

# Privatization of old age: suffering, disease and violence in the relationship between older adults and caregivers

Privatização da velhice: sofrimento, adoecimento e violência na relação entre cuidadores e idosos

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## Abstract

This article discusses the impact of “privatization of old age” on the quality of care and life of older adults and family-caregivers by crossing three procedures: study of data from medical records of older adults treated between 2009 and 2017 in the Specialized Protection and Care Service for Families and Individuals (PAEFI) of a municipality of São Paulo; study on the results of instruments to verify evidence of violence; and qualitative analysis of interviews with older adults and caregivers. The discussion introduces an original reflection of “privatization of old age”, considering not only the general tendency to dismantle social protection systems and the establishment of a family model of care for older adults, but also the effects of encapsulating the domestic sphere as private life, the progression of the nuclearization of family policies, the growing importance of neoliberal models of sociability and subjectivation. We addressed these processes considering the interwoven dynamics of social inequalities and family care policies. The results allow to capture pathogenic and violent effects of these processes, as corroborated by data on evidence (84%) and risk (62.1%) of violence, frequency of health problems (80%) and common mental disorders (55.2%) among caregivers. **Keywords:** Aged; Caregivers; Health of the Older Adults; Violence; Domestic Violence.

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## Resumo

Este artigo aborda o impacto da “privatização da velhice” sobre a qualidade do cuidado e a vida de idosos e familiares-cuidadores pelo cruzamento de três procedimentos: estudo dos dados de prontuários dos idosos atendidos entre 2009 e 2017 no Serviço de Proteção e Atendimento Especializado a Família e Indivíduos (PAEFI) de um município de São Paulo; estudo dos resultados de instrumentos de verificação de indícios de violência; e análise qualitativa de entrevistas com idosos e cuidadores. A discussão introduz uma reflexão original da “privatização da velhice”, considerando não somente a tendência geral à desmontagem dos sistemas de proteção social e ao estabelecimento de um modelo familista de cuidado ao idoso, mas igualmente os efeitos do encapsulamento da esfera doméstica como vida privada, da progressão da nuclearização das políticas familiares, da crescente pregnância de modelos neoliberais de sociabilidade e subjetivação. Esses processos são abordados levando em conta as dinâmicas entrelaçadas das desigualdades sociais e das políticas familiares de cuidado. Os resultados permitem captar efeitos patogênicos e violentogênicos desses processos, como corroboram dados sobre indícios (84%) e risco (62,1%) de violência e frequência de problemas de saúde (80%) e transtorno mental comum (55,2%) entre cuidadores.

**Palavras-chave:** Idoso; Cuidadores; Saúde do idoso; Violência; Violência Doméstica.

## Introduction

“Global Ageing: A Triumph and a Challenge”, title of the first chapter of the WHO document (2002) on active aging, summarizes how the issue of population aging has been addressed by “policy makers”. At the same time that aging is celebrated as an expression of the success of public health policies, we understand that this process generates new demands and challenges from the point of view of producing “continuous opportunities for health, participation and security” (P.13) that allow aging to be a positive experience.

We are interested in highlighting one of the challenges shown in a more recent WHO document (2015) on the same theme: care for “older adults” who have a decline in functional capacity. The document emphasizes that, due to changes in family and work contexts, “old models of family care are simply not sustainable” (P.10-11), generating the need for care systems that, among other things, are able to “[share] the risks and the burdens associated with care dependence” (p. 17), aiming to guarantee the quality of care and ensure, for family-caregivers (in general, women), the possibility of developing broader social roles.

In a way, this article focuses on this point, looking at the impact of what we call “privatization of old age” on the quality of care and life, and the experiences of older people and family-caregivers, analyzing data from the medical records of older adults treated between 2009 and 2017 in the *Serviço de Proteção e Atendimento Especializado a Família e Indivíduos* (PAEFI - Protection and Specialized Care Service to Family and Individuals) of Mogi-Guaçu (SP), and the results of the application of a questionnaire and in-depth interviews with older people and caregivers.

## Privatization of old age

On aging, it is important to consider the resonances of the growing importance of models of sociability and subjectivation immersed in the models of “company of the self” and performance in the ideology of the healthism and the “somatic culture” (Dardot; Laval, 2016; Ortega, 2008).

We refer to a context in which “being healthy” is something understood and exercised as a disengaged possibility of its cosmotropic quality, that is, supporting the appearance of independence from the ecological, social and cultural context. Health becomes its own responsibility, while the very notion of responsibility assumes “the appearance of an ethical power over regions increasingly distant from society and increasingly specialized ways of ‘bringing happiness’ through a delivery service” (Illich, 2019, n. p.).

