Importance of health literacy for men

Men worldwide have been seen to have a lesser life expectancy than that of their women counterparts. In a report by the World Health organisation (1), it was found that the gap between women's and men's life expectancy increased during the 40 years between 1970 and 2010. In a systematic analysis for the Global Burden of Disease Study (2), another statistic was found showing that women's life expectancy has increased from 61. 2 to 73. 3 years, whereas male life expectancy has only risen from 56. 4 to 67. 5 years. It must be noted that there are physiological differences between males and females that may account for the difference in total life span, but the difference in life expectancy increase, correlating with medicinal advancement, must be attributable to other influencing factors such as social, economic or cultural factors. In 2018 the Australian Medical Association (3), AMA, released an eleven-point statement outlining its position regarding this life expectancy difference between the sexes. This statement includes mention of health care services, the general practitioner's role, improving health literacy, addressing male suicide, changes to funding required, and migration among other issues. Analysis of this position and its impact on health and illness will be discussed in this report.

The first issue AMA names requiring urgent addressing is the implementing of a cohesive platform for the improvement of male health service access and men's health outcomes (3). A platform that is flexible and responsive to the complex and unique access needs of men. AMA believes that increasing men's engagement can be achieved through the provision of a health care outreach program, and that this will be beneficial to the male populations'

overall health. A study on men’s health conducted by White and Banks in 2001 (4) found four main reasons central to men and their health: Access to health services, Lack of awareness of their health needs, inability to express their emotions, and lack of social networks. This can be seen to support the need behind an increase in male health services as well as the required increase in engagement. General practitioners and specialists will be unable to provide the required service if the service is not sought out originally. Addressing men’s distrust or distaste of the health system will also encourage the initial contact between men in need and the health care system. This issue integrates itself as the overarching theme throughout the remainder of the AMA statement.

General practitioners (GP) are the first-line defence in health, and act as preventative healthcare, addressing problems that may lead to serious or life-threatening conditions in the future, overall reducing mortality. A study lead by Jeffries and Grogan (5) looking at the male populations reluctance to self-refer to a doctor found there to be a mentality disfavouring visiting a primary care doctor. The conclusion they drew found that the men participating in the study had accepted a masculine discourse, a view which causes men to be reluctant to attend for healthcare since they are required to be being strong and in control, and that seeking healthcare opposes this condition. Jeffries and Grogan also found that these men were comparing their healthcare practice as needed to be in opposition to the way women use it, that women are the ‘ weaker’ sex and more acceptable for the female population to use required healthcare. This leads to the discussion that the view of one’s health needs adjustment, that a visit to a GP does not reduce

the patient's autonomy or self-reliance. By encouraging the development of meaningful, ongoing relationships with a regular GP, the overall health of the patient can only improve. The World Health Organisation (6) suggest that medical guidelines need to account for gender, having doctors incorporating attention to gender in their daily clinical practice, not basing treatment decisions on ideas of how men should feel and behave, supporting men's health and addressing specific men's health needs.

Improving health literacy among boys and adolescents will help in the removal of barriers to help-seeking Australian men. In a study by Rhoads, Mehta and Shrier (7), the alarming statistic that young adult men are an underserved population in health care is discussed, a trend seen even when there is easily accessible health care. Several factors come into play when considering why health care is not sought by young men and adolescents, the most import of which is the non-realisation of health care importance. If this mindset were to be adjusted, through proper education of health care and preventative check-up importance, a change in this trend will be seen, with young men and adolescents fully understanding the importance of regular GP visits (5). This may also address the soaring male suicide figures in Australia, that, alongside with the requirement for specific and targeted measures to reduce the rates of suicide. Male suicide is a major social issue for men, with Australian Men's Health Forum (8) stating that 3 out of 4 suicides in Australia are male. This is a serious issue and one that can be addressed through the breakdown of social stigma surrounding the issue of mental health and the issue of bodily health. Kutcher and Wei (9) state that by caring for the body as a whole and initiating a change in the mindset of a

man being ‘ weak’ or ‘ lesser’ when seeking health care help, we can only increase the wellbeing of the male population. These factors point to targeted mental health initiatives being required to increase engagement between mental health services and Australian men.

