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Common Mental Disorders and Equity in Health Care Use: São Paulo-Capital Health Survey

Reinaldo José Gianini
Pontificia Universidade Católica de São Paulo

Gustavo Venâncio dos Santos
Pontificia Universidade Católica de São Paulo

Gabriel Salvestro
Pontificia Universidade Católica de São Paulo

ABSTRACT

Background: Common Mental Disorders (CMDs) compromise quality of life, thus generating socioeconomic costs. Objectives: To analyze equity regarding use of the services and health expenditures among individuals with CMDs, and their relationships with sociodemographic variables. Methodology: The data are from the 2015 São Paulo health survey, with application of SRQ-20. The participants have given their consent for their data to be used in this research. Results: The sample presented a CMD prevalence of 19.7% (95% CI=18.2%-21.4%). Higher CMD prevalence values were found among users of the public health services (PR=1.49; 95% CI=1.25-1.76) and in groups with ≥ 33 dollars of health expenditures in the last month (PR=1.28; 95% CI=1.08-1.52). For individuals with CMDs, the main variables associated with "used the public health system" and "health expenditure < 33 dollars" were lower schooling levels, lower *per capita* family income, and age < 60 years old. There was an inverse relationship between use of the Unified Health System (*Sistema Único de Saúde*, SUS) and health expenditure. Conclusion: Use of the SUS by people with CMDs follows the principle of equity in that it assists groups that are underprivileged in terms of schooling and family income, but not those over 60 years old.

BACKGROUND

Goldberg and Huxley (1) first defined Common Mental Disorders (CMDs) as encompassing a set of symptoms, which, although not sufficient to determine a formal diagnosis of mental disorders, compromises quality of life generating social and economic costs. Their global prevalence varies from 17% to 35%, evidencing the need for studies on this subject matter (2), especially in Brazil, where there are few studies capable of measuring the prevalence of CMDs, and even more among individuals assisted by Primary Care (3) and those belonging to different sociodemographic groups not frequently studied (4).

According to Monteiro (5), a number of studies show that people exposed to unfavorable social and economic conditions have worse health status, reinforcing the existence of a risk pattern. Thus, public health services emerge as a way to intervene in the health-disease process and to compensate health discrepancies produced by society. For Travassos (6), equity in the use of

health services becomes an important, though not sufficient, condition to reduce inequalities in contracting diseases and dying. This term includes all direct (medical consultations, hospitalization) and indirect (preventive exams, diagnosis and medication) contacts with the health services. Studying the use of health services is important to identify excluded population groups and coverage levels, as well as to assist planning in health to ensure universal and equal access (7, 8). In Brazil, immense socioeconomic and territorial inequalities mark the reality and have repercussions on the distribution of health services, affecting the opportunity to remain healthy (9, 10). Consequently, the concept of equity in health becomes fundamental to deal with these inequalities; it means that it is necessary to address the unequal approach among individuals, seeking to intensify measures for those who need it most (11, 12). The literature states that there is a major difficulty on the part of the health services in the diagnosis and treatment of CMDs. This favors the use of unnecessary tests and medications with high costs from the public health point of view and the possibility of iatrogenic harms or side effects, especially when there is insistence on treating only the physical repercussions, leaving aside important care measures in the psychological and social dimensions (2, 3, 13). It also states that this problem is greater in peripheral, disadvantaged and vulnerable populations, such as women, non-white-skinned people, older adults, individuals with lower incomes and/or schooling levels, widowers, people with chronic diseases, unemployed individuals and practitioners of religious minorities that are marginalized (2, 4, 13).

A global and large systematic review (14) compiled the main trends of the relationship between sociodemographic factors and use of the health services in individuals with CMDs. It observed a hill-shaped relationship with age, use being higher by middle-aged individuals and lower by young people and older adults. Female gender, Caucasian ethnicity and higher schooling levels presented higher use rates. Married people and employed individuals showed lower utilization. Income presented no association and immigration status showed no clear pattern, although there was only one Brazilian study in this systematic review (15).

