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# The Gender and Access to Health Services Study

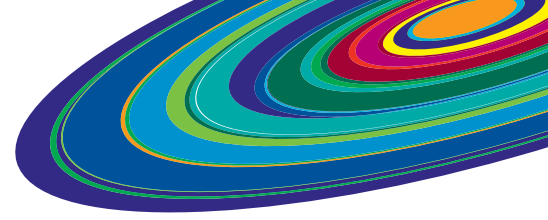
*Final Report*

David Wilkins  
Dr Sarah Payne  
Dr Gillian Granville  
Dr Peter Branney



**DH INFORMATION READER BOX**

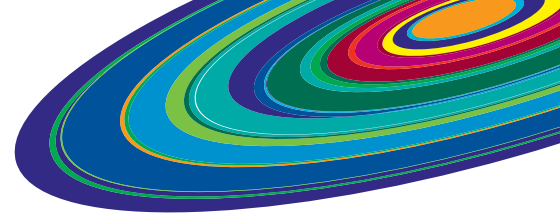
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*The authors acknowledge with gratitude the advice of Professor Kate Hunt who acted in a voluntary capacity as critical reviewer of this document. We are also extremely grateful to Gillian Mayo at the Department of Health for her continuing support and enthusiasm for this piece of work.*



# Executive summary

Men and women frequently think and behave differently. To observe that is very generally the case is by no means the same as asserting that there are only 'male' and 'female' modes of existence. To make such an assertion would be absurdly simplistic; behaviours and thought processes of course vary according to numerous other factors besides gender. At the same time, acknowledgement of the fundamental and continuing truth contained in that opening sentence frees us to recognise that there are broad – and often broadly predictable – differences in the way men and women engage with the world. Most commercial organisations understand this very well and plan accordingly. Some public authorities recognise it too and take these differences into account when developing and providing services. The NHS, however, has rarely done so.

It is widely known that there are differences between men and women in the incidence and prevalence of most health conditions. Sometimes there are clear biological reasons for these differences – but often there are not. Where biology offers little or no enlightenment, other questions need to be asked:

- Do men and women behave in ways that predispose them to particular health conditions to different degrees?
- Do men and women use health services with different degrees of effectiveness?
- Do men and women receive different kinds of service from the NHS?

The answer is yes; all these things happen frequently. Sometimes this is to the disadvantage of one sex, sometimes it is to the disadvantage of the other. Occasionally it is to the disadvantage of both. These disadvantages inevitably affect health outcomes.

This report looks at the reasons why gender remains such an important determinant of health status and considers the ways in which gender inequalities can be tackled within the present legislative and policy framework. It also brings together the knowledge and evidence in relation to six specific areas of health concern:

## 1. Cardiovascular disease

The mortality rate for coronary heart disease (CHD) is much higher in men, and men are more likely to die from CHD prematurely. Men are also more likely to die during a sudden cardiac event. Women's risk of cardiovascular disease in general increases later in life and women are more likely to die from stroke. Men and women often experience different symptoms for CHD, with the 'typical' symptoms being more often experienced by men. This may mean that women are less likely to recognise symptoms in themselves and tend to seek help at a later stage (although surprisingly little is known about the link between gender and help-seeking behaviour). Women are also less likely to be referred to specialists. Despite these differences, there is very little national policy that takes gender differences into account.

## 2. Overweight and obesity

The proportion of men and women who are obese is roughly the same, although men are markedly more likely to be overweight than women, and present trends suggest that weight-related health problems will increase among men in particular. Women are more likely than men to become morbidly obese. Women are much more likely to take part in private sector weight loss programmes and more likely to be treated for overweight in primary care. There are important differences between men and women in how they view weight problems. It is probable that men and women take different approaches to weight management and they may find different approaches helpful. It is also possible that health professionals may take different attitudes to men and women in relation to weight, although research into this is limited. There are no gender-specific national targets in relation to overweight and obesity, and very little consideration of gender in the relevant national strategies.

## 3. Mental health

Women are more likely to report, consult for and be diagnosed with depression and anxiety. It is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse. There is a national strategy for women's mental health but no equivalent for men, although there is a focus on the prevention of young male suicide in the *National Suicide Prevention Strategy* (DH, 2002b). The shortage of knowledge in relation to barriers to service use for both men and women is acknowledged in the equality impact assessment of the Mental Health Act 2007.

## 4. Alcohol misuse

Alcohol disorders are twice as common in men, although binge drinking is increasing

at a faster rate among young women. Among older people, the gap between men and women is less marked. Policy tends to see the consequences of unsafe drinking as different for men and women; men become violent or take unwise risks, women may become more vulnerable to abuse or attack. It is possible that women feel more stigmatised by alcohol-related problems and this may influence their response to services – at the same time, women are more likely to use some services than men, despite men's greater level of problems. National alcohol policy takes little account of the differences between men and women.

## 5. Cancer

Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex-specific. At the same time, cancer morbidity and mortality rates are reducing more quickly for men than women. The most common avoidable cause of cancer – tobacco – may be used by men and women differently. Tobacco use may also affect men and women differently. Many of the early signs of cancer are easily confused with minor health problems and there is some evidence that men may be less likely to consult for these kinds of symptoms. There are variations between men and women in their experience of the cancer care 'journey'. The reasons for these differences are not well understood. Historically, there has been little consideration of the need for gender-sensitivity in cancer services but the *Cancer Reform Strategy* (DH, 2007a) has highlighted the need for a better understanding of the issue and suggests that research is needed.

## 6. Sexual health

Sexual health is unique in that patterns of male and female health status are directly linked. It is, however, difficult to make judgements about the use of services

because detailed data about use of GUM (genito-urinary medicine) clinics are not currently available in gender-disaggregated form (although planned changes in data collection systems will eliminate this problem in the future). With the exception of gonorrhoea, incidence rates of all sexually transmitted infections are rising, with the increase being greater in women than men. HIV infection has always been much higher in men, although the rate of infection from heterosexual sex is increasing more rapidly than among men who have sex with men. It seems very probable that men and women view sexual health differently but there is little research in the field. Gender is considered frequently in sexual health policy in the sense that many services are for one sex or the other, but there is less consideration of the link between gender and help-seeking behaviour. The National Chlamydia Screening Programme has pioneered a strategy for increasing the take-up of services by men – currently the only strategy of its kind in any area of health provision.

The report makes a number of recommendations in relation to each area of health concern. It also makes the following eight recommendations for health policy overall:

### **1. Use and availability of data**

There are three ways in which better use of data could help reduce gender inequalities. The first is to undertake a detailed analysis of systems such as the General Practice Research Database to improve understanding of the relationship between gender and use of primary care services. The second is to ensure that gender-disaggregated data (i.e. data showing the differences between men and women) are always used in health planning. The third is to require that data

released publicly are always broken down by gender.

### **2. Future research**

The research base in relation to the link between gender and use of health services is surprisingly poor. We recommend that at least one of the leading areas of health policy is made the 'pilot' for developing greater understanding of this issue with a view ultimately to developing more sensitive provision of services.

### **3. Gender equality schemes and gender impact assessments**

These statutory obligations form part of the Equality Act 2006 and have the potential to reduce gender inequalities in health – but only if they are implemented rigorously. We recommend a set of minimum advisory standards emphasising that these processes should always include specific actions intended measurably to reduce differences in the use of services and/or in health outcomes between men and women.

### **4. The potential value of the Quality and Outcomes Framework**

We recommend that – on a trial basis – some Quality and Outcomes Framework points are made subject to the achievement of gender-equitable distribution of the service under consideration (e.g. that the record of the service delivered is required to show the percentage of male patients and the percentage of **female** patients, rather than the percentage of patients per se).

### **5. Supporting good practice locally**

We recommend the establishment of a national Tackling Gender Inequalities Programme with the express purpose of supporting, evaluating and disseminating local initiatives which seek measurably to close gender gaps in service use and health outcomes.

## **6. Influencing healthcare provision outside the NHS**

We recommend that the Department of Health and local health bodies actively seek to influence non-NHS organisations in favour of delivering a more gender-equitable service through local planning and commissioning processes. The Joint Strategic Needs Assessment in particular can be an important force for bringing about improvements.

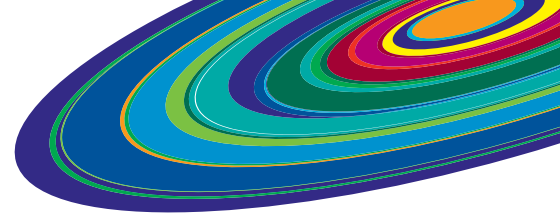
## **7. Making primary care more flexible**

Three models of enhanced primary care provision may have the potential to reduce gender inequalities. These are: more flexible opening hours; the provision of outreach services; and inviting patients to attend for 'health checks'. We recommend local commissioning of initiatives following each of these models, monitored for their effect on the gender balance of patient use of services.

## **8. Tackling Health Inequalities**

Gender is the most significant factor interacting with economic status to compound health inequalities. We recommend a review of the actions presently within the health inequalities strategy to ensure that they are implemented in a gender-sensitive way. Most importantly, it is our view that future Public Service Agreements in relation to health inequalities must aim to reduce gaps in health outcome between men and women in parallel with reducing gaps between the least well off and the rest of the population.





# Chapter 1: Definitions

## Sex and gender

In day-to-day use, these two words tend to be seen as interchangeable but a clear distinction is often made between them in official and academic documents. This distinction is helpful in the present context and we have tried to stick to it throughout this report (although this has not always been possible where we are quoting from other sources). The passage below from the World Health Organization's (WHO's) Madrid Statement on gender equity in health sums up the difference:

*The word 'gender' is used to define those characteristics of women and men that are socially constructed, while 'sex' refers to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men.*  
(WHO, 2004a)

In other words, a person's sex is a biological fact but his or her **gender** is a function of the behaviours, attitudes, values and beliefs that a particular cultural group considers appropriate for males and females on the basis of that biological fact.

## Equality and equity

There is often confusion about the different meanings of the terms **equality** and **equity** and – more importantly perhaps in the present document – their opposites **inequality** and **inequity**. There is some overlap between these terms and they may

be used interchangeably in some contexts but they are not synonymous. Throughout this report, we have tried to adhere to the commonly accepted principles that underlie the numerous official and academic definitions of the two words and the differences of emphasis between them.

In essence, an **inequality** is a straightforward measure of difference and does not necessarily reflect an injustice or a situation capable of change – although of course it very well may do. An **inequity**, on the other hand implies a potential lack of fairness, and it is often the case that the imbalance could be redressed by using resources in a different way. The key point is that resources delivered **equitably** are resources delivered on the basis of demonstrable need. The following passage from WHO's Health Promotion Glossary is written in the context of global health development but it summarises the key ideas nicely:

*The WHO global strategy of achieving Health For All is fundamentally directed towards achieving greater equity in health between and within populations ... This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable*

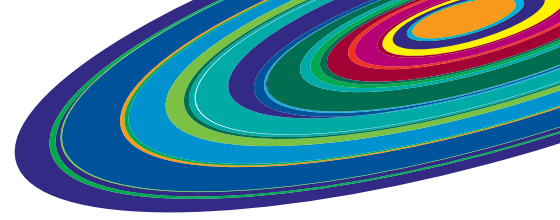
*consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences of opportunity which result for example in unequal access to health services, nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life.*  
(WHO, 1996)

## Gender equity

We also need to be clear what we mean by **gender equity** in the specific context of the development of health policy and the delivery of health services. Trying to achieve gender equity means developing policy and services that aim to meet the health needs of women and men in an **equitable** way. This does not necessarily mean that policy and services should aim to achieve equality of outcome since, for a variety of predetermined reasons, that may sometimes be impossible. Rather, it means to ensure that both men and women have their health needs appropriately met. This includes, of course, seeking to ensure equitable access to services.

## Gender sensitivity

The phrase **gender sensitive** is often used to describe policies and services that seek to achieve **gender equity**. Gender sensitivity involves identifying the ways in which the needs of women and men might differ and considering where policy and services might need to change to address those differences. Policy and services which take no account of the differing needs of men and women are sometimes described conversely as **gender blind**.



## Chapter 2: Introduction

### Gender as a determinant of health status

The driving force for this study is the increasing recognition among health policy-makers and service planners that an individual's gender is a central determinant of his or her health status. This perhaps seems hardly worth saying; it is commonly known for example that many diseases affect men and women disproportionately or occur at different times of life – but it may well be that the very obviousness of the connection between gender and health is the reason that it is often overlooked. Gender differences are so familiar that they may appear to be a 'given' that is not capable of being changed.

This difficulty in arriving at a meaningful understanding of the link between gender and health also has historical roots. The NHS was established to provide a **universal** service. It has taken a long time to realise that this admirable objective does not necessarily guarantee optimum health and healthcare for each individual – and by extension, that it need not preclude specific action to address differences in health status between population groups where those do occur.

Differences in health status are often described as 'health outcomes'. Health outcomes, however, are not the only measure to take into account when looking at the potential for achieving improvements in services. Indeed, taken in isolation, differences in health outcomes can sometimes give a misleading impression since they may also be a function of biological and

physiological differences between population groups. Obviously, this is especially so in the case of gender where biological and physiological differences are fundamental.

Biological explanations for differences in health outcomes can sometimes lead to decision-making that exacerbates those same differences (e.g. decisions predicated on the assumption that a particular condition is always a 'women's disease' or a 'men's disease'). Such differences should not therefore be put aside altogether – but it is the differences that are believed **not** to be attributable to biological causes that are most important in the present context. Where biological explanations are inadequate, health planners and policy-makers have come to realise that differences in outcome between men and women are often an indicator that health services are varying in effectiveness between the sexes.

Such variations occur sometimes to the detriment of one sex, sometimes to the detriment of the other. But the existence of variations in effectiveness is not, in itself, very surprising news. Such variations will already be familiar to many clinicians and health service managers from their day-to-day experience. It is the explanations for these variations that are important.

It could be observed that men and women tend to **use** health services differently and that that is all we need to know. In very broad terms this is true, although the explanations for gender differences in service use are as complex as this observation is simple. Exploring these kinds of difference

is an important objective of this report. More challenging though, is the fact that some of the variations in effectiveness may be a direct result of the way that services are constructed and/or delivered. Indeed, even where men and women are apparently 'choosing' to engage with services to a different extent from each other, the differences in uptake may, in reality, reflect a lack of sensitivity to attitudinal and behavioural differences between men and women in the way that services are designed. In other words, another important cause for variations in effectiveness between men and women is that some services have been allowed to develop in such a way that they actively fail to meet the needs of one sex as well as they meet the needs of the other.

### Gender differences are an inequality

It is important to understand whether variations in effectiveness are rooted in differing patterns of service use between men and women or are caused by the way services are structured – or by some combination of the two. Our starting point, however, is the simple recognition that these variations are undesirable and need to be tackled – they mean that individuals of one sex or the other are receiving a poorer service. Poorer services contribute to poorer health outcomes at both individual and population level. Not only is this inequitable in itself, it also clouds understanding of public health and causes reduced cost-effectiveness in the NHS.

The key principle underlying this report is that, once these problems with service delivery and service use are acknowledged, it can be seen that their differential impact on the health status of men and women is an **inequality** stemming from decisions made by health policy-makers and directly related

to the planning and organisation of health services. In this sense, gender inequalities are no different from inequalities associated with economic status or ethnic origin (and indeed gender inequalities interact with such other inequalities). It follows that it is possible to tackle gender inequalities by targeted actions, in the same way that other inequalities are being tackled. It is actions of this kind that this report is intended to inform and stimulate.

### The policy imperative

Significant added impetus for taking action to reduce gender inequalities has come from the Equality Act 2006. This legislation requires all public bodies (including all NHS bodies) not only to ensure that services do not discriminate between men and women but also actively to promote equality of opportunity for both sexes. In other words, the responsibility for tackling gender inequalities now rests squarely with those planning and delivering services. It will no longer be enough simply to say that the services are there to be used on a population-wide basis and that if men and women use them in disproportionate measure then that is not the business of the service provider. Nor will it be enough to wait until someone complains. Where it is probable that inequitable use of services is resulting in unequal outcomes between men and women, it is the statutory responsibility of the service-providing authority to examine the service and to adjust it towards achieving a better balance.

The primary mechanism within the legislation for achieving this change is the Gender Equality Duty (GED). The GED applies to all NHS trusts and to most of the organisations contracted to them. The GED requires the publication of a gender equality scheme (GES) which sets out the

action the public body intends to take to achieve the requirements of the legislation. The GED further requires that public bodies conduct a gender impact assessment of all new policies and programmes where those are likely to have a 'major' impact on the provision of services. It was made clear during the progress of the new legislation through Parliament that the introduction of the GED is intended specifically to improve **outcomes**. In the field of health, this means that changing the way services are provided will only meet the requirements of the GED if it ultimately results in more equal health outcomes.

Action to address the health inequalities associated with gender is also relevant to several other current drivers of health policy. All of the key areas for action identified in *Choosing Health: Making healthier choices easier* (DH, 2004b) are presently subject to gender differences in the kinds of challenges that they present (for example sexual health, smoking, mental health). Taking account of gender differences has the potential also to contribute to the delivery of wider choice and greater flexibility identified as important to NHS users in the White Paper, *Our Health, Our Care, Our Say* (DH, 2006c). Furthermore, the Public Service Agreement (PSA) plans for the period 2008–11 will introduce a number of specific indicators relating to the performance of local health systems in relation to gender (in the cross-cutting PSA 15).

Behind these policy imperatives however, there lie two much sharper and more straightforward reasons for addressing gender inequalities in health. The first is – obviously – that it is right and proper to do so, and entirely consistent with the founding objectives of the NHS. The second is that it is cost-effective to ensure that all people receive timely and appropriate

services regardless of whether they are male or female.

### Driving change

Seeking to change the gender balance in mortality rates from cancer or heart disease is, of course, immeasurably more difficult for health providers than achieving more equitable use of buses might be for a transport authority. Some of the shifts that are needed will take many years. It is therefore important that the GED is seen as providing a platform for longer-term change.

Many of the aspects of health where change will be necessary – for example, the incidence of work-related stress, alcoholism and drug misuse, injuries caused by domestic violence, and eating disorders – are associated with socio-cultural differences between men and women that are beyond the power of health service providers to change. In this sense, the Equality Act 2006, although not legislation enacted in the field of health, adds weight and value to the broader argument that it will be necessary to develop a 'cross-cutting' approach if significant improvements in population health are to be achieved. This approach is also one that requires a vision for the long term.

In some cases of course, the action required may be relatively simple and inexpensive and it will be reasonable to expect measurable improvements within a short period (for example, addressing gender inequities in attendance at support groups in primary care). But a properly effective programme of change will depend on those who make policy or plan services understanding the impact of gender differences on health outcomes and patterns of service use. Often even the most basic data used in planning health services have not been routinely considered in 'gender-disaggregated' form

(i.e. showing a breakdown of the differences between men and women). A survey of English primary care trusts (PCTs) by the Men's Health Forum in 2006 suggested for example, that fewer than a third of PCTs always used gender-disaggregated data when planning services in relation to heart disease and cancer, and less than a fifth when planning services in relation to diabetes (Wilkins, 2006).

Making sure that gender-disaggregated data are always used in the planning process is the most obvious starting point – but if the problem is to be tackled successfully, it will also be necessary to understand the underlying explanations for these differing patterns of service use between men and women. The impact of gender on health is widely acknowledged to be under-researched but the purpose of this report is to bring together some of the most relevant information, with a focus on the use of services in primary care. To our knowledge, no attempt has previously been made to do this – and much work remains to be done. Nevertheless, there is knowledge and information in this report which provides a strong argument for greater 'gender sensitivity' in policy-making and service planning, and which is capable of reducing gender differentials in use of health services and, ultimately, in health outcomes.

### The structure of this report

We have concentrated on six major areas of health policy. As it happens, these areas of health policy are all disease specific but we have taken great care to consider each within the broadest possible context in order to avoid an unduly medicalised approach. We accept that some readers will nevertheless feel that structuring the report by disease should have been avoided. It should be pointed out, however, that in addition to its

consistency with currently policy priorities, this approach also offered the pragmatic bonus of fitting neatly with the taxonomy of the literature which in turn helped maximise what could be achieved within our relatively limited resources.

Priority was given to those areas of policy most relevant to current activity within the Department of Health and the NHS. The six health policy areas examined are:

- cardiovascular disease prevention, diagnosis, treatment and survival;
- overweight and obesity;
- mental health;
- alcohol misuse;
- cancer prevention, diagnosis, treatment and survival; and
- sexual health.

The report contains a separate chapter about each of these areas of health policy. Each chapter follows a similar format:

1. Introduction and definitions
2. Statistical information and epidemiology
  - Incidence/prevalence
  - Consultation rates and use of services
3. Factors associated with gender differences
4. Gender and help-seeking behaviour
5. Gender and experience of services
6. Gender and current policy
7. Key messages
8. Recommendations

## Methodology and other points to note

The scoping reviews undertaken for this report have involved searching the following scientific databases: Applied Social Sciences Index and Abstracts (ASSIA); British Library Grey Literature; CSA Illumina Social Sciences; Cumulative Index to Nursing and Allied Health Literature (CINAHL); Embase; Google Scholar; International Bibliography of Social Sciences (IBSS); Medline; Ovid; PsycINFO; PubMed; and Web of Knowledge/Web of Science.

For each scoping review, searches used keywords associated with the chapter heading plus relevant terms such as 'gender', 'gender differences', 'primary care', 'health seeking', 'help seeking' and so on. Searches were confined to literature published in the last 10 years, although a few examples of earlier literature have been used where particularly helpful. Preference was given to UK literature, except where international literature had a particular insight to offer.

Some of the statistical information at the beginning of each chapter (particularly that which refers to consultation rates in primary care) is drawn from the fourth national study of morbidity from general practice (McCormick et al., 1995). This publication is a compendium of information drawn from the General Practice Research Database (GPRD). The GPRD is a continuously updated computerised database of anonymised medical records which currently collects data on over 3.4 million active patients from around 450 primary care practices around the UK.

The GPRD is the most important of the databases capable of providing the detailed information necessary to understand gender differentials in the use of primary care in the UK. Unfortunately, constraints of time

and resources made it impossible for us to gain direct access to current information on the GPRD and the 1995 compendium publication is the most recent publicly available source of data. One of our recommendations is for a more substantial piece of work in the future which should look in detail at the most recent statistics on the GPRD (see 'Recommendations' in Chapter 9). Tables drawn from the data in the fourth national study of morbidity from general practice give their source as McCormick et al. (1995).

As noted, there are important interactions between gender inequalities in health and other inequalities, including age, racial origin, sexuality, social class and disability. We have decided not to explore these interactions in any detail. This is not because we think they are unimportant – quite the reverse in fact – and we have drawn attention to them where they are especially relevant. We have, however, been constrained by limitations on time and space, and consequently decided to keep our focus specific; exploring gender inequalities in health was the central element in our brief and gender inequalities are those that have historically been paid the least attention.

For similar reasons, in respect of our capacity and because this report is particularly about differences in access to health services between all men and women, it does not seek to address specific issues affecting transgender (trans) people beyond the extent that they are men and women. It should be noted, however, that trans people are also covered by the GED and that the Government has made clear its commitment to ensuring fair and equal health outcomes for the trans community. In recent years, the Department of Health has commissioned and published a number of separate resources in

relation to the health of trans people. These resources are listed at Appendix 6.

We have also reported on two events that have enabled us to seek the views of senior planners and policy-makers.

On 21 February 2008, in partnership with the Men's Health Forum, the National Director for Primary Care, Dr David Colin-Thomé, hosted a small expert round table to discuss men's access to primary care. The round table was held in response to concerns that men tend not to use primary care services as effectively as women. This event was already scheduled before the present study was commissioned and was therefore not directly connected with it in its conception. However, the subject of the round table was clearly relevant to the present piece of work and the participants at the event kindly agreed that their discussions and conclusions could be reported in this document. It needs to be noted of course, that this event was specifically about **men** rather than about gender per se but it yielded useful insights that have contributed to the overall value of our study. A detailed report of this event is given at Appendix 5.

The second event was organised specifically to inform the development of this study and, in particular, its recommendations. On 6 May 2008, a symposium was held at the King's Fund in London for an invited audience of 50 people who were known to have an interest in the relationship between gender and health status. Symposium participants received a draft copy of this report in advance of the event. At the event, they were invited to consider the evidence that had emerged from the literature review and to participate in an open discussion aimed at drawing conclusions from its findings. They were also asked to advise on potential recommendations that could

be made. A report on the discussion at the Expert Symposium on Gender and Access to Health Services is given at Appendix 1, the programme for the event is at Appendix 2 and the names of participants at Appendix 3.

Each chapter concludes with recommendations specific to the subject in question. We have concentrated on making recommendations that are practical and workable and, of course, substantiated by the evidence base presented in the chapter concerned. Our important overarching recommendations are given in Chapter 9.

### The objective of this report

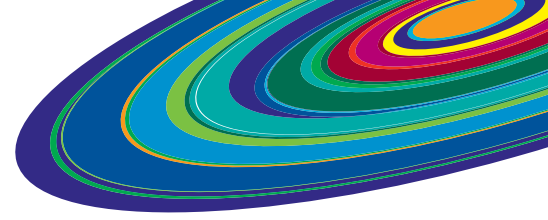
Gender inequalities in health status that are not attributable to biological factors have been around for a very long time. But durability should not be mistaken for permanence, and the fact that these inequalities are rooted in social, cultural or even 'inherent' differences between men and women is not a good enough reason to assume that they cannot or need not be tackled. It is not good enough either to contend that just because gender differences often occur independently of more accepted markers of inequality like race or economic status, they are not 'real' inequalities at all. All inequalities in health status need to be examined to see whether they are avoidable. If they are they should be tackled. Gender inequalities should be no exception to that.

To make a difference, it will be necessary to improve understanding of the behavioural and attitudinal factors that affect the way men and women engage with health services. More challengingly perhaps, it will also be necessary to examine the way policy is made, and services planned and delivered. The question to be asked here is whether gender inequalities in service use and health outcome have structural explanations.



Ultimately, action needs to be taken – policies and services, systems and processes must actively seek to encourage equitable use and to deliver equal outcomes where equal outcomes are possible.

This will be a long-term project but the benefits will be seen in improved engagement by NHS users, more cost-effective service delivery and, of course, in improved health outcomes at both individual and population level. Much remains to be done but it is the intention of this report to open the debate, and to provide sufficient information and guidance to enable the process of change properly to begin.



# Chapter 3: Cardiovascular disease prevention, diagnosis, treatment and survival

## 1. Introduction and definitions

Cardiovascular disease (CVD) refers to a number of diseases of the circulatory or cardiovascular system including conditions such as ischaemic or coronary heart disease (CHD) and cerebrovascular disease or stroke. CHD and stroke combined account for the majority of CVD deaths. Many of the risk factors for the different cardiovascular conditions are shared, including lifestyle factors and conditions such as hypertension, diabetes and high cholesterol blood level or triglyceride (fat) blood level.

Diseases of the circulatory system are major causes of mortality, accounting for nearly 200,000 deaths in England and Wales in 2005 (ONS, 2006a). Of these, CHD led to nearly 90,000 deaths, while there were over 50,000 stroke-related deaths.

CVD is often described as a preventable cause of mortality and morbidity, in that changes in health behaviours, including changes in diet, physical activity, obesity and the consumption of alcohol and tobacco, could make significant contributions to a reduction in the burden from this disease. CVD has been a major focus of government initiatives to reduce health inequalities over a number of years, and was the subject of one of the first National Service Frameworks identifying standards for treatment.

There are important – and complex – differences between women and men in their risk of various forms of CVD, the ages at which CVD risk increases, and underlying factors including both biological

and gender-related differences. Research evidence also reveals important differences between women and men in how well CHD is recognised, and in the appropriateness of treatment interventions.

This chapter will review the evidence and policy relating to gender differences in access to and use made of services relating to CVD, largely concentrating on CHD, cerebrovascular disease and hypertension, in keeping with the focus of Department of Health policy, including the Quality and Outcomes Framework (QOF) clinical indicators for CHD, and *The National Service Framework for Coronary Heart Disease* (DH, 1999b). We begin with a brief discussion of data on consultation in general practice for these conditions.

## 2. Statistical information and epidemiology

### Incidence and prevalence

The total number of deaths due to diseases of the circulatory system is slightly higher among women than men. In England and Wales in 2005, for example, more than 95,000 women died from CVD compared with 88,000 men. This includes 49,000 men who died from CHD compared with 39,000 women, and 19,000 male deaths from cerebrovascular disease in comparison with over 31,000 female deaths (ONS, 2006a). More women than men die from other heart and circulatory conditions.

There are also important differences between women and men in their risk of CVD across the life course. Age-standardised data, for

example, control for the greater number of women among older age groups where CVD is higher. Age-standardised mortality rates reveal a much greater risk of CHD deaths among men, with a male CHD mortality rate of 147 per 100,000 compared with 69 for women. On average, men develop CHD 10 to 15 years before women (Fodor and Tzerovska, 2004), and in all age groups between 15 and 85 the male CHD mortality rate is higher. The widest gap occurs between the ages of 50 and 54, when there are nearly five times as many male deaths as female (ONS, 2006a).

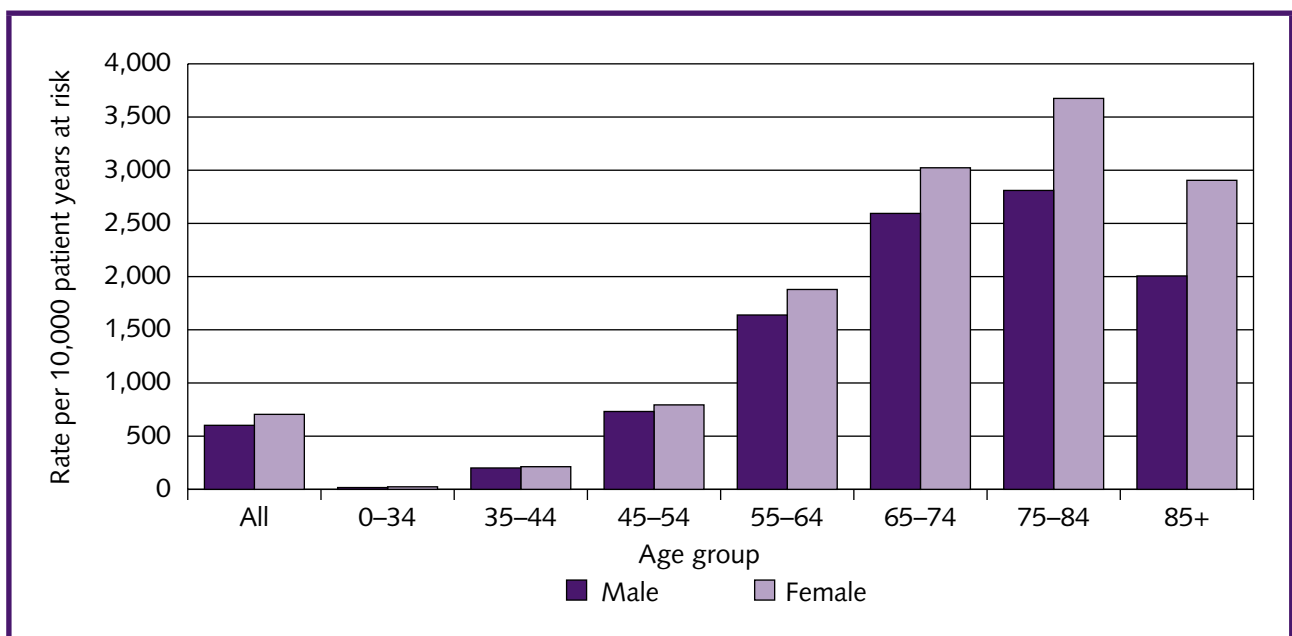
Women's risks of heart disease increase during the menopausal transition and following the menopause (Fodor and Tzerovska, 2004). Women's risks continue to increase in later life and the gap between women and men narrows with women over-taking men after the age of 85 (ONS, 2006a). These differences translate into a lifetime risk of developing CHD at age 40 of one in two for men, compared with one in

three for women (Purcell et al., 2004). The increase in CHD among women in later life is reflected in the lifetime risk of developing CHD at age 70, which is one in three for men compared with one in four for women (Purcell et al., 2004).

CHD rates are higher among both women and men in lower socio-economic groups, although male mortality is higher in every class. Lower social class is also associated with a reduced chance of surviving a heart attack (Morrison et al., 1997).

With cerebrovascular disease or stroke, mortality is also higher for men overall although the gap between women and men is much narrower. The male age-standardised mortality rate is 55 per 100,000 population compared with a rate of 52 for women (ONS, 2006a). Again, male deaths outnumber female deaths in early life in particular, while cerebrovascular mortality among women is higher over the age of 75.

Figure 3.1: Prevalence of treated hypertension in general practice, 1998



Source: ONS (2000)

### Consultation rates and use of services

Data from the GPRD give an indication of the prevalence of three leading cardiovascular diseases – hypertension, CHD and CVD. The figures in this chapter are based on GPRD data from 1991/92 and 1998. These show some important differences between women and men in these conditions. We begin with hypertension, which is a risk factor for CVD. Figure 3.1 shows prevalence standardised per 10,000 person years at risk, for treated hypertension in general practice in England and Wales.

