MEN AND PRIMARY CARE: IMPROVING ACCESS AND OUTCOMES

By: Peter Baker and Ian Banks

Summary: Men's health across Europe is unnecessarily poor with twice as many men as women of working age dying each year. Men's ineffective use of all primary care services is part of the explanation. This happens because men are reluctant to seek help and because, as yet, health services have not engaged with men effectively. The changes needed include changing services' opening hours and difficult-to-use appointment systems, developing the role of pharmacies as a first point of contact for men with the health system, improving training for health professionals on men's health issues and investing in better men's outreach services.

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Introduction

The evidence for the unnecessarily poor state of men's health across Europe is irrefutable. In the European region as a whole in 2011, average life expectancy at birth was 72 for men and 79 for women, a difference of seven years.[1] Life expectancy at age 60 was another 19 years for men and 23 for women, a difference of four years. The gap in life expectancy between men and women is highest in Eastern Europe where, in 2010, average life expectancy at birth was 64 for men and 75 years for women, a difference of 11 years.[2] Of particular concern is the high level of premature mortality among men. There were 630,000 deaths among men of working age (15–64) in 2007 across Europe, of which about 198,000 were before the age of 50.[3] By comparison, there were 300,000 deaths in women of working age and around 86,500 deaths before the age of 50. Recent improvements in the life expectancy at birth of men and women have mostly occurred at older ages; there has been little improvement in the high rate of premature death in younger men.

According to Michael Marmot's review of social determinants and the health divide in the World Health Organization (WHO) European Region, men's poorer survival rates reflect several factors: greater levels of occupational exposure to physical and chemical hazards; risk behaviours associated with male lifestyles (including smoking and hazardous levels of alcohol consumption); health behaviour paradigms related to masculinity; and the fact that men are less likely to visit a doctor when they are ill and to report the symptoms of disease or illness.[4] A study of inequalities and discrimination in access to health care by the European Union Agency for Fundamental Rights also found that 'women are generally more aware of their health status than men and are more frequent users of health care services'.[5] A *BMJ* editorial on men's health in Europe

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The **European Men's Health Forum** (EMHF) is an autonomous, non-profit-making, non-governmental organisation based in Brussels.

observed that 'a major challenge is to engage with the many men who do not access health services'.[6]

The problem

Primary care services are currently a 'no man's land' – they are used ineffectively by men. Men access the full range of primary care services – general practice, pharmacy, dentistry, optometry – less often than women. For example, in England, in 2008–9, women aged 15–80 years had significantly more consultations with general practitioners (GPs) than men; the biggest gap was in the 20–44 year age group.[7] A study of middle-aged Lithuanians found that 54% of women and 41% of men attended dental check-ups habitually,[8] while another study of the uptake of free eye tests in Scotland after their introduction in 2006 found that a larger proportion of women had their eyes tested both before and after. There was a significant increase in female utilisation after the change but no evidence of a change in male uptake.[9]

Of greater significance than the frequency of men's uptake of primary care services is the impact of the way they use services on their health outcomes. Much of the evidence about this is anecdotal – based on the experience of health professionals and men themselves – but there is robust evidence from Ireland where a study of the excess burden of cancer on men found that they were diagnosed at a later stage than women for colorectal, lung and stomach cancers, as well as for malignant melanoma.[10] Men's delay in seeking help for mental health problems could also be part of the explanation for their much higher suicide rate. A Danish analysis based on almost 36 million GP contacts and 1.2 million hospitalisations in 2005 hypothesised that men's lower use of GPs helped to explain their higher use of hospital services.[11] Spanish men aged 60 years and over have also been found to visit medical practitioners and receive home medical visits less frequently than women but to be admitted more frequently to hospital.[12]

There are two main explanations for men's less effective use of primary care services. The first is that the gender construct of masculinity inhibits help-seeking for health problems. Men are 'supposed' to be independent and invulnerable, strong and silent, stoical and self-reliant. Many men therefore do not feel comfortable admitting to a physical or emotional problem, whether that is to a partner, a friend or a health professional. Some men also find traditional health settings 'too feminine', especially community pharmacies which often have prominent displays of women's beauty products.