Concerning use of the SUS, Ribeiro et al (16) describe that it was lower for white-skinned people, those aged 45 years old or more and groups with higher incomes and schooling levels. The same authors describe health expenditures over 50 dollars (equivalent to 100 *Reais* in 2008) for individuals aged > 60 years old, white-skinned people, with incomes > 2.5 MWs (1 MW = 415 *Reais*, equivalent to 207.5 dollars), married, and with higher education. There was an inverse relationship between higher income or schooling levels and use of the SUS.

Figueroa (17) studied Medicare beneficiaries and reports a CMD prevalence equal to 7.5%, with a per-year mental health expenditure 181% higher for individuals with CMDs when compared to those without mental health diseases. For physical health problems, the difference in health expenditure for individuals with CMDs was 118% higher when compared to those without mental health problems. In general, the Medicare expenditures were 18.4% higher for individuals with CMDs, 8.5% being indirectly related to mental health services and 4.2% directly related to such services, adding up to 12.7%. This author observed higher prevalence of CMDs in younger individuals, women, people with chronic multimorbidities, and black-skinned people. Individuals with CMDs presented 33% more hospital admissions and longer hospitalization times; they also presented 40%-54% more need of rehabilitation, and more need of emergency assistance; for them, the need of home health assistance was 27% higher.

OBJECTIVES

The studies about the populations most frequently affected by CMDs, as well as the understanding of their relationship with the health services, are fundamental for the effective response offered by the SUS. These studies can address important issues for those patients who require multidisciplinary teams and trained managers (2, 4, 13, 18), problems that often extrapolate direct contact with health care, as they demand governmental interventions in fields such as education, social assistance and basic living conditions (3).

Given the above, and in view of the importance of CMDs in terms of public health and the organization of the current health care system, this study set out to analyze equity in health care for people with CMDs focusing on the use of health care services and health care expenditures. The objectives are as follows: to analyze the prevalence of CMDs according to sociodemographic variables; to analyze health expenditures and use of health services according to presence of CMDs; to analyze health expenditure in individuals with CMDs according to sociodemographic variables; to analyze the use of health health services by individuals with CMDs according to sociodemographic variables; and to analyze the relationship between health expenditure and use of health services by people with CMDs.

METHODOLOGY

The data from the 2015 São Paulo City Population Health Survey (ISA/SP-Capital 2015) are used as the basis for this analysis (19). The sample of this population-based health survey consisted in the residents of private households in the city urban area. The process to stratify the probabilistic sampling of clusters in domains was in two levels, namely: census sectors with four groups, and households with five groups. The sample domains were as follows: adolescents aged from 12 to 19 years old, adult men aged from 20 to 59 years old, adult women aged from 20 to 59 years old, and men and women aged 60 years old or more (older adults). The city stratification took into account the Regional Health Coordination Office (*Coordenação Regional de Saúde*, CRS), including thirty census sectors in each CRS, and following the 2010 demographic census urban sectors register. The prevalence estimate from sample calculation was 50% with an error of 0.10 at a 95% confidence interval and 1.5 design effect. The population selected for this survey consisted of all the residents aged at least 15 years old who answered emotional health Block E of the ISA/SP-Capital 2015 (19).

The Self-Reporting Questionnaire (SRQ-20), which refers to Block E, was the instrument used to establish absence or presence of CMDs. The World Health Organization recommends using this questionnaire in developing countries as a tool for screening psychiatric disorders (20). Twenty yes/no questions about mental and physical symptoms make up the questionnaire. The number of positive answers established as a cutoff point for the presence of CMDs was 6 or more for men under 65 years old, 8 or more for women under 65 years old, and 5 or more for men and women aged 65 or more. SRQ-20 has showed satisfactory performance as a diagnostic test for CMDs, with 83% sensitivity and 80% specificity (2).

