MEN'S HEALTH AT THE BEGINNING OF THE NEW MILLENIUM - TRENDS AND BLACK HOLES

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ABSTRACT

This paper considers two inter-related aspects of men's and boys' health in Australia. First, it considers the unnecessary confusion around the concepts which are used to guide our understanding of the poor health status of males. Secondly, it considers the evidence of action - or perhaps inaction - in addressing men's health issues in Australia through describing funding allocations to gender specific health services.

Introduction

The commencement of serious consideration of men's health in Australia was in 1992, with the publication of Fletcher's (1992) data on mortality, morbidity and sex differentials. However, differences in health outcomes between men and women was apparent in some of the earliest epidemiological data available in Australia. Figure 1 (below) shows the change in life expectancy over the past century - note that while there has been an improvement overall, that the gender differential in life expectancy remains.
More recently, the NSW Chief Health Officer's Report (1999) underscored earlier findings by noting it is still the case that:

- Men die at a greater rate in all age groups. (Among young Australians, there are nearly 3 male deaths to every 1 female death -ABS 1999:38).
- Men have higher levels of morbidity for many common illnesses
- Men are more likely to commit suicide (up to 8 times the rate of women in some age groups)
- Men suffer from a greater level of severe mental illnesses
- Men suffer from a greater rate of all cancers that are not sex related
- Men use health services (hospital and GPs, as well as other health related providers such as naturopaths and telephone counselling services) at a lower rate than women. (Research shows that males visit General Practitioners 30% less than females, and use hospitals 15% less than females - and stay for shorter times - de Looper & Bhatia, 2001. The Australian Institute of Health & Welfare also reports that the Australian health system spends 30% less on the health of males than females - AIHW, 1998).
- Men use preventive services at a lower rate than women
Men are the overwhelming majority of those injured or killed in work settings. (While comprising only 56% of the work force, male fatalities account for 86.7% of all industrial fatalities - NSW Workcover Statistical Bulletin, 1999/2000).

This is much the same bleak picture as that presented in the Health for All Australians Report as long ago as 1988. That Report noted at the time that the population group with the worst health outcomes in Australia was men. Despite this awareness, not only has there been no improvement, but there has been very little attention to the issue. We still have no national or even state men's health policies to provide a coherent framework for the health system.

**Underlying Causes of Men's Poor Health**

Unfortunately, much of the energy needed to address men's health has been diverted into the "black hole" of ideological bickering and academic posturing over the underlying causes. The main diversions have focused on two claims of causation:

1. That men's health and illness status is based in their biology, or
2. That men's health and illness differentials are a combination of lifestyle "choices" and masculine identity

Neither of these approaches can be seen as sufficiently encompassing to explain men's and boys' poor health status. The first - the biological focus (eg Kramer, 2000) explains the sex differential in health as based largely on biological (chromosomal and/or hormonal) differences. But it does not account for more than a very small proportion of data, primarily in regard to deaths in male infants and boys due to genetic abnormalities. The focus on biology cannot account for the far greater rates of workplace deaths, illnesses and injuries, nor early deaths due to largely preventable illnesses, such as cardio-vascular disease & cancers. The lower use of services by men also cannot be accounted for by a biological focus.

The second area of explanation - the social constructionist or “Men Behaving Badly” viewpoint is also fundamentally flawed. This approach often refers to “masculinities” or the “dominant hegemonic masculinity” as being the primary cause of men’s poor health, and is very commonly propounded in popular media as well as some professional journals (see eg Connell, 1996; Kimmel, 1996).

The line of reasoning in this approach proposes that men’s 'gender identity' is subsumed by an overall “dominant hegemonic masculinity”, and this "dominant form of masculinity" results in men:

- being unable to seek help;
- being unable to express feelings;
- being ignorant of their bodies;
- being involved in anti-health behaviours such as competitiveness and violence (see eg Edgar,1999).

The implication of this explanation for health actions – including Government policies – is that if men are to be healthier they themselves must change. This approach claims there is nothing faulty in the system of health delivery or in the social expectations placed on men & boys -
rather, it sees being male as a pathological state. Such an explanation neatly avoids governmental or institutional responsibility for men’s poor health, because it is, basically, their own fault. This view has been presented so often that it has almost come to be accepted as a fact, despite the absence of supporting evidence, and the significant conceptual problems with this approach, to which I will refer briefly.

- First, not all men are unhealthy (Woods, 1997). On average, men’s health is indeed worse than women’s health. But this is largely due to the health status of men from the lower socio-economic levels, whose health status is so poor that it drags the overall averages down (Blane, 1998). Men who have middle to high levels of income have health outcomes not dissimilar to that of women with similar incomes. These are often the men who compete in the corporate and professional worlds, and whose past-times include activities such as rugby, cricket, hunting, fishing and shooting which are seen as indicative of the “dominant masculinity”. But since poor health is experienced mostly by poorer men, it would mean that it is not the masculinity of the dominant social group of men, but rather the “masculinity” of the working (or perhaps non-working) class which is problematic. The phrase "blame the victim" readily springs to mind.

