

The state of men's health in Western Europe

Alan White and Keith Cash

Abstract

Background: A European-wide study of men's health was carried out to determine the health needs of men.

Methods: Mortality and morbidity statistics from the World Health Organisation Statistical Information Service (WHOSIS), the European Union (Eurostat), the Organisation for Economic Co-operation and Development (OECD), Globocan and other important European sources were used.

Results: Differences were found between the health of men and women across all age groups. Wide country-to-country variations in the influence of the different health issues were evident, with clear geographical differences for some disease states. Men had a higher rate of death than women for a wide range of risks such as ischaemic heart disease, cancer of the colon, accidents and deaths due to external causes.

Conclusions: There is a need to create greater equity in health status between countries and between the sexes. © 2004 WPMH GmbH. Published by Elsevier Ireland Ltd.

Introduction

Men's health increasingly is being recognised as a key area of concern for health professionals and policy makers. Differential data on men's and women's health has been collated on most diseases at national and international levels but until 1997 when the European Commission conducted a study to examine the data relating to women's health, the extent of the difficulties women face with their health had not been fully appreciated [1]. There has been no corresponding study of men's health across Europe. In this paper we report on a study commissioned by the European Men's Health Forum (www.emhf.org) to obtain an overview of men's health in Western Europe. The aim of the study was to determine the extent of the health problem facing men to ensure policy targets reflect the needs of both men and women in Europe. The study [2] focused on the state of men's health in 17 Western European countries: Austria, Belgium, Denmark, France, Finland, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom.

Methods

Key sources of data on mortality and morbidity statistics for men's and women's health were analysed to highlight the main health concerns within the different countries. We used mortality and morbidity statistics from the World Health Organisation Statistical Information Service (WHOSIS), the European Union (Eurostat), the Organisation for Economic Co-operation and Development (OECD), Globocan and other important European sources. These sources were used because they have standardised data, making comparison between the countries more feasible. Comparisons were made between countries and between men and women. This was not a study of causality but a descriptive study of the current situation. All the data were collected between June 2002 and March 2003.

Results

The male population

The population of men in the 17 countries which we studied is about 190,500,000. Most

Alan White, PhD
Leeds Metropolitan
University, Leeds, UK
Keith Cash, PhD
Leeds Metropolitan
University, Leeds, UK

Corresponding author:
Alan White
E-mail:
a.white@leedsmet.ac.uk

Online 12 May 2004

Data sources used in the report

Eurostat (2002) European Social Statistics: Demography, Luxembourg: Office for Official Publications of the European Communities, 2002

Eurostat (2001) Disability and social participation in Europe Luxembourg: Office for Official Publications of the European Communities

Statistics from the Eurostat Data Shop, Eurostat 2002.

First results of the demographic data collection for 2001 in Europe. Statistics in focus, Theme 3 17/2002

WHO Trends on incidence and mortality of AIDS in the EU (1985–2001)—Statistics in Focus 18/2002

WHO (1999) The 1997–1999 World Health Statistics Annual Report; WHOSIS <http://www3.who.int/whosis/menu.cfm>

The European Health For All 2003 database <http://www.euro.who.int/hfadb>

WHO World Health Report; 2002: reducing risks, promoting healthy life. <http://www.who.int/whr/en/>

World Report on Violence and Health 2002 <http://www.who.int/mediacentre/releases/pr73/en/>

Jernigan, DH (2001) Global Status Report: WHO http://www.who.int/substance_abuse/PDFfiles/globsta_al-coyoung%20people.pdf

The European Health Report 2002. <http://www.who.dk/eprise/main/WHO/Progs/EHR/Home>

European Union - Eurostat <http://www.europa.eu.int/comm/eurostat/Public/datashop>

men (just over 68%) are in the age range of 15–64 years. The next largest age group (18.5%) is 1–14 years old and the smallest (nearly 13%) is over the age of 65 years. The demographic profile however is changing with a reduction in the number of young men due to the declining birth rate and an increase in the numbers of men over 65 years. In Italy for instance there are now almost as many older men as younger men. Due to the decline in the numbers of young men the United Nations have projected reduced male population figures for many countries by 2020 [3]. The number of divorced

or separated older men living alone has greatly increased over the last 20 years with a continuing trend [4]. Men who live alone have been shown to have poorer health than those who live with a partner. Clearly the needs of this older more dependent group require urgent consideration [5].