Health is converted into another object of individual management within a sociocultural and political context in which, as Dardot and Laval (2016) describe, the company has become the norm by which the individual must become a subject. Each is called to act as a “company of the self”, to manage and maximize its resources and to entertain, with others, competitive relations. Instead of taking care of the cooperative engagement and common governance of the world we share, that is, of everything that really composes our health and ability to recover from illnesses, we treat health as a company treats its capital, aiming to increase performances and maximize resources. Despite this, health is not only another object of management of the self-entrepreneurial subject, it has also become an ideology or morality (Ortega, 2008); it represents an absolute value and an end in itself, so that, as they say, “the most important thing is to have health”. “Having health” is what guarantees our ability to continue to respond to the “excessive demands of modern ways of working, having fun and living” (Illich, 2019, n. p.).

When health becomes a morality, we become managers of what, in fact, governs us. We live in a “somatic culture” in which the body is at the center, but the body that is at the center is a body that lives subject to a series of models of health, beauty and performance and that, unsure of itself, seeks to achieve them through rules and scales of evaluation produced in the interaction of capital with biotechnologies and medicine (Ortega, 2008).

Of course, in this context, the way old age is represented and lived is transformed. If the emphasis is on the competence of taking care of oneself or to manage oneself as a company, the great issue

of aging becomes not autonomy as the ability to live according to the way of life chosen in close cooperation with the community, but independence.

Instead of assuming codependency as the necessity of existence, we abhor dependence and marginalize so-called “dependent” individuals as execrable parasites. As Ortega says, “thus appears the figure of the ‘good’ older adult and the ‘bad’ older adult, the latter without competence to take care of themselves” (2008, p.35).

In general, contemporary society has a negative view of old age. The older adult, even the “good” older adult, is an individual under suspicion, always at risk of falling into “dependence”, of becoming a “bad” older adult. In a society where risk itself is medicalized, old age becomes a disease to be treated, reason for an increasing consumption of services, drugs and other products or lifestyles considered beneficial for health (Castiel; Álvarez-Dardet, 2007; Paranhos; Albuquerque; Garrafa, 2017).

The situation of the “bad” older adult will depend on their ability to access the “deliveries” of “health care” under circumstances of **increasing privatization of care**. When “being healthy” becomes less about the social environment and its common government and more about the enjoyment of techniques and resources, accessing “health care” becomes the privilege of portions of the population, either because of the state that grants them citizenship, or because of the resources that individuals/families have privately.

One can speak of a general tendency to dismantle social protection systems, which ensured access to certain resources outside market relations, but the degrees and ways of this process vary in different countries, which greatly affects the possibilities of existence of the so-called “dependent” older adult.

In some countries, forms of support and care for the “dependent” older adult have been developed within the framework of public policies. If, on the one hand, care is increasingly assigned to families, on the other, there are forms of compensation, either in the form of a public financial supplement (salary to care for older adult at home, as in France, or public subsidy for civil society organizations that provide care services, as in Canada), or in the form of various social benefits for family-caregivers

(Esteves, 2018). Without implying a reversal of the trends indicated above, these measures create more favorable conditions for the care of older adults.

In many countries, with the exception of a limited number of institutions for permanent hospitalization, such devices do not exist or are poorly developed. This is the case in Brazil, where there is a tendency of new legislation to **hold the family accountable** for the care of older adults (Matias, 2014). Roughly speaking, this means that the older adult who permanently needs some kind of care must rely on their own resources to meet these needs in the market or on their own family members as resources.

The implications of this **privatist-familist** logic of care are entangled with the interwoven dynamics of social inequalities and intra-family policies:

1. The “delegation” (partial or integral) of the care of older adults is an option for certain socioeconomic classes, allowing attenuation of intra-family tensions that would arise from the need to divide or assign (without division) the care. This attenuation, which contributes to masking the permanence of sexism in family policies, increases, on the other hand, the classist cleavage among women as the “delegation” relies on the “enormous reserve of women in precarious situations” or other “feminized” subjects, located in conditions analogous to “feminine” ones by the world of work (Hirata; Kergoat, 2007, p.597; Haraway, 2009). In addition, it does not prevent the emergence of other sources of conflict, related to the way older adults are situated in family relationships, the autonomy of older adults and the relations between them and caregivers.
2. When “delegation” is unfeasible - generally for economic reasons - the pressure on family policies increases, raising tensions related to the division of domestic labor and the organization of relations between the domestic sphere and the professional, social and affective life of family members. Despite the current reconfiguration of social relations of sex, the care of older

adults continues to be predominantly considered as attribution of women or, if not, as attribution of “feminized” family members because they are more vulnerable (older adults, unemployed, etc.). In these contexts, care is carried out in a “reconciliation model” - in which it is up to women or “feminized” subjects to reconcile care and domestic activities with professional activities - and, more often, in a “traditional model”, that is, a regime of exclusive dedication to the care of older adults and domestic functions (Hirata; Kergoat, 2007). In these two models, in addition to the sexual division of labor, it is possible to capture the effects of individualism and nuclearization (pulverization of family cores) in family policies, producing situations in which there are no secondary caregivers or family or extra-family support.