The sociodemographic variables included in this study were Gender, Age, Ethnicity/Race, Religion, Marital Status, Place of Birth, Schooling, Occupation, and *Per Capita* Family Income in minimum wages (MWs) in effect in 2015: 788 *Reais* or 262 dollars; the tables describe their categories. The health care variables were Type of Health Service last sought, public or private; and Health Expenditure in the last month, < 33 or ≥ 33 dollars, with the median as cutoff point.

Health Expenditure includes all direct (medical consultations, hospitalizations, surgical procedures) and indirect (preventive exams, diagnoses, vaccines and medication) occurrences. The prevalence values of CMDs according to sociodemographic and health care variables were analyzed. The initial analysis performed was the unadjusted and weighted frequency distribution of the variables related to health care among those with and without CMDs. The statistical significance of the associations was assessed using the chi-square test corrected by F distribution (Satterthwaite), and their Prevalence Ratios (PRs) and respective 95% Confidence Intervals (95% CIs) were calculated by means of Poisson regression. Among the individuals with CMDs, the associations between sociodemographic variables and "used public health services in last search" were analyzed and, subsequently, their associations with "health expenditure equal to or greater than 33 dollars last month".

In the univariate analyses of the associations between health care and sociodemographic variables, the Prevalence Ratios (PRs) and respective 95% Confidence Intervals (95% CIs) calculated by means of Poisson regression are presented and p-values<0.05 were considered significant. In the multivariate analyses, performed with Multiple Poisson Regression, the regression equations were estimated by natural logarithm, having health care variables as y and sociodemographic variables as x_n, describing the respective independent coefficients (β) and intercept (a). For this, the categories of the sociodemographic variables received a code following their frequencies in "used public health services in last search" = "use of the SUS health services" and "health expenditure equal to or greater than 33 dollars last month" = "health expenditure equal or higher than 33 dollars". These codes varied from 1 for the lowest to n for the highest. To elaborate the Scatter Diagram, the *predict* command was used after these multiple regressions to estimate the probability of using the SUS health services (horizontal axis) and health expenditure equal or higher than 33 dollars (vertical axis) for each individual with CMDs.

All the analyses took into account stratification and sample weights, and the STATA 11 software was used to analyze the data and design ***Figure 1***. The Ethics Committee approved this research (CAAE 66296917.0.0000.5373). The participants have given their consent for their data to be used in this research.

RESULTS

The sample included 3,621 individuals, of which 780 were identified as having CMDs. Therefore, the prevalence found according to sample weighting was 19.7% (95% CI=18.2%-21.4%). ***Table 1*** presents social and demographic differences on the prevalence of CMDs. There are significant differences for gender, age, religion, marital status, *per capita* family income, schooling and occupation. There are no significant differences for ethnicity/race and place of birth.

According to the variables related to the health services, the prevalence of CMDs was higher among those who last sought a public health service when compared to individuals seeking private health services (22.8% vs 15.3%; PR=1.49; 95% CI=1.25-1.76; p<0.001). Prevalence of CMDs was also higher among those who had a health expenditure greater than or equal to 33 dollars in the last month (21.5% vs 16.7%; PR=1.28; 95% CI=1.08-1.52; p=0.004) (***Table 2***).

In addition, there was a strong association between use of public health services and spending less than 33 dollars; with a PR for the ≥ 33 dollars spending category equal to 0.62 for those using the SUS (95% CI=0.53-0.72 and p<0.001). The analysis of the "used public health services in last search" variable (***Table 3)*** showed that there were significant associations with individuals with CMDs:

- Age (lower PR for individuals aged 60 years old or more),
- Ethnicity/Race (higher PR for black-skinned people),
- Marital status (higher PR for single, separated or divorced people),
- Place of birth (higher PR for those from other states),
- Schooling (lower PR for college or graduate students) and
- *Per capita* family income (higher PR for the categories that report less than 4 MWs).