Men's perceptions of their health

The data relating to the perceptions of men towards the state of their health show substantial variations from country to country. Men from Greece and Sweden reported the best health and those from Portugal and Germany the worse (Fig. 1). Overall men reported their health to be better than women reported their health to be. Self-reported disability indicated that women had a greater range of both moderate and severe disability than the men [6].

Life expectancy, death rates and cause of death

Men were found to live longer than they had in 1980 with an average increase in life-span of 6.5%. Swedish men had the longest average lifespan of 77.5 years and Irish men the shortest with 73 years. Although the rate of increase in men's life expectancy is

The key findings of the study on the state of men's health in Western Europe

- Even though health is improving for many conditions there are still marked inequalities that exist, both between countries and between men and women.
- There are clear sex and gender-related differences in population health needs.
- Men have a distinct and universal disadvantage in all the major disease states that affect both genders.
- Men have a higher rate of incidence for the majority of cancers than women and a higher rate of death across a wide range of major illnesses.

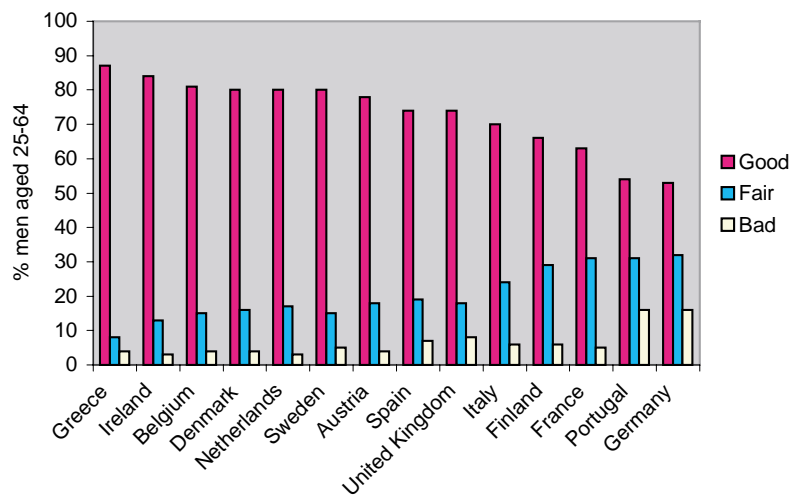


Figure 1 Self-perception of health, for men aged 25-64 years, ranked by good health, by country. Source of data [7].

greater than that of the women (3.6%) in these countries in no country does the life expectancy of men come close to the life expectancy of women, with France having the largest gap (7.5 years) between the two sexes (Fig. 2).

Men’s increased life expectancy was found to be due to the significant improvements in the health of men over the last 20 years. For instance, the death rate from coronary heart disease has decreased in Denmark and Sweden by over 50% since 1980. Over the same period Finland has seen a 62% reduction in deaths due to lung cancer, Greece and Italy reductions of over 130% in deaths due to liver disease, and Greece a 350% reduction in deaths due to diabetes.

In some instances, however, death rates have increased, for instance in Denmark

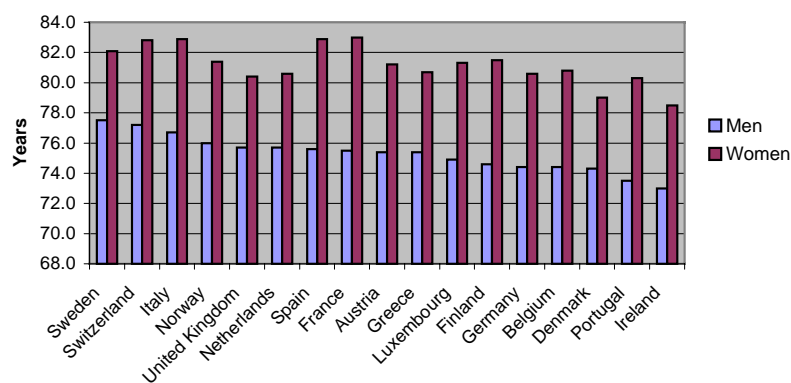


Figure 2 Life expectancy for men and women by country (2001). Source of data [8].

