

SOCIODEMOGRAPHICS, HEALTH, AND SOCIAL SUPPORT TO SENIOR USERS OF EMERGENCY SERVICES

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ABSTRACT

The aim of this study was to characterize the sociodemographic aspects, health issues and social support offered to the senior users of the Emergency Department of the Hospital de Clínicas in Porto Alegre. A cross-sectional survey was conducted with a random sample of 220 seniors. A structured data form was used to collect data related to the sociodemographic and health characteristics and social support. The majority of subjects were women, married, retired, from Porto Alegre, and aged from 60 to 69 years. Almost half reported having poor or very poor health and the prevalent self-reported morbidities were cardiovascular diseases. Differently from other studies with seniors from the community, the majority reported receiving support from family and few provided support. Social support from the formal network was small. Health care must occur in a comprehensive network to provide support to the seniors and their families and to prevent the frequent use of emergency services and to qualify assistance.

Descriptors: Seniors. Emergency service, hospital. Social support. Health of the elderly. Nursing.

RESUMO

Este estudo tem como objetivo caracterizar aspectos sociodemográficos, de saúde, e o apoio social de idosos usuários do Serviço de Emergência (SE) do Hospital de Clínicas de Porto Alegre (HCPA). Investigação transversal, realizada com amostra aleatória de 220 idosos. Foi utilizado questionário estruturado sobre características sociodemográficas, de saúde e apoio social. Idosos eram, na sua maioria, mulheres, casados, aposentados, procedentes de Porto Alegre, e encontravam-se na faixa etária dos 60 aos 69 anos. Quase a metade referiu ter a saúde ruim ou muito ruim, e as morbidades autorreferidas predominantes eram cardiovasculares. De modo diverso a outros estudos com idosos da comunidade, a maioria declarou receber apoio dos familiares e poucos forneciam. O apoio da rede formal foi pequeno. A assistência necessita ocorrer em rede, a fim de proporcionar suporte ao idoso e à família, evitando o uso frequente dos serviços de emergência e qualificando o cuidado.

Descritores: Idoso. Serviço Hospitalar de Emergência. Apoio Social. Saúde do Idoso. Enfermagem.

Título: Caracterização sociodemográfica, de saúde e apoio social de idosos usuários de um serviço de emergência.

RESUMEN

Este estudio tiene como objetivo caracterizar los aspectos sociodemográficos, de salud y apoyo social de los usuarios ancianos del Servicio de Emergencia (SE) del Hospital de Clínicas de Porto Alegre (HCPA). Estudio transversal realizado con una muestra aleatoria de 220 adultos mayores. Se utilizó un cuestionario estructurado sobre características sociodemográficas, de salud y apoyo social. Los sujetos eran en su mayoría mujeres, casados, jubilados, de Porto Alegre y tenían edades entre 60 y 69 años. Casi la mitad reportó tener una salud mala o muy mala y la morbilidad autoinformada prevalente fue la cardiovascular. A diferencia de otros estudios con los ancianos de la comunidad, la mayoría de los informes que reciben apoyo de la familia y pocos la proporcionaban. El apoyo de la red formal era pequeño. El cuidado de los ancianos necesita ocurrir en la red para prestar apoyo a los ancianos y la familia, evitando el uso frecuente de los servicios de emergencia y calificar la atención.

Descriptorios: Anciano. Servicio de urgencia en hospital. Apoyo social. Salud del anciano. Enfermería.

Título: Sociodemográfico, salud y apoyo social de los usuarios ancianos de un servicio de emergencia.

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INTRODUCTION

Old age is associated with a higher prevalence of chronic diseases and disabilities, more complex health needs, and frequent use of health services in comparison with other age groups. It is also known that during hospitalization, the time of hospital bed occupancy is longer⁽¹⁾.

National and international studies on the profile of users of emergency services have identified that the proportion of older people who use these services ranges from 12 to 29% and the number of users in this age group is increasing⁽²⁻⁴⁾. The possibilities of seeking care without any urgency are higher for those patients who are not referred by health services and who do not suffer from chronic damage⁽⁴⁾.

In Brazil, emergency services are the entrance door to the health system⁽⁵⁾. Due to the great organizational complexity and the difficulties in structuring these services, it is important to understand the demand and the profile of users to improve qualification and care. Investigating cases of elderly people seeking emergency services in a situation of worsening health and understanding the formal and informal network that these seniors can count on can help us identify aspects of the living conditions and health care.

