2016 Survey of State-Level Health Resources for Men and Boys: Identification of an Inadvertent and Remediable Service and Health Disparity

Ana Fadich, MPH, CHES¹, Ramon P. Llamas, MPH, CHES¹, Salvatore Giorgianni, PharmD², Colin Stephenson¹, and Chimezie Nwaiwu, MPH¹

Abstract
This survey evaluated resources available to men and boys at the state level including state public health departments (SPHDs), other state agencies, and governor’s offices. Most of the resources and programs are found in the SPHDs and these administer state-initiated and federally funded health programs to provide services and protection to a broad range of populations; however, many men’s health advocates believe that SPHDs have failed to create equivalent services for men and boys, inadvertently creating a health disparity. Men’s Health Network conducts a survey of state resources, including those found in SPHDs, every 2 years to identify resources available for men and women, determine the extent of any disparity, and establish a relationship with SPHD officials. Data were obtained from all 50 states and Washington, D.C. An analysis of the 2016 survey data indicates that there are few resources allocated and a lack of readily available information on health and preventive care created specifically for men and boys. The data observed that most health information intended for men and boys was scarce among states or oftentimes included on websites that primarily focused on women’s health. A potential result of this is a loss of engagement with appropriate health-care providers due to a lack of information. This study continues to validate the disparity between health outcomes for women and men. It continues to highlight the need for better resource allocation, outreach, and health programs specifically tailored to men and boys in order to improve overall community well-being.

Keywords
public health, health inequality/disparity, health communication, health policy issues, population based

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A survey of resources available to males, females, mothers, and fathers on the state level was conducted by Men’s Health Network (MHN) in 2016. Most health and parenting resources available to the public are found under the states’ public health department; however, MHN’s environmental scan included state governor’s offices and other state agencies to locate all available resources (Williams et al., 2010). The scan collected information on Commissions for men and women, gender specific health websites, and programs for fathers and mothers.

Public health plays an important role to the health-care system with one of its specific focuses on improving population health outcomes. While health-care providers can heal injuries, alleviate disorders, and treat many diseases on the individual level, public health practitioners focus on preventing the onset and spread of disease, increasing public awareness of health risk and health information and minimizing factors leading to disease for populations. The public health system is organized into three broad levels of government: federal, state, and local. While the division of responsibilities and authority vary by state, each level of the system has standard roles

¹Men’s Health Network, Washington, DC, USA
²American Public Health Association, Men’s Health Caucus, Nashville, TN, USA

Corresponding Author:
Colin Stephenson, Men’s Health Network, P.O. Box 75972, Washington, DC 20013, USA.
Email: research@menshealthnetwork.net

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Health Responsibilities.

The 51-state public health agencies (including the District of Columbia), also known as state public health departments, are responsible for an estimated 2,794 local health departments that serve counties or cities across the nation. Approximately 5% of local health departments serve populations of 500,000 or more. This represents approximately 46% of the U.S. population (Salinsky, 2010) and shows the magnitude of the reach of these key agencies. Table 1 illustrates state health agency responsibilities to ensure public health and well-being. State health agencies also monitor the adequacy of health-care resources, identify underserved areas and populations, and improve access to aforementioned programs.

With public health’s expanding role in health promotion and chronic disease prevention, the governmental infrastructure is charged with playing a leadership role in developing research, outreach and systemic interventions. As such, government agencies serve as a broker for social health focused change by facilitating partnerships with private and nonprofit sectors as well as with academia. Future returns on federal investments in community-based prevention may depend on how successful state and local health departments are in cultivating these interorganizational relationships. While the public health community celebrates and continues its progress toward improving population health, it must also remain diligent to ensure that other definable and differentiable populations are not inadvertently excluded from similar efforts.

Table 1. Typical (or General) State Department of Public Health Responsibilities.

- Disease surveillance, epidemiology, and data collection
- Laboratory services
- Preparedness and response to public health emergencies
- Population-based primary prevention (health promotion and disease prevention)
- Health-care services (mental health, treatment of communicable diseases, and individuals with disabilities)
- Regulation of health-care providers (licensing and inspections)
- Regulation of food processing facilities, waste removal, jails, and prisons
- Environmental health threats
- Administration of federal public health programs

Over the past several decades, state public health agency outreach, services, and resources allocated to enhancing the health of men and boys have inadvertently become underfunded and under-staffed and are inadequately represented in evolving public policy discourse and strategic development for these departments. While more work and funding in all of these important population areas is needed, some policy makers and health-care advocates have expressed concern that those services that are intended to achieve similar goals for men and boys have inadvertently declined.