with a nearly 60% increase in male deaths due to diabetes and Spain with a 30% rise in deaths due to lung cancer. In the United Kingdom the death rate due to liver disease and diabetes has increased.

The greatest proportion of male deaths, accounting for 17% of total male deaths, were due to diseases of the cardio-vascular system, with ischaemic heart disease being the biggest cause of premature death (which is taken in this report as death before the age of 75 years). The second major cause of death was cerebro-vascular disease, accounting for nearly 8.5% of male deaths. The next single most important cause of death in men was lung cancer, accounting for 8% of the total deaths. The specific male disease of prostate cancer accounted for 3.1% of the deaths in these 17 countries.

Age was an important variable of the principal causes of death. In young males, aged 1–24, accidents and deaths from external causes were by far the most prevalent cause of death, accounting for 60% of total deaths, followed by deaths due to neoplasm. In the age range 25–74 years the major cause of death was neoplasms, followed by coronary heart disease. Above the age of 75 years diseases of the cardio-vascular system were the major cause of death.

Differences between countries

A key finding of our study was the considerable differences between the causes of death in different countries. There were clear geographical differences for some disease states, the most notable being cardio-vascular disease with northern countries having far higher rates of death than southern countries for ischaemic heart disease (Fig. 3) although the trend was not as clear cut for cerebro-vascular accidents.

Portugal had by far the highest proportion of total male deaths due to cancer of the stomach (2.8%) and the highest incidence rate (30 cases per 100,000 population). Denmark had the lowest (1%) and an incidence rate of 8.43 per 100,000. For prostate cancer, Norway and Sweden were highest with over 5% of male deaths due to this cancer and Greece lowest with 2.2%.

Marked differences were seen in deaths from suicide. Deaths due to suicide

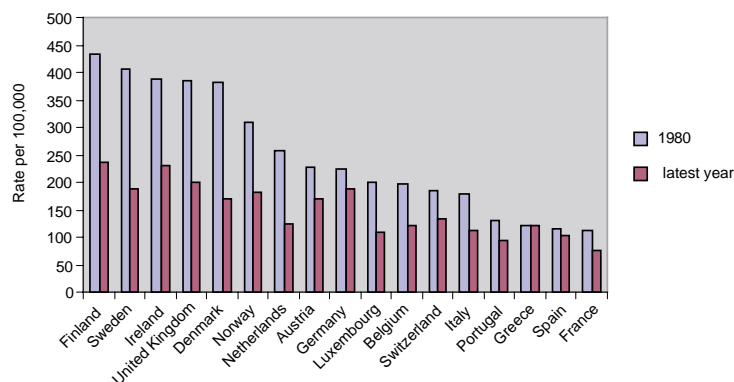


Figure 3 Difference in age standardised death rates between 1980 and most recent data for men with coronary heart disease, by country. Source of data [9].

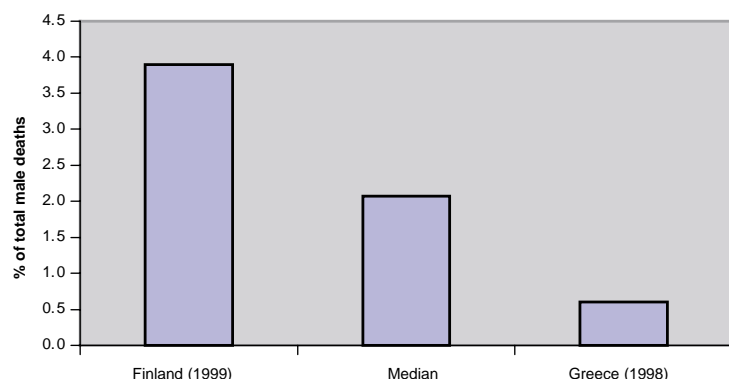


Figure 4 Percentage of male deaths in Finland and Greece as a result of suicide compared with the median for 17 European countries. Source of data for calculation [10].

