The need for men's health initiatives: 'connecting the dots'

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A strategy to improve health outcomes for men is dependent on the ability to 'connect the dots', requiring increased partnership and synergy within and between research, practice and policy contexts.

The women’s health lens has become an important aspect of planning in many healthcare systems around the world.1 The results to date have been impressive, with better-targeted public health policies, sophisticated research programmes and improved clinical services acting together to enhance health outcomes for women of all ages. An example from Canada is the British Columbia (BC) Centre of Excellence...
for Women’s Health, established in the early 1970s to respond to unmet health needs identified by leaders in the women’s movement,2 and continuing to thrive with provincial and federal funding. There is no equivalent centre for men.

GENDER DIFFERENCES IN LIFE AND HEALTH EXPECTANCY

In Canada and many countries around the world, a consistent pattern of life expectancy has developed over the past century: men die at an earlier age than women. BC provincial data from 2004 to 2008 indicate that men had a mean life expectancy of 78.9 years while women had a mean life expectancy of 83.3 years, a difference of 4.4 years.3

Data for BC over an extended time period (beginning about 1920) show a steady increase in life expectancy for both genders, with women consistently living longer than men (Figure 1). This gender difference in life expectancy was less than five years between 1920 and 1940, then increased steadily until 1980, at which time women had an almost eight-year advantage in life expectancy. This gender gap fell just as dramatically between 1980 and the present, returning to a level of just over four years.

There is no clear explanation for this marked fluctuation in relative life expectancy and we cannot predict whether the gender gap in life expectancy will continue to diminish (we simply do not know the factors responsible for changes in the size of this gap).

Beyond length of life, more revealing statistics relate to the age at which a person loses his good health (health expectancy) and the numbers of years of life lost because of dying at an early age (potential years of life lost, PYLL). In general, once men develop a serious health condition, the prognosis is worse than that for women and they are more likely to die from it: ‘in nearly all countries for which data were available, women live longer “healthier lives” and once sick live from 0.2 years to 7.3 years longer than men in sickness.’4

Such differential health outcomes affect millions of men every year.5 As one research team has observed: ‘There is a remarkable discrepancy between the health and survival of the sexes: men are physically stronger and have fewer disabilities, but have substantially higher mortality at all ages compared with women: the so-called male–female health–survival paradox.’6

Given this striking discrepancy in life expectancy, and the decrease in health expectancy, one would expect to find that men’s health has been a high priority for many years, drawing substantial investment of financial and intellectual resources from policymakers and researchers. But in fact, through most of the history of healthcare research and practice, findings of inferior health outcomes for men have been met with a kind of resignation, as though gender disparity in health outcomes were simply an unavoidable feature of the world – something to be accepted rather than addressed.7 There has been surprisingly little focused research attempting to discover the nature of sex differences associated with the observed life expectancy gap, their causation and potential remediation.8,9

CAUSES OF GENDER LIFE EXPECTANCY GAP

In Figure 2, we see the differences between men and women in BC, expressed in PYLL, organised by age at the time of death, for the year 2006. Not surprisingly, the pattern of mortality changes considerably across the age groups, with motor vehicle accidents accounting for a much higher proportion of PYLL in the younger, while cancer becomes the leading cause of death in the 45–74 year age group. Although not shown here, the pattern among those over 75 looks quite similar to that found in the 45–74 group.

One further step is needed to attain a clear understanding of the differences between men and women in life expectancy – an overall picture of the differences between men and women in years of life lost, across the age groups, ranked in terms of the leading contributors to the life expectancy gap. To obtain this overall picture, we calculated the difference between potential years of life lost by men and those lost by women: that is, men’s PYLL minus women’s PYLL, across the age groups. In this way, we...
were able to identify the five sources of mortality contributing most to the life expectancy gap between men and women (Figure 3, see page 13).

This provides a novel picture of the life expectancy gap, yielding a different type of information from that provided by tables of death rates. Here, we see that the first contributor to the gender gap is cardiovascular disease, which causes substantial mortality in men, at a younger average age than in women. The second greatest contributor to the gender gap is suicide, which affects men more often than women and occurs fairly often in younger age groups. Third is motor vehicle accidents – these are more common and more often fatal in men, occurring relatively often in the younger age groups. The fourth is infectious disease, primarily HIV/AIDS. The fifth greatest contributor to the gender gap is liver disease, with most being caused by alcohol dependence.

