

KILLING THEM SUBTLY - SOCIAL DETERMINANTS IN MEN'S HEALTH

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The Gender Contrast

There is clearly a sex differential in health status. Men have higher rates of death (mortality) and more serious and chronic illnesses (morbidity) than women (NSW Health, 1999). There can be no argument about the poor state of men's health in Australia. Mortality data shows that men have higher death rates than women from all major causes (Figure 1).

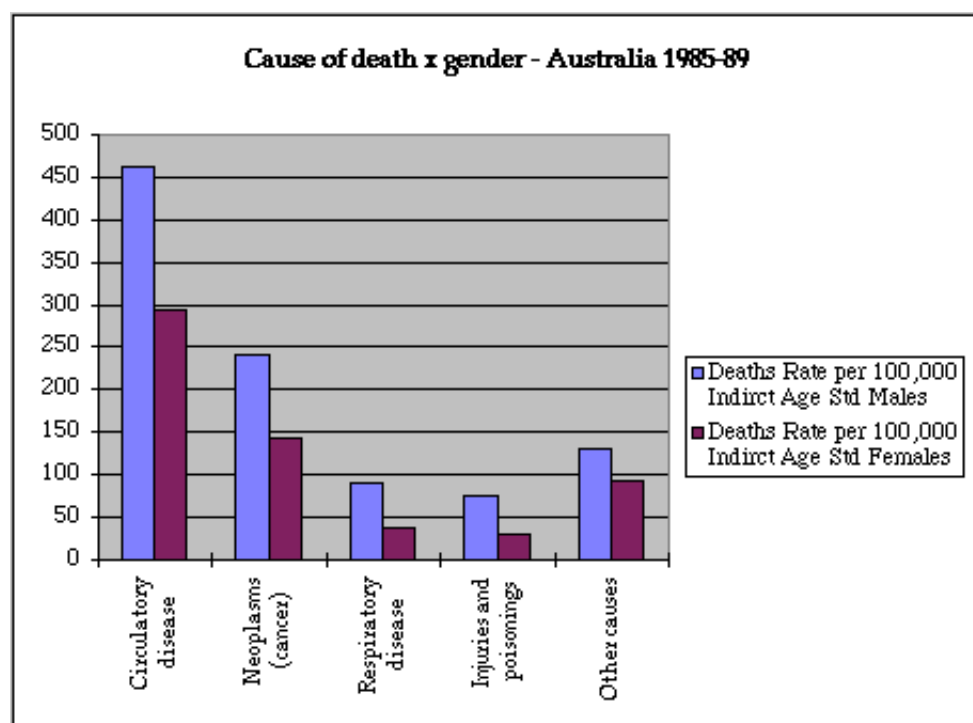


Figure 1. Major causes of death x gender in Australia 1985-89 (National Social Health Database).

This difference in death rate is not surprising - what is surprising is that it is only recently that this attracted any attention, given that reliable data showing higher male mortality has been available in Australia since 1921 (AIHW, 1994, p5). As would be expected from a higher death rate, men also have a higher incidence of severe illnesses. Cancer, one of the most serious of illnesses, has a more frequent occurrence amongst men than women (Figure 2). Smith, Taylor and Coates (1996) note that there is a strong relationship between high rates of mortality from cancer and low SES in both males and females. In NSW, the overall data shows that the link between SES and incidence of cancer is most evident in males.

