Gendered approaches to health policy

– how does this impact on men's health?

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ABSTRACT

New Zealand governmental agencies promote a gendered approach to health care policy and service delivery on the basis that women have special health needs not met by the existing health services. We argue against such an initiative on the basis that giving priority for female services disadvantages males, who already have higher morbidity and mortality than women. A needs rather than advocacy-driven public health policy directed at high-risk groups for specific health problems rather than specific populations may be a more efficient, equitable and effective means of disease prevention and treatment.

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Introduction

Over the past two decades there has been an increasing call for a gendered approach to health care policies, programmes and services. In New Zealand this has focused primarily on strategies relating to women's health. Women are seen as having special health needs not met by the existing health services, which are said to have catered for men as the norm.[1] In the 2001 Women's Health Strategy, the New Zealand Ministry for Women's Affairs argues that women are socially and economically disadvantaged relative to men; that this results in inequalities of health outcomes favouring men; and hence a gendered approach to health is required to redress these imbalances.[1] The Strategy argues that data collection, policy-making, health service planning and delivery, research, monitoring and evaluation should all follow this gendered approach.

In this paper we argue that, while men and women may have different health needs with respect to particular health issues, a global gendered approach based on redressing the social oppression of women and their perceived health care disadvantages is likely to neglect the health care needs of men. Such an exclusive approach would promote inequality of health care provision and reduce overall positive outcomes for the health of our population. Health strategies that are inclusive and acknowledge the value of both men and women will be more successful in producing an efficient, equitable and effective means of preventing and treating disease.

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Is there gender inequality in health?

Gender-specific health research

The neglect of women in medical research is often put forward as an argument in support of a gendered approach to health.[2,3] It is claimed that women have been excluded from major clinical studies and that inadequate attention has been given to diseases and conditions specific to, or more prevalent in, women. According to the reasoning, male norms were societal norms. Hence clinical trials would include only men as subjects, and then extrapolate the results to the population as a whole.

It seems, however, that this case is overstated. A retrospective examination of 441 original clinical studies published in the *JAMA*, *Lancet,* and *New England Medical Journal* during 1971, 1981, and 1991 found only 3% excluded women from the subject population in 1991 (compared to 11%

in 1971). In 1991, 12% of the studies were specific to women's health but only 0.7% were specific to men's health.[4]

For a broader, but less in depth analysis, we conducted a search of specific literature on women's health and men's health, both in New Zealand and internationally, through the Embase and Medline databases, from NZ government agencies, from Internet sources and other relevant publications. New Zealand mortality and morbidity data were obtained from various sources, including publications of the New Zealand Health Information Service of the Ministry of Health.

In general, there was a paucity of data pertaining to male health. A Medline search for the years 1980 to 2002 found 7 991 articles using the keyword 'women's health', compared to 179 using the keyword 'men's health', with 28% (51) of the latter related to HIV infection in homosexual men. 'Women's health' is a MeSH term but 'Men's health' is not. 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.

Gender-specific policies

Gender-specific health policies tend to focus on women's health. The call for a gendered approach is an initiative of women's organisations. The New Zealand Women's Health Strategy is promoted by the Ministry of Women's Affairs; there is no equivalent Ministry of Men's Affairs and no Men's Health Strategy has been proposed.

The message that women are deserving of special attention sends the implicit signal that men are less important

Policy-makers can be quite specific in focusing on women's health to the exclusion of men's. It is sometimes claimed that historically men have 'had more attention than they deserve' and therefore it is fair that they receive relatively less health resources now.[5] For example, an Auckland health authority identified Maori, Pacific Island, young people, women, older people, homosexual men, lesbian women, people with disabilities and rural people as priority groups for future alcohol, drug and tobacco regional services. Despite the fact that men in general are a high-risk group for drug and alcohol problems, the service manager stated that the exclusion of middle-class white males was deliberate: *'They are the ones who have been accessing these services predominantly for the last 20 years – the emphasis is now to redress the balance'*.[6] In our opinion, denying men equitable access to health resources because other men allegedly have had more than their share in the past is a policy unlikely to result in optimal public health care delivery.