Considering the "health expenditure equal to or higher than 33 dollars last month" variable (***Table 4)***, there were significant associations with individuals with CMDs:

- Age (higher PR in the 30-44 and 60 years old or more categories),
- Ethnicity/Race (lower PR in brown-skinned people),
- Religion (lower PR for no religion and higher PR for Spiritist or Buddhism or Judaism),
- Marital status (higher PR for widowers),
- Schooling (higher PR for college or graduate students) and
- *Per capita* family income (higher PR for the >9 MWs category).

No significant differences were observed between categories in the other variables for "used public health services in last search" and for "health expenditure equal to or higher than 33 dollars last month".

The multivariate analysis, using multiple Poisson regression, showed the following: age, schooling and *per capita* income family with p<0.05 for "used public health services in last search"; with marital status and schooling being the set of variables with p<0.05 for "health expenditure equal to or higher than 33 dollars". The Scatter Diagram between Use of the SUS and Health Expenditure in individuals with CMDs reveals an inverse relationship. Expressed as a natural logarithm, they present a concentration of points with a straight line trend, where the higher the probability of Use of the SUS, the lower the probability of spending less or more than 33 dollars (***Figure 1***).

DISCUSSION

Regarding use of the health services, the prevalence of CMDs observed was higher among users of the SUS. There was also lower use of the SUS by the older adults. There were no statistically significant differences between the genders regarding use of the SUS. However, these differences do exist in different ethnic groups, since black- and brown-skinned individuals tend to use this service more often when compared to white-skinned people and, for individuals with lower schooling levels, lower family incomes or those born in states other than São Paulo, use of the SUS is more frequent.

Except for the older adults, most of these findings were expected based on the literature. The fact that the prevalence of CMDs is higher in those who sought the public health service shows the importance of studying the specificities of this population for planning preventive measures

and treatment in the SUS. Silva et al. (21) characterized the sociodemographic profile and use pattern of SUS users in 2008. It is noted that, in that year, 56.7% (95% CI=55.9%-57.5%) of the health care services in Brazil were provided by the SUS. According to these authors, in the sociodemographic characterization of the SUS users, there was no statistical difference between the genders, and there was a higher proportion of demand among older adults and younger individuals. Use of public services was more frequent by black- and brown-skinned people when compared to white-skinned individuals. In addition, those with higher schooling and income levels and with some health insurance made lesser use of the SUS. These results corroborate the present study. However, in this research, for individuals with CMDs, the results obtained showed, for age, that older adults (60 years old or more) sought the SUS less.

The presence of CMDs as a disabling situation and associated to other comorbidities implies more dependence on the SUS, showing a greater need for public health preparation to deal with this condition. Due to their declining health condition, aged individuals with CMDs demand more assistance from the SUS, although they sometimes do not seek it due to the difficulties inherent to aging: overcoming access barriers, understanding the frequent changes in health care policies, knowledge about their rights, self-awareness of well-being and health, etc. As for widowers, in addition to this age issue, they are usually in more vulnerable health situations due to the implications of having lost their spouses.

Black- or brown-skinned individuals are historically discriminated against, not having opportunities or the necessary incomes to afford supplementary health expenses and, therefore, use the SUS more frequently when compared to white-skinned people or to individuals with better schooling levels, as these can afford supplementary health care services, which ensures lesser need to use the SUS (22).