- No causal connection between the nature of one’s “maleness” and one’s health status exists. At best there is a correlation between certain gender attributes and lifestyle and health-seeking behaviours - but no direct link from these gender attributes to health. Those who focus on this explanation are engaged in no more than conjecture. There may even be health enhancing effects associated with some of the classic characteristics of "masculinities", such as stoicism.

Why these limited or diversionary explanations have gained so much currency must be attributed to political rather than factual reasons. If we make the reasonable assumption that men are a normal part of the population, we can expect them to be affected by the same factors as others - and these factors are is clearly known. The Australian Institute of Health & Welfare (2000) outlines a model which is almost universally accepted as one which identifies factors which determine health & well-being:
Examination of this model reveals that the focus on causation in men's health has been on only those factors attributed to the individual, and that environmental factors, interventions and resource inputs have received scant, if any, attention.

The Social Environment
One other aspect of this model that demands attention in understanding men's health is the non-physical environment. There is a substantial body of research that links men's health to social factors. The first notable research was Emile Durkheim's 1897 monograph on suicide, where he demonstrated that suicide rates varied across Europe in relation to how well, or badly, people were integrated into their communities. He noted that suicide was more common amongst men.

At a more subtle level of social influence, recent studies highlight links between economic change, deterioration in social cohesion and life expectancy of males. Walberg, McKee, Shkolnikov, Chenet & Leon (1998) examined mortality increases in Eastern Europe and concluded that economic changes following the collapse of the USSR had significantly reduced the life expectancy of men. Kawachi, Kennedy & Lochner (1997) in the USA provide data showing increased unemployment rates correlate with increased rates of cardio-vascular disease in men. Johnson, Stewart, Hall, Fredlund & Theorell's (1996) extensive research in Sweden shows that low work control is a major risk factor for increased morbidity and mortality in men - even after controlling for SES and lifestyle. This finding is totally in accord with the landmark "Whitehall study" (Marmot, Davey-Smith, Stansfield, Patel, North, Head, White, Brunner, & Fenney, 1991).
The factor of social inclusion has received recent attention in some quarters, and is suggested as being more influential on health status than individual factors. Hupalo & Herden (1999) emphasise the link between social inclusion (social, cultural and political dimensions, and family relationships) and health. They demonstrate that barriers to social participation not only result from poor health, they are also a major cause of poor health - and a potential source of explanation of the persistent relationship between ‘poverty’ and poor health in developed countries. Wilkinson (1997) claims that the link between poverty and poor health seems to operate through the psychological factors of low control, insecurity, and loss of self esteem, combined with the emotional and psychological stresses associated with coping in deprived circumstances. The lack of suitable social support systems for men in developed countries could be seen as a major contributor to ill-health, especially in the context of the sweeping changes in economic and social life over the past few decades.

The best that can be said of a masculinities or biological approach is that they identify the individual components within an explanatory framework. It is clear that emphasis should not be placed on these at the expense of other causal factors, and especially in the absence of empirical support. In fact, to benefit the health of men and boys in Australia the research noted above indicates that our attention must include social factors, and avoid the attempts to divert attention to "individuals" as the cause of their own poor health. The individual may be the site where such factors operate, but this does not mean that the individual is the culprit for his own poor health.

Further investigation of causes of the health differential could benefit from adopting the World Health Organisation's (WHO) 1998 framework for health. The WHO states that different but interrelated aspects of the social determinants of health that must be addressed in order to provide a framework for higher standards of health in the population. Of the 10 areas identified, those that highlight the findings noted in the above research are:

- the need for policies to prevent people from falling into long term disadvantage;
- the importance of an understanding of how the social and psychological environment affects health;
- the importance of ensuring a good environment in early childhood;
- the impact of work on health;
- the problems of unemployment and job insecurity;
- the role of friendship and social cohesion;
- the dangers of social exclusion;
- the effects of alcohol and other drugs.

**Resource Allocation**

Resource allocation is another area identified by the AIHW model as a determinant of health. Its primary importance is that it enables effective prevention, early intervention and appropriate treatment. Yet no attention has been given to considering links between resource allocation in health and men's health status. This is surprising given the learning gained from the successes of women' health in Australia, which has shown that an amalgam of services (social support, preventive, screening and treatment) is necessary to address overall health status. Yet if we compare the reasonable outlay to address factors in women's health to men's health, it is clear that
men are subject to almost total neglect. "Put your money where your mouth is" is an Australian catch-cry indicating a general - and not unfounded - belief that one's sincerity can be assessed in terms of willingness to part with dollars. The following shows that the dollar allocation to men's health is as miserly as the rate of government utterances on the issues confronting men and boys.