Social support is considered one of the most important predictors of physical health and well-being, from infancy to old age. It comprises a complex and dynamic process that involves individuals and their social networks in order to meet their needs, and provide additional resources when facing new situations⁽⁶⁾. It can be defined as the totality of resources offered by other people. These are mutual exchanges in which both the recipient and those who provide support are benefited because they give greater meaning to life⁽⁶⁾. Social support consists of a function and structure which are different aspects and phenomena⁽⁶⁾. Function is related to the supply of emotional and practical resources⁽⁶⁾. The structure of social relations, i.e. the social support network, refers to the organization of the relationships among people⁽⁶⁾. The formal support network is composed of formal policies directed toward the elderly population in general, aggregating healthcare services, legal institutions to ensure rights, social welfare agencies, among others. Family, community, friends and neighbors are considered an informal network⁽⁷⁾.

At any level of health care, nurses and other health professionals should identify the resources used by the elderly as support to plan healthcare actions. Within this context of care to the elderly at emergency services, the questions that arise are as follows: Which is the health and socioeconomic profile of the elderly who use emergency hospital services? Which are the support demands of the elderly who use this service? To whom do these elderly turn to when they need support?

To analyze the support networks implies preparing, monitoring and supporting the family, community and voluntary groups who engage in the task of caring for the elderly. It also means managing the locations, equipments and techniques that promote the welfare of the elderly and those who respond for them⁽⁷⁾.

This study is part of a master's dissertation that investigated the networks and how the elderly who use the emergency services perceive social support⁽⁸⁾. The aim of this research was to characterize the sociodemographic aspects, health issues, and social support of the elderly who use the Emergency Service (ES) of the Hospital de Clínicas de Porto Alegre (HCPA). It is noteworthy that there are few studies on the profile of users of emergency services within the national context⁽⁹⁻¹⁰⁾. The aim of this study was to contribute to the knowledge of the characteristics of the elderly who use ES, collecting information on organizational effectiveness of the service and qualification of the assistance.

METHODS

This was a cross-sectional, observational study with a quantitative approach and service enquiry. The study was conducted at ES of the HCPA. This emergency service is registered at the municipal government; it has 49 hospital beds for adults and 15 pediatric beds and is currently structured as follows: reception for evaluation and risk classification, pediatrics, green observation room, orange observation room, hospitalization room and vascular unit. During data collection, the ES used the Canadian Emergency Department Triage & Acuity Scale that has colors for the parameters of severity and care: purple for immediate service; red, high risk; yellow, intermediate risk; and green, low risk. In September 2011, the Manchester protocol was adopted by the institution.

The study population was composed of elderly who used the ES of the HCPA. A random sample of 220 patients was based on the results of the study with the elderly population, in which 29.3% of respondents received some kind of support⁽¹¹⁾. A margin of error of six percentage points and a level of significance of 95% was adopted.

The inclusion criteria of the sample were: user of the emergency service, aged 60 years or older; obtain 13 points or more on the Mini-Mental State Examination (MMSE). If the senior person obtained 12 points or less on the MMSE, a substitute informant was used for the interview. This option allowed the characterization of the elderly who could not answer the questions of the instrument due to their fragility. The exclusion criteria were as follows: unaccompanied elderly and unable to answer the interview; those who died or were transferred to other locations immediately after admission to the ES.

The data collection was performed in 2011 for 60 days every day of the week. To ensure the randomness of the sample, one patient was interviewed in the morning, two patients in the afternoon (largest number of patients) and one patient during the night shift. The times within each of the three shifts were also systematically changed. From 11 pm to 8 am we did not perform data collection due to the reduced number of patients seeking the service at that time, according to a previous survey.

Data collection of the elderly classified as low risk (green) and intermediate risk (yellow) was performed in the sector for risk classification of the ES in rooms to ensure privacy. Patients classified as severe (purple) and high risk (red) were interviewed 24 hours after their arrival at the ES.

In addition to MMSE, a questionnaire on sociodemographics, health, and social support characteristics (support received/provided) was also used.

The Statistical Package for Social Sciences (SPSS) version 18.0 was used for data management. For the analysis, the categorical variables were expressed as absolute and relative frequency and continuous variables were expressed as mean \pm standard deviation (SD).