Seale and Charteris-Black (10) concluded in a study that men’s performance of conventional masculinity is often threatened by the experience of illness. This has led to disparity in analyses of illness, disease, and social determinants of health, as well as there being a difference in aims of initiatives. Hawkes and Buse (11) go on to show that gender disparities are not properly addressed in the health policies and programmes of the major global health institutions. The problems manifest as policymakers tending to assume that health improvements are to be primarily aimed at women rather then both sexes. It is also seen through the agreeance with negative stereotypes by many health-care providers (12), for instance assuming men are largely disinterested in their health, which can in turn discourage men from engaging with health services. Barker et al (13) describes men’s health as needing to be viewed as entailing complex subjects whose behaviours are influenced by gender and sexual norms. Any serious effort to improve public health must include attention to the health needs of both sexes and responsiveness to the differences between them. Men and women should be given equal opportunity to realise their full potential for a healthy life.

Social, cultural, and physiological determinants of health must always be considered from both a gender and lifespan perspective. Men are generally seen enjoy more opportunities, privileges and power than women, yet these multiple advantages do not translate into better health outcomes (1). The

determinants in play regarding this issue includes the factors discussed above; such as the health paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill and, when they see a doctor, are less likely to report on the symptoms of disease or illness (9). UCL Institute of Health Equity (14) describes other determinants of men's health to consider such as the greater levels of occupational exposure to physical and chemical hazards, and behaviours associated with male norms of risk-taking and adventure. These determinants are what is largely agreed on to be a significant factor contributing to the gender health disparity.

These determinants so far are inclusive for the man who does not seek health care advice or help. It must be considered if there is also a gender disparity arising amongst the population of men who do attend regular general practitioner visits and makes use of available health care when compared to the opposite sex (1). To ensure this is not an issue, AMA also suggested increasing funding for early detection and treatment of illnesses that predominantly impact on men, particularly male-specific cancers such as testicular and prostate (3). Lastly, targeted health care must also be seen to include the expanding cohort of migrant men in Australia, whose differing needs and expectations must be included in the health promotion initiatives.

After this comprehensive walkthrough of AMA's eleven-point statement outlining its position regarding the life expectancy difference between the sexes, alongside the discussion of the reasoning behind these statements, we must consider what the priority action areas are and how to effectively address these issues. The Commonwealth Department of Health released a draft statement in 2018 (15), in which they outline a national men's health

strategy for Australian men throughout 2020-2030. The strategies include improving awareness of healthy lifestyles, risks to men's health and wellbeing and the impact of health. They also describe promoting healthy choices and behaviours as well as de-stigmatising mental ill-health and help-seeking initiatives. Improving access to male-focused health services and focused efforts on closing the health burden gender gap. These factors are to be achieved alongside particular focus on the population groups of males with poorer health outcomes who require targeted interventions

The ways in which these health goals can be achieved are through providing services that are male-centred, being transparent and accountable, building on what is already in place, ensuring that equity drives investment and action, and focusing on prevention (15). Through consciously considering the needs and preferences of men in the design and delivery of programs and services, there will be a more likely chance of compliance from men who may have previously felt alienated or stereotypically non-masculine when it came to seek mental or physical healthcare (5). Equity in the provision of action will ensure programs aimed at the health requirements of the male population will be met, as well as the gendered bias potentially seen in diagnosis by general practitioners will be avoided (6). This will also ensure an all-inclusive approach is used, targeting both the majority and the marginalised male populations, including the Indigenous and Torres-Strait Islander people groups who require targeted and direct healthcare action (16). Focussing on prevention, these action areas will ensure chronic disease is minimised and the overall health of the male population will increase. An important part of this preventative health is the relationship built with

general practitioners and will enable the addressing of problems that may lead to serious or life-threatening conditions in the future, reducing the overall mortality.

In conclusion, there is a need for targeted investment across multiple areas in men's health to enable real progress to be made towards healthier lives for men in Australia. The gender gap seen between men's and women's life expectancies has no single determining factor. Physiological, anatomical, cultural and social determinants all play a crucial role in this complex issue of men's health. This complex issue requires both broad and targeted strategies, with focus to create male-centred and autonomous health care, enabling the most beneficial use of provided health care as well as improvement to the existing models.

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