A report on the health and well-being of men and boys in Rhode Island.

Recognizing and preventing men's health problems is not just a man's issue. Because of its impact on wives, mothers, daughters, and sisters, men's health is truly a family issue.

Representative Bill Richardson (NM)
Congressional Record, May 24, 1994
Passage of National Men’s Health Week

Men’s Health Network
www.menshealthnetwork.org
The State of Men’s Health™
Rhode Island

National Men’s Health Week provides an opportunity to call attention to the importance of a healthy lifestyle and the benefits of seeking early detection and treatment of diseases. Heart disease and cancers of the prostate, colon, and testicle remain a serious concern for men. Fortunately, the long-term outlook is often favorable if these afflictions are diagnosed early.

Recognizing and preventing men’s health problems is not just a man’s issue. Because of its impact on wives, mothers, daughters, and sisters, men’s health is truly a family issue.

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Congressional Record, May 24, 1994
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# Table of Contents

Introduction 3  
Life Expectancy at Birth: Male and Female 4  
Life Expectancy: Gender and Race 5  
Age Adjusted Death Rates for the Top Causes of Death in Rhode Island, by Gender 6  
State-Specific Leading Causes of Mortality, by Gender and Race 7  
Years Potential Life Lost 8  
Leading Causes of Death for Boys 9  
Two Specific Causes of Death: A Closer Look 10  
  - Suicide in Rhode Island 11  
  - Prostate Cancer Mortality 12  
  - Prostate Cancer Incidence Rates, by State 13  
  - Prostate Cancer Death Rates, by State 14  
Explaining the Gender Mortality Gap 15  
  - Why the Gender Mortality Gap? 16  
  - Aging in America: Effect on the Male-Female Ratio 18  
  - Male – Female Ratio by Age Groups: Rhode Island and USA 19  
Points of Hope by Eric "Ric" Bothwell 20  
Addendum 21  
  - Life Expectancy, USA 22  
  - Obesity and Its Complications 23  
  - Diabetes 23  
  - The Commonwealth Fund Study 24  
  - The Weaker Sex? 26  
Men’s Health Week Proclamation 27
Introduction

It has been called the “silent crisis” for good reason. It's Men's Health. Overall, men live “sicker” and shorter lives than women. It’s common knowledge that a woman the same age as her husband will most likely live longer than he will. But the true crisis lies in the popular acceptance of these statistics. Closer inspection indicates that we do not have to accept this as a fact of life.

Men die at higher rates than females of the same age for a number of reasons, due in no small part to a society that encourages men to engage in risky behaviors, where men work at the most dangerous jobs, and where men put their work above their own safety. Yet one behavior may well be the most threatening to their longevity of all – not being aware of their own health care needs. According to studies by the Commonwealth Fund and the Centers for Disease Control and Prevention (CDC) cited in this report, men are far less likely than women to have regular contact with a doctor over the course of their lifetime and are half as likely as women to have a preventive health exam. This means that men often do not receive any preventive care for potentially life-threatening conditions, nor are those conditions diagnosed early when they are easier to treat and/or cure.

According to the National Center for Health Statistics at CDC, overall per capita spending on healthcare nearly doubled in 12 years, from $4,128 in 2000 to $7,826 in 2013, and continues to grow.¹ However, due to the factors mentioned above, the health of America’s men has not benefited in proportion to this increase. In short, many men die long before their time because of diseases that could have been prevented if only they had known.

This is also a family crisis. Almost half of elderly widows who live in poverty were not living in poverty before the death of their husbands. In terms of lost years for societal contributions, the numbers are staggering.

For over two decades Men's Health Network has been seeking to educate the public on health disparities among men and women, and to support a new generation with the tools to turn the tide on these statistics. Education plays a major role in the understanding and eventual elimination of health disparities between men and women, rich and poor. Access to health care services is also key, and the ongoing changes in our health care delivery systems provide promise for a more engaged male, with retail clinics and neighborhood urgent care centers making health care more accessible to both men and women whose work schedules or lifestyles otherwise hinder their access to a health care provider.

This extensive report sheds light on the current male health crisis in our communities and should be the impetus for all of us to push for broader solutions nationwide and most importantly, bring the focus back home where we need to encourage our own men to lead healthier lifestyles. The report provides the data needed to begin to understand the problem, offering a starting point for changes in policies and attitudes that will allow us to improve the health and wellbeing of men and boys...and their families.