The project was approved by the Research Ethics Committee of HCPA (No110023). The seniors/caregivers signed an informed consent term.

RESULTS

In the sample of the elderly studied ($n=220$), the mean score on the MMSE was 18.1 points ($SD=10.4$ points). Of the 220 respondents, 160 (72.7%) were seniors and the other 60 (27.3%) were caregivers. Of the 60 caregivers, 63.3% were their children, 18.3% were spouses and 18.3% were friends or relatives. Of the 60 seniors who did not answer the interview, 40 (66.6%) were unable to answer and 20 (33.3%) obtained a score of ≤ 12 points on the MMSE.

With regard to the risk classification of the elderly in the study, 31 (14%) were classified as white, 174 (79%) as yellow, 11 (5%) as red, and four (1.8%) patients received purple risk classification.

As for the gender, 114 (51.8%) were women. The percentage of seniors aged 60-69 years was 45%, those aged 70-79 years was 37.3%, and 17.7% were aged 80 or older.

The majority of seniors were from Porto Alegre, as shown in Table 1. With regard to their marital status, 94 (42.7%) were married. Most were retired and the seniors had an average of 4.4 years of education ($SD=3.8$ years). As for the family income, most had an income of up to two minimum salaries.

The seniors had an average 3.5 children ($SD = 2.46$). It was also found that 38 (16.9%) lived alone and among those who lived with someone, 46 (21%) lived with a spouse (unigeracional household), 60 (27.4%) lived with their children or son and daughter-in-laws (household with two generations), and 61 (27.9%) lived with their grandchildren and great grandchildren (household with three generations or more). It was also found that 12 (5.5%) lived with other relatives (mother, nephew, brother) and three (1.4%) were hospitalized. The home where the elderly lived had an average of 2.9 residents ($SD = 1.7$).

When asking about their self-reported health status, most respondents reported having fair or poor health (Table 2). The elderly of the sample reported having an average of 1.8 morbidities ($SD = 1.0$). As for the self-reported morbidities, the most frequently mentioned were diseases of the circulatory system.

Table 3 describes the main forms of support received and support provided by the seniors studied. It was found that 175 (90.2%) seniors reported receiving support from family, whereas 153 (81.5%) reported providing family support.

Table 1 - Characteristics of elderly study participants according to social variables. Porto Alegre, RS, 2011. (n=220)

Characteristics	n	%
Place of origin		
Porto Alegre	126	57,3
Metropolitan region	64	29,1
Other city	30	13,6
Marital status		
Married or cohabiting	94	42,7
Widower	75	34,1
Divorced or separated	39	17,7
Single (never married)	12	5,5
Occupation		
Retired	150	68,2
Pensioner	36	16,4
Does not work	20	9,1
Housework	14	6,3
Education		
No schooling	40	18,2
Up to 4 years of schooling	90	40,9
Up to 8 years of schooling	60	27,3
Up to 11 years of schooling	14	6,4
More than 11 years	16	7,3
*Family Income		
Up to 1 M.L.	53	24,1
From 1 to 2 M.S	89	40,5
From 3 to 4 M.S	65	29,5
Above 5 M.S	13	5,9

Source: Author.

*S.M = minimum salary

As for formal support, 159 (72.3%) participants reported receiving support from a formal institution, the most frequently mentioned were the ones from health services. During the interviews, it was noted that the majority of seniors reported primary health-care unit as being the health service; the pharmacy for special medications provided by the State Government, and the popular pharmacy were also mentioned.

DISCUSSION

The proportion of seniors with a cognitive deficit in the present study was 9.0%. The propor-

tion was 6.9% when comparing the results with a population-based study⁽¹²⁾ that assessed the cognitive impairment of seniors in the city of São Paulo, which showed that elderly people who use the ES had more health needs due to their cognitive deficit.

With respect to the risk classification of the seniors in the study, it was found that the proportion was similar to the risk classification of adult users of the ES in 2011, according to the Management Information System of the HCPA, with a predominance of users with parameters of severity classified as yellow (79%), followed by those classified as white (14%), red (11%) and purple (1.8%).

