Men's Health Forum - response to Women & Equalities Committee Enquiry on COVID-19

About the Men's Health Forum

The Men's Health Forum was founded by the Royal College of Nursing in 1995 and has been the leading national charity in the field of men's health policy & practice since 2001.

How people have been affected by the illness or the response to it

1. **Based on UK data, men are 50-200% more likely to die from COVID-19 than women. How much of this is due to biology, how much to health behaviour and attitudes and how much to a policy response that takes no account of gender remains unclear.** Male NHS staff have been 3 times more likely to die from COVID-19 than female ones. Male behaviour and attitudes towards COVID-19 have been shown in polling to be different to those of women. And yet, at the time of writing, NHS England is still not publishing any sex-disaggregated data - and, as far as we have been able to identify, no gendered interventions of any kind relating to COVID-19 have been developed, researched, evaluated or acted upon by any government body.

2. There is also no public equalities analysis of most of the interventions taken. For example, even though men are the majority of those dying from COVID-19, we do not know the proportion of men on the government's shielded list. Non-medical interventions such as the furlough programme have also not published any equalities analysis.

3. Some of the health and wellbeing issues caused by lockdown are also gendered in nature - most obviously domestic violence - but also wider mental health issues as well as problems such as drug and alcohol.

4. We also need an urgent sex-disaggregated analysis of the shortfall in presentation on other health problems. Historically, men have tended to underuse health services, and while remote access may go some way to address this, we need to understand whether a gendered response is needed to what may be a gendered problem. While we have drawn attention to the proportion of deaths amongst men from COVID-19, it is striking that 59% of excess deaths which do not mention Coronavirus on the death certificate since the crisis began are also amongst men.

Excess mortality

5. There are currently 2 main sources of gendered data for England and Wales on mortality:
   - 5.1. ONS shows that men are 60% of deaths overall[1]
   - 5.2. ICNARC shows that men are 75% of deaths in critical care units[2]
   - 5.3. In Scotland, NRS shows that men are 53% of deaths - although men are 60% of deaths amongst the under 85s.[3]

6. The Health Service Journal has published an analysis of deaths of NHS staff. This shows that men are

---

[1] Men's Health Forum, COVID-19 Statistics (England and Wales) https://www.menshealthforum.org.uk/covid-19-statistics-england-wales (Accessed 30/04/2020)

[2] Men's Health Forum, The figures that prove COVID-19 is not 'Just Like The Flu', https://www.menshealthforum.org.uk/figures-prove-covid-19-not-just-flu (Accessed 30/04/2020)

[3] Men's Health Forum, COVID-19 Statistics (Scotland) https://www.menshealthforum.org.uk/covid-19-statistics-scotland (Accessed 30/04/2020)

48% of all NHS staff who have died[4]. For comparison, data from NHS Digital show that men are only 23% of staff[5].

7. The figures amongst doctors are more extreme - with men representing 94% of deaths amongst doctors and consultants - despite representing only 55% of NHS doctors[6]. While the age and ethnicity profile of male and female doctors are quite different, on average this means male doctors are more than 12 times as likely to die from COVID-19 than their female colleagues.

The role of biology

8. There is a growing understanding as to the reasons why men are more susceptible to both develop and to die from infectious diseases - although this has not yet been reflected in COVID-19 policy or practice[7].
    8.1. Women have a stronger immune response through their sex hormones, with oestrogens (specifically 17-β estradiol (E2)) and prolactin, acting to directly affect the function of the immune cells, whereas testosterone is immunosuppressive, there are also factors directly related to the X chromosomes, which has genes related to immunity that may also play a part. In a study of the effect of SARS-CoV on mice it was found that males were more susceptible to the disease, especially in their middle years, with less differences noted in young or old mice. When the female mice were deprived of their oestrogen, either through surgery or chemically, their mortality matched the male mice, which may help explain the diminished sex effect in the young or old (post-menopause) human victims of the disease.
    8.2. Once infected the main route into the cells of the body is via a receptor that is found on cell walls, called angiotensin-converting enzyme 2 (ACE2). This was also the case for SARS-CoV, but it seems that it is easier for SARS-CoV2 to use this route, which may result in greater transmission and more cases. This receptor is found to be more highly expressed in males than females and is present in the lungs along with the renal tubular cells, Leydig cells and cells in seminiferous ducts in testis. ACE2 is more actively expressed in the lung cells of current and past smokers making them more susceptible to the virus. With more men having a history of smoking this again increases their risk of the disease.
    8.3. Pre-existing chronic disease may also be a factor for those who have the most severe disease, with hypertension, diabetes mellitus, heart disease, and chronic lung conditions being present in 37.2% of patients in a study of 43 patients in Wuhan in January 2020. Pre-existing cardiovascular disease has been suggested as the biggest risk followed by respiratory disease. For all these chronic diseases there are a higher proportion of affected men, with a greater number affected at an earlier age. Type II Diabetes is particularly prevalent amongst BAME men - a group that has been identified as being at particular risk.

