# *Advancing Equality for Men and Women*

## The response of the Men's Health Forum to the consultation document

## 1. Introduction

1.1 The Men's Health Forum (MHF) has been making the case for improvements in health service delivery to men for several years. We have drawn attention on numerous occasions and in numerous ways to the inequalities between men and women in terms of both use of health services and health outcomes.* [see footnote to this section]

1.2 In our view, there can be no significant progress in public health in the UK until policy makers and service planners find ways of constructing healthcare systems that respond more sensitively to male attitudes, behaviours, needs and aspirations.

1.3 For these reasons, the MHF strongly welcomes the Equality Bill and the introduction of the public sector duty to promote gender equality.

1.4 It is our hope that adherence of health authorities to the requirements of the new legislation and – perhaps more importantly – their acknowledgment of the spirit and culture-changing intent of the "gender duty", will lead to a new recognition of the importance of gender as a determinant of health status.

1.5 This does not mean that we are anticipating a miracle - however, the MHF believes that over a period of time, the new legislation could lead to a step change in the way health services engage with men, and in the way men engage with health services. Potentially, this could lead to significant and measurable improvements in the health of the male population over the next decade and beyond.

1.6 In summary, although our response to the consultation document is not without its particular reservations, it should be read against this background of general approval and considered optimism.

1.7 Apart from the “General Comments” at section 2 and the “Additional Comments” at section 7 the remainder of this document is structured according to the questions posed in the consultation document. Where questions are not relevant to our area of interest and expertise they have been ignored (this applies to questions 2, 3, and 7).

* It is the policy of the MHF to make comparisons between men’s and women’s health only when it is unavoidably necessary to do so. We do not advocate shifting attention away from female health or re-allocating resources from women to men. Moreover we do not believe that women’s health should function as a “gold standard” for men’s health – the MHF is committed to improved health for both men *and* women.

# 2. General comments

2.1 The consultation document suggests that it is the intention of the gender duty to secure equality of outcome between men and women wherever that is possible.

2.2 This intention is made explit in the Minister’s foreword and is re-stated (among other places) in paragraph 2.4 which makes the case for statutory intervention, and in paragraph 3.11, which asserts that “improved outcomes” are the “key test” of the success of the new legislation. This emphasis is greatly to be commended.

2.3 Outcomes are of particular importance in measuring the effectiveness of health services. It is presently the case that outcome measures in many disease areas, demonstrate unequivocally that men are not doing as well as women (and some men – the least well off – are doing the least well of all).

2.4 At the beginning of the consultation document however, “outcomes” are referred to on a number of occasions in the context of a balance with “process”, as though more of one means less of the other. From this perspective, if achieving outcomes is good generating “process” must, by implication, be negative and unhelpful.

2.5 This is false logic - and from the MHF’s point of view it generates two potential problems.

2.6 The first is that the perceived difficulties with addressing the health of men have become endemic in many health bodies. Since services are generally provided on a whole population basis, it is often regarded as men’s “own fault” if they do not take advantage of them to the same extent as women. It is consequently not uncommon to hear the male 50% of the population referred to, without irony, as a “hard-to-reach” group.

2.7 Because these attitudes are so entrenched and because the evidence base for good practice is presently so poor, it is our view that we do need measurable process indicators to ensure that health providers actively engage with the issue.

2.8 This is not to say that MHF advocates increased bureaucracy. We believe however, that there is a strong case for intelligence gathering, statistical analysis, formal reporting procedures and so on where these processes will focus the minds of service planners on the background against which better outcomes need to be achieved.

2.9 The second problem is that this "process versus outcomes" approach undermines the recognition that outcomes often only have real value if they are measurable against comparitative indicators – most obviously, in this case, we need to close health outcome gaps between men and women (in a way that takes account also of the continuing need to improve the health of women).

2.10 It is hard to see how improvements can be achieved in pursuit of this objective unless health planners and providers are required to demonstrate via stated targets, publication of results and so on, that that they know why, how, and to what extent, progress is being made.

2.11 For these reasons, this document will, in response to some of the specific questions, make the case for process indicators as well as acknowledging and welcoming the emphasis on outcomes that informs the consultation document as a whole.

## 3. Question 1:
### The proposals for specific duties and how the general duty might best be framed.

3.1 It is our view that the first of the general objectives of the gender duty at paragraph 2.10 in the consultation document should be made stronger.

3.2 Instead of "making a difference to men's and women's lives, through improved public services responsive to their needs", we would like to see a form of words that incorporates more explicitly the intentions expressed in the preceding paragraph (2.9) and which acknowledges both the differences and the similarities between men and women.

3.3 We do not see the need indeed, to differentiate between the intentions of the gender duty (2.9) and the goals to towards which public authorities should be "led" (2.10).