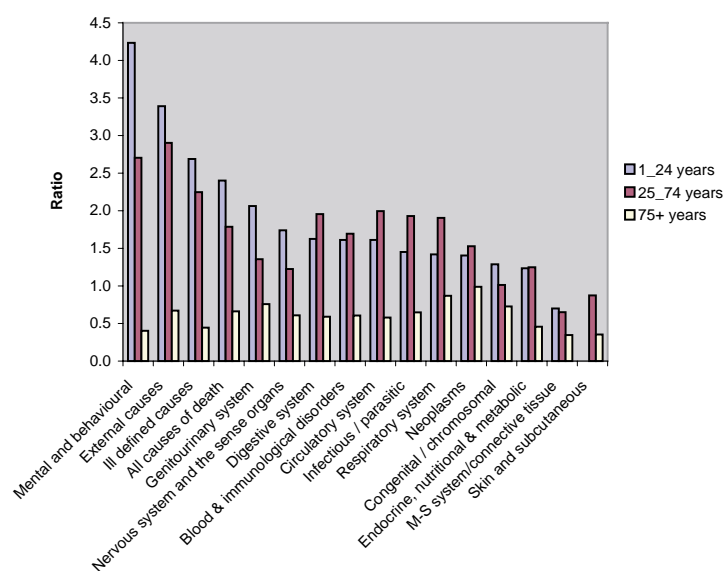


Figure 5 The ratio of male to female deaths for selected health conditions, by age. Source of data for calculation [10].

accounted for nearly 4% of total male deaths in Finland but only 0.6% in Greece (Fig. 4). Differing age profiles were also seen. In the majority of countries more older men committed suicide but for Finland and Ireland the rates were far higher among young men.

Similarly, large country-to-country variations existed for transport accidents, which caused 3.5% of male deaths in Greece and less than 1% in the United Kingdom and Sweden. For young men the greatest risk to life was road traffic accidents but there were large differences between the countries with Portugal, Spain and Greece all having rates above 53 deaths per 100,000 population compared with Sweden, Norway and the United Kingdom with less than 20 deaths per 100,000.

Differences between age at death for men and women

The number of deaths for men was equal to those for women for the majority of health conditions, but this was found to be age dependent (Fig. 5). Exclusion of the number of deaths in the upper age bracket (over 75 years) resulted in deaths for men being almost twice as many as those for women. This male excess of premature death was consistent for most of the major disease states. The only exceptions were diseases of the musculo-skeletal system, skin and connective tissue. When the ratios of deaths of men to women were compared across the age brackets the age-dependence became very apparent. For example for the diseases of the circulatory system the ratio of male to female deaths in the 1–24 years age group was 1.6:1, for the 25–74 years age group 2.5:1 and for the age group 75 years and older 0.6:1. For mental disorders (which exclude suicide) the respective ratios were: 1–24 years age group 4.2:1, 25–74 years age group 2.8:1 and the age group 75 years and older 0.4:1.

For some health conditions the increased rate of death extended across the age range, for instance deaths due to lung cancer (Fig. 6), liver disease and cirrhosis (Fig. 7) suicide (Fig. 8) and road traffic accidents (Fig. 9).

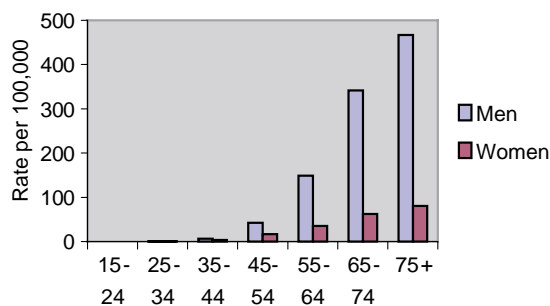


Figure 6 Median age-specific rate of death due to lung cancer, for men and women, by age for all 17 countries. Source of data for calculation [11].