For ideas on how to improve the health and wellbeing of men and boys in your state, contact: state@menshealthnetwork.org

Simply put, there is a silent crisis in America and in Rhode Island, a crisis of epic proportions: On average, American men live shorter and less-healthy lives than American women. As shown below, this is also true for Rhode Island.

This higher mortality of men leads to striking disparities in life expectancy as reflected in the statistics. The disparity is also illustrated by a 1990 study which found a life expectancy of 56.5 years for men living on two South Dakota reservations, and 97 for Asian women living in one New Jersey county.²

What does this mean for spouses and families? In Rhode Island, among women married to men the same age as themselves, more than 12% could be widows as they enter retirement (see page 19 of this report).

Rhode Island vs US Life Expectancy at Birth, 2010³

(The most current data available to compare state with national)

More than one-half the elderly widows now living in poverty were not poor before the death of their husbands.

Meeting the Needs of Older Women: A Diverse and Growing Population,
The Many Faces of Aging, U.S. Administration on Aging

Rhode Island vs US, Life Expectancy at Birth by Race and Gender, 2010

(The most current data available to compare state with national)

<table>
<thead>
<tr>
<th>Female/Race (Population)</th>
<th>Life Expectancy (Years)</th>
<th>Male/Race (Population)</th>
<th>Life Expectancy (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (US)</td>
<td>81.4</td>
<td>White (US)</td>
<td>76.7</td>
</tr>
<tr>
<td>White (RI)</td>
<td>82.0</td>
<td>White (RI)</td>
<td>77.7</td>
</tr>
<tr>
<td>Black (US)</td>
<td>78.4</td>
<td>Black (US)</td>
<td>72.3</td>
</tr>
<tr>
<td>Black (RI)</td>
<td>*</td>
<td>Black (RI)</td>
<td>*</td>
</tr>
<tr>
<td>Hispanic (US)</td>
<td>85.4</td>
<td>Hispanic (US)</td>
<td>80.2</td>
</tr>
<tr>
<td>Hispanic (RI)</td>
<td>*</td>
<td>Hispanic (RI)</td>
<td>*</td>
</tr>
<tr>
<td>Asian/Pac. Islander (US)</td>
<td>88.9</td>
<td>Asian/Pac. Islander (US)</td>
<td>84.1</td>
</tr>
<tr>
<td>Asian/Pac. Islander (RI)</td>
<td>*</td>
<td>Asian/Pac. Islander (RI)</td>
<td>*</td>
</tr>
<tr>
<td>Amer. Indian/ Alaskan Native (US)</td>
<td>83.5</td>
<td>Amer. Indian/ Alaskan Native (US)</td>
<td>78.7</td>
</tr>
<tr>
<td>Amer. Indian/ Alaskan Native (RI)</td>
<td>*</td>
<td>Amer. Indian/ Alaskan Native (RI)</td>
<td>*</td>
</tr>
</tbody>
</table>

* No significant data available

In 2013, the county with the highest life expectancy in Rhode Island for both men (78.8) and women (83.6) was Bristol County.

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4 Ibid
Every year, in every state, the death rate for men is higher than the rate for women. Rhode Island has the highest male: female death ratio in the country.

Rhode Island: Age-Adjusted Death Rates (All Ages) for the Leading Causes of Death, by Sex (1999 - 2014)

Mortality rates per 100,000; Age-Adjusted using 2014 Standard Population

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Top Ten</th>
<th>National Rate (Male)</th>
<th>Male</th>
<th>Female</th>
<th>Ratio Male:Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td></td>
<td>940.7</td>
<td>918.1</td>
<td>635.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Major cardiovascular diseases</td>
<td>a,b</td>
<td>321.1</td>
<td>309.7</td>
<td>211.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Cancer</td>
<td>a,b</td>
<td>219.8</td>
<td>229.1</td>
<td>156.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>a,b</td>
<td>52.9</td>
<td>48.5</td>
<td>22.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Diseases</td>
<td>a,b</td>
<td>50.6</td>
<td>44.6</td>
<td>34.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Stroke</td>
<td>a,b</td>
<td>46.2</td>
<td>38.3</td>
<td>34.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>a,b</td>
<td>26.9</td>
<td>23.3</td>
<td>15.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Influenza and Pneumonia</td>
<td>a,b</td>
<td>22.1</td>
<td>22.0</td>
<td>15.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Alzheimer's Disease</td>
<td>a,b</td>
<td>19.0</td>
<td>16.6</td>
<td>23.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Kidney Diseases</td>
<td>a,b</td>
<td>17.5</td>
<td>15.3</td>
<td>9.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Suicide</td>
<td>a</td>
<td>19.0</td>
<td>14.8</td>
<td>3.8</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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### State-Specific Leading Causes of Mortality, by Gender and Race

