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A Multidimensional Examination of Functional Health, Chronic Morbidity, Socioeconomic Inequalities, Healthcare Protection, and the Social Determinants of Health Among Jamaican Males: Evidence from the 2023 Jamaica Survey of Living Conditions

Paul Andrew Bourne, PhD, DrPH*

*Assistant Professor, Graduate Studies and Research, University of the Commonwealth Caribbean, Kingston, Jamaica, West Indies. Corresponding Author Email: paulbourne1@gmail.com**

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ABSTRACT

Background: Men's health remains an important but comparatively underdeveloped area of population-health research in Jamaica, despite longstanding evidence that Jamaican males use healthcare less frequently and experience distinctive morbidity and mortality risks. Earlier Jamaican studies have examined self-rated health, healthcare-seeking, ageing, chronic disease, marital status and selected cardiovascular risk factors, but contemporary nationally based evidence integrating functional health, chronic morbidity, health insurance, socioeconomic circumstances and independent predictors of functional limitation remains limited.

Objective: This study assessed the health status of Jamaican males and examined demographic, socioeconomic, residential, relationship and illness-related determinants of functional-health difficulty using the 2023 Jamaica Survey of Living Conditions (JSLC).

Methods: A secondary cross-sectional analysis was conducted on 2,177 male respondents identified in the JSLC 2023 dataset, using descriptive statistics, Pearson's chi-square tests, Cramer's V and multivariable binary logistic regression.

Results: Most males were uninsured (82.2%); 14.3% with valid functional-health information reported some degree of functional difficulty; hypertension was the most frequently reported chronic condition (11.8%); and functional-health difficulty was independently associated with age, illness status, single status, and household headship.

Conclusion: The findings indicate a male-health paradox in which apparently low levels of current illness coexist with chronic morbidity, functional limitation and substantial deficiencies in financial protection, thereby indicating that assessment of Jamaican men's health should extend beyond contemporaneous self-reported illness to incorporate functioning, diagnosed disease, social circumstances and access to healthcare protection.

Keywords: Jamaican Males; Men's Health; Functional Health; Chronic Disease; Health Inequality; Health Insurance; Socioeconomic Status; JSLC; Jamaica; Morbidity.

1.0. Introduction

Men's health has increasingly emerged as an important international public-health issue because male disadvantage is evident across mortality, premature death, risk-taking behaviour and engagement with health services, notwithstanding considerable variation between countries and socioeconomic groups. (World Health Organization, 2018, 2019) The World Health Organization (WHO) has emphasised that biological sex alone cannot explain these inequalities because men's health is simultaneously shaped by behaviours, occupational and environmental exposures, socioeconomic conditions, health-seeking practices and socially constructed expectations of masculinity. (World Health Organization, 2018) International evidence similarly indicates that men frequently access healthcare less readily than women even when confronted with comparable illnesses, potentially delaying diagnosis, treatment and secondary prevention. (World Health Organization, 2019) These patterns assume particular importance in low- and middle-income countries because noncommunicable diseases (NCDs) are responsible for substantial premature mortality and nearly three-quarters of global NCD deaths occur in these settings. (World Health Organization, 2025) Understanding men's health requires simultaneous consideration of disease, functioning, socioeconomic resources, healthcare utilisation and the structural circumstances within which men experience health and illness.

The global epidemiological transition has further complicated assessments of population health because longer survival does not necessarily mean that additional years of life are lived without morbidity or disability. (World Health Organization, n.d.-b) WHO estimates indicate that improvements in healthy life expectancy have not fully matched improvements in overall longevity, underscoring the importance of examining functional health alongside mortality and diagnosed disease. (World Health Organization, n.d.-b) Among males, this distinction is particularly relevant because chronic disease can remain asymptomatic, insufficiently diagnosed or functionally manageable for considerable periods before being interpreted by an individual as illness. International men's-health scholarship also identifies reluctance to acknowledge vulnerability, embarrassment, fear, preservation of control and masculine expectations concerning endurance as potential barriers to help-seeking. (McKenzie, Collings, et al., 2018) A population may simultaneously contain men who describe themselves as not ill, men with established chronic conditions and men experiencing limitations in everyday functioning. Such distinctions make multidimensional assessment essential when attempting to characterise contemporary male health.

Jamaica provides an especially important context in which to examine this phenomenon because earlier research has documented longstanding differences in men's health behaviour and healthcare utilisation. (Bourne, 2009; Morris et al., 2011) Research using earlier Jamaican population data found that men historically sought healthcare less frequently than women and highlighted the need to investigate male health independently rather than assuming that general population patterns adequately represent men. (Bourne, 2009) A study of 2,000 Jamaican men aged 55 years and older similarly found that 74% described their health as excellent or good, despite measurable chronic conditions and relatively low healthcare utilisation, with 67.6% reporting no healthcare-provider visit during the preceding year. (Morris et al., 2011) These findings illustrate an important discrepancy between favourable perceptions of health and the presence of objective or previously diagnosed morbidity. They also suggest that healthcare utilisation cannot be interpreted independently of the cultural and social meanings that Jamaican men attach to illness, strength, independence and functional capacity.

More recent Jamaican evidence reinforces the need to distinguish reported diagnosis from underlying morbidity because the Jamaica Health and Lifestyle Survey III (JHLS III) identified striking differences between perceived and measured NCD prevalence. (Ministry of Health and Wellness, Jamaica, 2024) Among males aged 15 years and older, for example, self-reported hypertension prevalence was 15.4%, whereas measured prevalence was 31.7%, while self-reported diabetes was 4.4% compared with measured prevalence of 14.4%. (Ministry of Health and Wellness, Jamaica, 2024) These differences indicate that self-reported disease histories may substantially underestimate the biological burden of chronic disease and should not be interpreted as equivalent to clinical prevalence. Research from urban Jamaica has additionally identified sex differences in cardiovascular risk, including higher systolic blood pressure and substantially greater cigarette smoking among men than women. (McKenzie, Younger, et al., 2020) The combination of under-recognition, behavioural exposure and potentially delayed healthcare engagement means that favourable self-reported health among Jamaican males may conceal clinically meaningful vulnerability.

Socioeconomic conditions provide another essential dimension because material resources influence healthcare affordability, insurance protection, living conditions, health literacy and opportunities for preventive care.

International evidence indicates considerable socioeconomic variation in male health, while WHO has emphasised those differences among men can be substantial even within the same national setting. (World Health Organization, 2018) Jamaican research has likewise shown that healthcare utilisation is socially patterned and that men's reluctance to seek healthcare may interact with cultural expectations surrounding illness and masculinity. (Bourne et al., 2010) However, socioeconomic disadvantage need not produce identical gradients across every health outcome because diagnosis itself depends partly on access to healthcare, screening and opportunities for disease detection. Higher reported morbidity among economically advantaged populations may sometimes represent greater disease recognition rather than greater underlying biological disease. Separating socioeconomic gradients in insurance, functional status and disease reporting is consequently necessary for a more nuanced understanding of male health inequality.