Considering the issues shown, we will use the phrase “privatization of old age” to refer to conditions arising out of a set of processes that are co-implicated: neoliberal subjectivation - synthesized in the diffusion of the “company of the self” model; the expansion of the commodification of “health” and “well-being”, associated with the growing commodification of social relations; and the mutilation of common life - which is expressed in the retreat of social protection systems, in the extreme privatization of domestic life, with the fraying of neighborhood ties and the progression of family nuclearization, in the undoing of traditional community arrangements and their architectural knowledge and meanings for the shared maintenance of life and mutual care. In this context, aging becomes, increasingly, the responsibility of older adults and their family (an entity “shrunk” by social egoism resulting from the neoliberal model of subjectivation), a task increasingly disjointed from any institutional framework for the reproduction of everyday life in a cooperative way and from any symbolic structure that grants old age a significant social place beyond its appreciation as a niche market for “health” and “well-being” products and services.

## Methodology

This article was developed from a qualitative-quantitative research which analyzed: medical records of older adults treated between 2009 and 2017 in the *Serviço de Proteção e Atendimento Especializado a Família e Indivíduos* (PAEFI - Protection and Specialized Care Service to Family and Individuals) of the o,(CREAS - Specialized Social Assistance Reference Center) of a municipality in São Paulo; results of the application of instruments to verify evidence of violence against older adults (*Caregiver Abuse Screen - CASE* and *Hwalek-Sengstock Elder Abuse Screening Test - H-S/EAST*) and verification of the health status of caregivers (*Self-Reporting Questionnaire-20*); interviews with older adults and caregivers (Paixão Júnior et al., 2007; Reichenheim et al., 2008; Santos et al., 2011).

The study collected data from the medical records of older adults with active registration from July to December 2017 (n=90). In this article, only the data related to illness and violence will be shown.

The 90 older adults who had active registration and their caregivers were considered eligible, and the cases of older adults who were not found, deceased or institutionalized were excluded. It was possible to conduct 63 Interviews/questionnaire applications (16 with caregivers, 21 with older adults without caregivers, 13 with older adults with caregivers), all conducted at the respondents' homes. In this article, we show the results of all the questionnaires applied (34 older adults and 29 caregivers), but we analyze only the interviews conducted with older adults/caregivers or only with caregivers, since we are interested in specifically addressing the issue of care.

The interviews were conducted from open-ended structured questions, guided by the interest of understanding the existing relationships between older adults and caregivers and the difficulties for conducting care. This material was analyzed according to the stages of Thematic Content Analysis (Minayo, 2010).

The floating reading of the interviews sought to locate significant content, from which we tried to identify the themes through which we could group them to conduct their analysis. Among them,

we highlight: the conditions surrounding care; family relationships; the autonomy of the older adult and the caregiver; and violence. The approach of these themes, in dialogue with literature, led to the more general issue of “privatization of old age”, which is the north from which this article was developed.

This research was evaluated and approved by the NN Research Ethics Committee (Opinion: 2,194,037). In this text, the names of the respondents were replaced by fictitious names.

## Results and discussion

We organized the presentation and discussion of the results into two subsections. In the first, we consider the emerging situations of what we call “privatization of care” in the context of the cases studied, in the second, we address signs of suffering, illness and violence resulting from these situations.

### Precariousness of care

The cases examined in this study correspond to situations in which the “delegation” of care for older adults is unfeasible. These are low-income older adults/families, without economic conditions to “delegate”, partially or fully, the care, hiring the service of third parties. They can only count on their own relatives as resources.

Chart 1 shows the caregivers interviewed (n = 29) and the relationship with the older adult, distributed according to sex.

**Chart 1 – Caregivers interviewed according to kinship in relation to the older adult cared for**

Kinship	Amount	Total by sex
Wife	2	20 women
Daughter	9	
Daughter-in-law	3	
Friend	2	
Sister	2	
Granddaughter	1	
Niece	1	9 men
Husband	1	
Son	8	

In relation to this framework, it is important to highlight:

- The permanence of “traditional” arrangements. Care seems to be delegated according to rules that comply with the criteria of degree of kinship and gender, since mainly children (17 cases) and spouses (3 cases) were accounted for and the female sex predominated (20 cases). Among men, care falls only on children and spouse, while among women, other relatives appear, such as daughter-in-law, granddaughter, niece or caregivers without kinship ties, as a friend.
- The presence of only one caregiver, which refers us to the effects of individualism and nuclearization. This is even more surprising when we consider that 21 families have three or more members residing in the same household and that, in seven of them, the caregiver is 60 years of age or older.
- The number of children, although it seems significant, does not stem from less generalized modes of distribution of care in families. They are, in all cases, subjects “feminized” by their status due to economic dependence, cohabitation and the use of psychoactive substances - subjects “elected” for care not because of any particular inclination or ability to care, but because they are the most vulnerable.

Interviews with older adults and caregivers explain negative implications of these family policies of care of older adults, developed in a neoliberal context. At their intersection, the reports outline a dramatic picture, in which minimum conditions for the exercise of care are absent.