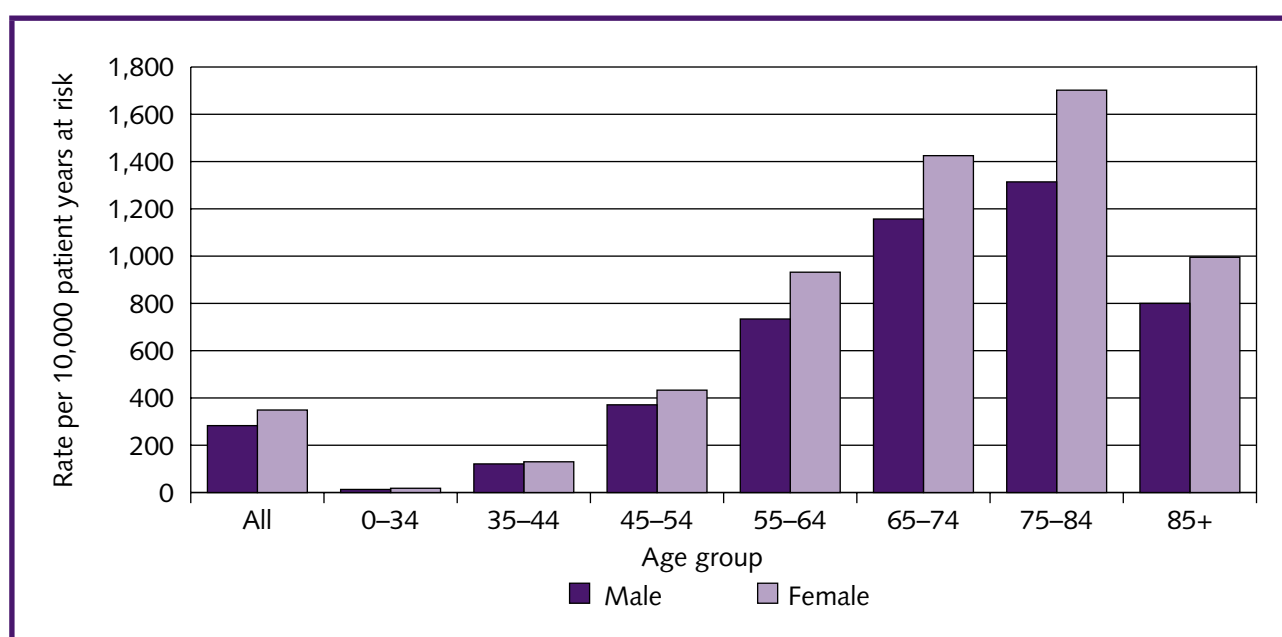
The figure shows that treated hypertension in general practice is higher among women both overall and in every age group, apart from among those aged 35–44, where the rates are virtually the same. The gap is highest in those over 75.

Figure 3.2 shows the prevalence of raised blood pressure in general practice in 1998. This is based on three sequential readings

of high blood pressure and does not include those who receive treatment which successfully reduces their blood pressure, so those included are those whose blood pressure remains problematic. As shown, both overall and in all ages over 45 more women have this risk factor.

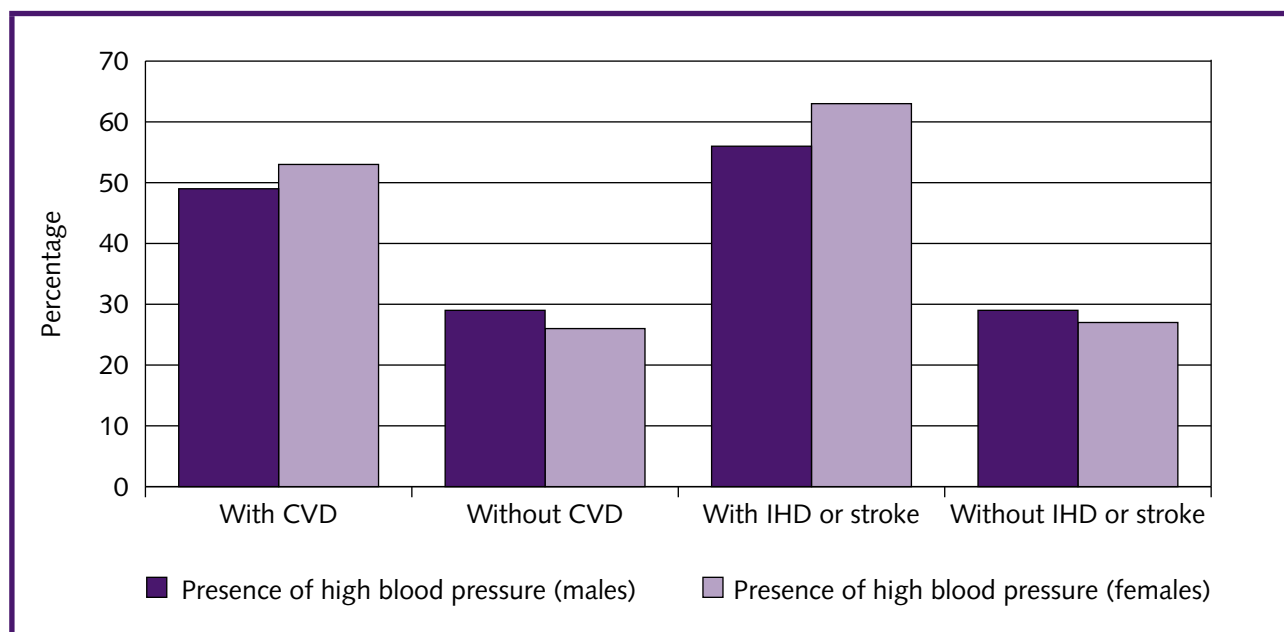
We can compare this with data from the 2003 Health Survey for England (HSE), bearing in mind the time gap between the data collection of the two sources. The HSE is a population-based study of over 6,000 adults for whom blood pressure readings were collected, and as such gives some indication of the prevalence of high blood pressure among both treated and untreated populations. In Figure 3.3, the categories ‘with CVD’ and ‘with ischaemic heart disease (IHD) or stroke’ refer to self-reported data on conditions which have also been diagnosed by a doctor – in other words, treated prevalence.

Figure 3.2: Prevalence of raised blood pressure in general practice, 1998



Source: ONS (2000)

Figure 3.3: Health Survey for England 2003 prevalence of risk factors – high blood pressure

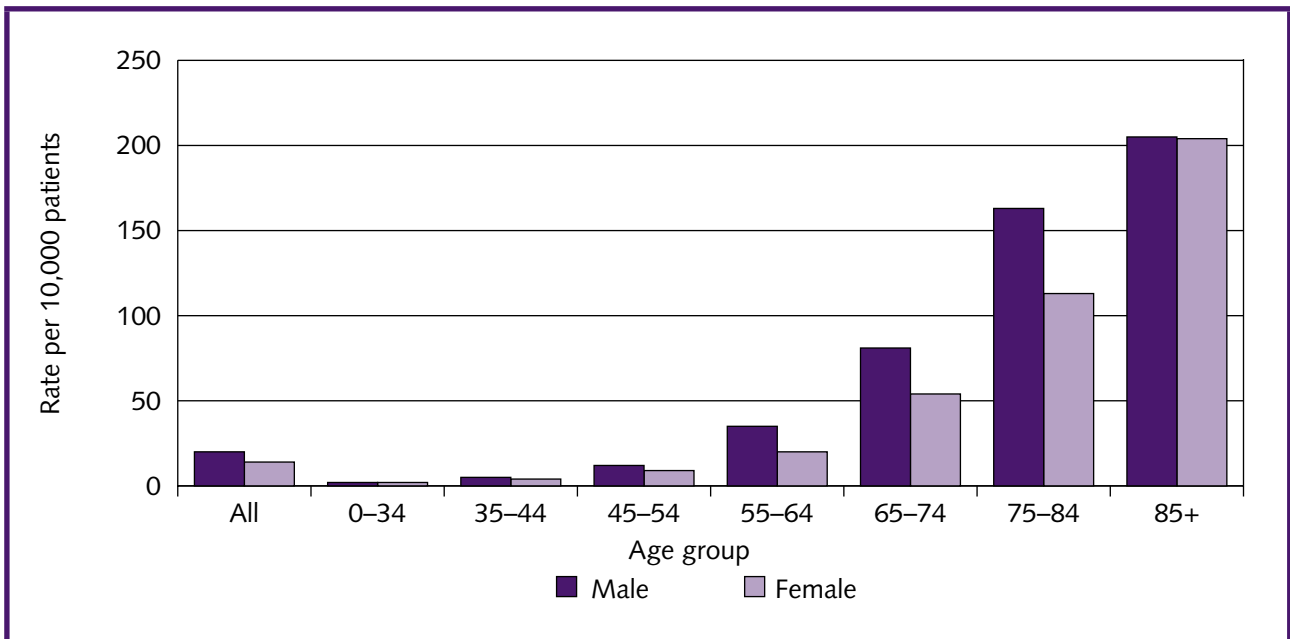


Source: DH (2005a)

Thus, among those without a diagnosis of CVD, IHD or stroke, more men than women are found to have high blood pressure. This might indicate an unmet need among men, where a key risk factor is not being identified and treated.

Data on the prevalence of stroke in general practice, based on patients treated for stroke during 1998 (Figure 3.4), reveal a higher rate of stroke among men than women with a particularly marked gap between the ages of 55 and 84.

Figure 3.4: Prevalence of treated stroke in general practice, 1998

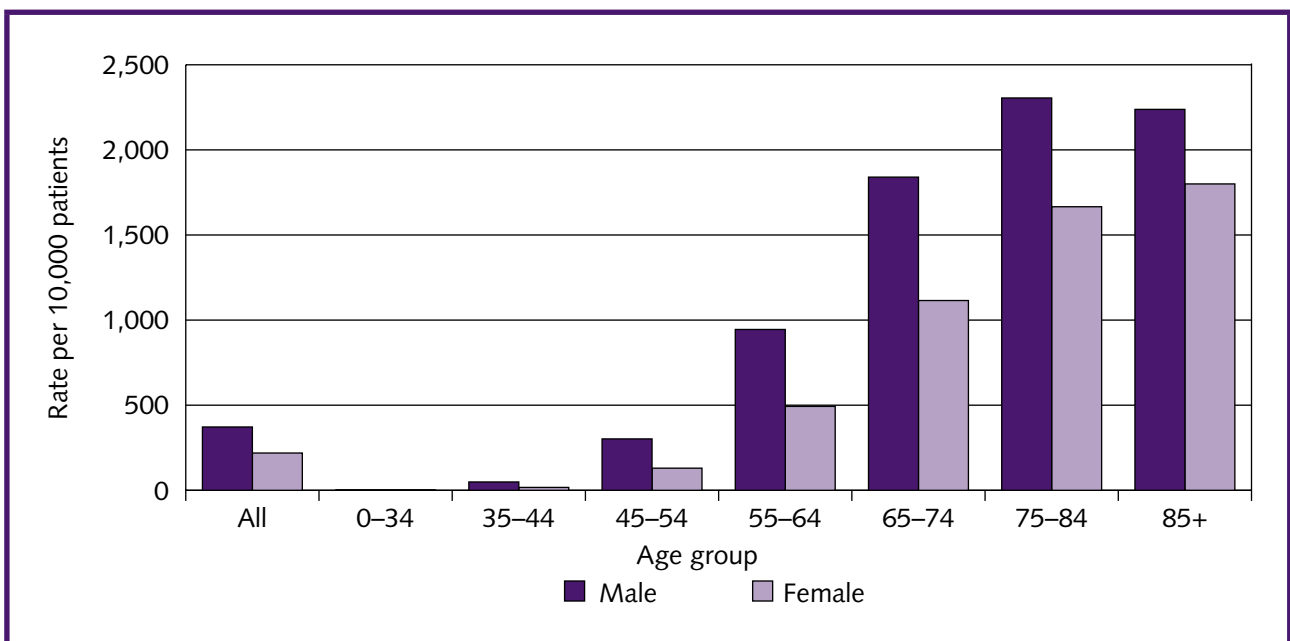


Source: ONS (2000)

For CHD, the prevalence in general practice is higher among men in all age groups, with the widest gap between women and men in younger age groups, especially 45-64 and

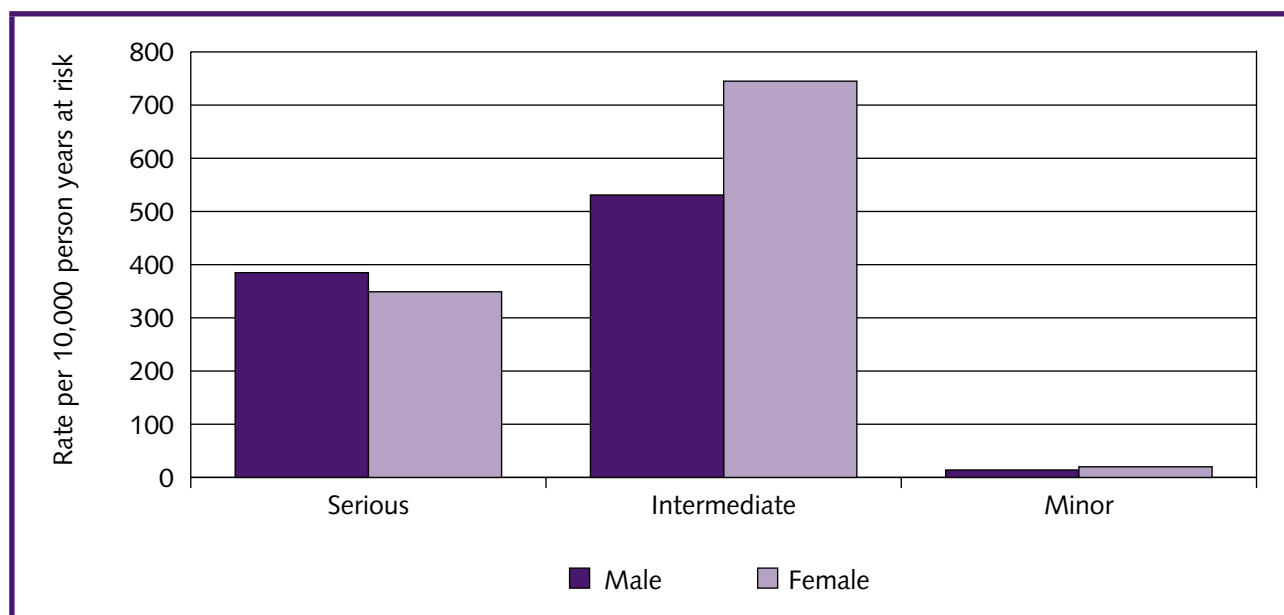
65-74. Figure 3.5 shows data for all patients in the GPRD database who had a diagnosis of CHD ever recorded.

Figure 3.5: Prevalence of treated coronary heart disease per 10,000 patients



Source: ONS (2000)

Figure 3.6: Consultations for cardiovascular disease by level of severity



Source: McCormick et al. (1995)

Finally, Figure 3.6 above shows data from the 1991/92 GPRD on consultations in general practice according to severity of the condition. More men are diagnosed with serious CVD conditions but the gap is perhaps surprisingly narrow given the data explored earlier for specific conditions. Women are more likely than men to receive a diagnosis reflecting an intermediate (less life-threatening) circulatory condition.

### 3. Factors associated with gender differences

The part played by modifiable risk factors also varies for women and men. One study has suggested that up to half the difference in CHD mortality between women and men can be explained by modifiable factors, particularly high-density lipoprotein (HDL) cholesterol levels and smoking, which has been more common among men historically (Purcell et al., 2004). Higher levels of HDL cholesterol are protective while low HDL cholesterol is one predictor of CHD risk. High HDL cholesterol is more common among

women, up to the menopause (Fodor and Tzerovska, 2004).

However, there is emerging evidence that the impact of some factors might also vary for women and men. For example, even though men are more likely to have low levels of HDL cholesterol, when women do experience low HDL cholesterol this confers a higher risk of CHD than for men (Fodor and Tzerovska, 2004). Similarly, smoking is a risk for both women and men but there is some evidence that smoking might increase the risk of CHD more for women, in comparison with their non-smoking peers, than for men (Prescott et al., 1998). This suggests that the gap in CHD mortality between men and women may narrow following the trend towards similar rates of smoking among men and women in the UK (GHS, 2006).

Obesity is another modifiable risk factor for heart disease and again there are important differences between women and men in the risk of obesity and also the nature of the risk. For example, central obesity, a particular risk factor for heart disease, is more common

among men. Obesity is discussed in more detail in Chapter 4.

Women, however, are more likely than men to experience co-morbidity, that is, to have CHD alongside other illness (Lefler and Bondy, 2004). As well as increasing the risk associated with some interventions, this can create particular difficulties in terms of pharmacology, particularly when much of the research on dose efficacy and safety of medicines has been carried out on male-only populations (Neutel and Walop, 2005).

#### 4. Gender and help-seeking behaviour

There is an increasing literature on differences between women and men in relation to the recognition of CVD symptoms, the decision to seek help or access services and gender barriers to care. This section explores the ways in which men and women consult for CVD, and the extent to which public health interventions are successful in targeting men and women. Various factors contribute to a gender gap in use of health services for CVD, particularly the extent to which common understandings of heart disease reflect gender stereotypes.

Research suggests important differences in what can be described as 'candidacy' for heart disease, particularly heart attack, with men more likely to be seen as typical candidates by both women and men (Emslie et al., 2001). Research looking at the ability to identify symptoms of CHD in the general population suggests that while the majority of both men and women are able to recognise chest pain as a symptom of heart attack, fewer people can identify all the potential symptoms (Greenlund et al., 2004). Men are less likely than women to recognise a wide range of symptoms and are less likely to recognise the need for emergency treatment (Martin et al., 1998; Greenlund et

al., 2004). However, women are more likely to die in the year following a heart attack (while men are more likely than women to die during the cardiac event before reaching hospital) (Lefler and Bondy, 2004) suggesting that gender differences in delays in treatment seeking may be important in understanding mortality.

There are a number of studies which look at the gap between the onset of symptoms related to heart attack/acute myocardial infarction (MI) and the decision to seek treatment. However, the evidence is not clear cut in terms of whether women or men are more likely to delay (Moser et al., 2005; Galdas et al., 2005). In addition, although delays in help-seeking have important clinical implications – increasing the risk of mortality or subsequent morbidity – research does not tell us whether differences in delay between women and men are long enough to have clinical implications (Moser et al., 2005).

One review of over 100 studies of treatment-seeking delay in patients with heart attack and stroke reported that women had longer delays before seeking help when experiencing symptoms of heart attack, but there were no differences between women and men when experiencing symptoms of stroke (Moser et al., 2005). Lefler and Bondy's (2004) meta-analysis of delays in treatment-seeking reported that larger-scale studies with greater statistical reliability were most likely to report longer delays in seeking treatment for women than men. In addition, one study suggested that, while men and women were equally likely to delay, the time elapsed before seeking treatment was longer for women than men, increasing their mortality risk (Johansson et al., 2004).

Research also suggests that there are differences between women and men in where they seek help and why they delay.



A study in Scotland, for example, found that men and women were equally likely to seek help when experiencing an MI but women were more likely to consult a GP first rather than seek emergency help (Leslie et al., 2000).

Differences between women and men in the reason for delay include women's belief that they are less likely than men to be having a heart attack, and that women often attribute their symptoms to a less threatening cause. Women are also more likely to say they wanted to avoid troubling other people, and they attempt self-treatment more often and are also more likely to consult a lay person (Walsh et al., 2004). Lefler and Bondy's (2004) meta-analysis of studies looking at treatment delay found that the most common reasons behind women's delay include the atypical presentation of symptoms (which are more common in women than men) and their belief that they were less at risk than men.

There is some evidence that hypertension may be under-treated in men in relation to need and that this reflects a lack of awareness among men of hypertension as a problem, and of the symptoms that should prompt consultation (Fodor and Tzerovska, 2004). However, Figures 3.1, 3.2 and 3.3 suggested that women's higher likelihood of consulting for hypertensive disease might reflect prevalence found in community surveys, and more work on this is probably needed.

## 5. Gender and experiences of services

There are also differences between women and men in their experiences once they do consult for CVD, including differences in detection of disease, treatment and outcomes.

### **Detection of CVD**

One of the key issues in relation to CVD is the role of the healthcare sector in detecting disease and within this there is a particular role for primary care. The QOF in primary care includes nine targets in relation to coronary heart disease in the clinical indicator groups. These focus on patients diagnosed with angina or CHD, and one of the outcomes of the QOF approach has been to increase detection of CHD and other CVD in primary care (Hippisley-Cox et al., 2006). Among diagnosed patients, QOF points are awarded in association with recording of blood pressure and total cholesterol, as well as treatment interventions.

However, research suggests that there are important differences between women and men in the detection of CVD. For example, at least a quarter of all MIs are not detected, and this is more common for women than men (Purcell et al., 2004). Women are less likely than men to receive a preliminary diagnosis of heart disease when they present with chest pain, and this is associated with a reduced likelihood of further investigation and specialist referral (Richards et al., 2000).

### **Treatment**

There is somewhat more evidence that women's CHD is poorly treated, rather than that of men. Comparisons of the treatment of women and men with ischaemic heart disease in primary care have reported that women were less likely than men to have a number of important indicators recorded including body mass index (BMI), smoking status, blood pressure, and that women were also less likely to have their fasting blood cholesterol concentration recorded (Hippisley-Cox et al., 2006). In addition, fewer women were taking aspirin and fewer had been prescribed lipid-lowering drugs, after adjusting for age, smoking

status, obesity, diabetes and hypertension. One study in Scotland found that women with CHD were less likely than men to be recorded for 9 of the 11 components of care listed in the QOF including cholesterol measurement, various forms of treatment and referral for specialist care (McGovern et al., 2008).

Data from the HSE reveal that more than twice as many men with CVD had had surgery for their condition, most commonly a coronary artery bypass, and this difference was not explained by severity of the illness (Sproston and Primatesa, 2003a). This reflects findings from other studies which show that women are less likely to be screened, or hospitalised, are managed less intensively once diagnosed and receive less invasive treatment than men (de Lusignan et al., 2006; Raine, 2000).

However, women also often present with atypical symptoms which may be less easily identified – more women experience silent MI for example, possibly because women are older on average when they experience MI and MI is more often silent among older people (Moser, 1997). CHD in women may also present with symptoms that are similar to menopausal conditions, particularly heart palpitations, and are therefore less likely to be identified by physicians. Younger women have a greater prevalence of non-coronary-related chest pain, some of it due to hormonal factors, and this in turn means that there is a higher risk of false positives with some coronary diagnostic procedures (Lefler and Bondy, 2004; Moser, 1997).

In addition, there is some evidence that standard diagnostic tests such as treadmill tests are less able to identify CHD in women although there is also evidence that women with chest pain or with abnormal results following such exercise tests are less often

referred for full evaluation and diagnostic procedures (Moser, 1997; McGovern et al., 2008).

There are also differences between women and men in the treatment of stroke, though again research shows a conflicting story. On the whole, studies seem to suggest that women are less likely to be prescribed anticoagulants such as warfarin, and also angiotensin-converting enzyme (ACE) inhibitor and statins, although more women are prescribed antiplatelet therapy (Majeed et al., 2001; Simpson et al., 2005). However, these findings are hard to interpret as there are differences between women and men in age at diagnosis, co-morbidity and patient preferences, particularly in relation to acceptance of warfarin after the risks have been explained (Simpson et al., 2005).

Interestingly, although much of the early gender-focused criticism of CHD research highlighted the failure of large-scale studies to include any, or sufficient, women in longitudinal research, a review of papers in recent years reveals a considerable number focusing only on women and CHD, and fewer focusing on men alone

## 6. Gender and current policy

CVD, and CHD and stroke in particular, have been at the forefront of public health policy for a number of years. This includes targets to reduce CHD mortality in the Health of the Nation strategy from 1992 to 1997, as well as policy since then. The 1999 *Saving Lives: Our healthier nation* White Paper (DH, 1999a) set targets to reduce deaths among under-75s from CHD and stroke by at least two-fifths by 2010, targets which have since been repeated in the Department of Health's Public Service Agreements. The 2007 annual report on progress in relation to coronary heart disease revealed that these targets

have been met, five years early, bringing the UK close to the European Union average (DH, 2008).

The 1999 National Service Framework (NSF) remains a key document shaping policy. The NSF identified two standards for CHD – to reduce inequalities in risks of developing heart disease and to reduce smoking. However, the NSF did not discuss gender differences in risk factors, screening and treatment needs (Doyal et al., 2004), and such differences have not been addressed by more recent policy statements. Policies to reduce the risk factors contributing to CHD mortality – diet and smoking, for example – are largely gender blind. NHS Stop Smoking Services and the Health Development Agency and National Institute for Health and Clinical Excellence guidance for primary care trusts on meeting targets on smoking cessation do not discuss gendered differences in smoking and in therapies to support cessation (women are only discussed separately in relation to pregnancy), despite the fact that research suggests important differences between women and men in the importance of the timing of a quit attempt, the role of social support and the value of nicotine replacement therapies (e.g. Allen et al., 2000).

One element in policy relating to CVD is the focus on food and diet. The initial consultation paper, *Choosing a Better Diet: A food and health action plan* (DH, 2005c), did recognise differences between women and men in diet. In particular, the plan argued that men were less likely to take an interest in what they ate, often saw themselves as 'helping out' when involved in cooking and shopping for food rather than having responsibility, and saw healthy food as unappetising. Women's interest in diet was seen as associated with their domestic role. However, the action plan was

followed by the *Choosing Health* White Paper (DH, 2004b), which included obesity as one target area, as well as more specific guidance, including 'Choosing a better diet' and 'Delivering *Choosing Health*'. In these various documents, gender issues – in relation to strategies to help shape food and diet choices – disappear.

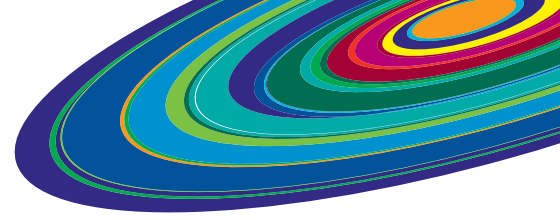
## 7. Key messages

- Men have higher mortality rates than women for both CHD and cerebrovascular disease – the male CHD mortality rate is 147 per 100,000 for men compared with 69 per 100,000 for women.
- Men are particularly at risk of premature mortality due to CVD, especially CHD.
- Women's risks of CVD occur later in the life course.
- Slightly more men are diagnosed in general practice with CVD conditions defined as 'serious' while more women are diagnosed with CVD conditions defined as 'intermediate'.
- Women may be more likely than men to delay when experiencing symptoms of CHD partly because of the persistence of the stereotype that heart disease is a 'man's problem'.
- Women and men present with different symptoms of CHD, with more women having 'atypical' symptoms which makes detection more difficult.
- Women with CHD are less likely than men to be referred to specialists and have their cholesterol recorded, and are less likely to be prescribed some medications.

- Men are more likely than women to die during a sudden cardiac event, while more women die in the year following such an event.
  - Policy in relation to CHD is not gendered but if it were, it might help planners and practitioners deliver gender-sensitive care; for example, QOF points are not gender specific.
3. There is also a need to develop gender-sensitive approaches to policies which aim to reduce CVD in both men and women. This would include more explicit attention to differences in presentation of symptoms and how to raise public awareness of CHD in women, consideration of health professionals' recognition of CVD and the appropriateness of different diagnostic tests, and gender analysis of wider public health and community strategies such as food and diet policy, and smoking cessation programmes.

## 8. Recommendations

1. There are a number of gaps in the evidence which need to be addressed. We know and understand too little about the interaction between gender and factors associated with the decision to seek care and the kinds of care – primary or emergency – sought. One major gap is the association between prevalence and consultation, and whether either men or women are consulting at the right level. How much unmet need is there, does this vary for women and men, by age, and in relation to other forms of diversity, particularly ethnicity?
2. We also need to understand more about differences between women and men in health behaviours, and how policy can address these differences – how can interventions be sensitised to the specific ways in which women and men identify health needs, seek assistance or address their risk factors in relation to CVD?



# Chapter 4: Overweight and obesity

## 1. Introduction and definitions

Obesity is becoming an increasingly significant contributor to the global burden of disease, with growing numbers of overweight and obese people in both less and more developed countries (WHO, 2004b). In the UK, nearly two thirds of adults are now defined as either overweight or obese and this figure is expected to increase over future decades (DH, 2005a; McPherson et al., 2007). Tackling obesity and reversing the trend in weight gain is a major government target and while the initial policy focus is obesity among children, the broader strategy also aims to combat obesity among the adult population.

Obesity presents a major threat to health and is associated with a number of health conditions, including type 2 diabetes, cardiovascular disease (CVD), osteoarthritis and some cancers, especially colorectal, oesophageal and kidney. In addition, obesity is associated with increased risks of chronic conditions such as back pain and depression, and also with infertility (WCRF/AICR, 2007). In 2001, the National Audit Office (NAO) estimated the national costs of obesity to include 18 million sick days per year, 30,000 deaths and an average reduction in life expectancy of 9 years (NAO, 2001).

There are a number of different ways in which obesity and overweight can be measured, but the most commonly used is the body mass index (BMI) based on weight (in kilograms) divided by height (in metres) squared. A BMI of 30 and over is usually classified as obese, while a BMI of 25–29

is classified as overweight. Alternative or additional measures of overweight based on waist-to-hip ratio and waist circumference, and what is known as central adiposity, reflect evidence that accumulated fat around the waist is also a risk factor for various diseases. For example, metabolic syndrome, identified by the presence of central obesity together with high blood pressure, decreased high-density lipoprotein (HDL) cholesterol and other risk factors, is also associated with cardiovascular disease and diabetes.

Although most interventions focus on problems associated with a BMI of 25 and above, and in particular individuals with a BMI of more than 29, a recent large-scale review of the evidence on associations between weight, diet, exercise and health by the World Cancer Research Fund (WCRF/AICR, 2007) concluded that, for optimum health, individuals should aim for a BMI of between 21 and 23 – that is, a lower target than the more commonly used cut-off point. This suggests that current data on the health consequences of obesity probably understate the proportion of the population whose health is compromised by their weight.

This chapter reviews the statistics for obesity and weight in the UK, the literature on gender differences in access to, and use of, services relating to weight management, and considers current policy measures from a gender perspective. It is important to note at the same time that there is some evidence of gender differences in the impact of obesity on health – CVD risks may be elevated more for obese women than men for example, while sleep apnoea appears to affect more

obese men, and the increased risk of colon cancer resulting from obesity is similar for men and women (Haslam, 2005). More research is needed into the sex and gender factors influencing the pathways between obesity and various health conditions.

## 2. Statistical information and epidemiology

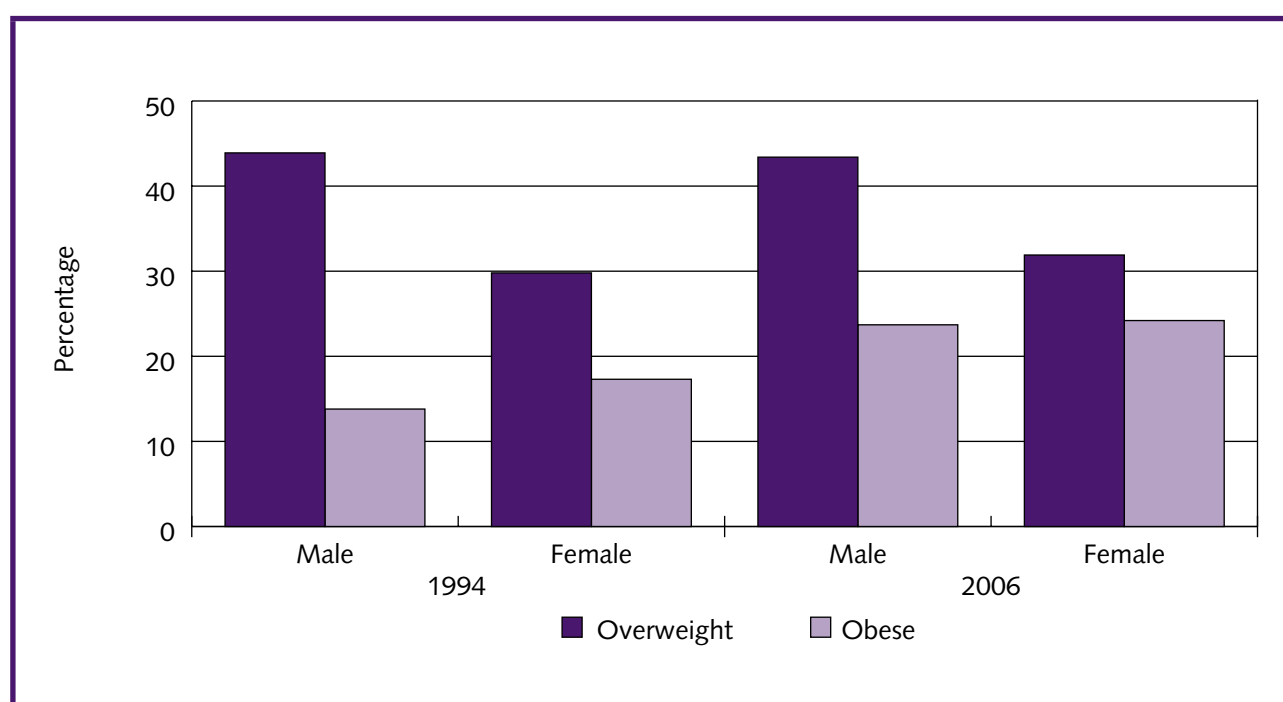
### Incidence and prevalence

The most notable aspect of data on obesity in England is the way prevalence figures have changed, and are expected to change in the future. Figures for England show that, in 2006, more men than women were overweight, while similar proportions of women and men were obese (ONS, 2008b). More men than women are also diagnosed with metabolic syndrome (ONS, 2008b). Obesity has increased among both men and women, although the increase for men has been somewhat greater, from 14% in 1994 to 24% in 2006 (see Figure 4.1).

