

The Construction of the Rights and Accessibility of the Elderly in Healthcare Programs

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ABSTRACT

Due to the aging of the population, accessibility policies for specialized healthcare for the elderly in Brazil have proven necessary, given the growing number of older adults and long-term projections. According to IBGE data, Brazil had 13.9 million elderly people in 2000; currently, this number has reached 27 million, and specialists project that by 2025 there will be around 32 million elderly individuals. This highlights the need to understand that healthcare policies and programs aimed at the elderly are a reality and will become a priority in addressing the needs of future generations of older adults. This justifies the importance of addressing the rapid growth of the elderly population in Brazil, with the objective of understanding the accessibility of seniors to healthcare programs, as well as the scope of these programs in facilitating their access. Using a literature-based methodology focused on specialists and the programs developed over the past 60 years, this study emphasizes the relevance of meeting the demands of Brazil's elderly population. Considering the systemic aging of the population and the country's low birth rate, both of which are pressing realities of modern society, it is important to recognize that advances in medicine and the expansion of healthcare programs have facilitated the extension of life expectancy among Brazilians. As such, this segment of the population requires more specific interventions. In this context, legislative progress has reinforced a right guaranteed by the 1988 Constitution.

Keywords

Elderly, Health, Increased Life Expectancy, Achievements, Policies for the Elderly, Healthcare Programs, Advances in Health.

Introduction

This study addresses the evolution of the healthcare system aimed at the elderly population since the creation of the SUS (Brazil's Unified Health System) and the implementation of policies focused on the prevention and monitoring of this segment of society. Over time, the elderly have gained numerous rights and benefited from new approaches in healthcare. Therefore, it is necessary to understand the development of the Brazilian healthcare system throughout the 20th century and its advances in securing elderly people's rights to access programs specifically designed to address the illnesses that affect all Brazilians as they age.

With the advent of the 1988 Constitution, which guaranteed the right to health for all Brazilians with the purpose of promoting a more fraternal and pluralistic society, placing everyone on the same level, it became necessary to legislate specific policies for certain social groups that require more specialized approaches due to their singularity. Based on this premise, advances in healthcare policies directed at women, children, and the elderly have played a central role since the creation of SUS, continuing to evolve today with new methods and approaches in order to achieve their main objectives: improving quality of life and fostering social promotion.

Thus, this study aims to analyze the history of healthcare in Brazil and how its actions over time have benefited programs targeted at the elderly, emphasizing their importance in prevention and in promoting healthy aging.

The justification for this lies in the fact that public health policies in Brazil respond to a natural reality: scientific advances over the decades, coupled with access to education, have made the population more aware not only of their rights but also of the importance of accessing information that improves quality of life and combats the illnesses that arise with aging. These include the practice of physical activities, dietary habits, healthy lifestyles, and medication specifically designed for conditions common among the elderly, among other age-related diseases.

Due to this demographic shift, with the rapid growth of the elderly population, policies to ensure accessibility to specialized healthcare for seniors in Brazil have become increasingly necessary. According to IBGE data, Brazil had 13.9 million elderly individuals in 2000; today, that number has risen to 27 million, and specialists project that by 2025 it will reach 32 million. This reality demands recognition that health policies and programs for the elderly are not only essential but will also be a priority in meeting the needs of future generations.

The objective, therefore, is to understand that accessibility to healthcare programs targeting the elderly is necessary to ensure a better quality of life during aging and to combat the illnesses to which this segment of the population is vulnerable. It is also important to explain that the advances in the healthcare system not only secured the right to health for all Brazilians but also specifically benefit this rapidly growing group, thanks to the progress in elderly healthcare policies in Brazil. Identifying its development and relevance is essential for the progressive advancement of healthcare policies and specific legislation that will provide the elderly with better access to programs and treatments for age-related diseases.