Regarding health expenditures, the prevalence of CMDs observed was higher among those who had higher health expenses in the last month. The older adults had higher expenses (data consistent with widowers). The age group between 30 and 44 years old also showed higher expenditures. There was no statistical difference between the genders. Black- or brown-skinned people tended to spend less, while individuals with higher schooling and income levels spent more. Those who reported professing no religion spent less. On the other hand, Buddhists, Jews and Spiritists reported higher expenditures. A study conducted in India (23) showed a higher proportion of family income spent on health services in women with CMDs. Another study conducted in São Paulo pointed to the same trend (24), where mental disorders have been systematically associated with an increase in health care costs as well as in workdays lost. Patients with CMDs and other comorbidities have higher health care costs, and this requires complementary diagnostic or therapeutic assistance not offered by the public health care network. Thus, the protection offered by the SUS is incomplete. This is less serious for higher-income groups, who can afford to spend larger amounts in the private health care network. There is also a need to understand the results related to religion, as this variable presents a relevant regression coefficient in the probability of expenditure.

The analysis of the relationship between use and expenditure on the diagram shows that the individuals with CMDs who are users of the SUS refer less expenses. However, older adults sought the SUS less frequently and presented higher expenses, facts that are consistent with widowers. There was no statistical difference between the genders, black- or brown-skinned

people tend to use the SUS more and spend less, and individuals with higher schooling and income levels use the SUS less frequently and spend more. As already stated, the results for the older adults diverge from the literature, while those regarding the other variables are consistent with it (24).

In summary, this study shows a relevant prevalence of CMDs, especially in women, older adults, individuals with low income and schooling levels and people who profess religions of African origin; in addition, the individuals with CMDs report greater use of the SUS and higher expenditures in health. It also shows lack of protection for people over 60 years of age and widowers, and a possible protection for black- and brown-skinned people related to use and expenditure. Clinically, these data are important because they present situations of vulnerability that should be on the Primary Care agenda for early diagnosis and treatment and, from an equity perspective, they point out the priority needs for health policies. This dataset reveals that, despite having evolved in the last 20 years, the SUS has not yet completed the transition from a selective Primary Care model that focuses only on maternal and child problems, infectious and parasitic, emerging, epidemic and endemic diseases. It is distant from a universal and comprehensive care model, inclusive for any health problem, in any person (25).

There are several strengths and limitations regarding the ISA/SP-2015 survey data. Because of the ISA/SP-2015 careful sampling strategy, the effortful data collection procedures and adherence of the target population, this study offers a low probability of selection bias (19). Slight misclassification of the CMDs is possible because SRQ-20 sensitivity and specificity are high but not perfect. There are also possible misclassifications of health expenditure and of use of health services due to recall bias, mainly compromising the information of ordinary values for expenditures, and for using the information about health problems that the individuals judged irrelevant. Elsewhere, the literature describes a reporting bias that is used to narrow income extremes, while for schooling, it describes its time- and age-dependent nature. Concerning the interpretation bias, the multivariate analysis helped us to reduce confounding; although over- and under-estimations remain possible in certain variables/categories. Individuals with CMDs included in certain sociodemographic and health-related groups had an insufficient *n* to establish significant associations between this condition and such variables. The cross-sectional nature of the study makes it difficult to establish the cause and consequence relationship between the sociodemographic variables studied and use of the health services, health expenditure and CMDs. To this end, studies with a larger *n* and in other locations are recommended, as well as longitudinal surveys.

CONCLUSION

This study reiterates the relevance of the SUS through the data obtained, as it states that there is higher prevalence of individuals with CMDs among its users, demanding multidisciplinary teams and trained managers with the necessary knowledge. Regarding this specific demand and its interrelationships with several sociodemographic issues, there is a need to provide significantly effective and efficient care and follow-up to these patients. The Primary Health Care sphere stands out in this context due to its greater accessibility for the patients; as well as its early detection capacity and effectiveness for conditions with potential worsening, in order to prevent occurrence of expenses, dependence or overload linked to services inserted in the sphere of the Secondary and Tertiary Health Care Levels (22).

Thus, if we consider the various vulnerabilities that make the obstacles between individuals with CMDs and the SUS less surmountable, it is possible to determine which measures in Public Health could be implemented in order to guarantee Equity in Health, one of the principles guaranteed by the SUS for marginalized groups known to be more prone to CMDs. This principle's indirect measure can be through evaluation of expenditures and demands in the services offered by the public health care network (26).