Although morbid obesity, with a BMI over 40, is rare, women outnumber men by three to one in this group (de Lusignan et al., 2006; McPherson et al., 2007; ONS, 2008b). Other measures of overweight also show a gender difference: 41% of women compared with 32% of men have a raised waist circumference (defined as over 102 cm in men and 88 cm in women) whereas there are more men with a waist-hip ratio over the healthy recommended limit (0.9 for men and 0.7 for women) (ONS, 2008b).

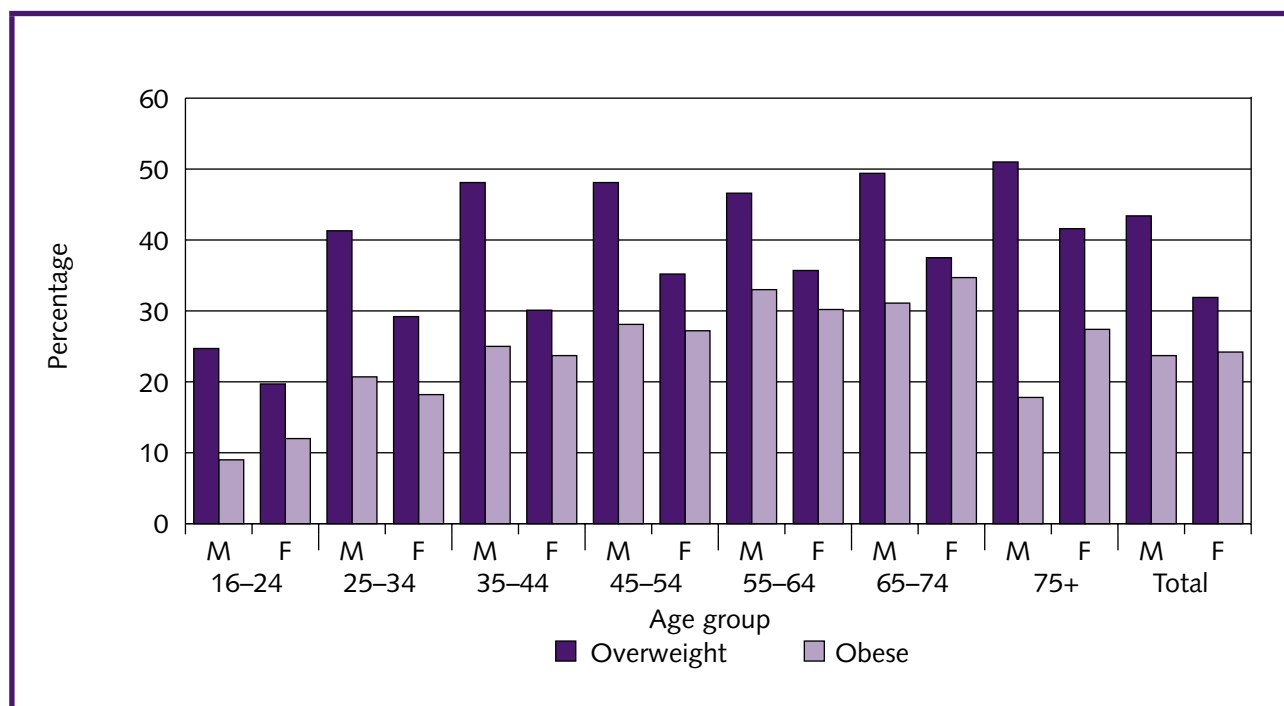
There are also differences in the gender gap across the life course (ONS, 2008b). Obesity rates are higher among older age groups for both men and women, but the peak of obesity among women occurs around 10 years later than that for men, while rates for men increase most rapidly in younger age groups (de Lusignan et al., 2006; Wilkins, 2007a). As Figure 4.2 shows, more men than women are overweight in all age groups. However, gender differences in obesity show

Figure 4.1: Percentage of men and women who were overweight or obese in 1994 and 2006



Source: ONS (2008b)

Figure 4.2: Percentage of men and women either overweight or obese, 2006, by age



Source: ONS (2008b)

more variation – more women than men are obese in early life and in older age groups. Men, however, are more likely than women to be obese between the ages of 25 and 64, although the gap is narrow at times.

In line with the more rapid increase in obesity among men, the recent Foresight report which predicted future rates of obesity concluded that, by 2015, 36% of men and 28% of women might be obese compared with 24% of men and 24% of women in 2006 (McPherson et al., 2007; ONS, 2008b). Perhaps most significantly, the report suggested that by 2025 only 13% of men and around a quarter of women will have a healthy BMI. Predictions for morbid levels of obesity are more problematic given the smaller numbers involved, but the Foresight report suggests that the higher rate among women will continue.

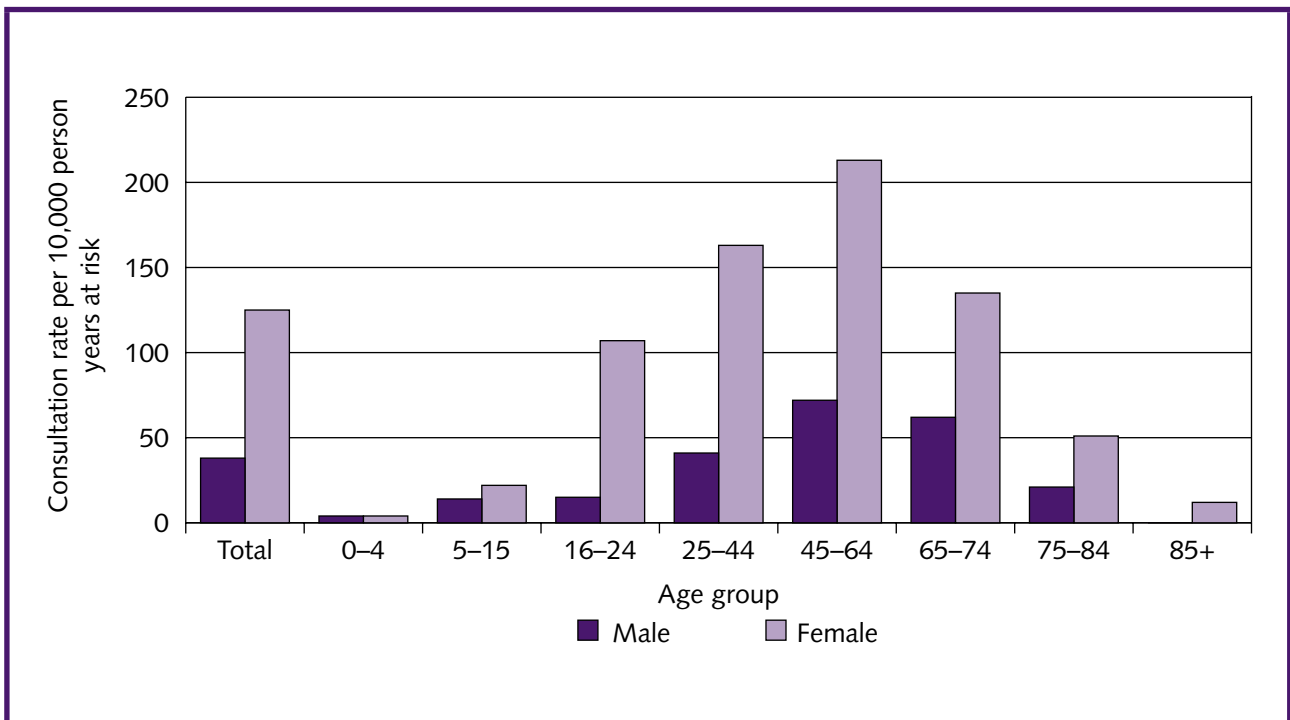
### Consultation rates and use of services

General practice figures taken from the General Practice Research Database (GPRD) reveal more women than men with a diagnosis of obesity and related conditions in primary care (Figure 4.3).

However, these figures are based on a GP diagnosis, rather than the total number of patients consulting for a specific problem and this will exclude those who are overweight or obese if this is not recorded by the GP. This distinction is particularly important with questions of obesity and weight problems, and gender differences in the use of health services in relation to these issues.

The more recent prevalence data from the population-based Health Survey for England, in Figures 4.1 and 4.2 above, revealed that 43% of men and 33% of women were overweight, and 24% of both men and women were obese or morbidly obese.

Figure 4.3: Consultations in general practice for obesity and other hyperalimentation



Source: McCormick et al. (1995)

If we compare these two sets of data, while bearing in mind the limits of the GPRD, it seems likely that men’s weight problems are not being fully dealt with in primary care. However, as we explore in the next section, we also need to recognise that the formal healthcare system is not the only source of help for people who are overweight or obese, and other forms of intervention and support are also important.

Returning to the data from general practice, one of the most common problems associated with obesity is diabetes mellitus, which shows higher consultation rates by men throughout the life course (Figure 4.4).

### 3. Factors associated with gender differences

Why are men more likely than women to be obese in the middle years of life, whereas more women are morbidly obese? And why

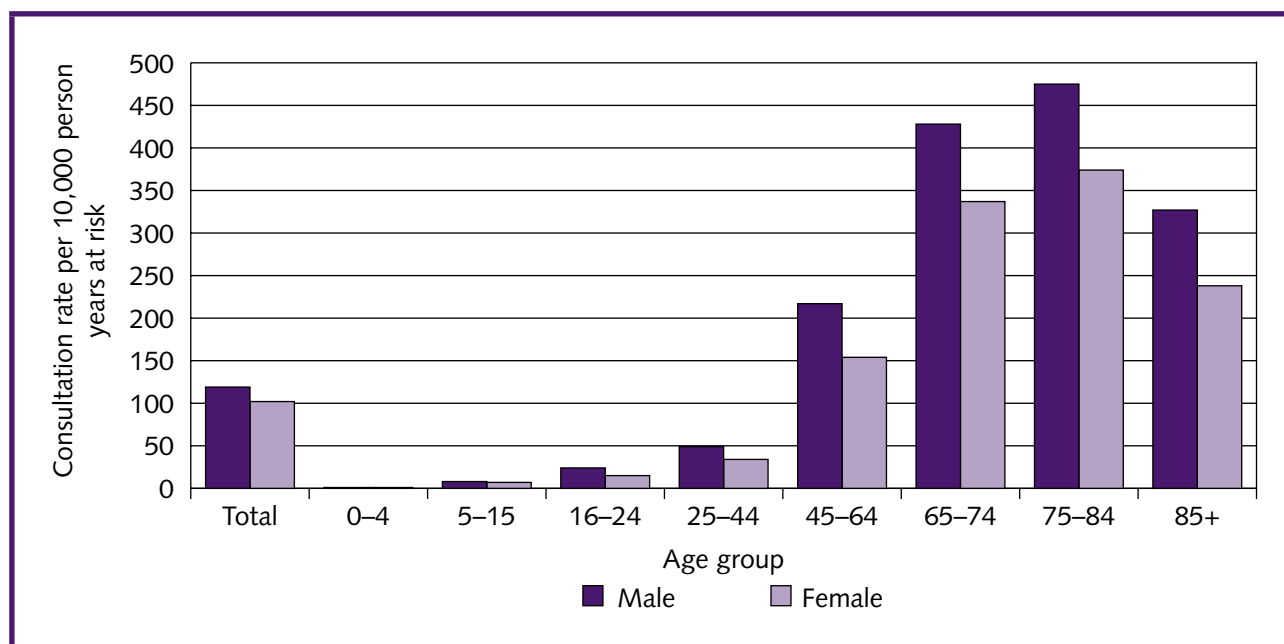
have rates of obesity among men increased so much in recent years? Research evidence highlights a number of important factors which help to explain this pattern.

#### Factors affecting weight gain and loss

There is some evidence of gender differences in the factors affecting weight loss and weight gain which suggests that gender-sensitive approaches to the design of interventions may yield better results. For example, for both women and men a low or normal weight is associated with smoking, leisure time physical activity and low scores for depression and anxiety. However, low weight is also associated with higher levels of education for women, but not men (Chiriboga et al., 2008). There is evidence that biological factors play a part – men respond better to a lower-protein diet for example, and are able to lose weight more easily due to hormonal differences (Egger,



Figure 4.4: Consultations in general practice for diabetes mellitus



Source: McCormick et al. (1995)

2007). There are also gender-specific explanations of weight gain: women are more likely than men to gain weight due to emotional and comfort eating, for example, while men's consumption of alcohol, particularly beer, plays a part in their weight gain (Ziebland et al., 2002). Women who are overweight are also more likely than men to suffer from low self-esteem (Tiggemann and Rothblum, 1997).

Weight gain is in part related to a lack of exercise, and gender differences in physical activity and sedentary lifestyles are important. Men are more likely than women to engage in physical activity (Addley et al., 2001) and this affects not only weight gain and efforts to control weight but also other dimensions of health and well-being, due to the positive effects of physical activity on the risk of disease (WCRF/AICR, 2007). Exercise in early life appears to be associated with continuing physical activity over the life course and evidence that, among young people, girls exercise less and their activity

levels drop off more quickly compared with those of boys (Sproston and Primatesta, 2003b) carries important implications for their risks of obesity and poor health in later life. This may reflect gender differences in body satisfaction and embarrassment, particularly in school-based activities (Williams et al., 2000).

The relationship between obesity and exercise also works the other way, in that weight gain can reduce participation in physical activity due to embarrassment, feelings of stigma and difficulties due to lack of fitness. However, research suggests there may be gender differences in this: for example, an Australian study reported that women were more likely than men to be put off exercise when they feel or are overweight (Ball et al., 2000).

The research on gender differences in exercise is important because it appears counter-intuitive in comparison with the evidence that men are more likely to be overweight and obese than women – despite

their greater participation in physical activity. This is partly because physical activity rates for both sexes are relatively low, but it also reflects the impact of changes in men's levels of exercise – on taking up longer hours of paid work for example – on weight. In particular, it draws attention to the implications for men of the decline in the proportion of jobs which call for heavy manual work and the corresponding increase in non-professional jobs which are more sedentary and require less energy expenditure (Campbell, 2004).

Diet is also significant and again there are important gender differences. One of the key changes in recent decades associated with increasing levels of obesity has been the increased consumption of energy-dense processed food – high in sugar and saturated fats – among both sexes. However, women's diets tend to be healthier than those of men – women consume more fruit and vegetables than men, particularly in higher income groups (Friel et al., 2003). Men's diets on the other hand tend to be higher than those of women in red and processed meat while lower in fibre, and such foods are identified as 'male' in popular discourse (Stibbe, 2004). Alcohol consumption is also higher among men (see Chapter 6) and this helps to explain men's weight (Stibbe, 2004). Patterns of food consumption are gendered in other ways. More women than men describe themselves as eating for comfort although both women and men eat in response to watching TV (Hawks et al., 2003). In addition, men are more likely to engage in 'night eating syndrome' in which most of the daily intake of food is consumed prior to sleep, and which is particularly likely to contribute to weight gain (Colles et al., 2007).

Research also shows associations between weight and poverty and social class but

the evidence is mixed. One study in Canada for example found that people in poorer neighbourhoods and from lower income groups had a higher average BMI than more affluent populations, and this relationship was more marked for men than women (Matheson et al., 2008). However, figures from the Health Survey for England suggested an inverse relationship between deprivation and overweight and obesity for men, in that men in the most deprived households were least likely to be overweight or obese while those in the least deprived households were more often obese or overweight (ONS, 2008b). In contrast, more women in manual class households are overweight or obese compared with women in professional and managerial households (ONS, 2008b). This suggests that there are important gender differences in these associations which need further analysis.

Other social factors affecting weight and the risk of obesity include marital status: men who are married or are cohabiting are more likely to be overweight or obese while women who are widowed are the most likely to be overweight or obese. Single men and women are the least likely to be either overweight or obese (ONS, 2008b). To some extent, this reflects the increasing risk of being overweight or obese among older age groups, as the married are on average older than the non-married.

### **Self-perception of weight and ideal size**

Self-perception of weight is also important in the risk of overweight and obesity. Wardle and Johnson (2002) found that, while those adults who were obese mainly identified themselves as obese, women were more likely than men to be aware of being overweight. Research also shows that women are more likely to report themselves as overweight, even when they are not, and

to think that they are heavier than they are; men on the other hand are likely to think themselves lighter than they really are, even when overweight (McCreary and Sadava, 2001; Leishman, 2007).

Women also describe their ideal weight in terms of a lower BMI than the one selected by men (Crawford and Campbell, 1999) and men are less concerned with being overweight (Gillon and McPherson, 2007). A recent National Opinion Poll, for example, found that 42% of men compared with 27% of women reported that being overweight 'wouldn't bother me at all' (Wilkins, 2007a: 4). These differences, which are observed in take-up of weight management programmes, reflect gendered differences in the cultural acceptability of higher body mass, in which men are less pressurised to meet a thin ideal while dieting is seen as a 'women's thing' by many men (Wilkins, 2007a).

### **Weight control**

Attempts to lose weight are more common among women than men, and evidence is mixed concerning gender and success at weight loss (Weiss et al., 2006). Some studies find that women experience more success with weight loss diets although they also are more likely to regain weight lost (Ziebland et al., 2002). However, others have found that successful weight loss attempts are more common among men than women (Jeffery et al., 2003) or that both women and men experience similar outcomes (Wilkins, 2007a). Studies finding greater weight loss among men may reflect the likelihood that men are heavier on average at the point when they attempt to lose weight and thus lose more, in terms of percentage of body weight as well as in overall pounds or kilos, because heavier people tend to lose more weight, particularly in the initial phase. This

might be important in gender-sensitive approaches to weight loss interventions – for example, there is some evidence that obese women have higher expectations when entering weight-loss programmes than obese men, and this may mean they are more likely to be disappointed with their results and drop out before reaching their target (Linne et al., 2002).

## **4. Gender and help-seeking behaviour**

This section explores the association between overweight and obesity and help-seeking behaviour particularly in the context of the health services, although it is important to recognise that other sources of support and non-medical interventions are likely to be as appropriate and accessible, if not more so, for overweight men and women.

Research suggests that obesity is associated with an increased use of health services, including primary care, for a variety of health conditions (Bertakis and Azari, 2006; van Dijk et al., 2006). Obesity is, however, also associated with a reduced take-up of screening services – for example, obese women are less likely than non-obese women to use cervical and breast cancer screening, while obese women are less likely than obese men and non-obese men and women to attend colorectal cancer screening (Rosen and Schneider, 2004). But there is little or no evidence on gender differences in use of health services by obese men and women in relation to the desire to lose weight. One small-scale study among truckers in the UK found that only 13% would visit their GP for help with weight loss (DeVille-Almond, 2007) but more research is needed here.

Most of those seeking to lose weight do so outside the healthcare system and here women dominate in terms of participants.

The evaluation of a BBC weight loss campaign found that more women volunteered to participate (Wilkins, 2007a) and more women join private slimming clubs such as Weight Watchers (Avery, 2007). In the recent Counterweight project, a primary care weight management programme in the UK, only a quarter of participants were men, while the pilot of one programme delivered in partnership with a commercial slimming organisation revealed a participation rate by men of 12% (Wilkins, 2007a). Similarly, the vast majority of those signing up to a community pharmacy initiative to deliver weight management services were women, with only 15% of users being men (Ramsden and Hunter, 2007). In a US initiative, Take the Stairs, more women than men responded although numbers were low for both women and men (Dolan et al., 2006).

### **Opportunistic identification of obesity and overweight in medical care**

Most people who are overweight or obese do not seek medical help and there is little research exploring what differentiates those who do seek help from the majority who do not (Annunziato and Lowe, 2007). Treatment for obesity within health systems is likely to be related to consultation for other reasons. Referral to weight management and exercise programmes, prescriptions for weight loss treatments such as orlistat, and dietary advice more commonly occur following consultation for health conditions which may be precipitated or aggravated by overweight or obesity, or are opportunistic interventions, when a consultation for other reasons offers the health professional an opportunity to discuss weight with an individual. The introduction of Quality and Outcomes Framework (QOF) incentives for weight recording of patients in general practice also offers opportunities for problems to be identified as part of consultations for other

health conditions. Outside the primary care sector, hospitals may identify obesity and offer advice as part of pre-operative screening but practice varies (NAO, 2001).

However, this opportunistic identification of overweight and obesity means that gender differences in use of healthcare, particularly primary care, result in gender differences in the opportunity to have weight problems identified and support offered by GPs.

Studies suggest that obesity is only detected in a minority of obese patients overall (Counterweight, 2004), although some argue this reflects health professionals' beliefs that interventions do little good, rather than a failure to observe when a patient is obese (Wilson and McAlpine, 2006). However, there is good evidence that patients advised to lose weight by a health professional are much more likely to attempt to lose weight than patients who are not recommended to do so and that men are more likely to need professional advice before making such an attempt (Counterweight, 2004; Ramsden and Hunter, 2007).

One measure which should be increasing as a result of QOF is the recording of weight and BMI in general practice (rather than relying on self-reported weight and height) as this enables easier identification of weight problems. In recent years, evidence has suggested that women are more likely than men to have both their weight and BMI recorded in primary care (Counterweight, 2004; de Lusignan et al., 2006). This finding, however, refers to weight and BMI having ever been recorded, rather than up-to-date records, and may reflect the practice of weight recording for women when prescribing contraceptives for example, as well as in pregnancy.

## 5. Gender and experience of services

### Weight management interventions

At the individual level, one commonly used approach aims to support individuals to lose weight through healthy eating programmes. Most studies on interventions in weight management, and weight loss programmes, have either been carried out on women alone, or data are not reported separately for men and women (Gillon and McPherson, 2007). There is less evidence about men in weight management programmes or about men and women from black and minority ethnic groups.

There may be differences between women and men in referrals by health professionals although UK literature is sparse. One US study for example suggested that, at the lower ends of the overweight BMI range, women are more likely than men to be encouraged to lose weight and referred for treatment by their physician, while among those with BMIs at the level of obesity and above, more men than women receive such advice and referral (Anderson et al., 2001). The source of referral – self or health professional – appears to be significant in terms of successful completion of a programme: people referred by their clinician as opposed to being self-referred are more likely to attend an initial consultation, but are less likely than the self-referred to join a programme and may be less motivated (Binks and O'Neil, 2002). Thus, while men may have a higher initial uptake, this does not seem to lead to more men entering programmes and suggests that more complex interventions, involving a wider range of starting points than primary care, are needed. Evidence concerning the completion of programmes is also mixed, although the men who do start a programme – usually advice and monitoring rather than

group activities – appear to be more likely than women to complete the programme and to lose more weight (Bautista-Castano et al., 2004).

It is also worth observing again that evidence about the success of weight loss programmes and other interventions is mixed, with a number of studies suggesting that the weight lost is often quickly regained (Wilson and McAlpine, 2006; Gunnell, 2007).

### Exercise interventions

There is a growing emphasis in policy, and recognition in the scientific literature, that physical activity is a public health problem in its own right and that increasing activity levels even among overweight and obese populations can help to reduce health risks (Blair, 2007). In addition, physical activity may help to reduce obesity and overweight. Exercise referral schemes (ERS) are increasingly used by GPs in the UK in relation to identified risk factors for disease, particularly coronary heart disease. Evaluation of such schemes is still relatively sparse but one study found that while more women are referred to ERS, and more attend initial consultations, men are more likely than women to complete a 14-week course (Dugdill et al., 2005; Gidlow et al. 2007). Possible explanations for the gender difference in completion include men's greater likelihood of physical activity at earlier points in their lives which encourages participation. This suggests that, alongside gendered approaches to the delivery of ERS, it is also important to focus on activity levels in younger age groups and the gender difference in the fall-off in activity rates in teenagers for example (ONS, 2008b).

Other factors that affect the take-up of ERS include the availability of free time, often something that is associated with reductions in previous levels of activity. Although men's

longer working hours in paid employment play a key part in men's reductions in leisure-based levels of activity (Wilkins, 2007a), for women it is the combination of paid work, caring responsibilities and domestic labour which reduces their opportunities for exercise. The recent Time Use Survey, for example, found that when time spent in employment and housework are combined, women spend on average 20 minutes per day more than men do in some form of work (ONS, 2006b). In addition, gendered differences in access to transport and childcare are also likely to be significant – for example, younger women are least likely to complete ERS while older men are the most likely (James et al., 2007).

### **Pharmaceutical interventions**

There is a range of pharmaceutical interventions including sibutramine and orlistat. In 2006, the National Institute for Health and Clinical Excellence (NICE) produced guidelines on the management of obesity including recommendations in relation to pharmaceutical interventions. These suggested that sibutramine and orlistat should be used primarily for those with a BMI of 30 or more, or 27 if there are other obesity-related risk factors, and treatment should be continued for between three and 12 months in most cases. The NICE guidelines do not mention gender as an issue in relation to prescribing, although the Counterweight project found that in addition to being more likely than men to receive diet counselling, dietetic or obesity centre referral, women were also significantly more likely than men to be prescribed orlistat (Counterweight, 2004).

### **Public health measures**

Public health measures, including advertising campaigns or programmes run by local Health Action Zones or community

pharmacists, are also important strategies in reducing the prevalence of obesity. Here we might ask questions about whether gender-blind approaches limit the potential of such programmes for either men or women. The National Audit Office (NAO, 2001) paper on tackling obesity in England, for example, recognised the key role of primary care while calling for more joint working across the public sector. The report also noted the greater risk of obesity among black and minority ethnic women and women in lower socio-economic groups, and the particular risks women experience in relation to CVD and diabetes. There was recognition of potential difficulties for women in terms of the strategies explored: walking might be less of an option for women in inner-city areas. However, the report did not address gender as a key factor to take into account in devising interventions, for either men or women. The 2006 NICE guidelines on the prevention and management of obesity also suggested that while primary care was important in tackling the problem, a wider ranging approach involving public health strategies and drawing on workplace, school, self-help and local authority initiatives was also needed.

## **6. Gender and current policy**

There are a number of ways in which obesity is addressed in policy in both the international and national arena. Globally, the World Health Organization has drawn attention to the increasing contribution of obesity to the global burden of disease, and has published a number of strategy documents to try to support the work of national governments in tackling this problem.

In England and Wales, obesity was identified as a problem some years ago. As far back as the early 1990s, the government identified

targets for a reduction in obesity, and these were different for women and men. The targets set in 1992 in the *Health of the Nation* strategy published under the Conservative government are startling when placed against current levels of obesity among men and women. In 1992, the goal was to reduce obesity among men from 7% in 1986/87 to 6% in 2005 (McPherson et al., 2007) whereas in fact it has increased to 24%. For women, the target was a reduction from 12% in 1986/87 to 8% in 2005, compared with actual current levels of 24%.

More recently, targets have been set out in the Treasury's Public Service Agreements (PSAs) as part of the Spending Review. The only mention of obesity in the PSA targets for 2005–08 related to obesity among children and responsibility for the target was shared between the Department of Health and two other departments, the Department for Education and Skills (now the Department for Children, Schools and Families) and the Department for Culture, Media and Sport. The specific target was to 'halt the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole' (HM Government, 2007b). The target was not gender specific and did not reflect differences in levels of obesity in early life, nor differences in exercise and physical activity. The Department for Education and Skills also had a target to improve take-up of sport among 15–16-year-olds, but again this was not gender specific.

PSA targets on obesity for 2008–11 also relate to children, and while the discussion about the problem of obesity refers to differences in figures for boys and girls, the target itself in PSA 12 is not gendered: 'Reduce the proportion of overweight and obese children to 2000 levels by 2020 in

the context of tackling obesity across the population' (HM Government, 2007b).

Primary care has a central role in obesity strategies – partly because an estimated two-thirds of the population visit their GP for a variety of reasons over the course of a year, and partly because of the responsibilities identified for primary care in the National Service Frameworks for diabetes and for coronary heart disease (NAO, 2001; Counterweight, 2004). However, in 2007 Gunnell reported that only half of all primary care organisations and only 30% of GP practices had weight management programmes in place.

While recognising the key role of primary care, NICE (2006) also identified the contributions to be made by local authorities and schools, in the public sector, and a role for workplaces, self-help groups and other private organisations.

The main aim of policy has been to increase positive health behaviours including in particular physical activity and healthy eating, rather than simply promoting weight loss and reductions in BMI. The Government intends to publish annual reports on adult weight and obesity levels, and also data on 'early indicators of success' including, for adults, nutrient intake data; consumption of foods high in fat, salt or sugar; vegetable and fruit intake; and figures for physical activity (Cross-Government Obesity Unit, 2008).

A commitment made in the White Paper, *Choosing Health* (DH, 2004b), has led to the production of an evidence-based clinical care pathway document and guidance for GPs to manage weight, although it appears that not all GPs currently use it (Cross-Government Obesity Unit, 2008). Recommendations in this guidance include setting individual targets with patients but again these are

not gender sensitive. The cross-government strategy on obesity sees PCTs as having a key role in work with overweight and obese adults, and has offered both additional funding over the next three years and also support in their commissioning of weight management services through the development of a toolkit for PCTs and local authorities. There is also recognition of the need for further research into obesity and weight management in primary care.

The QOF also offers incentives to GPs to keep a register of their patients with a BMI of more than 30. GPs and other primary care health professionals will also be supported through other means, including the development of a resource pack (*Let's Get Moving*) to help sedentary adults.

It is also worth reiterating that obesity has a close association with inequality, particularly for women. This reflects the greater cost of many healthy foods, issues around the availability of some foods, access to exercise facilities, the demands of some manual occupations as well as psychosocial influences on health behaviours. As such, the gendered dimensions of obesity and overweight should be addressed within the health inequalities agenda in policy.

### **Is current policy gendered?**

Most current policy pays little explicit attention to gender as illustrated by the following summaries of current policy statements. In the recent cross-government strategy, there is only one reference to gender equality in the main document, and the document includes an equality impact assessment, but this is brief in terms of gender and only notes that one arm of the strategy – relating to efforts to improve activity and healthy eating in the workplace – needs to recognise that women are less often employed than men. As a solution, the

strategy suggests that workplace initiatives should engage with families as a whole, which is problematic in that it assumes men and women will be in families and can be reached this way. The equality impact assessment carried out within the strategy does however note that there is insufficient evidence in relation to the issues of gender and obesity.

In the NICE (2006) recommendations on the prevention, identification and management of overweight and obesity, gender is mentioned briefly in relation to barriers to exercise and how advice might best be offered. However, gender-sensitive approaches and potential differences in the needs of men and women are not dealt with in detail, despite the good coverage of gender-related issues in the comprehensive evidence review which underpins the guidance. For example, public health recommendations include work with local authorities to increase the provision of opportunities for exercise, improving cycling schemes and the safety of public space. Although the evidence review includes research which shows gender to be important in men's and women's use of such interventions, the recommendations do not discuss gender or how strategies might take gender into account in practice. Similarly, the NICE 'presenter' slides for public bodies to use in publicising their recommendations make no mention of gender as a factor needing to be considered when developing policy, despite the comment in the review of evidence that 'A range of studies suggest that tailoring advice is key to the effectiveness of interventions and that this will obviously impact on issues related to gender' (NICE, 2006: 344).

Further, one of the key tools in the implementation of the obesity strategy in primary care, QOF targets, is not



differentiated by gender, potentially missing a crucial opportunity to consider gender-sensitive approaches to obesity and weight management in primary care.

Finally, the national and local PSA targets in relation to childhood obesity are not gender specific, despite data showing differences between boys and girls in their risk of obesity and their health behaviours, including participation in physical activities.

If we look at the unintended consequences of other policy changes, there are additional reasons to suggest that a gender-sensitive analysis of policy would be of value. For example, recent reductions in GP surgery hours may have created further barriers for men or women in full-time work who wish to consult about weight worries but who do not want to have to divulge this to workmates or supervisors.

Although we need to remain aware of the many ways in which individuals deal with weight problems outside of the health system including primary care, it is also important to recognise that where health policy aims to address these problems within health services then failure to explicitly build in gender-sensitive strategies from the beginning may leave some sectors of the population under-served.

## 7. Key messages

- More men than women are overweight and, while obesity is increasing among both men and women, the proportion of men likely to have an unhealthy body weight in the future constitutes a serious public health problem.

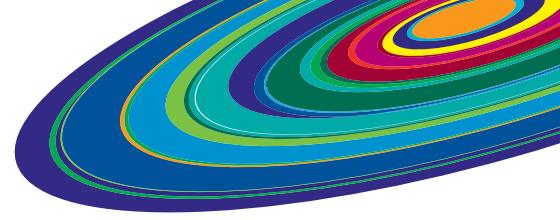
- Women are more likely than men to enter weight management programmes in the private sector and are also more likely to be treated for weight problems in primary care.
- There are important differences between women and men in how they view weight problems with men being less likely to recognise when they are overweight and obese.
- There are differences between women and men in how they approach weight management, and how successful they are when attempting to lose weight and keep weight off, but we need more research on this.
- Similarly, there may be important differences in how health professionals view weight problems for men and women but further research is needed.
- Current policy initiatives do not go far enough in identifying gender differences and gender-sensitive approaches to weight management.
- Targets currently being used may be more effective if they were gender specific.

## 8. Recommendations

1. Most people who are overweight or obese do not seek medical help and there is little research about gender differences in the factors affecting help-seeking behaviour and where people turn for such support. Clearly, more work in this field would be helpful in trying to develop evidence-based, gender-sensitive approaches to the delivery of weight management programmes in primary care as well as other health services.
2. There are also important gaps in the research evidence in relation to gender

differences in the identification by health professionals of problematic weight and also in relation to what health professionals do when a problem is identified. This again suggests that more research is needed into the way professionals deal with overweight and obesity and factors affecting their decisions regarding interventions.

3. The recent NICE recommendations call for the continued collection of data on overweight and obesity disaggregated by gender and we would endorse this. The recommendations also call for further research on the cost-effectiveness of different interventions, and for evaluation of the health impact of both broader community policies and national schemes including social marketing campaigns. Again, we endorse this but would stress the need for such research to report on gender differences.
4. The recent NICE systematic review of the effectiveness of orlistat also called for more research on gender and the value of this drug in weight loss, noting that most studies do not report disaggregated data for men and women. We would support this recommendation.
5. Policy recommendations arising from this review focus on the need to develop ways in which interventions and guidelines specifically identify gender differences in how services are used, across the public and private sector, and how to mainstream gender in such interventions. The role of QOF points for example could be reconsidered to direct GPs towards a more gender-aware approach to the identification and management of weight problems in general practice.