Age is equally fundamental because chronic disease accumulation, physiological decline, disability, household responsibilities and socioeconomic position all change substantially across the life course. Previous Jamaican work has concentrated particularly on men aged 55 years and older, thereby providing important evidence about later-life health but less information about how older men compare with children, youth and working-age males within one contemporary analytical framework. (Morris et al., 2011) The 2023 JSLC provides an opportunity to overcome this limitation because its male population extends across childhood, youth, young adulthood, middle age and later life. The official JSLC 2023 overview reports that the survey contained 4,442 individuals from 1,719 households and collected information through computer-assisted personal interviews between July 2023 and March 2024. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) Its coverage of demographic characteristics, consumption and poverty, health, education, housing and social protection permits health to be located within the broader social circumstances of Jamaican households. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) This multidimensional structure is especially useful for examining whether functional-health difficulty is independently related to socioeconomic circumstances after age and illness have been considered.

1.1. Research Gap

Despite the contributions of earlier Jamaican scholarship, a clear empirical gap remains concerning the contemporary multidimensional health profile of Jamaican males. Existing studies have investigated older men, marital differences, self-rated health, chronic disease, healthcare utilisation and selected cardiovascular risks, but much of this evidence predates the JSLC 2023 and frequently examines particular ages, outcomes or dimensions separately. (Bourne, 2009; McKenzie, Younger, et al., 2020; Ministry of Health and Wellness, Jamaica, 2024; Morris et al., 2011) There remains limited research integrating functional limitation, illness reporting, multiple chronic diseases, health insurance, socioeconomic position, union status, household headship, age and residential location specifically among Jamaican males using recent national living-conditions data. Particularly underexplored is whether socioeconomic gradients apparent at the descriptive level remain independently associated with functional-health difficulty once ageing, illness status, relationship circumstances and household roles are simultaneously controlled. This distinction matters because socioeconomic position may affect insurance and disease detection without independently predicting functional impairment after demographic composition is

considered. The current study addresses this gap by constructing a multidimensional profile of male health using the JSLC 2023 and locating the Jamaican evidence within both national and international men's-health literature.

1.2. Aim and Objectives

The primary aim of this study was to assess the contemporary health status of Jamaican males and identify factors independently associated with functional health difficulty using the JSLC 2023. Specifically, the study described the demographic, socioeconomic, educational, employment, residential and relationship characteristics of Jamaican males and examined how these characteristics varied across age cohorts. It subsequently assessed health-insurance coverage, functional status, injury, illness reporting, healthcare utilisation and the distribution of chronic diseases and cancers. A further objective was to determine whether health outcomes and chronic conditions differed across socioeconomic groups and to estimate the magnitude of those relationships. Finally, multivariable binary logistic regression was employed to determine whether socioeconomic position, residence, union status, education, household headship, age and illness status independently predicted functional-health difficulty. Collectively, these objectives move the analysis beyond a narrow disease-based conceptualisation towards an integrated assessment of morbidity, functioning, socioeconomic inequality and healthcare protection among Jamaican males.

2.0. Methods

2.1. Study Design

This investigation employed a quantitative, cross-sectional, secondary-data analytical design based on individual-level observations from the 2023 Jamaica Survey of Living Conditions. The JSLC is a recurring national living-conditions survey jointly published by the Planning Institute of Jamaica (PIOJ) and the Statistical Institute of Jamaica (STATIN), with the survey providing information on interconnected dimensions of household and individual welfare. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) The official 2023 survey comprised 4,442 individuals residing in 1,719 households, and fieldwork was undertaken between July 2023 and March 2024 using computer-assisted personal interviewing. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) The survey encompasses demographic characteristics, consumption and poverty, health, education, housing and social protection, with analyses capable of being disaggregated by age, sex, region and socioeconomic circumstances. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) The present investigation constituted a male-specific secondary analysis rather than an analysis of the complete JSLC population, thereby allowing men's health to be treated as the principal analytical subject rather than merely a sex-disaggregated subsidiary outcome. This cross-sectional design permits estimation of associations and population patterns but does not establish temporal ordering or causal relationships between explanatory variables and functional-health outcomes.

2.2. Data Source and Access

The empirical data analysed in the present study originated from the JSLC 2023, which is jointly associated with PIOJ and STATIN within Jamaica's national statistical and development-planning architecture. PIOJ is responsible

for publication and analytical dissemination of the JSLC, while STATIN performs an integral role in national survey data collection, and the official overview identifies the 2023 sample and survey fieldwork arrangements. (Planning Institute of Jamaica & Statistical Institute of Jamaica, 2025) For the current secondary analysis, the actual microdataset was obtained from the SALISES Documentation and Data Centre, Sir Arthur Lewis Institute of Social and Economic Studies, The University of the West Indies, Mona, Jamaica. Access through this documentation and data facility permitted analysis of respondent-level variables required to construct demographic, socioeconomic and health measures rather than relying solely on aggregate figures published in the national report. The analytical dataset was processed in IBM SPSS, with the male subsample identified using the sex variable and all subsequent analyses restricted to cases satisfying the male selection criterion. The final working male dataset contained **2,177 cases**, which constitutes the denominator for variables without item-level missing observations.

2.3. Study Population and Analytical Sample

The study population comprised male respondents represented in the JSLC 2023 microdataset, including children, adolescents, working-age adults and older persons. Application of the male-selection criterion produced an analytical working file of 2,177 respondents, although valid sample sizes differed across variables because of questionnaire routing and missing information. Complete information was available for age cohort, socioeconomic group, area of residence, household headship, insurance status, injury and the principal disease-history variables, whereas union status, educational attainment and employment status contained missing observations. Union status was available for 1,679 males, educational attainment for 1,622 and employment status for 843, meaning that percentages for these variables were calculated from their respective valid denominators. Functional-health information was available for 2,044 respondents, leaving 133 cases without valid functional-health data. The multivariable regression employed complete-case analysis and consequently included 1,580 males, representing 72.6% of the male working sample, while 597 cases were excluded because at least one model variable was missing.

2.4. Measures and Operationalisation

Functional health constituted the central health outcome and was originally represented by four categories indicating no difficulty, some difficulty, a lot of difficulty and inability to perform the assessed function. For descriptive analysis, these categories were retained, permitting the severity distribution of limitation to be presented without discarding information. For binary logistic regression, functional health was dichotomised into **0 = no functional-health difficulty** and **1 = functional-health difficulty**, with the latter combining respondents experiencing some difficulty, a lot of difficulty or inability to perform the relevant function. Illness status captured whether respondents reported illness, while injury measured the occurrence of an incident requiring medical attention, and healthcare utilisation identified reported visits to a doctor, nurse or pharmacist where applicable. Health-insurance status was dichotomised as uninsured or insured, while chronic-disease variables included asthma, diabetes, hypertension, arthritis, chronic obstructive pulmonary disease, heart disease, sickle-cell disease, depression, dementia, other mental disorders, cancer, epilepsy and kidney disease. Disease-history responses

distinguished diagnoses within the preceding 12 months from those reported more than 12 months previously, enabling the study to differentiate recent reporting from longer-standing morbidity.

2.5. Sociodemographic and Socioeconomic Variables

Age was examined both continuously and categorically because the two operationalisations served different analytical purposes. The categorical age variable comprised children aged 0–14 years, youth aged 15–24 years, young adults aged 25–44 years, middle-aged males aged 45–59 years, older adults aged 60–74 years and seniors aged 75 years or older. Socioeconomic position was derived from population consumption quintiles and grouped into poor (quintiles 1–2), middle (quintile 3) and wealthy (quintiles 4–5) categories. Area of residence differentiated the Greater Kingston Metropolitan Area, other urban centres and rural Jamaica, while educational attainment was grouped as primary and below, secondary and post-secondary. Union status incorporated married, common-law, visiting and single categories, and household headship distinguished household heads from respondents who were not heads. For multivariable analysis, these categorical measures were represented through indicator variables, with omitted categories serving as reference groups, while age was entered as a continuous measure in years.

2.6. Statistical Analysis

Statistical analysis proceeded sequentially from univariate description through bivariate association to multivariable modelling. Frequencies and percentages were initially calculated to describe demographic characteristics, health insurance, functional status, injury, illness, healthcare utilisation and chronic-disease histories, with valid percentages used where item-level missing information occurred. Pearson's chi-square tests were subsequently employed to examine associations between categorical variables, including age cohort and selected social characteristics as well as socioeconomic group and health outcomes. Cramer's V was reported alongside chi-square statistics to distinguish statistical significance from the magnitude of association, an important consideration because relatively large samples can generate statistically significant results for substantively weak relationships. Statistical significance was evaluated at an alpha level of 0.05, while exact *p-values* are reported where available and values below 0.001 are presented as $p < 0.001$. The bivariate analysis was followed by binary logistic regression to identify independent predictors of functional-health difficulty while simultaneously adjusting for socioeconomic group, residential location, union status, educational attainment, household headship, age and illness status.

2.7. Logistic Regression Model and Diagnostics

The dependent variable in the multivariable model was binary functional-health difficulty, with absence of difficulty coded 0 and presence of difficulty coded 1. The Enter method was used so that all theoretically relevant explanatory variables were entered simultaneously rather than selected according to automated significance criteria. Adjusted odds ratios (AORs), regression coefficients, standard errors, Wald statistics, 95% confidence intervals (CIs) and *p-values* were used to interpret the independent associations. Overall model significance was assessed using the omnibus likelihood-ratio chi-square test, while Cox and Snell and Nagelkerke pseudo-R^2 statistics were used to describe explanatory improvement relative to the intercept-only model. Calibration was

evaluated using the Hosmer–Lemeshow goodness-of-fit test, and classification performance was examined by comparing baseline and final classification accuracy as well as class-specific correct classification. Because only 25.5% of respondents with functional-health difficulty were correctly classified despite an overall final accuracy of 84.6%, the model is interpreted primarily as an explanatory model of independent associations rather than as a high-performing individual clinical prediction instrument.

2.8. Missing Data and Analytical Cautions

Missing information was treated as missing rather than being assigned to substantive response categories, and analyses were based on cases with valid information for the variables involved. This approach resulted in varying denominators across descriptive and bivariate analyses and a complete-case sample of 1,580 respondents for multivariable regression. Healthcare-utilisation variables require particularly cautious interpretation because only 97 respondents had valid information on visiting a doctor, nurse or pharmacist and only 38 had valid information identifying their most recent place of care. These small valid denominators appear to reflect questionnaire routing and/or missingness and cannot appropriately be interpreted as population-wide utilisation estimates for all 2,177 Jamaican males. Similarly, several rare chronic conditions generated small cell counts, making effect estimates and socioeconomic comparisons less stable than those involving common conditions such as hypertension and diabetes. No imputation procedure was undertaken because the supplied analysis used observed valid responses, and interpretation explicitly acknowledges differences in denominators and missingness.

2.9. Ethical Considerations

The present study constituted a secondary analysis of an existing national survey dataset rather than primary collection of identifiable health information from participants. The researchers did not recruit respondents, administer questionnaires or intervene in participants' healthcare, and the analytical data were obtained through the SALISES Documentation and Data Centre at The University of the West Indies, Mona. Analyses were undertaken for scholarly purposes and reported at the aggregate level, thereby avoiding presentation of information that could identify individual respondents. The study respected the original survey structure and restricted interpretation to variables available within the JSLC dataset. Because ethical approval and consent procedures for the original JSLC are not documented in the supplied analytical output, the present manuscript does not invent or attribute a specific institutional review board number or consent procedure. Any journal submission should include the exact secondary-data access, ethical-review and exemption wording applicable to the authors' institutions and the conditions governing use of the SALISES-provided dataset.

3.0. Results

3.1. Sociodemographic Profile of Jamaican Males

Table 1 indicates considerable social and demographic heterogeneity within the male population represented in the JSLC 2023. Among respondents with valid union-status information, 49.4% were single, compared with 20.7% married, 18.1% in visiting relationships and 11.8% in common-law relationships. Employment information showed that own-account workers constituted 45.1% and private-sector workers 44.2% of valid employment cases,

meaning that these two categories together dominated recorded male employment. Rural residents represented the largest geographical group at 42.0%, followed by the Greater Kingston Metropolitan Area at 29.9% and other urban centres at 28.1%. The socioeconomic distribution was polarised between the wealthy group at 41.3% and the poor group at 40.0%, whereas 18.7% occupied the middle socioeconomic category. These distributions establish that Jamaican male health is being examined across markedly different economic, residential, relationship and life-course circumstances rather than within a socially homogeneous population.

Educational and household characteristics provide further context for interpreting subsequent health inequalities in Table 1. Among the 1,622 males with valid educational information, 70.4% were classified as having post-secondary education, 22.9% secondary education and 6.7% primary education or below, although this distribution must be interpreted alongside the inclusion of children and the pattern of missing educational information. Household heads constituted 42.3% of the sample, compared with 57.7% who were not household heads, a distinction that is strongly dependent on age and life-course position. Children and young adults each represented 22.9% of the male sample, middle-aged males constituted 18.7%, older adults aged 60–74 years accounted for 15.3%, youth represented 14.6%, and seniors aged at least 75 years represented 5.6%. The wide age distribution is analytically important because it prevents the health profile from being interpreted exclusively as an adult or older men's health study. Age must be considered throughout the analysis as both a potential determinant of functional health and a confounder of socioeconomic, educational and household relationships.

Table 1. Sociodemographic, Socioeconomic, Employment and Residential Characteristics of Jamaican Males, JSLC 2023, N = 2,177.

