



A Position Paper Issued by the Men's Health Braintrust, Dialogue on Men's Health

## A Framework for Advancing the Overall Health and Wellness of America's Boys and Men





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*On Behalf of the Dialogue on Men's Health Conference Attendees*

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## EXECUTIVE SUMMARY

No other health problem that affects so many Americans has suffered from as much benign neglect and for so long as male health. The Affordable Care Act of 2010 presents an unprecedented opportunity to improve access to health care services and enhance the health of all Americans. Over the past two decades, there has been a growing interest in gender-specific approaches to improving health status. It is only recently that boys and men have begun to be recognized as a distinct biomedical and sociological population with unique health care challenges. In terms of mortality and morbidity, the disparity between American females' and males' quality of life, access and motivation to engage in health care services and products represents a significant challenge for all stakeholders. According to the U.S. Centers for Disease Control and Prevention, America's boys and men, on average, die 5.6 years earlier than women and die at higher rates from 9 of the top 10 leading causes of death. Men make half as many preventive care visits than do women, and far fewer men than women can identify with a primary care provider. The data across sectors clearly show that America's boys and men face poorer overall health outcomes across a wide range of key indicators and live less healthy lives than would be expected given generalized trends in morbidity and mortality. While U.S. epidemiologic trends point to a problematic picture for the overall health of boys and men, the health status of low income men and men of color is at particular risk.

There are enormous costs associated with the poor health status and premature death and disability of America's boys and men. These costs adversely impact families, widowed women and communities. It has been estimated that excess costs attributed to health disparities in boys and men approximates \$142.2-\$148 billion annually. These stunning financial implications affect the overall economy of the U.S. as well as the financial strength of health care providers and fiscal intermediaries.

The epidemiologic, financial and sociologic information regarding the health of boys and men make it abundantly and powerfully clear that there is a significant need for all stakeholders to increase the attention, resources and prioritization given to males in our society.

This powerful and insightful Position Paper published by the Men's Health Braintrust presents important perspectives of experts in health care, government and male health advocacy regarding the landscape of issues and opportunities to enhance the health of boys and men. This paper outlines a bold and strategic call to action to:



- Develop a national framework and dialogue to better understand the needs and motivations of boys and men to successfully engage the health care system for wellness and disease management,
- Stimulate the development of innovative approaches to reach boys and men and provide successful wellness and health management programs for them, and
- Foster public-private partnerships and policies that harness the initiatives during restructuring of health care and disseminate successful strategies across health provider sectors.

The nine co-sponsoring organizations and fifty organizations that participated in the October 2012 landmark Dialogue on Men's Health conference that form the basis for this Position Paper have set a goal of significantly reducing the gender mortality/life expectancy gap between American males and females by 50% within two generations. Such a targeted and needed goal would have a significant impact on health care providers, institutions, families and communities across America.

**Areas of Development:** Five areas of near term focus, which parallel those issued in 2011 by the American Public Health Association constituency group, the Men's Health Caucus, are offered to help achieve these goals:

1. **Policy Development** to strengthen national and state public policies and reimbursement models for services to boys and men.
2. **Research** to advance the understanding of optimal drivers of male health and delivery of services and to disseminate gender, age and sociocultural appropriate information and programs.
3. **Educational Outreach** to develop greater health education programs targeting boys, men, their support networks and families.
4. **Professional Training** to develop better trained and more gender competent health care providers and systems.
5. **Access to Health Services** by promoting strategies that ensure greater delivery and access, in a gender competent manner, to wellness and care for boys and men.

The oldest and largest advocacy organization with a mission to advance the health of boys, men and their families across the lifespan, the Men's Health Network (MHN), serves as conference conveners and coordinator for the Men's Health Braintrust. Along with its partners MHN is committed to continuing and broadening the Dialogue series. This work is intended to foster cross functional

dialogue and activities by all stakeholders and form a framework for change. Over the course of the next several years, panels of experts involved at all levels in the health and wellbeing of boys and men will come together to discuss needs and approaches as well as resources and best practices in each of the action areas identified in this framework Position Paper.

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## INTRODUCTION

This Position Paper is being issued by the Men's Health Braintrust in response to the proceedings and follow-up efforts from the Dialogue on Men's Health conference, held on Oct. 18, 2012 in Washington, DC. Hosted by Men's Health Network (MHN) and nine co-sponsoring organizations, the event was held in partnership with a broad base of over 50 organizations and experts involved in advancing the health of all Americans. Since its establishment in 1992, MHN has been the leading U.S. non-profit, educational organization committed to improving the overall health and wellness of men, boys, and their families through education campaigns, public policy advocacy, and research into men's health. MHN's principal goals are to save boys' and men's lives by reducing premature mortality and to increase their overall wellness, health awareness, and engagement in their own healthcare.

The Dialogue meeting had five main objectives:

1. *Define the health needs of America's boys, men, their families and loved ones.*
2. *Identify the challenges and obstacles that undermine the health of boys and men, as well as opportunities to overcome them.*
3. *Create working relationships between key stakeholders to achieve those goals.*
4. *Provide a platform for ongoing dialogue, work-groups, and programs to sustain progress in this critical area.*
5. *Identify programs and initiatives that are working to improve the health and wellbeing of boys and men, and invite them to participate on some level with the Dialogue.*



## BACKGROUND

The passage of the Affordable Care Act in 2010 presents an unprecedented opportunity to improve access to health care services and enhance the health of Americans—and provides important tools to capitalize on those opportunities. Regardless of the areas of excellence in health care Americans now enjoy, more can be done and more needs to be done. This position paper, consistent with the objectives of the Dialogue on Men's Health conference, attempts to sharpen the focus on the health of American boys and men, recognizing that this is only one component of the broader discussion of the complex and interwoven health care needs of all. Many involved in health policy believe that just as it is futile to leave half of a crop field untended, it is also true that not vigorously tending to the comprehensive health needs of any segment of our population will have an adverse impact on the entire population.

Furthermore, in terms of mortality and morbidity, the disparity between American females' and males' quality of life and lifespan is arguably one of the most significant public health problems we face. Lacking a systematic, well-coordinated national focus, no other health problem that affects so many has suffered from as much benign neglect—and for so long—as male health disparities. Nevertheless, there is a growing awareness across all levels of society that these gender-based health disparities are not likely to be resolved without enhanced efforts to specifically address them. The medical and public health communities have the knowledge and the means to mitigate many of the problems in men's health. That knowledge and means need to be effectively applied.



