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The Real Face of Men's Health Report USA

TECHNICAL METHODOLOGY NOTES

SECTION 1: HEALTHY MEN, HEALTHY WORLD SURVEY (CAREGIVERS OF MEN)

1. **Objectives**

This study sought to explore the lived experiences of informal caregivers who provide unpaid care or health-related support to men with physical or mental health conditions. Examine time investment, emotional and practical burdens, barriers to effective care, the impact of gendered expectations, mental health and wellbeing outcomes for caregivers, and the supports that enable sustainable caregiving.

2. **Research Methodology**

- **Data Collection Period**: May–June 2025
- **Method:** 15-minute online survey administered via Dynata.
- **Sample:** 2,109 U.S. adults (ages 18–59) who reported providing unpaid emotional, logistical, domestic, or health-related support to at least one man in their personal life with a diagnosed or treated health condition in the past 12 months. Respondents answered about the man to whom they provide the most care. National coverage with designed diversity across age, gender, race/ethnicity, and U.S. region; household income, sexual orientation, and relationship type captured at screening.
- **Questionnaire**: ~60 questions covering caregiving activities, relationship to care recipient, mental health impact, barriers/enablers, and demographics. Analysis: Standard statistical methods; subgroup comparisons evaluated at the 95% confidence level.
- **Notes on representativeness (selected distributions):**
    - Age (caregivers): 18–24: 146; 25–34: 515; 35–44: 641; 45–54: 502; 55–59: 305. • Gender: Women: 1,290; Men: 818; Other gender identities: 1.
    - Race/Ethnicity: American Indian or Alaska Native: 154; Asian: 172; Black/African American: 338; Hispanic/Latino: 375; Middle Eastern/North African: 11; Native Hawaiian/Pacific Islander: 8; White: 1,332.
    - Region: Northeast: 365; Midwest: 385; South: 896; West: 463.
    - Household income: Full range captured from less than $10k to $200k+, with representation across all brackets.

Inclusion (screening) criteria: Adults aged 18–59 providing unpaid support to at least one man with a diagnosed/treated health condition in the prior 12 months. Excluded: formal/professional caregivers without a personal relationship and those only supporting boys under 18.

3. **Accuracy**

- **Sample population:** U.S. adults (18–59) providing unpaid care to men with health conditions.
- **Error margin:** Approximately ±2.1 percentage points at 95% confidence for the full sample (higher for subgroups).

Limitations: Not a census; results may contain sampling error and potential non-response or measurement error. Subgroup findings are indicative and should be interpreted in light of base sizes.

4. **Survey Sections**

Section	Purpose	Number of Questions
Screener & Introduction	Establish eligibility, relationship to care recipient,	8

	condition type, and demographics	
Caregiving Role & Time	Hours, duration, type of support, setting, and motivation	10
Impact on Life Domains	Effects on work, finances, relationships, time, and personal wellbeing	8
Healthcare Navigation & Barriers	Ease of accessing services, inclusion in care, systemic pain points	6
Mental Health & Emotional Burden	Caregiver mental health, emotional labour, informal/formal supports	8
Positives & Enablers	Benefits, fulfilment, strengthened relationships, community/social support	6
Final Reflections & System Improvements	Open feedback on healthcare and caregiver support	4
Demographics	Detailed profiling (age, gender, race/ethnicity, income, education, politics, family)	10

Total Questions: ~60

SECTION 2: MEN'S EXPERIENCES OF CARE AND CONNECTION SURVEY

1. Objectives

This survey aimed to identify factors influencing men's engagement and satisfaction with healthcare providers (e.g., family physicians, specialists, allied health, mental health, social work) across the stages of reach, respond, and retain; assess men's perceptions of gender stereotypes, social connectedness, and their effects on health behaviours, attitudes, and care experiences.

2. Research Methodology

- **Data Collection Period:** May–June 2025
- **Method:** 15-minute online survey administered via Dynata.
- **Sample:** 4,126 U.S. men (ages 18–69) who reported at least one interaction with a healthcare provider in the past 12 months (per screener). National coverage with designed diversity across age, race/ethnicity, and U.S. region; income and sexual orientation collected and quota-managed where applicable.
- **Questionnaire:** ~50 questions, including screening, designed to gather essential data while maintaining engagement and data minimization.
- **Analysis**: Standard statistical methods; subgroup comparisons evaluated at the 95% confidence level.

Notes on representativeness (selected distributions):

- **Age (18–69):** 18–24: 465; 25–34: 865; 35–44: 912; 45–54: 774; 55–64: 627; 65–69: 483.
- **Race/Ethnicity (selected)**: Hispanic/Latino: 807; Black/African American: 638; White non-Hispanic: 1,835; South Asian: 149; East Asian: 268; Southeast Asian: 152; American Indian/Alaska Native: 165; Middle Eastern/North African: 48; Native Hawaiian/Pacific Islander: 57.
- **Region:** Northeast: 728; Midwest: 736; South: 1,571; West: 1,083.
- **Household income:** Less than $10k: 174; $10k–$24,999: 369; $25k–$49,999: 749; $50k–$74,999: 712; $75k–$99,999: 551; $100k–$149,999: 819; $150k–$199,999: 417; $200k or more: 335. *(Totals reflect self-reported annual household income before tax.)*
- **Inclusion (screening) criteria:** Men aged 18–69 with a healthcare interaction in the prior 12 months (including in-person, virtual, emergency, allied health, mental health, dental, pharmacy consultations).

