



EU action to reduce health inequalities

EMHF contribution to the Commission's consultation – 08 April 2009

In summary, EMHF urges the Commission to:

- Recognise that both men and women suffer from health inequalities, and that gender in this sense should not just mean women. Ignoring men or women through a one policy fits all approach would only perpetuate or increase current health inequalities.
- Acknowledge the vulnerability of male population groups in relation to health. Men, particularly of lower socio-economic groups, must be considered among priority groups if the EU is serious about tackling health inequalities.
- Ensure health promoting interventions address the differences in health outcomes between women and men, boys and girls in terms of their biology and their socialisation in an equitable manner.
- Commission the first EU report on the status of men's health in Europe and to increase data availability to monitor health inequalities with new health service usage data and levels of disaggregation.
- Use the legal basis of its remit to make the reduction of health inequalities in Europe a top long-term priority across all EU policy sectors and to facilitate the exchange of expertise in men's health among Member States as an important tool to reduce health inequalities.
- Commit a minimum budget within EU Structural Funds to the development of long term health promotion and prevention initiatives specifically targeting group most vulnerable to health inequalities which most often include men.
- Ensure greater gender equality in access and usage of health services and EU health investments benefit all socio-economic groups not just the higher ones.

The European Men's Health Forum (EMHF) is an independent, non-governmental, non-profit making organisation established to raise male awareness across Europe. EMHF represents 25 member organisations across Europe. It promotes collaboration between interested individuals and organisations on the development and application of health policies, research, education and prevention programmes. EMHF provides a unique platform for non-discriminatory co-operation and information exchange within Europe and with other countries worldwide. EMHF actively promotes collaboration with other international networks and institutions sharing the same goals.

EMHF welcomes the Commission's initiative to consult on actions to reduce health inequalities. One of EMHF's main objective concerns the reduction of gender-based health inequalities, and health inequalities among male population groups.

A draft response was prepared based on a formal consultation with EMHF's membership. The responses of EMHF members were considered and incorporated in the development of this document.

The EMHF welcomes the Commission's consultation on health inequalities. This document presents hereafter EMHF's views with regard to men's health inequalities with an analysis of barriers to and opportunities for improvement. EMHF's answers to some of the Commission's questions are provided at the end of this document as are additional key facts on men and health inequalities.

Overview European inequalities in men's health

Although average life expectancies and quality of life have increased over the last sixty years, concerns have grown over health inequalities with the European region. According to the most recent Eurostat figures, the gap in life expectancy at birth between EU countries for women is eight years (Bulgaria 76.3, France 84.4) and for men it is 14 years (Latvia 65.4, Sweden 78.8). The "health gap" is characterised by much higher although decreasing mortality rates from cardiovascular diseases in Eastern European countries.

In EU neighbouring countries such as Russia and Ukraine, the health status of the population is already critical for both men and women. It is set to worsen with the deepening of the current economic crisis. The report, *Health inequalities: Europe in profile*¹, noted in particular that life expectancy in men in countries undergoing social and economic change drops dramatically as seen in the Eastern European countries since the collapse of the communist regime. The average life expectancy of a Russian man is currently 59. In Estonia and Latvia the death rate in men was over four and a half times that in women in the age groups 15-24 and 25-34 years (White & Holmes 2006). Uncertainties regarding employment during periods of economic instability have been shown to particularly affect men's health and particularly their mental health. Current research cites the central importance of employment in the expression of most forms of masculinities as a potential reason for marked increases in suicide rates among men to over 75% of cases. Member States are worried that health may worsen as unemployment rises, safety nets for social protection fail, and spending on health drops. They are concerned about mental illness and anxiety, and a possible jump in the use of tobacco, alcohol and other harmful substances, as happened in the past².

National life expectancy figures can hide profound variations between groups of men at local level, even in countries reporting some of the longest average life expectancies in Europe. In the UK, men in the most deprived areas of Glasgow are only expected to live until 54 (Carlton). This is 8 years less than the average life expectancy for men in India (62) and 28 years less than in the more affluent areas of the same city (82 in Lenzie)³.

Men are less likely to make effective use of health services, which adds to their risk of premature death. This situation could be exacerbated by marked lifestyle differences between countries

¹ Mackenbach JP., *Health inequalities: Europe in profile*. An independent expert report commissioned by and published under the auspices of the United Kingdom Presidency of the European Union, October 2005.