The data clearly show that America's boys and men face poorer overall health status and health outcomes across a wide range of key indicators (CDC, 2011) and live less healthy lives than would be expected given generalized trends in morbidity and mortality.

## Focusing on the Health of Boys and Men

Over the past two decades, there has been a growing interest in gender-specific approaches to improving health-status. But it is only recently that boys and men have begun to be recognized as a distinct, definable biomedical and sociological population with unique health care challenges. While there is no universally agreed upon definition of what is commonly referred to as “men’s health,” proponents of this evolving field of knowledge and practice recognize the need to rectify the common misperception that men’s health is about only a few, albeit important, conditions, such as prostate cancer and sexual health. They seek to redefine “men’s health” more comprehensively, to include the wellness of boys and men across the lifespan (see Table 2 in Appendix 1 for the key issues that affect the health of boys and men). For the purposes of this paper, we will use the definition suggested by the British Health Development Agency in 2001:

*“Men’s health encompasses all conditions or diseases that are unique to males, are more prevalent in males, for which risk factors, both biologic and socioeconomic, are different for males, or for which different behavioral or medical interventions are required.”*

The data clearly show that America’s boys and men face poorer overall health status and health outcomes across a wide range of key indicators (CDC, 2011) and live less healthy lives than would be expected given generalized trends in morbidity and mortality.

Over the past three decades, there have been many significant advances in health and access. However, irrespective of ethnicity or race, a case can be made that nationally our health care system lacks male-health cultural competence and is ineffective in ensuring that our male population becomes health-literate. Excluding pregnancy-related office visits, American women make twice as many preventive care visits as men. Thanks in part to their socio-cultural aversion to seeking preventive care, men suffer higher death rates in 9 of the top 10 causes of death, which include cardiovascular disease, cancer, diabetes, and unintentional injuries (NCHS, 2010). (See also Figure 1 and Table 3 in Appendix 1.) The CDC reports that more than half of the premature deaths of men in America are preventable, in many cases through changes in personal health behaviors.

While U.S. epidemiologic trends point to a problematic picture for the overall health of men, there are identifiable populations, most notably those of color, which suffer the lowest levels of health status and access of any American sub-population. It has been suggested that these gender-based health disparities have actually *increased* in recent years. The data and statistical information on the health issues faced by American males make it abundantly and powerfully clear that there is a

significant need for all stakeholders to increase the attention, resources and prioritization given to males in our society.

### **Key Issues that Affect the Health of Men and Boys**

Adapted From: *A Poor Man's Plight: Uncovering the Disparity in Men's Health*,  
W.K. Kellogg Foundation, 2002

#### **Policy and Training**

- ▶ Lack of a National Leadership
- ▶ Fractionated Federal, State and Local Policy Development
- ▶ Little Professional Education and Training in Comprehensive Men's Health
- ▶ No Clear Medical Specialty To Address Comprehensive Men's Health

#### **Access to Services**

- ▶ Navigating Through the Health Care System
- ▶ Choosing a Health Care Provider
- ▶ How to Address Concerns to Your Provider
- ▶ Provider Perspectives

#### **Mental Health**

- ▶ Suicide and Homicide
- ▶ Work-related Injuries
- ▶ Trauma and PTSD
- ▶ Substance Abuse
- ▶ Stress Reduction
- ▶ Spirituality

#### **Social Justice**

- ▶ The Nature of Oppression
- ▶ Racism
- ▶ Sexism and Homophobia
- ▶ Criminal Justice
- ▶ Fatherhood Rights

#### **Meaning of Manhood**

- ▶ Sociologically Reinforced "Anti-health" Predispositions
- ▶ Body Image
- ▶ Gendered Health Attitudes

#### **Health**

- ▶ How to care for your body
- ▶ Basic Prevention
- ▶ Early Recognition and Compliant Intervention for Evolving Health Issues
- ▶ Fitness and Nutrition
- ▶ Sexual Health

#### **Life Skills**

- ▶ Parenting Education
- ▶ Understanding the Culture of Work
- ▶ Employment Negotiation Conflict Resolution

### **The High Cost of Ignoring Men's Health**

There are enormous costs associated with men's premature death and disability, which are the consequences of the sub-optimal health status and poor access that men, particularly those of color, experience. Men's poor health, morbidity, and early mortality affect families, employers, and society as a whole. Men play a critical role in families as fathers and sons providing care and support to other family members. As members of the workforce, they are employers and employees whose

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health and well-being greatly affect productivity and economic well-being. When men are absent—either through premature death or reduced capacity due to preventable injury or health conditions—American businesses suffer billions of dollars in lost productivity and federal and state governments lose billions in tax revenue that would have been generated had those men been alive and in good health.

Premature mortality also directly and adversely affects newly widowed Americans. In a paper on the economic burdens that flow from the male morbidity and mortality, Brott et. al. (AJMH, 2011), cite data from the

U.S. Administration on Aging (AOA) showing that more than half of elderly widows living in poverty were above the poverty line before the death of their husband (US DHHS, 2001). In total, approximately 20% of elderly widows are living in poverty compared to the approximately 4% of married women the same age (McGarry & Schoeni, 2002-2003). Further, according to the AOA, the mean income for elderly widowed women drops from \$23,284 to \$11,121 soon after losing their husband. The impact of widowhood also negatively affects women's health and overall costs of health care. In the first month of widowhood, the risk of death from any cause doubles (Bonhomme, 2007).

Currently, U.S. men die approximately six years earlier than women. Much of this is secondary to preventable causes or conditions which, had they been properly managed earlier, may have given additional years of higher-quality life. Targeting a goal of significantly narrowing the gender mortality/life expectancy gap between men and women by 50% within two generations would have a significant positive impact on married women, extended families, and society overall. Regardless of the raw economic implications of this goal it is simply the right thing to do. Overall Brott, et al. (AJMH, 2011) estimate that the excess annual cost attributed to health disparities in boys and men under our system of care approximates \$142.2-\$148.7 billion. (See Table 5 in Appendix 1.) Full implementation of ACA mandated programs provides a very unique opportunity to begin systematically engaging men in care provision elements of the Act. Additionally, it will address the subsidiary costs associated with neglecting male health.



“...men of color fared worse than white men across a broad range of health measures in almost every state – and in some states the magnitude of the disparities was striking.”