It seems that the SUS honored the Principle of Equity according to the data obtained through this study. The families with lower incomes are those that make most use of the SUS and have lower monthly health expenses, when facing the different family income groups in which patients with CMDs are found and, therefore, are less able to afford health expenses, either because they do not have the purchasing power to do so or because they do not need expenses such as those not covered by the SUS. The same may not be true among individuals with CMDs in different age groups, as adults with this condition, who demand more assistance guaranteed by the SUS, use this service less when compared to young people with CMDs.

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Table 1: Prevalence of Common Mental Disorders according to sociodemographic variables. São Paulo-Capital Health Survey, 2015.

Variable/Category	CMD Prevalence (%)	Variable/Category	CMD Prevalence (%)
Gender	p<0.001	**Marital Status**	p<0.001
Female	24.3	Widower	30.4
Male	14.9	Married or stable union	19.0
Age (years old)	p<0.001	Single, separated	19.3
60 or more	25.3		
45-59	19.2	**Place of birth**	p=0.97
30-44	17.7	State of São Paulo	19.7
15-29	19.1	Other states	19.8
Ethnicity/Race	p=0.337	Abroad	18.6
Asian or indigenous	18.6		
White	18.5	**Schooling**	p<0.001
Brown	21.1	Higher education and graduate studies	14.3
Black	21.4	High School or technical school	19.0
Religion	p<0.001	Elementary school	24.8
Spiritist or Buddhism or Judaism	19.0	Never attended	31.4
Catholic	17.5	***Per capita* Family Income** (MWs)*	p<0.001
Evangelical/Protestant	23.7		
None	17.8	>9	11.2
Umbanda/Candomblé	37.8	+4 - 9	16.5
Occupation	p<0.001	+2 - 4	21.7
Inactive	28.3	+1 - 2	21.5
Active	17.7	Up to 1	28.8

***MWs - Minimum Wages**

Table 2: Prevalence of Common Mental Disorders and Prevalence Ratio according to variables related to health care. São Paulo-Capital Health Survey, 2015.

Variable	Without CMDs N (%)	With CMDs N (%)	Corrected CMDs prevalence*	Prevalence Ratio	Confidence Interval	p
Type of Health Service last sought						
Private	1,074 (38.0)	237 (30.4)	15.3%	1		
Public	1,756 (62.0)	543 (69.6)	22.8%	1.49	1.25-1.76	<0.001
Health Expenditure last month**						
< 33 dollars	1,267 (49.7)	278 (40.6)	16.7%	1		
≥ 33 dollars	1,283 (50.3)	406 (59.4)	21.5%	1.28	1.08-1.52	0.004

***Considering weighting of the sample. **The value of 33 dollars is a proxy for the median health expenditure in 2015**

Table 3: Analysis of the associations between the prevalence of "Used public health services in last search" with the sociodemographic variables in individuals with Common Mental Disorders. São Paulo-Capital Health Survey, 2015