# Chapter 5: Mental health

## 1. Introduction and definitions

Mental health disorders are relatively common and services for people with mental illness are delivered across a range of sectors including primary care and specialist hospital services. A major study of psychiatric morbidity in Britain reported that, in 2000, one in six people had a neurotic illness, including anxiety and depression, while one in 200 had a psychotic disorder such as schizophrenia (Singleton et al., 2001; Cooper and Bebbington, 2006). One in seven people in the same survey had considered suicide at some point in their lives (Cooper and Bebbington, 2006).

Although definitions of mental health disorders vary, such conditions can largely be grouped into what are often described as common mental disorders including anxiety and depression, and more serious conditions including psychotic illness such as schizophrenia. In addition, suicidal behaviour, including both completed suicide and suicide attempts or deliberate self-harm, falls under the remit of mental health policy.

While more serious conditions and those related to substance use are often treated in specialist services, people with such conditions also draw on their primary services for support. Minor conditions are more often wholly treated in the community and by primary care, although depression and anxiety are also common diagnoses among those admitted to hospital. In-patient treatment also includes more serious conditions, including psychotic illnesses and disorders associated with substance use

(Cooper and Bebbington 2006; Hospital Episode Statistics, 2005/06). However, many of those with mental health disorders, particularly those described as 'minor', do not receive treatment, and people appear to be less likely to consult for depression and anxiety than other mental health conditions. Thus questions about gender differences in unmet need and consulting behaviour are particularly important.

Mental health conditions have been a major focus for health policy in England and Wales for a number of years. Early *Health of the Nation* targets identified suicide mortality as an indicator of mental health and the Department of Health laid out directions for mental health policy in 1999 in the *National Service Framework for Mental Health* (NSF) (DH, 1999c), setting seven standards for mental health services. In 2002, the Department of Health launched the National Institute for Mental Health in England (NIMHE) with the goal of improving quality of life for people experiencing mental health difficulties, working with NHS organisations and others involved in care and services in local areas. Mental health policy has seen a number of initiatives in recent years including the *National Suicide Prevention Strategy* in 2002 (DH, 2002b), *Delivering Race Equality in Mental Health Care* in 2005 (DH, 2005d) and the development of specialised community mental health services including assertive outreach, crisis resolution and early intervention services. The legislation governing mental health is also changing following the 2007 Mental Health Act.

## 2. Statistical information and epidemiology

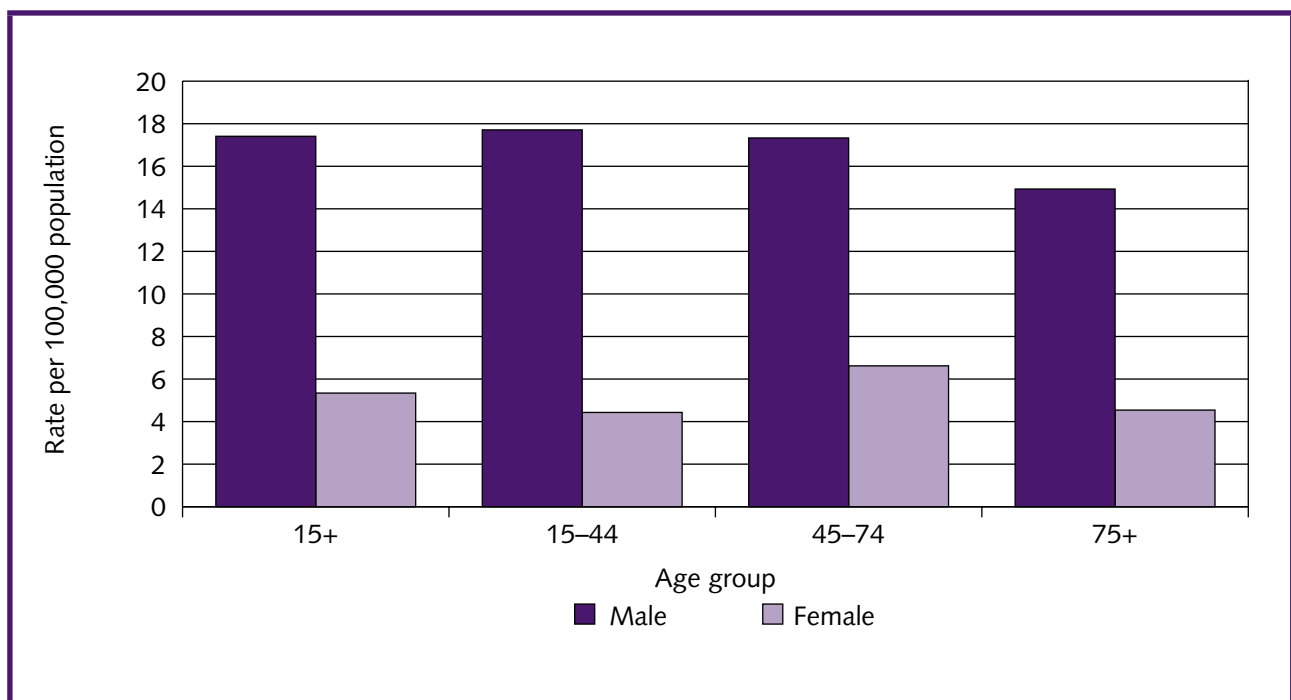
Mental health disorders are not always identified and not all of those experiencing poor mental health will receive treatment. This means that incidence and prevalence data can under-estimate the extent of the problem, depending on how such data are constructed. There are two main sources of data on the gender distribution of mental health problems: community-based surveys such as the National Psychiatric Morbidity Survey of adults in private households, and data drawn from treatment by health services, including primary care and specialist psychiatric services.

### Incidence and prevalence

Community surveys in the general population rely on validated questionnaires to collect data on the presence of symptoms indicative of mental health problems and therefore identify untreated as well as treated mental

health disorders. As such, these surveys are useful indicators of prevalence. Such surveys also reveal important gender differences in risk. Some disorders, including the rarer psychotic illnesses, are experienced by similar numbers of men and women, while more men than women experience personality disorder (Cooper and Bebbington, 2006). However, the more common neurotic disorders show higher rates of prevalence among women than men (Piccinelli and Wilkinson 2000; Cooper and Bebbington, 2006). The National Psychiatric Morbidity Survey in England and Wales, for example, shows the weekly prevalence of all neurotic disorders apart from panic disorders as higher for women than men, particularly for mixed anxiety and depressive illnesses (Singleton et al., 2001). Mental illnesses associated with substance use and misuse, however, are higher among men than women (Singleton et al., 2001). In addition, suicide mortality is greater among men than women (see Figure 5.1), while suicide attempts and deliberate

Figure 5.1: Age-standardised suicide rates in the UK, 2006



Source: ONS website, [www.statistics.gov.uk/statbase/Product.asp?vlnk=6725](http://www.statistics.gov.uk/statbase/Product.asp?vlnk=6725) (accessed 7 March 2008)

self-harm are higher among women (Gunnell and Harbord, 2003).

The prevalence of all mental health disorders also varies across the life course. For example, the highest rates of neurotic illness are found among those up to the ages of 45–54. However, while rates are higher for women than for men throughout the life course, the gender gap narrows around the ages of 55–64 mainly because the rate falls for women in this age group (Singleton et al., 2001; Bebbington et al., 1998). Levels of neurotic illness are also higher among people in lower socio-economic groups and for some ethnic minority groups, including Irish men and Pakistani women (Moser, 2001; Cooper and Bebbington, 2006).

There are also differences in relation to socio-economic status. Moser (2001) looked at treated depression, anxiety and schizophrenia in general practice in relation to practice-level figures for deprivation. For both men and women, treatment was higher in the poorest practices, with an age-standardised rate for depression, for example, of 610 per 10,000 among women and 250 per 10,000 among men in the poorest areas while in the most affluent areas it was 540 and 220 respectively.

However, the difference was particularly marked for depression among men aged 25–44, with nearly 50% higher treatment rates in the least affluent sector compared with the most affluent. This compares with research showing that suicide mortality and admissions to psychiatric hospital are also both increased among men in poorer areas (Whitley et al., 1999).

Trends in treated mental illness show some important differences for women and men. There has been an increase in prescriptions of antidepressant and anti-anxiety medication

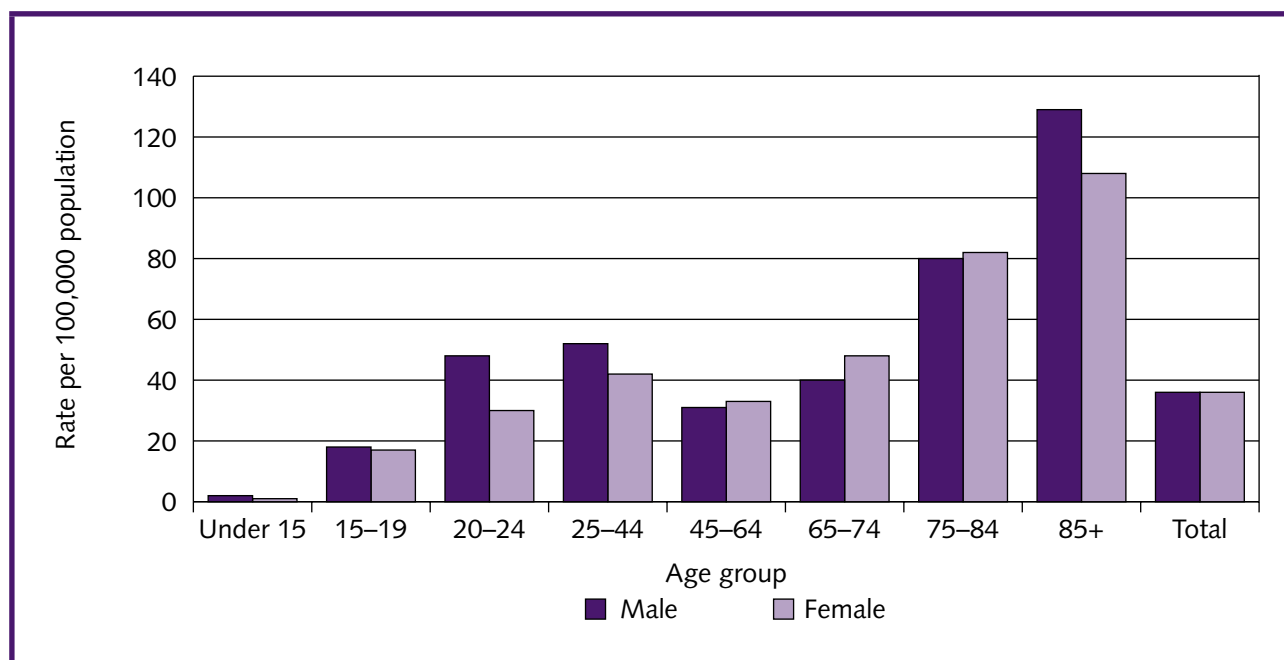
for both men and women in recent years, but the increase has been slightly more marked for men than women, narrowing the gender gap. Between 1994 and 1998, for example, male prevalence rates for treated depression in general practice increased from 200 per 10,000 patients to 290, while male prevalence rates for treated anxiety increased from 180 per 10,000 patients to 240 (Cooper and Bebbington, 2006). In comparison, female prevalence rates for treated depression had increased from 500 per 10,000 patients to 700, and for anxiety from 420 to 540 per 10,000 patients. With suicide attempts, there are also signs that the gap may be narrowing particularly in the white population and among those under 45, due to an increase in non-fatal suicide attempts among men (Hawton et al., 1997; Cooper and Bebbington, 2006).

### **Consultation rates and use of services**

Two sources of treatment data offer information on gender differences in service use. The first of these, hospital admission statistics, reflects the most serious conditions where a period of in-patient treatment is required. As Figure 5.2 shows, admissions to in-patient treatment for mental illness in 2001/02 were equal for men and women with both sexes having an admission rate of 36 per 10,000 population (DH, 2006a). However, as with prevalence data, there are gender differences in admissions across the life course, with higher rates for women than men among those aged 45–85, whereas in younger age groups and among the very old, men are more likely to be admitted.

Men are more likely than women, however, to be admitted to in-patient treatment under a section of the Mental Health Act (Information Centre, 2007). In 2006/07, for example, men made up 53% of all formal admissions under the legislation, including

Figure 5.2: Hospital admissions under mental illness specialties, 2001/02



Source: Hospital Episode Statistics, [www.performance.doh.gov.uk/HPSSS/TBL\\_B25.HTM](http://www.performance.doh.gov.uk/HPSSS/TBL_B25.HTM)

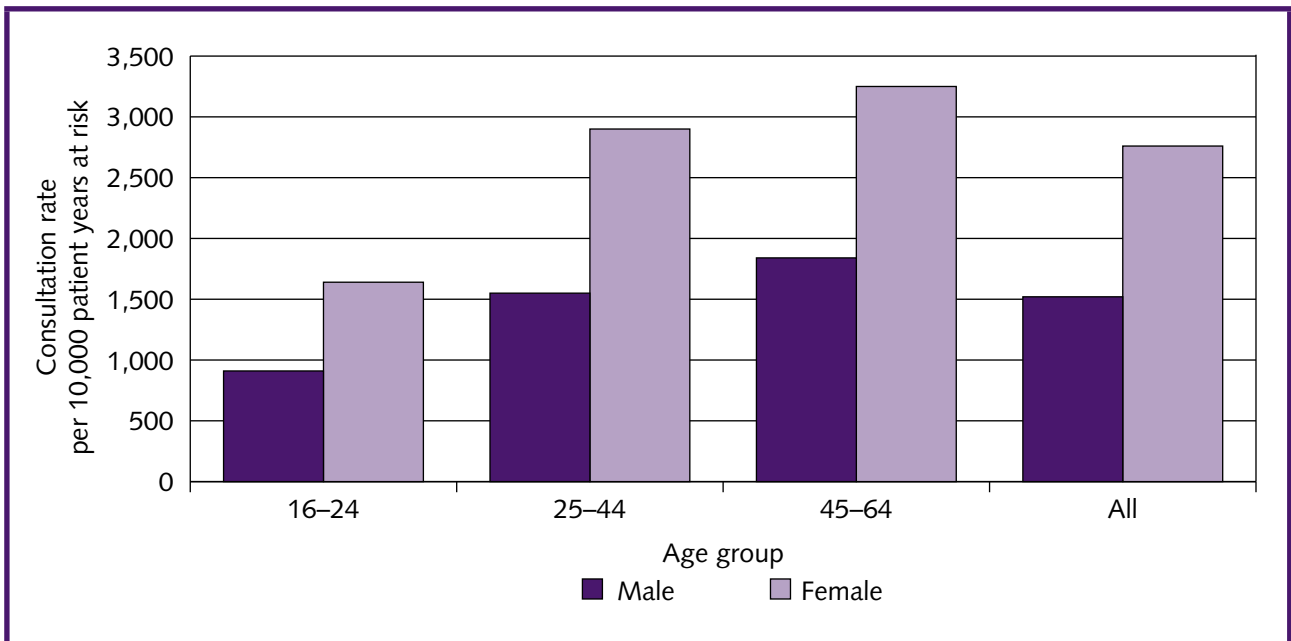
over 90% of all court and prison disposals. However, figures for detained patients show more than twice as many men as women, probably because their length of stay is also typically longer or because more men than women become formally detained following admission as a voluntary patient.

The second source of data on service use comes from the General Practice Research Database (GPRD). A study using the GPRD for 1991/92 found that nearly 6% of all GP consultations among those aged 16–64 were for psychiatric disorder (Shah et al., 2001). One in 14 patients consulted at least once for a psychiatric condition during the study year and the majority of consultations were for neurotic disorders and depression. As Figure 5.3 shows, women are higher consulters in every age group, with the widest gap in mid-life.

However, it is difficult to estimate how many consultations in primary care have a component of mental health problems – it may take several consultations for a problem to be identified for example, and poor mental health is also often associated with other health conditions. Some experts suggest that up to a third of all consultations may be related to mental illness.

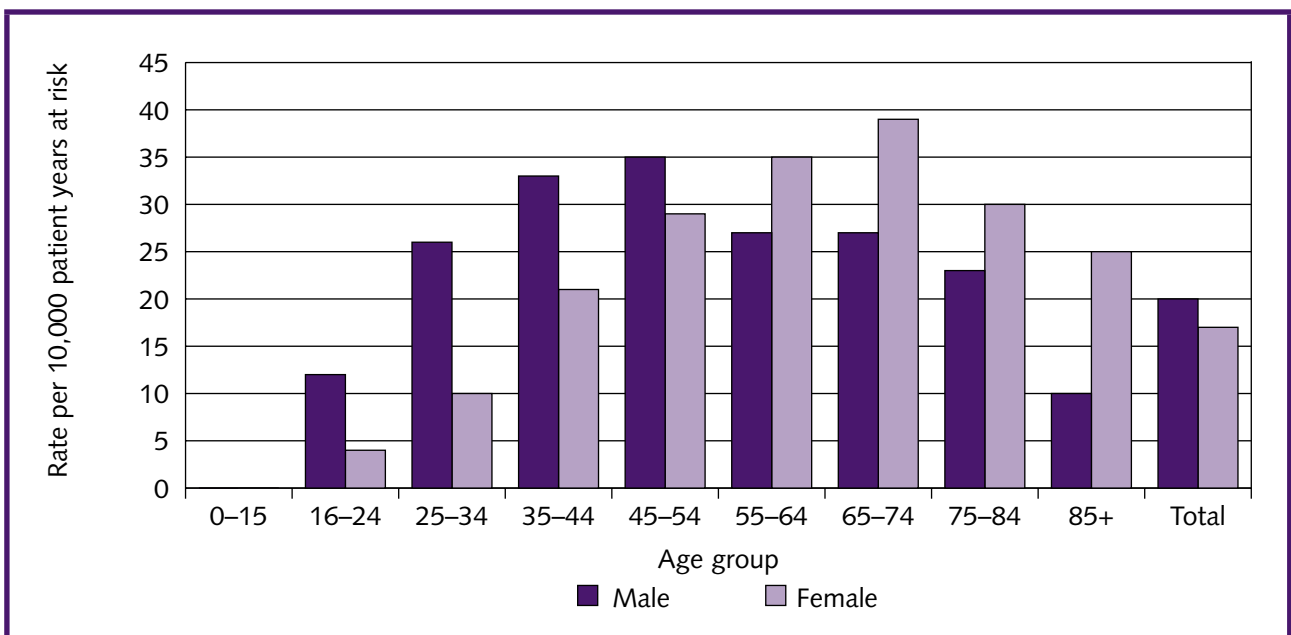
If we look at treated prevalence in general practice for specific kinds of illness, there are different patterns for men and women. Prevalence for treated schizophrenia in general practice in 1998 (Figure 5.4) is higher overall among men, but while male prevalence rates are greater than those of women in younger age groups, up to the age of 54, in later life, prevalence is higher among women.

Figure 5.3: Consultations in general practice for psychiatric disorders by age



Source: Shah et al. (2001)

Figure 5.4: Prevalence of treated schizophrenia in general practice, 1998

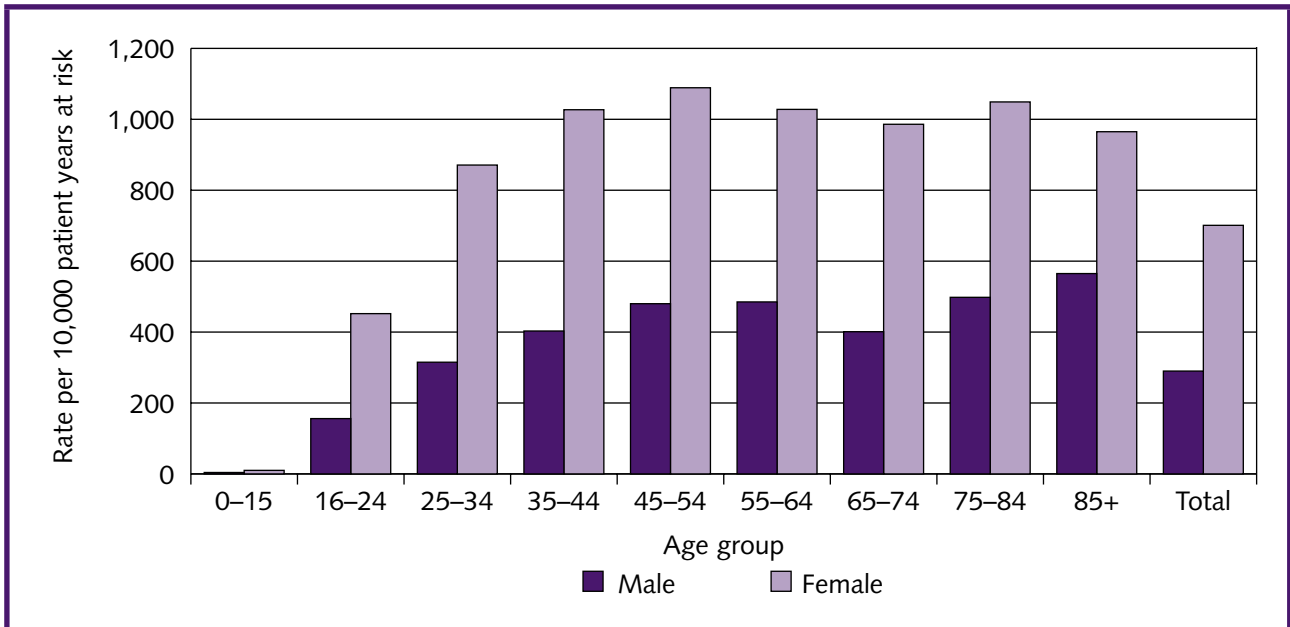


Source: ONS (2000)

In contrast, Figures 5.5 and 5.6 show that considerably more women than men are

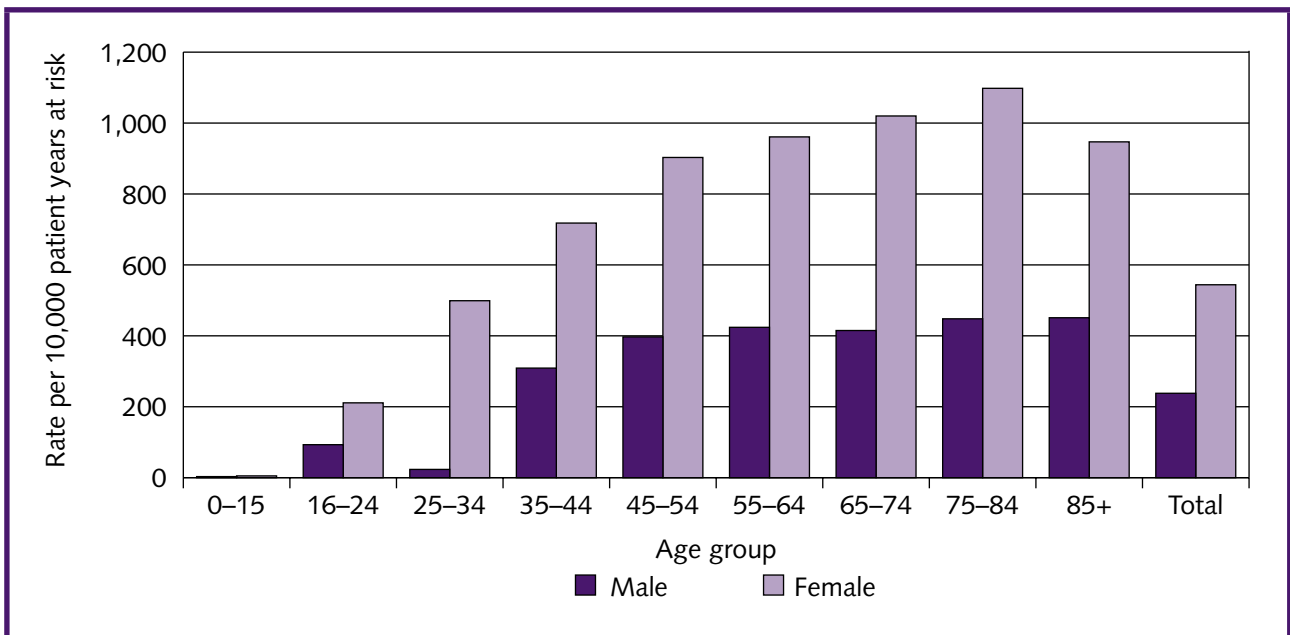
diagnosed with depression and anxiety in general practice in every age group.

Figure 5.5: Prevalence of treated depression in general practice, 1998



Source: ONS (2000)

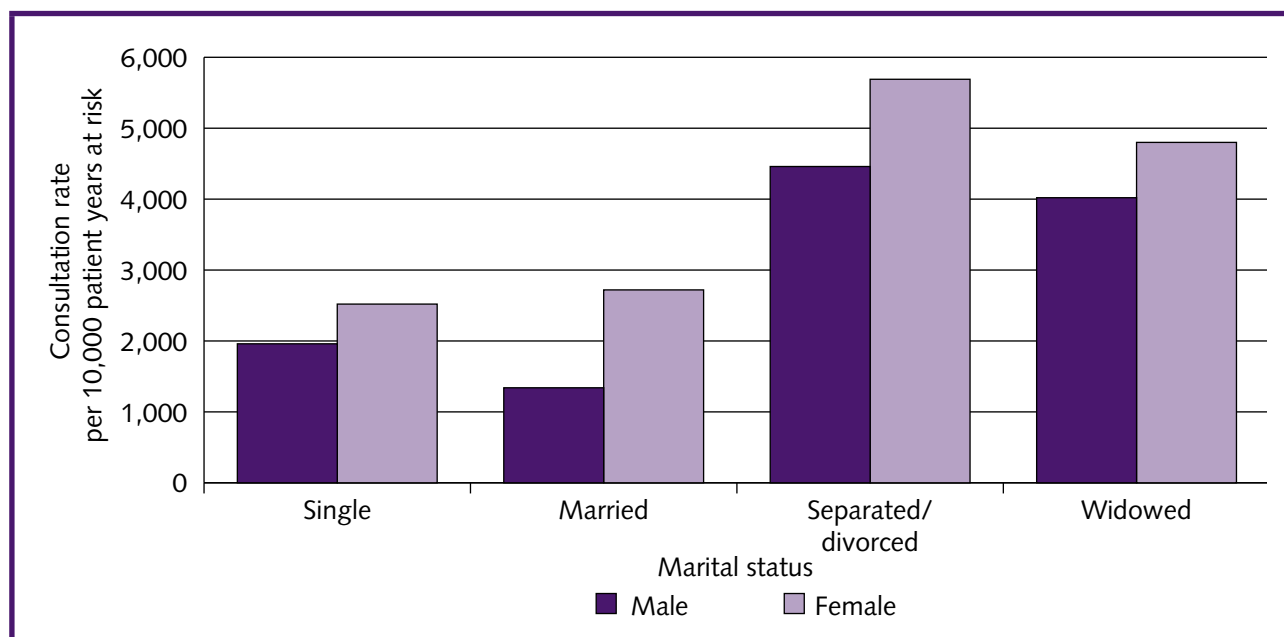
Figure 5.6: Prevalence of treated anxiety in general practice, 1998



Source: ONS (2000)



Figure 5.7: Consultations in general practice for psychiatric disorders by marital status



Source: Shah et al. (2001)

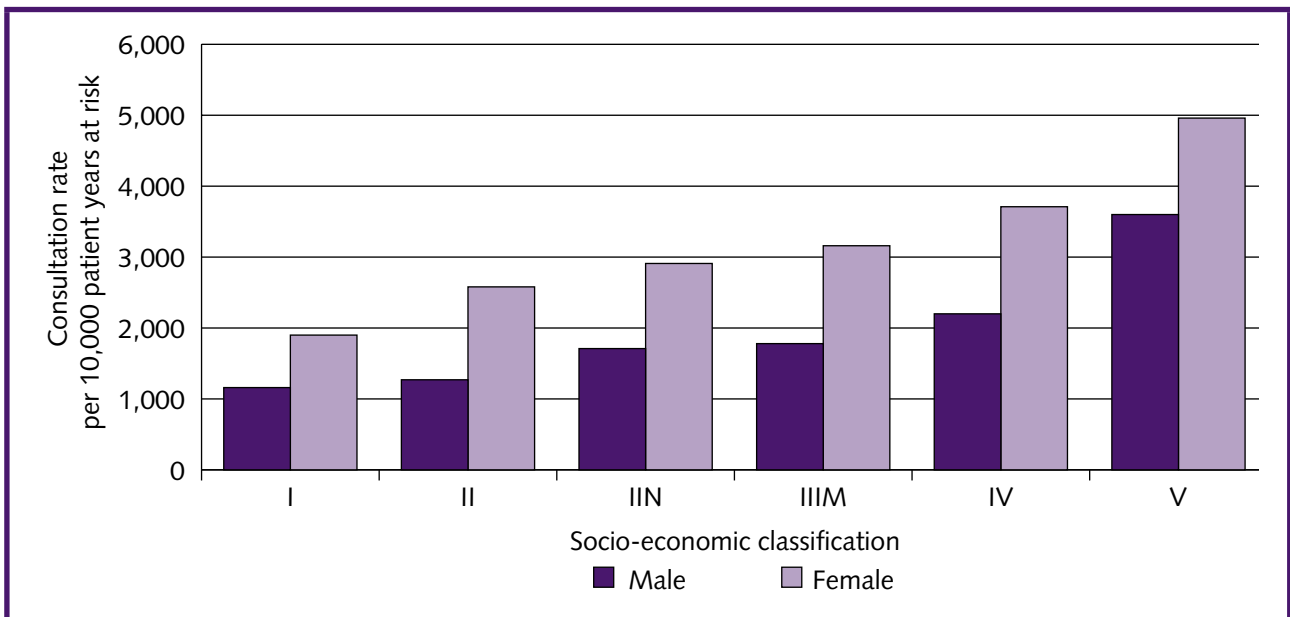
There are further differences between women and men in relation to demographic factors. As Figure 5.7 shows, in relation to marital status, consultations are higher among widowed, and separated or divorced, men and women but the gender gap remains.

Similarly, Figure 5.8 shows that while consultations for psychiatric disorders are higher in lower income groups in comparison with higher income groups, women are more likely than men to consult in general practice for these conditions in every class.

There are also differences between women and men in relation to ethnicity. Figure 5.9 shows higher consultations for white women and men in comparison with other ethnic groups, but in all groups more women consult than their male counterparts.

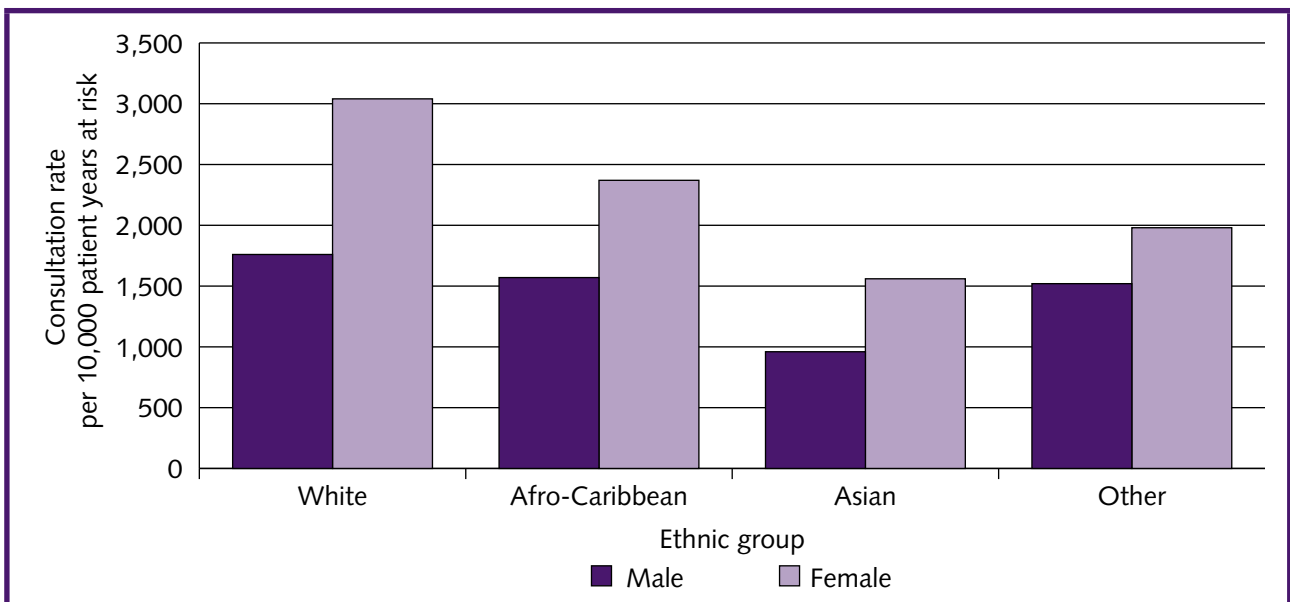
Finally, there are differences between women and men in the severity of the illnesses diagnosed. As Figure 5.10 shows, the greatest number of consultations in general practice are for psychiatric disorders described as intermediate in severity. More women than men consult for both intermediate and minor conditions in all age groups over 15, although rates are higher among boys up to that age. Consultations for serious conditions are higher among women overall and in all age groups except 16–24 years when rates are slightly higher for men.