Secondly, men's reluctance to access services makes them less willing to overcome the many practical barriers they experience, especially the lack of extended opening hours (men are more likely than women to be in full-time work which can make it difficult for them to attend services provided only during 'normal' working hours). Men also seem more likely than women to be deterred by appointment booking systems and delays in seeing a clinician after an appointment has been made.

Some specific groups of men face additional barriers to accessing primary care. Men in low-paid occupations tend to have less flexible working hours and may lose pay if they take time off to attend an appointment. Men who have been recently released from prison, who are homeless, or who are Roma/Travellers or migrants find it harder to access a GP. Gay men are also deterred by experiences of homophobia from some practitioners.[13,14]

Responses

One possible response to the problem of men's use of primary care is to point out that services are provided for whoever needs them and that it is therefore men's own fault if they fail to make use of them. Blame may seem tempting but it leaves men at risk of unnecessarily poor health – with human and financial consequences for them and their families, communities and employers, as well as for health services and the wider economy. The financial costs of poor men's health are difficult to quantify but one study has estimated that men's premature mortality and morbidity costs the US economy US$479 billion (about €350 billion) annually.[15]

> "primary care services are used ineffectively by men

Blaming men is also unfair because their attitudes and behaviours are in large part socially determined. The pressures on men, especially on boys and young men, to confirm to gender stereotypes are difficult to resist for many. In addition, health and related services have been slow to respond to men's needs. There is only one European country, Ireland, which has developed a national men's health policy.

The European Men's Health Forum (EMHF) has begun a long-term project to improve men's use of primary care. The first stage was a roundtable event held in June 2013 where EMHF brought together the widest possible range of primary care professions from across Europe to identify the barriers to men's effective engagement with services and, more importantly, how these could be overcome. The roundtable's findings were discussed further at an EMHF workshop at the European Health Forum Gastein in October 2013. The next steps include discussions with the European Commission and other Europe-wide organisations, as well as with EMHF roundtables within individual states to support the development of primary care services that work better for men.

A number of potential solutions have already been identified and are summarised in **Box 1**. These are much more likely to be implemented if health systems – Europe-wide, national and local – make an over-arching commitment to tackle men's health problems through a policy-led approach that leads to comprehensive action at all levels. In 2011, the European Commission published a detailed analysis of the state of men's health in Europe but the report contained no recommendations for action.[14] The EC Commission should now take a lead and produce a plan for tackling the deep-seated problems revealed by its analysis. Without that kind of focus and commitment, too many men, especially those in

Box 1: Potential ways of improving men's use of primary care services

- The **practical barriers** that deter men from accessing primary care must be addressed. These include limited opening hours, difficult-to-use appointment systems and, for pharmacy services especially, an emphasis on products and services for women. The solutions include greater use of digital technologies for making appointments and for information, advice and even some consultations, some consultations (see, for example, EMHF's Your Prostate service: http://www.yourprostate.eu) extending opening hours beyond the 'normal' working day and making services feel more 'male-friendly'.
- **Pharmacies** have a potentially significant role as a first point of contact with the health system. Community pharmacies are often more conveniently located for men, an appointment is not needed and they are often open for longer than general practice.
- **Training** for health professionals on men's health issues is important. In the UK, training modules are now available for pharmacists and GPs but these are optional and not yet part of pre-qualification training; as yet, take-up is relatively low.
- There is a need for better **outreach services**. Taking services to where men are has been shown to be an effective strategy. The new EuroFIT project (http://eurofitfp7.eu), which aims to improve men's health through programmes delivered via football clubs, and 'Men's Sheds' (http://menssheds.eu) are good examples of this approach. Workplaces, faith and leisure venues (such as clubs and pubs) provide other settings where men can be engaged.
- Men's **health literacy**, including symptom awareness, should be improved. Possible actions include: better health education for boys at school; effective targeting of public health campaigns on heart disease, cancer, diabetes and other major conditions; and the production of health information in 'male-friendly' formats.
- More support for the development of men's **health champions** and **role models** – including celebrities, health professionals and 'ordinary' people – who can influence health care policies and practices as well as men's attitudes, knowledge and behaviours.
- Key **transition points** in men's lives, such as becoming a father or retirement, present opportunities for engagement.
- More **research** is needed into men's use of primary care services, including better evaluation and dissemination of initiatives to help develop and extend good practice.
- The main focus of work to improve men's use of primary care services should be those groups of men with the worst health outcomes, including low-income men, migrants, gay men, homeless men, prisoners and offenders, and black and minority ethnic men.