In recent years, policy makers and researchers have paid more attention to the rapidly growing field of health-disparities research that focuses on gender, race, and ethnicity. It is still the case that men have higher morbidity and mortality then women, thus fulfilling the essential definition requirements of a population with health disparities. Premature death and mortality in men is costly in terms of lost productivity, lives lost, and financial costs for the federal, state, and local governments (Brott et al., 2011). Nevertheless, men are still noticeably absent from these discussions, despite being significantly harmed by disparities in preventive care, quality of life, and overall health outcomes. One prominent example is found in the Affordable Care Act, which provides for an annual Well Woman visit that includes counseling and advice on smoking, eating, and drinking habits, basic physical exams like blood pressure, body mass index, breast and pelvic exams, sexually transmitted diseases, diabetes, and screening for depression. There is no “Well Man” visit, denying them much needed annual wellness visits while providing a disincentive for men to purchase health insurance (ODPHP, 2017).

Ignoring these disparities is costly, not only from health-care services, but also from lost productivity (Brott et al., 2011). Brott et al. estimated that premature death and morbidity in men costs federal, state, and local governments in excess of $142 billion annually. Additionally, it costs employers roughly $340 billion annually in direct medical payments, lost productivity, and decreased quality of life (Brott et al., 2011). As federal and state governments and the private sector struggle with increasing health entitlement burdens—including escalating health-care costs—eliminating male health inequities emerges as an important source of savings.

There has been legitimate concern expressed that these declines may have inadvertently led to an unintended, but remediable, service and health disparity in these populations. The value of reinstating outreach, health-care services, and resources to improving the health of men and boys exists. The main challenge is to demonstrate the value of targeted resource allocation to men and boys to key stakeholders who make decisions on annual budget
appropriations. The results of this survey are intended to inform those stakeholders.

Men’s Health Network is a national nonprofit organization whose mission, since its founding in 1992, is to reach men and their families where they live, work, play, and pray with health prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation. MHN’s core goals are outlined in Table 2.

In 2008, MHN embarked on a benchmarking survey of state agencies to validate the concerns voiced about this potential health disparity. It has been administered every 2 years since. Table 3 outlines the goals of this survey.

Survey Structure and Methodology

Population Definition

For the purposes of this survey, the demographic of “men” was broadly identified to include all ages, racial, and socioeconomic subcategories of the gender.

Background Research

Prior to Men’s Health Network’s biennial survey, there had never been a comprehensive and systematic survey of the available health resources dedicated to men. MHN dedicates a portion of its own resources to fund regular studies in this area. The survey of health resources provided by state health departments is but one part of the overall analysis. MHN also conducts a comprehensive analysis of state government web sites to identify health and parenting programs.

| Table 2. Goals of the Men’s Health Network. |
|---------------------------------------------|
| • Save men’s lives by reducing premature mortality of men and boys |
| • Foster health-care education and services that encourage men of all ages to implement positive lifestyles for themselves and their families |
| • Increase the physical and mental health of men so that they can live fuller and happier lives |
| • Significantly reduce the cycles of violence and addiction that afflict so many men |
| • Energize government involvement in men’s health activities so that existing government health networks can be utilized to increase the health and well-being of men and boys |
| • Encourage women to expand on their traditional role as the family’s health-care leader and activist for enhancement of health-care services |

| Table 3. Survey Goals. |
|------------------------|
| • Develop and appropriate, validated and replicable methodology to survey state agencies about programs for men and boys |
| • Determine the range and nature of state initiated funded and promoted public health programs for men and boys |
| • Analyze the results to determine if an unintended health disparity has developed; |
| • Identify where program lapses occur |
| • Serve as useful data for the Healthy People 2030 strategic plans and work and |
| • Provide policy makers, MHN, and other stakeholders in fostering better health for men and boys with an evidence-based blueprint to help identify strategies to remediate any identified lapses that may contribute to the disparity |

Note. MHN = Men’s Health Network.

Survey Procedure

MHN staff, in conjunction and collaboration with select members of its Board of Scientific Advisors, created a survey instrument and survey methodology that would provide needed information to achieve the purposes of this study. The survey instrument was designed to identify key demographic information regarding appropriate contacts within state public health agencies, types of programs, educational and outreach specific to men and boys that are offered, and how any such information is made available to and promoted to the public.

