The state of men's health in Europe: how do we compare in the UK?

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In this article, Alan White provides an overview of some of the main findings from the *State of men's health in Europe* report and relates them to the health of men in the UK.

In August, the European Commission’s *State of men's health in Europe* report was launched. The report covers the health of 290 million men across the 27 countries of the European Union (EU27), the four countries of the European Free Federation Association (Iceland, Liechtenstein, Norway and Switzerland) and three candidate countries (Croatia, the former Yugoslav Republic of Macedonia and Turkey).

The scope of the report was very broad, as the remit was to try and capture the breadth of issues that are facing men in the 21st century. The only stipulation for the commissioned team was that there should be no recommendations. The report was compiled by a team of writers, who were supported by a management advisory group, a reviewing group and a broader reference group. The work was co-ordinated by the lead author, Professor Alan White.

CHANGES IN THE MALE POPULATION

The report gives a detailed account of the male population and how it is changing. One of the most challenging aspects facing society is its increasing longevity, especially as this is coupled with declining birth rates in many countries. By 2060, it is projected that there will be 24 million fewer men between the working ages of 15 and 64 years and 32 million more men over the age of 65 years.

The position in the UK is not quite so stark, as we still attract a large number of migrant men, but the age dependency ratio (Figure 1) shows that the total proportion of over 65-year-olds will rise considerably from the current 14.7 per cent of the total population to more than 24 per cent.

![Figure 1. Age dependency ratio in the UK. Source: Statistical Office of the European Union (Eurostat)](image)
To support this increasing older population we have to strive hard to keep the younger population in good health, both as an economic and social necessity and also to ensure that they enter into older age as fit and able as possible.

Analysis of education, work and relationships suggests that many men are tending not to gain full benefit from the educational opportunities open to them, are now working in more fragile employment (if at all), and are living in the parental home for longer before settling into relationships.

The vulnerability of many men is highlighted by the scale of the male population in prison and those classified as homeless. With the majority of first migrants and asylum seekers being male, this is another subpopulation often found to be struggling with their health.

LIFESTYLE AND PREVENTABLE RISK FACTORS
Detailed analysis of men’s lifestyles and preventable risk factors reinforces the view that generally men are not living healthy lives. This propensity to overindulge in dangerous habits such as smoking, drinking excess alcohol and drug taking is coupled with reduced levels of physical activity, higher levels of obesity and a generally unhealthy diet, high in calories, fat and red meat and low in fibre, vitamin and mineral content.

It is noticeable, however, that smoking levels are reducing across most of the European countries and this is being mirrored by improving health. Analysis of sexual activity suggests that both men and women are having sex at an earlier age, for men many before the age of 15 years, with men more likely to have multiple sexual partners. However, there is an improving picture with regard to condom use, with younger men reporting greater usage.

USE OF HEALTH SERVICES
The overview of men’s usage of health services is problematic, in that there are conflicting messages. Though women have higher usage of GP services, there is no evidence that men do not have similar reporting of symptoms as women. A detailed analysis from Denmark of every GP attendance (some 35.8 million GP contacts and 1.2 million hospitalisations) in 2005 suggested, however, that the overall pattern among men of lower contact rates with GPs was linked to their higher hospitalisation and mortality rates. Across Europe this higher hospitalisation rate as compared to women was seen for diseases of the circulatory system, injuries, poisoning, external causes, diseases of the digestive system, diseases of the respiratory system, neoplasms and mental and behavioural disorders.

There is evidence that men have lower contacts for preventive health checks, and for mental and emotional health issues, and that most counselling and weight-loss services seem to find reaching out to men difficult. There is also a worrying trend in men using the internet for health advice and treatment, missing out on proper diagnosis and increasing the possibility of receiving counterfeit drugs.

LIFE EXPECTANCY
Examination of life expectancy, healthy life expectancy, and the mortality and morbidity data reinforces the fact that men’s high rates of premature death may have an element of biophysiological inevitability, but the majority of the problems emanate from sociocultural factors.

The differences between men and women, though striking, are not as large as those seen between men when comparing region by region and country by country. Average life expectancy for men in the EU27 countries is 76.1 years for men as compared to 66.3 years in Latvia and 80 years for Liechtenstein and Iceland; in the UK the figure is 77.6 years. When the life expectancies of men are explored for the regions within countries, we see a 15.5-year difference between the highest and lowest levels as compared to 10.3 years for women. There is a definite higher effect of worsening social conditions on the life expectancy of men, with no country being able to be complacent over the health of their male population.

When the causes of death were analysed, the rate of death for men was seen to be higher than that of women at every age (Figure 2). For the EU27 countries, men
have a 64 per cent higher rate of death for all ages than women, with that rate ranging from a 24 per cent higher rate in the 0–14 year age range, a 236 per cent higher rate in the 15–44 age range and just over twice as high a rate in the 45–64 age range. In the over-65 age range there is a 50 per cent higher rate of death in men.

For men in the UK, the overall rate of death is lower across the age span, but still remains high for the 15–44 age range, at 95 per cent higher, and for all ages it is 40 per cent higher than that for women. In numerical terms, in the EU27 countries there are 630 000 male deaths per year in the 15–64 year age range as compared to 300 000 female deaths. In the UK there are 59 505 male deaths per year and 37 827 female deaths in this working-age population.

HEALTH CONDITIONS
When the causes of the premature deaths are analysed, it is apparent that men seem more vulnerable than women across nearly the whole spectrum of disease states (Figure 3).

What is noticeable from the analysis of causes of death across the countries is how the relative burden of different diseases to overall mortality changes. In Bulgaria, for instance, nearly 62 per cent of all deaths are a result of cardiovascular disease, as compared to 33.1 per cent in the UK and just 25.5 per cent in France.

The conclusion from the section on mental health is that there are substantial undiagnosed mental health problems in the male population across Europe. This is not only a consequence of men’s reluctance to come forward with emotional problems, but also because the male form of anxiety and depression is not generally recognised within mainstream services.

The challenges posed by problems with men’s reproductive system, including the complexities of erectile dysfunction, benign prostatic hyperplasia, prostatitis and male infertility, all point to underinvestment in research and practice development over the years, as major breakthroughs are only just emerging.

The report covers many other forms of disease state. The higher incidence of periodontal disease and poorer oral health care is a serious cause of ill-health in men. Men’s increased risk of developing and dying prematurely of the major communicable diseases, including pneumonia, viral hepatitis, tuberculosis and HIV/AIDS, are apparent across Europe. Double the death rate from diabetes in men under the age of 65 years, higher rates of deaths from chronic lower respiratory diseases, and even the increase in osteoporosis, all point to a need to take all disease states as potentially problematic for men in a way that has not been officially recognised previously.

INEQUITY NOT INEVITABILITY
Although the report does not make recommendations, it does make observations on the data. The most significant is that men’s health disadvantage is an issue of inequity and not biological inevitability.

What is important also, is that this is not a case of men being reckless with their health. To have nearly 44 per cent of male deaths in Lithuania and over 21 per cent of male deaths in the UK as compared to 18 per cent in Sweden occurring in the working years (15–64 years) suggests that the social determinants of health are more to blame than the risk taking of individual men.
This is not to say that only societal change is required (although the blanket ban on smoking would certainly help) – services at the local level also need to become more responsive to men’s needs. Supporting men to be better at self-care, getting services out into the workforce to help in the early diagnosis of problems, and advising weight loss and counselling services that they could easily fall foul of the equality legislation are as important as widening GP access opportunities for men.

**CONCLUSION**

This first *State of men’s health in Europe* report is an important milestone and sets the baseline data against which future generations of men will be mapped. The information provided should help the European Commission, national governments and local strategy development to take a more informed look at how their current policy meets the needs of men and to think seriously as to how they tackle men’s health in the future.

**Declaration of interests**

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**REFERENCES**


