**Men’s access to services: Evidence review**

**Introduction**

Acknowledging the broad differences in the way men and women interact with the world is something commercial organisations understand very well and take into account when planning and developing products and services. The NHS however, rarely does so, even though gender is an important determinant of health [13]. There are many reasons for gender health inequalities, many of them biological, but recent evidence does also support the hypothesis that men delay or avoid seeking medical advice, which leads to poorer prognosis [5].

This briefing considers the evidence around how men’s access to health services can be improved, thereby improving health outcomes.

**Background**

There are many factors which are generally accepted as being reasons why men use health services less than women, including; biology; health beliefs; men’s behaviour (particularly risk taking); the male role; and health agencies reluctance to develop appropriate services [1]. There are also many myths surrounding men’s health, the greatest of which is that men do not care about it. In fact, evidence suggests men worry about their health as much as women, but feel unable to talk about their concerns or seek help until it is often too late. This is all compounded by the impact of social class, with morbidity and mortality increasing in direct proportion to levels of deprivation.

**Some important points from the evidence about gender and health**

- Men in the UK have higher mortality for all 15 leading causes of death and life expectancy of on average, 7 years less than women [2]. In Wirral, average life expectancy is currently 5 years less for men than women [3].
- In particular, the mortality rate for CHD and CVD is higher in men than women and men are also more likely to die from this cause prematurely [13].
- Women are more likely to use general health services than men [4]
- A large study carried out in Denmark (which also has a comparable free access healthcare system similar to the UK’s) during 2005 which looked at 35.8 million contacts with general practitioners and 1.2 million hospital admissions supported the hypothesis that men seek medical advice later than women, leading to poorer prognosis [5]
- The same study also found that women have higher rates of contacts with general practitioners then men and overall, appeared to have higher rates of hospitalisation. However, when hospitalisation connected to childbirth was excluded, the difference disappeared and when just the over 50’s age group were looked at, it was indeed the case that men do have lower rates of GP contact and higher rates of hospitalisation and mortality [5].
- This reluctance to consult a doctor is regardless of income or ethnicity [6], but is exacerbated by social class inequalities [8]
- Men often delay or avoid talking to anybody about serious health concerns because they are socialised not to show pain, to be self sufficient and not to appear weak, all of which are inconsistent with help-seeking behaviour [4]. In current western society, work is a central means of establishing masculine identity, so men’s perception of when it is appropriate to seek help is closely...
linked to their capacity to work and fulfil social commitments, i.e as long as they are able to work, men tend to perceive themselves as being healthy [4]

- Health and the lack of it, is perceived by many men from an early age, to be the ‘domain’ of women [7] and practitioners should keep in mind that many older men believe there is a stigma attached to seeking help [8]

- Men can and do take ill-health seriously, yet when the concern is about preventative health, most men felt that they would be wasting the doctors time in attending [9]. In particular, certain approaches, particularly those seen as more ‘medical’ may be perceived as removing scarce resources from where they should best be used (i.e I’d be stopping the doctor attending to the really ‘ill’ people) [9]

- There is evidence that men are less likely than women to recognise a wide range of symptoms and less likely to recognise the need for emergency treatment [13]. In particular, research suggests hypertension is under-treated in men in relation to need, reflecting a lack of awareness both of the condition itself as a problem, but also of the symptoms which should prompt a consultation [13]

- The majority of people with an important risk factor for CVD (obesity) do not seek help and this is particularly the case with men. A recent study of truckers found only 13% would consult their GP for help with weight loss [13]. Even amongst those who seek help to lose weight outside the healthcare system, women dominate (Weightwatchers freely admit they have more female then male participants and a recently evaluated pilot project delivered by a commercial slimming organisation in conjunction with the local NHS Trust had a male participation rate of 12%) [13]. This could partly be due to awareness (women are more likely to be aware of being overweight then men and in a recent National Opinion Poll, 42% of men and 27% of women reported that being overweight, ‘Wouldn’t bother me at all’) and partly due to cultural differences (it is seen as less acceptable for women to be overweight plus dieting is seen as , ‘a women’s thing’) [13].

So does the evidence suggest we can do about it? What works?