The survey instrument along with a cover letter from MHN, shown in Figure 1, was mailed to the appropriate contacts. Information contained in the survey mail-out included: the survey instrument; instructions for return of the survey instrument; basic background information about Men’s Health Network; and disclosures (including notice that the results of would be submitted for peer-reviewed publication). Surveys were mailed out during the first week of February 2016. Replies were requested within a 3-week period of the date of the mail-out. In the first week of April, MHN staff and volunteers sent a second mail request to those departments that did not respond to the initial mail-out. For those that did not respond to either the first or second request, a phone call was made to the director of the health department to complete the survey. The phone contact served to determine whether the contact person identified by MHN staff was the correct one to supply the data. If not, a referral to the correct person was obtained. This specific process yielded responses from all 50 states and the District of Columbia. The survey procedure is outlined in Figure 2.

After the surveys were returned from the state public health departments, MHN personnel performed a comprehensive analysis of state government websites to identify other gender-specific resources. Websites from each
The state’s health department, governor’s office, and other related offices were searched to identify programs and commissions dedicated to men, boys, women, girls, fathers, and mothers. These data were compiled with the results of the mailed survey.

Survey Yield Information Validation

Recognizing the limitations of self-reporting, MHN made every attempt to validate the accuracy of key publicly accessible data provided by the interview subjects. After the close of the official survey period, responses to key
questions regarding publicly available services, initiatives, and resource materials were checked using the specified state website or information resource site.

Survey responses sometimes did not correspond with information reported on the websites. This was found to be the result of the compartmentalization of government agencies, or lack of inclusive information on state agency websites.

**Results**

As reported in Figure 3, 47 (92%) state public health agencies have a website that contains information specifically related to women’s health, compared to 18 (35%) that have a website with information specifically covering men’s health.

Of all state public health agencies and the District of Columbia, 36 (71%) indicated that they have established an office or coordinator for women’s health, while 14 (27%) states reported having an office or coordinator for men’s health (see Figure 4).

Thirty-five (69%) states have established and continue to have a commission to study and make recommendations regarding the health or general status of women. Only four states (8%)—California, the District of Columbia, Georgia and Maryland—have a comparable entity for men (see Figure 5).

All states, including the District of Columbia, have appointed liaisons to the federal Office of Women’s Health within the U.S. Department of Health and Human Services. At this time, there is no federal Office of Men’s Health. An Office of Indian Men’s Health was authorized by Congress in 2010 but has yet to be established (Byron, 2009). Table 4 summarizes the total number of gender-specific resources available in the United States, including the District of Columbia.

**Discussion**

One of the principle reasons for conducting this survey is to address the ongoing concerns posed by men’s health advocates about the continued lack of
male-gender-specific, male-gender-appropriate, and readily available information on health and preventive care created specifically for men and boys. The results of MHN’s survey confirm, as it has since 2006, that there is a significant disparity in terms of resources and information for men and boys, compared to those available for women and girls. The fact that only 18 of 51 state public health agencies (35%) have any information designed for men and boys underscores the magnitude of the concerns. While no formal analysis of the gender-appropriateness of the content of the materials intended for men and boys provided by these 18 states was undertaken, MHN observed that most of the health information intended for men and boys was included under a women’s health website. As a result, the target audience (men and boys) seeking health information or resources may be discouraged from engaging with appropriate health-care providers on their specific concerns because pertinent information is difficult to reach. MHN’s survey focused primarily on the state level of the public health system and identified the inequality between men and women’s health resources. Studies, such as this one, at the local level are necessary to assess the resources that are available for men and women.

Public Health policymakers continue to provide guidance and leadership on developing a broad agenda designed to address our nation’s health concerns. One important tool for this work is the HHS’s Healthy People initiatives, which have provided essential snapshots and blueprints for the nation. Validated information, contained in these survey results, is essential in helping policy makers and stakeholders develop meaningful recommendations to support the diverse needs of our populations, including the unique needs of men and boys. Results of MHN’s comprehensive survey highlight the need for concrete plans and policies to address these unmet needs and underserved populations. There are many ways to address the gender gap within state public health agencies relating to education, outreach, services, and access to care. It is imperative to perform a comprehensive environmental scan of current women’s and men’s health tools, resources, and infrastructure at the state and local level to ensure that these gender-based health disparities do not continue to be systematically perpetuated.

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