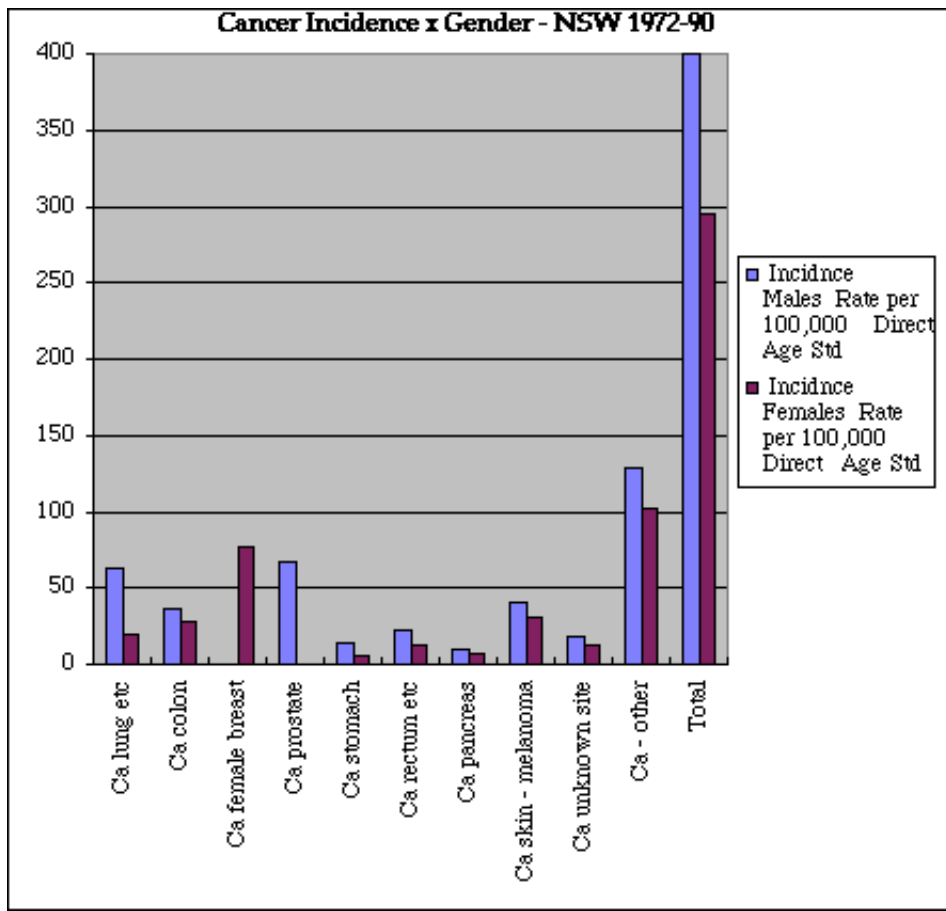


Figure 2. Incidence of Cancer x Gender 1972-90. National Social Health Database.

It is worth noting at this point that there is some disagreement over sex differentials in health. At least one author (Broom, 1998) suggests that women suffer from a greater level of sickness than men. However, this is inaccurate - the primary data which could be used to support this contention is women's greater use of health services. This data, however, does not indicate that women suffer greater health problems, merely that they utilise health services to a greater degree. There are valid alternative explanations (other than greater need) why women more frequently utilise medical and health services - one being that the range and availability of these services may make it easier for women to access them. In fact, this possibility is logically preferable to Broom's argument, as it is congruent with the other data discussed above - that is, if men have restricted access to appropriate health services (especially primary services), this would at least partially account for men's more deleterious state of health.

Theorising Health Differentials

The degree of presence or absence of health services alone cannot account for gender differences in health. While timely and appropriate services can reduce the consequences of illnesses and injuries, they cannot reduce the incidence of these in the first place. We have to look for other reasons. There have, of course, been many attempts to account for the differences in incidence of illness between genders, with approaches generally falling into one of three categories:

1. Biological explanations. These often refer to the fact that boys are more likely to have problems in utero or early infancy due to having a single X chromosome. Occasionally, reference may be made to the hormonal differences between men and women as contributory. Overall, while biology must play some part, it does not seem to account for much of the gender difference - the largest variations in health status within a given population can be directly attributed to social factors, not biological.
2. Behavioural/cultural explanations. Most emphasis on explaining men's health issues in recent times

has been given to explanations based in cultural analysis, so that discussions of gender and health (e.g. Grbich, 1996; Germov, 1998) stress the factor of "masculinities" as causal in men's mortality and morbidity data. This approach suggests that factors inherently male - men's "risk-taking" behaviours and the "male role" are the real culprits of poor health. This perspective implies that attempts to improve men's health must focus on changes in lifestyle, behaviours and attitudes.

3. Material/structural explanations. These are based in the belief that social factors (such as employment patterns, income, educational opportunities, government policies, provision of health services etc.) largely determine health outcomes. This perspective is commonly used in discussions of women's health (Broom, 1998; Grbich, 1996), and suggests that structural factors are the main cause of women's health problems. It leads to the conclusion that attempts to improve women's health must focus on changes in social systems, such as government policies.

As noted, biology is not seen as a major influence in gender variations in health outcomes, so will not be explored here. The following discussion will offer some comments on the latter two approaches, although the intriguing question of why different theoretical approaches are used to analyse the health of men and women must be held in abeyance.