In many cases, one of the missing conditions is the motivation of caregivers. In fact, many of the caregivers interviewed do not feel particularly invited to exercise the practice of care or have become unmotivated because of the exhaustion resulting from the conditions of this exercise. This is the case with Vanda, who does not hide her dissatisfaction with the obligation to care: *I don't like to do it because I don't have patience anymore* (Vanda).

Another interviewee, Cassia, apparently performs the function of caregiver out of moral obligation:

*I do it obviously because it's my father. I honor my parents* (Cassia). Another interviewee, Joca, son of the older man, seems to have been led to this function only by chance and economic reasons. According to Joca, he became a caregiver *to please, tidy up my life, pay my bills, raise my head and have a normal life again*, although he has since then begun to *take it more seriously*.

The situation is even more complicated when the obligation to care is attributed to a family member who previously had weak, worn out or negative relations with the older adult. An example is Elizabeth's. According to her, the previous relationship with the older woman, her grandmother, was characterized by estrangement and hatred and crossed with verbal aggression. She says that *the relationship was terrible* and that grandmother *hated* her, addressing her in such insulting terms as *demon* and *slut*, preventing the granddaughter from accessing her residence.

Another example is that of Corina, who takes care of her mother. She refers to previous relationships marked by the lack of affective ties and her mother's abandonment, recalling, with sorrow, having been abandoned when she was two years old: *I went to see her again when I was already married* (Corina). It is a case similar to that of Fruma, who oscillates between attempts to forgive the mother for abandonment, with repeated efforts of affective rapprochement - *then one day I go there and start talking to her [...] it seems, then, that nothing happened* (Fruma) - and the reappearance of resentment - *some days it's a struggle*.

The caregiver Ernani blames the father for the *struggle* that led him to drug addiction and alcoholism: *My father was imprisoned for six years and it messed with us a lot. [...] That's why I got into drugs, alcohol. I was kind of angry, because we had no father* (Ernani).

Regardless of the motivation and quality of previous relationships between older adults and caregivers, the “privatization of old age” produces other negative effects on care. We refer to some difficulties recurrently reported by the caregivers interviewed: the lack of preparation of caregivers to exercise care and the lack of adequate material and environmental resources, as well as social and family support.

As the literature on home care has emphasized, the exercise of care depends not only on the development of technical skills, but on physical, emotional and cognitive qualities (Esteves, 2018; Munhoz et al., 2008). The lack of preparation, as stated by Pampolim & Leite (2020), is, however, a difficulty recurrently referred by caregivers, which this research confirms:

Vanda claims that it is *hard, because we're not prepared to take care*. She says that it was only by the providential circumstance of having a nurse in the family that she had the opportunity to learn how to change diapers: *I learned, my sister-in-law taught how she does it, she's a nurse. I used to do it as I could [...]* (Vanda).

Another interviewee, Pedro, who cares for an older adult with visual impairment, recalls that at first he felt *invalid, unable* for what the case required: *I didn't know how to deal with it, I had to learn how to deal with it, because I didn't know how to take care of such a person*. Another caregiver, Melissa, reports the lack of knowledge about the disease of the older adult: *Look, at first I didn't understand the disease [...], now I do*.

As explained in these cases, learning needs vary greatly. What is missing, sometimes, are simple guidelines, a *know-how* that would be easily integrated into the repertoire of skills of caregivers, who seem, however, Robinsons Crusoes islanded in the exercise of care. These examples lead us to think not only of public disregard for the provision of technical subsidies, but also of a cultural inability to exercise the potential of care. This stems from the breakdown of cultures, techniques, spaces and networks that supported the "art of care" as a common, individual and community repertoire, which is aggravated by the expansion of neoliberal modalities of subjectivation.

To the lack of preparation of the caregiver, social and family support is added. Vanda, who cares for her mother-in-law, reports that the brothers-in-law have a distant relationship with their mother and that the visits are sporadic and spaced out. The financial aid offered by family members is minimal and discontinuous, despite the financial difficulties of the older woman: *They come here every four, five, six months. They buy a diaper, help a little, spend a little with us*.

Rosalva says that, despite worrying about her mother, she can not help but be indignant to think that *things didn't have to be my responsibility*, for his mother has three children: *So where are the other three children?* This situation generates conflicts within her family nucleus. Her husband, for example, complains of situations caused by this tacit family (dis)agreement: *My husband is going on vacation now in February and said, "Look, I'm not getting stuck here because of your mother. If no one comes to pick her up, I'll drop her off at your brother's house"* (Rosalva).

Dina points out the lack of support from family members, reporting that despite the approach of a surgery that she must perform, no one has expressed any willingness to learn how to administer her father's medications: *I know all the medications, they don't. And I already told them that they have to learn because sometimes I may not be there [...]* (Dina).