#### Rhode Island’s 10 Leading Causes of Death by Gender*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Major cardiovascular diseases</td>
<td>Major cardiovascular diseases</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>3</td>
<td>Unintentional injuries</td>
<td>Chronic lower respiratory diseases</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower respiratory diseases</td>
<td>Stroke</td>
</tr>
<tr>
<td>5</td>
<td>Stroke</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes mellitus</td>
<td>Unintentional injuries</td>
</tr>
<tr>
<td>7</td>
<td>Influenza &amp; Pneumonia</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>8</td>
<td>Alzheimer’s disease</td>
<td>Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>9</td>
<td>Kidney diseases</td>
<td>Kidney disease</td>
</tr>
<tr>
<td>10</td>
<td>Suicide</td>
<td>Septicemia</td>
</tr>
</tbody>
</table>

*Rankings only account for deaths due to singular cause of death and does not account for multiple causes of death.

#### Rhode Island’s 10 Leading Causes of Death by Race*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Non-Hispanic White</th>
<th>Non-Hispanic Black</th>
<th>Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Major cardiovascular diseases</td>
<td>Major cardiovascular diseases</td>
<td>Major cardiovascular diseases</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>3</td>
<td>Chronic lower respiratory diseases</td>
<td>Stroke</td>
<td>Stroke</td>
</tr>
<tr>
<td>4</td>
<td>Stroke</td>
<td>Diabetes mellitus</td>
<td>Unintentional injuries</td>
</tr>
<tr>
<td>5</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>6</td>
<td>Alzheimer’s disease</td>
<td>Chronic lower respiratory diseases</td>
<td>Chronic lower respiratory diseases</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes mellitus</td>
<td>Alzheimer’s disease</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>8</td>
<td>Influenza &amp; Pneumonia</td>
<td>Influenza &amp; Pneumonia</td>
<td>Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>9</td>
<td>Kidney diseases</td>
<td>Kidney diseases</td>
<td>Kidney diseases</td>
</tr>
<tr>
<td>10</td>
<td>Chronic liver diseases</td>
<td>Septicemia</td>
<td>Chronic liver diseases</td>
</tr>
</tbody>
</table>

**Asian/Pacific Islander**

<table>
<thead>
<tr>
<th>Rank</th>
<th>American Indian/ Alaskan Native</th>
<th>Other**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Major cardiovascular diseases</td>
<td>Cancer</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>Major cardiovascular diseases</td>
</tr>
<tr>
<td>3</td>
<td>Stroke</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower respiratory diseases</td>
<td>Chronic lower respiratory diseases</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes mellitus</td>
<td>Unintentional injuries</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional injuries</td>
<td>HIV</td>
</tr>
<tr>
<td>7</td>
<td>Influenza &amp; Pneumonia</td>
<td>Stroke</td>
</tr>
<tr>
<td>8</td>
<td>Septicemia</td>
<td>***</td>
</tr>
<tr>
<td>9</td>
<td>Chronic liver diseases</td>
<td>***</td>
</tr>
<tr>
<td>10</td>
<td>Suicide</td>
<td>***</td>
</tr>
</tbody>
</table>

*Rankings only account for deaths due to singular cause of death and does not account for multiple causes of death.

**The 10 leading causes for “Other” may not necessarily be ranked as listed in the chart above, due to inadequate population data.

*** Data not available.

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*ibid*
Years of potential life lost (YPLL) is an estimate of the average years a person would have lived if he had not died prematurely. Premature death is considered any death that occurred before the age of 75. These numbers are reflective of the toll of premature deaths from specific causes affecting younger age groups. YPLL calculates the sum of all the years lost from all specific diseases for all Rhode Island residents. For example, Rhode Island males lost 6,503 years of life in total from heart disease in 2014. For Rhode Island in 2014, total YPLL for all causes of death for males was 36,960 years and 23,109 years for females, which represents a 59.9% greater total years lost for males.

Rhode Island: Years of Potential Life Lost (YPLL) Before Age 75, 2013

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* infant deaths of less than 7 days of age and fetal deaths of 28 weeks of gestation or more.
Leading Causes of Death for Boys

While the rates of birth defects, cancer, and heart disease are similar for both boys and girls, many more boys die from unintentional injuries, homicide, and suicide than girls. It can be concluded that the higher rate of death in boys may be preventable.