- Putting Men's Health Care Disparities on the Map: Examining Racial and Ethnic Health Disparities at the State Level (2012)

91.2%, and 91.1%, respectively. Looking at this more closely reveals that the life expectancy gap between males and females within an ethnic group actually widens in the regions of the country where life expectancy is lowest for the respective group. African American males living in Washington D.C. provide one of the most extreme examples, as their life expectancy is only 88% of their female counterparts. Native American males that live on reservations in the northern plains have a life expectancy of 89% of their female counterparts and the lowest overall life expectancy in the nation. Beyond life expectancy, a conclusion the landmark Kaiser Family Foundation Report, *Putting Men's Health Care Disparities On the Map: Examining Racial and Ethnic Health Disparities At The State Level* (2012), states that “...men of color fared worse than white men across a broad range of health measures in almost every state – and in some states the magnitude of the disparities was

If the largely preventable crisis in men's health is further allowed to worsen, the adverse economic impact will grow. This may lead to a downward spiral of disastrous health and economic consequences—consequences that could have been largely averted. Conversely, improving male health through early detection of male health problems and timely treatment of disease will result in reduced morbidity and mortality, which, in turn, will result in significant economic benefits for men, families, and society.

### Minority Boys and Men

In the context of gender and health status, it is relatively well known that males have a shorter life expectancy and higher overall death rates than females. It has also been repeatedly documented that the life expectancy gap between males and females is greater for African Americans and Native Americans than for whites. Based on the most recent CDC data (see Figure 1 and Table 1 in Appendix 1), the life expectancy for white males is 93.8 % of white females. The comparative figure for Hispanic, Native American, and African-American males is 95.3%,



striking.” Unfortunately, there were several health status indicators in numerous states where males of color indicators of poor health were two to three times that of white men. It is suggestive of the powerful influence of the social determinants of health to note the following additional findings from recent analyses:

- ▶ African American males have the lowest life expectancy in Washington, D.C.
- ▶ Native American males have the lowest life expectancy in South Dakota.
- ▶ Asian/Pacific Islanders and Hispanics have the lowest life expectancy in Hawaii.

Racial and gender-based morbidity and mortality rates follow a similar pattern, but with wider variations linked to gender. Collectively, these disparities in disease burden and longevity for males of color represent health inequities of national significance. A few specific examples of the disparate health behaviors and health status for males of color include:

- ▶ African American males are twice as likely to die from prostate cancer as white males.
- ▶ Native American males ages 15-24 are three times as likely to commit suicide as Native American females and white males of the same age group.
- ▶ Among Native Americans ages 45-54, males suffer alcohol-related deaths eight times greater than whites and twice as often as Native American females, and die from diabetes at a rate four times greater than white males and 40% higher than Native American females of the same age.
- ▶ Hispanic males have almost three times the rate of HIV/AIDS as white males and are 2.5 times more likely to die from HIV/AIDS as white men.
- ▶ Hispanic males are six times more likely to have never seen a primary health care provider and eight times less likely to have never seen a dentist than white males.
- ▶ Native Americans are the only racial group in which males score higher in psychological distress than females, based on the CDC National Health Interview Survey.

**While U.S. epidemiologic trends point to a problematic picture for the overall health of men, there are numerous sub-populations, most notably those of color, which experience the lowest levels of health status and access of any American sub-population. There is growing evidence that these gender-based health disparities have actually *increased* in recent years.**

The recent Kaiser Family Foundation report also describes that in a few areas of the country the life expectancy of racial groups may present specific epidemiologic patterns that indicate significant



disparities between white and non-white groups that are contrary to those generally seen. For example, the District of Columbia had a six-fold difference in the rates of poor health for minority men compared to white men, which was in stark contrast to the state of West Virginia that had ratings of fair or poor health for minority men that was half that of white men. The report found additional challenges

for white men, reporting, “White men fared better than minority men on most access and social determinant indicators, but had higher rates of some health problems than men of color. In particular white men nationally had higher rates of smoking, binge drinking, and serious psychological distress than men of color.” As we aim to understand the factors that drive poor health in the general population, these recent finding clearly depict that health status is undeniably tied to an individual’s local environment. Thus, in continued efforts to alleviate health disparities, we must focus additional attention towards understanding the drivers of health status in these clearly vulnerable areas.

While more difficult to measure, males also experience multiple co-morbid physical and mental health conditions that compromise their quality of life. Frequently undiagnosed and untreated, these conditions contribute to some groups’ disproportionately higher rates of domestic violence and sexual abuse. The resulting strain on the nation in terms of medical expenditures, judicial system costs, and loss of productivity are immense, but the deleterious impact on the families and communities of those directly affected are truly catastrophic.

### **Causes of Male Health Disparities**

The growing disparities in morbidity and mortality between men and women are caused by a number of complex and intertwined biological and sociological factors. Health and well-being may also be affected by income, education (both in terms of years of schooling and health-specific learning), family background, and family/community support. There are additional factors that are subject to some debate. For example, many experts in men’s health have suggested that the



current unacceptable state of men's health is, at least in part, the unintended consequence of our society's having benignly neglected the health and welfare of men and boys for at least a generation. As important as it is to examine the genesis of past, current, and projected epidemiologic trends, the participants of the Dialogue conference believe that it is imperative to take action in identifying areas that can move the trajectory of these trends onto a more positive path.

As it is true for any very large defined population in our diverse country, men are not a homogeneous group. Thus, the factors that negatively (and positively) impact boys and men must also be studied and addressed for all relevant male medical, ethnic, and sociological sub-groups. The need to better understand these factors and ways to address them is an important area of future work for those involved in this Dialogue conference (and the others that will follow). On a policy level, we need more comprehensive and coordinated federal and state government efforts to enhance efforts already in place and to bring needed focus to men's health. The substantial investments in women's health over the past 25 years, and the millions of lives that have been saved, extended, and improved are a testimony to the potential for these efforts to produce results.

In this same light, services for boys and men at the state and regional levels are less prevalent than those for females, and where they do exist, they are often embedded as add-on components of non-male specific programs and services (for example, offering men's health services in a women's health clinic). More often than not, male-specific health services lack coordinated direction within relevant state health agencies. (Williams and Giorgianni, 2009 & 2011). We do acknowledge that this is in no small part fallout from budget constraints, particularly in recent years.



Of the 38.4 million Americans aged 18 to 64 years who lack health insurance, 55% (21.2 million) are men.