Characteristic	**Category**	**n**	**%**
Union status (n=1,679)	Married	348	20.7
	Common-law	198	11.8
	Visiting	304	18.1
	Single	829	49.4
Employment (n=843)	Local government	49	5.8
	Other government agencies	13	1.5
	Private-sector business	373	44.2
	Unpaid worker	1	0.1
	Employer	27	3.2
	Own-account worker	380	45.1
Residence	Greater Kingston Metropolitan Area	651	29.9
	Other urban centres	612	28.1
	Rural	914	42.0
Socioeconomic group	Poor	871	40.0
	Middle	407	18.7

	Wealthy	899	41.3
Education (n=1,622)	Primary and below	108	6.7
	Secondary	372	22.9
	Post-secondary	1,142	70.4
Household head	No	1,257	57.7
	Yes	920	42.3
Age	0–14	498	22.9
	15–24	317	14.6
	25–44	499	22.9
	45–59	407	18.7
	60–74	333	15.3
	≥75	123	5.6

3.2. Age and the Social Organisation of Male Life

Table 2 reveals that age was strongly associated with several dimensions of male social position, most notably household headship and educational attainment. Household headship increased from 0% among children and 5.4% among youth to 74.4% among middle-aged males, 87.4% among those aged 60–74 years and 83.7% among seniors, producing $\chi^2(5)=1079.001$, $p<0.001$ and Cramer's V=0.704. Educational attainment also varied substantially by age, $\chi^2(10)=818.191$, $p<0.001$, Cramer's V=0.502, with post-secondary education most prevalent among youth and young adults but progressively less common in older cohorts. Socioeconomic position was significantly but more modestly associated with age, $\chi^2(10)=135.040$, $p<0.001$, Cramer's V=0.176, with children and youth disproportionately represented among poorer households. Union status likewise varied by age, $\chi^2(12)=392.511$, $p<0.001$, Cramer's V=0.279, as youth were predominantly single, visiting relationships were concentrated among young adults and marriage became more prominent in middle and later adulthood. These findings indicate that age is not simply a biological measure but is closely intertwined with men's household authority, relationships, educational history and economic position.

In contrast, Table 2 shows no statistically significant relationship between age cohort and geographical residence, $\chi^2(10)=15.201$, $p=0.125$, Cramer's V=0.059. Rural residence remained substantial across every age group and was particularly common among males aged 60–74 years, of whom 49.5% lived in rural areas. The absence of a statistically significant residential-age relationship is important because it distinguishes geography from the much stronger life-course restructuring occurring in household and educational domains. These results also caution against interpreting unadjusted health differences between socioeconomic or relationship categories without considering the confounding influence of age. Household headship, for example, may appear health-protective or health-adverse in simple comparisons partly because household heads are disproportionately concentrated in older age groups. The multivariable analysis becomes essential for separating the independent contribution of these interconnected social characteristics to functional-health difficulty.

Table 2. Age-Cohort Differences in Selected Social Characteristics Among Jamaican Males, JSLC 2023.

Characteristic	χ^2	df	*p*	Cramer's V	Interpretation
Household headship	1079.001	5	<0.001	0.704	Very strong age pattern
Educational level	818.191	10	<0.001	0.502	Strong age pattern
Socioeconomic group	135.040	10	<0.001	0.176	Modest age pattern
Area of residence	15.201	10	0.125	0.059	Not significant
Union status	392.511	12	<0.001	0.279	Moderate age pattern

3.3. Health Status, Functional Health and Healthcare Protection

Table 3 identifies an important contrast between apparently favourable functional health and weak healthcare financial protection among Jamaican males. Fully, 82.2% of respondents were uninsured, leaving only 17.8% reporting health-insurance coverage, despite the presence of functional limitations and chronic morbidity elsewhere in the data. Among 2,044 males with valid functional-health information, 85.7% reported no difficulty, but 7.9% reported some difficulty, 3.7% a lot of difficulty and 2.7% an inability to perform the relevant function. Thus, 14.3% of males with valid data experienced at least some functional-health difficulty, a proportion that should not be obscured by the majority reporting no limitation. Only 1.0% reported a recent injury requiring medical attention, while 96.2% reported no illness other than injury during the relevant reference period. Taken together, Table 3 presents a population in which contemporaneous illness reporting is low but a meaningful minority experience compromised functioning, and the overwhelming majority lacks health insurance.

Healthcare-utilisation results in Table 3 require more restricted interpretation because the relevant valid samples were substantially smaller than the total male sample. Among the 97 males with valid information on whether they had visited a doctor, nurse or pharmacist, 58.8% reported a visit and 41.2% did not, while only 38 respondents supplied valid information concerning their last place of care. Among those 38 respondents, 63.2% reported a doctor's office and 23.7% a public health centre, with much smaller proportions reporting a private health centre, private hospital or UWI. These figures should be regarded as descriptive characteristics of respondents routed to and answering those questions rather than estimates that 58.8% of all Jamaican males recently accessed healthcare. This caution is particularly important given international evidence that men often engage with healthcare less frequently than women and Jamaican research documenting historically limited utilisation among males. (Bourne, 2009; World Health Organization, 2018; World Health Organization, 2019) The stronger conclusion from Table 3 is consequently not a national utilisation rate but the coexistence of low insurance coverage, low contemporaneous illness reporting and measurable functional limitation.

Table 3. Health Status, Functional Health, Injury, Insurance and Healthcare Utilisation Among Jamaican Males, JSLC 2023.

Health characteristic	Category	n	Valid %
Health insurance	Uninsured	1,789	82.2
	Insured	388	17.8

Functional health (n=2,044)	No difficulty	1,752	85.7
	Some difficulty	162	7.9
	A lot of difficulty	75	3.7
	Cannot do at all	55	2.7
Injury requiring medical attention	Yes	22	1.0
	No	2,155	99.0
Illness other than injury	Chronic illness	21	1.0
	Other illness	59	2.7
	Both	2	0.1
	No illness	2,095	96.2
Healthcare visit (n=97)	Yes	57	58.8
	No	40	41.2
Last place of care (n=38)	Doctor's office	24	63.2
	Public health centre	9	23.7
	Private health centre	3	7.9
	Private hospital	1	2.6
	UWI	1	2.6

3.4. Chronic Morbidity

Table 4 indicates that hypertension was the dominant reported chronic condition among Jamaican males, with 257 respondents or 11.8%, reporting a history of the disease. Asthma was reported by 5.4% and diabetes by 5.2%, followed by arthritis at 2.5%, other mental disorders at 1.5%, cancer at 1.3% and heart disease and the other-disease category at approximately 1.2% each. COPD, depression, dementia, epilepsy, sickle-cell disease and kidney disease were reported comparatively infrequently, although low self-reported prevalence cannot be assumed to represent equally low clinically measured prevalence. This qualification is supported by JHLS III, where measured hypertension and diabetes among Jamaican males substantially exceeded self-reported prevalence. (Ministry of Health and Wellness, Jamaica, 2024) For most conditions in the JSLC, diagnoses dating from more than 12 months previously outnumbered those reported within the preceding year, indicating that much of the observed morbidity reflected established disease histories. The chronic-disease findings contradict any interpretation that the 96.2% reporting no contemporaneous illness in Table 3 were necessarily free from disease.

The distinction between illness experience and disease history observed in Table 4 has substantial conceptual importance for men's-health research. A man with controlled hypertension or diabetes may not regard himself as currently ill, particularly when the condition does not prevent employment, mobility, household responsibilities or other valued activities. Earlier Jamaican evidence among older males similarly found generally favourable self-assessments of health coexisting with cancers, kidney or bladder disorders, hypertension, diabetes and prostate

problems. (Morris et al., 2011) Globally, this pattern is compatible with recognition that men's healthcare engagement can be affected by expectations surrounding independence, endurance and reluctance to express vulnerability. (McKenzie, Collings, et al., 2018; World Health Organization, 2018) The JSLC findings do not directly measure masculinity and cannot indicate that masculine norms caused low illness reporting, but they provide empirical evidence of a discrepancy that such theories may help investigate in future research. Accordingly, Table 4 strengthens the argument for evaluating Jamaican male health through multiple indicators rather than treating a single current-illness question as a comprehensive measure of morbidity.