The science of male health is still very much in its infancy. Many questions need to be asked and answered on issues affecting all the ages and stages of the male lifespan. Each identified source of excess male mortality should be seen not as an indication of men's inevitable health disadvantage, but rather as an opportunity to improve men's health status and longevity. Only by understanding the contributors to men's reduced life expectancy can we develop ameliorative interventions. Each of the top causes of PYLL that account for the gender life expectancy gap have modifiable risk factors to be researched and then mediated by carefully designed, implemented and evaluated 'upstream' interventions.

**CONNECTING THE DOTS**
Over the past decade in Canada, issues around 'men's health' have captured the increasing interest of health professionals, researchers, the media, the lay public and politicians. However, a lack of partnership and synergy within and between research,
practice and policy contexts has encumbered the advancing of men’s health promotion in our country.

We believe that the success of a men’s health strategy is dependent on the ability to ‘connect the dots’, establishing a male-friendly health and wellness oriented society. These ‘dots’ represent the diverse foci of excellence that currently exist throughout healthcare delivery sectors, government, public health, educational and research communities, the critically important areas of research to be explored, the male-specific and/or dominant health issues, and the diverse communities in which men of different ethnicities, races and socioeconomic situations live, work and play.

The critical connections are those between:
• foci of excellence
• education, self-risk assessment, prevention, early diagnosis and future health outcomes
• different male health issues
• regions: geographic and societal
• male healthcare sectors
• male health and wellbeing of other groups.

The connection between foci of excellence
While there is expertise in different areas of male health, there is little in the way of collaboration, interconnectivity and co-ordination. By forming a network in which experts in diverse fields and communities can communicate, discuss standards of care, share research opportunities, partner in grant applications and interrelate electronically, ‘the whole will far exceed the sum of the individual parts’.

The connection between education, self-risk assessment, prevention, early diagnosis and future health outcomes
Many illnesses have risk factors, early signs and symptoms that are ignored or not recognised because of a lack of awareness. By helping men understand their individual, unique risks and vulnerabilities, they will have the option of modifying their behaviour and attendance in healthcare systems to prevent future problems and achieve better outcomes in managing their illnesses.

The connection between different male health issues
Over the past decade, it has become apparent that there are many linkages between behaviour, lifestyle, diet, activity, environment, workplace, employment opportunities, availability of social services and the various illnesses that affect males across all age groups. As researchers, educators, healthcare administrators and politicians plan the healthcare policies of the future, a male lens must be applied to help to bring these linkages into focus.

The connection between regions: geographic and societal
Though all men share a Y chromosome, the differences across the diverse cultures and societies are significant. The males of various
socioeconomic status, races, ethnicities and geographies should be connected through common policies and standards of care. These ‘dots’ are diverse and unique, but the system needs to be adaptable so as to communicate with each in their own way, and address unique concerns and needs.

The connection between male healthcare sectors

The variety of biopsychosocial issues that are male specific, or dominant, have different features and requirements when they are addressed in the greater community, in acute care institutions and in chronic care facilities. Standards of care and best practices need to be disseminated (developed where not available) within the context of our healthcare system, so as to connect men’s health issues across these sectors.

The connection between male health and wellbeing of other groups

The approach to gender-specific community health is not an ‘either–or’ question. Men’s health policies, and ultimately improved health outcomes, must be connected as an equal partner to women’s, children’s and minority health. Failure to address the health needs of any of these groups impairs the ability to fully serve the others.

Looking through a male lens

The lens through which men’s health is examined will ultimately influence how it is understood and advanced. As Courtenay highlights: ‘Most of what we currently understand about men’s health is fragmented and diffuse. It is fragmented by the individual disciplinary lenses through which we view men’s health as epidemiologists, health educators, medical anthropologists, nurses and physicians, psychiatrists, ethnographers, psychologists, public health workers, social workers and sociologists. These individual lenses enable us to deeply understand very specific aspects of men’s health. However, they also often limit the ways in which we conceptualize and understand men’s experiences more broadly.’

Men’s health initiatives around the world need to reach out to men across all ages, races and socioeconomic groups and apply a ‘male lens’ to current and future health promotion, educational collaboration, awareness, research and policy activities. A male-gender approach will benefit spouses and children, extended families and communities by highlighting key gender-specific biological, psychological, social and cultural determinants aiming to achieve the best healthcare possible for men. Men’s health is truly the missing piece of the ‘family health puzzle’.

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references