Not All Men Are Equal

Discussions of men's health often begin, as does this, with a comparison of data between men and women. However, there is a serious problem with overall data comparing death rates and morbidity measures for all men and all women. Aggregation of data can conceal as much as it reveals, and has hindered our understanding of the causes of poor health in men, thereby preventing appropriate responses to attempt to improve the situation. Aggregate data has led to generalisations about "male culture" and men's behaviours as being causal in their poor health. But the reality is that not all men experience relatively poor health compared to women. It is one sub-group - low socio-economic status (SES) males - who suffer a disproportionate burden of health problems, and skew illness data in a way that suggests all men face massive health problems. The National Health Strategy's Research Paper (1992), notes that men from low SES, compared to their high SES counterparts, are:

- 55% more likely to die from lung cancer
- 74% more likely to die from diabetes
- 54% more likely to die from ischaemic heart disease
- 102% more likely to die from cerebro vascular disease
- 265% more likely to die from pneumonia / influenza
- 98% more likely to die from bronchitis / emphysema / asthma
- 77% more likely to commit suicide.

Where poverty is compounded with other forms of social disadvantage, such as aboriginality, the picture is even grimmer for men. While the average life expectancy of an Australian non-aboriginal male living in the 1980s was around 72 years, that for an Aboriginal male was between 49 and 56 years (Davis & George, 1988, p84). For middle class health professionals to apportion the responsibility for aboriginal men's high mortality to their "gender identity" or form of "masculinity" would ignore the more pertinent factors of structural oppression and social disadvantage. Very few health professionals or researchers would have the temerity to blame aboriginal men for their own health problems, much less suggest that simple changes in lifestyle and the provision of screening services will solve the problems. Instead, we acknowledge that structural and material changes are needed to address the health issues of aboriginal men.

Yet with those non-aboriginal men who suffer high mortality and morbidity, there is a careful avoidance of things structural - they are, according to much of current thought, themselves to blame through their unhealthy choices and damaging behaviours. It does not seem to matter that many non-aboriginal men may also be marginalised or alienated by current social arrangements, and that this can undoubtedly have adverse effects on their health. The popular press, together with some sections of academia, seems to prefer the novelty of cultural analyses which result in politically acceptable (if largely ineffective) interventions to change individuals, thereby avoiding any critique of the social injustices which result in the poor health of many men.

This link between poverty and poor health is not a new finding. Engels, in 1844, clearly illustrated this fact, as did Virchow (1847 - cited in Black et al, 1984), who concluded that poverty was the breeder of disease, and that changes in social conditions were needed to lead to favourable health. More recently, in the United Kingdom, the Working Group On Inequalities In Health noted that health (and illness) are determined by multiple factors, and that material and structural factors are central in influencing health. Crucially, their report recognised that some individuals and certain sectors of society have limited, if any, control over these factors (Townsend & Davidson, 1982). Further support for this line of reasoning derives from Navarro (1986) and Najman (1994) who both claim that the failure to address poverty and other social factors is the major cause of poor health. Power, Manor & Fox (1991) "locate the responsibility for inequalities in health in the social structure governing the distribution of resources toward different groups of people". In Australia, the National Health Strategy's Research Paper No 1 (1992) arrives at exactly the same conclusion - the social environment is the major determinant of poor health. If we accept this data, then the focus on lifestyle and individual behaviours can be seen to be misleading. We must attempt to explicate which social factors are most influential (and amenable to change), and design our interventions accordingly. This may not be as glamorous as elegantly scripted texts on masculinities, but it will be far more effective.

Exploring The Poverty/Gender Nexus

The preceding sections present evidence that there are not only differences between genders, but significant differences within gender. This section considers the mechanisms by which poverty impacts on the health of men. This is not to suggest that poverty does not have deleterious effects on women too, rather it assumes that experiences of poverty differ somewhat across genders, and focuses primarily on the experiences of men.

The primary factor to be considered is that of "social cohesion" - the degree to which people sense they belong to a society or community, and which translates into levels of social support. That social cohesion enhances well-being is an established fact. Since Emile Durkheim's study (1897) of the social basis of suicide rates, numerous studies have shown that people who are socially integrated live longer and that socially isolated people die at two to three times the rate of people with good networks of support (Kawachi & Kennedy, 1998). These authors suggest that this reflects the former's limited access to sources of emotional and instrumental support. They go on to note that presence or absence of support is not an individual phenomenon, but that entire communities or societies might be lacking in social connections. This is supported by Quick & Wilkinson who claim that there "is something about the quality of life in an unequal society that is damaging to people's health, over and above the direct effects of material conditions themselves", and that this inequality "has its main effect through psychological and social processes" (1991, p5). And it seems entirely plausible that these processes will differ across genders, and thus may be contributory to the poorer health of men of low SES. Support for this view comes from UNICEF (1996) who analysed the deteriorating patterns of mortality in Eastern Europe following the collapse of the communist bloc. UNICEF notes that:

Increases in 'paternal mortality' are in fact mainly responsible for the overall deterioration in crude death rates and life expectancy rates at birth. Most affected are men between 30 and 59, especially in the 30-39 age group. Together with "inherited weaknesses" (poor lifestyles, bad nutritional habits, environmental degradation), psycho-social stress is recognized as a major cause in the 'mortality crisis' among young male adults, in particular in Russia, Ukraine and the Baltic countries.... In Russia, life expectancy at birth has fallen to a record low of 58.2 years for men, a value lower than in Pakistan. The gap between genders has further widened, with Russian women having a life expectancy at birth 13.2 years greater than men.