Table 4. Reported Chronic Diseases and Health Conditions Among Jamaican Males, JSLC 2023, N=2,177.

Condition	**≤12 months n (%)**	**>12 months n (%)**	**Ever reported n (%)**
Hypertension	46 (2.1)	211 (9.7)	**257 (11.8)**
Asthma	20 (0.9)	98 (4.5)	**118 (5.4)**
Diabetes	24 (1.1)	90 (4.1)	**114 (5.2)**
Arthritis	18 (0.8)	36 (1.7)	54 (2.5)
Other mental disorder	4 (0.2)	28 (1.3)	32 (1.5)
Cancer	2 (0.1)	26 (1.2)	28 (1.3)
Other illness/disease	8 (0.4)	19 (0.9)	27 (1.2)
Heart disease	6 (0.3)	20 (0.9)	26 (1.2)
Sickle-cell disease	1 (<0.1)	15 (0.7)	16 (0.7)
Kidney disease	3 (0.1)	9 (0.4)	12 (0.6)
Epilepsy	4 (0.2)	7 (0.3)	11 (0.5)
Dementia	1 (<0.1)	8 (0.4)	9 (0.4)
COPD	0	7 (0.3)	7 (0.3)
Depression	1 (<0.1)	6 (0.3)	7 (0.3)

3.5. Cancer Profile

Table 5 indicates that prostate cancer dominated the reported cancer history among Jamaican males, accounting for 22 of 28 identified cases, or 78.6%. Colon cancer accounted for three cases, or 10.7%, while lung cancer and lymphoma each represented one case, and one additional case was not specified. The numerical predominance of prostate malignancy is notable given the established importance of prostate disease within Jamaican men's health research and preventive-health discussions. Nevertheless, the denominator of only 28 cancer cases means that these percentages are highly sensitive to very small changes in case numbers and should not be interpreted as population cancer-incidence proportions. The JSLC is a living-conditions survey rather than a cancer registry or diagnostic surveillance system, and the findings represent respondent-reported disease histories rather than histologically verified incidence. Table 5 is consequently best understood as descriptive evidence that prostate malignancy overwhelmingly predominated among cancers reported by males in this JSLC sample.

The concentration of prostate cancer also reinforces the value of male-specific health surveillance because aggregation of male and female cancers could obscure sex-specific disease priorities. Previous research among Jamaican men aged 55 years and older found cancers among the major reported health conditions and noted that only 35% of respondents had ever received a prostate examination. (Morris et al., 2011) The present JSLC analysis cannot determine screening history, tumour stage, treatment status, survival or whether reported cancers were active at the time of interview. It cannot establish whether the predominance of prostate cancer resulted from biological incidence, age composition, screening, survival differences or reporting patterns. What it does establish is that prostate cancer constituted most reported cancer histories within the male analytical sample. Future linkage or triangulation with cancer-registry and screening data would provide a stronger basis for translating this descriptive pattern into cancer-control recommendations.

Table 5. Distribution of Reported Cancer Types Among Jamaican Males with a Cancer History, JSLC 2023.

Cancer type	**n**	**%**
Prostate cancer	22	78.6
Colon cancer	3	10.7
Lung cancer	1	3.6
Lymphoma	1	3.6
Not stated	1	3.6
Total	**28**	**100.0**

3.6. Socioeconomic Inequalities in Health and Insurance

Table 6 provides the clearest evidence of socioeconomic inequality in health protection, as insurance coverage increased systematically from 6.5% among poor males to 16.2% among middle-income males and 29.5% among wealthy males. The relationship was statistically significant, $\chi^2(2)=159.737$, $p<0.001$, with Cramer's V=0.271, making insurance one of the more substantively important socioeconomic associations identified in the study. Functional health, by contrast, did not differ significantly by socioeconomic position, $\chi^2(6)=5.117$, $p=0.529$, Cramer's V=0.035, with more than four-fifths of each socioeconomic group reporting no functional difficulty. Injury requiring medical attention was similarly unrelated to socioeconomic position, $\chi^2(2)=0.841$, $p=0.657$, Cramer's V=0.020. Illness other than injury reached statistical significance, $\chi^2(6)=14.893$, $p=.021$, but its Cramer's V of 0.058 indicates a very weak relationship. The findings indicate that socioeconomic inequality among Jamaican males is much more visible in financial protection against healthcare costs than in contemporaneous functional limitation or injury.

This pattern challenges any simple assumption that poorer males must report uniformly worse health across every indicator. Wealthier respondents may possess greater resources for preventive visits, diagnostic testing and disease recognition, while poorer men may experience barriers that reduce both insurance coverage and opportunities for diagnosis. The JHLS III discrepancy between measured and self-reported disease prevalence illustrates why the absence of a reported diagnosis cannot safely be interpreted as absence of underlying pathology. (Ministry of

Health and Wellness, Jamaica, 2024) Socioeconomic differences in self-reported disease may reflect a combination of true morbidity, age composition, healthcare access, screening and awareness rather than biological disease burden alone. At the same time, the extremely low 6.5% insurance coverage among poor males represents a clear inequality because it concerns access to financial protection rather than disease detection. Table 6 consequently identifies insurance coverage as a particularly important social-policy dimension of Jamaican men's health, even though socioeconomic group was not independently predictive of functional-health difficulty in the final model.

Table 6. Health Characteristics of Jamaican Males by Socioeconomic Group, JSLC 2023.

Outcome	**Poor**	**Middle**	**Wealthy**	**χ^2 (df)**	***p***	**Cramer's V**
Insured	6.5%	16.2%	29.5%	159.737 (2)	<0.001	0.271
No functional difficulty	87.2%	86.8%	83.9%	5.117 (6)	0.529	0.035
Injury requiring care	1.1%	1.2%	0.8%	0.841 (2)	0.657	0.020
No current illness	97.4%	95.3%	95.6%	14.893 (6)	0.021	0.058

3.7. Socioeconomic Patterning of Major Chronic Conditions

Table 7 indicates that socioeconomic gradients in chronic morbidity were disease-specific rather than uniformly concentrated among economically disadvantaged males. Diabetes differed significantly across socioeconomic groups, $\chi^2(4)=19.596$, $p<0.001$, Cramer's V=0.067, with reports of diabetes dating beyond 12 months increasing from 2.4% among poor males to 4.2% among middle-income and 5.8% among wealthy males. Hypertension exhibited a similar but somewhat stronger pattern, $\chi^2(4)=29.865$, $p<0.001$, Cramer's V=0.083, with longer-standing hypertension reported by 6.4%, 9.1% and 13.1% of the respective socioeconomic groups. Neither association was large according to Cramer's V, indicating that socioeconomic position explains only a limited proportion of the variation despite statistically reliable differences. Asthma, arthritis, COPD, heart disease and sickle-cell disease were not significantly associated with socioeconomic group. Table 7 provides no evidence for a universal social gradient across male chronic diseases and instead identifies diabetes and hypertension as the principal conditions displaying statistically detectable socioeconomic patterning.

