MHF MEN'S HEALTH FORUM

Challenges & Choices

Improving health services to save men's lives

A policy briefing paper for National Men's Health Week 2009

Key messages

1. Men's health is much worse than it need be – too many men are still dying young. 40% of men die before the age of 75.
2. Men's poor use of primary care and health improvement services has not been systematically addressed even though it contributes to higher rates of hospitalisation and death.
3. There are some encouraging examples of national, regional and local initiatives that are improving service delivery to men and which provide an evidence base for further activity.
4. Government, the NHS and other providers must now rise to the challenge of developing services that more men will use.
5. With the recession increasingly impacting on men's health, choosing to do nothing is no longer an option.

Men die young

Men's health is unnecessarily poor. 40% of men still die prematurely (before the age of 75)[1] and, in some parts of England, male life expectancy is as low as 65.[2] Male death rates are significantly affected by social deprivation[3] and the recession will have a major impact on men's mental and physical health.[4]

Biology provides only a partial explanation for poor health in men.[5] Lifestyle is a much more significant factor. Men are more likely than women to drink alcohol above recommended levels, smoke cigarettes and eat a poor diet.[6] Just over one third of men are physically active at the level that results in health benefits. By 2015, 36% of men will be obese and, by 2025, only 13% will have a healthy body mass index.[7]

Men's use of primary health services is critically important – and is the main focus of this report as well as National Men's Health Week (15-21 June 2009). While neither men nor women use health services optimally, the overall pattern is that men use health services far less effectively.

Men's use of services

In Great Britain, men visit their GP 20% less frequently than women. The difference in usage is most marked for the 16-44 age group – women of this age are more than twice as likely to use services as men.[8] Women have higher consultation rates for a wide range of illnesses, so the gender differences cannot be explained simply by their need for contraceptive and pregnancy care.[9]

Men, especially young men, are much less likely than women to have regular dental check-ups[10] or to use community pharmacies as a source of advice and information about health.[11] Just 10% of NHS community contraception service users are male.[12]

NHS smoking cessation programmes are less well used by men than women[13] and the same is true of NHS and commercial weight management services[14], health trainers[15] and of disease-specific helplines run by third sector organisations.[16] Male uptake was markedly lower than female uptake in the pilot programmes for the NHS Bowel Cancer Screening Programme.[17]

A recent analysis of men's use of GP services shows the potential impact on men's health and the healthcare system.[18] This research was based on a total of 35.8 million contacts with GPs and 1.2 million hospitalisations in Denmark in 2005. (Like the UK, Denmark has free access to primary and hospital healthcare.) The data is compatible with a scenario in which men are reacting later to severe symptoms than women with the result that they are more likely to be hospitalized or die.

This is also consistent with UK and Europe-wide data on malignant melanoma which shows that while women are more likely to develop this type of cancer, men are more likely to die from it.[19] This is almost certainly because men present when the cancer is more advanced and harder to treat. Also, nearly four men in 10 are not diagnosed with prostate cancer until it has spread.[20]

One probable consequence of men's poorer use of health services is that many attempt inappropriate self-diagnosis and self-treatment. Every year in the UK, an estimated 330,000 men purchase prescription-only medicines without a prescription from illicit sources, particularly internet sites.[21] A failure to diagnose correctly a serious underlying condition creates a significant risk – erection problems, for which many men obtain counterfeit drugs online, are often caused by undiagnosed diabetes or cardiovascular disease.

Why men don't go

Men's reluctance to seek help is an underlying cause of their poor use of primary health services. This is a result of the way men are brought up to behave. Men are not supposed to admit to personal problems, weakness or vulnerability. Embarassment leads many men to delay seeking help with prostate disease (intimate examinations are perceived as a particular threat to the male image) and many want to appear strong, independent and in control in front of a male GP.[22] As a consequence, men often wait until they are in considerable pain or are convinced they have a serious problem.[23]

Men's unwillingness to seek help is reinforced by a number of practical barriers, including the demands of long working hours and problems with accessing primary care services near the workplace.[24] Anecdotal evidence suggests that some men are deterred by a perception that GP and pharmacy services are aimed mainly at women and children and feel like 'feminised' spaces. 'It's like visiting a ladies' hairdresser' was the comment of one man responding to a MHF survey on men's use of GP services.[25]

Lack of familiarity with the health system may also be a factor. Women are much more likely to use health services routinely – for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and for their children's health. When they are ill, they are more likely to know how to access services, and which services to use, and to feel more comfortable with a healthcare professional.