² WHO, Financial Crisis and global health. Background paper, 2009

³ Commission for the Social Determinants of Health, Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. World Health Organisation, Geneva 2008.

(tobacco smoking, diet and alcohol consumption) and by disparities in EU healthcare systems, not least in terms of availability and access to information, services and innovative treatments⁴.

Morbidity rates and rates of premature mortality are higher among those with lower levels of education, occupational class, or income. Such inequalities exist in all age groups and can be found for many specific causes of death, including cardiovascular disease, many cancers, and injury rates. Across Europe as a whole, these inequalities are more marked among men than among women and, are calculated to represent a reduction in life expectancy at birth of 4-6 years among men, and 2-4 years among women. Similar gaps exist in health between some ethnic and migrant groups and the general population which further compounds gender-based health inequalities³.

In many Western European countries mortality differences between socio-economic groups widened during the last three decades of the 20th century. This is, at least partially, explained by a faster mortality decline in higher socio-economic groups who seem to have most benefited from improvements in cardiovascular disease prevention and treatment³.

Much of male morbidity and early mortality is avoidable.

If the gap in life expectancy between men and women was solely due to biological differences it would be expected to be more or less constant across all EU countries. The scientific consensus tends to be that inherent differences between men and women are at most only partially responsible for the discrepancies in morbidity and mortality rates⁵. Since non-biological factors are not fixed - that is to say that they are capable of change in response to external intervention - it is consequently safe to conclude that untold numbers of men around Europe are dying earlier than they need to.

Do men deserve poorer health and an early death?

It is widely accepted that men take less effective care of their personal health and that they tend to use health services less frequently. They are also believed to delay seeking help until later in the development of symptoms. This may lead to perceptions among policy makers and clinicians that it is men's own fault that their health is often so poor.

It is certainly true that men, by and large, tend to be less knowledgeable about personal health than women and that they are less likely to seek help from medical practitioners. It is also true that men take more "health risks" than women, whether those are direct physical risks such as working in more dangerous professions or driving at higher speeds, or "lifestyle" risks like drinking alcohol to excess or eating a less healthy diet. It is remarkable indeed, how entirely consistently these patterns of behaviour are across the European region with such wide cultural differences.

The need for a political shift around the provision of health services

A regrettable political view may subsist that it is up to men to change, not services. This argument fails to acknowledge men's poorer health as the inequality that it is. Furthermore, cultural pressures

⁴ Eugloreh project, The Status of Health in the European Union: Towards a Healthier Europe 2009, EU public health programme project, global report on the health status of the European Union, March 2009 (retrieved 13 March 2009 from http://www.eugloreh.it/ActionPagina_993.do).

⁵ Gjonca A, Tomassini C, Toson B, Smallwood S. Sex differences in mortality, a comparison of the UK and other developed countries. Health Statistics Quarterly No. 26. London: National Statistics; 2005.

and social expectations make help-seeking very difficult for men all over the world. If men are to change, we must accept that whole societies must change. Some may argue that it would be desirable - but the only realistic view to take is that change on that scale is not going to happen in the foreseeable future.

If poorer use of services was an underlying cause of poorer health in a particular minority ethnic community, the political consensus would be that existing services were failing that community. Most EU member states with a developed understanding of health inequalities accept that health systems sometimes need to take account of differences between population groups in order to achieve fairer outcomes. There is no logical reason why gender differences in health outcome should not be treated in the same way.

Politicians and clinicians may have simply become so used to men dying sooner than women that they have ceased to wonder why it happens. This perception may be reinforced by the fact that – as we have seen – there are some potential biological explanations for some of the differences. This may lead people to regard men’s greater burden of premature disease and death as “natural”.

Persistence of the view that gender inequalities only affect women.

Nowhere does anyone take issue with the view that women are seriously disadvantaged in many areas of life in many countries. Unfortunately however, the widespread association of the very word “gender” solely with the concerns of women is extremely unhelpful. The chapter on “Gender Equity” in *Closing the gap in a generation*⁶, the World Health Organisation’s important recent report on the need for worldwide action to address health inequalities, does not contain a single sentence about male health. The opening paragraph illustrates the point very effectively:

Gender inequities are pervasive in all societies. Gender biases in power, resources, entitlements, norms and values and in the organization of services are unfair. They are also ineffective and inefficient. Gender inequities damage the health of millions of girls and women
.....