One of the specific mechanisms that may be at work in differentially effecting men and women of low SES is employment. While women have no less need than men for the financial benefits of employment, it may be that the incidental benefits of employment are more important for men. While much of the work available to men of low SES is arduous, boring and hazardous (95% of all industrial deaths are men), it appears that the lack of work is even worse. For many men, work is central to their social identity and self-esteem, and is a primary site for developing social networks and support. Women, who have a history of being excluded from the paid workplace, have a long and successful tradition of developing social networks outside of the workplace, so are not as reliant as men on work as a source of social connections. Additionally, a woman who is not working can be perceived, and perceive herself, as socially valuable through child bearing and parenting, an option not readily available to men. Returning to the question of the impact of unemployment, research indicates that unemployment can (and often does) involve:

- strain in relationships with family and friends
- community breakdown in the case of large layoffs (increased crime and other social problems)
- loss of self-esteem
- problems with structuring time and social identity
- where there are additional problems (e.g. psychosis/ disabilities) the experience of unemployment compounds psychological difficulties
- increase in suicide, depression, schizophrenia

Freund and MacGuire (1991)

One of the clearest explanations of the links between unemployment and health is provided by Hart (1997) who reports studies by Brenner (1979) and Brenner & Mooney (1983), which linked mortality rates with the business cycle in the UK using cross-sectional data. They found that a quantified increase in unemployment led to a proportionate increase in the death rate. They suggested that the psychological stress of unemployment was likely to be the intervening variable which could account for the increased death rates. Hart (1997) elaborates on this explanation, and notes that it is not the single episode of unemployment which is of concern, but rather the "career" of the unskilled worker, whose lifetime is punctuated by episodes of unemployment which expose the person to material deprivation and economic insecurity. She concluded that unemployment has a corrosive effect on health. And it may be that this corrosive effect is amplified in men.

Naturally, no simple explanation can do justice to the complexities of illness causation. But it is clear that class/poverty or whatever we term it, as well as gender, plays a major role in causation, and that the current attention to questions of lifestyle and risk-taking behaviours is largely misplaced. Both Grace (1991) and Colquhoun (1992) warn that emphasis on such individual factors leads to "healthism", an ideology that targets individual decision making and ignores the social context by which decisions effecting one's health are enabled or constrained. Healthism allows health professionals to be seen to be doing something, without causing any discomfort to those who benefit from currently inequitable social arrangements, and obviously without having any impact on the problems.

The preceding is not an attempt to decry investigations of masculinities - this is a worthy topic of intellectual investigation in its own right. However, it does attempt to indicate that the application of such theorising to men's health is a largely futile enterprise, only serving to divert attention (and resources) from areas where a difference can be made. In the absence of any plausible research that links class to certain forms of "masculinities", and then links these forms to health outcomes, we must reject such a woolly explanation. A focus on the structural aspects associated with men's poor health would seem far more productive than a cultural emphasis. It also helps explain one of the paradoxes

of men's health - if men control society, and the health system, why don't they have the better level of health? The argument presented above can explain this - those men in control do have a better level of health, and they control society in the interests of their class rather than in the interests of all men.

Neither is this an attack on women's health (a complaint that tends to be voiced whenever men's health needs are raised). Instead, I would suggest that women's health services are an extremely beneficial addition to mainstream medical services, as they do not simply address overt biological health threats, they aim to provide essential social and emotional support. This is precisely the type of model that needs to be tested with men.

Of course, all of us will die at sometime, and experience episodes of illness during our lives. The concern is whether or not men have a reasonably equitable chance of living out their potential years fully, and with the minimum possible amount of illness. The preceding sections indicate that both gender and poverty will have a profound impact on these outcomes. It is indisputable that poor men have worse health than any other sector in society, followed closely by similarly disadvantaged women. From this, it follows that the greatest gains to health will not be made from a focus on gender alone, but from addressing the structural factors that so adversely effect people's health - and doing so with in conjunction with an understanding of the differing needs of each gender.

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