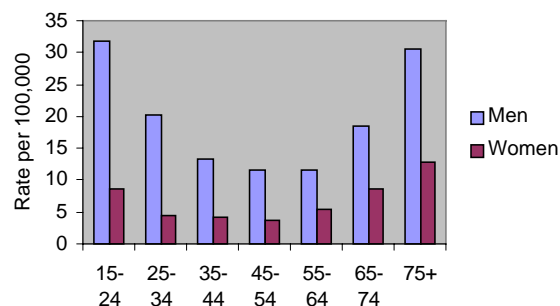


Figure 9 Median age specific rate of death due to road traffic accidents, for men and women, by age for all 17 countries. Source of data for calculation [11].

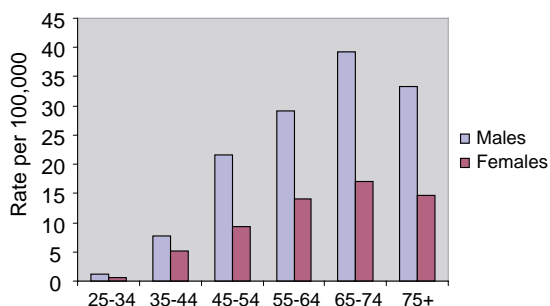


Figure 7 Median age-specific rate of death due to liver disease and cirrhosis for men and women, by age for all 17 countries. Source of data for calculation [11].

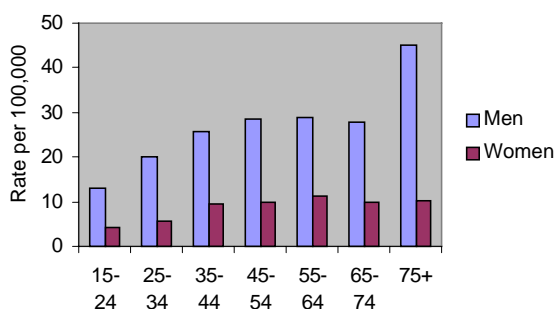


Figure 8 Median age specific rate of death due to suicide, for men and women, by age for all 17 countries. Source of data for calculation [11].

Discussion

The study did not explore causality but men's greater problems with health compared with women might be attributable to

- the biological differences between men and women
- the nature of men's lifestyles, for example alcohol consumption and smoking, which lay them more open to risk
- men's delay in seeking help

A key finding of our investigation is that men are at greater risk than women of developing nearly all the major diseases that can affect both sexes.

The study suggests that it is necessary to look both at the biological entity of man and the role men's perception of their masculinity has in their attitude towards their health. The role of men's 'nature' as well as that of their 'nurture' has to be explored. We have a well rehearsed argument for men's increased risk compared with women of cardio-vascular disease, by which we attribute it to increased central fat distribution, lower insulin sensitivity at body mass indexes equivalent to those of women, lower high density lipoproteins-cholesterol concentrations and higher triglyceride concentrations [12]. We need however to consider if there are further elements at play if, as Kraemer [13] states, men are more 'fragile' than women or if being a man is in itself a 'disease' [14]. A wide-ranging study by the Institute of Medicine in America on the biological differences between men and women and the influence of those differences on health clearly supports the notion that the biological difference between men and women is an important variable for inclusion in all health research [15].