disadvantaged groups, will continue to die too young from a major health inequality that is still all too often overlooked.

References

1 World Health Organization. *World Health Statistics 2013*. Available at: www.who.int/gho/publications/world_health_statistics/2013/en/

2 Wang H, Dwyer-Lindgren L, Lofgren KT, et al. Age-specific and sex-specific mortality in 187 countries, 1970–2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet* 2012;380:2071–94.

3 White A, McKee M, de Sousa B, et al. An examination of the association between premature mortality and life expectancy among men in Europe. *European Journal of Public Health* 2013 doi: 10.1093/eurpub/ckt076.

4 UCL Institute of Health Equity. *Review of social determinants and the health divide in the WHO European Region: final report*. Copenhagen: WHO Regional Office for Europe, 2013.

5 FRA (European Union Agency for Fundamental Rights). *Inequalities and multiple discrimination in access to and quality of healthcare*. Luxembourg: European Union, 2013. Available at: http://tinyurl.com/oy3ud23

6 Malcher G. The state of men's health in Europe: conventional primary care won't get the job done. *BMJ* 2011;343:d7054.

7 Hippisley-Cox J, Vinogradova Y. *Trends in consultation rates in general practice 1995/1996 to 2008/2009: Analysis of the QResearch® database*. QResearch and NHS Health and Social Care Information Centre, 2009. Available at: http://tinyurl.com/puvpqdm

8 Sakalauskienė Z, Vehkalahti MM, Murtomaa H, Mačiulskienė V. Factors related to gender differences in toothbrushing among Lithuanian middle-aged university employees. *Medicina* 2011;47(3):180–6.

9 Dickey H, Ikenwilo D, Norwood P, Watson V, Zangelidis A. Utilisation of eye-care services: the effect of Scotland's free eye examination policy. *Health Policy* 2012;108: 286–93.

10 Clarke N, Sharp L, O'Leary E, Richardson N. *A report on the excess burden of cancer among men in the Republic of Ireland*. Carlow: Irish Cancer Society, National Cancer Registry Ireland and Institute of Technology Carlow, 2013.

11 Juel K, Christensen K. Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005. *Journal of Public Health* 2008;30:111–3.

12 Redondo-Sendino A, Guallar-Castillón P, Banegas JR, Rodríguez-Artalejo F. Gender differences in the utilisation of health-care services among the older adult population of Spain. *BMC Public Health* 2006;16;6:155.

13 Guasp A. *Gay and Bisexual Men's Health Survey*. 2012. London: Stonewall. Available at: http://www.healthylives.stonewall.org.uk/includes/documents/cm_docs/2012/g/gay-and-bisexual-mens-health-suvey.pdf

14 Stagg HR, Jones J, Bickler G, Abubaker I. Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study. *BMJ* Open 2012;2:e001453.

15 Brott A, Dougherty A, Williams ST, et al. The economic burden shouldered by public and private entities as a consequence of health disparities between men and women. *American Journal of Men's Health* 2011;5(6): 528–39.

16 European Commission. *The state of men's health in Europe*. Extended Report. Luxembourg: European Commission Directorate-General for Health and Consumers. Available at: http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf