



Men's health and the health of the nation

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Abstract

The health of the male population is a substantial contributor to the health of the nation. In general, men have a poorer health status and lower utilisation of health services than women. They have a lower life expectancy and are more likely to die from avoidable deaths than women. Men's health is increasingly being recognised as a specialty area of health promotion and of clinical practice. Male-specific approaches may assist in maximising the positive outcome of interventions aimed at educating men about their health issues, attracting men into seeking clinical services, and establishing and maintaining a gender-orientation in health services that encourages men to engage. With appropriate training and resources, primary health care is ideally placed to provide accessible, male-friendly services with lead to reduction in gender inequalities in health.

Why is health, and men's health, so important?

A person's health is a foundation which enables or constrains his or her lifestyle, social, education, or employment choices. A decline in individuals' health has significant ramifications for their employment status and participation in the workforce. Furthermore the idea of health as the foundation of individual wellbeing extends to the health of a nation.

Health is not simply a by-product of economic development, but is a substantial driver of economic development as well. The health of the population affects a country's productivity, labour supply, education levels, and capital formation. Healthy people learn better, live longer—and work, earn, and save more.¹

The increasing cost of health care, fuelled by new technologies and an ageing population, itself places a substantial economic burden. This highlights the importance of improving the overall health status of the population rather than simply extending the average life expectancy of the population—adding life to years, rather than years to life. If health is important then, what is it about men's health that is worthy of attention?

In New Zealand (NZ), men comprise 49% of the population and 52% of the labour force.¹ Building on the above arguments, the health of the male population is a substantial contributor to the health of the nation. However men's health *per se* has received relatively little attention. While in some instances male subjects may have been assumed to be 'generic' for human beings, there has been little research specifically on the health of men.²

The United States (US) National Library of Medicine's controlled vocabulary MeSH (Medical Subject Heading) terms used for indexing articles for MEDLINE/PubMed has included the term "women's health" (the concept covering the physical and

mental conditions of women) since 1991. The equivalent term “men’s health” was only introduced in 2008.

Moreover, a Medline search from 1980 to 1999 found 3667 articles using the keywords ‘women’s health’, compared to 89 using the keywords ‘men’s health’.² A similar search in 2008 yielded 18,249 references for women’s health compared with 442 for men’s health.

This does not mean that men are healthier than women and hence require less attention. In fact, the health status of men appears markedly poorer and their utilisation of health services is lower than that of women’s. Without devaluing the importance of women’s health, this raises the issue that if greater health equality were to be achieved between the sexes, the impact on NZ’s economic and social wellbeing could be significant.

The importance of men’s health is not simply a utilitarian matter of the greater good in relation to the economic health of the country. If health inequalities between social and occupational classes or ethnic groups are considered to be a major issue of equity—or intrinsic fairness—then the poorer health status of men poses a similar challenge.³ It is difficult to diminish the importance of men’s health on the basis of either riskier/unhealthy behaviours, or as a function of occupational roles, when such issues are seen as being important factors to be addressed when confronting other forms of health inequality.

Although addressing inequalities in health in NZ is a key focus of health strategy and policy,⁴ men’s health does not specifically feature in this regard. Rather, the focus is more on addressing inequalities patterned by ethnicity and deprivation, and issues of men’s health within these groups appears at best in the margins.

Health status of men and women

In most modern societies, women tend to live longer than men. This has often been taken as a given and a reflection of improvements in health services for women over the last century, particularly maternity care, together with the generally higher exposure of men to occupational or environmental hazards. Yet an examination of data on the status of men’s health suggests that there are many issues specific to men that should justifiably concern health planners and policymakers, and for which a systemic or societal response may be required.

In developed countries, the evidence points to a substantial health inequality between men and women.⁵ A study of 17 European countries found men under 75 years have almost twice the number of deaths as women in the same age group in most disease states, with the exception of diseases of the musculoskeletal system, skin, and connective tissue.⁶

Another study which analysed the World Health Organization Statistical Information Services Mortality Database for patterns of premature death in men and women aged 15–44 years across 44 countries found that more men than women died prematurely in all these countries, and in many cases, the causes of early deaths were avoidable.⁷

The study focused on six potentially avoidable causes of death - accidents, suicide, malignant neoplasms, diseases of the circulatory system, homicide and chronic liver

disease and cirrhosis. It found that among men a median of 7.4% of all deaths from all causes in the age group 15–44 year olds, whereas the corresponding figure for women was 3.1%.⁸