## Access to Health Insurance

The unfortunate fact that men, particularly men of color, have inadequate access to health insurance is well known. Of the 38.4 million Americans aged 18 to 64 years who lack health insurance, 55% (21.2 million) are men. Of those aged 18 to 34 years, 57.4% of the uninsured are men (Institute for Women's Policy Research, 2010). Uninsured individuals have poorer overall health and higher mortality than those with insurance (Kaiser, 2010). Uninsured adults, regardless of ethnicity, with chronic medical problems (including diabetes, high blood pressure and asthma) are three times more likely to skip medical care than those with insurance (CDC, 2010). In addition, people diagnosed with cancer who don't have health insurance are more likely to die because they are less likely to get screening tests and so are typically diagnosed with advanced disease (Ward, 2008).

Given the current economic and employment issues faced in the U.S., men's access to appropriate levels of health care is even further challenged. Hopefully, through full implementation of the Affordable Care Act of 2010 (ACA), many of these insurance challenges will be addressed. Some obstacles will still exist. The important specialty of Family Medicine meets many of the comprehensive needs of boys and men. However, unlike in many other defined areas of medical specialization, most notably women's health, U.S. health professional curricula offer few formal courses, training programs, or program tracks specifically in men's health. The absence of a men's health specialty, or men's health training within existing medical associations, makes it harder for adolescent boys and men to identify a primary care practitioner, which leaves them without a medical "home" throughout their lifespan. More can and should be done while boys and men are in a medical encounter to foster a continuum of health awareness, early interventions and management.

For example, while cursory sports physicals represent an annual "medical moment" for a sub-population of boys, these encounters are not regularly converted into comprehensive medical examinations and consultations about health and wellness. Anecdotally, many adolescent boys relate how when going for the sports physical the physician will end the all too brief encounter with

**How do we motivate boys and men to view their health as their responsibility and access appropriate preventive and health care services?... Improving male health literacy is clearly a life-long process that this country has consistently failed to adequately address.**

a demotivating phrase such as “OK, it’s over. Now get out of here and come back when you’re really sick.” All too frequently, males, particularly those ages 18-40, are totally disconnected from primary care until they are very sick. There is a great need to provide men with easy access to physicians and other primary care services through broad-based outreach programs, appropriate payment coverage, and incentives for both the practitioners and the prospective male patients in this age cohort. The goal of this directed outreach is to not only identify and address health issues early on but to bring and keep men regularly involved in their own health long before health problems begin to develop. In essence, improving health literacy is clearly a process that this country has consistently failed to adequately address, especially as it relates to males and men’s health.

### **Redefining the Definition of Masculinity**

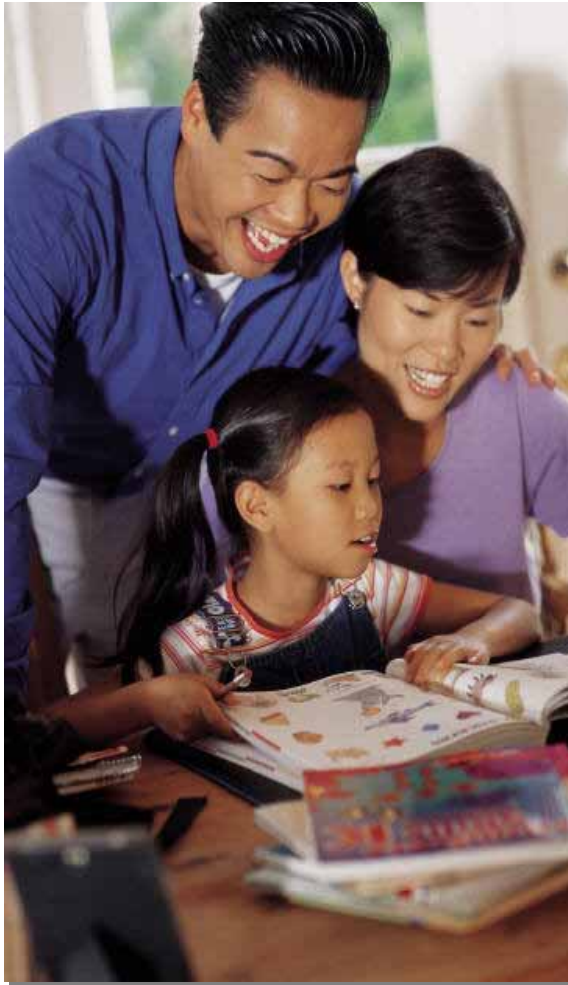
Media and social messages about male body image, gender roles, masculinity, and health issues—other than those related to sexuality—also contribute to the view many men have that health is a “women’s issue.” Many advertisers, for example, incorrectly believe that only women make health purchasing decisions, all too frequently ignoring men and boys. A study presented at the American Public Health Association (Giorgianni, et al. 2012) on print media advertising for health products to males compared to females showed that only 25.1% of advertising impressions in the sample of 7,017 ad pages reviewed were intended for male consumers. Similarly there are few entertainment vehicles, particularly in prime-time broadcast slots, that target health messages for males. These and other messages aggravate what is already a difficult dilemma: How do we motivate boys and men to view their health as their responsibility and access appropriate preventive and health care services?

Socio-culturally, we need a contemporary definition of masculinity that embraces health as a core attribute across the lifespan. Men are acculturated through a myriad of social and commercial formats to feel as if they share their emotions, feelings, or stressors with anyone, then they aren't

The male is conditioned to achieve and compete; they play with head injuries, broken bones, sprains and strains, and may become angry if removed from participation. Supporting and encouraging this behavior may translate into ignoring pain or symptoms that may be important warning signs of chronic disease later in life.



really a man. They must “suck it up” and “tough it out.” To show pain is un-manly. To feel pain is un-manly. To seek help is un-manly. From the time boys first participate in athletics, they tend to be socialized to play no matter what. The male is conditioned to achieve and compete; they play with head injuries, broken bones, sprains and strains, and may become angry if removed from participation. Supporting and encouraging this behavior may translate into ignoring pain or symptoms that may be important warning signs of chronic disease later in life.



There is growing recognition of the important role health plays in fatherhood and that fathers play in their children's health.