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<th>Project or research evidence details</th>
<th>What they found</th>
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| The Department of Health’s Gender & Access to Health Services Study [13] | The report recommends three models of enhanced primary care provision which would improve men’s access to services, these are:  
  - More flexible opening hours to accommodate men who work (men are twice as likely as women to have full time jobs and more than 3 times as likely to work more than 45 hours per week)  
  - The provision of services in non-medical settings such as workplaces and social/community venues  
  - Personalised invites sent asking men to attend for ‘health checks’ |
| Knowsley PCT’s ‘Pitstop’ project [6] | Evaluation highlighted a number of ‘positives’ identified by the men who attended (which was in contrast to the negative associations many of the men described when discussing other primary care services)  
  - Men said the ‘PITSTOP’ health checks reassured them and they felt and positive coming away from the |
Important strategies to improve men’s access to health services were listed as:  
- Evening surgery opening hours  
- Improved information on the internet  
- Targeting places men already visit (sports activities, pubs, barbers shops etc..) so they have to do very little or risk feeling 'less masculine' for seeking help  
- Staff being positive, friendly and enthusiastic (this was more important than their gender)  
- The services were there 'long enough'. There seemed to be a gap between men knowing about a service and using it. Some men only used a service when they had heard it was, ‘ok’ from a friend or somebody who’s opinion they trusted |
| Research published in the BMJ in 2001 [7] | The review stated that although the recognition that health services need to go to men has long been acknowledged, a full shift in the activity, skills and attitude of professionals is still required. The article also stated that in practical terms, uptake of health information and health services can be improved by making them;  
- Friendlier  
- Anonymous  
- More convenient |
| Men Managing Health Review carried out in 2003 [9] | This review maintains that men are not unwilling to access health services, as is often suggested, but suggests they often need a means of legitimising their visit to that they can maintain ‘face’ and keep their male identity intact. This study suggests that health professionals need to think about the ways in which men legitimise healthy behaviour because these represent ‘levers’ (i.e good opportunities for helping men to engage in their own health and wellbeing):  
- Linking into times of life change for men (becoming fathers, family breakdown, bereavement) because these can lead men to re-evaluate issues of lifestyle  
- Recognising and using specific aspects of family history to ‘legitimise’ getting checked. Family histories of ill-health/death can and do lead men to consider taking action about their health and well-being, providing the opportunity to bring up lifestyle change |
The importance of third parties (e.g. partners) although it was also acknowledged that this last could be counter-productive, allowing some men to continue to think of health as a female responsibility and reinforcing the idea that they are not responsible for their own health.

Improving men's knowledge. The review pointed out that men often lack the knowledge which would enable them to recognize illnesses or diseases (especially those with minimal symptoms in the early stages).

Policy Briefing Paper produced by the Men's Health Forum [10]

According to a policy briefing paper by the Men’s Health Forum, ‘A shift in favour of delivering health improvement services in the workplace would significantly improve male health in England and Wales’. This approach is also supported by Dame Carol Black’s recent review, ‘Working for a healthier tomorrow’ which draws particular attention to the capacity of the workplace to contribute to, “the prevention of illness and the promotion of health and well-being” [11].

Bradford’s Health of Men project [14]

Key findings from focus groups held during this initiative found that men:
- Do care about their health, especially as they get older and they are willing to talk about it, they just need an appropriate place and opportunity to do so.
- Don’t see the GP as an appropriate place to go unless they are, ‘ill’
- Tend to seek help, ‘on the spur of the moment’, they like to make a snap decision and then act on it, current appointment arrangements in primary care hinder this.
- Were likely to favour familiar, non-medical settings where they congregate anyway (e.g. barbers shops)
- Liked having ownership of sessions and freedom to set the ‘topics’, rather than having particular health messages forced upon them.

Themes, conclusions & key messages

- GP is not considered appropriate unless they are ‘ill’ (meaning they are unlikely to attend for health checks or ‘preventative’ services)
- Men want convenient, flexible session times (e.g. longer/evening opening hours or drop-in’s)
- Friendly staff (this is more important than gender!)
- Non-medical venues (especially workplaces, or other places they already go)
- Being personally invited (legitimises their attendance)
- Using levers such as life events and family history (again, this ‘legitimises’ taking an interest in their health, so they don’t seem ‘unmanly’)
- Anonymous, confidential services
Above all, they want it to be EASY (see all of the above!)

References

6. Knowlsely PITSTOP evaluation
15. 

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