Men in specific groups may be deterred because they fear or experience discrimination. There is evidence of widespread homophobia among health professionals that impacts on the ability of gay and bisexual men to access healthcare.[26] African and Caribbean men can be deterred from approaching mental health services because of a belief that they will be discriminated against.[27] Gypsy and traveller men – the group with the lowest life expectancy in the UK (estimated at 48) – face particular difficulties accessing mainstream primary care services.[28]

Older men often do not feel that services run specifically for their age group are appropriate for their needs except perhaps as a last resort.[29] They tend to avoid services where participants (and staff) are mostly women and consider that attendance at a day centre suggests that they have 'given up'. Older men are frequently not referred on to relevant support services by social services, GPs or other professionals.[30]

Even though men have poor health outcomes, these barriers to men's effective use of health and related services have not yet been systematically addressed by government, the NHS and other organisations. Services are not routinely being delivered in ways that take proper account of men's attitudes and behaviours. This is despite the Gender Equality Duty, in force since April 2007, which requires services to be tailored to the specific needs of men and women and to work towards achieving more equitable outcomes.

The recent House of Commons Select Committee inquiry into health inequalities acknowledged that health inequalities related to gender are not even 'being adequately measured let alone addressed' and called for a proper examination of the issue that would encompass 'not just unequal outcomes' but also 'unequal access that would lead to unequal outcomes'.[31]

Recent progress

The present situation is not good – but it is significantly better than just a few years ago. In April 2009, the Department of Health (DH) appointed MHF as one of 11 Strategic Partner organisations. This reflects a growing understanding that men's health must be tackled at a national level.

DH has also commissioned MHF to recommend ways of increasing male uptake of screening within the National Bowel Cancer Screening Programme and to develop new forms of health information aimed at specific groups of socially-disadvantaged men. In Yorkshire and the Humber region, DH has worked with MHF to develop a new male-targeted health guide.

Choosing health through pharmacy, the national plan for the future of pharmacy services, recommends that 'pharmacy services should be promoted and developed as a source of advice, information and support for self care for men.'[32]

The National Chlamydia Screening Programme has developed a strategy for engaging men and there has been increase in male participation in screening from 17% in 2004/5 to 28% in 2007/8.[33] The Cancer Reform Strategy, which will set the direction for cancer services until 2012, acknowledges that there is a particular need for services to address late presentation by men with potential cancer symptoms.[34]

The recent extension of GP opening hours should make it easier for men as well as women in full-time work to access services. The national vascular checks programme (branded 'NHS Health Checks'), now being rolled out around the country, offers a significant opportunity for creative thought about service delivery in relation to male health, not least because this is a programme of particular value to men given their high levels of morbidity and mortality from cardiovascular disease. The new abdominal aortic aneurysm (AAA) screening programme, the only national screening service specifically for men, could not only reduce deaths from AAAs but also has the potential to improve older men's contact with health services more generally.

Knowsley PCT/MBC's Pitstop programme used social marketing principles to deliver health checks to over 3,000 local men. 85 per cent of men who were followed up reported lifestyle changes.[35] NHS Halton and St Helens' Go campaign encourages men over 40 in deprived areas to take better care of their health and to make more use of health services. 57% of men attending health checks have gone on to access further services, including diet and exercise interventions, smoking cessation and health trainer services.[36]

Through Premier League Health, 16 top football clubs will develop physical activity and wider health programmes targeting a total of some 4,000 men in deprived communities near their stadia. Some major employers like Royal Mail and BT have made major efforts to improve the health of their male staff.