Certainly for some illnesses the influence of men's lifestyles, including the destructive nature of men's addictive and risk-taking behaviour, are evident. For example, the number of men who develop lung cancer reflects the high level of male smoking, and the greater mortality from liver disease and cirrhosis reflects their excessive alcohol consumption. More men are overweight than

women, which with the tendency for men to deposit fat around their abdomen places them at greater risk for developing cardiovascular disease and diabetes. There are also links to smoking and diet that help explain, for instance, men's increased risk of cancer of the stomach. The figures for mortality due to mental health disorders highlight men's greater vulnerability to addictive disorders. In the age group 1–24 years 60% of deaths are from external causes, e.g. road traffic accidents. Accordingly young men's risk taking is a lifestyle factor with a negative effect on their health. Further research is needed to determine why men from different countries have such differing health outcomes and whether this is due to variations in lifestyle.

Irrespective of the relative influence of biology and lifestyle men's greater susceptibility to premature death would be compounded by delay in seeking health advice when problems emerge. The literature presents conflicting messages about men's help-seeking behaviour. Across a broad band of health issues men are reported to delay in seeking help from the conventional services. This is the case for men with HIV/AIDS [16,17], emotional problems [18,19], and chest pain [20]. Specific groups of men who are reluctant users of the health services such as homeless men [21,22] and young men [23–26] can also be identified.

Although most of the literature suggests that men delay in seeking help from health services some studies seem to refute that men have a different approach to women. Macintyre et al. [27] in a review of Scottish data found no evidence that men were less willing than women to report health-related symptoms or to seek health care. They also found no difference between the sexes in the degree of suffering experienced before seeking help. Wyke et al. [28] analysing the same data set found that although women reported more symptoms than men there was no difference in the probability of them reporting them. Similarly Adamson et al. [29] found no difference between men and women in the likelihood of them seeking health advice, the differences were based on socio-economic and ethnic backgrounds.

These studies however tended to depend on the analysis of questionnaire data rather than observation of health-related behaviours and it is possible that what men

report to be their intentions do not reflect their subsequent actions. Likewise, a study in which 20 men were interviewed in-depth reported limited evidence of delay [30]. Again self-reporting may not equate with the behaviour of the men with regard to, for example, the timing of the visits and what health changes occurred as a result of the consultation with the family doctor.

The experience of most practitioners [31] and weight of publications show that men do procrastinate in seeking help, and this warrants closer examination. It is feasible that men delay because their notions of masculinity and what it is to be male have a mediating effect on their behaviour. They might for instance consider a man is someone who is independent, in control and strong and see seeking help as admitting weakness. Exploration of this possibility should include investigation of men's decision-making processes relating to their health.

Coupled with this is the need to research men's actual usage of health services across Europe. If the supposition is that men have a problem with seeking help and guidance and this delay has a negative influence on their health this needs to be supported by data. Comparative studies should be undertaken both between men and women and between men from the different countries.

Focus must be on determining which aspects of men's beliefs and behaviour militate against successful help seeking as well as possible failures in current health service systems. Such an approach will hopefully result in finding ways to ensure that men gain early and effective care.

What emerges from the study for practitioners is that although health is improving for many conditions there are still marked inequalities, both between countries and between men and women, with clear sex and gender-related differences in population health needs. This concern needs to be tackled at many levels and cannot be seen solely as an issue for the family doctor. Action is required at the level of society in general. Health and social policy along with policy relating to education, employment, crime, housing, and transport should address how men's lifestyles and behaviour influence their long-term health needs. But on a more local level all those involved in healthcare

must consider how the men in their care can be specifically targeted such that their health requirements are identified and effectively managed. If there is an increased vulnerability of men to illness then even greater attention needs to be paid to the promotion of healthy lifestyles and the early detection and management of disease.

References

- [1] Commission E. The state of women's health within the European Community. Brussels: European Commission; 1997.
- [2] White AK, Cash K. The state of men's health across 17 European countries. Brussels: The European Men's Health Forum; 2003.
- [3] UN. United Nations population division, world population prospects. United Nations: Siege; 2003.
- [4] Eurostat. European social statistics: demography. Luxembourg: Office for Official Publications of the European Communities; 2002.
- [5] Davidson K, Arber S. Older men's health: a life course issue? *Men's Health J* 2003;2(3): 72–5.
- [6] Eurostat. Disability and social participation in Europe. Luxembourg: The European Commission; 2001.
- [7] Eurostat. The life of women and men in Europe: a statistical portrait 1980–2000. Luxembourg: The European Commission; 2002.
- [8] Eurostat. First results of the demographic data collection for 2001 in Europe. Statistics in focus. 2002;Theme 3 17/2002.
- [9] WHO. European health for all database. Copenhagen, Denmark: Regional Office for Europe; 2003.
- [10] Eurostat. Released 19th September New Cronos Theme 3 health, public, cdeath cod nr—all data 1999, except Italy 1998, Belgium and Denmark 1996, 2002.
- [11] WHO. The 1997–1999 World Health Statistics Annual; WHO Statistical Information Service (WHOSIS) website. The World Health Organisation; 2002.
- [12] Sattar N. Why are men at higher risk of cardiovascular disease? *Men's Health J* 2003;2:53–6.
- [13] Kraemer S. The fragile male. *Br Med J* 2000;321:1609–12.
- [14] Meryn S, Steiner M. Is being a man a disease? *Men's health in the 21st Century. Men's Health J* 2002;1:100.
- [15] Wizemann TM, Pardue M-L. Exploring the biological contributions to human health: does sex matter? Washington, DC: Institute of Medicine; 2001.
- [16] Randall M, Barroso J. Delayed pursuit of health care among HIV-positive gay men enrolled in a longitudinal research study. *J Assoc Nurs AIDS Care* 2002;13(4):23–31.
- [17] Petchley R, Farnsworth B, Williams J. 'The last resort would be to go to the GP'. Understanding the perceptions and use of general practitioner services among people with HIV/AIDS. *Soc Sci Med* 2000;50:233–45.
- [18] Green C, Pope CR. Gender, psychosocial factors and the use of medical services: a longitudinal analysis. *Soc Sci Med* 1999;48: 1363–72.
- [19] Möller-Leimkühler AM. Barriers to help seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *J Affect Disord* 2002;71: 1–9.
- [20] White AK, Johnson M. Men making sense of their chest pain—niggles, doubts and denials. *J Clin Nurs* 2000;9(4):534–41.
- [21] Shiner M. Adding insult to injury: homeless and health service use. *Sociol Health Illness* 1995;17(4):525–49.
- [22] Brush BL, Powers EM. Health and service utilization patterns among homeless men in transition: exploring the need for on-site, shelter based nursing care. *Sch Inq Nurs Pract* 2001;15(2):143–54.
- [23] Davies J, McCrae BP, Frank J, Dochnahl A, Pickering Y, Harrison B, et al. Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *J Am Coll Health* 2000;48:259–67.
- [24] Richardson CA, Rabiee F. A question of access: an exploration of the factors that influence the health of young males aged 15–19 living in Corby and their use of health care services. *Health Educ J* 2001;60(1):3–16.
- [25] Lloyd T, Forrest S. Boy's and young men's health: literature and practice review. An interim report. London: Health Development Agency; 2001.
- [26] Addis M, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol* 2003;58(1):5–14.
- [27] Macintyre S, Ford G, Hunt K. Do women 'over-report' morbidity? Men's and women's responses to structured prompting on a standard question on long standing illness. *Soc Sci Med* 1999;48:89–98.
- [28] Wyke S, Hunt K, Ford G. Gender differences in consulting a general practitioner for common symptoms of minor illness. *Soc Sci Med* 1998;46(7):901–6.
- [29] Adamson J, Ben-Shlomo Y, Chaturvedi N, Donovan J. Ethnicity, socio-economic position and gender—do they affect reported health—care seeking behaviour? *Soc Sci Med* 2003;57:895–904.
- [30] Robertson S. Men managing health. *Men's Health J* 2003;2:111–3.
- [31] White AK, Banks I. Help-seeking in men and the problems of late diagnosis. In: Kirby R, Carson C, Kirby M, Farah R, editors. *Men's health*, 2nd ed. London: Martin Dunitz & Parthenon Publishing; 2004.