The argument runs the risk of alienating politicians who adhere to the view that men can never be seen as disadvantaged and may be perceived as diminishing the importance of those aspects of life where women do suffer discrimination. In fact, an emphasis on “true” gender-sensitivity in health and healthcare provision has the potential greatly to benefit both sexes.

Women’s health not a gold standard

Comparison between men and women must be used primarily as a basis for identifying outcomes that may be susceptible to improvement. It is very clear that there are major issues affecting women’s health – and men’s health – that need to be tackled. Health promoting interventions need to address the differences in health outcomes between women and men, boys and girls in terms of their biology and their socialisation in an equitable manner if they are to be effective⁷.

⁶ Commission on Social Determinants of Health. *Closing the gap in a generation*. Geneva: World Health Organisation; 2008

⁷ Ostlin P et al. *Gender and health promotion: a multisectoral policy approach*, Department of Public Health Sciences, Division of International Health (IHCAR), Karolinska Institute. *Health Promot Int*. 2006 Dec;21 Suppl 1:25-35

The onus is on politicians and policy makers

The following definition of a male health issue has been proposed:

*A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or requires male-specific actions to achieve improvements in health or well-being at either individual or population level.*⁸

This definition acknowledges that there are more factors at play than the biological; that the health of men and boys cannot be divorced either from prevailing notions of masculinity or from the influences of the wider world of (for example) work or relationships. By stressing however, that one of the defining characteristics of a male health issue is that “male-specific” actions are needed to bring about an improvement, the definition also recognises the crucial point that services will need to differ by gender in their design and content. In other words, the onus is on policy-makers to take the initiative if they are serious about improving male health.

Some European governments have taken exactly this kind of positive action. Ireland is the first EU country to launch a national policy to address men’s health. An emphasis on gender equality in social policy overall in other countries has opened the door to arguments that men’s poorer health outcomes should be addressed within this context. Examples of progress here include England & Wales, Scotland and Norway. This route is probably available in a good number of other nations too, at least in theory.

In other EU countries, non-governmental organisations are still pressing political leaders to begin to tackle the issue. In the absence of a political response, these non-governmental organisations are themselves often delivering programmes that target men’s poorer health. A key advocacy initiative of the EMHF has been the Vienna Declaration on the Health of Men and Boys⁹. The Declaration was launched in 2005 and received the official support of Commissioner for Employment and Social Affairs V. Sipdla and former Commissioner for Public Health M. Kyprianou. The Declaration calls on “the EU, national governments, providers of health services and other relevant bodies” to:

- Recognise men’s health as a distinct and important issue
- Develop a better understanding of men’s attitudes to health
- Invest in “male sensitive” approaches to providing healthcare
- Initiate work on health for boys and young men in school and community settings
- Develop co-ordinated health and social policies that promote men’s health.

⁸ Wilkins D and Baker P. Getting It Sorted: a policy programme for men’s health. London: Men’s Health Forum; 2003.

⁹ See: www.emhf.org/index.cfm/item_id/305

EMHF answers to some of the Commission's questions

- **What kind of indicators do you think would be necessary to better monitor the extent of Health Inequalities in the EU?**

EMHF also calls on the Commission to commission the first EU funded report on the status of men's health in Europe and to guarantee the active involvement of civil society in the shape of men's health NGOs in its delivery.

With regard to the dynamics underlying health inequalities in men, EMHF calls on the Commission to pursue current EU initiatives on health indicators to include:

New data: availability and usage of health services: screening, health promotion/prevention services, primary care and secondary care services including accident and emergency admissions.

New concurrent levels of disaggregation: By sex, sub-national geographical areas, socio-economic grouping (national averages often don't tell the whole story). This is necessary for main causes of mortality and morbidity (incidence and prevalence), and new proposed data on availability and usage of health services (see above).

- **To what degree can health inequalities be addressed through health policy?**

Tackling health inequalities effectively require a multiplicity of approaches across several policy sectors (e.g. environment, occupational health and safety, transport, housing, employment, education, justice). However, EMHF believes that much is still to be done within health policy. The production of increasing detailed sex-disaggregated epidemiological data must be pursued (see above) and accompanied by an improved understanding of gender sensitive-application in public health policy. Examples of areas where such application can and need to be further improved include targeted health promotion initiatives, addressing lowest levels of health literacy and unhealthy lifestyles.