Attitudes and behaviours

9. Men's attitudes and health behaviours are different to women's in a range of areas that directly relate to the risk of COVID-19. To date, we are not aware that this has been reflected in any government-funded public health campaigns[8].
    9.1. Smoking is likely to be of particular significance because of the long-term damage it can cause to

---

[4] Tim Cook, Emira Kursumovic, Simon Lennane, Exclusive: deaths of NHS staff from covid-19 analysed, April 20, 2020 https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article (Accessed 30/04/2020)

[5] NHS Digital, Analysis of the representation of women across the hospital and community health services workforce, April 11, 2018 https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/analysis-of-the-representation-of-women-across-the-hospital-and-community-health-services-workforce (Accessed 30/04/2020)

[6] NHS Employers, Gender in the NHS, https://www.nhsemployers.org/-/media/Employers/Documents/Plan/DIVERSITY-AND-INCLUSION/EQW19/Gender-in-the-NHS-infographic.pdf (Accessed 30/04/2020)

[7] Professor Alan White, Men's biological risk from COVID-19 - Men's Health Forum, https://www.menshealthforum.org.uk/news/mens-biological-risk-covid-19 (Accessed 30/04/2020)

[8] Peter Baker, Our own fault? Men and COVID-19 - Men's Health Forum https://www.menshealthforum.org.uk/news/our-own-fault-men-and-covid-19

the lungs - although the UK the 'sex gap' has declined over the long term, recently it has been growing - currently 17% of men and 13% of women smoke.

9.2. In 2016/17, men in the UK were twice as likely as women to be admitted to hospital for conditions attributable to smoking (an estimated 6% vs 3% of all hospital admissions). This suggests that even though smoking rates have fallen in men in recent years and are now closer to the rates in women, the legacy of previously higher levels of male smoking could be relevant to the differential impact of COVID-19.

9.3. Men could be more exposed to COVID-19 because they are less likely to have improved their hygiene in response to COVID-19. A YouGov survey of 2,000 UK adults conducted on 19/20th March 2020 found that, in the past two weeks, most men and women had taken steps to protect themselves from COVID-19 by improving their personal hygiene (e.g. by washing their hands frequently or using a hand sanitiser). But fewer men than women had taken this step: 67% vs 74%.

9.4. A separate YouGov survey of over 2,000 adults in Great Britain conducted on 24/25th March concluded that men are more likely to downplay the severity of the virus. Nearly a quarter of men (24%) inaccurately believe coronavirus is 'just like the flu' compared with just 16% of women. Similarly, men are more likely to believe that coronavirus only affects older people and those with underlying health conditions at 14% versus 8% of women. They are also less inclined to believe official Government advice such as staying at home to stop the virus from spreading, with 10% saying this is false compared with 2% of women.

9.5. It has been reported in the media that men's outcomes following COVID-19 infection could be worse because they are delaying seeking medical help - although we are not aware that this data has been researched in the UK. It has been suggested that men have been arriving in hospital in China with more advanced disease, for example. While there are no known published studies specific to COVID-19, it has historically been the case that working-age men use health services less effectively than women.

Shortfall in data and lack of gendered response

10. To date, NHS England has published no sex-disaggregated data that we are aware of. PHE has started publishing some sex-disaggregated data within the last 8 days - although the Government's daily report on COVID-19 (produced by PHE) still does not include a breakdown of mortality by sex[9].

11. Critical initiatives such as the shielding list have not published any equalities analysis. Nor has there been enough sex-disaggregated research published on wider interventions such as the furlough programme.

12. In our contact with UK health and research bodies, we have not managed to identify any gender-aware initiatives to tackle COVID-19 - nor have any health bodies made us aware of any such initiatives in response to our requests.

Other emerging issues

13. Reducing use of primary, mental health and emergency department services

13.1. Emergency department attendance has fallen by 30% from March 2019 to March 2020 with weekly attendance figures showing a steep decline over the fourth quarter of 2019/20[10]. There has been a sharp drop in the number of admissions of cardiac cases, from just under 800 attendances on March 1st 2020 to under 400 cases by March 29th[11].

13.2. While it is possible that the move to remote consultation and home-working may have improved men's use of health services - historically poor use of services could also mean that gender plays a role in the declining use of primary, mental health and emergency care services.

13.3. The indicator which causes most alarm is that 59% of excess deaths that do *not* mention

---

[9] Public Health England, Coronavirus (COVID-19) in the UK, https://coronavirus.data.gov.uk/ (Accessed 30/04/2020)

[10] NHS England, FT Analysis https://www.ft.com/content/d5ac0a79-6647-4f49-bb64-d1cc66362043 (Accessed 30/04/2020)

[11] Public Health England, EDSSS Bulletin - April 1, 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877600/EDSSSBulletin2020wk13.pdf.pdf (Accessed 30/04/2020)

COVID-19 on the death certificate are amongst men[12]. While this could relate to under-reporting of COVID-19 deaths, it could also be linked to lower usage of health services for other conditions. A full equalities analysis of this shortfall needs to be conducted with urgency.