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Another reason given for women to have priority with respect to health services is because of their role as caregivers: women merit preferential treatment because of the importance of their nurturing role.[7,8] The assumption is that men are not caregivers to their spouses, their children and others in their lives. The message that women are deserving of special attention sends the implicit signal that men are less important, that their contributions to their family and their community are not valued.

In their document *The Health of Women*, aimed at improving the health of women throughout their lives, an Auckland health authority asserted that women *'are pivotal to the health of families'*[9] and advocated health service improvement to *'better meet the needs and wishes of women'*. In contrast, their equivalent document *The Health of Men* identified the primary cause of male ill-health as *'the social construct of masculinity'* with the chief message that male health gains require men to change, to be less *'masculinist'*.[10,11] The view of masculinity promoted (the 'masculinist' outlook) was of competitiveness, 'toughing-it-out' and not wanting to appear weak; having a high level of anger and hostility; an inability to express emotions; having poor social support because of a 'pervasive homophobia'; and high risk-taking behaviour.

A similar gendered approach can be found in a comprehensive Ministry of Health report on mental health.[12] The chapter on women offers a sympathetic approach to their mental health problems,[13] whereas the chapter on men describes attitudes critical of men or is blind to their needs.[5]

This reflects a growing body of literature on men's health suggesting that men themselves are largely culpable for their health problems.[14–16] A number of other commentators develop the theme that being a man is 'bad' for one's health and make the unsubstantiated suggestion that men will be better off if they develop more feminine traits and behaviours.[17,18]

Gender differences in illness and health

The World Health Organisation defines health as *'a state of complete physical, mental and social well-being and not merely the definition of disease or infirmity'*. Gender-specific definitions may be more limited in their scope – for example, men's health has been defined as *'a disease or condition unique to men, more prevalent in men, or for which dif-*

ferent interventions may be required for men'.[19]

Disorders related to the reproductive organs are clearly gender-specific – for example, obstetric conditions and cervical cancer in women, and testicular cancer and disorders of the prostate in men. Health services for conditions unique to one gender by their nature will have a gendered approach.

However there are many other conditions where women and men's morbidity and mortality differ in prevalence. Differences may be related to biological factors such as different ratios of sex hormones, or there may be psychological and social components which are much more prevalent in one gender than the other.

Life expectancy

New Zealand men die significantly earlier than women. In 1999–2001 New Zealand men's life expectancy was 76.0 years, 4.9 years less than women's (80.9 years).[20]

In general, as a country becomes more industrialised, the overall health of the population improves, the maternal mortality rate drops and longevity increases, so the gap between women and men's life expectancy grows.[21]

In 1995 the average life expectancy in the least developing countries was 52.3 years for women and 50.3 for men (a difference of two years); in developing countries 63.67 and 60.78 respectively (a difference of 2.89 years), and for industrialised countries 77.9 and 70.36 years (a difference of 7.5 years).[21]

In 1951 in New Zealand the male: female ratio of age standardised all-cause mortality was 1:1.33. In 1996 the ratio was 1:1.54 and males had a higher mortality risk than females at all ages.[22] The gender gap in life expectancy therefore has increased significantly over the past forty-five years.

The higher male mortality rate starts from birth. In 1998 the infant mortality rate was 5.4 per 1 000 live births (6.4 male and 4.3 female per 1 000). Of the total of 309 foetal and infant deaths from all causes, 190 (62%) were male.[23]

Biomedical conditions

In general, New Zealand men and women are equally likely to have elevated blood pressure.[24] Men have a greater incidence of ischaemic heart disease (345 compared with 92 per 100 000) and stroke (148 compared with 124 per 100 000). Men die from ischaemic heart disease at a greater rate than women (165 per 100 000 compared with 48).[22] They also have an increased rate of death from stroke.[22]

Men have an increased rate of cancer overall compared to women (377 compared to 296 per 100 000), and an increased cancer mortality rate. There is little overall gender difference in the incidence of diabetes.[22] Asthma is slightly more prevalent in women than men.[24] Women are more likely to suffer from osteoporosis, a condition where biological factors play a major part.

With respect to gender-specific conditions, prostatic disease is a significant health problem. In the UK, by the age of 60, 50% of all men have prostatic hypertrophy, and 90% by the age of 85. Occult prostatic cancer is present in about 30% of men over 50 years of age, and there is currently no way to determine which of these will develop metastatic cancer.[25] Total New Zealand registrations for cancers specific to women (breast, uterus, cervix uteri, ovary, other uterine adnexa) number 764 per 100 000, whereas male-specific cancers (prostate, testes) total 1 226 per 100 000.[22]

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Men have a much greater risk of contracting HIV and AIDS. In New Zealand by the end of June 2002 a total of 765 people (711 male and 54 female) had been notified with AIDS (93% male), and 1 818 people (1 552 male, 248 female, and 18 sex not stated) had been found to be infected with HIV.[26]

Injury

The incidence of injury and poisoning is much greater in men than women, particularly for young men aged 15–24 years.[24] Males are far more likely to die from injuries than females, both work and non-work related. In 1996 the age standardised injury death rate for males was 2.7 times that for females.[22] More males than females lose their lives in road traffic accidents.[22]

Key Points

- Policy-makers can be quite specific in focusing on women's health to the exclusion of men's.
- In 1951 in New Zealand the male : female ratio of age standardised all-cause mortality was 1:1.33. In 1996 the ratio was 1:1.54 and males had a higher mortality risk than females at all ages.
- The denigration of qualities considered male and elevation of characteristics considered female does not acknowledge the mutual contributions men and women make to their families and to society.
- General practitioners might consider introducing a recall system for the men in their practice, for example two-yearly for men over the age of forty, where high-risk men are identified and appropriate interventions instigated.

Again, this gender difference starts from infancy. From the age 0 to 4 years, more boys than girls are hospitalised for burns (1.6 compare 1 per 1 000); for falls (7.7 compare 5.7 per 1 000) and for poisonings (2.6 compare 2.2 per 1 000). By the age of 15 years, twice as many boys as girls will have died from injury (15.5 compare 7.4 per 100 000).[27]

Men predominate in high-risk occupations. National injury data for 1996–1997 show 25 488 new work related claims by men and 11 406 by women.[28] Injury rates in 1989–90 show higher rates for men in every industry.[29] The highest rates per 1 000 labour force for men were 103.4 in mining and quarrying, and 89.5 in manufacturing.[30]

Very few women suffer work-related fatality. In the decade from 1985 to 1994, *'The overwhelming majority of work-related injury deaths of workers were of males. Although males accounted for 57.6% of the workforce in the decade of study, they accounted for 97.8% of fatal work-related injuries of paid workers. The rate for males for the study period was 8.6 per 100 000 persons per year, about 30 times higher than for women for whom it was 0.3 per 100 000 persons per year.'*[31]

Men are far more likely to be the victim of violent crimes. Nearly twice as many men are murdered than women.[5] In 1991–1998 there were 319 male and 192 female homicides.[32]

Mental disorders

Severe mental illness appears to occur in men and women in about equal frequency, although men develop schizophrenia at a younger age and have a worse prognosis than women.[2]

The overall male suicide rate is almost four times that of females.[33] Between 1988 and 1998, there were 4 391 male and 1 156 female deaths from suicide.[32] Male suicide is on the rise – between 1984 and 1994 the rate increased by nearly 40%, compared to 12% for females.[34]

Disability

Adult men and women have a similar rate of disability, but boys are significantly over-represented among children with disability and chronic conditions. This is said to reflect boy's biological vulnerability to negative health and disability outcomes, as well as the increased probability of injury among boys.[35] In advanced old age (75 years and older) there are more women than men with disabilities, but this results from women's increased life expectancy and therefore the high female/male ratio in the elderly population, not from a higher incidence of disability.[35]

One approach to measuring population health is the 'disability adjusted life year' (DALY) which incorporates both loss of life years and loss of quality of life, hence measuring both the fatal and non-fatal burdens of disease and injury. Males do not expect to live as long as females, and females on average can expect to live for more years independently and in dependent disability than males (11.7 years compared to 9.7).