The international literature has identified that men tend to have higher mortality rates, but that women tend to have higher morbidity rates, especially at advanced age.³ However the reduced quantity of life on the part of men does not appear to be offset by the reduced quality of life on the part of women. Rather, the emerging international literature on quality-adjusted life expectancy and disability adjusted life expectancy in developed countries indicates a persisting inequality of poorer lifetime health outcomes among men compared to women in the same community.³

This pattern of inequality is reflected in NZ data. Although life expectancy has increased over the past half-century, women have consistently lived longer than men. Since the 1970s there has been a steady narrowing of the life expectancy gap between men and women, from 6.5 years in 1975–77, to 4.8 years in 2000–2002.⁹ In 2002–2004 the gap was still 4.3 years, with the average life expectancy at birth of 77 years for males and 81.3 years for females.¹⁰

The *Decades of Disparity* report focused on widening inequality between ethnic groups over the periods 1980–84 to 1996–99.¹¹ Yet clear patterns of gender inequality also emerged, with life expectancy at birth showing lower life expectancy for males compared to females. More startling was that life expectancy for males in each of the three ethnic groups (Māori, Pacific, and non-Māori/non-Pacific) in the 1996–99 period was actually lower than life expectancy for females in each ethnic group in 1980–84, 15–20 years earlier.¹¹

This difference in life expectancy, patterned by gender, is reflected in NZ mortality data for major causes of death. These data indicate that males are more likely than females to die of most major causes, including coronary heart disease, cancer (all types), transport accidents, and intentional self-harm. Eighty-four percent of all fatal accidents are male, and males are more likely to die from injury than females at all ages.¹² Almost 100% of occupational deaths are male.²

In 2002–2004 men were 3.1 times more likely to commit suicide than females, and this rate was unchanged from 2001–2003.¹³ Females are more likely than males to die of hypertensive disease and forms of heart disease other than coronary heart disease, cerebrovascular disease, pneumonia and influenza, and falls.¹⁴

Health service utilisation

The literature also points to men experiencing barriers to service, either as a result of apparent reluctance, or potential systemic barriers. US research has shown men with health problems are more likely than women to have had no recent contact with a doctor, regardless of income or ethnicity. United Kingdom (UK) data indicate that men tend to visit their general practitioner (GP) later in the course of a condition than women, a problem that is compounded by social inequalities.¹⁵

A similar picture is evident in NZ. The 2002/03 NZ Health Survey found that GP utilisation in past 12 months was lower among men (75.7%) than women (85.5%).¹⁰ This could suggest men are generally healthier and have less need of seeing a GP. However, there were no conclusive findings in the survey to support this contention.

In terms of prevalence of most chronic diseases, apart from osteoporosis (higher among women), no significant differences emerged. In risk and protective factors, men were more physically active, but consumed fewer fruit and vegetables than women and there were no significant differences in obesity levels. Alcohol and marijuana consumption was higher among males than females, but there was no significant difference in tobacco smoking.¹⁰

However, the data also indicate that a blanket category of men obscures important differences between ethnic and socioeconomic groups: Māori and Asian males tend to access GPs less frequently than European/Other, and males in the most deprived quintile are more likely to report needing to see a GP but do not do so, than those in the least deprived quintile.¹⁶

The evidence suggests that men do care about health issues, but often find it difficult to engage with health services. This may be for a range of reasons, including:

- Lack of knowledge, either of services or of risk factors such as obesity¹⁵
- Lack of motivation, or stoic predispositions^{17,18}
- Inappropriate opening times of services^{2,19}
- Inappropriate targeting of interventions or insufficient available services^{15,20}
- Perception that health services are not ‘male-friendly’ and are primarily for women.²¹

An analysis of the way in which men see their place in their community and in their networks found that norms and values with which men associate their masculinity, such as self-sufficiency and self-control, may lead to difficulties in seeking out health care.²² This may be due to the perceived risk involved in discovering other’s reactions, leading to a potential threat to their identity as men.

Emergence of an international men’s health movement

Against a backdrop of a growing awareness of particular issues relating to men’s health is an emerging international men’s health movement.⁵ This is evidenced by “men’s health” becoming an indexed MeSH term in 2008. Although the field remains relatively small, notable advances are occurring in Europe, UK, US, and Australia.