Figure 5.8: Consultations in general practice for psychiatric disorders by social class



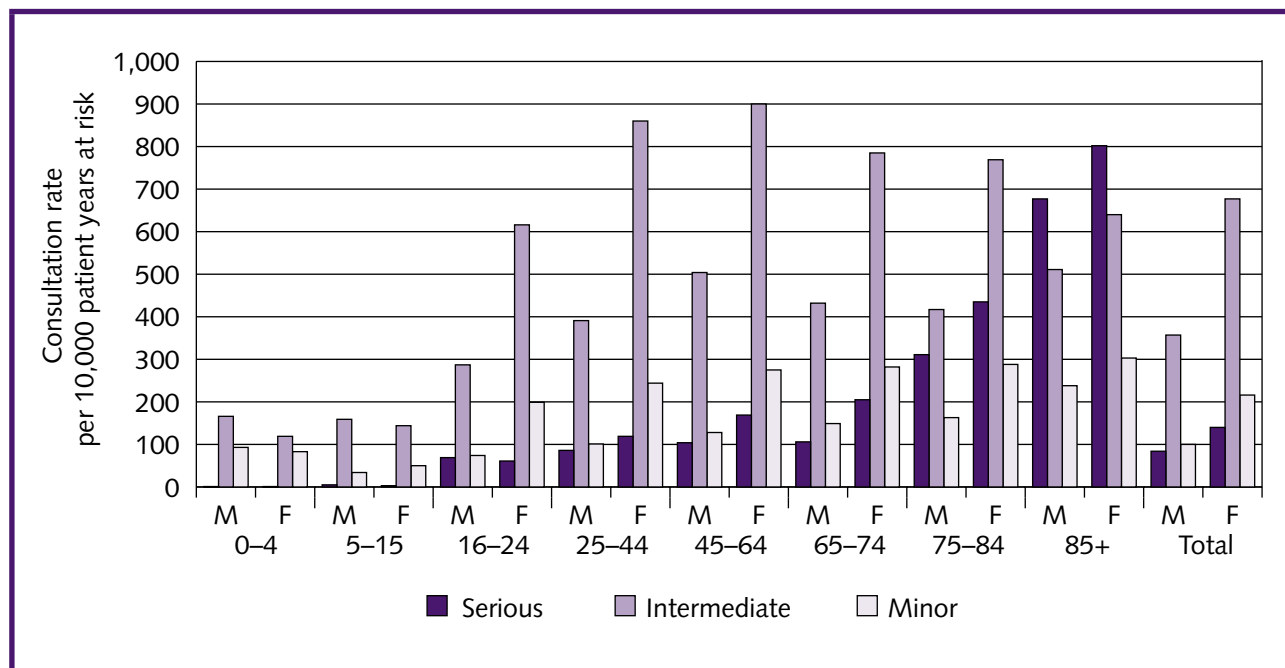
Source: Shah et al. (2001)

Figure 5.9: Consultations in general practice for psychiatric disorders by ethnic group



Source: Shah et al. (2001)

Figure 5.10: Consultations in general practice for psychiatric disorder by severity of condition, age and gender



Source: McCormick et al. (1995)

### 3. Factors associated with gender differences

Sex differences in mental health disorders are not fully understood, although key factors will include both biological influences and also social ones. Explanations for women's higher risks of depression and anxiety, for example, include the differential effects of male and female hormones, and also gender differences in socio-cultural factors, coping skills, patterns of employment and unpaid work, and life events (Bebbington et al., 1998; Piccinelli and Wilkinson, 2000).

Biology appears to exert an influence at key stages in the life course associated with hormonal change but evidence suggests the impact of such influences is moderated by gender. For example, declining levels of testosterone appear to increase men's risk of depression in later life while gendered expectations may result in their depression

not being recognised by themselves, their families or by health professionals (Seidman and Walsh, 1999).

With some socio-cultural factors, women may be more at risk. More women report stress as a result of some stressful life events, such as the death of a close relative or friend, and separation in a relationship. Research has also shown that gender-based violence, including physical, emotional and sexual violence, is an important factor in women's experiences of mental distress, with an increased risk of depression, anxiety, post-traumatic stress disorder and risk of suicide associated with gender-based violence (Abbott and Williamson, 1999; WHO, 2002).

However, more men report other adverse events such as unemployment, serious illness or injury, workplace violence and serious money problems (ONS, 2002b). Women also report more depression

following bereavement in comparison with men, although men in such circumstances are more at risk of suicide which may reflect undiagnosed and untreated post-bereavement mental health problems (Lehman, 2003). Poverty and social exclusion are also risk factors that have gendered dimensions: more women than men experience poverty, for example, due to differences in labour market participation and responsibility for children and other dependants (Payne, 2001a). However, loss of paid work may have particularly marked effects for men's mental health and their risk of suicide (Payne et al., 2008). Similarly, women may be more protected from suicide by social support systems, while men's risks are increased following failed relationships and family breakdown (Payne et al., 2008).

There are further important differences between women and men in suicidal behaviour relating to gender stereotypes. Literature on meanings attached to suicide, for example, reveals that suicide attempts or 'failed' suicide are seen by both men and women as feminine whereas completed suicide is seen as masculine (Cannetto and Sakinofsky, 1998; Payne et al., 2008). A study (Hunt et al., 2006) of suicidal thoughts among three generations of men and women found quite complex associations between suicide and gender, which varied by age. This is a relatively under-explored area and is worthy of further research.

Men are also more likely to use violent and more lethal methods of suicide, including hanging, exhaust gas asphyxiation and firearms, and this increases the likelihood of their attempts being fatal (Payne et al., 2008).

#### 4. Gender and help-seeking behaviour

Whether people with mental health problems are in receipt of treatment, either from primary care or specialist services, depends on a number of factors including whether the individual, or their family, friends and others, believe that they need help, whether they decide to seek such help, and whether the individual is recognised as having mental health problems by health professionals when they do consult. Deciding to seek help will reflect both a willingness to accept that there is a problem and to accept help, as well as a belief in the value or appropriateness of services offered. In addition, the decision to seek help reflects ability to access services. Gender, alongside other cultural and social factors, will play a part in these processes.

A number of the studies offering an insight into gender differences in help-seeking and treatment have been carried out in other countries, particularly the US, and although the discussion below draws on these where useful, it is important to remember the influence of insurance status and user fees on help-seeking and service use in other countries.

##### **Willingness to seek help and help-seeking behaviour**

Most people with common mental disorders do not consult their GP and more of those who have not consulted their GP are men than women (Bebbington et al., 2000). In the 2000 National Morbidity Survey, for example, most people with neurotic disorders (60%), and a surprisingly large number of those with psychotic illness (40%), had not consulted their GP in the last year (Cooper and Bebbington, 2006). Most of those living with a psychotic condition were receiving treatment from other sources, however, especially specialist psychiatric services, while

many of those with symptoms of neurotic disorders were not in any form of treatment.

Although there is some variation in the research literature over gender differences in decisions to seek help when experiencing mental health difficulties, many studies have shown that men are less willing to use mental health services, have less positive attitudes towards service use and are less likely than women to decide in favour of consultation in either primary care or specialist services (Mackenzie et al., 2006). A recent large-scale European study across six countries, for example, reported that women were twice as likely to consult as men for mental health difficulties in the previous 12 months (ESEMeD Investigators, 2004). However, other research has challenged the idea that women find it easier to consult for depression. For example, in a recent qualitative study of women and men who identified themselves as having had depression, both women and men reported difficulty in recognising and talking about mental health problems (Emslie et al., 2007). This is an area where more work is needed.

Gender also interacts with age and marital status in help-seeking behaviour, with older adults being more likely to seek help in comparison with younger age groups (Mackenzie et al., 2006). Men appear to have more negative attitudes towards psychological expression, defined in this study as an openness towards talking about emotions and help-seeking, and this helps to explain their under-use of mental health services (Mackenzie et al., 2006). Gender differences in help-seeking behaviour in relation to mental health problems start early, with male teenagers reporting less understanding of mental health, more stigma associated with mental illness, and less willingness to use mental health services (Chandra and Minkovitz, 2006). Boys are

also less likely than girls to talk to friends about emotional problems, although they are more likely to talk to parents.

In the National Psychiatric Morbidity Survey, only a minority (30%) of those who consulted their GP were receiving treatment, although this study did not find a difference between men and women in the likelihood of treatment (King et al., 2003). A follow-up study over an 18-month period found that, among those with symptoms of common mental disorders, more women than men were in receipt of mental health treatment – 29% of women compared with 17% of men (King et al., 2003). While at every level of illness more women than men received treatment, and the percentage treated for both sexes increased with illness severity, the gap between women and men was widest in the least severe categories of illness. That is, among those with relatively minor symptoms, women were much more likely than men to be in receipt of psychiatric treatment from either their GP or specialist services (King et al., 2003). Similarly, Hunt et al. (1999) found that, while women and men were as likely to consult primary care physicians for most health conditions and at most levels of severity, women were more likely than men to consult for 'less limiting' minor mental health problems. Young men in particular are unlikely to have consulted a GP or to be in receipt of mental health treatment.

A further difference emerges in relation to frequency of consultation, suggesting that a key factor might be a gender gap in the number of consultations. One study in the Netherlands, for example, found differences between new care use and frequent care, with gender only predicting frequent use of psychiatric care – while women and men were equally likely to consult once for psychiatric conditions, more women were

regular consultants (ten Have et al., 2001 cited in King et al., 2003).

Finally, it is worth noting the potential consequences of under-consulting which include the risk of suicide (see below) but also other difficulties. Bebbington et al. (2000), for example, found that men were more likely to suffer functional difficulties in daily living than women with the same level of psychiatric symptoms, suggesting that unmet need in relation to mental health problems might have particular consequences for men which need investigating further.

Men's undiagnosed mental health difficulties may also be reflected in their higher risk, compared with women, of experiencing other problems. For example, more men are imprisoned each year, men are more likely to be homeless, more men have problems with drugs and alcohol, and more boys than girls are excluded from school. These figures may represent a wide range of ways in which male mental health problems are expressed and also their needs are not met (Rutz and Rihmer, 2007).

### **Help-seeking and suicidal behaviour**

As we have seen, suicide is higher among men and there are also gender differences in use made of services and consultation with health professionals prior to death. Men, especially younger men, are least likely to consult health professionals in the months before a suicidal act and the gap between last consultation and suicide is longer among young men than other groups (Foster et al., 1997; Vassilas and Morgan, 1997). Men are also unlikely to consult other services or use alternative sources of support.

## **5. Gender and experience of services**

In addition to differences between women and men in consulting behaviour, we can

explore the services men and women receive in relation to mental health problems, and ask how well mental health services in primary care and specialist services meet their needs.

### **Gender differences in diagnosis and recognition of mental health conditions by health professionals**

Figures above have indicated that, for common mental disorders such as depression and anxiety, women are more likely to receive treatment for psychiatric symptoms both in primary care and in the hospital sector, and more women than men are diagnosed each year with minor disorders. However, there is also concern that the attitudes and beliefs of GPs and other health professionals might affect the gender gap, particularly in relation to under-diagnosis among men. Equally, there are concerns that services may not meet the needs of women in some respects, especially in relation to safety.

One US study which has explored some of these questions noted that women make more visits to their primary care physician or GP, and they also score more highly for symptoms of depression (Bertakis et al., 2001). However, more frequent consultations are associated with a greater likelihood of diagnosis, suggesting that women's depression may be more likely to be identified partly as a result of this higher attendance. But the same survey noted that, after controlling for differences in symptom level, evidence of gender bias in diagnosis remained, helping to account for women's higher rates of depression in primary care (Bertakis et al., 2001).

Another factor which might play a part is the extent to which women and men accept their diagnosis. Studies have suggested that men, particularly younger men,

are less willing to accept a diagnosis of depression and this might affect frequency of consultation and return visits (Van Voorhees et al., 2005). Ross et al. (1999) found that GPs were more likely to ask men than women to attend a follow-up consultation and suggested that this might be due to a belief that women would be likely to return without prompting, possibly because women are more likely to accept that they have a mental health disorder. Thus gender stereotypes of depression may play a part both for health professionals and their patients, decreasing the chances that men's problems are identified.

However, this may be changing. Figures on prescribing indicate that while women remain higher consumers of psychotropic medicine, prescribing rates among men, particularly younger men, have increased faster than for other groups and the gap is narrowing (Middleton et al., 2001). This might reflect better recognition of men's mental health problems, as well as increased consultation and increased prevalence for mental illnesses among men.

### **Gender issues in the delivery of care**

Research into treatment also suggests that there may be important gaps between women and men which affect their experiences of mental health services as well as outcomes. There are a number of important issues in relation to gender and specialist care, particularly the question of single-sex services. Women in mixed psychiatric wards experience a number of problems including the risk of sexual and physical abuse, harassment and the stress of feeling unsafe (Samarasekera, 2007). While these mirror problems women may experience outside hospital, they are particularly significant for women who are already distressed. In addition, women who

have experienced gender-based violence in the past are highly likely to find such settings problematic. The problems associated with mixed-sex services are found both in ordinary hospitals and in secure settings, and have been recognised in mental health services and policy through a commitment to the use of women-only wards and other services and an increased articulation of the specific needs of women (Williams et al., 2001).

However, it is difficult to know how quickly the commitment to the availability of single-sex services is being met. The NIMHE expert briefing (2003) reported that, while examples were found across England where women-only and women-sensitive services had been introduced, often in the voluntary sector, there were also gaps in provision. Although not focusing on psychiatric wards, the more recent *Privacy and Dignity* (DH, 2007b) reported that 99% of NHS trusts stated that they provided single-sex sleeping accommodation and 97% reported that they had single-sex toilets and bathrooms. However, the paper also noted that this conflicted with information derived directly from patients which suggested many trusts still used mixed-sex wards and facilities.

Consultation with women users about what they would like from mental health services reveals that, as well as safer women-only in-patient units, there is a demand for crisis-type alternatives to admission, which are also single sex, combined with better training for staff, involvement in decisions about their treatment, opportunities to share experiences with other women, more recognition of diversity between women, and a bigger, better resourced role for the voluntary sector (NIMHE, 2003). However, a study in medium-secure services reported that women prefer mixed-sex psychiatric wards,

often saying that they feel safer in such settings (Mezey et al., 2005).

In addition to the question of mixed-sex facilities, if health professionals fail to recognise experiences of gender-based violence as important in women's mental distress, and simply treat the symptoms, this is also likely to act as a barrier to recovery and can reinforce the idea that the symptoms – rather than their experiences of violence – are the problem (Abbott and Williamson, 1999).

The NIMHE report suggested that good practice might include the appointment of a local 'champion' for women's mental health services with responsibility for addressing gender issues in policy (NIMHE, 2003). However, the lack of specific targets has meant that gender issues are sometimes left behind due to other pressures on services. In addition, the emergence of men-only services and units is seen as problematic, partly because such units often arise informally when managers choose not to admit women because of perceptions of the dangers which might be posed for women, which unintentionally reduces service availability for women.

Mental health workers see training as crucial in developing appropriate gender-sensitive responses to the people they work with. For example, while workers may be aware of the significance of early experiences of sexual abuse in women's mental health as adults, they are often reluctant to initiate discussions with women service users about such experiences because they do not feel qualified to deal with such stories either on a personal level or in a therapeutic way (Williams et al., 2001). Equally, staff may lack the confidence and training to support men in relation to experiences of abuse and their mental health. Often this is allied with a lack

of therapeutic supervision needed to support staff in this work.

There are also gender differences in perceptions of female and male patients, particularly in secure settings where there may be a status or prestige attached to working with violent or disturbed men, while men are also seen by staff as being more straightforward to deal with and more accepting of rules of behaviour (Williams et al., 2001). Thus men may be seen as easier to deal with while also conferring a higher status on those working in male-only settings.

With men, services may fail to provide appropriately for specific minority groups within the population. Research on service use by the Asian population, for example, suggests a particular gap in provision for South Asian men with mental health problems (Bhui et al., 2002). This is related both to stereotypes about who is at risk, willingness to consult for mental health conditions and also issues around the language of mental disorders.

A report on a range of projects addressing young men's health, including their mental health needs, found that when projects specifically addressed the reasons why young men did not make use of services on offer and shifted their delivery style – for example locating mental health services in bars and clubs – they were more able to meet the needs of young men (Lloyd, 2002). Similarly, the recent evaluation of the suicide prevention strategy pilots aimed at young men found that non-NHS services were seen as more acceptable, less stigmatising and more approachable by young men (Oliver and Storey, 2006).



## Services and suicide

Research on suicide among people already receiving treatment for mental health problems also helps to identify gaps in access to services. Prevention of suicide in primary care is particularly difficult – for example, the number of people with suicidal thoughts is around 400 times greater than the number committing suicide each year (Gunnell and Harbord, 2003). Preventing suicide following discharge from mental health treatment is also an issue in specialist care.

Among completed suicides, women are more likely than men to have a history of treated mental illness and to have received treatment in the previous 12 months, as well as being more likely to have made a previous attempt – although attempted suicides, particularly those involving hospital treatment, also increase the likelihood of being diagnosed as having a mental health condition and of being treated (Haste et al., 1998). While this study suggests there is not a difference in terms of most recent contact with a GP, women who commit suicides were more frequent consulters than men who commit suicide, which also increases their likelihood of being diagnosed with depression or having suicidal thoughts identified.

The period following discharge from psychiatric in-patient treatment is particularly risky in terms of suicide but again there are differences between women and men, with men experiencing a higher risk of suicide compared with women for the first 12 months following discharge, while women's risks are higher than those of men in the first four weeks (Geddes et al., 1997). A variety of factors are likely to be involved in this, including age, marital and employment status for example, and also the efficacy of support services following discharge.

## 6. Gender and current policy

Key components in mental health policy at national level in England and Wales include the National Service Framework published in 1999 (DH, 1999c), the *National Suicide Prevention Strategy* (DH, 2002b), and the *Choosing Health* White Paper (DH, 2004b). The Public Service Agreements (PSAs) have also been used to target mental health – specifically targets on reductions in suicide mortality have been included in the 2004–07 and the 2007–10 PSAs.

The *Mental Health Implementation Policy Guide* (DH, 2001a) makes specific reference to the need for gender-sensitive services including the provision of single-sex accommodation and also services which take into account the specific needs of different user groups, including women. This might include, for example, the provision of same-sex workers if requested. The guide also acknowledges the need for training in gender issues for all staff. This approach is extended to work with children and young people as well as adults. The implementation guide focus on gender-sensitive services does not explicitly address the needs of men, although when considering the impact of the Gender Equality Duty, the guidelines include questions concerning the impact of policy on men as well as on women.

The Women's Mental Health Strategy introduced in 2002 as part of a cross-government gender equality strategy brought many of these points together. The strategy aimed to mainstream gender in provisions for women's mental health, involve women in the delivery and planning of services, increase multi-agency work, provide single-sex services and identify service standards relevant to women (DH, 2002a).

The 2001 implementation guide identifies gender roles as potential risk factors for men and women but also notes that these are difficult to address in isolation or by health services alone, and calls for policies and strategies which strengthen protective factors. The guide also articulates specific factors affecting women and their mental health, including the experience or threat of domestic violence, abuse and post-natal depression.

The implementation guide and the Women's Mental Health Strategy both recognise the need for good, regular, accurate and appropriate data which are gender disaggregated. It is suggested that data to be collected at local level should include indicators on gender, including users of services, the provision of services and how well they meet the needs of different user groups.

### **Is policy gendered?**

While there are examples of gender-specific mental health policies in the Women's Mental Health Strategy and the identification of young men as a key target group in the *National Suicide Prevention Strategy* (DH, 2002b), gender issues have not been integrated across all policy areas.

However, the 2007 Mental Health Act includes an equality impact assessment which notes the need for gender-sensitive policy and services, and the need for people to be offered opportunities for same-sex health professionals and care workers, and for privacy to be respected. Clinicians wishing to take on a statutory role under the new legislation will need to demonstrate their understanding and up-to-date knowledge of gender issues in mental health, and competency in how to challenge discrimination. At this moment in time, consultation in relation to secondary

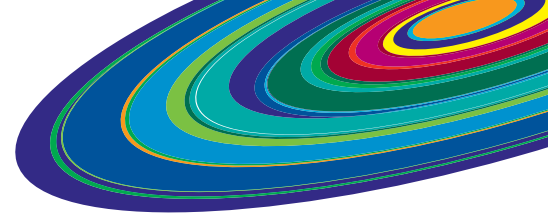
legislation to bring in many of the 2007 Act's changes is still under way, and as yet it is difficult to know what difference this equality impact assessment will make to how policies are experienced by women and men in the system.

## **7. Key issues**

- Women are more likely than men both to report and to be diagnosed with depression and anxiety, and more women are treated for these conditions.
- On the other hand, mental health disorders related to alcohol and substance use are higher among men, and more men commit suicide each year.
- Due to gender differences in willingness to recognise a problem and to seek help, and perhaps also assumptions of healthcare providers, men with depression and anxiety are more likely than women not to be diagnosed and this has consequences for their treatment and for outcomes.
- Current mental health policy has identified the needs of women, and some men, particularly younger men, but many of the policies are not gender sensitive and this affects the way interventions are experienced by women and men.
- Data on mental health conditions and services are mostly disaggregated by gender, although there is a gap in knowledge in terms of the barriers to consultation experienced by women and men, and how well services meet needs.

## 8. Recommendations

1. Although, in mental health policy, gender issues are identified, this recognition is partial – in the Women’s Mental Health Strategy and the focus on young male suicide in the *National Suicide Prevention Strategy*. The new Mental Health Act 2007 includes an equality impact assessment and this recognises the gaps in knowledge about barriers to care experienced by men and women. However, the mental health needs of some groups – particularly older and minority ethnic men – appear to be obscured in current approaches. While the treatment needs of women have been recognised, data do not show how well these are being met and the treatment needs of men are less discussed. These conclusions suggest that policy needs to prioritise gender impact assessment, and gender-sensitive approaches to mental health interventions across various sectors including primary care.
2. It is important to build in from an early stage evaluation of progress in relation to gender-sensitive mental health policy and this should involve different stakeholders.
3. Research gaps include lack of insight into the mental health needs of specific minority users including older men and women, black and minority ethnic groups, and people of different sexuality. Research also needs to be carried out on different service models and how well they meet the needs of different users. Gender-sensitive approaches in the delivery of care – single-sex services, crisis centres and wellness checks for example – also need to be evaluated. However, the most important gap in research evidence relates to the question of reach – what are the gendered implications of unmet need, and how can different groups be encouraged to make better use of primary healthcare in particular when experiencing mental health difficulties?



# Chapter 6: Alcohol misuse

## 1. Introduction and definitions

Alcohol misuse accounts for almost 10% of the disease burden in England – a level surpassed only by tobacco use and elevated blood pressure – and represents a major burden to the NHS and the wider health and social care system (Donaldson, 2005).

The *Alcohol Harm Reduction Strategy for England* ('Alcohol Strategy') (Cabinet Office Strategy Unit, 2004) identified a high level of alcohol misuse in society and consequent alcohol-related harm. Problems associated with alcohol misuse include alcohol-related health disorders and disease, violence, anti-social behaviour and divorce; 17 million lost working days per annum and 70% of all peak-time admissions to accident and emergency departments are related to alcohol misuse. The Alcohol Strategy identified a lack of focus on alcohol treatment and limited information on the extent to which service provision met demand.

In this chapter, the different drinking behaviours of men and women are explored, along with the consequences these are likely to have on their health. The treatments offered in primary care services and the different responses of men and women to these services are also discussed.

The most widely recognised way of defining alcohol misuse in the UK is through 'safe' levels of drinking based on thresholds of units of alcohol consumed. These limits were set in the UK in 1987 after the Royal College of Physicians produced its first health

report on alcohol misuse (Royal College of Physicians, 1987), and were reaffirmed recently in a study by the North West Public Health Observatory (Khundakar et al., 2007). Safe drinking levels are different for men (3–4 units a day, or 21 units a week) and for women (2–3 units a day, or 14 units a week); consumption above these levels is thought to confer a serious risk to health (NHS Direct, 2008). The Government report *Sensible Drinking* (DH, 1995) changed the guidelines for sensible drinking from a weekly to a daily measure of consumption, expressing the concern that weekly consumption can have little relation to single drinking episodes and may indeed mask short-term episodes of binge drinking that correlate strongly with medical and social harm.

The apparent differences in men's and women's levels of risk of health harm from alcohol is considered to be biologically determined. Women are typically smaller, and they absorb alcohol more quickly because they tend to have a higher proportion of body fat than men (Alcohol Concern, 2008). However, different countries have different ideas of what constitutes safe drinking; some consider gender difference to be less pronounced (WHO, 2000).

The Alcohol Strategy defines two patterns of drinking likely to raise the risk of harm: binge drinking and chronic drinking.

### **Binge drinkers**

There is currently an increased focus on binge drinking because of national concern about anti-social behaviour and the social issues involved (Alcohol Concern, 2003).

However, there is a lack of consensus on the definition of binge drinking (BMA Board of Science, 2008): the definition used by the Office for National Statistics (ONS, 1999) uses volume (8 or more units for men and 6 or more units for women at least 1 day per week), while others have argued that it is important to move away from clinical definitions based on consumption to a distinction between responsible and reckless drinking behaviour (International Centre for Alcohol Policies, 1997). One definition offered by Alcohol Concern is 'drinking sufficient alcohol to reach a state of intoxication on one occasion or in the course of one drinking session'. This element of risk is used by other commentators (Murgraff et al., 1999) to describe binge drinking as episodes of heavy social drinking that are potentially harmful to the individual.

### **Chronic drinkers**

The term 'chronic drinker' is defined in terms of the amount of alcohol drunk. Again there is a gender difference: a chronic drinker is a man who drinks more than 50 units a week or a woman who drinks more than 35 units. Chronic drinkers are likely to be aged over 30 years, and two-thirds are men (DH, 2004a). They are considered to be at increased risk of health harms such as cirrhosis of the liver, cancer, haemorrhagic stroke, premature death and suicide.

### **Alcohol use disorders**

This is a generic term used to denote mental, physical and behavioural conditions of clinical relevance that are associated with the use of alcohol (BMA Board of Science, 2008). Alcohol use disorders have been categorised into three areas (WHO, 1993) which are now widely used in policy and research literature. They are:

- hazardous drinking – the individual drinks above the recognised 'sensible' levels, increasing their risk of harmful consequences, but is not yet experiencing harm;
- harmful drinking – the individual drinks above 'sensible' levels and experiences harm. Harmful use commonly, but not invariably, has adverse social consequences; and
- dependent drinking – the individual drinks above 'sensible' levels and experiences harm and symptoms of dependence.

In terms of alcohol quantity consumed and health harms, there is a marked gender difference. In England, 38% of men and 16% of women are thought to have an alcohol use disorder (DH, 2005b), equivalent to approximately 8.2 million people.

## **2. Statistical information and epidemiology**

### **Incidence and prevalence**

Binge drinking is likely to raise the risk of health harm to individuals and has a consequential impact on health services. An examination of the prevalence of binge drinking shows a marked gender difference in behaviours, although there are variations between studies. For example, in the UK binge drinking has been found to account for 40% of all drinking occasions among men and 22% among women (Cabinet Office Strategy Unit Alcohol Harm Reduction Project, 2003), although a later study (Drummond et al., 2005) has put these figures at 21% for men and 9% for women.

Binge drinking tends to be a characteristic of young people, particularly those aged 16–24 years, with 36% men and 27% of women in that age group likely to binge drink (ONS, 2002a). Evidence suggests

that this gender difference in behaviour is related to cultural symbols of masculinity, and that men reaffirm their masculinity by drinking (Lemle and Mishkind, 2002; de Visser and Smith, 2007). However, between 1998 and 2001 the proportion of young women binge drinking in this age group increased from 23% to 27% (ONS, 2002a), raising widespread concerns about whether there is a gender convergence in potentially problematic drinking (McPherson et al., 2004).

In older age groups both men and women drink smaller quantities of alcohol, but drinking frequencies do not appear to change consistently with age (Wilsnack et al., 2000). For some people, binge drinking continues into middle age (45–64 years) – around one in three men and one in five women drink twice the recommended daily safe drinking limits (3–4 units for men and 2–3 units for women) at least once a week (ONS, 2002a).

Of the few detailed studies of incidences of binge drinking in communities, most have focused on young people (MacLachlan, 2004; Kuntsche et al., 2004). An exception was a survey of drinking patterns among the population of nine Welsh health districts (Moore et al., 1994), which showed that 28.2% of men and 8.2% of women reported binge drinking (defined as over half the weekly recommended units on one occasion) at least weekly. The study also established a clear link between binge drinking and other types of health behaviour; for example, people who smoked regularly were 33% more likely to binge drink, and people classified as overweight were 24% more likely to binge drink (Moore et al., 1994).

Some researchers argue that there is a lack of longitudinal research to determine the relationship between patterns of

consumption and the development of disease (Plant et al., 2002). However, one study in Europe (McKee and Briton, 1998) looked at the significant increase in sudden cardiac death at weekends among young and early middle-aged men, and concluded that the cardio-protective effect of regular moderate alcohol drinking did not apply in men. Another study from Scotland (Evans et al., 2000) linked patterns of alcohol consumption with mortality from coronary heart disease in men and women under 50, by finding that mortality was 20% higher on Mondays than on other days of the week.

The prevalence of alcohol use disorders has been brought together in a comprehensive *Alcohol Needs Assessment Research Project* (ANARP) in England (DH, 2005b). Across all the categories of alcohol misuse, men have a significantly greater problem than women. These gender differences in alcohol misuse have been mirrored in international studies looking at the characteristics of drinkers (Wilsnack et al., 2000; Kuntsche et al., 2004), with men consistently exceeding women in rates of heavy drinking episodes and adverse drinking consequences.

In England, 6% of men and 2% of women are alcohol dependent, equating to 1.1 million people with alcohol dependence. This means that alcohol dependence is considerably more prevalent than problem drug use, which is estimated to affect 0.8% of the adult population in England (Drummond et al., 2005).

In terms of life lost and mortality, alcohol-specific mortality in people aged under 75 years increased by about 4% for men and 3% for women between 2001 and 2005. Each man in England dying from an alcohol-attributable cause loses an average of 20.2 years, and each woman loses an average of 15.1 years (Khundakar et al., 2007).

### Consultation rates and use of services

ANARP also identified alcohol use disorders in primary care using the General Practice Research Database (GPRD). It concluded that there were low levels of formal identification, treatment and referral of patients with alcohol use disorders by GPs. However, another study carried out as part of ANARP (Drummond et al., 2005) surveyed a random sample of 424 GPs in England and showed a higher level of awareness of alcohol use disorders than is shown in the GPRD research or previous surveys. GPs identified 1 in 67 males and 1 in 82 females as harmful/hazardous drinkers, and there were fewer women identified as alcohol dependent (1 in 20 males and 1 in 28 females). There tended to be an under-identification of younger patients as alcohol dependent among both men and women.

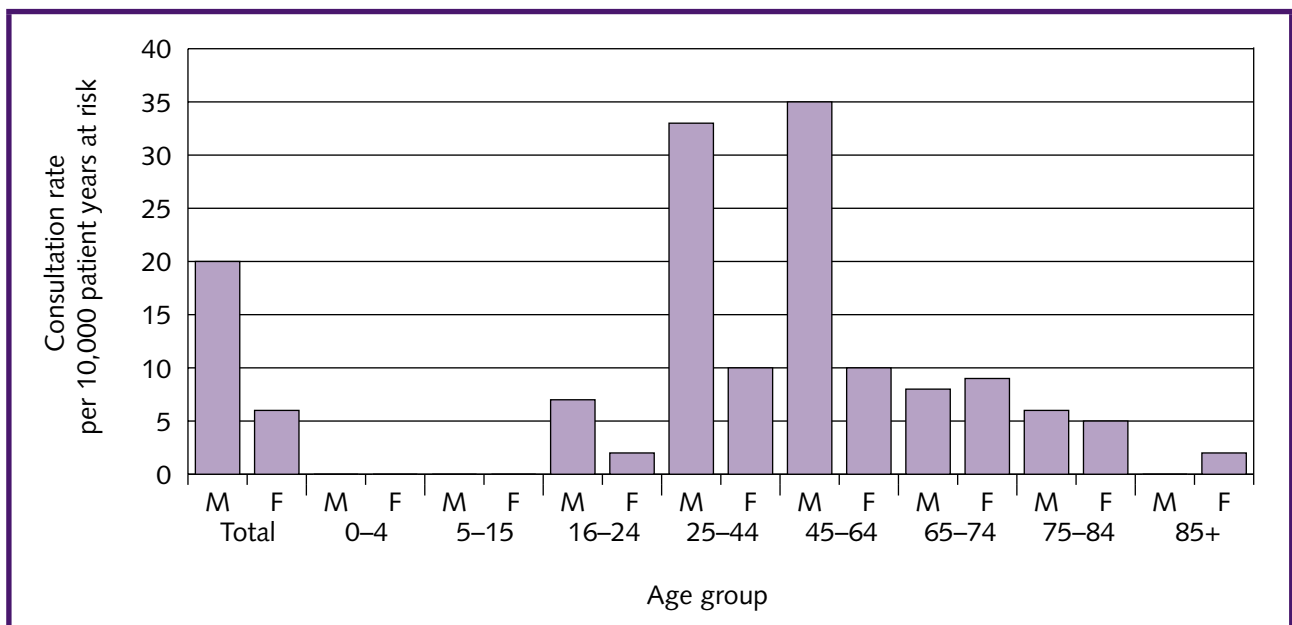
There is a marked gender difference in consulting rates for diseases associated with alcohol misuse. For example, men consult with alcohol dependence syndrome much more than women up to the age of 65

years; at older ages there is little difference in the consulting rates for men and women (Figure 6.1).

When the data are compared with GP consulting rates for problems related to alcohol misuse such as chronic liver disease and cirrhosis (DH, 2004a), there is a marked gender difference up to the age of 45, a much smaller difference in late middle age and very little apparent gender difference in old age (Figure 6.2).