3.4 Our suggestion therefore is to merge the ideas expressed in paragraphs 2.9 and 2.10 and introduce a form of words along the lines of: "improve the quality of life for all people by ensuring that services and policies fully acknowledge

men's and women's different attitudes, experiences, behaviours, needs and sensitivities wherever those factors have a bearing on the achievement of the public authority's objectives and the discharge of the public authority's duties".

3.5 We are also concerned that the concept of "discretion" as it is presently expressed in paragraph 3.11 may allow public authorities too much leeway in local decision-making.

3.6 We acknowledge absolutely the importance of recognising that public authorities are best equipped to make decisions relevant to the particular circumstances in which they are required to deliver services. At the same time, we are uncomfortable with the idea that public authorities' implementation of the specific duties should be subject to their own definition of "proportionate and relevant".

3.7 This latter approach seems inconsistent with the Equality Bill's over-arching objective of achieving significant change nationwide and is rather oddly out of step with the formal requirements to identify goals, draw up schemes and so on. In particular such an approach seems likely to lead to inconsistencies of provision and approach between different parts of the country.

3.8 Furthermore, our experience suggests that many health authorities firmly believe that the action they presently take in respect of gender differences already is "proportionate and relevant" (i.e. that services delivered on a whole population basis are entirely appropriate for men). This complacency needs to be challenged.

3.9 It seems at least possible too, that the degree of flexibility proposed in the consultation document will allow those public authorities that are not motivated to do so, to postpone – if not to disregard completely – the need to take significant action on this matter.

3.10 For this reason we would like to see the specific duties enshrine the concept that while it may be necessary to allow public authorities some latitude on the issue of what is "proportionate", it will certainly *always* be "relevant" for them to take effective action under the duty to achieve improvements to people's lives. We would also like to see the development of formal guidance on the definition of "propotionate".

3.11 We would emphasise again however, that these preceding comments need to be viewed in the context of our positive response to the introduction of the new legislation as a whole. In particular we commend the ambition to ensure that the specific duties have equal status with the existing duties on race and disability (para 2.12). We urge that the drive to achieve this ambition is maintained once the duties come into force.

3.12 We also welcome the three components that make up the detail of the specific duties. The "goals and schemes" and "gender impact assessments" components however, are far more relevant to our concerns than the

requirement to develop and publish and equal pay policy and we will be restricting our response to those two components.

3.13 It is not clear whether Question 1 refers particularly to the first component of the specific duties ("goals and schemes") as well seeking views on the specific duties in general. It seems likely however, that it does, since Questions 2 – 6 refer to the other two components.

3.14 Our response to the "goals and schemes" element is very positive. It has been the policy of the MHF for some long time that health bodies should be required to set goals and targets aimed at tackling gender inequalities. It might be worth stressing at this point however, that goals and targets should concentrate on closing gaps in health service use and health outcomes between men and women (rather than, for example, increasing use of services by one sex or the other, which might have the effect of increasing numbers overall but maintaining gaps proportionately).

3.15 It certainly makes sense for public authorities to consider the specific duties within the context of their own sector's existing policy guidance (para 3.24) and we welcome this approach.

3.16 As a side issue, it is interesting - if not ironic - that the consultation document chooses specifically to highlight the "gender perspective" contained within *National Standards, Local Action* as an example of useful mechanisms already in place in particular sectors. Our experience is that changes made between the consultation version of the Healthcare Commission's inspection programme on *National Standards, Local Action* and the final published version, resulted in the disappearance of clear process indicators connected with gender inequalities and equity audit. In practice, this has probably resulted in a reduced emphasis on the "gender perspective" than would otherwise have been the case.

3.17 We welcome the requirements for public authorities to consult stakeholders in drawing schemes up, and to make their schemes public (paras 3.27 and 3.28).

3.18 On the former requirement however, we must draw attention to the need – in health at least – for the development of guidance and good practice on engaging with male service users and male members of the public in general. As well as necessity to do this to ensure the effective implementation of the new legislation, this is work that potentially would pay worthwhile dividends more generally – the evidence base about men's attitudes to health services is presently very weak.

3.19 An important final point however, concerns the apparent lack of a mechanism to bring together sectoral reporting centrally. It is hard to see how any objective judgement can be made about the effectiveness of the new legislation unless there is provision to collate and analyse local schemes and local progress reports at a national level.

3.20 We welcome the duty placed on the Commission for Equality and Human Rights (CEHR) (para 3.25) to report on "progress towards better equality and human rights outcomes in specified areas". We believe that the clearest way to ascertain progress in health however, would be to require the Secretary of State to report on the matter annually, and for national priorities emerging via this route to be used as the basis for subsequent planning at a local level.

## 4. Questions 4, 5 and 6:

### The perceived value of GIAs; the guidance needed to undertake them; and criteria for when to apply them.

4.1 We welcome the proposal (paras 3.44 – 3.53) that authorities should be required to conduct and publish "gender impact assessments" (GIAs) of "major" changes to policies and service delivery.