Rhode Island: Age-Adjusted Leading Causes of Death for Ages 0-17\(^9\) (rates per 100,000; age-adjusted using 2010 Standard Population)

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 0-4 5-9 10-14 15-17</td>
<td>0-17 0-4 5-9 10-14 15-17</td>
<td></td>
</tr>
<tr>
<td>All causes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>11.7</td>
<td>15.4</td>
</tr>
<tr>
<td>Birth defects</td>
<td>8.5</td>
<td>30.6</td>
</tr>
<tr>
<td>Homicide</td>
<td>3.1</td>
<td>*</td>
</tr>
<tr>
<td>Cancer</td>
<td>2.5</td>
<td>*</td>
</tr>
<tr>
<td>Suicide</td>
<td>2.0</td>
<td>*</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1.8</td>
<td>4.1</td>
</tr>
</tbody>
</table>

* = negligible number

The higher rates unintentional injuries, homicide, and suicide may be explained, in part, by risky behaviors. High school boys in Rhode Island\(^10\) are more likely than girls to:

Percentage of High School Students in Rhode Island (2011)

- Not wear a seatbelt
- Drive while drinking
- Carry a weapon (including guns)
- Carry a weapon at school
- Attempt suicide\(^\wedge\)
- Get into a physical fight (including at school)


\(^\wedge\) = high school boys in Rhode Island are significantly more at risk than the United States average.
Two Specific Causes of Death: A Closer Look
Suicide in Rhode Island

Former Surgeon General Dr. David Satcher has stated; “Suicide is our most preventable form of death.” For the nation (as of 2014), suicide is the third leading cause of death in males 15-44, and the fourth leading cause of death for females in the same age group. On average, 20.9 men per 100,000 will commit suicide, compared to 5.4 women, making suicide the single largest gender-based mortality disparity.\textsuperscript{11} By age group, suicide rates are highest for men over 85 years of age, and by race for Whites in Rhode Island.

**Rhode Island: Suicide Rates per 100,000 (2014)\textsuperscript{11}:**

The rate of suicide for men in Rhode Island is 3.9 times the rate for women.

Risk factors for suicide include: loss (relational, social, work, or financial), family history of suicide, history of child maltreatment, history of depression, history of mental disorders, history of alcohol and substance abuse, feelings of hopelessness, local epidemics of suicide, social isolation due to bullying and other factors, and unwillingness or inability to seek help for mental health issues or suicidal thoughts.\textsuperscript{12}


Prostate Cancer Mortality

Data found from the National Cancer Institute, State Cancer Profiles indicates that compared to the national average, males in Rhode Island are at lower risk for death from prostate cancer.\textsuperscript{13}

In 2016, the American Cancer Society estimates:\textsuperscript{14}

- 640 new cases of prostate cancer will be diagnosed among men in Rhode Island.
- 90 men will die of prostate cancer in Rhode Island.

The National Cancer Institute provides the following age-adjusted death rates for prostate cancer for the years 2008-2012 (per 100,000)\textsuperscript{13}:

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rhode Island</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>20.8</td>
<td>21.4</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>20.7</td>
<td>19.9</td>
</tr>
<tr>
<td>Black (Includes Hispanic)</td>
<td>32.7</td>
<td>46.3</td>
</tr>
<tr>
<td>Hispanic (Any Race)</td>
<td>**</td>
<td>17.8</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>**</td>
<td>9.4</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>**</td>
<td>16.1</td>
</tr>
</tbody>
</table>

** Data has been suppressed to ensure confidentiality and stability of rate estimates. (less than 15 deaths per year)

As of the 2008-2012 data (most currently available), the county in Rhode Island with the highest death rates due to prostate cancer:\textsuperscript{13}

- For White men (23.9) is Newport County
- For Black men (29.1) is Providence County
- With Newport County having the highest prostate cancer death rate (24.9) overall in the state for men, when not considering race/ethnicity

Pros
tate Incidence Cancer Rates 2013

Invasive Cancer Incidence Rates by State (Table 5.23.1M)
Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130).15

Rankings by State: 2013, Male, Prostate

Prostate Death Cancer Rates 2013

Cancer Death Rates by State (Table 5.23.2M)
Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25-1130).¹⁶

Explaining the Gender Mortality Gap
Why the Gender Mortality Gap?