Table 2 - Self-reported health status, number of comorbidities, and self-reported groups of morbidity of the elderly who used the emergency service. Porto Alegre, RS, 2011. (n=220)

Characteristics	n	%
Self-related health status		
Very poor	53	24,1
Poor	54	24,5
Regular	69	31,4
Good	35	15,9
Very good	9	4,1
No of morbidities		
None	16	7,3
1 morbidity	72	32,9
2 morbidities	73	33,3
3 or more	58	26,5
Self-reported groups of morbidities		
Diseases of circulatory system	152	43,6,
Neoplasias	72	20,6
Endocrine, nutritional and metabolic diseases	44	12,6
Diseases of respiratory system	24	6,9
Diseases of the musculoskeletal system and conjunctive tissue	18	5,2
Mental and behavior disorders	10	2,9
Infectious and parasitic diseases	9	2,6
Diseases of the nervous system	8	2,3
Diseases of digestive system	6	1,7
Diseases of the genitourinary system	6	1,7

Source: Author.

* More than one answer

It is possible that by using the Manchester protocol, the number of seniors with parameters of severity classified as yellow is higher than the proportion of adults in general, considering that this protocol better discriminates the severity of the complaints of the users attended as urgent and less urgent.

It was found that the number of elderly women was slightly higher than men, which is in accordance with studies on the population profile of those who use emergency services⁽⁹⁻¹⁰⁾. Another outstanding aspect is the significant number of seniors aged 80 or older, similar to international studies⁽²⁾, which may be associated with an increase in the elderly population in the city of Porto Alegre⁽¹³⁾. The trend is that the proportion of seniors who seek the ES will increase and the service must be

prepared to meet the needs of this age group, who are much more fragile.

With respect to the city of origin, similar data were found in studies with adult users of emergency services in Florianópolis⁽¹⁰⁾, São Paulo⁽¹⁴⁾ and Campinas⁽⁹⁾ in which most of the users came from the city where the service was offered, but a significant amount of users came from other cities. Although a specific question about the reason for seeking care in Porto Alegre was not asked during the interviews, we found that seniors frequently reported that their health problems were solved at the ES and that in other municipalities where the elderly lived, health-care services were poor. Another reason reported by the elderly was that they received follow-up treatment at the outpatient clinic of the institution.

Table 3 - Characteristics of support received and provided to elderly users of the emergency service at HCPA. Porto Alegre, RS, 2011. (n=220)

Characteristics	n	%
* Support received from family		
Personal care	132	29,4
Mobility assistance	103	23,6
Money	75	16,7
Living	61	13,6
Transportation	15	3,3
Food	6	1,3
Medications	5	1,1
Company	5	1,1
No support received	45	9,8
*Provided family support		
Financial	93	26,1
Housing	76	21,3
Taking care of grandchildren	63	17,6
Services	59	16,5
No support provided	67	18,5
Support from a formal institution		
Yes	159	72,3
No	61	27,7
*Source of support received		
Health Service	151	83,0
Federal Government	16	8,8
Municipal Government	5	2,7
State Government	4	2,2
School	1	0,5
Association	1	0,5
*Type of support received		
Medication	152	83,1
Continuous care benefit	9	4,9
Basic food need	6	3,3
Hospital products	6	3,3
Benefit during diseases	4	2,2
Bolsa familia	3	1,6
Transportation	2	1,1
Education for youngsters and adults	1	0,5

Source: Author

*More than one answer

In the present study, the majority of the seniors were married and retired, as found in other studies conducted in Porto Alegre^{(15-16)*}. This find-

ing may be considered as a protective factor for the elderly who use the service, since they have a spouse to support them, or as a factor of greater

* Due to the lack of published information on elderly users of emergency services, we chose to compare the results with population-based data or from other services.

vulnerability, when one senior is taking care of another senior person. It was also found that retirements, pensions or benefits of the seniors in the present study were incomes, though small, that contribute to the financial and material support of their families. The average years of schooling of the seniors in the present study was slightly lower than the average schooling of the elderly from Rio Grande do Sul in 2009, which was of five years⁽¹⁷⁾. The findings are similar to data from the national household sample survey (PNAD) of the last decade, in which the dependent elderly person with low income helped or supported their families, a fact which gave them some empowerment so their relatives took care of them⁽¹⁸⁾.

It was found that the number of children is still sufficient to provide support to the elderly, but it is known that this does not necessary mean that they will receive support from them⁽¹⁹⁾. As for the number of seniors living alone, the values are similar to the results of a national survey conducted in the Southern region. It is noteworthy that in the south of Brazil the number of seniors living alone is the largest in the country⁽¹⁸⁾. This information may have implications for the emergency services, as older people who have fewer children and live alone could receive less support and therefore, experience situations or health hazards that require the frequent use of emergency services, such as falls or even the exacerbation of chronic problems.