To carry out this work, a literary methodological approach was necessary, fulfilling the premises of gathering data from scholarly authors related to the proposed theme. By analyzing the role of the elderly in the current Brazilian healthcare system, the selected authors make it possible for the reader to better understand the structural dimension to which elderly Brazilians have been subjected in the context of public policies specific to their group and their origins within the SUS.

As Gil [1] points out, descriptive research is a way of gathering information, facts, and phenomena that provide the reader with broad knowledge of the subject, encouraging reflection on the proposed theme. It is based on facts and data collected through descriptive research and published studies in various communication outlets, which strengthen the discussion and allow the reader to debate and propose new approaches. Such data must be grounded in the reality studied and aligned with the object of analysis so that, once knowledge in the field is deepened, theoretical conceptions and hypotheses can corroborate the expansion of knowledge and actions derived from it.

Based on the knowledge of specialists and scholars in the field, the researcher—still following Gil [1]—understands that the subject is not limited to a final analysis. In other words, even if the author

concludes with a specific perspective, some indicators may have been overlooked, and additional perspectives may not have been addressed. Thus, future research and new concepts may contribute to reshaping the understanding of the topic, altering both the author's and the reader's point of view in relation to the work.

History of Elderly Care Practices in Brazil

The history of elderly assistance dates back to the Byzantine Empire in the 5th century A.D., as highlighted by Debert [2], where records show the first institutions created to serve the elderly, most of whom were poor and without family support. However, the first institution focused specifically on specialized care, albeit precarious, was founded by Pope Pelagius II, who transformed a house into what is considered the first philanthropic hospital for the elderly on record.

In general, assistance to the elderly was initially limited to providing shelter for housing purposes only. Its character was intrinsically linked to religious doctrine, meaning there was no support from the government; rather, it originated from religious organizations. In Brazil, since its colonization, elderly care practices followed this same pattern, as Haddad [3] points out. These practices were linked to Catholicism and followed the models proposed by the Portuguese church, known as the “Santas Casas de Misericórdia” (Holy Houses of Mercy).

According to Alcântara [4], over the centuries in Brazil, models of elderly support were created that always carried the concept of asylums. A particularly turbulent period in Brazil's healthcare history stands out with the creation of the “Casa dos Inválidos” (House of the Disabled) in 1794, founded by the fifth viceroy, which was intended for elderly soldiers. At the end of the 19th century, the first philanthropic institutions specifically aimed at the elderly were established and referred to as asylums. However, in the early 20th century, these institutions began housing not only the elderly but also individuals with various conditions, such as leprosy, mental disabilities, blindness, homelessness, amputations, among others. As a result, they deviated from their original purpose of caring for the elderly and instead addressed broader social demands in a society unwilling to coexist with those requiring special care.

Thus, Alcântara [4] notes that organizations, recognizing this lack of proper care, began to classify demands into specific facilities for each group: mental health patients were confined to asylums, children to orphanages, the elderly to asylums, and leprosy patients to isolated villages.

Haddad [3] emphasizes that until 1930, there was no state involvement in elderly care policies, and all interventionist actions were religious in nature. It was only with the 1934 Constitution that the state first mentioned elderly support policies, guaranteeing rights exclusively to workers. This scenario, however, would change after the military regime, when in 1979 even elderly people outside the social security system gained access to social assistance.

During the 1980s, social organizations became decisive in shaping and developing elderly healthcare policies. Haddad [5] describes a significant rise in retirees' and pensioners' associations, which sought greater visibility from the state and stronger support within the healthcare system. The Brazilian Confederation of Retirees and Pensioners took on the task of studying and debating issues to incorporate benefits into the new 1988 Constitution, whose Article 194 states:

“Social security comprises an integrated set of actions by public authorities and society, aimed at ensuring rights related to health, welfare, and social assistance” [6].