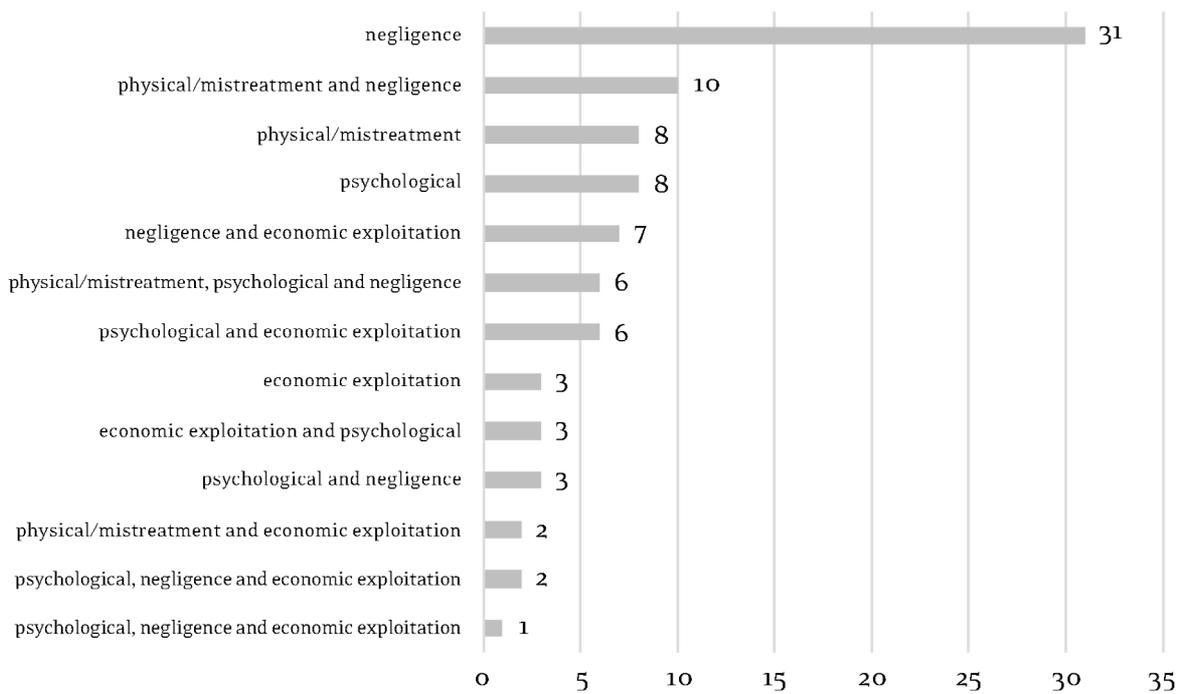
A complicated case is that of Jerome, older adult, with health problems and who takes care of his wife alone. He kept quiet about it during the interview, but Lis, the wife, says the situation makes her desolate and she resents the lack of support from her son: *I feel sad because I see my husband, who isn't in good health [...]* *My husband has no condition to carry me to the bathroom, give me a shower and all [...]* *my son gives me no joy, only gives me sadness* (Lis).

All the above led us to reflect on the problem of assigning to a family a "natural" ability to exercise care and, therefore, to assume full responsibility for the care of the older adult, without considering problems related to the family's economic situation, disruptions in intra-family solidarity, the spatial fragmentation of families, physical and psycho-affective conditions and practices of exercise of care by the family member who will have to perform that task. As we will see, as the conditions of exercise of taking care become precarious, the possibility of suffering, illness and violence increases.

## Suffering, illness and violence

The analysis of data from the social care records of the older adults treated between 2009 and 2017 at CREAS allowed to capture several types of violence against older adults. Graph 1 shows the distribution of cases (n=90) according to the type of violence.

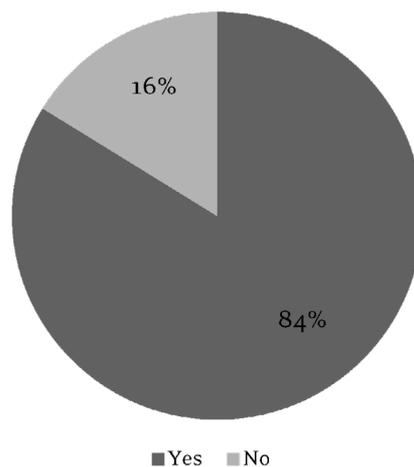
**Graph 1 Distribution of cases, according to type of violence. CREAS/Municipality in the interior of the state of São Paulo, 2009-2017**



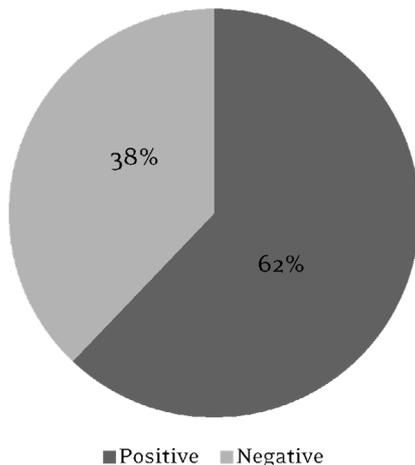
In the interviews, we applied to the older adults the H-S/EAST, used to verify signs of violence, and the CASE, applied to caregivers to check for signs or suspicion of violence. In the application of H-S/

EAST (N=25) (Graph 2), we found that 84% of the cases were positive to indicate signs of violence. CASE (n = 29) indicated an increased risk of violence in 62.1% of cases (Graph 3).

