; KALACHE, A.; GIATTI, L. Does health status explain gender dissimilarity in health use among older adult? *Cadernos de Saúde Pública*, Rio de Janeiro, v. 22, n. 2, p. 347-355, 2006.

BARROS, R. P.; MENDONÇA, R.; SANTOS, D. *Incidência e natureza da pobreza entre idosos no Brasil.* Rio de Janeiro: Instituto de Pesquisa Econômica Aplicada, 1999. (Texto para discussão, n. 686/1999).

BRASIL. Ministério da Saúde. *Conferências de saúde.* Brasília, DF, 2003. Disponível em: <http://portal.saude.gov.br/portal/arquivos/pdf/12_CNS_Relatorio%20Final.pdf >. Acesso em: 25 jun. 2010.

BRASIL. Ministério da Saúde. Portaria nº 2.528, de 19 de outubro de 2006. Aprova a Política Nacional de Saúde da Pessoa Idosa. *Diário Oficial da União*, Brasília, DF, 20 out. 2006a. Seção 1, p. 149.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas e Estratégicas. Área Técnica Saúde do Idoso. *Comentários às deliberações da Conferência Nacional dos Direitos da Pessoa Idosa – eixo saúde.* Brasília, DF, 2006b. Disponível em: <http://portal.saude.gov.br/portal/arquivos/pdf/relatorio_cndi_2006_idoso.pdf>. Acesso em: 25 jun. 2010.

BUSSE, R.; SCHELLER-KREINSEN, D.; ZENTNER, A. *Tackling chronic disease in Europe*: strategies, interventions and challenges. Copenhagen: WHO, 2010. Disponível em: <http://www.euro.who.int/__data/assets/pdf_file/0008/96632/E93736.pdf>. Acesso em: 27 jun. 2010.

CAMARANO, A. A. *Idosos brasileiros*: indicadores de condição de vida e acompanhamento de políticas: Presidência da República Subsecretaria de Direitos Humanos. Brasília, DF: Associação Nacional de Pós Graduação em Economia, 2005.

CAMARANO, A. A. et al. (Coord.). *Como vai o idoso brasileiro?* Rio de Janeiro: Instituto de Pesquisa Econômica Aplicada, 1999. (Texto para discussão, n. 681/1999).

CECÍLIO, L. C. O. Mudar modelos de gestão para mudar o hospital: cadeia de apostas e engenharia de consensos. *Espaço para a Saúde*, Londrina, v. 1, n. 2, p. 4-26, 2000.

DEBERT, G. G. Envelhecimento e curso da vida. *Revista de Estudos Feministas*, Rio de Janeiro, v. 18, n. 1, p.120-128, 2010.

DEBERT, G. G.; SIMÕES J. A aposentadoria e invenção da terceira idade. In: DEBERT, G. G. (Org.). *Antropologia e velhice.* Campinas: Unicamp, 1994. p. 31-48.

FALEIROS, V. P.; REBOUÇAS, M. Gestão social por sujeito-idade na velhice. *Revista Kairós*, São Paulo, v. 8, n. 2, p.77-101, 2005.

GUIMARÃES, R. M. Proteção e saúde do idoso. *Revista de Saúde Pública*, São Paulo, v. 21, n. 3, p. 274-275, 1987.

IBGE - INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. Conselho Nacional de Estatística. Serviço Nacional de Recenseamento. *Brasil: censo* demográfico. Rio de Janeiro, 1956. (Série Nacional, v. 1). Disponível em: <http://biblioteca.ibge.gov.br/visualizacao/periodicos/67/cd_1950_v1_br.pdf>. Acesso em: 25 jun. 2010.

IBGE - INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. *Censo Demográfico, 2000*. Brasília, DF, 2001. Disponível em: <http://www.ibge.gov.br/home/estatistica/populacao/default_censo_2000.shtm>. Acesso em: 25 jun. 2010.

IBGE - INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. *Censo Demográfico, 2010*. Brasília, DF, 2013. Disponível em: <http://censo2010.ibge.gov.br/resultados >. Acesso em: 25 de jun. 2010.

LIMA, R. A. S. *A construção do envelhecimento*. 2004. Dissertação (Mestrado em Gerontologia) - Pontifícia Universidade Católica, São Paulo, 2004.