According to Lobato [7], after various discussions on elderly issues in Brazil, by the late 1980s a document titled “Public Policies for the Elderly” was created, which subsequently served as the foundation for the National Elderly Policy (Law 8.842/1994). However, the author emphasizes that until 1994, actions targeting the elderly in Brazil were either timid or nonexistent, and governmental initiatives benefited only a small portion of the elderly population.

The Achievement of Elderly Rights

As previously mentioned, until 1994 there was a gap in the history of elderly care in Brazil, which was only addressed with the approval of Law No. 8.842 of 1994. This law guaranteed the social rights of the elderly, as stated in Article 1: “to ensure the social rights of the elderly, creating conditions to promote their autonomy, integration, and effective participation in society.” It also aimed to ensure the quality of life of all elderly individuals through social organizations linked to or partnered with the government. To make social programs viable across all levels of government, it became necessary to promote the integration of social organizations so that state services could achieve broader outreach.

Based on this new approach to healthcare in Brazil and considering the ongoing evolution and aging of the population, in 1998 Senator Paulo Paim (RS) proposed Bill No. 10.741, which addressed the Elderly Statute. The bill was debated in Congress for five years until it was approved and enacted on.

October 1, 2003. The Statute reinforced the rights of elderly individuals, which were already guaranteed by the Constitution, but it adopted a broader approach by explicitly defining the responsibilities regarding individuals aged 60 and over, and by emphasizing the role of families and society in safeguarding elderly rights.

The main function of the Statute is to establish a well-defined charter of rights, reinforcing the continuous role of the state in protecting life, promoting healthy aging, and improving quality of life. As Lobato [7] highlights, although these fundamental principles were already clarified in the 1988 Federal Constitution, the Elderly Statute represents progress in Brazil's legal system, as it more comprehensively outlines how the public sector should act in response to the needs of this group, given the significant growth of the elderly population in recent decades.

Public Health and the Elderly in Brazil

The origins of public health in Brazil date back to the late 19th and early 20th centuries, arising from the high number of deaths caused by widespread diseases and the lack of effective medicines to treat them. This was largely attributed to the intense movement of people through ports and major trade centers. Once this factor was identified as a key source of disease spread, large-scale sanitation and vaccination campaigns began. As Mestriner [8] explains, such diseases were common at the time, but access to treatment was limited to those with sufficient economic resources, while the poor were left with the option of turning to the *Santas Casas de Misericórdia* (Holy Houses of Mercy) for a chance at some form of care.

Haddad [5] notes that elderly individuals at the time had to accumulate savings from their working life to contribute to Retirement and Pension Funds, which could then cover the cost of treatments and provide access to reasonable medical care. Bravo [9] points out that this reality, combined with population aging, led Brazilian social policy to reconsider its approach, integrating programs, health campaigns, and disease control measures to reduce mortality among the elderly. Bravo [9] also highlights that the healthcare model in Brazil at the time was extremely costly, selective, exclusionary, and deficient, requiring profound reform in its structure and functioning. This reform began with the new 1988 Constitution, which introduced a new concept of healthcare in Brazil, as defined in Article 196:

“Health is the right of all and the duty of the State, guaranteed through social and economic policies aimed at reducing the risk of illness and other health problems, and at ensuring universal and equal access to actions and services for its promotion, protection, and recovery.”

With this new emphasis on health and on the reformulation of the basic principles made possible by the new State, a broad debate was held among social entities, and the new health model in Brazil was established by Law No. 8,080 of 1990, which regulated the SUS (Unified Health System), concomitantly with Law No. 8,142 regarding the organizational and operational principles required by the system. Costa and Castanhar [10] argue that, even moving away from the exclusivity of serving only those under the social security regime, the current system requires measurement methods, performance evaluation, control, feasibility studies, and adjustments to achieve its ultimate goal.