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Lifestyle risks

There do not appear to be major gender differences with respect to physical activity and diet. The 1996/97 Health Survey found that overall similar proportions of men and women were physically active with respect to their leisure-time activity, although more men than women were likely to be sedentary. This study did not take into account relative levels of physical exercise occurring in the work place.[24]

Similarly, the 1997 NZ National Nutritional Survey did not find major dietary discrepancies. Both males and females derive 35% of their energy from dietary fats, with equal percentage of saturated fat. Males 45–64 years were least likely to meet the NZ Nutritional Taskforce guideline for percentage energy from carbohydrate, but had higher intake of dietary fibre than females (23g/day compared to 18g/day). Slightly fewer males than females were considered obese (15% compared to 19%).[36] The mean total cholesterol level (5.7 mmol/L) was the same for both sexes.

While overall, more men smoke than women, young people (15–24 years) smoke more than older people, and in this age group, young women now smoke more than young men, suggesting there has been a positive response by men to smoking, which may translate into reduced ischaemic heart disease over the next couple of decades.[24]

Significantly more men than women (25.5% compared with 9.5%, $p<0.0001$) have a potentially hazardous alcohol drinking pattern.[24]

Gender differences in access to, and utilisation of, health services

New Zealand women access and use health services at a significantly greater rate than men. Women are more likely to visit their general practitioners than men.[24,37] Women's capacity to conceive and bear children brings them into contact with the health system for a number of reasons, including contraception, abortion and obstetric services as well as screening for cervical and breast cancers. There is also a tendency for men to be less willing than women to seek medical assistance for certain kinds of health problems. Women are more likely to obtain a prescription item than men, and are admitted to hospital at a greater rate than men.

While in general men have higher morbidity and mortality rates than women, a study using the SF-36 questionnaire (a self-assessment questionnaire containing standardised questions to determine health status) found that they tend to self-report their health as better than women's.[24] This suggests that either men tend to under-report ill health, women tend to over-report, or both.

A number of barriers to men accessing traditional health services have been recognised.[38] There are a number of systematic barriers. One relates to time and access. Men are more likely to be in full-time work and experience difficulties accessing health services during normal working hours. There is also a perception that health services are not 'male-friendly'. The lack of a male care provider may give the sense that health care services are primarily by women for women.[38]

Personal barriers include factors related to a man's traditional social role – the sense of invulnerability associated with being the 'protector/provider'. It can be 'unmanly' to admit to having problems.[5] Other personal characteristics identified were difficulty with relinquishing control; believing that seeking help is unacceptable; and a belief that men are not interested in prevention.[38] Tudiver also found that men reported having to state the reason for a visit as a barrier to attending.

Discussion

New Zealand men die earlier than women and their health is worse in a number of major physical and mental areas.[39] Men have a significantly higher rate of death from avoidable causes than women (age standardised rates of 270 and 175 per 100 000 respectively).[22] They are likely to die younger from common diseases and to suffer illnesses in which environment and lifestyle play an important part.[25]

Men have a significantly higher rate of death from avoidable causes than women

It seems likely that there are biological factors which also contribute to increased female longevity. Even if male risk-taking behaviours were able to be reduced to the point where their external causes of death (accidents, homicides and suicide) were the same as women, and their lifestyle behaviours (smoking, drinking, diet, exercise) were also the same, evidence indicates that men would still age and die somewhat younger than women.[40]

Labelling male risk-taking as 'bad' and female caregiving as 'good' is a selective application of values to behaviour. The denigration of qualities considered male and elevation of characteristics considered female does not acknowledge the mutual contributions men and women make to their families and to society. The traditional position of provider is also a caregiving role to the family, as attested by the increased health and social problems associated with poor material circumstances in low-income families.

Men are much more likely to suffer injury and death in the workplace than women. While their attitude to risk-taking may differ from women, this has not been shown to be a major contributor to their morbidity and mortality; rather, the primary component appears to be the factors leading to the selection of men for the most hazardous work.[41] Men overwhelmingly predominate in active military service, law enforcement and fire fighting, as well as other high-risk occupations such as forestry, mining and heavy industry. Risk-taking is not necessarily harmful for society. Men bear most of the burden of these high-risk jobs from which the whole of society benefits.

