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The Real Face of Men's Health Report Aotearoa New Zealand

TECHNICAL METHODOLOGY NOTES

SECTION 1: MEN'S EXPERIENCES IN PRIMARY CARE SURVEY

1. Objectives:

The primary goal was to identify factors influencing men's engagement and satisfaction with healthcare providers, including general practitioners, allied health practitioners, and social workers. The analysis focused on three stages of engagement: **reach**, **respond**, and **retain**. Additionally, the study examined men's perceptions of gender stereotypes and their impact on health behaviours, attitudes, and healthcare experiences.

2. Research Methodology:

- **Data Collection Period:** January – February 2025
- **Method:** 15-minute online survey via panel provider Dynata (https://www.dynata.com/)
- **Sample:** 1,005 New Zealand men, nationally representative of age, Māori and Pacific Islander status, and rurality
- **Questionnaire:** Approximately 50 questions, including screening, designed to gather essential data while maintaining engagement and data minimisation
- **Analysis:** Standard statistical methods, utilising significance tests at a 95% confidence level to identify trends and subgroup differences

3. Accuracy:

- **Sample Population:** New Zealand men aged 18 and above
- **Error Margin:** ±3% at 95% confidence, indicating the range within which the true population value likely falls
- **Limitations:** Not a census; results may contain sampling error; data is preliminary and subject to revisions

4. Survey Sections:

Section	Purpose	Number of Questions
Screener & Introduction	Establish demographics, recent healthcare engagement, and long-term health conditions	4
Healthcare Usage & Satisfaction	Assess satisfaction and reasons for healthcare visits	4

Section	Purpose	Number of Questions
First Encounters & Catalysts	Explore triggers for seeking care and first encounter experiences	11
Communication & Relationship	Evaluate practitioner communication, relationship quality, and continuity of care	9
Awareness & Education	Measure knowledge of services, screenings, and health information sources	6
Gender Responsiveness & Myth Busting	Assess perceptions of gender-specific needs and stereotypes	7
Conclusion & Demographics	Final thoughts and demographic information	9
Total Questions		**50**

SECTION 2: HEALTHY MEN, HEALTHY WORLD SURVEY (CAREGIVERS OF MEN)

1. OBJECTIVES:

Investigate how men's health issues affect their caregivers and society, aiming to foster awareness and support for program and service improvements. The focus was on understanding caregiver responsibilities and their emotional, physical, and social impacts.

2. Research Methodology:

- **Data Collection Period:** January – February 2025
- **Method:** 15-minute online survey via panel provider Dynata (https://www.dynata.com/)
- **Sample:** 579 informal caregivers, nationally representative by age, Māori and Pacific Islander status, and rurality

- **Gender Split:** 28% male caregivers, 72% female caregivers, with diversity across health conditions and roles
- **Questionnaire:** About 50 questions, with a focus on relevant caregiving experiences and impacts
- **Analysis:** Employing standard statistical tests (95% confidence) to discern trends and subgroup differences

3. Accuracy:

- **Sample Population:** Caregivers aged 18+
- **Error Margin:** ±4% at 95% confidence
- **Limitations:** Not a census; results may contain sampling error; data is preliminary and subject to revisions

4. Inclusion Criteria:

- **Caregiver Definition:** Any individual providing at least 3 hours/week of support to a man over 16 with a diagnosed or ongoing health condition
- **Health Condition Definition:** Experience or recent diagnosis/treatment (within last 12 months) of mental or physical health issues, excluding childhood or neurodevelopmental conditions
- **Key Activities:** Research, transportation, appointment management, emotional, physical, domestic support, communication, and advocacy roles

5. Survey Sections:

Section	Purpose	Number of Questions
Screener & Introduction	Define caregiver roles, eligibility, purpose	13
Caregiver Impact	Assess burden, responsibilities, and resources	9
Mental Health Deep Dive	Evaluate emotional impact and wellbeing	5
Barriers & Pain Points	Identify challenges and support needs	6
Positive Aspects & Enablers	Explore benefits and positive motivators	4
Conclusion & Demographics	Final thoughts and demographics	12

Section	Purpose	Number of Questions
Total Questions		**49**

SECTION 3: SUMMARY OF NEW ZEALAND PREMATURE MORTALITY DATA ANALYSIS

1. Data Sources

The dataset utilised in this analysis derives from the following sources:

- **Premature mortality data:** Obtained via a Ministry of Health custom data extract focusing on deaths occurring before age 75 for the year 2020, categorised by age, gender, and location-based designations. The Mortality Collection (MORT) is a New Zealand Ministry of Health database that records and collates information on all registered deaths and stillbirths in New Zealand.
- **Leading causes of premature mortality:** Obtained via a Ministry of Health custom data extract focusing on the leading causes of deaths occurring before age 75 for the year 2020, categorised by age, gender, and location-based designations.
- **Population data:** Statistics New Zealand. National and subnational period life tables: 2017–2019. 2021 [cited 2025 Jun 30]. Available from: https://www.stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019/. This data provides demographic estimates necessary for rate calculations.