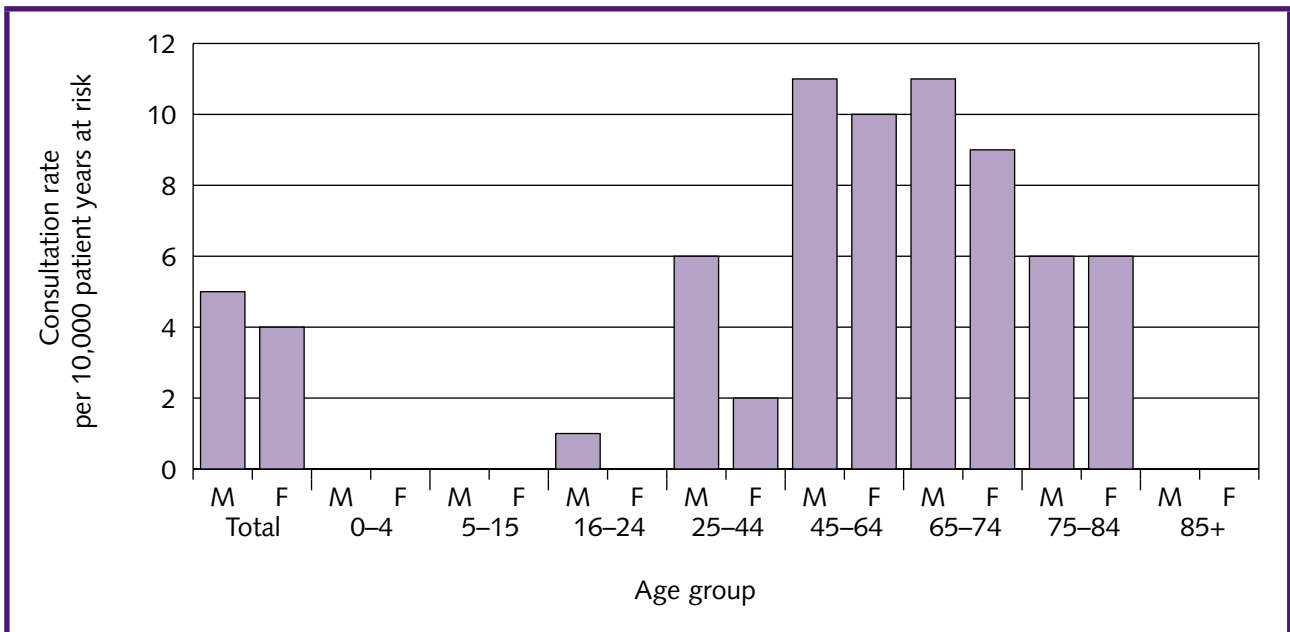
When consulting rates for alcohol dependence syndrome are compared with consulting rates for diseases related to alcohol misuse (Figure 6.3), both men and women show less diagnoses of diseases between the ages of 25 and 44. However at ages 45–64, different gender patterns emerge: women are diagnosed with alcohol misuse diseases at the same rate as consultations for alcohol dependence syndrome, while men are less likely to be diagnosed with alcohol-related diseases compared with consultations for alcohol

Figure 6.1: Consultations in general practice for alcohol dependence syndrome



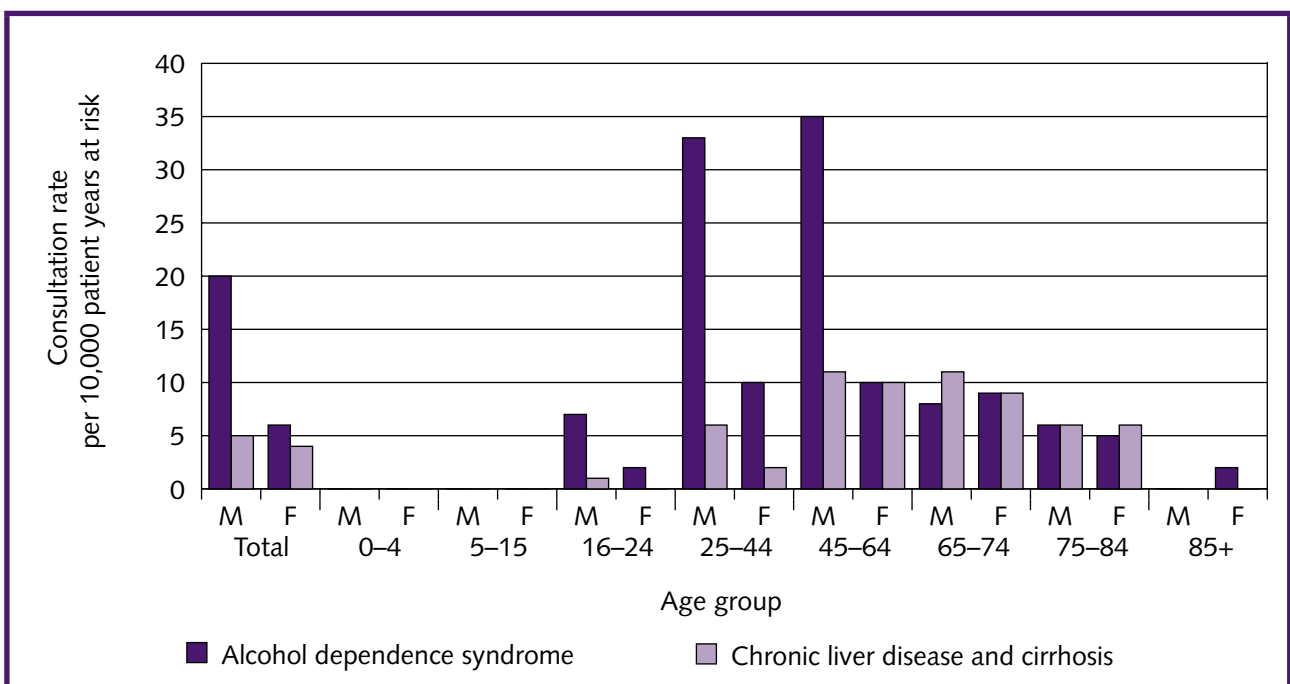
Source: McCormick et al. (1995)

Figure 6.2: Consultations in general practice for chronic liver disease and cirrhosis



Source: McCormick et al. (1995)

Figure 6.3: Consultations in general practice for alcohol dependence syndrome and liver disease, 1990-92



Source: McCormick et al. (1995)

misuse. It is not clear whether this is a result of biological differences in alcohol-related disease compared with alcohol misuse

behaviour, or of the under-diagnosis of men by GPs.



If these consultation rates are compared with behaviours related to drug dependency and non-dependent abuse of drugs (Figure 6.4), women over the age of 45 consult more often for drug dependency than men, with a particularly marked increase in women aged 65–74. Non-dependent abuse of drugs is higher for men, though overall rates are low.

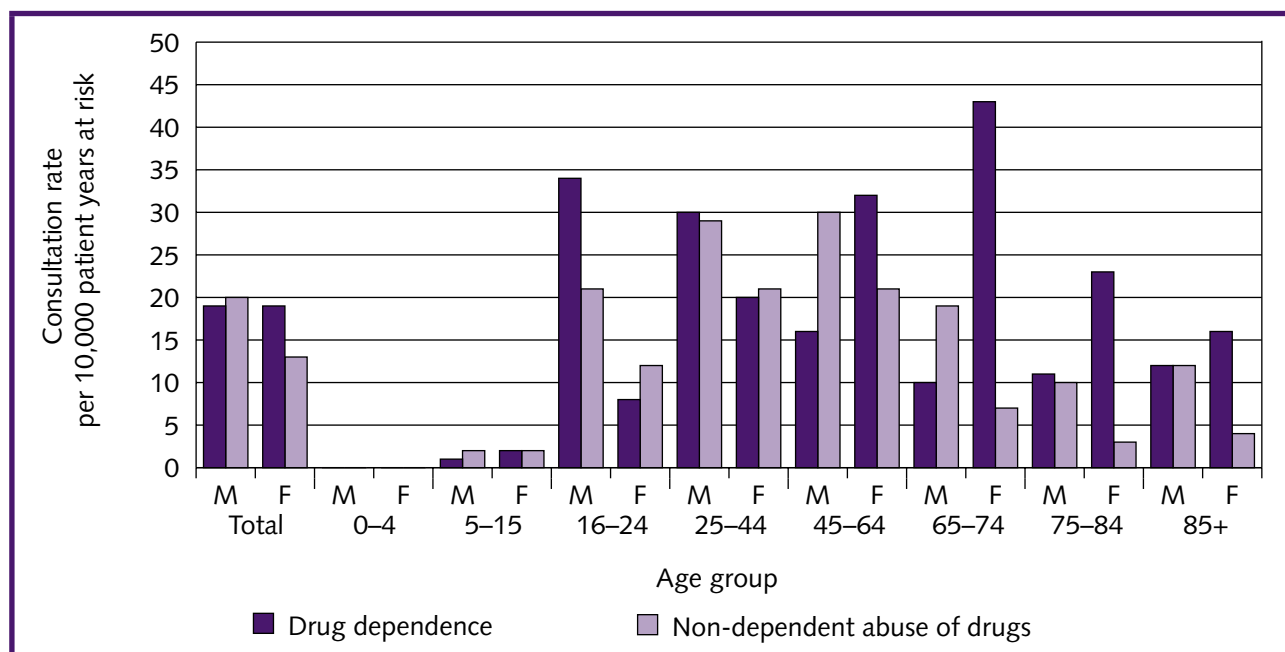
### 3. Factors associated with gender differences

One of the problems when looking at factors associated with alcohol misuse and gender difference is that there is no clear consensus about the amount of alcohol that men and women can consume before it causes health harm. While in Britain a hazardous drinker is defined as a man who drinks more than 21 units a week or a woman who drinks more than 14 units a week, the World Health Organization (WHO) International Guide for Monitoring Alcohol Consumption and Related Harm (WHO, 2000) set more generous drinking limits for men and women. For a man, fewer than 35 units per

week was considered low risk for chronic alcohol-related harm and 53 units was considered high risk. For a woman, fewer than 17.5 units was low risk and 36 units was high risk. A further complication is that different countries use different quantities of alcohol to define a unit (Norfolk, 2007). For example, in Britain a unit is 8 grams of ethanol, in America it is 14 grams and in Japan 19.75 grams. The picture becomes more complex still when some countries, including Britain, say women should drink less than men, while other countries such as Canada, the Netherlands and Spain make no distinction (Norfolk, 2007).

A UK survey carried out by Webster-Harrison and colleagues (2002) to assess knowledge about basic sensible drinking recommendations and to gauge the accuracy of the unit content of alcoholic drinks, found that a worrying number of people underestimate unit content. A total of 196 people aged 16 and over (49% men and 51% women) were asked if they knew the current recommendations for sensible

Figure 6.4: Consultations in general practice for drug use



Source: McCormick et al. (1995)

drinking, and whether they looked at the labels on alcohol containers to assess the percentage of alcohol by volume. As many as 46% did not know the sensible drinking guidelines, but among those who did, there was no significant gender difference. However, there was a gender difference in drink preferences, with men preferring bitter and lager and women preferring wine and spirits.

In spite of a lack of clarity about what constitutes harmful drinking, alcohol misuse policy and interventions in the UK use unit measures to record the differences in levels of alcohol consumption before health harm occurs in men and women. Research indicates that in women and men of the same height and weight, the effects of alcohol are different; alcohol makes women more vulnerable to organ damage, notably liver disease and brain damage (Blume, 1997; Lieber, 2001; Alcohol Concern, 2008). This difference has been attributed to women having a lower volume of body fluid in which to distribute alcohol, leading to higher blood alcohol concentrations in women than in men drinking similar amounts (Lieber, 2001). Also, women are affected more rapidly because they tend to have a slightly higher proportion of fat to lean muscle tissue, thus concentrating alcohol a little more easily in their lower percentage of body water. Women also have less of a gastric or stomach enzyme (dehydrogenase) that metabolises or breaks down alcohol before it enters the bloodstream (Frezza et al., 1990); hormonal changes during the menstrual cycle might also affect alcohol absorption (Blume, 1997).

In relation to heart disease and gender difference in alcohol consumption, a report by Tolstrup and colleagues (2006) found that among women alcohol intake may be the primary determinant of the inverse association between drinking alcohol and risk

of coronary heart disease, whereas among men drinking **frequency**, not alcohol intake, seems more important.

Alcohol excess is also linked to behavioural consequences such as impaired performance at work, higher incidence of unsafe sex, a disproportionate vulnerability to attack and increased mental and social problems (Alcohol Concern, 2007). Evidence suggests that male drinking is closely linked to male identity, particularly in regard to male risk-taking behaviour and a 'macho' identity. Social drinking is seen as a primary cultural symbol of 'manliness', and portrayals in the media strengthen this association (Lemle and Mishkind, 2002). A recent British study by de Visser and Smith (2007) showed that many men saw drinking as part of their identity and a means to display masculinity. Others have suggested that the biological basis for gendered patterns of alcohol consumption set the rules, but these may then become modified by social changes in gender roles (Wilsnack et al., 2000).

There is a strong association between heavy drinking, depression and suicide. Men who are chronic problem drinkers are more likely than women to attempt suicide: 39% of men compared with 8% of women (DH, 1995).

Another factor associated with gender difference is the response to women who are pregnant or wanting to conceive. The Government's guidelines state that women who do drink in pregnancy should limit themselves to 1 or 2 units once or twice a week, in order to protect the baby (HM Government, 2007a). Research indicates that the blood alcohol level rather than the dose is critical in determining the effects on the physical and mental development of the foetus (Guar et al., 1999).

## 4. Gender and help-seeking behaviour

This section explores the evidence relating to whether men and women have different help-seeking behaviours for alcohol misuse. It looks in particular at people seeking help for drinking problems, an example of a gender-sensitive self-help service and people seeking help through cognitive behavioural therapy offered by the NHS and in community organisations.

In a study based on data drawn from a survey of 12,167 18–64-year-olds in Wales (Moore et al., 1994) examined patterns of binge drinking among men and women using a self-completion questionnaire. It found that there was very little gender difference in seeking help with binge drinking, and although weekly binge drinkers recognised their drinking was harmful to their health, only 24% of men and 31% of women stated they would like to reduce their consumption. Weekly binge drinkers who had seen their GP in the previous 12 months were more likely to report receiving advice, although the majority (80% of men and 88% of women) had not been advised about alcohol reduction.

The UK component of *Gender, Alcohol and Culture: an international study* (GENACIS) (Institute for Medical Informatics, 2005) found that in a sample of 2,027 people aged 18 in England, Scotland and Wales, there was ambivalence about the adverse effects of alcohol. A small in-depth study of young men living in London found widespread ambivalence about excessive alcohol consumption (de Visser and Smith, 2007).

### Self-help

The best-known self-help organisation for alcohol problems is Alcoholics Anonymous (AA), an international organisation founded

in 1935 that now has over 2 million members worldwide.

Raistrick and colleagues (2006) recognised that it is difficult to conduct research within self-help organisations such as AA, mainly because of the anonymity upon which they insist and the consequent difficulty of identifying suitable comparison groups. Although it is widely acknowledged that AA has been enormously successful in reaching alcohol misusers around the world, there appears to be no data to suggest whether it is of more help to men or women, or whether there is no difference.

When seeking help for a problem that may be considered to be a result of a self-induced behaviour, the appeal of self-help on the internet is obvious because it allows privacy and flexibility of access. In a study of the website of a mutual aid group for people with an alcohol problem, 'Moderation Management', nearly half of those accessing the site were women (Humphreys and Klaw, 2001). This was seen as an important finding because women are considered more sensitive to the possible stigma of admitting alcohol misuse than men (Sanchez-Craig, Spivak and Davila, 1991).

Further insights into gender difference in help-seeking behaviour may be observed by studying a women-only self-help organisation operating in the US; Women for Sobriety (WFS) was founded primarily as a feminist alternative to AA. It was inspired by a perception of AA meetings as male-dominated and frequently chauvinistic in content. The emphasis in AA on powerlessness, a life-time dependence on the group and the reprocessing of past traumas was thought to be detrimental to women's best interests and counter-therapeutic. A postal survey of WFS members found that most women attending were middle class

and well-educated, a low proportion were atheists and a large number also continued to attend AA (Kaskutas, 1992). A further cross-sectional survey of WFS members, Kaskutas (1996a,b) reached the conclusions that the average member had been sober for 3.5 years, and that WFS involvement was associated with higher self-esteem, less negative thinking and better emotional adjustment. However, it was not possible to tell whether these gains were due to WFS as a women-only organisation, or to the high social stability and economic advantages of the typical member.

### **Cognitive behavioural therapy**

This section is included here as an example of help-seeking behaviour for alcohol misuse in accessing an intervention known as cognitive behavioural therapy (CBT). The treatment relies on service user choice, particularly regarding choice of abstinence or moderate drinking goals. In one study (Sanchez-Craig, 1990), all groups had markedly reduced consumption with female participants showing significantly better outcomes than males, particularly with regard to moderate drinking. These findings were broadly replicated in a later study by Sanchez-Craig, Spivak and Davila (1991). The authors suggest that female alcohol misusers may value the personal responsibility involved in self-initiated change and may be more motivated to change than men due to the greater stigma attached to problem drinking by women. Whatever the explanation of these findings, this kind of treatment seems especially suited to women with a mild or moderate level of alcohol dependence (Raistrick et al., 2006). However, it was noted that all service users in both the studies above were recruited via newspaper advertisements and may have been especially motivated to change.

## **5. Gender and experience of services**

This section reviews some of the literature on men's and women's experiences of using health services. In particular it focuses on the effectiveness of services in meeting the differing needs of men and women alcohol misusers. The focus is mainly on primary care services although when it is appropriate other services are mentioned. It is important to note that some of the literature describes single gender studies, that most only sample men or women and therefore do not offer the possibility of a gender comparison of services. Some studies included here were published more than 10 years ago, but they are included as they remain some of the best examples of gender and experience of services in alcohol misuse.

In 2004, the Alcohol Needs Assessment Research Project (ANARP) (Drummond et al., 2005) was commissioned by the Department of Health to measure the gap between the demand for and the provision of specialist alcohol treatment services in England. A gap analysis estimated that women were 1.7 times more likely to access treatment services than men, with access being defined as the number of individuals with alcohol dependence that access specialist alcohol treatment in a year. This is in inverse proportion to the prevalence of alcohol misuse. However, it is not clear whether this is due to better identification of women alcohol misusers by healthcare professionals, or that the services are designed in a way which is more suitable for women than men.

The Alcohol Use Disorders Identification Test (AUDIT) is a screening tool developed by WHO in 1989 and updated in 2001. It is intended as a simple method of screening for excessive drinking and to assist in brief assessment. A US investigation into the use of a screening tool in primary care

supported the consistency of the AUDIT tool in identifying both male and female patients who had alcohol misuse problems (Volk et al., 1997).

The most recent comprehensive review of treatment services for alcohol problems that considers a number of studies involving the use and design of services is the one commissioned by the National Treatment Agency (Raistrick et al., 2006). This was in response to both the *Alcohol Harm Reduction Strategy for England* (Cabinet Office, 2004) and the *Choosing Health* White Paper (DH, 2004b). These documents both expressed the need for better identification and treatment of alcohol problems. The evidence base informed the publication of *Models of Care for Alcohol Misusers* (MoCAM) (DH, 2006b), which provides guidance on the development of local systems to identify and intervene with alcohol misuse problems.

The authors of the review acknowledge that: 'everyone attending a treatment service has the right to expect that their culture, gender and practical needs will be sensitively accommodated in so far as this is reasonably possible' (Raistrick et al., 2006: 50). They explain that people's lives are too complex to align them with a single special population service, and that perverse inclusion and exclusion criteria can quickly appear and detract from the usefulness of a service.

There is evidence to support the fact that women have different alcohol-using patterns to men in that they generally start drinking later and appear to respond better to treatment (Raistrick et al., 2006). Women with alcohol problems are also more likely to have higher rates of physical and psychiatric co-morbidity, which may complicate treatment (Davis et al., 2002). In an eight-year follow-up, Timko and colleagues

(2002) found outcomes for women were somewhat better than for men using the same services. Jarvis (1992) concluded there are only small differences across a variety of services in the effectiveness of treatment for women compared with men but, notably, women are likely to do less well in mixed-sex group therapy. Furthermore, women who have been abused tend to prefer a female therapist but women who have not identified themselves as having experienced violence from men do equally well with male or female therapists (Connors et al., 1992).

### **Brief interventions**

This section considers the gender differences for people accessing brief intervention services and is the area where there is considerable evidence about experiences of services. However, the evidence on the differential effectiveness of this approach for men and women is unclear and often contradictory, although more recent studies tend to suggest that they are probably less effective in changing behaviour in women.

Brief interventions are practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it (WHO, 2001). They are carried out in general community settings and are delivered by non-specialist personnel such as general medical practitioners and other primary healthcare staff. They are directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem and may be identified by opportunistic screening or some other identification process. For this reason, brief interventions are sometimes called 'opportunistic interventions' (Raistrick et al., 2006).

An early WHO Collaborative Study (Babor and Grant, 1992) researching male responses to a brief intervention found that

simple advice worked better for men who recognised they had a recent alcohol-related problem, while extended brief interventions worked better for men who had not had a recent problem. In another male-specific study (Longabaugh et al., 2001), heavy-drinking men of all ages showed that a brief intervention with a booster session 7 to 10 days after the initial session was more effective in reducing alcohol-related negative consequences than a stand-alone brief intervention.

A gender-specific study in the US (Chang et al., 1999) assessed the impact of brief interventions on alcohol consumption among pregnant women receiving antenatal care. Both intervention and assessment-only control participants had reduced consumption at follow-up, and there were no significant differences between groups. The authors commented that, considering the importance of reducing excessive alcohol consumption among pregnant women, more studies of intervention in this context were warranted.

Ballesteros and colleagues (2004) explored gender difference in their meta-analysis of studies of effectiveness of brief interventions. Although previous research had indicated that brief interventions may be less effective among women than men (Scott and Anderson, 1991; Anderson and Scott, 1992), they found no evidence of any difference in response between genders.

A more recent review (Bertholet et al., 2005) concluded that brief interventions are effective in reducing alcohol consumption among both men and women at 6 and 12 months following intervention. The authors suggested that because it excluded studies that used patient lists, registers or specially arranged screening sessions, it was more relevant to the conditions of general practice

than other reviews. A randomised controlled trial assessing brief interventions in general practice and primary care (Kaner et al., 2007) found a marked gender difference in effect; the intervention was effective in men after one year but unproven in women. Longer duration of counselling had little additional effect in both genders.

Researchers in Denmark looked at routine alcohol screening and brief counselling intervention in primary care, using a random control methodology (Beich et al., 2007). Thirty-nine Danish GPs were involved and outcome measures focused on patients' acceptance of screening and intervention, and their self-reported alcohol consumption. After one-year follow-up, there was a reduction in male binge drinking, but adverse intervention effects for women, leading the authors to conclude that women may be more defensive of their drinking behaviour than men.

Reinhardt and colleagues (2008) analysed gender difference in the efficacy of stepped care brief interventions for general practice patients with alcohol problems through a randomised control trial with follow-up a year later. The team concluded that in a heterogeneous sample, the intervention was only effective in women.

### **Brief interventions in accident and emergency departments**

This section looks at some of the evidence on delivering brief interventions in accident and emergency (A&E) departments rather than primary care, because men in particular with alcohol misuse problems often present at hospitals. The *Alcohol Harm Reduction Strategy for England* (Cabinet Office Strategy Unit, 2004) estimated that 40% of all A&E admissions are related to alcohol, rising to 70% at peak times. It is believed that alcohol

misuse is a major risk factor for nearly all kinds of injury (Gentilello et al., 1999).

American research in Seattle (Gentilello et al., 1999) reported that a brief intervention delivered mainly to male patients in a trauma centre was more effective in reducing both alcohol consumption and injuries requiring admission to an emergency department or a trauma centre. Reductions were most apparent among those with mild to moderate alcohol problems.

A randomised control trial (Smith et al., 2003) evaluated the effectiveness of a brief intervention on drinking and alcohol problems among young men with alcohol-related face injuries. Although this was a single-sex study it is included as an example of a gender-sensitive service because it demonstrates an intervention that was linked to gender-specific behaviour. The study took place in an oral and maxillofacial outpatient surgery, as against an A&E department, where young men had been referred from the A&E department within 10 days of initial presentation. At one-year follow-up, there was a significantly greater reduction in alcohol consumption and alcohol-related problems in the intervention group compared with controls, and a lower percentage of participants classified as hazardous drinkers from the AUDIT questionnaire. The authors concluded that: 'A proportion of young men change their alcohol consumption following alcohol-related injury. A nurse-led psychological intervention adds significantly to the proportion and magnitude of the response' (Smith et al., 2003: 43). This study is of particular interest because heavy-drinking young men are less likely to attend primary healthcare services and may be more efficiently detected in A&E and related hospital services.

Other studies on internet-based interactive interventions for the promotion of sensible drinking (Linke et al., 2007) and opportunistic screening for alcohol misusing patients in an emergency department (Crawford et al., 2004) did not analyse gender difference.

## 6. Gender and current policy

There has been a commitment from Government since 1999 to consider the harmful effects of alcohol misuse on health and society. The White Paper, *Saving Lives: Our healthier nation* (DH, 1999a) stated that the Government would produce a National Alcohol Harm Reduction Strategy, and in 2000, the NHS Plan (DH, 2000) reinforced this commitment.

In 2004, the *Alcohol Harm Reduction Strategy for England* (Cabinet Office Strategy Unit, 2004) set out a cross-government approach for tackling the harms and costs of alcohol misuse. It includes alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace and problems in family life. The Department of Health has responsibility for all policy addressing alcohol misuse that affects health.

The publication of the Alcohol Strategy gave the National Treatment Agency for Substance Misuse (NTA) a remit to develop models of care for alcohol treatment (MoCAM) (DH, 2006b). The document is intended to provide best practice guidance for local health organisations in delivering a planned and integrated local system. The NTA has also developed standards, criteria and inspection procedures that are consistent with other NHS arrangements in collaboration with the Healthcare Commission. This work builds on the *Models of care for treatment of adult drug misusers* (NTA, 2002), which

the Agency says contains many points and principles that apply equally to both alcohol and other drug treatment.

Alcohol misuse has now become a key focus of public health policy in England. *Choosing Health: Making healthier choices easier* (DH, 2004b) gave a number of commitments to reduce harm caused by alcohol, including piloting approaches to targeted screening and brief intervention in primary care and hospital settings, and publishing audits of the demand for, and provision of, alcohol treatments.

In 2007, the Department of Health and the Home Office jointly produced a review of the progress of the Alcohol Strategy called *Safe. Sensible. Social* (DH, 2007c) which set out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause. The review promotes local alcohol strategies, and suggests links to local area agreements. It also announced a public information campaign to promote a new 'sensible drinking' culture. The Know Your Limits campaign, the biggest alcohol awareness campaign to date in England, was launched in May 2008 with the aim of ensuring that everyone has the information they need to estimate how much they actually drink.

The most significant policy development since then has been the first Public Service Agreement (PSA 28) for reducing alcohol and drugs misuse announced as part of the 2007 Comprehensive Spending Review (HM Treasury, 2007). This became operational in April 2008.

A review of the PSA and other alcohol policies shows there are no gender-specific measures or incentives to encourage local services to take a more gender-sensitive approach to service design and

implementation. This is surprising given the different biological responses of women and men to alcohol, and the differences in the effectiveness of treatments shown in the literature. It is also surprising given all the research suggesting that drinking behaviours are culturally important as an expression of gender.

The approach to gender difference in alcohol policy has tended to focus on the differences in health harm and the differing recommended alcohol levels for men and women. Women who are pregnant or wishing to conceive have been particularly highlighted in recent tools to support the alcohol strategy. In the Alcohol Strategy Local Implementation Kit (HM Government, 2008) there are examples of interventions to tackle sexual violence and harassment. However, a section on improving provisions by assessing the needs of, and developing appropriate services for, diverse groups lists older people, black and minority ethnic communities, homeless, gay, lesbian, bisexual and transgender, but does not include gender. We would argue that services have to be designed differently to appropriately meet the needs of men and women.

## 7. Key messages

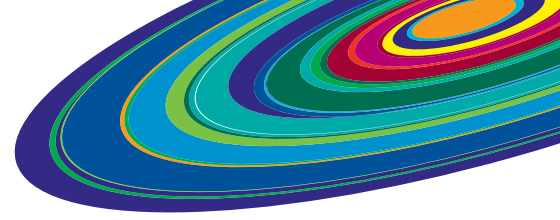
- The number of units of alcohol consumed is the most widely recognised way of measuring levels of alcohol misuse and the links to health harm, although there is no international consensus as to what constitutes safe levels for men and women – furthermore some countries specify different thresholds for harmful levels of drinking while in others there is no gender differentiation.



- Binge drinking has become an increased focus for alcohol misuse policy and research, although more gender-sensitive research is needed to understand what constitutes harmful drinking.
  - Between 1998 and 2001 there has been a greater increase in the number of young women defined as binge drinkers than young men, reflecting widespread concerns about a gender convergence in potentially problematic drinking.
  - There is a gender difference in the way alcohol misuse behaviour is perceived; in men it is often linked to risk-taking and 'macho' behaviour, while for women, alcohol misuse is seen to result in an increased vulnerability to abuse.
  - There is some evidence that women feel more stigmatised over alcohol misuse than men and this may affect the way they respond to services.
  - Alcohol dependence is more prevalent in England than problem drug use.
  - More men are thought to have an alcohol abuse disorder than women: 38% compared with 16%.
  - Conversely, women are more likely to access some treatment services than men.
  - Among chronic problem drinkers, men are more likely than women to attempt suicide (39% compared with 8%).
  - GPs identify more men than women with alcohol dependence syndrome up to the age of 65 years; thereafter there is little gender difference.
  - Brief interventions are considered an effective way to treat people with alcohol misuse disorders, but the evidence is contradictory as to whether it is equally effective for men and women.
  - The first Public Service Agreement (PSA 28) for reducing alcohol and drugs misuse came into operation in April 2008.
  - Alcohol misuse policy lacks a gender-sensitive approach in spite of gender differences in alcohol use in relation to both behaviour and biology.
  - There are no gender-specific measures or incentives to encourage local services to develop a more gender-sensitive approach to service design and implementation.
- ## 8. Recommendations
1. There is a need for gender-sensitive research into a number of aspects of alcohol misuse. The most important are as follows:
    - To study the effectiveness of brief interventions on men and women with alcohol misuse disorders, and why they may respond differently.
    - To understand what works in promoting sensible drinking in men and women.
    - To understand the differences in health professionals' attitudes to men and women drinkers and how this affects people's access to preventative and treatment services.
    - To understand how gender differences in drinking behaviours can lead to heart disease.
  2. Policy guidance should be produced which promotes a gender-sensitive approach to the development of local alcohol strategies as well as alcohol prevention and treatment services. In particular, the commitment in the updated Alcohol Strategy to establish a framework to support commissioners in

planning local investment by December 2008 would be greatly strengthened if it demonstrated a gender-sensitive approach.

3. Additional guidance on the production of Joint Strategic Needs Assessments (JSNAs) for local health economies should include a gender breakdown in assessing the needs of men and women who misuse alcohol. The JSNA therefore would allow preventive and treatment services to be commissioned that are designed to meet the different health outcomes of men and women who misuse alcohol. Similarly, Crime and Disorder Reduction Partnerships, which are to have an alcohol harm reduction strand as part of crime reduction strategies, should take a gender-sensitive approach.



# Chapter 7: Cancer prevention, diagnosis, treatment and survival

## 1. Introduction and definitions

Cancer is a group of illnesses characterised by abnormal cell growth and is one of the largest causes of mortality across the globe. It is estimated that there were some 7 million deaths to cancer worldwide in 2004 and by 2015 this could reach 83.2 million, making cancer an international disease control priority. In the UK, about one in four deaths is due to cancer (Cancer Research UK (CRUK), 2008e) and cancer accounts for 6% (over £1 billion) of all NHS expenditure (Quinn et al., 2001). Consequently, it is little surprise that reducing cancer was a target in the 1992 White Paper *The Health of the Nation* (DH, 1992), and has remained a key priority ever since. As is noted in *Choosing Health* (DH, 2004b), the UK has seen a change from acute illnesses that occur quickly and may last a short period to chronic health problems that take longer to become evident, have a greater duration, and may recur. As short-term illnesses have increasingly been controlled, the incidence of cancer has inevitably increased.

When cancer is identified at an early stage, treatment appears to be much more effective. This means that primary care has a crucial role in helping to ensure that cancer is appropriately and promptly diagnosed – although it does not mean that detection of disease is the only important role for primary care in relation to cancer. Primary care also has a role in prevention, screening, co-ordination of care between different specialties, managing the side effects of treatment, and palliative care.

Detecting cancer is not always straightforward because key symptoms for particular cancers may be equally indicative of other health problems. For example, the UK referral guidelines for suspected lung cancer (National Collaborating Centre for Primary Care, 2005) identify an unexplained or persistent cough as a symptom warranting further investigation with a chest X-ray – but a cough is usually relatively harmless. Indeed, health professionals may find it difficult to recognise when cancer should be an important consideration. For example, Hornung (2007) conducted a study in the US where a woman with a higher likelihood of skin cancer needed a physical examination for a job that would expose her skin to further risk and found that GPs took little, if any, time to discuss measures that could help protect her skin from cancer. Contemporary symptom profiles, however, may have little relevance for primary care where health professionals may see less than 10 cases of cancer each year. Summerton (2007) has pointed out that much of the evidence identifying symptoms is taken from patients seen by specialists, which may not be representative of the variety of health problems encountered in primary care. In addition, Hamilton and Sharp (2004) found little evidence from primary care studies to support referral guidelines for lung cancer. Importantly, there is some evidence that those who use their primary care practice more frequently may be more likely to take up opportunities to discuss, and screen for, the possibility of cancer (Lemon et al., 2008; Patel et al., 2004; Zimmerman et al., 2006).