With rare exception there are few courses or curricular components to our formal education of boys that reinforce health as part of masculinity. Besides school physicals, there is relatively little that requires apparently healthy boys to engage the healthcare system. Consequently, on graduation from high school or college, there are few incentives for young men to seek health care whether it be for physical, emotional, or psychological issues. To change this anti-health messaging and adapt men's behaviors to the 21st century, the physical and emotional well being of men and boys should be encouraged through positive messaging, role modeling and embracing a concerted effort for change. By portraying women in careers that are generally male dominated the media has sent a very positive message that girls and women can do anything they want. We can, and must do the same for boys, particularly when it comes to portraying men's and boys' health engagement. Programs in schools and organizations where boys learn how to become good men, such as in the Boys & Girls Clubs of America and the Boy Scouts of America, are uniquely positioned to help them learn how to deal with relationships, stressors, and how to safely live one's life so as to promote quality and longevity.

## The Importance of Parenting

There is growing recognition of the important role health plays in fatherhood and that fathers play in their children's health. Programs supported by federal and state agencies to enhance the health and wellness of mothers and children fill an important role and are now numerous. Over the past few years a few of these programs, for example, the Fathers Connection, based in D.C., and The Fatherhood Connection, in upstate New York, have developed tandem programs directed at fathers. Such stand-out programs provide educational outreach to men in areas that include understanding the process of pregnancy, pre- and post-partum maternal support, basic neonatal child care skills, the important and unique contributions fathers make to their children's development, and fatherhood role modeling.

New research has illuminated the need to better understand how maternal prenatal stress (which fathers can often reduce by providing more support to the mother) affects subsequent birth and child health outcomes. Likewise, more research on the important role fathers play in mitigating the effects of maternal allostatic load, that is the physiological consequences of chronic exposure to fluctuating or heightened neural or neuroendocrine response from repeated or chronic stress during pregnancy, is needed. Now this research must be directed into developing and implementing programs to help bring fathers more integrally into the prenatal and immediate postnatal health equation.

A few programs, like the Fathers Connection, also are beginning to incorporate health and wellness for prospective fathers that provide education on health matters that impact fertility and fetal-health. A focus on increasing support to potential, expectant, and new fathers will pay important health and social dividends just as programs for potential mothers and new mothers have over the decades.

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## Best Practices and Models of Progress

While there is a great need to advance the health of boys and men, there is some cause for optimism in the opportunities for and ability of policy makers, health advocates and providers to make progress. Among several federal initiatives are those at the Indian Health Service focusing on Native American male health, comprehensive care for veterans provided by the Department of Veterans Affairs, public outreach and educational materials, such as the televised Men's Preventive Health public service campaign by the Agency for Health Research and Quality and the Ad Council, and strong policy, programmatic and outreach initiatives by the Office of Minority Health at HHS to address the dire needs of minority and socioeconomically disadvantaged boys and men.

Additionally, some of the Offices on Women's Health provide a men's health section within their information area and the NIH Office of Research on Women's Health has engaged in men's health-oriented outreach initiatives over the years. Initiatives such as these provide noteworthy outreach initiatives that acknowledge the interdependence of the gender and population based health initiatives on the overall health of the country.

Early progress at the state level should also be noted. A survey of state department of health resources for men and boys conducted in 2010 showed a modest increase of 6.5% above the base year (2008) in web-based informational services directed and created with boys and men in mind. So-called State "Report-Cards" on Men's Health show areas of decreased morbidity and mortality in some markers, in particular prostate cancer rates and deaths and prevalence of smoking.

A number of successful male-centric pediatric and adult health practices, both in private clinics and government facilities, have also begun to take shape and prosper. While relative to overall population-based facilities, those for men and boys are fewer in number and smaller in scope, they provide a model framework for future practices. Outreach programs to help others



*"Overall, men have a life expectancy that is 6 years less than that of women and have higher death rates for each of the 10 leading causes of death."*

- Healthy People 2010

mirror these early successes are very much needed. A more descriptive review of these successful provider driven programs is beyond the scope of this framework paper, but will be discussed in detail in future papers in the Dialogue series.

### **Health Policy Interests**

The *Healthy People 2010* and *Healthy People 2020* documents are important roadmaps for all health care stakeholders and policy makers, as they provide a national framework for addressing health care issues as well as shedding light on the social determinants of health. The interrelated nature of health status and care is no more prevalent than when examining the interdependence of the health of women and men in our society.

As an example, it makes little sense from a clinical, public health or policy perspective to engage in vigorous well-funded programs to address and treat contagious diseases in one gender, particularly those that are sexually transmitted, and not to equally vigorously conduct programs for the other. The sociologic, economic, interpersonal and health-system implications of doing all that can be done to provide optimum access, health funding and clinical care for one-half of our citizens while allowing disparities to develop in the other is equally perplexing. Addressing these inequities is one of the principal goals and priorities of HP2010 and HP2020. Health disparities are real and are defined by the public health community. As such disparities are identified for any population base, it is the obligation of health professionals and society to develop a plan and a political will to correct those disparities.

While it must be noted that the health of boys and men is not identified as a specific stand-alone goal in either of the plans, HP2010 and HP2020 do lay out important overarching definitions and goals of importance to men's health and the addressing of gender disparities. HP2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage," including gender, racial or ethnic group, age, etc. Goal 2 of HP2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. The following discussion of this goal highlights ways in which health disparities can occur among various demographic groups in the United States.



## Healthy People 2010 Goal 2 Statement Regarding Gender Disparities

*Whereas some differences in health between men and women are the result of biological differences, others are more complicated and require greater attention and scientific exploration. Some health differences are obviously gender-specific, such as cervical and prostate cancers.*

*Overall, men have a life expectancy that is 6 years less than that of women and have higher death rates for each of the 10 leading causes of death. For example, men are two times more likely than women to die from unintentional injuries and four times more likely than women to die from firearm-related injuries. Although overall death rates for women currently may be lower than for men, women have shown increased death rates over the past decade in areas where men have experienced improvements, such as lung cancer. Women also are at greater risk for Alzheimer's disease than men are and twice as likely as men to be affected by major depression.*



Together, HP2010 and HP2020 clearly provide a national charge for policy makers to identify and correct those elements of health care policy and practice that, even unintentionally, may lead to the overall disparity in the health status of boys and men in America.

### International Initiatives on Men's Health

The growing health policy interest in the health of boys and men is by no means unique to the U.S. Some experts and men's health advocates have noted that initiatives in some other countries are ahead of those currently underway in the U.S. For example, national government level formal reports and work plans regarding the health of boys and men have been issued by health agencies in Ireland (2008), the European

Union (2011) and Australia (2010); no such national government driven review and policy agenda has, as of this discussion, been initiated in the U.S. Several countries have established national government level agencies to provide policy direction and support for health initiatives for boys and men. In the U.S., the beginnings of important initiatives are underway within some federal health agencies and offices and in a few states as of this writing, which is encouraging. Notable among these are the focus on men's health in the Department of Health and Human Services, Office

of Minority Health and the authorized, but yet to be established, Office of Indian Men's Health within the Indian Health Service. However, currently there is no overarching focus for the development of a national health strategy for America's boys and men.