Simply put, there is a silent crisis in America, a crisis of epic proportions: on average, American men live shorter and less-healthy lives than American women. A recent study based on data from the Centers for Disease Control and Prevention (CDC) on ambulatory care and health behavior illustrates just how wide the health care gulf between the two sexes is. Among other things, the study found that:\n
- Women make nearly twice as many preventive care visits as men. In 2006, 22.8% of adult men and 11.8% of adult women did not make any health care visits whatsoever.\n
- Overall, amongst those aged 18-64 years, 23.9% of men do not have a usual source of healthcare, as compared to 13% of women.\n
- 11.3% of Rhode Island’s residents are currently uninsured. Of these, 58.2% are men. 18\n
- A woman spends $615 more annually on healthcare and medicine ($3,316) than a man ($2,701).\n
- Men are more likely to be regular and heavy alcohol drinkers, heavier smokers who are less likely to quit, non-medical illicit drug users, and are more overweight compared to women.\n
A study done by The Commonwealth Fund (see page 24 of this report) presents research revealing that an alarming proportion of American men have only limited contact with physicians and the health care system generally. Many men fail to get routine checkups, preventive care, or health counseling, and they often ignore symptoms or delay seeking medical attention when sick or in pain. When they do seek care, social taboos or embarrassment can sometimes prevent men from openly discussing health concerns with their physicians.\n
Some researchers19 have offered several possible explanations for this disparity. One theory is that women generally are responsible for their family’s health and so may think about health care needs more than men. They are more likely to have a usual source of care, which is a strong predictor of health care utilization. They also tend to use medical care for screening and health education more often than men do. Women have been said to also be more likely to report and act on illness.\n
Other research has shown that the mortality gap is mostly due to gender differences in the way health is viewed or discussed. “Hundreds of empirical studies consistently show that men are more likely to engage in almost every health risk behavior (e.g., alcohol use, tobacco use, not seeking medical care) increasing their risk of disease, injury, and death.”20

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The reason for this, according to researchers, is that the way a man perceives what is “normal” masculine health behavior influences his own behavior. Men often adopt traditional masculine ideals, and these ideals often involve risky behavior. Thus, the trend continues from generation to generation. Researchers have found no correlation, on the other hand, of such trends for women. Women are less motivated by what they perceive to be as “normal” for other women.

Men’s devotion to the workplace may also be partly to blame. Studies have shown that men are less likely than women to take time off from work for health related issues. Men’s reluctance to make timely health care visits, however, is not only a function of work and time, but also of the way our culture socializes boys from the earliest age: “big boys don't cry." That attitude extends to the workplace where men feel compelled to ignore their own physical (and mental) health needs and put in a "full 40 hours" ... or more ... knowing in their hearts that if they take time off for anything less than a true health emergency, they will lose status in the workplace, and, in the case of hourly workers, most probably their job.
Aging in America: Effect on the Male-Female Ratio

Although the older population in America is living longer and has a better quality of life than any other previous generation, disparities among gender still exists. Due perhaps to the lack of awareness and culturally induced behavior patterns, men generally have poorer health habits than women, and are generally in worse health condition. This leads to premature death, and thus, a lower life expectancy for men.

Health data reflects on the poor health status of aging men and its effect on spouses and loved ones:

- Despite the fact that approximately 100,000 more males than females are born each year, the number of living males decreases rapidly as they age.\(^{21}\)
- As of 2012, older women outnumber older men at 23.4 million older women to 17.9 million older men.\(^{22}\)
- Almost half of older women (46%) age 75+ live alone.\(^{19}\)
- Due to the fact that men die earlier, older women are nearly twice as likely to reside in a nursing home, and are more than twice as likely to live in poverty.\(^{20}\)
- Older women have less money than their male counterparts. The median income of older persons in 2011 was $27,707 for males and $15,362 for females.\(^{19}\)
- Older men were much more likely to be married than older women—72% of men vs. 45% of women. 37% older women in 2012 were widows.\(^{19}\)
- 7 out of 10 “baby boom” women will outlive their husbands and many can expect to be widows for 15 to 20 years.\(^{23}\) This is because women often marry older men and then go on to outlive their husbands.

Aging in Rhode Island

In Rhode Island, the male-female ratio converges in the late 20s and then drops rapidly as shown in this chart developed from year 2010 Census data.