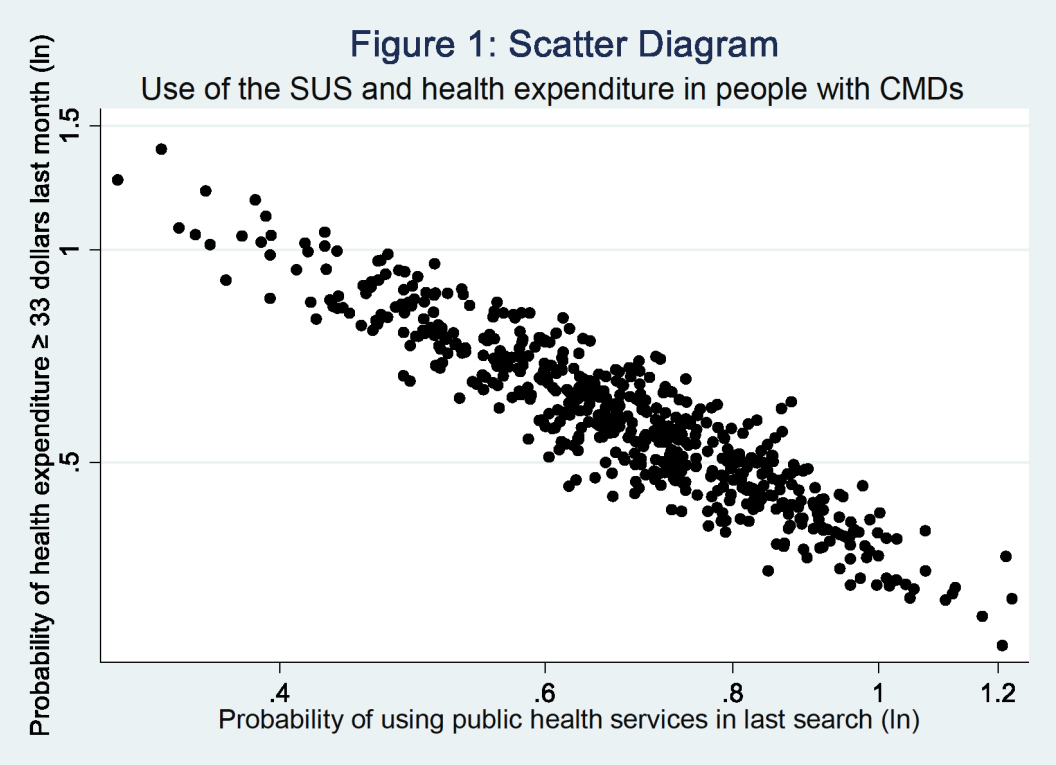
Variable/Category(*)	Used public health services in last search			
	%	Prevalence ratio	p	95% CI
Gender				
Female(1)	68.5	0.99	0.812	0.94 - 1.05
Male(2)	69.6	1		
Age (years old)				
60 or more(1)	57.7	0.89	<0.001	0.84 - 0.94
45-59(2)	69.9	0.96	0.124	0.91 - 1.01
30-44(3)	67.7	0.94	0.079	0.89 - 1.01
15-29(4)	77.5	1		
Ethnicity/Race				
Asian or indigenous(1)	59	0.97	0.727	0.81 - 1.16
White(2)	64.3	1		
Brown(3)	71.6	1.04	0.103	0.99 - 1.1
Black(4)	80.6	1.1	0.005	1.03 - 1.17
Religion				
Spiritist or Buddhism or Judaism(1)	52.3	0.92	0.181	0.81 - 1.04
Catholic(2)	65.4	1		
Evangelical/Protestant(3)	73.5	1.05	0.089	0.99 - 1.11
None(4)	74.4	1.06	0.131	0.98 - 1.13
Umbanda/Candomblé(5)	77	1.07	0.456	0.89 - 1.28
Marital Status				
Widower(1)	57.7	0.93	0.103	0.86 - 1.01
Married or in a stable union(2)	65.4	1		
Single or separated or divorced(3)	76.7	1.07	0.016	1.01 - 1.13
Place of birth				
State of São Paulo(1)	65.9	1		
Other states(2)	73.7	1.05	0.039	1 - 1.09
Abroad(3)	71.2	1.03	0.663	0.89 - 1.19
Schooling				
Higher education and graduate studies(1)	50.6	0.82	0.001	0.74 - 0.92
High School and/or technical school(2)	71	0.93	0.100	0.86 - 1.01
Elementary school(3)	74.7	0.95	0.272	0.88 - 1.04
Never attended(4)	83.1	1		
Occupation				
Inactive(1)	66.8	0.98	0.534	0.94 - 1.03
Active(2)	69.4	1		
***Per capita* Family Income** (MWs)**				
>9(1)	42.5	1		
+4 - 9(2)	54.5	1.08	0.310	0.93 - 1.27
+2 - 4(3)	76.3	1.24	0.002	1.08 - 1.41
+1 - 2(4)	74.1	1.22	0.005	1.06 - 1.40
Up to 1(5)	91.5	1.34	<0.001	1.17 - 1.54