2. Location-Based and Ethnicity Designations

The data is organised across multiple geographical and ethnicity stratifications:

- **Total New Zealand:** National overview from 2011 to 2020. Population count data via Statistics NZ populations web tool (https://tewhatuora.shinyapps.io/populations-web-tool/)
- **Urban and rural status:** Based on Stats NZ definitions of rural and urban locations where 'rural' were defined are urban rural (UR) areas classified as 'Rural settlement' or 'Rural other'. Population count data access via 'Aotearoa Data Explorer'. (https://explore.data.stats.govt.nz/)
- **Socioeconomic status:** Deprivation quintile data are based on the New Zealand Index of Deprivation (NZDep) socioeconomic deprivation indices provided by the University of Otago based on the 2018 census. The indices rely on variables from each census and provide a deprivation score for each Statistical Area 1 and meshblock. Population count data via Statistics NZ populations web tool (https://tewhatuora.shinyapps.io/populations-web-tool/)

- **Health New Zealand | Te Whatu Ora Districts (previously known as District Health Boards):** Population count data access via 'Aotearoa Data Explorer' (https://explore.data.stats.govt.nz/)
- **Ethnicity:** Asian, Māori, Pacific Peoples, 'European and other'. Population count data via Statistics NZ populations web tool (https://tewhatuora.shinyapps.io/populations-web-tool/)
- **Māori:** Māori and non- Māori status. Population count data via Statistics NZ populations web tool (https://tewhatuora.shinyapps.io/populations-web-tool/)

Classifications within tables

- **Sex:** Male and female
- **Age group:** ten-year age brackets (for the purpose of age standardisation)

3. Definitions and Descriptions

- **Data period:** For causes of premature mortality, the most recent data available for New Zealand as of 2020. For premature mortality, data between 2011 – 2020.
- **Data access:** mortality data -This information was compiled upon a custom request and is not publicly available on official Ministry of Health websites, though it has been approved for public release. Population data - accessed via publicly accessible Stats NZ demographic data and estimates, sources above.
- **Premature mortality:** Defined as deaths occurring before the age of 75.
- **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.

  Age standardisation allows for the comparison between groups (regions, deprivations levels, regions) with different age structures, facilitating a more accurate assessment of mortality patterns without the impact of the variation in age structures.

- **Age standardisation:**
  - All mortality rates are adjusted through age standardisation, which recalculates the rates to reflect a hypothetical population with a uniform age structure.
  - This process corrects for demographic differences and ensures that comparisons across locations are not confounded by varying age distributions.
  - Age standardisation enhances the reliability of interpretations concerning true differences in mortality risks and trends.
  - The data was age standardised to the WHO World Standard population profile to match prior Ministry of Health produced data.
  - The age standardisation was undertaken using the 'calculate_dsr' function from the package 'PHEindicatormethods' in R.
- **Limitations and considerations:**

- Age-standardised 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-standardised data may be more appropriate.

SECTION 4: SUMMARY OF NEW ZEALAND HEALTH SURVEY DATA ANALYSIS

Technical Notes on Data Extraction and Source

- **Data Source:** The data was sourced from the New Zealand Health Survey Annual Data Explorer, available at https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer.
- **Data Extraction Method:** Data was downloaded from the 'download-data-sets' tab within the online platform.
- **Datasets Utilised:**
  - The **'Subgroup comparison'** sheet was used to analyse and compare data across different demographic and population subgroups, between males and females and within male subgroups such as:
    - Age brackets
    - Ethnicity (Asian, Māori, Pacific Islander, European/Other)
    - Socioeconomic status (NZDep)
    - Disability status
  - The **'Changes over time'** sheet was utilised to examine trends and variations within groups over the 10-year period from 2014 to 2023.

SECTION 5: 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]

[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

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]

Costs used in this study were estimated through various cost approaches across the published literature, and as such, costs between diseases are likely to be incomparable

End of Methodology Section

[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/.