To address this deficiency and integrate the agencies and intelligence data of the Ministry of Health, Ordinance No. 1020 of 2002 was established, which created the National Information and Coverage System on Responsible Management Agencies, composed of the following sectors: Mortality Information System (SIM), Information System for Notifiable Diseases (SINAN), Live Births Information System (SINASC), Outpatient Information System of SUS (SAI-SUS), Primary Care Information System (SIAB), Hospital Information System of SUS (SIH-SUS), and the Goal Agreement System (SiS Pacto). According to Rouquayrol

[11], this conglomerate of data made it possible to evaluate the progress of goals, measure the reality of health in Brazil, and propose advances through estimates and trends presented by the data.

The Brazilian Health System and its Approach to the Elderly

Observing the growing change in Brazil's demographic profile regarding the elderly, the Federal Government created the National Policy for the Health of the Elderly, first established in 1999. It was only with Ordinance No. 2,528 of 2006 that the National Policy for the Health of the Elderly (PNSPI), under the Ministry of Health, was approved, aiming at policies directed toward the population over 60 years of age. Gordilho [12] had already pointed out that the creation of the PNSPI in 1999 was a major step forward, as it defined State guidelines for building strategies that enable healthy aging, in which the human, psychological, and physical needs of individuals contribute to improving citizens' quality of life.

Saldanha and Caldas [13] consider the National Health Policy to be a new approach, since it addresses health not only from the perspective of disease, but also as an ideology of improving quality of life and pursuing social well-being. For Silvestre and Costa Neto [14], actions aimed at the health of the elderly must be carried out in agreement with the family and the community, making treatment and its approach as dignified and satisfactory as possible.

It is important to reflect that the concept of health must be understood within a wide range of management outcomes across various fields. When we understand that multiple factors are connected to a final health outcome, we realize that physical, mental, and social aspects are part of an individual's life, and to achieve satisfactory results, these must be harmonized and worked on so that their interactions in each of these areas can promote social well-being. Thus, an individual in a favorable social environment and mentally strengthened tends to minimize risks of physical illness.

Specific Programs for the Elderly

In the early 1990s, there were no health programs specifically aimed at the community, since efforts were still being made to meet the requirements of the new health model envisioned by the 1988 Constitution and the law regulating the SUS. Observing this need, the National Health Agents Program was created, which in 1992 was renamed the Community Health Agents Program (PACS). Its task was to carry out disease prevention activities through educational campaigns directly within the communities it served.

The community health agents (ACS) are professionals directly linked to primary health units under the Family Health Program (PSF), currently known as the Family Health Strategy (ESF). According to Costa [15], these professionals are responsible for collecting community data and presenting the local reality to the government so that it can base public health policies on evidence and act to meet local needs.

Although Costa Neto [10] emphasizes that these professionals are

not directly trained for the specific needs of the elderly, they are gradually adapting to the reality and fulfilling the PNSI guidelines. Costa [15] further argues that these professionals should, in their activities, identify the epidemiological and demographic realities of families, assess the risks to which the population is exposed, plan collective and individual health actions, promote healthy habits, and encourage self-care.

Diseases Related to the Elderly and their Programs

With the increase in the elderly population in the country, the Ministry of Health recognized the need to develop strategies aligned with the basic principles of the Constitution and SUS legislation. Over time, the Ministry of Health has adapted to the most common diseases affecting the elderly population, and several programs have been created through ordinances and regulations to assist ESF units in expanding their actions toward the elderly.

Potter [16] notes that age-related diseases most common among the elderly were recognized as requiring proper treatment, such as: arteriosclerosis, Alzheimer's disease, osteoporosis, Parkinson's disease, cancer, diabetes mellitus, vision and hearing problems, hypertension, heart disease, and infections from viruses and bacteria to which this group is historically more vulnerable due to a more sensitive immune system.

Accordingly, some ordinances became necessary to provide resources and health guidelines for specific groups of patients, either because they were susceptible to certain conditions or to prevent disease progression with age. Examples include SUS Ordinance No. 3,128/2009 and Ordinance No. 15/2007, which address vision problems, ensuring access to care for individuals with visual impairment, as well as policies for hearing health.