LIMA-COSTA, M. F.; BARRETO, S. M.; GIATTI, L. Condições de saúde, capacidade funcional, uso de serviços de saúde e gastos com medicamentos da população idosa brasileira: um estudo descritivo baseado na Pesquisa Nacional por Amostra de Domicílio. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, n. 3, p. 735-743, 2003.

LUNA, E. J. A. A emergência das doenças emergentes e as doenças infecciosas emergentes e reemergentes no Brasil. *Revista Brasileira de Epidemiologia*, São Paulo, v. 5, n. 3, p. 229-243, 2002.

MAIA, G. F.; LONDERO, S.; HENZ, A. O. Velhice, instituição e subjetividade. *Interface: Comunicação, Saúde, Educação*, Botucatu, v.12, n. 24, p. 49-59, 2008.

MARIN, M. J. S. et al. Diagnósticos de enfermagem de idosas carentes de um Programa de Saúde da Família (PSF). *Escola Anna Nery Revista de Enfermagem*, Rio de Janeiro, v. 12, n. 2, p. 278-284, 2008.

MATOS, M. R. *Os ciclos do dengue em São Paulo e o modelo de intervenção*. 2009. Tese (Doutorado em Ciências da Saúde) – Universidade Federal de São Paulo, São Paulo, 2009.

MINAYO, M. C. S. A vida e a saúde do idoso na sociedade global e pós-industrial. *Arquivo Geriatria e Gerontologia*, Rio de Janeiro, v. 4, n. 2, p. 169-181, 1997.

NERY, M. C. (Coord.). *A nova classe média.* São Paulo: Fundação Getúlio Vargas, 2008.

PAPALÉO NETTO, M. Processo de envelhecimento e longevidade. In: PAPALÉO NETTO, M. (Org.). *Tratado de gerontologia.* 2. ed. São Paulo: Atheneu, 2007. p. 3-14.

RAMOS, L. R.; GOIHMAN, S. Geographical stratification by socio-economic status: methodology from a household survey with elderly people in S. Paulo, Brazil. *Revista de Saúde Pública*, São Paulo, v. 23, n. 6, p. 478-492, 1989.

RAMOS, L. R. et al. Significance and management of disability among urban elderly residents in Brazil. *Journal of Cross-Cultural Gerontology*, Berlin, v. 8, p. 313-323, 1993.

RAMOS, L. R.; SIMÕES, E.; ALBERT, M. Dependence in activities of daily living and cognitive empowerment strongly predicted mortality in older urban residents in Brazil: a 2 year follow-up. *Journal of the American Geriatrics Society*, New York, v. 49, n. 9, p. 1168-1175, 2001.

RAMOS, L. R. Fatores determinantes do envelhecimento saudável em idosos residentes em centro urbano: projeto Epidoso, São Paulo. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, n. 3, p. 793-798, 2003.

REBOUÇAS, M.; PEREIRA, M. G. Indicadores de saúde para idosos: comparação entre o Brasil e os Estados Unidos. *Revista Panamericana de Saúde Pública*, Washington, DC, v. 23, n. 4, p. 237-246, 2008.

RUGER, J. P. Health capability: conceptualization and operationalization. *American Journal of Public Health*, Birmingham, v. 100, n. 1, p. 41-49, 2010. Disponível em: <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1508006>. Acesso em: 28 jun. 2010.

SEADE - FUNDAÇÃO SISTEMA ESTADUAL DE ANÁLISE DE DADOS. *População e estatísticas vitais*: estimativa 2010. São Paulo, 2008.

SERAPIONI, M. O papel da família e das redes primárias na reestruturação das políticas sociais. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 10, p. 243-253, 2005. Suplemento.

SILVEIRA, F. G.; OSÓRIO, R. G.; PIOLA, S. F. Os gastos das famílias com saúde. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 7, n. 4, p. 719-731, 2002.

SINGER, P. *A crise do "milagre"*: interpretação crítica da economia brasileira. São Paulo: Paz e Terra, 1975.

THIRY-CHERQUES, H. R. Max Weber e a ética nas organizações: cinco hipóteses sobre a cultura e a moral de conceitos. *Revista de Administração Pública*, Rio de Janeiro, v. 31, n. 2, p. 5-21, 1997.

Received: 24/04/2012
Approved: 25/07/2013