14. Gender impact of unemployment, furloughing, isolation and social distancing

14.1. There is a shortage of robust sex-disaggregated data on the wider impacts of COVID-19 - but the data that is available indicates that gender is also playing an important role in these areas too.

14.2. If, as seems likely, there is a recession and increased unemployment associated with COVID-19 then historical experience is that this will lead to a disproportionate increase in male suicide. (Although, encouragingly, this is an area where local and national government and the health system is planning a gender-aware approach).

14.3. There has also been a concerning increase in calls to domestic violence helplines during the COVID-19 period - whether targeted to support women or to support men[13].

14.4. The UCL COVID-19 study suggests that the wellbeing impact of COVID-19 appears to be worse for younger adults and those living alone[14]. Recent ONS data showed that men are the clear majority of those living alone under the age of 55[15]. Further gendered analysis of this is needed.

14.5. Men generally drink much more than women and alcohol consumption also appears to have risen for men during the period of the restricted movement and social distancing. A survey[16] was conducted by YouGov of more than 4000 adults with figures published on the 17th of April 2020, showed that 21% of men reported drinking ‘a bit more’ or ‘much more’ alcohol.

14.6. Finally, men are much more likely to work full-time and there is some evidence (from YouGov) that men are much more likely to be leaving the home to travel to work (although this is another area where data is lacking).

Specific impacts on people due to them having a protected characteristic

15. **The most important impact that shows variation based on protected characteristics (to date identified and reported for age, sex and ethnicity) is premature death.** While action has been taken based on age and for some disabilities - some action based on ethnicity is now being proposed - no action has been taken or proposed based on sex.

16. **Sex and gender can often be the “canary in the coalmine” for equality data.** It was striking that during the early part of the crisis, the only protected characteristic reported against was age. All other protected characteristics were ignored and action to address the risk faced by those other characteristics was delayed as a result.

17. **And without data, inequalities are invisible - except to people facing them.**
This has now improved with the publication by all bodies (except NHS England) of age, sex and ethnicity data - but there is still an urgent need for more intersectional data - where, to date, the only data available has been sex and age disaggregated. It is striking, for example, that the overwhelming majority of doctors who have died have been BAME men - a combined factor that has led to tragically disproportionate deaths amongst this group.

---

[12] Unpublished Men’s Health Forum research - Analysis of ONS data (30/04/2020)

[13] Jamie Grierson, UK domestic abuse helplines report surge in calls during lockdown, Guardian 9 April 2020 https://www.theguardian.com/society/2020/apr/09/uk-domestic-abuse-helplines-report-surge-in-calls-during-lockdown (Accessed 30/04/2020)

[14] The March Network, University College London https://www.marchnetwork.org/research (Accessed 30/04/2020)

[15] ONS, The Cost of Living Alone, April 4, 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/articles/thecostoflivingalone/2019-04-04 (Accessed 30/04/2020)

[16] YouGov Are you drinking more or less alcohol than you normally would? April 17, 2020, https://yougov.co.uk/topics/health/survey-results/daily/2020/04/17/1798d/3 (Accessed 30/04/2020)

What needs to change or improve, which could be acted on within three weeks:

18. **All COVID-19 related data - by all public bodies - should be reported in sex-disaggregated form - as well as, where possible, other key protected characteristics and deprivation.** Without deep insight into who is being affected by COVID-19 and how, the risk is that any loosening of lock-down measures is targeted at the wrong people. This must also include a full equalities analysis of the decline of health service usage for non-COVID conditions.

19. **NIHR and other research bodies should commission research to analyse the excess death amongst men and the interventions that can be taken to address them.** We strongly welcome their recent initiative to understand the relationship between ethnicity and COVID-19 - and want to see a similar initiative for sex.

20. **NHS England should do an urgent review of the risks to staff based on <u>all</u> protected characteristics - and implement policies accordingly.**

21. **Public Health England should review its programme and identify those areas where male-targeted public health interventions are needed.**

What needs to change or improve, which could be acted on within 6 months:

22. **Develop and implement a men's health policy.** The former Chair of the Women and Equalities Committee, Maria Miller MP, wrote to the Department for Social Care calling for a National Men's Health Strategy in October 2019 in response to the committee's work on the mental health of men and boys. The heavily gendered impact of COVID-19 - as well as the compounding effect of other conditions such as cardiovascular disease and type 2 diabetes which could be tackled through more gender-aware health policy - provides powerful extra support for this change. Any such strategy should cover both physical and mental health.

23. **Follow WHO guidelines and fully reflect sex, gender and other health inequalities in future pandemic planning - right from the very beginning.** The WHO has made the case for sex and gender to be reflected in epidemic planning and management at least since 2007[17]. The failure to start on this basis - and the resulting need to catch-up over time has wasted time and led to a less effective response - and needs to be built into planning for future pandemics and future waves of COVID-19.

Martin Tod
Chief Executive
Men's Health Forum

April 30, 2020

---

[17] World Health Organisation - Addressing sex and gender in epidemic-prone infectious diseases- https://www.who.int/csr/resources/publications/sexandgenderinfectiousdiseases/en/ (accessed 30/04/2020).