**Graph 2 - Distribution of cases according to H-S/EAST. CREAS/Municipality in the interior of the state of São Paulo, 2017-2018**



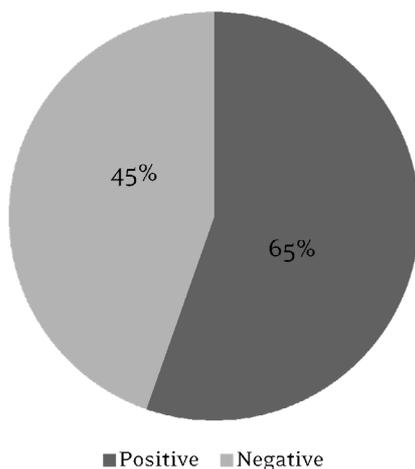
**Graph 3 - Distribution of cases according to CASE. CREAS/Municipality in the interior of the state of São Paulo, 2017-2018.**



Understanding the need to complement these data with others regarding the health situation of caregivers, we identified, from the medical records of the CREAS (n=90) that, in 80% of the monitored cases, there was a record of health problems of the caregiver, with depression being the most mentioned. It is noteworthy that, in 50% of the medical records, there was a record of medication use by caregivers.

In the interviews, we applied, with caregivers (n=29), the SRQ-20, an instrument used for diagnostic suspicion of common mental disorders. The results were positive in 55.2% of cases. An important and worrying fact was that, for the question “Have you had thoughts of the idea of ending with your life? ”, the response was positive for 38% of the caregivers interviewed (Graph 4).

**Graph 4 - Distribution of cases according to SRQ-20. CREAS/Municipality in the interior of the state of São Paulo, 2017-2018.**



We can say that the “privatization of old age” has **pathogenic** and **violentogenic** effects, producing situations of suffering for older adults and caregivers, both constrained to interact and fight for their existential project in the conditions of an encounter that takes place within narrow margins, under conditions that would be different if the quality of social life were another. There is no doubt that the conditions of this meeting would be different in a social context in which the happiness and autonomy of older adults were socially valued and in which care for them was collectively assumed, placed “in common”, instead of being “privatized”.

Suffering, illness and violence emerge in the reports of caregivers and older adults as a result of their (dis)agreement. They are lives *hovering in the air*, as an older woman, Bianca, says, lives suspended and immobilized, *stuck* in time, as a caregiver, Virginia, laments, she does not envision another future than her extended present, because she lacks the main material for the composition of another future: time to perform it.

The caregiver overload, which is mentioned in part of literature (WHO, 2002; Lira; Barros, 2017; Manoel et al., 2013), is higher in cases such as those reported, in which a single caregiver, almost without any social support, has to take care of the older adult full-time.

What Guillaumin (1978), about 40 years ago, wrote about the unspoken and non-contractualized appropriation of women’s time and work for the material care of the family applies to these care relationships. Indeed, since there is no time measurement expressed in hourly form and there is not a single caregiver, care becomes a relationship of integral availability: “No one clocks in in this context, we speak of a life in which all time is absorbed” and, with time, their individualities as well (Guillaumin, 1978, p.37).

Matias (2014) points out that, for caregivers who devote much of their time to older adults, isolation and feelings of self-annulation are common. This is often referred to in interviews with caregivers, but perhaps no one has expressed it as ostensibly as Virginia:

*I have to continue my life, as elderly I am now... I don't have a child anymore, I have no more freedom*

*to go out, I have no freedom to rest. When I think I have finished my service, she's already calling me. [...] My life stopped, you know, stopped, my life is stopped.* (Virginia)

Apparently, Virginia’s desires are the most trivial, like going out and resting, but there is more than that: she wants to continue life, which suggests the interest of recovering something lost, her existential project. She feels a certain urgency in this reappropriation of her story because of the feeling of time running out: *as elderly I am now* [...]. If the feeling of a frustrated life is what characterizes the disease, which cannot be determined outside the context of the difficulties that the organism/person encounters to respond to environmental demands (Canguilhem, 2009), Virginia’s “disease” is called suppressed autonomy and the “etiological agent” is a complex social and family context that has made her the sole responsible for the care of her sister. It is a “disease” that affects other caregivers interviewed.

Malu takes care of her husband. When asked what had changed in her life after her husband’s illness, she was silent for a few seconds and stated: *I went out more, and today I have to stay by his side more, because he doesn't know how to live alone. Oh, I feel sad, very sad with my problems*” and again there was silence. We will not delve into the meaning of this silence, but there is no doubt that there is something painful in the way she experiences the social and existential shrinkage produced by the fact that she is solely responsible for caring.