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Male morbidity and mortality could be reduced by health promotion strategies such as lifestyle advice (diet, exercise, smoking, drinking and other drug-taking) and education on issues such as reducing risk-taking (including recreational and occupational safety). Greater utilisation of health care services by men would increase opportunity for earlier detection and intervention of disease. Possibilities include including checking blood pressure, weight and height, cholesterol level, diet, tobacco and alcohol use, as well as questioning to disclose possible depression or suicidal tendencies. Current evidence does not support screening for prostatic cancer.[42]

The cervical cancer and mammogram screening programmes for women mean that they are recalled by their health care provider regularly, allowing for opportunistic screening also to occur. The development of 'well man check-ups' should be investigated.[43] While some evidence indicates that comprehensive specialised health promotion clinics may not be effective with respect to morbidity reduction or cost,[44,45] there may be a place for screening of men to occur on more than an opportunistic basis (given the current infrequency of men utilising health services). General practitioners might consider introducing a recall system for the men in their practice, for example two-yearly for men over the age of forty, where high-risk men are identified and appropriate interventions instigated.

The gender mortality gap is greatest in the 15–24 and 25–44 age groups, due to higher male risk of death from injury and suicide at these ages. In health promotions, dealing with conditions where men are clearly the high-risk group, a male focus needs to be more publicly visible. For example, while the vast majority of occupational deaths and suicides are male, this is largely reported in the media as 'people' or 'New Zealanders'.[46] Reporting that it is men who are dying in the workplace and by their own hand and that society wishes to address this, would communicate to men that their health and well-being as a group is valued.

Rather than expecting the nature of men to change, health providers

should work to remove perceived barriers as they have done for women. *'It is not just the impact of lifestyles and biology but society's expectations of men that need to be addressed. Such expectations have created an environment in which men are less able than women to recognise physical and emotional distress and to seek help'.*[25] In health policies where men are the targeted high-risk group, available services will have to show men that they are not being blamed, but rather that they are valued enough to be allowed to care about their own health.[47] At present there are marked differences in approaches taken for men and for women.

This may be addressed by softening the implicit message given by the special focus on health services for women. It may also require special attention to make services male-friendly, such as after-work consulting hours; consulting within the work place; and taking services to traditionally male settings such as sports clubs and public bars.

Eradicating 'maleness' is neither an achievable nor a desirable aim. It is counter to evidence indicating that lack of self-identity as a male; male/female relationship difficulties and being parentally disenfrachised are major contributors to the high rates of male depression and suicide.[48,49] We should not ignore the social and political determinants of men's health.

Conclusion

The gendered approach to health currently being promoted by government agencies focuses on improving the well-being of women, on the basis that they should be given special priority by virtue of their role as caregivers and their position of relative social and economic disadvantage which impinges negatively on their health.

We argue that the increased morbidity and mortality of males does not support the claim that men are favoured by the existing health system. Furthermore, the mutual contributions made by men and women in providing and caring for their families means neither is more deserving of health care resources than the other.

Rather than expecting the nature of men to change, health providers should work to remove perceived barriers as they have done for women

A gendered approach is flawed. Given the finite and limited health resources available, if services for women are further extended, then services for men must be decreased (women will get more of the pie and men less). A gendered approach should only be taken where there are real differences required by gender – for example in the detection and management of conditions relating to the reproductive organs.

Rather than trying to improve the health of one subset of the population unilaterally, the focus should be on addressing the prevention and management of specific health problems and targeting the high-risk populations for these conditions. Where high-risk populations who merit special attention are identified, design of approaches should be needs- rather than advocacy-driven, taking a broad inclusive social focus rather than the exclusive approach of seeing men or women in isolation.

For example, addressing social problems such suicide and occupational morbidity and mortality would largely target men. Reducing the incidence of ischaemic heart disease by improved blood pressure and cholesterol screening and other health promotion strategies might mean providing services in the workplace or other male-friendly venues. Reducing the incidence of osteoporosis means largely targeting women.

Health strategies that are inclusive and acknowledge the value of all members of a population, both our women and our men, with specific policies targeting those in greatest need for a particular health problem, will be most successful in producing an efficient, equitable and effective means of preventing and treating disease.

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