In relation to the self-reported health status, the results found diverge from population-based studies^(15,20) in which the majority of the elderly mentioned having good or very good health, possibly because they showed lower care needs at that moment. As for the number of self-reported morbidity, the results of the study are similar to those found in the national survey. In a Brazilian population-based study⁽²⁰⁾, almost one third of the seniors mentioned having a disease; the remainder mentioned two or more diseases. In contrast, 24.9% of seniors of the PNAD reported not having any pathology, showing the difference between the data collected from the community and at the emergency service. This disparity among data shows that elderly patients present exacerbation of chronic damage and their problems require intensive care when seeking emergency services.

In view of the data collected, it is clear that many seniors opt for the emergency service to monitor

chronic damage and do not use other health services. In addition, 7.3% of respondents reported, despite not reporting any illness, to seek emergency services. It is believed that effective access to other services, which is part of the Ordinance related to the network of emergencies, could supply the demands of these users⁽⁵⁾. Among the self-reported morbidities, circulatory diseases and neoplasias are similar to the major causes of death in Brazil and Rio Grande do Sul⁽¹⁸⁾.

Studies on the transfer of support among the elderly in Brazil are restricted. Comparing an investigation⁽¹¹⁾ that assessed the perception of 329 elderly women in a low-income neighborhood in the city of Rio de Janeiro regarding the kind of support received and given to the family, only 29.3% of the women reported receiving support from their family and 58.3% provided support, in contrast to the data found in the present investigation in which the results were better. However, the type of support received (personal care, mobility assistance and housing) and provided (financial and housing) was similar to the present study. Another fact that should be taken into consideration is that this study was conducted only with women, who tend to provide more support than they receive. In this study it was also found that intergenerational support and transfer were not restricted only to co-residence. It is possible that the type of support is similar in low-income families, indicating the importance of generation support and transfers.

Comparing the results of the study from Rio de Janeiro with this investigation regarding formal support, it was found that the elderly women in that study also reported receiving little support. It seems that the network structure of formal support for seniors is a major challenge in many Brazilian cities that are already experiencing the process of population aging.

In the results of this study, the type of support offered by health services was distribution of medication and not other type of support that could be offered by the primary healthcare network, such as home visits, consultations with health staff, and groups. This suggests that people who used the emergency service possibly did not do so systematically and that the type of support received is related to more specific actions than the actions provided by professional care.

An international study⁽²⁾ found that elderly people who receive supported from primary health-

care units use emergency services less frequently. In this investigation, the only health services mentioned were the hospital and a Basic Healthcare Unit, showing the link established between the elderly and the hospital service. Another important aspect is the question of the completeness and function of the formal network support focused on providing income or products that were provided timely. Although it is important, financial support and medication supply cannot be the only means of support.

CONCLUSIONS

It appears in this study that the elderly users of the emergency service present social and health vulnerabilities such as low education, low family income, poor or very poor perceived health, presence of exacerbation of chronic damage, and comorbidities. Furthermore, many elderly aged 60-69 years seemed to rely on the informal support network, since most were married, had children and lived in intergenerational households.

With regard to the support received, most seniors reported receiving support from their family for personal care, mobility assistance, financial help, and housing. Fewer respondents reported offering some form of family support, especially financial, taking care of grandchildren and providing services.

Although the terms of trade have occurred in both directions, the flow was much greater from the family to the elderly. Therefore, alternative support should be sought to support the elderly and their caregivers. The health needs of older people are complex and need to be known and provided by the healthcare services.

As for formal support, nearly three-quarters of the elderly reported receiving support from an institution, but the types of support were limited to medication supply, Continuous Care Benefit and basic food needs, which are not considered sufficient.

Considering the increase in the elderly population and their needs, the use of healthcare services and health care demands will increase. The informal network has been facing this challenge and will not be able to provide care alone. It is believed that nurses who work at all levels of health care, based on integrated and responsible care, must assist the informal network to address the challenges and

plan/implement actions to meet the demands of this population in healthcare services. Research in the area should be encouraged to broaden the analysis of the profile and support network for the elderly.

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