The direction of these gradients requires careful interpretation because higher reported diabetes and hypertension among wealthy males does not establish that wealth biologically increases disease risk. Age is strongly associated with socioeconomic position in this sample, while healthcare access, screening frequency, health literacy and diagnostic opportunity can also produce greater recognition of chronic disease among people with more resources. Jamaican JHLS III evidence is particularly instructive because objectively measured male hypertension and diabetes were considerably more prevalent than men's own reports of those conditions. (Ministry of Health and Wellness, Jamaica, 2024) This suggests that undiagnosed disease may be an important source of distortion when socioeconomic comparisons depend exclusively on self-reported diagnosis. The modest Cramer's V values further indicate that statistical significance should not be confused with a large socioeconomic effect. Accordingly, Table 7 supports a diagnosis-sensitive interpretation in which observed socioeconomic differences represent reported disease histories shaped potentially by both morbidity and differential detection.

Table 7. Major Chronic Conditions Among Jamaican Males by Socioeconomic Group, JSLC 2023.

Condition	χ^2 (df)	*p*	Cramer's V	Socioeconomic association
Asthma	3.876 (8)	0.868	0.030	No
Diabetes	19.596 (4)	**<0.001**	0.067	**Yes**
Hypertension	29.865 (4)	**<0.001**	0.083	**Yes**
Arthritis	6.528 (6)	0.367	0.039	No
COPD	6.576 (6)	0.362	0.039	No
Heart disease	4.652 (6)	0.589	0.033	No
Sickle-cell disease	10.604 (8)	0.225	0.049	No

3.8. Socioeconomic Patterning of Less-Common Conditions

Table 8 indicates that most less-prevalent chronic and serious conditions were not significantly associated with socioeconomic position. Depression, dementia, other mental disorders, cancer, epilepsy and the residual other-disease category produced no statistically significant overall socioeconomic relationships at the conventional 0.05 threshold. Kidney disease constituted the exception, $\chi^2(6)=15.231$, $p=0.019$, Cramer's V=0.059, with reported cases concentrated in the middle and wealthy groups rather than the poor group. However, kidney disease was rare overall, with only 12 cases identified in Table 4, meaning that several cells necessarily contained very small numbers. The statistically significant result should be treated as exploratory rather than compelling evidence of a socioeconomic gradient in male renal disease. Table 8 illustrates why inferential significance, effect magnitude and cell stability must be considered jointly rather than treating $p<0.05$ as sufficient evidence of substantive importance.

Cancer provides a useful example of this distinction because it appeared descriptively more frequent among wealthy males, but the overall association did not achieve statistical significance, $\chi^2(6)=9.870$, $p=0.130$, Cramer's V=0.048. Likewise, the other-disease category approached but did not cross the conventional significance threshold, $\chi^2(8)=14.457$, $p=0.071$, while its effect size remained small. Rare-condition analysis is particularly vulnerable to unstable percentages because one or two observations can materially change the apparent distribution across socioeconomic groups. The absence of significant socioeconomic differences should also not be interpreted as proof of socioeconomic equality because limited statistical power can obscure genuine differences when diseases are uncommon. Conversely, the significant kidney-disease result cannot establish a robust socioeconomic pattern without replication in larger samples or clinically validated surveillance data. The most defensible conclusion from Table 8 is that strong socioeconomic patterning was not indicated for most less-common conditions in the JSLC male sample.

Table 8. Other Chronic and Serious Conditions Among Jamaican Males by Socioeconomic Group, JSLC 2023.

Condition	χ^2 (df)	*p*	Cramer's V
Depression	4.728 (6)	0.579	0.033
Dementia	7.450 (4)	0.114	0.041

Other mental disorder	8.832 (6)	0.183	0.045
Cancer	9.870 (6)	0.130	0.048
Other illness/disease	14.457 (8)	0.071	0.058
Epilepsy	2.683 (4)	0.612	0.025
Kidney disease	15.231 (6)	**0.019**	0.059

3.9. Independent Predictors of Functional-Health Difficulty

Table 9 indicates that the multivariable model significantly distinguished Jamaican males with and without functional-health difficulty, $\chi^2(12)=282.307$, $p<0.001$, with Nagelkerke $R^2=0.270$. Age was the strongest independent predictor, with each additional year associated with a 6.6% increase in the odds of functional-health difficulty (AOR=1.066, 95% CI 1.054–1.078, $p<0.001$). Males reporting illness had approximately 2.30 times the adjusted odds of functional difficulty compared with males not reporting illness (AOR=2.297, 95% CI 1.214–4.346, $p=0.011$). Single males had 45.6% greater adjusted odds of functional difficulty relative to the omitted union-status reference category (AOR=1.456, 95% CI 1.033–2.052, $p=0.032$). Household heads had 33.9% lower adjusted odds than non-heads (AOR=0.661, 95% CI 0.460–0.950, $p=0.025$), whereas socioeconomic position, residence and education were not statistically significant independent predictors. The results show that functional-health difficulty was structured principally by ageing, illness status and selected social-role characteristics rather than independently by socioeconomic class or geography after simultaneous adjustment.

The model indicated acceptable calibration according to the Hosmer–Lemeshow statistic, $\chi^2(8)=14.170$, $p=0.077$, while overall classification improved from 82.4% in the intercept-only model to 84.6% after predictors were introduced. Nevertheless, the final model correctly classified 97.2% of males without functional difficulty but only 25.5% of males experiencing functional difficulty, revealing substantial imbalance in predictive sensitivity. The apparently high 84.6% overall accuracy is driven predominantly by successful classification of the much larger group without functional health difficulty. The model should be regarded as useful for identifying population-level correlates rather than as an individual screening or clinical prediction algorithm. The absence of independent socioeconomic and educational effects also indicates why bivariate relationships should not automatically be interpreted as direct determinants when age and other social characteristics are strongly interrelated. Most importantly, the persistence of illness status after adjustment confirms that reported illness contains meaningful information about functional health even though the descriptive findings show that current illness alone substantially underrepresents the broader chronic-disease profile.

Table 9. Multivariable Binary Logistic Regression Predicting Functional-Health Difficulty Among Jamaican Males, JSLC 2023.

Predictor	**B**	**SE**	**Wald χ^2**	***p***	**AOR**	**95% CI**
Middle socioeconomic group	−0.097	0.221	0.192	0.661	0.908	0.589–1.399
Wealthy socioeconomic group	−0.071	0.176	0.162	0.687	0.931	0.659–1.316
Urban residence	0.284	0.183	2.412	0.120	1.329	0.928–1.903
Semi-urban residence	−0.150	0.187	0.648	0.421	0.860	0.597–1.241

Single	0.376	0.175	4.594	**0.032**	**1.456**	**1.033–2.052**
Visiting relationship	−0.482	0.282	2.933	0.087	0.617	0.356–1.072
Common-law relationship	−0.260	0.277	0.880	0.348	0.771	0.448–1.328
Secondary education	−0.316	0.298	1.127	0.288	0.729	0.407–1.307
Post-secondary education	−0.437	0.306	2.045	0.153	0.646	0.355–1.176
Head of household	−0.414	0.185	5.002	**0.025**	**0.661**	**0.460–0.950**
Age, years	0.064	0.006	127.990	**<0.001**	**1.066**	**1.054–1.078**
Illness status	0.832	0.325	6.539	**0.011**	**2.297**	**1.214–4.346**

Model diagnostics: *n=1,580; omnibus $\chi^2(12)=282.307$, $p<0.001$; −2LL=1187.710; Cox and Snell $R^2=.164$; Nagelkerke $R^2=.270$; Hosmer–Lemeshow $\chi^2(8)=14.170$, $p=0.077$; overall classification=84.6%.*

4.0. Discussion

The principal contribution of this study is the identification of a multidimensional male-health profile that cannot be adequately represented by contemporaneous illness reporting alone. Although 96.2% of Jamaican males reported no illness other than injury during the applicable reference period, 14.3% of respondents with valid functional-health information experienced some degree of limitation, and substantial numbers reported histories of hypertension, asthma and diabetes. This juxtaposition represents what may be described as a reported-illness–morbidity paradox, in which absence of perceived or recent illness coexists with established chronic disease and functional compromise.