**Some experts and men's health advocates have noted that international initiatives are ahead of those currently underway in the U.S. For example, national government level formal reports and work plans regarding the health of boys and men have been issued by health agencies in Ireland (2008), the EU (2011) and Australia (2010); no such national government driven review and policy agenda has as of this discussion been initiated in the U.S.**

In the private sector, there are a few established organizations and associations, such as the Men's Health Network, that have a focus on men, boys and fatherhood and several voluntary health and health professions associations, such as the American Osteopathic Association and the National Foundation for Continence, are beginning to establish programs and coordinating committees to identify ways of better addressing gender focused health needs. Veterans groups, such as The Veterans Health Council, have also stepped up in advocating for military men and women and their families.

### **Developing a National Framework**

The U.S. Congress has also recognized the special needs of boys and men. The Congressional Men's Health Caucus, which was created in 2007, has actively engaged in several briefings on important issues facing the American male and discussed legislative issues regarding boys and men's health and access to needed health and wellness services.

The approval and formation of a Men's Health Caucus as part of the American Public Health Association in 2010 signaled a new era in attention to public health policy, research and

advocacy with men's health as the mission. This seminal event provided a necessary infrastructure for, and recognition of, the special interests and approaches that can be brought to public health initiatives that have boys and men as their primary focus. Developing its national level policy framework was one of the first responsibilities of the caucus. This document, published by the American Public Health Association's Men's Health Caucus in November 2011 (Men's Health Caucus National Policy Agenda 2011-2012, [www.menshealthcaucus.net](http://www.menshealthcaucus.net)), is the first such document by any mainstream professional health organization in the U.S.

This document outlines five broad areas of near term focus. Specifically:

**1. Policy Development**

Strengthen national and state public policies that aim to improve the health of men, boys, and their families.

**2. Research**

Advance men's health-specific research initiatives that disseminate gender, age, and socio-culturally appropriate information through suitable mediums.

**3. Educational Outreach**

Develop greater health education outreach targeting men and their families.

**4. Professional Training**

Ensure the development of a better-trained and more gender competent U.S. public health workforce in the field of men's health.

**5. Access To Health Services**

Promote strategies that ensure greater delivery and access of health services to men, boys, and their families.

At the state, county and municipal levels, despite the constraints of tight health budgets, there have been several programs that address overall men's health issues and fatherhood issues. A systematic and comprehensive assessment of such programs, how successful they are in regards to their accomplishments and how well they are being evaluated in terms health outcomes would be an important first step toward the creation of a centralized master action plan.

There is a great deal of work to be done within each of these domains. As priorities are established by stakeholders and policy makers, there is an urgency in the need for initiating more specific and focused efforts to address the needs of boys and men of color and those below the poverty line. Of course, this work will require a significant change in the narrative regarding gender health policy as well as increasing resources to enhance the health and wellness of males. Men need nurturing relationships with the women, children, partners, and loved ones in their lives to be healthy; in turn these healthy men contribute to the development of healthy families of all types.



Thus a principle goal ... is to develop a national action plan to address the disparities that are increasingly evident in the health of America's boys and men.

## **Call to Action and Work Plan for the Planned Dialogue Series**

The Dialogue on Men's Health Conference in October 2012 brought together a broad array of experts in men's health, health policy, reimbursement and men's health advocacy. Addressing the unintended health disparities that have developed over several decades for boys and men needs to be attended to with some sense of urgency by all stakeholders who must secure the political will of our nation's leadership in order to achieve this goal.

As an important part of the national imperative to advance the health of boys and men, the Men's Health Network and its partners are committed to continuing and broadening the Dialogue series to address issues in men's health by fostering cross-functional dialogue by all stakeholders. Thus a principal goal of the Men's Health Braintrust and the Dialogue on Men's Health series is to develop a national action plan to address the disparities that are increasingly evident in the health of America's boys and men. The October conference offered a unique opportunity for stakeholders to share perspectives and develop the needed framework to more effectively accomplish the critical work ahead as the first in a series of planned conferences. MHN, as the coordinators of this conference and at the epicenter of male health advocacy in this country, is committed to shepherding, obtaining funding for and continuing and broadening this series. Over the course of the next several years, panels of experts in the health and wellbeing of men and boys will come together and discuss needs and approaches as well as resources and best practices in each of the action areas identified in this framework Position Paper.

## **Narrowing the Gender Gap Within Two Generations**

As our nation continues to strive to increase the health status and longevity of all Americans and decrease health disparities we must be cognizant of the gender health gap that has inadvertently evolved over the past several decades and strive to reverse that trend. We believe that a reasonable national goal is to narrow the gender mortality gap between men and women in America by 50% within two generations.

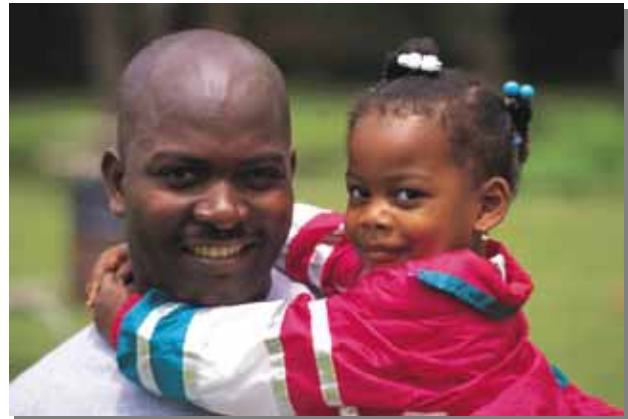
A combination of strategies, including a careful identification of opportunities to improve male health, will be needed to achieve meaningful outcomes. These critically needed efforts can be condensed into two strategic focus areas for improving the health of American boys and men:

1. Increasing quality, access, and utilization of critical primary health care services for prevention and controlling chronic and infectious diseases (thus improving health outcomes), and

2. Targeting recognized social determinants of health (positive and negative) through multifaceted approaches in community settings that address hope, healing, and wellness for males and their families.

Full implementation of Affordable Care Act mandated programs provides a unique opportunity to begin to systematically address health disparities in men and address these shocking human and expensive fiscal consequences of our system of care. The ACA outlines a plethora of strategies for improving the quality and access to health care that could be tailored to males. For example, heart attacks and strokes are the leading causes of premature death for racial and ethnic minorities over 40 years of age and particularly for males. It is also imperative to focus on preventive and life-skills training with a focus on the role men play in the overall preventive health and nutritional needs of their children.

These problems could be reduced by taking actions to develop, implement and evaluate male-targeted interventions. Such interventions could include controlling risk factors and preventing cardiovascular diseases and strokes, ranging from improving the quality of care and developing reimbursement incentives, to the development of new male health-focused policies and health system changes. These initiatives would need to carefully address the complexity of wellness issues particularly in minority males and those with incomes below the poverty line.



But first, there must be a greater awareness of the profound loss that is experienced by not only individuals and families, but society at large, as the lives of men and boys are negatively impacted by such existing health disparities. There is a link between wellness and productivity, health and economic security.



New health care delivery models that effectively address the barriers to the appropriate utilization of health services by males will likely need to include training of a diversity of cost-effective alternative providers. Training community health workers and health educators with an enhanced understanding and knowledge of approaches to reaching males is a strategy for strengthening health and human services infrastructure and workforce. Other complementary strategies created by the ACA to improve access to primary health care services may also be helpful. A careful review and evaluation of ACA coverage requirements to identify opportunities to engage men, particularly men who are not part of

a traditional family unit, should also be undertaken to look for every opportunity to enhance access to care given the circumstances of poverty and familial disenfranchisement.

Better utilization of the media, both traditional and emerging forms of social media that today's younger generations use extensively, as a vehicle to address the negative sociocultural overlays that undermine the health system approaches will be essential. The media must become sensitive to the need for responsible approaches to advertising and promotion as well as entertainment programming, including sports programming, that dispel the harmful view that health is the purview of women and foster the more appropriate view that comprehensive attention to health is a part of true masculinity and men must take co-ownership of health matters for themselves and their families and loved ones.

But first, there must be a greater awareness of the profound loss that is experienced by not only individuals and families, but society at large, as the lives of men and boys are negatively impacted by such existing health disparities. There is a link between wellness and productivity, health and economic security. For men and boys to continue to experience such disparities is unacceptable.

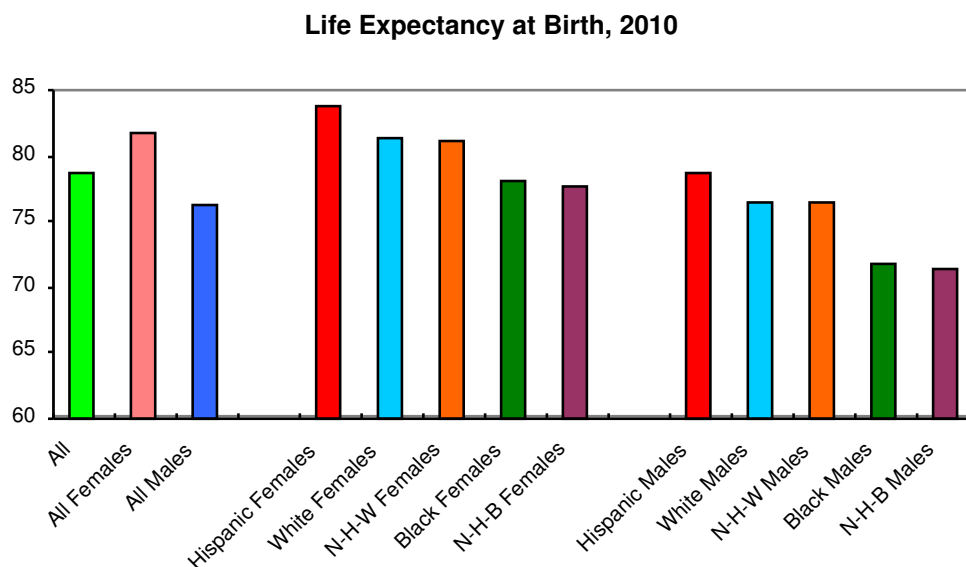
While government programs represent important portals to improving men's health, they are by no means the only vehicles that can or should be activated. Private sector initiatives in health and wellness also have an important role to play in creating programs, supporting infrastructure and encouraging and incentivizing boys and men to take an active role in their own health care and wellness. Insurers, employers, unions and foundations will play key roles in these areas. We can and must do better to engage individuals and all potential stakeholders in an effort to reduce male health disparities.



## APPENDIX I – Table Data

**Figure 1 - Mortality by Sex and Race**

This chart is based on preliminary data released by CDC in January of 2012. The life expectancy at birth for the U.S. total population was 78.7 years in 2010, which represents an increase in life expectancy of 0.1 years when compared to 2009 data. Hispanic females have the highest life expectancy. Black males have the lowest life expectancy even though a record-high life expectancy of 71.8 years was reached in 2010. White males have the next-lowest life expectancy.



**Table 1**

Life Expectancy at Birth				
Life Expectancy at Birth	2010	1970	1950**	1920**
Population	78.7	70.8	68.2	54.1
All females	81.8	74.7	71.1	54.6
All males	76.2	67.1	65.6	53.6
Hispanic females	83.8	***	***	***
White females	81.3	75.6	72.2	55.6
Non-Hispanic white females	81.1	***	***	***
Black females	78.0	68.3	62.9	45.2
Non-Hispanic black females	77.7	***	***	***
Hispanic males	78.8	***	***	***
White males	76.5	68.0	66.5	54.4
Non-Hispanic white males	76.4	***	***	***
Black males	71.8	60.0	59.1	45.5
Non-Hispanic black males	71.4	***	***	***