Gender is an important consideration for primary care professionals working with cancer because it can have implications for prevention, diagnosis and treatment. This does not mean that gender is the only consideration. Indeed, other group differences, such as class and ethnicity, may also be relevant for the work of primary care when managing cancer. Nevertheless, if there are aspects of gender that affect the detection and management of cancer, then it is crucial to attempt to understand them. Some may argue that healthcare professionals work with individuals and that consequently group differences are irrelevant. There are, however, important differences between women and men in the incidence and mortality of different cancers, and these reflect both sex and gender differences. Sex-related factors influence vulnerability to a number of cancers beyond the obvious cancers of the reproductive system. Social processes also affect the body, such as by increasing the risk of exposure to carcinogenic agents, and these processes are likely to be gendered through, for example, differences in occupation, lifestyle and health-related behaviours. These variations between men and women are important in the development of public health strategies, as well as in the detection and management of cancer in primary care and in specialist services.

This chapter will review the evidence and policy relating to gender differences in the use and provision of primary care services for cancer. CRUK (2008a) reports that there are over 200 types of cancer and the amount of detail required to consider all of them could leave the main messages hidden. Instead, this chapter will consider information on cancer in general and will provide some depth by examining three of the most common cancers. Excluding some cancers

will help us to examine the gendered aspects of primary cancer care. Non-melanoma skin cancer, for example, is particularly common, not serious and is, therefore, generally excluded from cancer data (CRUK, 2008e). Cancers that occur in only one sex, such as cancer of the prostate in men and the ovary in women, cause considerable morbidity and mortality but including these would make it more difficult to differentiate aspects of gender from biology. Finally, although breast cancer occurs in both sexes, the rate is overwhelmingly higher in women to the point that breast cancer is most usefully regarded for present purposes as sex-specific.

From CRUK statistics (2008a), the three cancers most commonly diagnosed during 2004 within our criteria are lung, colorectal and bladder cancer. These cancers will be examined in more detail in this chapter.

## 2. Statistical information and epidemiology

### Incidence/prevalence

Overall in the UK, cancer incidence and mortality are both consistently higher in men than in women (CRUK, 2008b). Over the last 30 years there has been an upward trend in incidence with little change in the last 10 years. This increase has been greatest in women (32%) compared with men (15%). In contrast, there has been a downward trend in mortality, with the greatest decrease seen in men (24%) compared with women (12%). In 2004 there were over 180,000 new cancer cases in men and over 174,000 new cases among women, the rate per 100,000 population being 490 for men and 400 for women (CRUK, 2008e; 2008a). In 2005 there were 80,000 (216 per 100,000) male and 74,000 (156 per 100,000) female deaths due to cancer. In a more detailed examination of morbidity and mortality

statistics for England and Wales in 2004, White (in press) found a female-to-male ratio of 1:1.10 for cancer diagnoses and 1:1.14 for cancer mortality. When breast and sex-specific cancers were excluded, the ratio was 1:1.34 for diagnoses and 1:1.37 for mortality.

### **Lung cancer**

There has been a gradual decrease in lung cancer over the last 30 years but larger decreases for men mask increases for women. More recently, incidence and mortality have continued to decline in men but appear to be remaining relatively constant in women. From 1995 to 2004, there was a 23% reduction in lung cancer incidence in men, little change in women, and an overall decrease of 16% (CRUK, 2008f). Despite the trend for increasing incidence in women, numerically and proportionately many more men are affected by lung cancer. In 2004 there were 22,495 new cases in men and 15,818 among women, with rates of 62.8 and 35.9 per 100,000 population respectively (CRUK, 2008e; 2008a). In 2005 there were 19,457 lung cancer deaths in men (52.6 per 100,000) and 14,008 (30.2 per 100,000) in women. Across England and Wales there was a 1:1.52 female-to-male ratio for incidence and a 1:1.53 ratio for mortality during 2004, and the estimated total number of years of life lost (in thousands) was 216 for men and 145 for women (White, in press).

### **Colorectal cancer**

Colorectal cancer occurs in the large bowel and includes neoplasms of the anus, colon and rectum. The last 30 to 40 years has seen a steady increase in colorectal cancer, while mortality has decreased (Quinn et al., 2001). The rise in incidence has been mainly in men, while incidence has remained relatively stable in women. In 2004 there were 19,675 (55.3

per 100,000) and 16,452 (35.5 per 100,000) cases of colorectal cancer in men and women respectively (CRUK, 2008e; 2008a). In 2005 there were 8,637 (23.3 per 100,000) male and 7,455 (14.3 per 100,000) female deaths due to colorectal cancer. In England and Wales the female-to-male ratio was 1:1.25 for incidence and 1:1.20 for mortality during 2004. The estimated total number of years of life lost (in thousands) was 93 for men and 63 for women (White, in press).

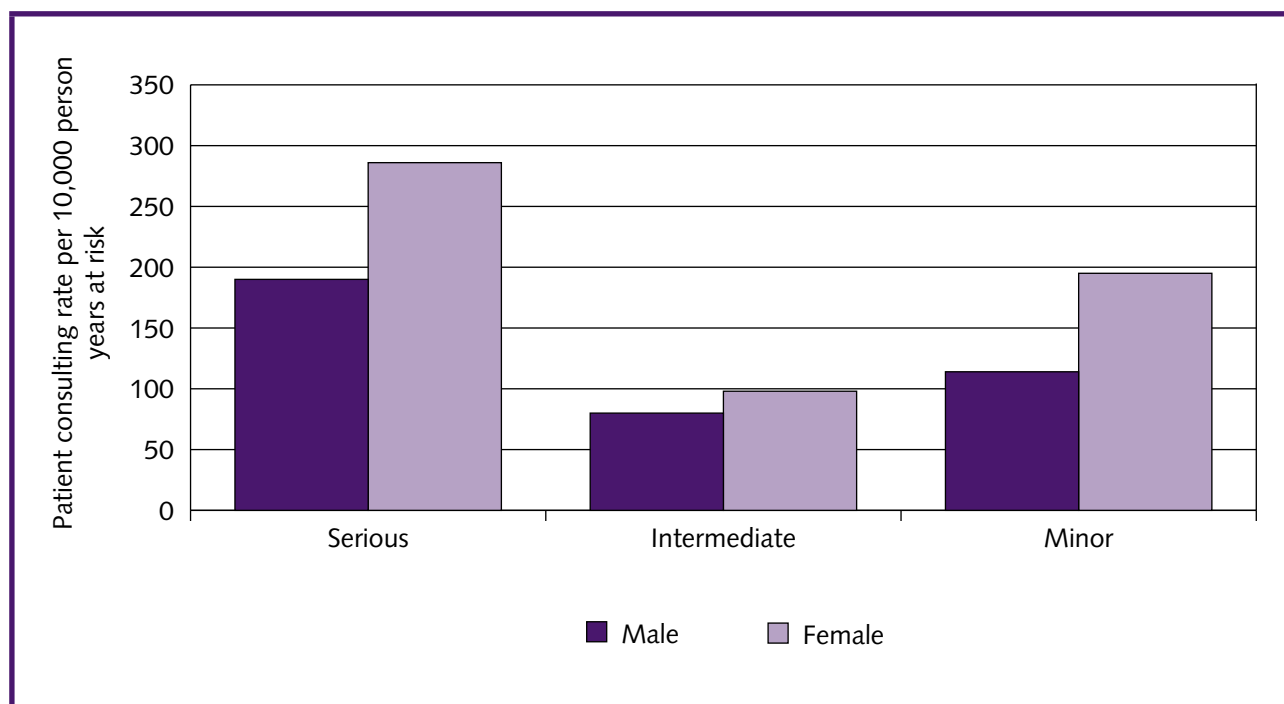
### **Bladder cancer**

More men are diagnosed with, and die from, bladder cancer than women, although morbidity and mortality are declining in men but not in women (CRUK, 2008c; 2008d). It is difficult to examine trends in the morbidity and mortality of bladder cancer because classification practices have changed. In 2004 there were 7,168 (19.5 per 100,000) cases of bladder cancer in men and 2,925 (4.7 per 100,000) in women (CRUK, 2008a; 2008b). CRUK information also shows that in 2005 there were 3,103 (8.1) male and 1,631 (2.8) female deaths due to bladder cancer. Also, there was a 1:2.60 female-to-male ratio for incidence and a 1:2.02 ratio for mortality, and the estimated total number of years of life lost (in thousands) was 25 for men and 10 for women across England and Wales during 2004.

### **Consultation rates and use of services**

Information on the number of consultations for cancer in primary care adds to data on the incidence and prevalence of cancer by allowing us to explore how healthcare services are used by men and women in relation to symptoms of cancer. Data on all neoplasms provide a useful overview and the most recent source is an analysis of the General Practice Research Database (GPRD) from 1991/92 (McCormick et al., 1995). Figure 7.1 shows consultation rates

Figure 7.1: Consultations in primary care for all neoplasms by level of severity



Source: McCormick et al. (1995)

per 10,000 person years at risk according to severity. Women have the highest consulting rate for all categories of severity, with more women consulting in each category. Overall figures that exclude sex-specific and breast cancer are not provided and it may be that the greater rates of consultation in women are for these cancers.

Neoplasms may be either benign or metastatic (cancerous). The word 'cancer' is generally used to indicate the latter. Many people would exclude benign neoplasms when considering cancer but these can still be dangerous and may eventually become malignant. The information on consultation rates does not specify the severity of each neoplasm but it is likely that benign neoplasms are classified as 'minor'. Looking at each cancer individually, the highest consultation rate from the 1991/92 data is for benign neoplasms, with a rate of 159 per 10,000 person years for women and 91 per 10,000 for men. This contrasts

with epidemiological statistics showing greater cancer morbidity and mortality in men. Women may be more susceptible, although it is also possible that women are better at recognising potential symptoms of benign neoplasms as something that can be discussed in primary care. Unfortunately, cancer statistics on incidence and mortality (discussed in the section above) often exclude benign neoplasms so it is difficult to relate the number of consultations to data on prevalence.

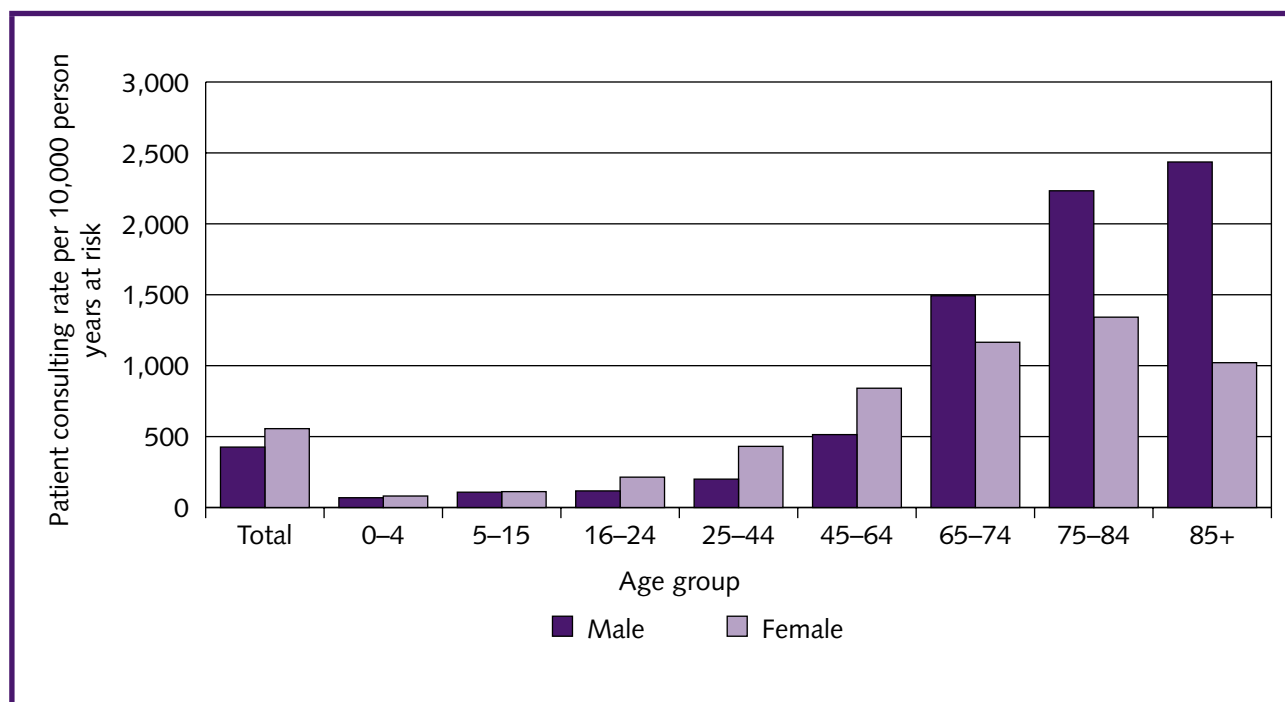
The consultation from the 1991/92 GPRD data can also be separated by age to look at consultation rates across the lifespan for all neoplasms (where serious, intermediate and minor neoplasms are combined), which is shown in Figure 7.2. At almost 500 per 10,000 person years, consultation rates across the lifespan look very high, but many illness classification groups have higher rates (for example, consultation rates for diseases of the respiratory system are 1,538 for men and 1,919 for women). Consultation rates for cancer increase with age, with more women than men consulting between 16 and 64 years while more men than women consult from 65 onwards. This pattern is the same when looking at severity, where consultation rates are higher for women until the age of 75, when there are more men consulting for serious and intermediate cancers, and after 85, when more men consult at all categories of severity.

Looking at cancers individually reveals much lower consultation rates, so it is important to consider the differences between cancers. When compared with all neoplasms, lung, colorectal and bladder cancer consultation rates are less than 10 per 10,000, start occurring in the 45–64 age group, and increase with age. Each is considered in more detail below.

### Lung cancer

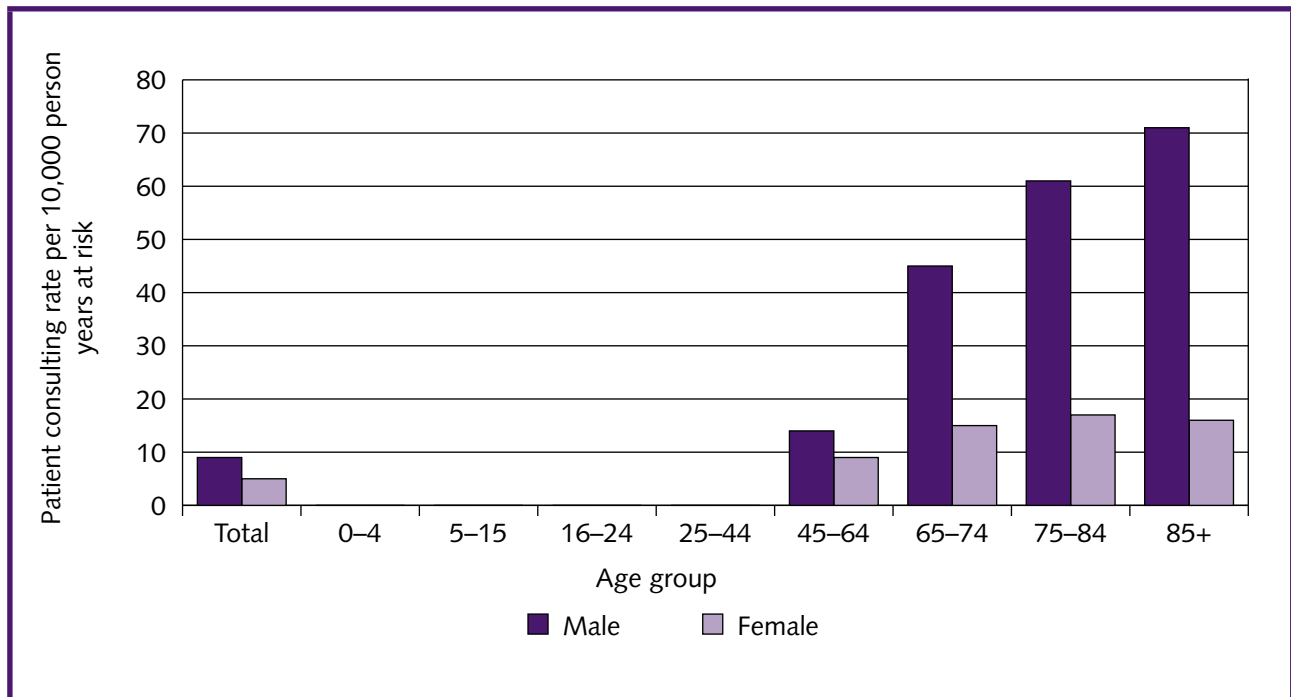
Data for consultations in relation to lung cancer shown in Figure 7.3 also include cancer of the trachea and bronchus. Compared with overall figures, lung cancer has a much lower consultation rate. Below the age of 44 there were too few consultations to be able to calculate a figure. Cancer of the lung shows a slight increase in consultation rates for women as they age, while there are large increases for men at every succeeding age group. This is consistent with epidemiological trends for

Figure 7.2: Consultations for all neoplasms by age



Source: McCormick et al. (1995)

Figure 7.3: Consultations for neoplasm of the trachea, bronchus and lung by age



Source: McCormick et al. (1995)

lung cancer in the UK and reflects gender differences in smoking in the past.

### Colorectal cancer

Data for colorectal cancer include consultations for neoplasm of the colon (see Figure 7.4) and neoplasms of the rectum, rectosigmoid junction and anus (see Figure 7.5). Colon cancer has the same overall rate for men and women and begins to increase from the age of 45. Men have slightly more consultations in the 45–64 age group and their consultations increase until 85 years, when the number of consultations dips. Consultation rates for women also start at 45–64 and rise until 85 and over, at which point the rate is greater than for men. Consultations start in the same age group for rectum, rectosigmoid junction and anus cancer although the rate of increase is lower for women. The gender differences observed in consultations are narrower than prevalence data and highlight an important disparity between morbidity

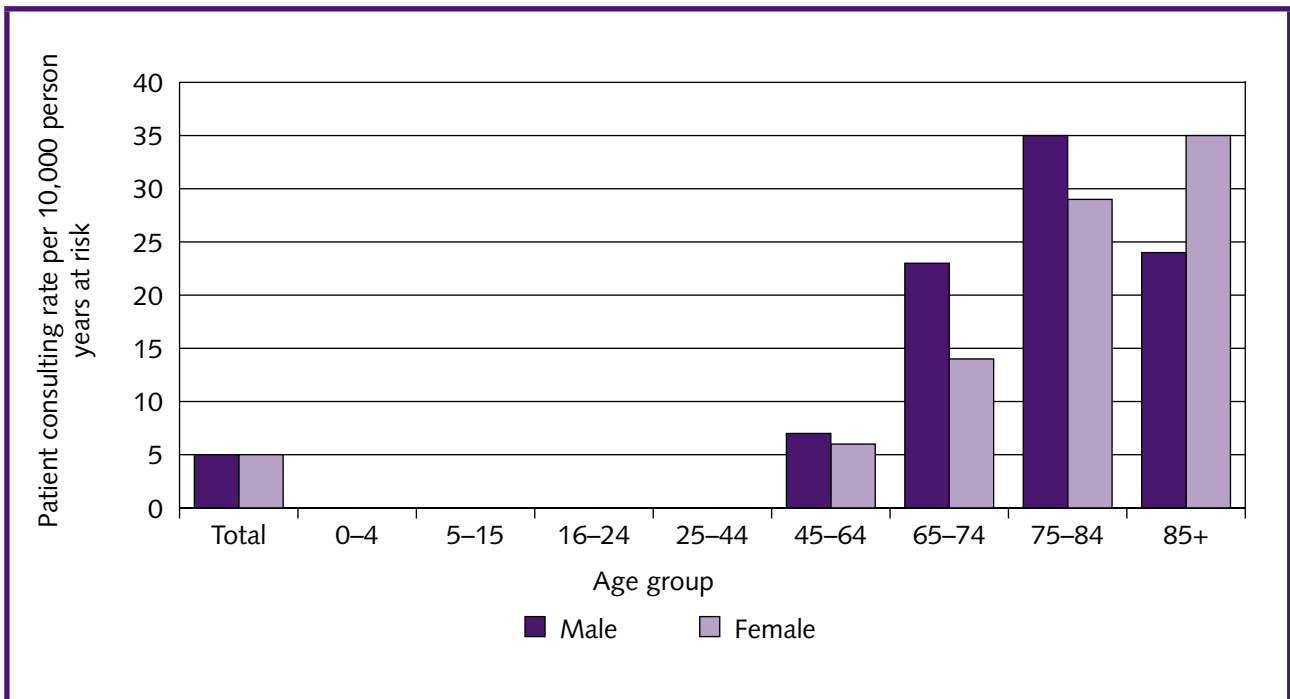
and mortality data and how primary care services are used. It is possible that men with colorectal cancer have fewer primary care consultations regarding their cancer than women and this might, for example, reflect poorer identification of symptoms. In relation to this, Patel et al. (2004) found that discussions regarding screening for colorectal cancer were most likely to occur during preventive care visits. Also, Zimmerman et al. (2006) found that colorectal cancer screening uptake was positively related to the number of primary care visits, and Lemon et al. (2008) found that this was particularly important among men.

### Bladder cancer

Consultations for bladder cancer, like lung and colorectal cancer, do not occur frequently enough to calculate a rate until the 45–64 age group (see Figure 7.6). More men consult in all age groups, with large increases as they age. The consultation rates for women show a similar pattern

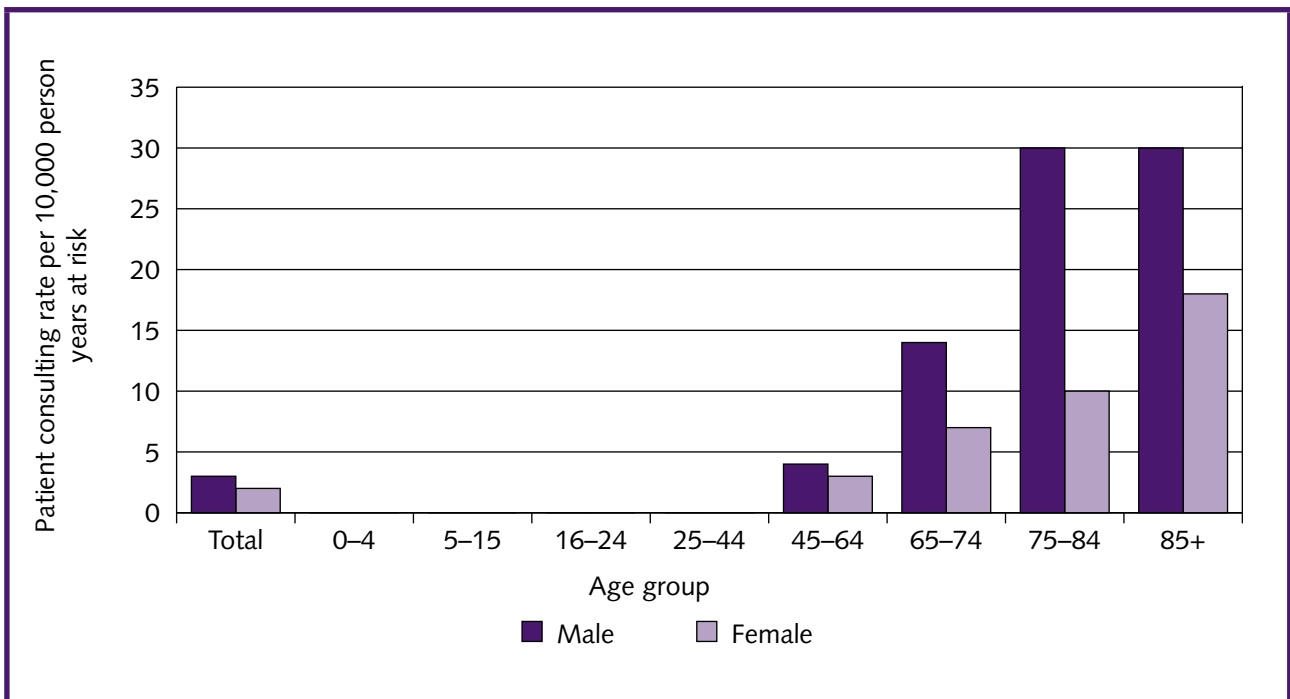


Figure 7.4: Consultations for malignant neoplasm of the colon



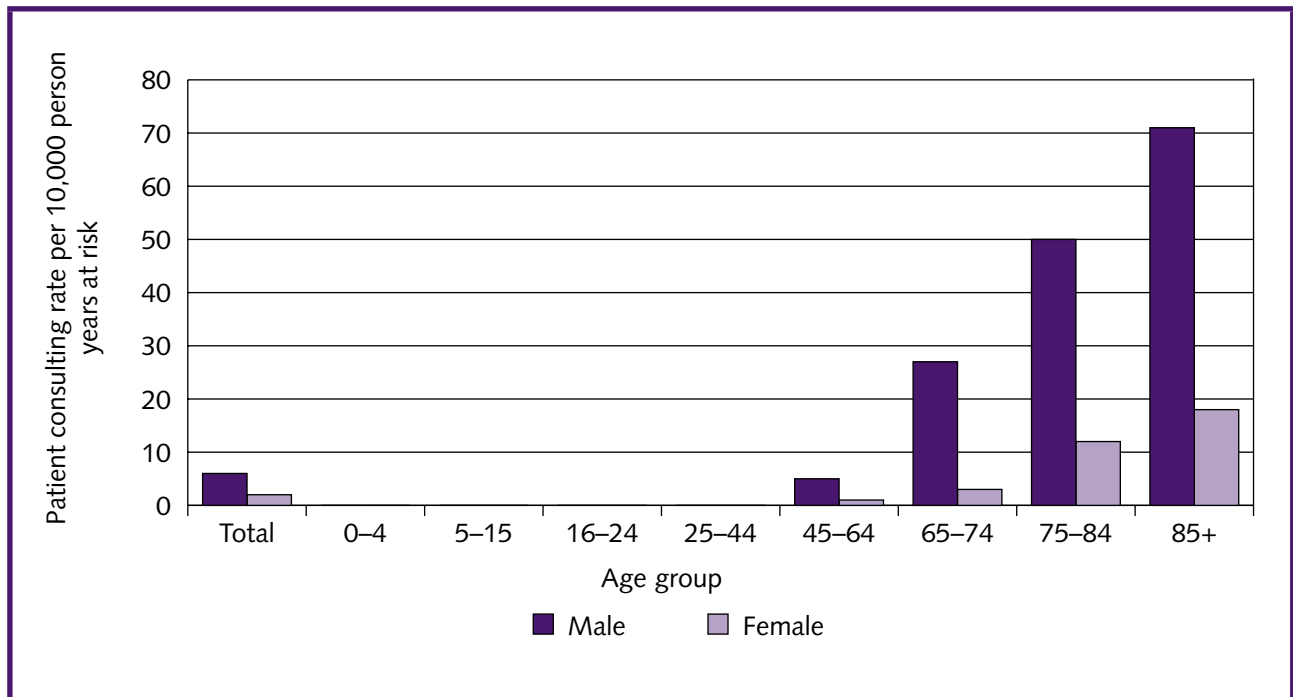
Source: McCormick et al. (1995)

Figure 7.5: Consultations for malignant neoplasms of the rectum, rectosigmoid junction and anus



Source: McCormick et al. (1995)

Figure 7.6: Consultations for malignant neoplasm of the bladder



Source: McCormick et al. (1995)

but rates are lower. As with lung cancer, these consultation rates are consistent with epidemiological findings in the UK.

### 3. Factors associated with gender differences

Social processes put people in contact with agents that cause the cell damage underlying cancer. This means that it may be possible to reduce the incidence of cancer and improve survival by changing factors external to an individual (there is an unhelpful tendency to term these 'lifestyle choices' as if they are solely the responsibility of the individual concerned). Martin-Moreno et al. (in press) reviewed research on the causes of cancer to examine the proportion of cancer that is attributable to 'avoidable factors'. There was evidence available for eight factors but only three were relevant for both men and women: tobacco use causes 29–38% of cases in men and 2–10% in women; alcohol causes 5–9% in men and 2–4% in

women; and being overweight causes 3% in men and 6% in women. The other factors appeared to be important only for men. This could suggest female-specific biological and social processes that are protective against cancer and/or male-specific processes that are deleterious, or that too few women were included in the research. These avoidable factors were: inadequate physical activity (causing 2% of cases in men); poor diet (30%); low intake of fruit and vegetables (5–12%); infection (8%); and sunlight and environmental exposure (5%).

#### Lung cancer

Tobacco use (including smoking) is one of the main avoidable causes of lung cancer and may provide the best explanation for morbidity and mortality trends. In particular, Payne (2001b) reviewed research on gender and lung cancer and pointed out that men have given up using tobacco faster than women, which may be why the incidence of lung cancer in men is declining while

there is little change for women. Bray et al. (1995) estimate that 86% and 49% of lung cancer in men and women are attributable to tobacco use, which may mean that men and women use, and/or are affected by using, tobacco differently. Payne also noted that rates of lung cancer are higher among non-smoking women than non-smoking men and that women suffer greater ill effects from the same dose of tobacco than men do, which emphasises that men and women are affected by tobacco use differently. In particular, biological factors, particularly related to gene expression, may make women more vulnerable.

### **Colorectal cancer**

Colorectal cancer has a number of causes that are avoidable, including obesity, unhealthy diets, too little exercise and tobacco use. Reviewing the research, Payne (2007) found that obese men seemed to have a greater risk than obese women and that women tended to have healthier diets. Also, men seemed to benefit most from physical activity but the research neglected activities that women do more often, such as unpaid caring work.

### **Bladder cancer**

As with lung and colorectal cancer, tobacco use is a cause of cancer in the bladder. Other avoidable risk factors include exposure to chemical agents known as 'aromatic amines' and infections of the bladder. Silverman et al. (1992) point out that there is a risk of bladder cancer in a number of occupational groups where it is likely that the occupation is putting them in contact with aromatic amines. These occupations include painters, truck drivers and those working with aluminium, dye, leather and rubber. The greater incidence and mortality of bladder cancer in men is likely to be because they were employed in these activities more often

than women. The reduction in incidence and mortality in the last 10 years may be an effect of changing occupational trends in the UK and may be a sign that these chemicals are being successfully removed from working practices.

## **4. Gender and help-seeking behaviour**

Help-seeking requires awareness of potential symptoms and the ability to recognise them. In a review of studies examining help-seeking experiences, Smith, Pope and Botha (2005) found that a common theme emerging from the studies was that patients knew little about the symptoms of cancer. There are, however, particular examples where awareness seems high. Breast cancer mainly affects women but Chamot and Perneger (2002) found that men and women were equally knowledgeable about breast cancer. The gender difference in morbidity and mortality is less marked in cancer of the bowel, and O'Sullivan and Orbell (2003) found that knowledge about bowel cancer in a high-risk age group (60–69 years old) was good for both men and women. In a systematic research review of delays in seeking and receiving treatment for symptoms of cancer, Macdonald et al. (2004) found that women and those with more education, strong social networks and experience of cancer were more likely to be knowledgeable about cancer and to seek help earlier.

Once a symptom is appropriately recognised, an individual will need to seek help initially from their primary care service. Macdonald et al. have coined the term 'patient delay' for the time it takes to do this and argue that it is this aspect of delay in cancer that lasts the longest and is the hardest to change. The review by Macdonald et al. of this kind of delay in cancer included an analysis of gender, from which a complex picture

emerged. For 10 different groups of cancers combined, 13 studies showed greater delay in men (10 of the studies were rated as strong methodologically, 2 moderate and 1 insufficient), 11 studies showed greater delay in women (8 strong and 3 moderate), and 23 studies found that gender had no impact (11 strong and 12 moderate). There was only one cancer where research was decisive but this was because there was only one study for that cancer, otherwise gender had no impact or the effect of gender was inconclusive. This suggests that there are important methodological issues underlying these findings – the difficulty may lie in the shortage of information on the context of the delay in help-seeking.

Symptom awareness and symptom recognition do not in themselves bring people to the attention of primary care. Patients generally need to have reached a particular level of concern. Macdonald et al. (2004) and Smith et al. (2005) found that people were most concerned when symptoms became debilitating and affected everyday life. In particular, Macdonald et al. found evidence suggesting that rectal bleeding or a lump in the breast most concerned women whereas men were worried when they had a persistent cough or blood in their urine (haematuria). The review by Smith et al. of help-seeking found that people were more likely to be concerned about well-known symptoms, such as a lump, or when the number of symptoms increased, especially when they also experienced pain.

As we have seen, many symptoms, such as a cough, can be attributable to illnesses that are not debilitating. It is therefore important to consider signs that do not cause potential cancer sufferers significant concern – in other words, symptoms that are potentially indicative of cancer but that are unlikely to

lead people to consult primary care services. Smith et al. (2005) found that individuals reported doing little to seek help for mild symptoms that are easily linked with mental ill health or age-related decline, or common physical ailments that do not usually necessitate urgent treatment. In the absence of pain or a lump, other symptoms were also less likely to raise concern (although many cancers do not form solid masses that are observable). Some individuals did not want to seek help because they had previously seen their GP and been told that a particular symptom was not cancerous. They were therefore wary of repeating the experience.