Many of these initiatives have sought to take services and health improvement campaigns to men – at work, sports stadia, military bases, pubs and prisons – and have used male-targeted health information, such as MHF booklets designed to look like Haynes' car maintenance manuals. This work demonstrates that men are willing to take greater responsibility for their own health if the services provided are sensitive to their needs and it provides a good evidence base for further activity.

The challenges

Recent progress has been encouraging but there is still a long way to go. The overwhelming majority of men in England have not had an opportunity to take advantage of the few initiatives introduced so far. Men remain, overwhelmingly, poor users of services and the number of health organisations making a concerted effort to tackle the problem is small. The commitment to men's health shown by the minority of service providers must now be mainstreamed throughout the primary health care system.

Action is particularly important at a time of recession. Financial and job insecurity and unemployment affect both men and women adversely but the impact on men's health is greater. It is vital that health services now seek to fully engage men, especially those facing the biggest social and economic problems. In this bleak climate, choosing to do nothing is no longer an option.

The 20 key challenges are to:

1. *For the Department of Health and Government*
   a. Ensure that all policy takes proper account of men's health and gender inequalities through rigorous equality impact assessments that draw both on robust evidence and the insights of relevant external stakeholders.
   b. Establish a national Tackling Gender Inequalities Programme to support, evaluate and disseminate local initiatives which seek to improve men's health and close gender gaps in service use and health outcomes.[37]
   c. Because gender is the most significant factor interacting with economic status to compound health inequalities, ensure that the Review of Health Inequalities Post 2010 in England (the Marmot Review) includes the issue of men's access to health services.
   d. Commission more research into men's use of health services and how it can be improved.

2. *For Strategic Health Authorities*
   a. Ensure that local health trusts, particularly PCTs, properly implement the Gender Equality Duty. The Equality and Human Rights Commission also has an important role in ensuring compliance throughout the NHS.
   b. Bring together equality stakeholders to support the development of a strategic approach across each region. NHS North West's Equality Stakeholder Reference Group provides a model of how this can be done.
   c. Produce regional men's health guides, such as Yorkshire and the Humber's 'Yorkshire Man' developed in partnership with MHF in 2009.

3. *For Primary Care Trusts*
   a. Develop outcome-focused Gender Equality Schemes containing specific actions to improve men's health. These Schemes must take account of cross-cutting inequalities, including social class, race, sexuality, age and disability.
   b. Embed improving men's health and tackling gender equalities into the commissioning process.
   c. Address men's under-use of GPs, pharmacies, smoking cessation, weight management services and health trainers. Better marketing of walk-in centres – a relatively accessible primary care service – could significantly increase male uptake.
   d. Ensure that men are fully part of the new vascular checks programme by offering health checks in a variety of settings, including workplaces, and by marketing it effectively to men.
   e. Take advantage of the opportunities offered by the World Cup in 2010 and the Olympics in 2012 to use sport and sports stadia to encourage men to be more physically active and for the development of new settings for outreach activity.
   f. Make greater use of male-targeted health information to support better self-care by men and their more effective use of services.
   g. Work with schools to improve boys' awareness of health and health services. Boys should leave school with knowledge of the main primary care services and how to use them.

4. *For employers*
   a. Improve the health of men at work – and also the financial health of businesses[38] – through a range of health services and improvement activities, eg. on mental health, diet, physical activity, smoking.
   b. Address the health problems caused by job insecurity at a time of rising unemployment.

5. *For third sector organisations*
   a. Undertake equality impact assessments of their services to ensure they are equitably meeting the needs of both men and women.
   b. Ensure that improving men's health and tackling gender inequalities is addressed in tenders for public sector health contracts.

6. *For men*
   a. Increase their understanding of the range of available health services and to use them more effectively, especially by seeking help early for potentially serious conditions. Men should avoid purchasing drugs online from unregulated sources.
   b. Improve their health and wellbeing, both in the short- and long-term, through small but significant lifestyle changes.

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Registered Office as above. A registered charity (No 1087375). A company limited by guarantee (No 4142349 – England).

June 2009
ISBN 978-1-906121-33-4.