(*) It indicates the category order in multivariate Poisson regression – see Figure 1.
****MWs - Minimum Wages**

Table 4: Analysis of the associations between the prevalence of "Health expenditure equal to or greater than 33 dollars last month" and the sociodemographic variables in individuals with Common Mental Disorders. São Paulo-Capital Health Survey, 2015

Variable/Category	Health expenditure equal to or greater than 33 dollars last month			
	%	Prevalence ratio	p	95% CI
Gender				
Female	58.7	0.97	0.321	0.92 - 1.03
Male	63.4	1		
Age (years old)				
60 or more	68.4	1.10	0.011	1.02 - 1.18
45-59	53.5	1	0.949	0.92 - 1.1
30-44	66.5	1.09	0.035	1.01 - 1.18
15-29	53	1		
Ethnicity/Race				
Asian	67.1	1.01	0.888	0.85 - 1.20
White	65	1		
Brown	53.3	0.93	0.036	0.87 - 0.99
Black	59.6	0.97	0.498	0.88 - 1.07
Religion				
Spiritist or Buddhism or Judaism	81.6	1.12	0.021	1.02 - 1.22
Catholic	62.9	1		
Evangelical/Protestant	59.3	0.98	0.481	0.92 - 1.04
None	43.9	0.88	0.018	0.80 - 0.98
Umbanda/Candomblé	69.5	1.04	0.681	0.86 - 1.26
Marital Status				
Widower	76	1.09	0.018	1.01 - 1.16
Married or in a stable union	61.7	1		
Single or separated or divorced	54.6	0.96	0.166	0.90 - 1.02
Place of birth				
State of São Paulo	61.8	1		
Other states	58.5	0.98	0.453	0.93 - 1.03
Abroad	44.9	0.90	0.343	0.71 - 1.13
Schooling				
Higher education and graduate studies	82.4	1.15	0.06	0.99 - 1.33
High School and/or technical school	56	0.98	0.81	0.85 - 1.13
Elementary school	53.7	0.97	0.65	0.84 - 1.11
Never attended	58.7	1		
Occupation				
Inactive	58.7	0.99	0.687	0.93 -1.05
Active	60.6	1		
Per capita* Family Income (MWs)				
>9	94.4	1		
+4 - 9	74.2	0.90	<0.001	0.85 - 0.95
+2 - 4	60	0.82	<0.001	0.78 - 0.87
+1 - 2	46.8	0.75	<0.001	0.70 - 0.82
Up to 1	45	0.75	<0.001	0.66 - 0.84

***MWs - Minimum Wages**



X-axis - Poisson regression for "Probability of Use of the SUS". Coefficients (β): gender=-0.02; age=0.10*; ethnicity=-0.02; religion=0.05; marital status=0.09; place of birth=0.02; schooling=0.18*; activity=0.04; *per capita* family income=0.10*; constant (a)=-1.76*. Y-axis - Poisson regression for "Probability of Health expenditure ≥ 33 dollars". Coefficients (β): gender=0.12; age=-0.05; ethnicity=-0.02; religion=-0.07; marital status=-0.15*; place of birth=0.03; schooling=-0.19*; activity=0.03; *per capita* family income=-0.12*; constant (a)=0.88*. *p<0.05. Table 3 describes the categories of the variables and their codes. (ln)=Natural logarithm. CMDs=Common Mental Disorders. Data from the São Paulo-Capital Health Survey, 2015