Momentum has been generated and accelerated by the establishment of men’s health advocacy organisations in many countries, such as the Men’s Health Forum in the England and Wales (www.menshealthforum.org.uk), and the Men’s Health Information and Resource Centre in Australia. Such organisations have acted as focal points for national and local activity, developing and publicising initiatives, acting as clearinghouses for resources, and providing health and policy advocacy.²³

Conferences on men’s health have become regular events in many Western countries, providing opportunities to showcase initiatives and advocate for health planning and policy solutions. In 2006, Age Concern organised men’s health evenings in several localities in NZ as part of international men’s health week.

Evidence of benefits of men's health awareness activities

The evidence base of the benefits of men's health awareness programmes is sparse, reflecting its relatively recent emergence as a field of activity. However, there are some known benefits of activities that are targeted at men's health. No single programme will cater for the needs of men across all ethnic or social groupings. Rather, programmes need to be developed according to the particular ethnic, social, or geographical circumstances within which men live.

There is a paucity of evaluation evidence of events such as 'health weeks', and none that would signal their health benefits. However such events cannot be evaluated merely in terms of their possible health benefits, which are too difficult to disentangle from the effects of any number of other policy or service interventions.

It is more appropriate to assess the impact on their more immediate aims of motivating action and raising awareness. A recent such event was attended by 350 men.²⁴ Participants indicated that key requirements for ongoing men's health care are that men want facts to be presented without fuss and provided with a simple pathway for them to follow for ongoing health care.

Other interventions shown to contribute to an improvement in men's engagement in health services include men's health clinics and special centres,^{19,25,26} and workplace interventions such as prostate health awareness, nutritional knowledge, and diabetes.²⁷⁻²⁹

Primary health care

The place of primary health care, as the delivery point for men's health initiatives, has often emerged in the literature. Once awareness of men's health issues is raised, the success of such initiatives lies with men to consult with their GPs. However, as noted in an Australian study, primary care is not always equipped to provide effective health promotion activities in the course of GP or nurse consultations.¹⁷ Adequate training and resources may be needed for primary care to be effective in this role.^{18,20}

Possible approaches include:

- Offering services at 'work-friendly' hours.
- Setting up health checks targeting at-risk men.
- Offering choice of female or male health professionals.
- Using more information or communication technology such as email or txtng.
- Encouraging primary health care staff to work in wider community initiatives.¹⁷

Personal health care approaches include:

- A primary care environment that is more responsive to men, including waiting room ambience.
- Specific health promotion resources on offer in surgeries.
- Avoiding language that is negative about masculinity.

- Following up on family difficulties.
- Avoidance of judgemental attitudes.^{2,15}

The appeal to many men of a ‘warrant of fitness’ analogy for accessing health services to receive a health check, has previously been reported.³⁰

These are ways of ensuring a male orientation in providing primary health care services for the identification of health risk. Many men have idiosyncratic issues about seeing their GP (or even enrolling with a GP), recognising their own health problems or risk of problems, and traditionally have a much lower number of contacts with GPs than NZ females. Additionally, there are ethnic differences in access to primary care that need to be addressed.

The place of screening programmes in primary health care is controversial. Some of this controversy is driven by confusion around terminology. *Case finding*, which is germane to general practice and involves identifying disease or risk of disease in individuals or families, is an activity that GPs manage every day.

Population health screening, which is germane to public health and the new area of NZ Primary Health Organisations’ (PHOs) concern, population health, is when a particular disease or risk of disease is identified in sub-set(s) of the total population. For example when prostate cancer risk is identified by a GP (based on history, blood tests, and physical examination) this could be called “screening” the practice male population, but it is not “population screening”; rather, it is case-finding within a practice. In population screening for a whole population, the subset would be based on gender and age alone, and all would receive a screening test with no prior health consultation or examination.

The “case finding” approach applied to a personal health evaluation, particularly when recorded electronically, means that GPs and practice nurses use evidence-based guidelines to identify health risks in a population subgroup. This approach can be targeted, and based on age groups appropriate for the health risk being surveyed.

Conclusion

Only a paucity of interventions have been comprehensively monitored and evaluated, and which in turn have shown clear beneficial impact on men’s health. However there is potential for men’s health awareness activities to catalyse interest in health and to seek advice or support. Three possible benefits of men’s health activities are: raised awareness of health issues, connecting men with health or other support networks, and some degree of behaviour change.³¹

In his inaugural address at Leeds Metropolitan University upon taking up the first Chair in Men’s Health, Professor Alan White described his perspective on the current state of knowledge of men’s health.⁵ While he described men’s health as being problematic, the evidence base of knowledge as being incomplete, and our understanding of the theoretical issues as being unclear, he also portrayed changes and new approaches to care that are encouraging.