4.2 Our only significant reservation here is with the unduly negative form of words used in the list of areas of concern that the GIA should ensure it covers (para 3.47). It would surely be more within the spirit of the new legislation to require GIAs to seek opportunities to achieve positive change, rather than testing only "whether there is an adverse impact on men and women"

4.3 We also welcome the requirement that authorities should publish the local criteria that they have put in place to identify changes that qualify for the application of a GIA.

4.4 While we recognise the importance of allowing authorities the freedom to set such criteria in a way that is relevant for local circumstances, we are concerned that too much flexibility will allow some authorities to "set the bar" so high that most changes do not meet their qualifying criteria. We would therefore like to see some generalised national guidance setting out the kinds of criteria that need to be considered.

4.5 We support very strongly the proposal (para 3.54) that public authorities undertake an "initial screening" of *all* changes to policy and service development. Indeed this seems to us such an important matter in relation to the objectives of the Equality Bill as a whole, that we would like to see the proposal strengthened by the replacement of the phrase "could consider" in the first line by the word "must".

4.6 This seems an especially reasonable suggestion, given that the process would, in most cases, not be particularly onerous while its establishment as "routine" in all cases would do much to encourage the development of a "changed climate" that the Bill is seeking to achieve.

4.7 We have been given to understand that the broad intention of this section of the document is also to encourage authorities – subject to local capacity – to use the impetus of the new legislation to instigate the review of existing

services and policies (i.e. in other words, the proposals for GIAs and initial screenings do not apply solely to new or future developments and changes).

4.8 We would strongly favour that this should be the case but do not find this intention stated clearly in the text. Consequently we would like to see the document contain an explicit requirement for public authorities to screen all established policy and provision for its differential impact by gender and to measure the most important aspects against the criteria it has established for GIAs.

4.9 The consultation question about the "what constitutes a 'major' service or policy development" is extremely difficult and we are only qualified to comment specifically in terms of health provision.

4.10 The crucial issue for us is that of outcomes. It is clearly established and rarely disputed, that men fare less well than women in the great majority of disease areas. Indeed this issue was highlighted by Sir Donald Acheson in 1998 in his *Independent Inquiry into Inequalities in Health*:

> ". . . . . across the whole of adult life, mortality rates are higher for men than women for all the major causes of death."

4.11 In our view therefore, a "major" development would be one that has the capacity to impact on the incidence, prevalence or mortality rates of any disease or other area of health concern where the difference between men and women is not subject to variation for known biological or physiological reasons.

## 5. Question 7: The content of guidance to assist authorities when planning the procurement of services.

5.1 This area of the guidance is somewhat outside our area of expertise so we will not be offering comment on the generalities raised by the question.

5.2 This may however, be the most appropriate place to refer to a specific concern of the MHF about the gender duty and its associated guidance. This concern is to do with an issue of the highest possible importance in achieving gender-equitable service provision within the NHS – especially where that relates to equitable services for men.

5.3 Our concern is that it is still not obvious to us whether general practitioners (GPs) will be automatically covered by the gender duty or if they are not so covered, what mechanism will need to be used to ensure that they are.

5.4 GP services are obviously a central element of PCT provision but GPs are not employed directly by the PCT . It seems probable therefore, that they fall to be considered as contrators from whom a service is procured.

5.5 Our understanding however, is that there is not, as yet, a clear understanding of how the gender duty could or should be factored into the contractual relationship between PCTs and GPs.

5.6 In our view, it is absolutely crucial that GPs are unequivocally included within the requirements of the gender duty. If there is any doubt on this point it is our recommendation that the matter is addressed with the very greatest urgency; that the intended position of GPs in relation to the duty is made explicit; and that the precise mechanisms for achieving GPs compliance with the duty are spelled out from the outset.

5.7 There are three reasons for this. The first is that general practice is currently demonstrably failing to meet men's needs effectively. There are numerous examples that could be used to demonstrate this point but two might serve; the first general, the second specific:

i) Men are much less likely to visit their GP than women. Under the age of 45, men visit their GP only half as often as women. It is only in the elderly that the gap narrows significantly – and even then women see their GP measurably more frequently than men. There is no doubt that one of the most significant reasons for these differential is that services in general practice are frequently structured and delivered in a way that effectively discriminates against men – a recent online survey by the MHF found that many male patients recognise this and feel very unhappy about it.

ii) Despite the much higher prevalence of overweight and obesity in men, men are massively under-represented in weight management programmes in primary care. For example, only 26% of participants in the national "Counterweight" intervention (delivered in general practice) are men, and only 12% participation by men was achieved in a pilot partnership programme between "Slimming World" and general practice. Men are also much less likely to have their weight routinely recorded by their GP.