Rhode Island Resident Population: 2010 Census by Age and Sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Number Both sexes</th>
<th>Male</th>
<th>Female</th>
<th>Males per 100 females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>1,052,567</td>
<td>508,400</td>
<td>544,167</td>
<td>93.4</td>
</tr>
<tr>
<td>Under 5 years</td>
<td>57,448</td>
<td>29,396</td>
<td>28,052</td>
<td>104.8</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>60,440</td>
<td>31,051</td>
<td>29,389</td>
<td>105.7</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>63,824</td>
<td>32,673</td>
<td>31,151</td>
<td>104.9</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>80,046</td>
<td>40,157</td>
<td>39,889</td>
<td>100.7</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>82,167</td>
<td>41,229</td>
<td>40,938</td>
<td>100.7</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>65,799</td>
<td>33,126</td>
<td>32,673</td>
<td>101.4</td>
</tr>
<tr>
<td>30 to 34 years</td>
<td>61,163</td>
<td>30,056</td>
<td>31,107</td>
<td>96.6</td>
</tr>
<tr>
<td>35 to 39 years</td>
<td>63,730</td>
<td>31,185</td>
<td>32,545</td>
<td>95.8</td>
</tr>
<tr>
<td>40 to 44 years</td>
<td>73,130</td>
<td>35,635</td>
<td>37,495</td>
<td>95.0</td>
</tr>
<tr>
<td>45 to 49 years</td>
<td>81,300</td>
<td>39,435</td>
<td>41,865</td>
<td>94.2</td>
</tr>
<tr>
<td>50 to 54 years</td>
<td>81,050</td>
<td>39,138</td>
<td>41,912</td>
<td>93.4</td>
</tr>
<tr>
<td>55 to 59 years</td>
<td>70,634</td>
<td>33,908</td>
<td>36,726</td>
<td>92.3</td>
</tr>
<tr>
<td>60 to 64 years</td>
<td>59,955</td>
<td>28,969</td>
<td>30,986</td>
<td>93.5</td>
</tr>
<tr>
<td>65 to 69 years</td>
<td>42,802</td>
<td>19,999</td>
<td>22,803</td>
<td>87.7</td>
</tr>
<tr>
<td>70 to 74 years</td>
<td>31,077</td>
<td>13,805</td>
<td>17,272</td>
<td>79.9</td>
</tr>
<tr>
<td>75 to 79 years</td>
<td>26,645</td>
<td>11,219</td>
<td>15,426</td>
<td>72.7</td>
</tr>
<tr>
<td>80 to 84 years</td>
<td>24,607</td>
<td>9,262</td>
<td>15,345</td>
<td>60.4</td>
</tr>
<tr>
<td>85 years and over</td>
<td>26,750</td>
<td>8,157</td>
<td>18,593</td>
<td>43.9</td>
</tr>
</tbody>
</table>

Male – Female Ratio by Age Groups 2000 and 2010: USA

<table>
<thead>
<tr>
<th>Age</th>
<th>0 to 5</th>
<th>5 to 14</th>
<th>15 to 24</th>
<th>25 to 34</th>
<th>35 to 44</th>
<th>45 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>104.8</td>
<td>104.9</td>
<td>104.3</td>
<td>99.9</td>
<td>97.9</td>
<td>95.6</td>
<td>89.4</td>
<td>78.1</td>
<td>59.9</td>
<td>38.6</td>
</tr>
<tr>
<td>2010</td>
<td>104.4</td>
<td>104.6</td>
<td>104.7</td>
<td>100.9</td>
<td>99.0</td>
<td>96.8</td>
<td>93.2</td>
<td>86.9</td>
<td>72.2</td>
<td>48.3</td>
</tr>
</tbody>
</table>

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Points of Hope

by Eric "Ric" Bothwell, DDS, MPH, PhD

This report of the health of the citizens of the state of Rhode Island highlight long standing gender -related health disparities that have been largely invisible to most people in the U.S. Overcoming these health disparities will be a difficult task but has never been more achievable than it is today.

For over a decade, Men’s Health Network has in fact been supporting efforts such as engaging/offering to assist boys and men toward accepting better health practices in a diversity of “safe and male friendly” environments with considerable success. And this same nuanced approach toward offering help and support from a trusted person may help explain why research continues to show that women are successful in promoting better health behavior for the males in their lives by supporting, nudging, or even demanding it.

Research has shown several radical points of hope:

- **The Internet:** A promising approach for assisting males to accept help on virtually any topic including health that is anonymous, safe, and private is the internet. Like using a GPS when one is lost (which males disproportionately buy), the internet is increasingly being shown to be a powerful tool in reaching males with information.