There is increasing academic activity around improved understanding of the important issues of men’s health and clinical interventions, as well as a greater acknowledgement that men’s health may be a specialised area of clinical practice. His

view of a way forward includes a synthesis of clinical practice and research with sociological investigation into understanding men's health beliefs and behaviours. This can guide the development of health policy to reduce gender inequities, as well as informing education programmes for health professionals and for men.

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References:

1. Statistics New Zealand. Household Labour Force Survey. Wellington; 2006.
2. Goodyear-Smith F, Birks S. Gendered approaches to health policy: how does this impact on men's health? *NZ Fam Physician*. 2003;30:23–9.
3. Tsuchiya A, Williams A. A "fair innings" between the sexes: are men being treated inequitably? *Soc Sci Med*. 2005;60:277–86.
4. Ministry of Health. The New Zealand Health Strategy. Wellington; 2000:59pp.
5. White A. Men's health in the 21st Century. *Int J Men's Health*. 2006;5:1–17.
6. White A, Cash K. The state of men's health across Europe. *Men's Health J*. 2002;2:63–5.
7. White A, Holmes M. Patterns of mortality across 44 countries among men and women aged 15–44 years. *J Men's Health Gender*. 2006;3:139–51.
8. Dobson R. Men are more likely than women to die early. *BMJ*. 2006;333:220.
9. Statistics New Zealand. New Zealand Adjusted Life Tables 2002–2003. Wellington: Statistics New Zealand; 2004.
10. Ministry of Health. The Annual Report 2004/05, including the Health and Independence Report. Wellington; 2005.
11. Ajwani S, Blakely T, Robson B, et al. Decades of Disparity: Ethnic mortality trends in New Zealand 1980–1999. Wellington: Ministry of Health and University of Otago; 2003.
12. ACC. Injury Statistics 2006 (First Edition) Section 21. Fatal Claims. Wellington; 2006.
13. Ministry of Health. Suicide Facts: 2004–2005 data. Wellington; 2006.
14. McKinlay E. Men and Health: A literature review. Wellington School of Medicine and Health Sciences, . Wellington: University of Otago; 2005.
15. Banks I. No man's land: men, illness, and the NHS. *BMJ*. 2001;323:1058–60.
16. Ministry of Health. A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey. Wellington; 2004.
17. Aoun S, Donovan RJ, Johnson L, Egger G. Preventive care in the context of men's health. *J Health Psych*. 2002;7:243–52.
18. Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Soc Sci Med*. 2000;50:1385–401.

19. Leishman J, Dalziel A. Taking action to improve the health of Scottish men. *Men's Health J.* 2003;2:90–3.
20. McMahon A, Hodgins M, Kelleher CC. Feasibility of a men's health promotion programme in Irish primary care. *Ir J Med Sci.* 2002;171:20–3.
21. Tudiver F, Talbot Y. Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. *J Fam Pract.* 1999;48:47–52.
22. Dolan A. 'That's just the cesspool where they dump all the trash': exploring working class men's perceptions and experiences of social capital and health. *Health (Lond).* 2007;11:475–95.
23. Baker P. The international men's health movement. *BMJ.* 2001;323:1014–5.
24. HealthWest PHO. *Men's Health Week.* Waitakere City; 2007.
25. Ekundayo OT, Bronner Y, Johnson-Taylor WL, et al. Formative evaluation of a men's health center. *Am J Public Health.* 2003;93:717–9.
26. Price R. *By Men for Men: A men's pit stop in Alice Springs.* Alice Springs, Australia: Department of Health and Community Services; 2006.
27. Aoun S, Johnson L. Men's health promotion by general practitioners in a workplace setting. *Aust J Rural Health.* 2002;10:268–72.
28. Cook C, Simmons G, Swinburn B, Stewart J. Changing risk behaviours for non-communicable disease in New Zealand working men--is workplace intervention effective? *N Z Med J.* 2001;114:175–8.
29. Summer S, Dolan A, Thompson V, Hundt G. Prostate health awareness: Promoting men's health in the workplace. *Men's Health J.* 2002;1:146–8.
30. McKinlay E, McBain L, Kljakovic M, et al. *The Men's Health Project.* Wellington: Wellington School of Medicine and Health Sciences, University of Otago; 2005.
31. Johnson L, Field A, Stephenson P. *Improving men's health in New Zealand.* Waitakere City: Health West Primary Health Organisation; 2006.
<http://www.healthwest.co.nz/documents/MensHealthinNewZealand.pdf>