Table 1: Commonwealth Government Funding For Women Only Health Programs (Annual), Commonwealth of Australia, 2001

<table>
<thead>
<tr>
<th>FOR</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>National Cervical Screening + GP incentives</td>
<td>$118,000,000</td>
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<tr>
<td>National Breast Cancer Screening</td>
<td>$ 90,812,938*</td>
</tr>
<tr>
<td>Family Planning</td>
<td>$14,700,000</td>
</tr>
<tr>
<td>Jean Hailes Foundation (women's needs research)</td>
<td>$500,000</td>
</tr>
<tr>
<td>National Womens Longitudinal Study</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Development of Sexual Assault Program</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>Women's Legal Services (11)</td>
<td>Unknown</td>
</tr>
<tr>
<td>Legal Aid funding (generic, but targeted at Family Court &amp; DV)</td>
<td>$15,800,000</td>
</tr>
<tr>
<td>Partnerships against Domestic Violence</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>Domestic Violence Clearinghouse</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Office for the Status Of Women</td>
<td>Unknown</td>
</tr>
<tr>
<td>OSW additional programs</td>
<td>Unknown</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$212,500,000</strong></td>
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* includes grants to States for breast cancer Screening

Table 2: Commonwealth Government Funding For Specific Men Only Health Support Programs (Annual)

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<th>FOR</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>Australian Centre of Excellence in Male Reproductive Health</td>
<td>$1,000,000</td>
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There is no official publication which summarises expenditure for male only programs. However, examination of health resource allocation from the Department of Health & Ageing in the Commonwealth Government indicates that the only male specific allocation was to the Australian Centre of Excellence in Male Reproductive Health at Monash University. This centre was allocated approximately $A4 million over a period of 4 years to examine "topical issues" ranging from androgen or anabolic steroid abuse in the young to hormone replacement therapy for the older man. The rationale as to why this is the main area selected as a priority to meet men's health needs is not provided in any of the Minister's public statements. Note that the above does not
include State Government funding to specific women's programs. It is reasonable to assume that there is a similar differential.

Another means of tracking health dollars is not allocation, but actual expenditure. The only national Australian study which identifies total expenditure of health funds, and which provides a gender breakdown, shows that spending on males is $A4.6 billion less than for females (see below). Even subtracting costs associated with child-bearing still leaves expenditure on females far higher than for males. If we assume that the health system does indeed have an impact on health outcomes - as one would hope - then the amount expended on males would in itself guarantee that their health status would be lower than for females.

Table 3: Health System Costs by Gender (1993-4)
Mathers, Penn, Carter, & Stevenson, 1998

<table>
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<tr>
<th>MALE</th>
<th>FEMALE</th>
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<td>$13.4 billion</td>
<td>$18 billion</td>
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The inequity in sex differentials has led to some interesting intellectual acrobatics seeking to avoid consideration of men as a specific population group altogether. For example, Schofield, Connell, Walker, Wood & Butland (2000) suggest:

"A more useful way of understanding men's health is (by) examining health concerns in the context of men's and women's interactions with each other"

The avoidance tactic is also explicit in a statement from the New South Wales Department of Health (2000), which:

"...introduces an overarching framework for promoting women’s and men’s health in NSW. It recognises that gender has a significant influence on the health of women and men... there are historical and social disadvantages which prevent one sex, often women, from benefiting fully from society’s resources" (my emphasis added)

Despite these indications of an embedded bias – or even misandry – in regard to the health of males in Australia, there are many people - both women and men - conducting innovative and effective projects to enhance the health & well-being of males of all ages. Some of these people work in mainstream services, where they orient their services to facilitate access to services by men and boys. Some conduct programs through the generosity of the private sector. Some are working under the limited security of project funding, and many are working for free. This is essential for the continuation of men's health, but it is not enough, nor should we accept a model of "grass-roots" activism as the answer to men's poor health status.

It is the role of elected governments to address the health needs of their populations. It is clear in Australia that the elected governments are not doing this for a large section of the population -
men and boys. Edwards (1997) offers a critique of the government inaction over men and boys, stating:

1. The occurrence of preventable death is contrary to the mandate of government to protect its citizens.

2. There should be equal access to resources & specific health-providing services to address the needs of all sections of the population.

Recognition of the problem is an initial step, and requires common sense to over-ride the vested interests of those who minimise or divert attention from the central issues of men's and boys' health. This must then be followed by policy initiatives & change strategies that are affordable and effective. It is time to stop neglecting the health of men and boys.

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REFERENCES


Edgar, D, 1999, "Calling for the absent male" in *Australian Family Physician*, 28(8), pp 797-9.