**Table 2**

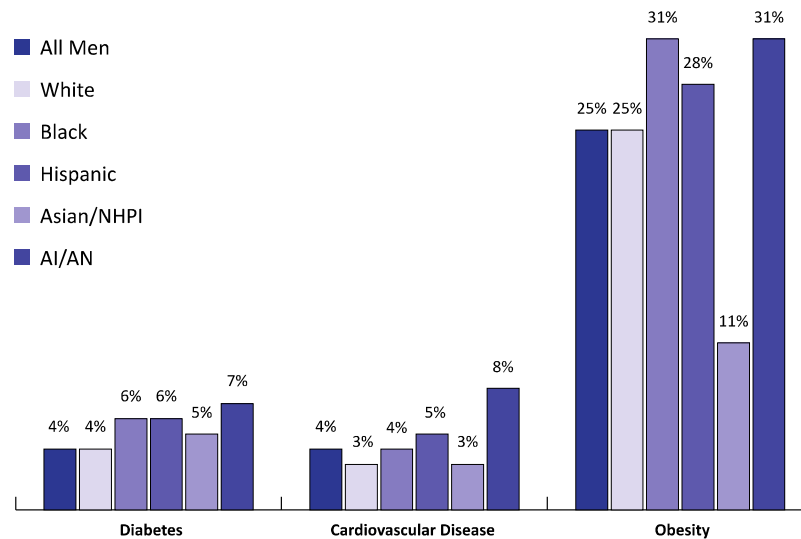
**Top Causes of Death by Race, Sex, and Ethnicity \* – 2008** Age- adjusted death rate per 100,000 populations

Cause	All Persons	Men	Women	Ratio m/w	White	White, not Hispanic or Latino	Black or A-A	American Indian or Alaska Native	Asian or Pacific Islander	Hispanic or Latino
All causes	758.3	900.6	643.4	1.40	750.3	766.2	934.9	610.1	413.7	532.2
Diseases of the Heart Total	186.5	232.3	150.4	1.54	183.9	188.0	238.6	119.8	100.5	126.3
<i>Diseases of the Heart Ischemic heart disease</i>	122.7	161.2	93.0	1.73	122.5	124.8	143.7	79.5	70.9	90.0
Cerebrovascular diseases	40.7	40.9	39.9	1.03	39.1	39.5	57.4	24.5	33.0	30.9
Malignant Neoplasms Total	175.3	213.6	148.5	1.44	174.7	179.4	209.1	119.6	106.5	114.6
Malignant neoplasms Trachea, broncus, and lung	49.5	63.6	39.0	1.63	50.2	52.8	53.4	33.2	25.1	20.5
Malignant neoplasms Colon, rectum, and anus	16.4	19.5	14.0	1.39	16.0	16.3	22.8	13.8	11.3	11.9
Malignant neoplasms Prostate	22.8 <sup>†</sup>	22.8	§	~	21.2	~	49.5	17.6	9.4	17.1
Malignant neoplasms Breast	22.5 <sup>‡</sup>	§	22.5	~	21.9	~	31.2	12.8	11.9	14.6
Chronic lower respiratory disease	44.0	51.4	39.1	1.31	46.4	48.7	30.4	29.3	14.1	18.3
Influenza and pneumonia	16.9	19.9	15.0	1.33	16.7	16.9	18.9	17.2	14.3	14.0
Chronic liver disease and cirrhosis	9.2	12.7	6.0	2.12	9.6	9.1	7.0	25.7	3.4	13.7
Diabetes mellitus	21.8	25.6	18.8	1.36	19.9	19.1	40.5	34.5	16.0	27.7
Alzheimer's	24.4	20.1	26.7	0.75	25.4	26.1	19.7	11.4	8.9	15.0
HIV disease	3.3	4.8	1.9	2.53	1.7	1.4	15.3	2.1	0.6	3.6
Unintentional injuries Total	38.8	53.6	25.1	2.14	40.7	42.6	33.3	53.5	15.4	27.9
Unintentional injuries Motor vehicle-related injuries	12.9	18.8	7.3	2.58	13.3	13.6	12.3	21.1	6.3	11.4
Poisoning	10.2	13.5	6.8	1.99	11.1	12.2	7.8	14.4	1.4	6.0
Suicide	11.6	18.9	4.8	3.94	12.9	14.1	5.3	11.7	5.8	5.6
Homicide	5.9	9.3	2.4	3.88	3.7	2.8	19.5	7.1	2.3	6.6

† Rate for men only.      ‡ Rate for women only.      § Number not reported by the Centers for Disease Control and Prevention. ~ Rates not available

Source: United States Cancer Statistics (USCS) 2008.Cancer Types Grouped by Race and Ethnicity.<<http://apps.nccd.cdc.gov/uscs/cancersbyraceandethnicity.aspx>> Retrieved July17, 2012

Centers for Disease Control and Prevention, National Center for Health Statistics; *Health, United States, 2011.With a Special Feature on Socioeconomic Status and Health*. Table 24, pages 112-115.

**Table 3****Chronic Condition Rates Among Men, by Race and Ethnicity, 2006-2008**

Among men 18 to 64 years.

Source: Kaiser Family Foundation, *Putting Men's Health Care Disparities on the Map, Examining Racial and Ethnic Disparities at the State Level*, 2012

**Table 4****U.S. Male v. Female Mortality**

Ten leading causes of death (per 100,000 population) Age-adjusted 2008

Heart disease	232.3	150.4
Cancer	213.6	148.5
Injuries	53.6	25.1
Cerebrovascular disease	40.9	39.9
Diabetes	25.6	18.8
Pneumonia/flu	19.9	15.0
Alzheimer's	20.1	26.7
HIV	4.8	1.9
Suicide	18.9	4.8
Homicide	9.3	2.4

Source: National Center for Health Statistics (2011).

**Table 5**

Annual Federal Costs Attribute to Excess Health Disparities in Men	
Insuring the uninsured	\$6.5-\$13 billion
Uncollected tax revenues	\$5 billion
Uncollected Social Security and Medicare payroll taxes	\$4.2 billion
Social Security disability payments	\$5.9 billion
Social Security survivors’ benefits	\$65 billion
Supplemental Security Income program for low-income widows	\$6.5 billion
Medicaid/dual eligible expenses for low-income widows	\$47.9 billion
SNAP (Food Stamp) program for low-income widows	\$1.2 billion
Total annual federal cost	\$142.2-\$148.7 billion

Source: Brott, A., Dougherty, A., et. al., The Economic Burden Shouldered by Public and Private Entities as a Consequence of Health Disparities Between Men and Women, American Journal of Men’s Health, 2011

## **APPENDIX II – Co-Sponsoring Organizations**

**Men’s Health Network**

**Men’s Health Caucus (a Constituency Organization of the American Public Health Association)**

**Boy Scouts of America**

**Association of Black Cardiologists**

**Boehringer Ingelheim**

**Veterans Health Council**

**Louisiana State University Health Sciences Center School of Nursing**

**American Osteopathic Association**

**Men’s Health Alliance**

**HealthHIV**

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