5.8 The second reason is that GPs are of course, directly involved in the management of PCTs by virtue of their statutory representation on both the PCT Board and the Professional Executive Committee of each PCT. It would be anomalous for GPs to be formally engaged in making decisions in respect of the PCT's obligations under the duty if there was ambiguity about their own professional position in relation to the duty.

5.9 Thirdly, at the level of individual GP practices, GPs are directly involved in the day-to-day management of staff who are employed not by the practice but by the PCT, and who would therefore be covered by the duty (e.g. health visitors, community nurses). Again, if there was any doubt about GPs responsibilities under the duty, this would be entirely anomalous and wholly unsatisfactory. Such a situation could easily lead to local conflicts of interest.

5.10 Finally in this section, it is worth pointing out that there may be other anomalies resulting from doubts about which authorities are covered by the gender duty, or by situations in which staff employed by authorities that are covered spend their working day in agencies that are not.

5.11 One such potential example, which is of some concern to us, is that of school nurses. School nurses typically are employed by PCTs but deliver services in schools which - to our understanding - are not currently intended to be covered by the specific duties (although we note that this position may have changed recently).

5.12 This situation and others like it, could clearly restrict the ability of individual staff to deliver the gender-equitable service that is their responsibility – especially if they happen to find themselves working in an environment where management and colleagues are unsympathetic.

## 6. Questions 8 and 9: The criteria for determining the bodies required to comply with the specific duties; and the range of bodies that the Government intends to require to comply.

6.1 We are happy with both the criteria for determining the bodies required to comply and the range of bodies listed in the Appendices to the consultation document - subject to our comments in the preceding section in respect of general practice and to our comments about educational institutions in the two paragraphs below.

6.2 We are disappointed with the failure to ensure that educational institutions in England and Wales are included from the outset of the new legislation and urge that they are fully included once "further consideration" has been given (para 4.11).

6.3 It is widely recognised that boys are under-performing in school in relation to girls (indeed, the Minister rather incongruously draws attention to this very point in the Foreword to the consultation document as an example of the "great strides" made towards "achieving equality between the sexes").

6.4 There is an established life-long link between higher educational achievement and the likelihood of better health, so this issue is of concern to us beyond the simple need to ensure equitable delivery of health education in schools.

# 7. Additional comments

**Inspection processes**

7.1 There are no consultation questions relating to Section 5 of the document which relates to the mechanisms for securing effective performance and compliance in respect of the gender duty.

7.2 Nevertheless it important to say that we hope and trust that there will be effective co-operation between the relevant sectoral inspectorates and the CEHR. It is important that the requirements to meet the gender duty begin to be sharply reflected within existing inspection procedures.

7.3 It would undoubtedly help with this process if national strategic health guidance – for example, in health, National Service Frameworks – began to reflect both the spirit and the letter of the Equality Bill. It is to be hoped that will increasingly become the case in years to come. It is disappointing that the consultation document does not lay more stress on the need for central leadership of this kind.

**Need for training**

7.4 It is also clear to us from our own regular experience of engaging with health service providers and individual NHS staff, that there is a limited understanding of the relationship between gender and health inequalities.

7.5 In so far as gender concerns are understood at all, they are generally seen as a "women's issue". If men's needs are taken into account, it is often solely in relation to male-specific health issues, like prostate cancer.

7.6 This is attitude prevails at the most basic level of recognition of (say) different levels of disease incidence. It is even more the case at the more sophisticated level of recognising the impact on health behaviours of the socio-cultural expectations of men and women. It seems probable incidentally, that our experience in the field of health is parallelled in other areas of public provision.

7.7 It is therefore our view that there should be some formal requirement - or at least a statement of strong expectation - that the introduction of the specific duties should be accompanied by the compulsory provision of local training initiatives for all relevant staff. Indeed, we would like to see the provision of a national training resource to perform this function.

**Promotion of the benefits of the gender duty**

7.8 Finally, we urge that all forms of publicity given to the Equality Bill and the duties arising from it should give due prominence to the benefits for men as well as women.

7.9 We congratulate the government and the DTI on its efforts to do this so far and we hope that this trend will continue. There is little doubt that there is a widely held public perception that action to achieve “gender equality” is limted to the need to tackle discrimination against women.

7.10 Few - and least of all the MHF - would seek to argue that the need to end discrimination against women is still an extremely important and pressing issue for public authorities to tackle. In the field of health however, the concern is frequently one of inadequate services for men and demonstrably, of poorer outcomes for men than should be the case.

7.11 If maximum support for the new legislation is to be achieved it is important that service providers and the general public alike are encouraged to recognise that the Equality Bill offers, among other possibilities, the opportunity to tackle this long standing and wholly unacceptable inequality.

David Wilkins
Policy Officer
Men’s Health Forum
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