The finding extends earlier Jamaican research showing that men can report favourable health despite recognised chronic conditions and limited healthcare utilisation. (Bourne, 2009; Morris et al., 2011) It is also consistent with JHLS III evidence demonstrating large differences between self-reported and objectively measured hypertension and diabetes among Jamaican males. (Ministry of Health and Wellness, Jamaica, 2024) The present study advances Jamaican men's-health scholarship by empirically separating current illness, disease history and functional status within the same contemporary national living-conditions dataset.

The distinction is especially important because illness, disease and disability are related but conceptually non-identical dimensions of health. A chronic condition may be medically established yet sufficiently controlled that the individual does not perceive himself as presently ill, while functional limitation may emerge from chronic disease, ageing, injury or other circumstances that are not captured by a recent-illness question. International evidence similarly indicates that improvements in longevity do not necessarily translate into equivalent improvements in years lived without disability. (World Health Organization, n.d.-b) WHO's global health framework consequently emphasises morbidity and disability alongside mortality when evaluating population health. (World Health Organization, n.d.-a, n.d.-b) The present results provide a Jamaican illustration of this broader principle because relatively favourable immediate illness reporting did not eliminate either chronic-disease histories or functional-health difficulties. Male-health surveillance should consequently triangulate subjective illness, diagnosed morbidity, measured biological risk and functional status wherever appropriate data are available.

Age emerged as the most powerful independent correlate of functional-health difficulty and represents a central organising dimension of male health in Jamaica. The AOR of 1.066 means that each additional year was associated with 6.6% higher odds of functional difficulty after the other variables were controlled, producing a substantial cumulative difference over decades of ageing. This result is consistent with the biological accumulation of morbidity and disability across the life course and with previous Jamaican research highlighting the distinctive health needs of men aged 55 years and older. (Morris et al., 2011) However, the present analysis extends that literature by situating older males within a sample spanning childhood through advanced age rather than beginning observation in later adulthood. Age was additionally strongly related to household headship, education, socioeconomic position and union status, demonstrating that biological ageing occurs simultaneously with major transformations in men's social roles. Policies designed to improve functional health should adopt a life-course orientation that begins prevention before limitations become concentrated in middle and later adulthood.

The independent association between illness status and functional-health difficulty provides an additional validation of the functional outcome while also illuminating the limitations of illness reporting. Males reporting illness had approximately 2.30 times the adjusted odds of functional difficulty, demonstrating that perceived illness is strongly associated with compromised functioning when illness is acknowledged. Nevertheless, because most respondents did not report contemporaneous illness while chronic-disease histories remained observable, illness status should not be treated as a comprehensive morbidity measure. The result is compatible with research suggesting that men may delay help-seeking or interpret health problems through thresholds involving severity, independence and capacity to continue ordinary activities. (Bourne et al., 2010; McKenzie, Collings, et al., 2018) Jamaican cultural scholarship has similarly discussed expectations surrounding male strength and reluctance to display vulnerability, although the JSLC variables analysed here cannot directly test those psychosocial mechanisms. (Bourne et al., 2010) Future Jamaican surveys could strengthen explanatory analysis by combining health measures with validated indicators of masculinity, health literacy, perceived vulnerability, preventive behaviour and thresholds for defining oneself as ill.

Relationship status also remained relevant after adjustment, as single males experienced significantly greater odds of functional-health difficulty than the omitted reference category. This result is noteworthy in light of earlier Jamaican research examining differences between married and unmarried men and showing that relationship status can be associated with illness reporting even when self-rated health differences are less straightforward. (Bourne, 2009) Partnership may provide emotional support, practical assistance, encouragement to obtain healthcare, monitoring of symptoms and other resources potentially relevant to functioning. However, the cross-sectional JSLC evidence cannot establish whether being single increases functional difficulty or whether health and life-course circumstances influence partnership formation and dissolution. The relationship between union status and age observed in Table 2 further indicates that partnership patterns are embedded in the life course rather than functioning as isolated exposures. The single-status result should consequently stimulate longitudinal investigation rather than being interpreted as causal evidence that partnership itself protects functional health.

Household headship was associated with lower adjusted odds of functional-health difficulty despite household heads being disproportionately concentrated in older age groups. This finding may reflect selection into household

leadership, whereby men capable of maintaining functional independence are more likely to occupy or retain the role of household head. It may also reflect economic resources, social authority, family support or other unmeasured characteristics associated simultaneously with headship and functioning. Because the relationship remained significant after controlling for chronological age, its association cannot be attributed solely to household heads being older than non-heads. Nevertheless, reverse causation remains plausible because serious functional impairment could reduce the likelihood that an individual is identified as the household head. The finding illustrates both the analytical value and causal limitations of cross-sectional social-health data.

One of the most policy-relevant findings concerns the pronounced socioeconomic gradient in health-insurance coverage. Only 6.5% of poor males were insured compared with 16.2% of the middle socioeconomic group and 29.5% of wealthy males, producing a considerably stronger socioeconomic association than was observed for functional health, injury or most chronic conditions. This pattern suggests that economic inequality operates particularly clearly through financial protection and access capacity, even when it does not manifest as an equally strong gradient in reported functional impairment. Such a distinction is important in Jamaica's mixed public-private health environment because insurance may influence choice, timeliness, continuity and financial consequences of healthcare without necessarily producing immediate cross-sectional differences in functioning. The fact that socioeconomic status ceased to predict functional difficulty independently after adjustment should not be interpreted as evidence that socioeconomic inequality is irrelevant to men's health. Rather, the findings suggest that socioeconomic circumstances may operate through pathways such as insurance, diagnosis, prevention, material resources and accumulated exposures that require more detailed longitudinal investigation.

The socioeconomic patterning of diabetes and hypertension deserves similarly cautious interpretation because both conditions appeared more frequently among economically advantaged groups in the self-reported JSLC data. A superficial interpretation could imply that wealthier Jamaican males experience greater chronic-disease risk, but such a conclusion would disregard age composition and differential opportunities for diagnosis. JHLS III provides particularly compelling comparative evidence because measured prevalence among Jamaican men exceeded perceived prevalence substantially for both diabetes and hypertension. (Ministry of Health and Wellness, Jamaica, 2024) The current JSLC socioeconomic gradients may consequently represent some combination of true risk, age, healthcare access, screening and awareness rather than a simple wealth-to-disease causal pathway. This interpretation is strengthened by the small Cramer's V values for diabetes and hypertension, indicating statistically significant but substantively modest relationships. Future studies linking socioeconomic information to objectively measured blood pressure, glucose and renal biomarkers would be better positioned to distinguish disease prevalence from diagnostic inequality.