3. **Accuracy**
    - **Sample population:** U.S. men ages 18–69 who engaged with the healthcare system in the past year.
    - **Error margin:** Approximately ±1.5 percentage points at 95% confidence for the full sample (higher for subgroups).
    - **Limitations**: Not a census; results may contain sampling error and potential non-response or measurement error. Subgroup findings are indicative and should be interpreted in light of base sizes.

4. **Survey Sections**

Section	Purpose	Number of Questions
Screener & Introduction	Establish eligibility and demographics (incl. age, race/ethnicity, region, income, sexual orientation)	4
Healthcare Usage & Satisfaction	Capture service types used and overall satisfaction	4
First Encounters & Catalysts	Triggers for seeking care; first-contact setting and experience; time with symptoms; influencers	11
Communication & Relationship	Communication quality, respect, time, follow-up, continuity, switching providers; barriers & enablers	9
Social Connection & Support	Trusted people to discuss health, barriers to connection, and social facilitators of care	5
Awareness & Education	Confidence, sources used, barriers to health education, improving uptake	6
Gender Norms & Perception Gap	Beliefs about masculinity, perceived norms vs. own comfort/behaviour; impact on help-seeking	8
Conclusion & Demographics	Relationship/parent status, education, employment, politics; feedback	9

Total Questions: ~50

SECTION 3: SUMMARY OF PREMATURE MORTALITY DATA ANALYSIS

1. **Data Sources**

The datasets utilized in this analysis derive from the following sources:

- Life expectancy data (https://www.cdc.gov/nchs/data-visualization/mortality-trends/index.htm)
- Underlying Cause of Death, 2018-2023, Single Race Request via the Centers for Disease Control and Prevention WONDER online databases system (https://wonder.cdc.gov/)

2. Data source details

Life expectancy data

- Data reflects estimated life expectancy at birth between 1900 and 2018, the most current data available in the contiguous data series
- A range of data was used to calculate period life expectances
    - This includes relevant censuses and intercensal population estimates.
    - The pool of data collected underwent some variation between 1900 and 1930 but reflects the current best estimates
- Additional data on the underlying data can be found at the CDC site (https://www.cdc.gov/nchs/data-visualization/mortality-trends/index.htm)

Underlying Cause of Death Data

- This data does not include data on non-resident aliens and nationals living abroad.
- Fetal deaths are excluded
- Mortality data from the death certificates are coded by the states and provided to NCHS through the Vital Statistics Cooperative Program or coded by NCHS from copies of the original death certificates provided to NCHS by the State registration offices
- When possible, data was accessed as a single download/file
    - Where the size limitations of the WONDER system did not allow for the downloading of a single file, individual reports for each race were downloaded and aggregated to produce the full dataset
    - Rates: All rates are expressed as the number of deaths per 100,000 population, where 'population' is the population subtotal e.g. males or the specified ethnicity.
- Premature mortality where the term is used is defined as deaths occurring before the age of 75.
- Where age was limited, for example when calculating premature mortality, this was determined via the use of the 'Ten-Year Age Groups' filter in the Underlying Cause of Death, 2018-2023, Single Race Request dataset via the CDC WONDER system.

Location

- The subnational data reported is limited to the 50 United States and the District of Columbia
- This data does not include residents of Puerto Rico, Guam, the Virgin Islands, and other territories of the U.S.
- This is as per the data available via the CDC data

Age standardization

- Age standardization allows for comparison between groups (for example counties or deprivations quintiles) with different age structures, facilitating a more accurate comparison of mortality patterns without the impact of the variation in age structures.
- All mortality rates are adjusted through age standardization. This recalculates the rates to reflect a hypothetical population with a uniform age structure.
    - This hypothetical population was the '2000 U.S. standard population' as per CDC data.
- This process adjusts for demographic differences and ensures that comparisons across locations are not confounded by varying age distributions.
- Age standardization enhances the reliability of interpretations concerning true differences in mortality risks and trends.
- For any full population estimates the age standardized data provided by CDC (vis the WONDER system) was used.
- For less than full population estimates, for example premature mortality, age standardized rates were calculated based on CDC data
    - Output data from the WONDER Underlying Cause of Death data included both the count of deaths and estimated population
        - The estimated population as per CDC was used in the age standardization to maximize compatibility between age standardize rates.
    - This was undertaken using the 'calculate_dsr' function from the package 'PHEindicatormethods' (version 2.1.0) in R.
    - The data was accessed and age standardized using 10-year age brackets
    - The populations were standardized to the 2000 U.S. standard population as per the CDC produced values
    - When age standardizing premature mortality data the population, including the standard population, was restricted to the population under 75.

- Age-standardized rates may not precisely reflect the actual mortality experience within specific populations, but allow for more appropriate trend analysis and geographic comparison.
- For purposes requiring actual counts, such as health service provisioning, non-age-standardized data may be more appropriate.

Ethnicity

- Ethnicity categories were defined as per the 2024 Revised Definitions for Minimum Race/Ethnicity Reporting Categories (https://www.census.gov/newsroom/blogs/random-samplings/2024/04/updates-race-ethnicity-standards.html)
- These categories were:
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Hispanic or Latino
    - Middle Eastern or North African
    - Native Hawaiian or Pacific Islander
    - White
- In addition, the option of 'More than one race' was reported on
    - This is a predefined category in the CDC 'Single Race 6' classification system
    - The use of the 'Single Race' data was used to prevent double counting of individuals
- The WONDER system has separate filters for
    - Hispanic Origin and
    - Race
- Filter settings

- To access ‘Hispanic or Latino’ data (as per the 2024 ethnicity categories) the ‘Hispanic or Latino’ option from the ‘Hispanic Origin’ filter was selected and ‘All Races’ was selected from the ‘Single Race 6’ version of the ‘Race’ filter.
- To access all other categories the ‘Not Hispanic or Latino’ option from the ‘Hispanic Origin’ filter was selected and the ‘Single Race 6’ filter used to access race stratified data.

Sex

- The ‘Sex’ filter was used to separate male and female results
- The options were: female, male

Cause of Death

- Where data was presented by cause of death the ‘ICD-10 113 Cause list’ filter was used from the ‘Select cause of death:’ section
- The data available in this section is hierarchical and overlapping so risks double counting deaths
  - For example ‘Malignant neoplasms (C00-C97)’ mortality well as individual neoplasms mortality (e.g. ‘Malignant neoplasms of stomach (C16)’
- To prevent this the data was restricted to ‘rankable causes’ as per the National Center for Health Statistics (NCHS)
  - These are identifiable by the ‘#’ used as a prefix

SECTION 4: SUMMARY OF HEALTH ECONOMIC MODELLING ON THE COST OF ILL HEALTH

Conducted by Health Lumen, 2024.

1. Overview:

This study assessed the cost of men's ill health across six countries: Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States. The 2019 Global Burden of Disease study by the Institute of Health Metrics and Evaluation was used to identify the top five leading causes of years of life lost (YLL) in these countries (Table 1).[1]

Table 1: Top 5 Leading Causes of Years of Life Lost Per Country

Country of Interest	Leading Cases of YLL
Australia	COPD, CHD, lung cancer, stroke and suicide.
Canada	COPD, CHD, colorectal cancer, lung cancer, and suicide.
Ireland	COPD, CHD, colorectal cancer, lung cancer, and suicide.
New Zealand	COPD, CHD, lung cancer, stroke, and suicide.
United Kingdom	COPD, CHD, colorectal cancer, lung cancer, and suicide.
United States	COPD, CHD, colorectal cancer, lung cancer, and suicide.

Direct healthcare costs and indirect costs for the diseases of interest were also identified through a literature search. Official government sources were considered the most robust and accurate estimate of disease cost. If no official government sources were identified, costs from the published literature or grey literature sources were identified.

2. Health Economics:

National and per-patient costs were included in this analysis. Where national cost estimates were chosen, costs were divided by the estimated patient population from the cited cost year, to obtain per-patient costs. These costs, as well as any per-patient costs identified, were then multiplied by the projected estimate of the male patient population in 2023, to obtain male disease cost estimates. Costs were then converted to the country's local currency, and inflated using the CCEMG-EPPI purchasing power parity (PPP) tool from the cited cost year to 2023, using International Monetary Fund (IMF) 2022 data.[2] [3]

Preventable costs of disease were calculated by multiplying the estimated male cost in 2023 by the proportion of disease caused by mitigatable factors. Suicide and drug use disorder were assumed to be completely preventable. The proportion of avoidable coronary heart disease (CHD) costs was calculated by multiplying the cost of disease by the percentage of cases that are in men aged under 75 and then multiplying by the relevant percentage of disease that is found to be preventable. Male disease cost estimates were also used to estimate the cost per male of the diseases of interest. This was achieved by dividing the male disease cost estimates by the total estimated male population of

the country of interest in 2023, taken from the United Nations, World Population Prospects 2022 data.[4]

[1] Global Burden of Disease Collaborative Network. Global Burden of Disease (GBD) IHME2021 [updated March 7 2023. Available from: https://ghdx.healthdata.org/series/global-burden-disease-gbd
[2] Campbell & Cochrane Economics Methods Group (CCEMG), EPPI Centre. CCEMG - EPPI-Centre Cost Converter 2024 [updated January 2024. Available from: https://eppi.ioe.ac.uk/costconversion/.
[3] International Monetary Fund. World Economic Outlook: Countering the Cost-of-Living Crisis. Washington, DC; 2022 October,
[4] Department of Economic and Social Affairs. World Population Prospects 2022. United Nations. 2022 [Available from: https://population.un.org/wpp/.

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End of Methodology Section