This special report, based on vital statistics, census data, nationally representative findings from the National Population Health Survey (NPHS) and data from the cancer registries, compiles new evidence of the differences in health attitudes, behaviours, illness and mortality between Canadian males and females.

CONCLUSION

Consistent with findings from other countries, the health and illness experiences of men and women are paradoxical. Women experience more illness, more years of disability and more stress than do men, but they also live longer. Even after diagnosis of fatal diseases, women appear to survive longer than men do.

A number of factors might explain these differences. Women's greater likelihood of being sick may be due to environmental influences, such as closer exposure to children, higher levels of stress at work and at home and generally lower socio-economic status.

In 1998/99, 15% of females aged 12 or older, compared with 10% of males, lived in low-income households. The gap was particularly pronounced among seniors: 26% of women versus 13% of men. Yet regardless of income level, most of the key male–female differences in health behaviour, chronic conditions, and health care use persisted.

The socialization of males and females may also account for some of the difference. Women seem to take more interest in measures to prevent illness and to promote health in general, and they may be more likely to acknowledge illness or pain. Women also make greater use of the health care system, thereby creating more opportunities for diagnosis.

Genetic or physiological differences may partially account for women's greater longevity, meaning that women may be more physically resilient than men. However, the greater amount of social support that women receive may also contribute to the difference.

Cultural and societal influences on behaviour also affect health. For example, the narrowing of the male–female gap in life expectancy in recent years reflects tobacco use, a factor strongly based in the cultural context. Due to differences in the wartime experiences and advertising pressures experienced by men and women, women lagged behind men in taking up smoking, and never smoked to the same extent. However, among young Canadians today, there is no difference between male and female smoking rates, and sex differences in mortality due to smoking-related respiratory diseases seem to be narrowing.

The reasons behind the differences in health attitudes, health-related behaviours, health status and health care use between men and women are often a matter of speculation, and will no doubt be the focus of considerable future research. However, at issue for public health policy are the implications of the differences, as much as the root causes. Specific areas in which the health-related needs of men and women differ signal the potential for public health intervention. Men, for example, could benefit from measures to encourage more awareness of the links between diet and disease, and to discourage binge drinking and other potentially harmful practices that result in higher rates of injury. Increasing men's use of preventive health practices, including the use of the health care system for screening and health promotion counselling, might also improve men's health status. Women need support to become more physically active and to lower their stress levels. They also require assistance in living with pain and disability.

This report documents sharp differences in the health of Canadian men and women. The mechanisms of the biological, social, cultural and socio-economic influences that give rise to the differences are not known. However, the findings emphasize the need for sex-specific public health programs that recognize the different trajectories to illness and disease for men and women.