The Jamaican findings also fit within a wider global men's-health problem in which NCDs, delayed healthcare engagement and premature mortality intersect. WHO reports that cardiovascular diseases, cancers, diabetes and respiratory diseases constitute major causes of male morbidity and mortality, while behavioural and service-use patterns contribute to inequalities both between men and women and among groups of men. (World Health Organization, 2018) More recent international policy analysis has argued that men's health remains insufficiently prioritised despite shorter male life expectancy and higher mortality in many settings. (Cornell, 2025) The present

Jamaican evidence adds a Caribbean perspective by demonstrating that health inequality is not confined to overt disease prevalence but also involves insurance protection, disease recognition, functioning and social roles. It additionally indicates why national men's-health strategies should avoid treating men as a homogeneous population because age, partnership, household roles and economic resources produce different forms of vulnerability. Jamaica can contribute to the international men's-health literature by showing how gender-responsive policy can be integrated with life-course and socioeconomic approaches in a middle-income Caribbean society.

5.0. Implications for Public Health and Policy

The findings support a shift from illness-responsive men's healthcare towards preventive, function-oriented and life-course approaches. If healthcare engagement begins primarily when men perceive themselves as ill, chronic hypertension, diabetes and other asymptomatic conditions may remain undetected until complications develop. Screening opportunities should be expanded in settings routinely frequented by men, including workplaces, community organisations, sporting environments and other non-traditional health-service locations, an approach also suggested by earlier Jamaican research among older males. (Morris et al., 2011) Preventive encounters should incorporate blood-pressure measurement, diabetes-risk assessment, cardiovascular risk, renal health, cancer awareness and functional-health screening rather than depending solely on spontaneous symptom reporting. Attention should be directed towards middle-aged and older males because age indicated the strongest independent relationship with functional difficulty. Such strategies would operationalise the central finding that absence of reported illness cannot safely be equated with absence of health need.

Insurance inequality represents a second major policy priority because more than four-fifths of males were uninsured and coverage among poor men was particularly low. Jamaica's public health system provides an important foundation for access, but insurance remains relevant to financial protection and options for obtaining services across public and private sectors. The observed gradient suggests that economically disadvantaged males may have fewer mechanisms for absorbing healthcare expenditure or accessing alternative providers when public services are constrained. Policies designed to increase male preventive engagement should consider financial barriers alongside cultural and behavioural explanations for under-utilisation. Insurance expansion alone will not resolve men's-health disparities because socioeconomic position did not independently predict functional difficulty, but financial protection represents one measurable inequality on which intervention is possible. A comprehensive men's-health strategy should consequently combine prevention, health literacy, accessible screening, financial protection and gender-responsive service delivery rather than relying on any single intervention.

6.0. Strengths and Limitations

A major strength of the study is its use of contemporary JSLC 2023 microdata to provide a multidimensional analysis of Jamaican males across the entire life course. The analysis simultaneously incorporates demographic structure, socioeconomic position, education, residence, union status, household headship, insurance, illness, functional health and multiple chronic conditions, thereby extending beyond studies restricted to one disease or age category. The sequential use of descriptive statistics, chi-square tests, effect sizes and multivariable logistic

regression also permits differentiation between simple group differences and independent adjusted relationships. Reporting Cramer's V alongside significance tests is particularly valuable because several statistically significant socioeconomic associations were small in substantive magnitude. The regression model further indicated acceptable calibration and identified age, illness status, single status and household headship as independent correlates of functional difficulty. Together, these strengths allow the study to address the identified research gap concerning the contemporary intersection of functioning, morbidity and social circumstances among Jamaican males.

Several limitations nevertheless require careful consideration when interpreting the findings. First, the cross-sectional design precludes causal inference and cannot establish temporal direction between social characteristics and functional-health difficulty. Second, chronic conditions are based on reported histories rather than systematic clinical measurement, making underdiagnosis and differential disease awareness plausible, particularly given JHLS III evidence of substantial differences between self-reported and measured NCD prevalence. (Ministry of Health and Wellness, Jamaica, 2024) Third, healthcare-utilisation findings are based on very small valid subsamples and should not be generalised to all Jamaican males, while the regression excluded 27.4% of the male working sample because of missing model information. Fourth, rare conditions such as kidney disease, cancer, depression and COPD generated sparse cells, reducing the stability of socioeconomic comparisons and making some statistically significant results exploratory. Fifth, the regression model displayed low sensitivity for functional-health difficulty despite high overall classification accuracy, meaning that it should not be employed as an individual prediction tool. Finally, the JSLC variables analysed here do not directly measure masculinity, healthcare attitudes, health literacy, occupational exposure or behavioural risk, thereby limiting explanations of the mechanisms underlying the observed statistical associations.

7.0. Conclusion

This study provides a contemporary multidimensional assessment of health among Jamaican males using the 2023 Jamaica Survey of Living Conditions and addresses an important gap in male-specific population-health research. The central finding is that favourable contemporaneous illness reporting does not necessarily indicate an absence of morbidity, because chronic disease and functional limitations remain evident among a population in which 96.2% reported no current illness other than injury. Hypertension, asthma and diabetes constituted the principal reported chronic conditions, while prostate cancer dominated reported cancer histories, and 82.2% of males lacked health insurance. Age emerged as the strongest independent predictor of functional-health difficulty, while illness status and single status increased adjusted odds, and household headship was associated with lower odds. Socioeconomic position displayed a pronounced relationship with insurance coverage and selected reported chronic diseases but did not independently predict functional difficulty after adjustment for other factors. Jamaican men's health should be conceptualised through the interconnected domains of reported illness, diagnosed morbidity, functional capacity, social relationships, ageing and healthcare protection, rather than through any single indicator.

The study also has implications beyond Jamaica because it illustrates how conventional self-reported illness measures can obscure dimensions of male vulnerability relevant to global men's-health policy. International

evidence increasingly recognises that male health disadvantages emerge from complex interactions among biology, behaviour, socioeconomic conditions, gender norms and healthcare-system engagement. (Bourne, 2009; Cornell, 2025; McKenzie, Collings, et al., 2018; McKenzie, Younger, et al., 2020; Moon, 2018; Rata Mohan et al., 2025; Stack, n.d.; Vlassoff, 2007) Jamaica's experience indicates that these relationships can coexist with substantial within-male heterogeneity and that socioeconomic inequality may be more visible in access-related resources such as insurance than in cross-sectional functional status. Future research should integrate longitudinal observation, objectively measured biomarkers, healthcare-use histories, health literacy and measures of masculinity with the socioeconomic breadth available in the JSLC. Such research could determine whether apparently healthy men with unrecognised chronic disease represent an important target population for earlier detection and prevention. Ultimately, improving Jamaican male health requires moving beyond the question of whether men say they are ill towards the more comprehensive question of whether they are functionally well, adequately screened, appropriately treated and financially protected across the life course.

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Authors' Contributions

Author's independent contribution.

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