- **Male Peer Support:** From the other end of the technology spectrum, the timeless approaches of male peer support and trans-generational mentoring continues to be a useful approach to assisting males adopt healthy life styles and accept needed help. Several successful programs such as Aha Kane and Sources of Strength have shown the power of male-male mentoring.

- **Targeted Suicide and Violence Prevention Programs:** In response to rising rates of suicide in its predominantly male population, the Air Force in the early to mid-1990’s implemented a comprehensive multi-dimensional suicide prevention initiative. Comparing rates from 1990-1996 with those observed during the period of the prevention program (1997-2002), suicide rates were reduced by 33%. Homicide rates were reduced 51%, severe domestic violence was reduced 54%, moderate domestic violence was reduced 30% and unintentional injuries dropped 18%25.

Men’s Health Network seeks to reduce health disparities by focusing on two broad areas:

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.

We strongly encourage you to join us in this critical effort. As John F. Kennedy noted: *There are risks and costs to action. But they are far less than the long range risks of comfortable inaction.*

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Addendum
The life expectancy at birth for the U.S. total population was 78.8 years in 2013. This chart is based on data released by CDC in 2015.

Hispanic females have the highest life expectancy. Non-Hispanic black males have the lowest life expectancy, even though a record-high life expectancy of 71.8 years for non-Hispanic black males was reached in 2013. Life expectancy for females exceeds that of males in every category.

### Life Expectancy at Birth, 2013

<table>
<thead>
<tr>
<th>Classification</th>
<th>2013</th>
<th>1970</th>
<th>1950*</th>
<th>1920*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population**</td>
<td>78.8</td>
<td>70.8</td>
<td>68.2</td>
<td>54.1</td>
</tr>
<tr>
<td>All females</td>
<td>81.2</td>
<td>74.7</td>
<td>71.1</td>
<td>54.6</td>
</tr>
<tr>
<td>All males</td>
<td>76.4</td>
<td>67.1</td>
<td>65.6</td>
<td>53.6</td>
</tr>
<tr>
<td>Hispanic females</td>
<td>83.8</td>
<td>75.6</td>
<td>72.2</td>
<td>55.6</td>
</tr>
<tr>
<td>White females</td>
<td>81.4</td>
<td>68.3</td>
<td>62.9</td>
<td>45.2</td>
</tr>
<tr>
<td>Non-Hispanic W females</td>
<td>81.2</td>
<td>68.0</td>
<td>66.5</td>
<td>54.4</td>
</tr>
<tr>
<td>Black females</td>
<td>78.1</td>
<td>66.5</td>
<td>59.1</td>
<td>45.5</td>
</tr>
<tr>
<td>Non-Hispanic B females</td>
<td>79.1</td>
<td>66.5</td>
<td>59.1</td>
<td>45.5</td>
</tr>
<tr>
<td>Hispanic males</td>
<td>76.7</td>
<td>66.5</td>
<td>59.1</td>
<td>45.5</td>
</tr>
<tr>
<td>White males</td>
<td>72.3</td>
<td>60.0</td>
<td>59.1</td>
<td>45.5</td>
</tr>
<tr>
<td>Non-Hispanic W males</td>
<td>76.5</td>
<td>60.0</td>
<td>59.1</td>
<td>45.5</td>
</tr>
<tr>
<td>Black males</td>
<td>71.8</td>
<td>60.0</td>
<td>59.1</td>
<td>45.5</td>
</tr>
</tbody>
</table>

* Life expectancies for the black population for years prior to 1970 are estimated using figures for the total nonwhite population.
** Includes all races.
*** Prior to 2006, data on life expectancy by Hispanic origin were not available.
Obesity and Its Complications

Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer. The estimated annual medical cost of obesity in the U.S. is $190 billion, or 20.6% of the U.S. health care expenditures.  

Adults with a Body Mass Index (BMI) between 25 and 29.9 are considered overweight, and adults with a BMI of 30 or higher are considered obese. According to the 2013 Behavioral Risk Factor Surveillance System survey, 64.8% of Rhode Island’s residents are overweight or obese, including 72.2% of men. This is compared to 64.6% of US residents that are overweight or obese, including 70.8% of men, nationally.  

Rhode Island: Weight Classification by Body Mass Index (BMI), 2013

Obesity is directly correlated with the development of Type II diabetes. Nationally, men are more likely to have diabetes than women.