Of particular importance to men must be a focus on improving the delivery of primary prevention and care services to ensure usage rather than availability - often labelled as "access". In the area of colorectal cancer screening, for example, huge efforts have been deployed across member states to increase service provision however the facilities remain largely under-utilised by men in particular. Based on successful pilots at national and regional level in several Member States, EMHF now also advocates for a greater choice in the delivery of health services, particularly outside of traditional clinical settings. Settings such as the workplace and sports stadia have proven most successful in reaching out to men with either care or information services.

- **Which and to what extent should other policy areas, such as social policy, contribute to reducing health inequalities?**

Education: health literacy (lower with SEG, but particularly among men not socialised to be health literate (seen as a preserve of the female gender)).

- **Do you think action at EU level could make a difference in addressing health inequalities? Why?**

EMHF would welcome and support EU actions that can help share and develop existing knowledge and expertise in men's health across all member states. Men's health is increasingly developing as a "science" directly contributing to the reduction of health inequalities.

Gender may also be seen as a "nice concept" for use in wealthier EU countries or linked to foreign cultural aspirations such as Western or Nordic. Knowledge development and application is therefore more likely to be sacrificed in times of economic crisis if leadership only reliant on national governments.

- **Given the current economic situation can you think of any immediate action that EU or Member States could take to avoid an increase of health inequalities in the short term?**

The Commission must secure a provision within all EU stability or rescue packages to ensure current national health budgets are not drastically reduced and vulnerable population groups remain protected particularly in times of difficult economic conjuncture.

- **Do you believe that investments through structural funds could help to reduce health inequalities. If so, how and why?**

The Commission must ensure that a minimum budget within EU Structural Funds is committed to the development of long term health promotion and prevention initiatives specifically targeting group most vulnerable to health inequalities which most often include men. Currently little or no provision exists to this effect.

Key Facts – Men and health inequalities

Accidents

- Injuries disproportionately affect males and younger people. Males comprise three out of four people who die from injury and account for 77% of the DALYs lost¹⁰
- Road traffic injuries are the leading cause of unintentional injury death for people aged 5-29 in the region. In 2002 the estimated 127000 death from RTI in the European region, comprised one in 6 injury deaths, 55% of the people killed were aged 15-44 old and 75% were male¹¹
- In the 15-64 age group, men have four times the death rate due to an accident compared to women, with the majority of them related to transport
- Among men, those with a lower level of education have higher rates of traffic injury mortality than those with a higher level of education in all countries with available data, with the largest inequalities usually seen in the younger age-groups¹²
- Poisoning is the 3rd leading cause of death from injury in the EU. Poisoning mortality rates in males in LMIC in the European Region are the highest in the world, particularly in the group aged 30-59, which accounts for 67% of all poisoning deaths¹³.

Suicide

- In the EU, there are about 58000 suicides per year of which ¾ are committed by men. Males have 5 times the risk of suicide of females in low and medium income countries (LMIC) and 3 times the risk of females in high income countries (HIC). Actual suicide are 2, 5 times more prevalent in LMIC than in HIC¹⁴
- Suicide rates are higher in lower socio-economic groups in most populations, but only among men. One of the underlying risk factors, mental ill health, also tends to be more prevalent in lower socio economic groups¹⁵

Cardiovascular diseases

- In all countries with available data, mortality from cardiovascular disease is higher among men and women with a lower socio-economic position¹⁶
- In men, cardiovascular disease account for almost 40% of the difference in mortality rate between higher and lower educational groups¹⁷

Cancer

- Among men, the usual pattern of higher mortality in lower socio-economic groups applies to cancer as it does to most other diseases¹⁸

¹⁰ World Health Organisation. Injuries and violence in Europe : why they matter and what can be done, WHO Europe 2006

¹¹ World Health Organisation, Injuries and violence in Europe : why they matter and what can be done, WHO Europe 2006

¹² Mackenbach J, Health inequalities :Europe in profile , ,2006

¹³ World Health Organisation, Injuries and violence in Europe : why they matter and what can be done, WHO Europe 2006

¹⁴ World Health Organisation, Injuries and violence in Europe : why they matter and what can be done, WHO Europe 2006

¹⁵ Mackenbach J ,Health inequalities :Europe in profile,2006

¹⁶ Mackenbach J,Health inequalities :Europe in profile ,2006

¹⁷ Mackenbach J, Health inequalities :Europe in profile ,2006

¹⁸ Mackenbach J,Health inequalities :Europe in profile ,2006