Melissa, who takes care of her mother, points out the irreconcilability between her projects and the workday imposed by care, emphasizing, above all, the impossibility of engaging in an extradomestic labor activity: *I can't work, I feel like working.*

Cassia takes care of three people: the bedridden father, the mother and the autistic son. She left her home to live with her parents, left her career. Their “social life”, in addition to the domestic sphere, is quite restricted. During the interview, she was moved to find that: *I live only on their account now. Everything has changed. I canceled myself to live*

*their lives*. She says she is exhausted and sick and wants an institution to assume at least the care of her father, care *whose quality is already falling, due to my situation*.

The declining quality care referred to by Cassia often translates, in similar cases, into **negligence**, within a situation that is already **socially neglected**. Neglect as a form of violence against the older adult predates the relationship between them and caregivers, referring to the broader social context, in the sense that we tried to explain earlier. In addition to neglect, this decline in the ability to care can unfold in **forms of psychological and physical violence** depending on how the caregiver responds to stressors related to the conditions of care exercise.

In some cases, violence can be established as a **standard** for care, so that shaking and shouting at older adults become **normal** strategies of the caregiver, as it appears in Ernani's account: *Beating him, no, you got it? Sometimes I just go and shake him: "Dad, it's not like that, I've already said it." Because he's stubborn. So, sometimes I have to be firmer like that, shout.*

In others, the relationship of care is marked by the oscillation between explosions of irritation and impatience and moments of self-control or cordiality of the caregiver, as Fruma tells us: *I feel like there are days when I control myself and there are days that I don't*. In other cases, the caregiver resorts to drug violence. Leni was referred to CREAS on suspicion of abusive medication delivery by her daughter. After the intervention of CREAS, the daughter began to take the older woman to a private doctor, apparently to escape the "indiscretion" of the public health system.

We thus see the production of a double process of vulnerability: the older adult - exposed to violence of various kinds and the failure or precariousness of care - and the caregiver - exposed to the imposed responsibility of a care that, in the conditions in which it is carried out, absorbs, along with their time, their individuality and their future and, sometimes, in the circumstances of a painful and mutually destructive encounter between the older adult and the caregiver. This is the meaning of "privatization of old age" for those on the "wrong side" of social inequalities.

## Final considerations

In the current context, in which the norm of competition and the model of enterprise penetrate all dimensions of life, the privatization of the reproduction of everyday life reaches an extreme degree. The reproduction of everyday life becomes the "responsibility" of each person. This "responsibility" does not mean that each one must perform the reproductive work on which they depend on to stay alive, but rather that each one must be able to appropriate, through the market or other means and institutions (the family, for example), the resources and work that they are not able to do or do not want to provide alone.

This social arrangement, described by the retreat of community forms of reproduction of life, the dismantling of public-state social protection devices and the increasing commodification of reproductive work, intensively affects care-dependent older adults. The contradictions of this arrangement become evident in this situation, when the word "dependence" cannot be successfully purged and the paradox that each one must be responsible for their own "dependence" has emerged.

The discussion conducted in this article allows us to realize that such an arrangement can produce even more destructive effects, for older adults and caregivers, in the context of low-income populations. Here, care (which cannot be outsourced by market mediation) becomes "house" work, but not of the "home as the center of collective life, of a life permeated by different people and forms of cooperation" (Federici, 2014, p.156), and rather of an atomized family nucleus. Within it, it seems that the most common thing is that care is assigned to a single person, selected by a perverse criterion, that of greatest vulnerability. Under such conditions, care is degraded to the condition of forced labor and synonymous with confinement, reaching the physical and psychological integrity of the caregiver. Suffering, illness and violence are the result of this degradation of care.

The questions shown invite to reflect on the need to build public devices that favor the sharing of "risks and burdens associated with care dependence", requiring expansion/reorientation of existing services and production of new ones.

The issues arising from what we call “privatization of old age” cannot be solved by this route alone, requiring answers that go through cultural and civilizational changes, capable of remaking the senses for cooperation and mutual care and of producing an age-politics based on the appreciation of older adults and their autonomy. The task is not only to produce an effectively democratic control of the social resources that allow to use a significant part of them for the benefit of older adults, but to put the older adult “in common”. It is necessary to assume the care of older adults as a socially shared responsibility and cooperative work of an extensive network of families, community and public services - a network that can no longer be a network of women reduced to the condition of “common resources”, but a network of all of us as subjects of the “common”, understood as systems of co-work and co-government. These are difficult and complex changes that interest everyone not only because (except for early interruptions of existence) aging is a common destiny for all, but also because, with the devaluation and vulnerability of “older adults”, much of relevant social experience is wasted.

## References

CANGUILHEM, G. *O normal e o patológico*.

Rio de Janeiro: Forense Universitária, 2009.