- In Rhode Island, men are 47.5% more likely to die from diabetes than women.  
- In 2013, the national age-adjusted prevalence of diagnosed diabetes in men was 9.6%, compared to 8.6% in women. (In 2001, the rate in men was 5.1%, and in 1991 it was 2.8%.)  
- Nationally, men around retirement age (65-74) have the highest prevalence: 23.9% of them have diabetes.  
- More than 1 in 10 health care dollars in the U.S. are spent directly on diabetes and its complications, and more than 1 in 5 health care dollars in the U.S. goes to the care of people with diagnosed diabetes.  

Women are diagnosed with diabetes 1 year after the onset of symptoms, but men are diagnosed 10 years after.

Dr. Ian Banks, World Congress on Men’s Health

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The Commonwealth Fund Study

The Commonwealth Fund released data on men from a study of women’s health. The findings from “Out of Touch: American Men and the Health Care System”\(^{31}\) were featured in virtually every media outlet and in foreign language newspapers and magazines. Those findings help identify the gaps in health care for men:

- This report presents research revealing that an alarming proportion of American men have only limited contact with physicians and the health care system generally. Many men fail to get routine checkups, preventive care, or health counseling, and they often ignore symptoms or delay seeking medical attention when sick or in pain. When they do seek care, social taboos or embarrassment can sometimes prevent men from openly discussing health concerns with their physicians. These and other findings point to a need for expanded efforts to address men’s special health concerns and risks and their attitudes toward health care.

- Men’s irregular contact with doctors means they often do not receive any preventive care for potentially life-threatening conditions.

- More than half of all men did not have a physical exam or a blood cholesterol test in the past year (2000). In 2000, 6 of 10 men age 50 or older were not screened for colon cancer, and by 2012, the rate has remained roughly the same\(^{32}\). 4 men of 10 were not screened for prostate cancer as of 2012. Roughly, a third of these men had not been screened for either disease in the past five years.

- Only 58% of adult men who saw their doctor at least once (as of the year 2000) had a complete physical exam.

- Only 57% of men who made one or more visits to the physician (as of the year 2000) received a blood cholesterol screening. In 2009, 74.5% of men had had been screened.\(^{33}\)

- 24% of males stated that even if they were in pain or sick, they would delay seeking health care as long as possible.

- 17% of males stated that even if they were in pain or sick, they would delay going to a doctor for a week or more.

- Hispanic men have the hardest time gaining access to care.


A subsequent study, conducted by the federal Agency for Healthcare Research and Quality (AHRQ) further explored men’s lack of contact with physicians:

<table>
<thead>
<tr>
<th>Race</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>72.9</td>
<td>83.8</td>
</tr>
<tr>
<td>Black</td>
<td>58.8</td>
<td>70.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>55.2</td>
<td>70.5</td>
</tr>
<tr>
<td>All</td>
<td>67.4</td>
<td>79.1</td>
</tr>
</tbody>
</table>

The Weaker Sex?

Evidence suggests that men may in fact be the weaker sex. As shown in this report, men live shorter, less healthy lives than women. Here are some more startling facts:

- The male fetus is at greater risk of miscarriage and stillbirth.35
- Male births slightly outnumber female births (about 105 to 100), but boys have a higher death rate if born premature: 22 percent compared with 15 percent for girls.33
- Boys ages 15-19 are almost 11 times as likely to die by drowning.33
- Boys have higher rates of death than girls from all causes of death36.
- Boys are three times as likely to have Tourette's syndrome.33
- Men die at higher rates from the 9 of the top 10 causes of death.33
- 1 in 2 men, and 1 in 3 women, will be diagnosed with cancer in their lifetime37.
- Men account for 92% of workplace deaths.33
- In the year 2010, more men under 44 died of unintentional injuries than major cardiovascular disease and cancer combined.34
- Men are 16 times as likely as women to be colorblind.33
- Men suffer hearing loss at twice the rate of women.33
- The male hormone testosterone is linked to elevations of LDL, the bad cholesterol, as well as declines in HDL, the good cholesterol.33
- Men have fewer infection-fighting T-cells and are thought to have weaker immune systems than women.33
- Among people 65 and older, men account for 84 percent of suicides.33
- By the age of 100, women outnumber men eight to one.33

Men’s Health Week Proclamation

Recognizing the need for men to become more engaged with the health care system, the governors issue Men’s Health Week proclamations to correspond with National Men’s Health Week.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawai‘i
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Mexico
New Jersey
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming
************
American Samoa
Guam
Puerto Rico
Saipan, Northern Mariana Islands
Virgin Islands