The Basic Health Care Guide [17] establishes that initial diagnoses of the population served must be prepared by ESF units to guide the elderly toward specialized care when necessary. This includes neurological conditions such as dementia, Alzheimer's disease, depression, and Parkinson's disease, covered by Federal Law No. 10,216/01 (on mental health) and Ordinance No. 228/10 (on Parkinson's disease). These regulations aim to establish treatment standards for patients and their caregivers.

Regarding mobility, Law No. 10,098/00 sets basic accessibility and mobility criteria for people with disabilities or motor impairments, including the elderly. For chronic diseases requiring continuous medication, the Ministry of Health established the National Pharmaceutical Assistance Program for Arterial Hypertension and Diabetes Mellitus through Ordinance No. 371/02, ensuring free or affordable access to essential drugs. Medications for osteoporosis and asthma are also included.

Over the years, numerous laws and programs have been created for the elderly population, such as: Decree No. 5,109/04 (National Council for the Rights of the Elderly – CNDI), Law No. 10,741/03 (Statute of the Elderly), Law No. 8,926/94 (drug labeling for people over 65), Ordinance No. 280/99 (right to a companion for

hospitalized elderly patients), Ordinance No. 5,153/99 (National Program for Elderly Caregivers), Ordinance No. 73/01 (elderly care standards), Ordinance No. 702/02 (state-level elderly care networks), Ordinance No. 249/02 (Reference Centers for Elderly Health), Ordinance No. 648/06 (revision of PSF and PACS guidelines), Ordinance No. 2,529/06 (home hospitalization within SUS), Ordinance No. 3,213/07 (osteoporosis and falls prevention committee), Ordinance No. 254/09 (Project “Olhar Brasil”), Ordinance No. 442/10 (tobacco dependence treatment), and Ordinance No. 491/10 (guidelines for Alzheimer’s disease treatment).

With the rapid growth of the elderly population, coupled with legal and structural advances in cities and organizations, aging has become a central focus of government public policies—not only in health but also in leisure, urban mobility, security, education, and other areas requiring strategic interventions to accommodate this new demographic.

However, as Aguiar [18] warns, Brazil faces a worrying scenario regarding its pension system and declining health resources. The high cost of elderly care makes the system fragile and at risk of collapse due to fiscal imbalances and poor government spending control. A revision of the health system may be necessary, possibly with stricter selectivity in access for the elderly, ensuring services are directed to those who truly need them.

Final Considerations

As observed in the historical review of elderly care in Brazil, the health policy for the elderly dates back to the early colonial period, when religious initiatives sought, albeit experimentally, to provide support to the elderly. With the advent of the Republic and subsequent political advances, elderly-focused initiatives began to gain relevance in the early 20th century, though still timidly.

A true turning point occurred with the 1988 Federal Constitution, which guaranteed the right to health for all citizens. From then on, the reform of the Brazilian health system and the regulation of the SUS included the elderly as a public policy priority. With demographic changes, better education, and access to medications and advanced treatments, Brazilian life expectancy has steadily increased, requiring both government and private organizations to expand their actions in this area.

Since the 1980s, Brazil’s elderly health policies have evolved substantially: continuous-use medications, elderly-specific treatments, protective legislation, and mobility aids are now part of daily life. Still, small municipalities often face gaps in care.

Currently, the Brazilian health system already operates at its budgetary limit. Although the evolution of elderly programs is notable, the high cost of elderly care may render universal free healthcare unsustainable. Thus, society must reflect on the system’s long-term viability.

Nevertheless, the evolution of accessibility and elderly assistance

remains of vital importance. The projects developed have contributed to greater longevity and improved quality of life among Brazilians. Preventive actions and self-care campaigns have shown positive results, although inequalities persist due to Brazil’s continental dimensions. Ultimately, the health system is still relatively new and requires significant adjustments to ensure comprehensive coverage nationwide.

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