CASTIEL, L. D.; ÁLVAREZ-DARDET, C. La salud persecutoria. *Revista de Saúde Pública*, São Paulo, v. 41, n. 3, p. 461-466, 2007. DOI: 10.1590/S0034-89102006005000029

DARDOT, P.; LAVAL, C. *A nova razão do mundo*. São Paulo: Boitempo, 2016.

ESTEVES, D. B. *Cuidador formal de idoso: vergonha, delicadeza e cuidado*. 2018. Tese (Doutorado em Saúde Coletiva) - Universidade Estadual de Campinas, São Paulo, 2018.

FEDERICI, S. O feminismo e as políticas do comum em uma era de acumulação primitiva. In: MORENO, R. (Org.). *Feminismo, economia e política*. São Paulo: SOF, 2014.

GUILLAUMIN, C. Práctica del poder e idea de Naturaleza. In: CURIEL, O.; FALQUET, J. (Org.). *El patriarcado al desnudo*. Buenos Aires: Brecha Lésbica, 1978. p. 19-56.

HARAWAY, D. J. Manifesto ciborgue. In: TADEU, T. (Org.). *Antropologia do ciborgue*. Belo Horizonte: Autêntica, 2009. p. 33-118.

HIRATA, H; KERGOAT, D. Novas configurações da divisão sexual do trabalho. *Cadernos de Pesquisa*, São Paulo, v. 37, n. 132, p. 595-609, 2007. DOI: 10.1590/S0100-15742007000300005

ILLICH, I. Saúde como responsabilidade de cada um - não, obrigado! *Centro Brasileiro de Estudos de Saúde*, Rio de Janeiro, 2019. Disponível em: <<https://bit.ly/32Nfb6p>>. Acesso em: 1 maio 2019.

LIRA, I. C. D.; BARROS, J. C. Velhice dependente e serviço de cuidado no domicílio na política de assistência social. *Estudos Sobre Envelhecimento*, São Paulo, v. 28, n. 68, p. 42-61, 2017.

MANOEL, M. F. et al. As relações familiares e o nível de sobrecarga do cuidador familiar. *Escola Anna Nery*, Rio de Janeiro, v. 17, n. 2, p. 346-353, 2013. DOI: 10.1590/S1414-81452013000200020

MATIAS, M. L. *Política social para idoso: um estudo do Brasil e Canadá*. 2014. Tese (Doutorado em Política Social) - Universidade de Brasília, Brasília, DF, 2014.

MINAYO, M. C. S. *O desafio do conhecimento: pesquisa qualitativa em saúde*. São Paulo: Hucitec, 2010.

MUNHOZ, C. M. D. et al. Como a família ajuda ou dificulta o cuidado com a pessoa idosa. In: BORN, T. (Org.). *Cuidar melhor e evitar a violência: manual do cuidador da pessoa idosa*. Brasília: SEDH, 2008. p. 70-78.

OMS - ORGANIZAÇÃO MUNDIAL DA SAÚDE. *Envelhecimento ativo: uma política de saúde*. Brasília, DF: 2002.

OMS - ORGANIZAÇÃO MUNDIAL DA SAÚDE. *Relatório mundial de envelhecimento e saúde*. Genebra: 2015.

ORTEGA, F. *O corpo incerto*. Rio de Janeiro: Garamond, 2008.

PAIXÃO JÚNIOR, C. M. et al. Adaptação transcultural para o Brasil do instrumento Caregiver Abuse Screen (CASE) para detecção de violência de cuidadores contra idosos. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 23, n. 9, p. 2013-2022, 2007. DOI: 10.1590/S0102-311X2007000900010

PAMPOLIM, G; LEITE, F. M. C. Negligência e violência psicológica contra a pessoa idosa em um estado brasileiro: análise das notificações de 2011 a 2018. *Revista Brasileira de Geriatria e Gerontologia*, Rio de Janeiro, v. 23, n. 6, p. e190272, 2020. DOI: 10.1590/1981-22562020023.190272

PARANHOS, D. G. A. M.; ALBUQUERQUE, A.; GARRAFA, V. Vulnerabilidade do paciente idoso à

luz do princípio do cuidado centrado no paciente. *Saúde e Sociedade*, São Paulo, v. 26, n. 4, p. 932-942, 2017. DOI: 10.1590/s0104-12902017170187

REICHENHEIM, M. E. et al. Adaptação transcultural para o português (Brasil) do instrumento Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST). *Cadernos de Saúde Pública*, Rio de Janeiro, v. 24, n. 8, p. 1801-1813, 2008. DOI: 10.1590/S0102-311X2008000800009

SANTOS, K. O. B. et al. Avaliação de um instrumento de mensuração de morbidade psíquica: estudo de validação do Self-Reporting Questionnaire (SRQ-20). *Revista Baiana de Saúde Pública*, Salvador, v. 34, n. 3, p. 544-560, 2011.

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Estevam, Francisco and Silva carried out all stages of the fieldwork and participated in all stages of drafting the article (proposal, writing and revision).

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