Different aspects of help-seeking emerge from the review by Smith et al. as important for men and women. Men considered help-seeking as emasculating and were particularly concerned about appearing to consult for trivial matters that might indicate that they worried too much about their health. As many symptoms of cancer appear harmless, men may be less likely to seek help. When men do seek help and are told that their concern does not warrant further exploration, they may feel like they have attended unnecessarily, which may affect how quickly they attend in the future. Reports by men also demonstrated that they thought women were better at using healthcare services because women have to use them more often. Indeed, Patel et al. (2004) and Zimmerman et al. (2006) provide evidence to suggest that those people using primary care services most often are also those most likely to take up the opportunity for cancer screening services, so this may be true regardless of gender. Women reported that they had other concerns, such as work and family, that took precedence over seeking help for potential cancer symptoms. This highlights that an awareness of symptoms has to compete with other

issues to be acted upon. Pessimism may also be important, particularly for men; Wilkins (2008) explored aspects of pessimism and denial in relation to screening for colorectal cancer and concluded that it is possible that men are more fatalistic about cancer and are more likely to believe that screening will make no difference; women, on the other hand, may have a more sophisticated understanding of cancer and cancer treatment, which leads them to realise that early detection increases the likelihood of a better outcome.

## 5. Gender and experience of services

Most cancers require complex interventions and gender continues to be important after an individual has sought help. As many signs of cancer are also symptoms of innocuous illnesses, primary care professionals have a difficult task. Indeed, GPs may see only a few cases of cancer a year. The review by Macdonald et al. (2004) of research on delay uses the term 'practitioner delay' for the period between first consultation for symptoms and an appropriate referral. Overall, for the 10 different groups of cancers, four studies show greater delay when the patient was male (two strong methodologically and two moderate), six studies show greater delay for female patients (six strong), and four studies found that the gender of the patient had no impact (four strong). As with patient delay, there are conclusive results for individual cancers only when there has been a single study (on skin cancer, in which women had greater delay). Macdonald et al. also found that studies of delay tended to focus on secondary care, which is unfortunate given the importance of primary care in managing cancer. Untangling the complexities of practitioner delay is extremely difficult, but Macdonald et al. suggest that there are cases were

gender plays a role and this needs further exploration.

Once a healthcare professional suspects that a particular symptom is a sign of cancer, there is usually a need to refer the patient to specialist services. UK healthcare services are required to report waiting times but the most comprehensive information comes from the National Cancer Patient Survey (NAO, 2005), which was first undertaken by the Department of Health in 1999/2000 and was conducted again in 2004. In the latest survey, reports of referral waiting times showed that the shortest wait was associated with breast cancer whereas cancer of the prostate had the longest wait. Men with bladder cancer were seen much more quickly than women. For bowel and lung cancer, women were also more likely to deteriorate while waiting for a referral. Also, men were slightly more likely to report receiving advice during their treatment; this finding was mainly for men with bowel cancer. The findings concerning bowel cancer suggest that there may be underlying differences in the service provision that affect men and women differently and need exploring further.

There is limited research exploring the ways in which the use of different services varies by gender. It is likely that gender is a factor in decisions made during the 'cancer journey'. Again, the National Cancer Patient Survey (NAO, 2005) offers the most comprehensive picture. The 2004 survey included 80 questions requiring a judgement of the quality of care; the answers from men with cancer of the prostate were less positive for 54 of these questions when compared with all other cancers included in the survey. It may be that prostate cancer is especially difficult to treat effectively and that it results in an unusually high level of suffering. The 1999/2000 survey also found that men with prostate cancer had the worst experience

of services, which means that there is a consistent pattern emerging that warrants further investigation.

## 6. Gender and current policy

Ever since the 1992 White Paper *The Health of the Nation*, cancer has been integral to government targets for health. In 2000, *The NHS Cancer Plan* (DH, 2000) was published and confirmed that tackling cancer effectively was a priority for investment and reform. *The NHS Cancer Plan* included a commitment to address health inequalities, particularly in relation to deprivation. Gender is mentioned only in this context – specifically in references to the differences between unskilled and professional men and between women with and without learning difficulties.

The *Cancer Reform Strategy* (CRS) (DH, 2007a) builds on *The NHS Cancer Plan* and will be the main policy plank for cancer services until 2012. The CRS recognises that survival rates have improved but incidence is increasing, which means that more people are living with cancer or the effects of cancer and its treatment. The CRS re-states the commitment to tackling inequalities seen in *The NHS Cancer Plan* but makes a point of specifying the inequalities that are of concern: deprivation, race, age, gender, disability, religion and sexual orientation. A short section on gender and cancer discusses gender differences in mortality, noting that for most cancers mortality is higher for men, and highlights that research needs to explore how gender impacts on cancer. This same point is made by the Men's Health Forum, which held a national symposium in 2006 with practitioners, patient groups, researchers and men who have had cancer (Wilkins, 2007b).

While recognising that the inclusion of gender in national policy is an important part

of bringing concern about gender inequalities into the mainstream, there is also a need to ensure that there are substantive plans that can be put into practice. Subsequent to the publication of the CRS, there are now moves to develop a National Cancer Equality Initiative. At the time of writing, an advisory group is in the process of being established. In addition to the CRS, there are Public Service Agreement (PSA) targets in relation to cancer for the period 2008–11. The national PSA target for cancer mortality is a reduction of at least 20% in people aged less than 75 years from 1995–97 rates (139.7 per 100,000 population) by 2010. In addition, the PSA targets have service level agreements, which include ensuring that those with suspected cancer see a specialist within two weeks.

Concern about gender differences in the use of a specific cancer service has led to an important initiative that will report in 2009. The NHS Bowel Cancer Screening Programme for England had significantly fewer men than women accepting invitations to take part during its pilot stages. A Department of Health-funded project led by the Men's Health Forum is seeking to understand the reasons for the difference in uptake between men and women and to develop interventions intended to close the gap.

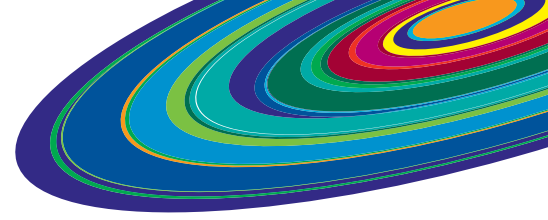
## 7. Key messages

- Cancer morbidity and mortality are consistently higher in men than in women once sex-specific cancers are excluded from the figures (breast cancer is generally regarded as sex-specific although a small number of men do develop breast cancer each year). However, cancer morbidity and mortality rates are reducing more quickly for men than for women.

- Tobacco is the main avoidable cause of cancer but may affect, and be used by, men and women differently.
  - Some of the signs of cancer are also symptoms of harmless illnesses that many people, particularly men, would not want to raise with primary care practitioners.
  - A large number of consultations in primary care that are related to cancer are for benign neoplasms, and how health professionals deal with these may have implications for how men and women seek help when they notice signs of cancer in the future.
2. There is a need to examine the cancer patient 'journey' in more detail so that we can understand how men and women move between different services. This is important for prostate cancer, for example, where the experience of care is the worst of all cancers, and also for bowel cancer, where differences suggest that men fare better than women. It may be that there are similar gender variations in relation to other forms of cancer.

## 8. Recommendations

1. Symptom recognition is crucial for both men and women in bringing them to primary care. Symptom recognition by primary care practitioners is crucial in making a timely referral to secondary care. There is good evidence that symptom recognition is subject to delay at both these levels and that the causes of that delay vary between men and women. There is also evidence (not covered in detail in this report) that there is an inter-relationship between gender and other demographic factors such as economic status, ethnicity and geographical location in relation to these kinds of delay. There is a particular need to develop a better understanding of why these delays occur, and how and why this varies according to gender. Ultimately, there is likely to be a need for gender-sensitive approaches to address this problem.



# Chapter 8: Sexual health

## 1. Introduction and definitions

Sexual health is a complex combination of the experience of biological sex, the way in which identity is gendered and how we relate to others through our experience of sex and gendered identity. There are three overlapping elements in sexual health:

1. diseases and infections: the human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and cancers resulting from STIs;
2. family planning: this includes ensuring the ability to reproduce, which is seen in infertility treatment, and the ability to control reproduction, such as contraceptive use; and
3. relations and emotions: these encompass sexual and gender-based violence, and sexual dysfunctions that are not due to biological conditions.

Primary care services should be able to fulfil a number of roles to meet the sexual health needs of their patients. These include providing information on contraception; prescribing contraceptives; pregnancy testing; screening and immunisation, such as for hepatitis B; assessment and some tests for STIs; and HIV counselling. Where appropriate, primary care services will need to make referrals to genito-urinary medicine (GUM) clinics and specialist secondary services, and to co-ordinate care between different services.

The UK National Strategy for Sexual Health and HIV highlights the recent increases

in diagnoses for both HIV and STIs (DH, 2001b), and locates sexual health as a key area for action in UK health policy (DH, 2004b). Primary care is an important part of the comprehensive range of services dealing with sexual health. Indeed, Young (2007) argues that the increase in HIV diagnoses and STIs means that sexual health services should move into primary care. Sadovsky and Nusbaum (2006) suggest that when sexual health is understood as emotional and physical well-being – rather than just dysfunction – it fits well with a person-centred model of primary care. In addition to diagnosing sexual health difficulties, exploring sexual health with patients in primary care can, for example, help identify signs of cardiovascular disease in men, low serum oestrogen in women, and mental ill health in men and women (Sadovsky and Nusbaum, 2006).

Gender is an important element to consider when dealing with sexual health in primary care. An understanding of gender would already seem integral to the domain of sexual health but it is essential to extend this understanding to considerations of how men and women access sexual health services in primary care – for example, how men and women use primary care services, if at all, after risky sexual activity. This is not to suggest that gender is the only consideration. Other group differences, particularly in relation to sexuality, are also relevant to the work of primary care when managing sexual health.

This chapter will review the evidence and policy relating to gender differences in the



use and provision of primary care services for sexual health. While there are three overlapping and broad elements (to re-cap: diseases and infections; family planning; relations and emotions), grouping them all under the same umbrella could blur the relevance of any conclusions for specific health services. STIs and HIV are the dominant focus of the UK National Strategy for Sexual Health and HIV (four out of five of the aims of the strategy focus on STIs and HIV) and, as these usually result in discrete diagnoses, they are some of the easiest to relate to information on access to primary care services.

GUM is a medical specialty that is primarily concerned with the treatment and prevention of STIs and HIV. Many GUM clinics are effectively primary care services because they can be accessed directly by patients even though they are often located in secondary care settings, particularly hospitals. In order to acknowledge the differences between GUM clinics and traditional primary care services, such as GP practices, GUM clinics will be referred to separately (i.e. the term 'primary care' will exclude GUM clinics). While there is very little research that is relevant to primary care services, there is much more on GUM clinics so they will be a dominant focus. Consequently, this chapter will focus on diseases and infections in GUM clinics but will include aspects of family planning and emotional issues where relevant. It will attempt to draw conclusions for primary care where possible.

## 2. Statistical information and epidemiology

### **Incidence/prevalence**

Infections and diseases relating to sexual health, termed 'sexually transmitted infections' (STIs), are those that can be

transmitted through sexual activity and/or affect the sexual organs. This does not always mean that transmission of such infections necessarily occurs through sexual activity – for example, HIV may be transmitted by the sharing of intravenous needles. The same treatment is often required, however, regardless of the mode of infection. In addition, in data on sexual health, HIV is usually separated from and considered alongside STIs, rather than as a subtype of STIs.

Information from the UK Collaborative Group for HIV and STI Surveillance (UK CGHSS, 2006) shows that, from 1996 to 2005, new diagnoses of STIs rose by 60% and new diagnoses of HIV by 175%. It is sometimes difficult to separate infections in men from those in women either because data are presented in graphs without numbers, or because men are separated into heterosexual men and men who have sex with men (MSM). Overall, however, the greatest rise in STIs has been among women in the 16–24 age range, and then among men aged 16–34. There has been a slight increase in STIs in men and women in other age groups. The Health Protection Agency (HPA) is the key body for tracking and examining patterns of infectious diseases in the UK. GUM clinics have a statutory obligation to report STIs and HIV to the HPA and it is in GUM clinics that most diagnoses of STIs and HIV are made. The HPA focuses on five STIs and HIV, which we shall consider in turn.

### ***Chlamydia***

Chlamydia is the most common STI. It can infect both the genitals and the eyes of those affected. Up to 50% of infected men and 70% of infected women are believed to be asymptomatic (UK CGHSS, 2006). In women, chlamydia infection of the genitals can

develop into infections that can cause chronic pain in the pelvis and ultimately result in difficulties getting pregnant and complications during pregnancy. For men, genital chlamydia can cause a burning sensation when passing urine and testicular inflammation, which in some cases can ultimately result in infertility. Between 2004 and 2005 there was a 7% increase in new diagnoses in men and a 3% increase in women. It is unclear whether these increases in diagnoses represent greater incidence of the disease or are a reflection of improved detection.

### **Gonorrhoea**

Gonorrhoea is a bacterial infection that affects the genital organs, rectum, eyes and throat and, like chlamydia, many of those infected are asymptomatic. Gonorrhoea usually causes difficulty urinating and discharge from the vagina or penis, and, in women, can lead to spotting after intercourse and bleeding between periods. The UK CGHSS (2006) shows that, while gonorrhoea is the second most common STI, it is the only STI that has been decreasing in recent years. Men are still twice as likely as women to be infected but between 2004 and 2005 there was an 11% decrease in male infection rates and an 18% decrease in female rates.

### **Syphilis**

Syphilis is primarily transmitted through contact with infected lesions located on the genitals and rectum. These lesions, known as 'chancres', are usually painless and heal by themselves, which means that for much of the time people with syphilis lack any noticeable symptoms. Except for antibiotic-resistant strains, syphilis is easily treated with antibiotics but left untreated it can affect the central nervous system. In pregnant women syphilis can lead to miscarriage and stillbirth, or the infection may be passed on

to the baby. In addition, syphilis increases the risk of HIV transmission and there is a possibility that people with HIV who also have syphilis go undiagnosed because they are asymptomatic. Syphilis remains extremely uncommon but the UK CGHSS (2006) shows an increase of nearly 2,000% between 1996 and 2005. The greatest increases in syphilis have been seen in MSM and to a slightly lesser extent in heterosexual men. The smallest increase has been in women.

### **Genital warts**

Warts can occur all over the body and are caused by viral infections. Transmission occurs through contact. The term 'genital warts' usually refers to warts that are caused by the human papilloma virus (HPV), although HPV infection does not necessarily develop into noticeable symptoms. There are a number of strands of HPV, some of which are associated with cancers of the cervix, vagina or vulva in women, cancer of the penis in men, and cancer of the anus in both sexes. There is little information on each of these cancers to make comparisons because they are relatively rare when compared with other cancers, such as breast or prostate cancer. HPV, however, seems to increase the risk of cancer in women more than in men (CRUK, 2008g). Of the viral STIs, UK CGHSS (2006) reports that genital warts are the most common. From 1996 to 2005 the number of new – first attack – diagnoses of genital warts increased by 26%, with the greatest increase of 76% in MSM.

### **Herpes**

Herpes is a viral disease caused by herpes simplex viruses that infect the genital area and mouth. These two strains are known as 'anogenital' and 'oral' herpes respectively. Anogenital infection occurs through sexual activity and, while most cases are asymptomatic, herpes can

produce painful blisters on the infected sites. Symptoms usually disappear within a short period and the infection lies dormant before reappearing. There is no cure for anogenital herpes. Information from the UK CGHSS (2006) shows that there was a small increase in new – first attack – cases of anogenital herpes between 1996 and 2005. The greatest number of cases is in women aged 16–24, although there has been a disproportionately higher increase in the number of cases in men in the 16–19 age group.

### **HIV**

HIV is a viral infection that can result in a condition, acquired immunodeficiency syndrome (AIDS), where the immune system stops working, leaving the body at risk of other infections. Transmission occurs through contact with bodily fluid and is therefore not limited to sexual contact. Upon first infection, a flu-like illness may occur, although many will remain asymptomatic and serious symptoms may not occur for many years, when the immune system becomes so weak that other infections take hold. There is no cure for HIV but there are drug treatments that can help stabilise symptoms. HIV testing was introduced in the UK in 1983 and consistently the highest number of new infections has been in MSM (UK CGHSS, 2006), although rates are now stabilising. While HIV infection through heterosexual contact is still lower than infection through homosexual contact, HIV infection through heterosexual contact has increased more in recent years. It is important to note that MSM may not be exclusively homosexual as they may also engage in heterosexual activity. Between 1996 and 2005, rates among MSM increased by around a half (1,555 to 2,356) while rates increased five-fold in heterosexual women (481 to 2,571) and four-fold in heterosexual

men (359 to 1,478). HIV testing is now a routine part of antenatal screening, where 18% of women are diagnosed, and this may explain the greater detection of HIV in heterosexual women. UK CGHSS information suggests that 84% of new HIV infections occur through male homosexual contact and 15% through heterosexual contact.

### **Consultation rates and use of services**

Data on the number of consultations for potential sexual ill health in GUM clinics and primary care can help our understanding of how different healthcare services are used by men and women in relation to sexual health, particularly STIs. Information collected quarterly by the HPA shows that in 2005 there were 790,443 diagnoses and 1,841,886 consultations (termed 'attendances' by the HPA) in GUM clinics. Unfortunately, information on these consultations is not disaggregated by disease category or by sex. In 2007, a Common Data Set for Sexual Health (CDSSH) was approved as a draft operational standard for collecting information across the NHS, and the Genito-Urinary Medicine Clinics Activity Database (GUMCAD) is a new surveillance system that should be providing reports from all GUM clinics by September 2008. CDSSH should mean that data is provided from the complex array of sexual health services (GPs, GUM clinics, family planning clinics, etc.) and GUMCAD will provide disaggregated data. Consequently, information on consultations in primary care is currently the best source available but we shall see that it has severe limitations, particularly because the last available analysis is from 1991–92.

Information in government and health service reports is usually given for each STI, but it is practically impossible to do the same with GP data because of the way in which diseases are classified. In addition, there are

surprising differences between the number of consultations and the rates of incidence given above. It is perhaps most likely that people go directly to GUM clinics without consulting primary care services first. Alternatively, it could be that GP practices make referrals to more specialist services, such as GUM clinics, without allocating a diagnosis code, which suggests that providing details of GP referrals could also help understand how men and women use health services. There is information on the referrals made from primary care consultations but it is often difficult to determine whether these are related to sexual health. Research has shown that only one-third of GUM clinic patients initially attended primary care (Neale et al., 2008) and there seems some support (Cassell et al., 2003) to suggest that men, particularly young men (Lewis et al., 2004), are less likely to attend primary care than women. The lack of information from routine practice, however, means that it is difficult to draw firm conclusions other than that analyses of consultation rates and use of services in the future need to ensure that STIs and HIV can be distinguished from other infections. The information presented here is, however, the best available for sexual health infections from the consultation data.

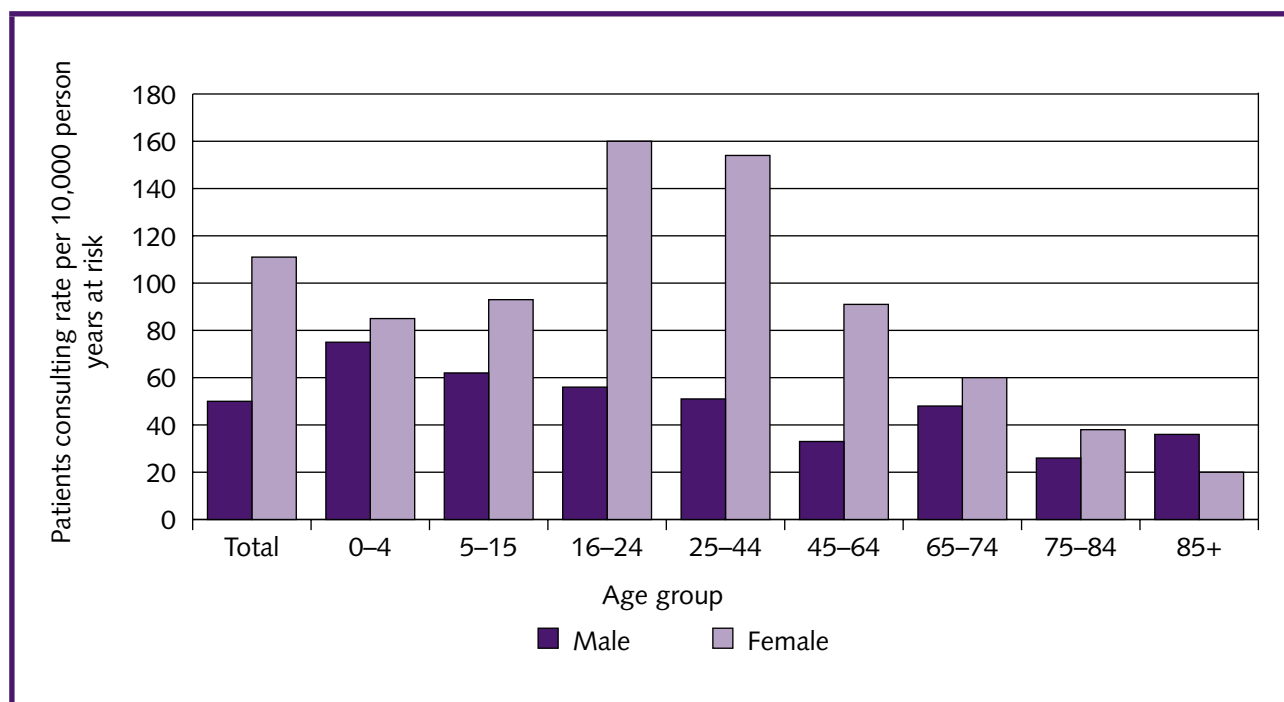
Unfortunately, because of the way in which consultations were coded and the codes that were reported, it is almost impossible to say anything useful about gonorrhoea, syphilis or HIV. There are very few consultations for 'gonococcal infections', and for most age groups there is too little data to provide accurate information. The rate for all age groups is 1 per 10,000 for both men and women. As epidemiological evidence shows that gonorrhoea is the second most common STI in the UK, this is quite surprising. Syphilis has a number of different classification codes, but even when these are combined

there is too little data to make useful interpretations. However, as syphilis (unless antibiotic resistant) is relatively treatable and predominantly sexually transmitted, its relative absence from such data is not surprising.

Most surprisingly, HIV codes have been excluded from the consultation data and no explanation is offered. It is possible that HIV was too marginal an issue for primary care during the period in which the 1991/92 consultation data were collected and analysed, but it does mean that it is not possible to examine the use of primary care services at this time by men and women for HIV. Given the complexity of HIV, primary care must play some role in the management of patients infected, but without adequate information it is difficult to say with any confidence what this role is. This is the one area of sexual health where information from GUM services is better for exploring the gendered aspects of access to health services. In 2003, there were 85,463 HIV antibody counselling sessions that included HIV testing and 203,778 that did not include HIV testing. More men than women had the counselling with HIV testing, whereas more women than men had the counselling without testing.

Data on herpes ('herpes simplex') are much easier to interpret and are shown in Figure 8.1. Herpes simplex has the second highest rate of consultations linked to STIs for men (50 per 10,000 person years at risk) and women (111). The rate is highest for women in all age groups except 85 years and over. While the data on consultations pre-date the epidemiological evidence, they do show similar patterns, with higher rates in women, particularly among those aged 16–44. The data on consultations for herpes are the easiest to interpret but there is a risk that they include infections that are not sexually

Figure 8.1: Consultations in primary care for 'herpes simplex'



Source: McCormick et al. (1995)

transmitted, particularly when related to the eyes and in the younger age groups.

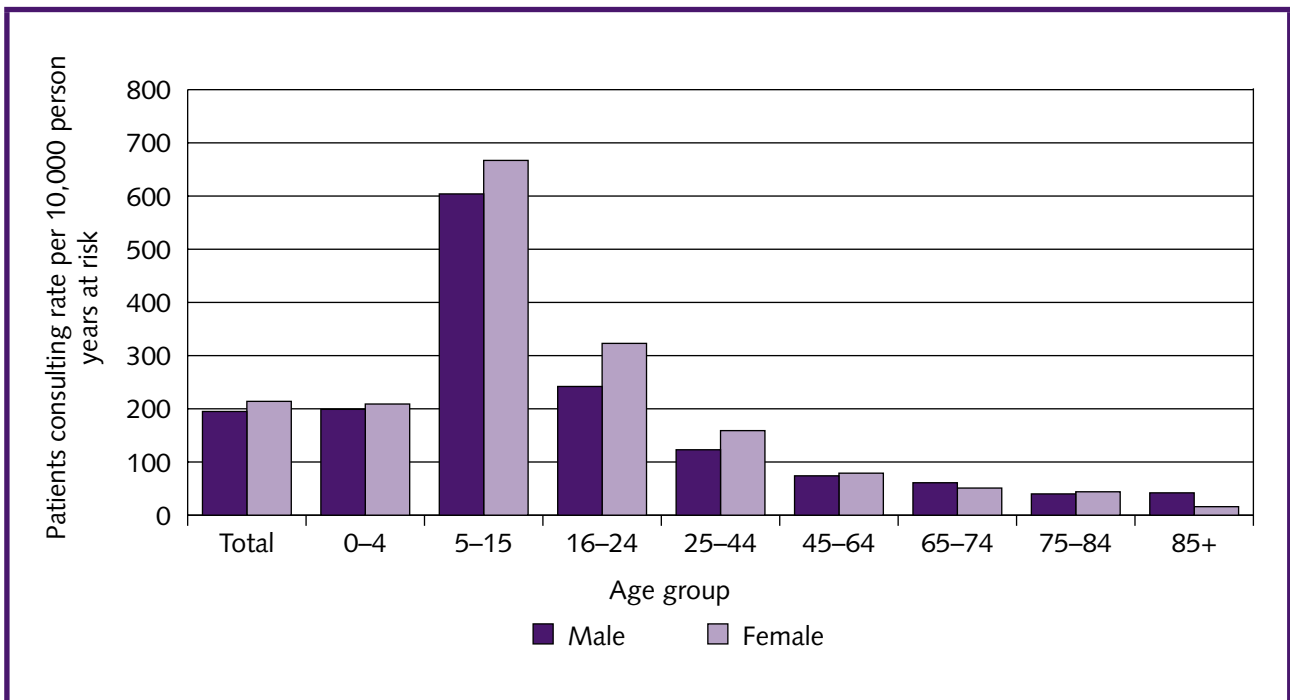
There are two 'other' classification codes that relate to STIs. The first is 'other diseases due to viruses and chlamydiae', shown in Figure 8.2, which includes genital warts. Confusingly, although this classification includes 'chlamydiae', it is unlikely to include sexually transmitted chlamydia infections, which are usually classified in the second 'other' category, described below. The total rate of consultations is slightly higher for women (214 per 10,000) than for men (195 per 10,000), and in all age groups except 65–74 and over 85 years the rate is higher for women. The highest rate for men (604 per 10,000) and women (667 per 10,000) is in the 5–15 age group.

The second 'other' category is 'other venereal diseases', as shown in Figure 8.3, which is where chlamydia as an STI would usually be coded. This group of diseases

had one of the lowest rates of consultations in primary care in 1991–92, although it is the only one where the rate is higher for men (8 per 10,000) than women (3 per 10,000). The highest rate for both men (22 per 10,000) and women (6 per 10,000) is in the 16–24 age group. As this code includes other infections, it is unlikely that these consultations are only for chlamydia and it is therefore difficult to make comparisons with epidemiological evidence.

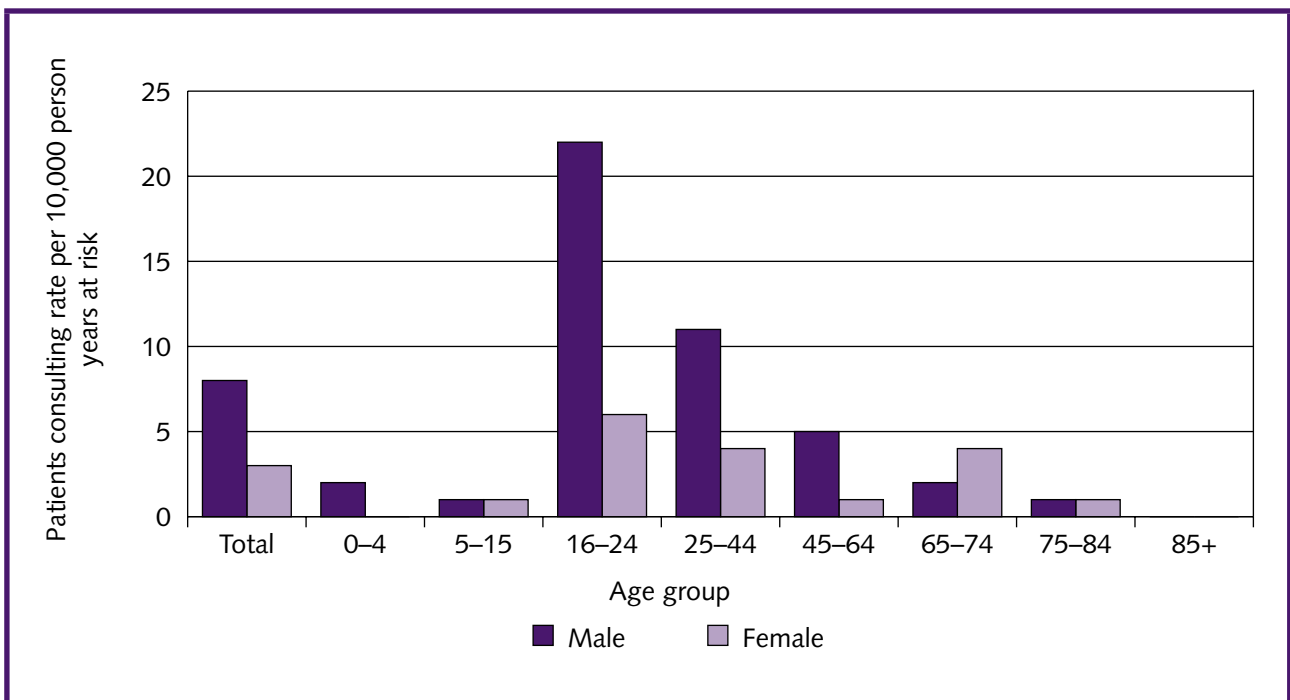
GUM clinics play a pivotal role in the management of STIs and HIV in the UK and it is unfortunate that it is not possible to examine thoroughly how men and women use them. When the new surveillance system for collecting information on GUM service use is put in place, it would seem prudent to ensure that it is analysed to examine patterns of service use by men and women for each STI and HIV. In addition, primary care is currently expected to take on a greater role in the care of sexual health in the UK and it

Figure 8.2: Consultations in primary care for 'other diseases due to viruses and chlamydiae'



Source: McCormick et al. (1995)

Figure 8.3: Consultations in primary care for 'other venereal diseases'



Source: McCormick et al. (1995)

is disappointing that it is so difficult to make clear interpretations from the information on consultations in relation to STIs and HIV. The new data collection protocol for collecting information across the complex array of sexual health services should mean that information from primary care should be comparable with that from GUM services. Datasets on routine practice in primary care in the UK are large and complex, however, and analysing them requires a great deal of effort. An initial step to understanding how men and women use primary care services for their sexual health needs would be to start a new analysis of routine data with information that is specific to the domain of sexual health. At present, the overall picture from consultation data is that women consult for STIs more often than men except for chlamydia, although the data have too many flaws for these conclusions to influence policy and service delivery.

### 3. Factors associated with gender differences

Much of the focus in research on gender differences in STIs is on behaviours that can lead to the transmission of infections. This has two aspects. First, there is the nature of sexual encounters and, second, the use of methods to prevent transmission during sexual encounters, which will be termed 'prophylactic'. The National Surveys of Sexual Attitudes and Lifestyles (termed the 'Natsal surveys') provide the most comprehensive information on sexual encounters and contraceptive use in Britain. The most recent Natsal survey in 2000, of over 11,000 people (43% men and 57% women), is the main source used to examine gendered differences in sexual encounters and contraceptive use below. The survey includes data on first sexual encounter or 'debut' as well as subsequent experiences. However, this

survey excludes respondents with little or no sexual experience and is mainly limited to heterosexual penetrative sex.

Using the Natsal data, Wellings et al. (2001) found that the median age at first intercourse was 16 for both men and women, although more men than women were younger than 16 years old. Wellings et al. developed a measure of sexual competency in relation to first sexual encounter, which combined information about 'regret' (respondents wishing they had waited longer before having sex), willingness, autonomy and contraceptive use. Using this measure, only around half of those questioned could be defined as 'competent'. More men (56%) were sexually competent than women, and the older they were at the first sexual encounter the more likely they were to be sexually competent. Women were more likely to have a partner who was more willing than them during this encounter. Men were more likely to be inebriated at the time. Women were more than twice as likely as men to wish they had waited longer. As women are more likely to be the less willing partner, it is perhaps not surprising that they are also more likely to regret their first penetrative heterosexual experience. The contrast between men and women suggests that for many the first sexual encounter may be one where the man is the more dominant partner. This could have important implications for the promotion of contraceptive use.

The Natsal survey also contains information about the number of partners and the length of time between meeting a partner and having penetrative sex (Cassell et al., 2006). Overall, men had more sexual partners than women and had sex sooner after meeting a new partner. Over a 12-month period, men were more likely to have only one sexual partner but also more likely to have

more than five partners. Men were also more likely to have more partners over a five-year period. Over 15% more men than women had penetrative sex within the first week or month of meeting. Of those people surveyed who had had more than one sexual encounter in the last year, men were more likely to have had concurrent sexual partners than women.

As the overall pattern is for a greater prevalence of infections and diseases related to sexual health in women, it could seem counterintuitive that men appear to have more sexual partners. This may be explained by the greater risk of transmission of STIs that women face because the vaginal wall is more permeable than the penis and sperm carries higher rates of infection than vaginal fluid. Another possibility is that the Natsal survey shows a reporting bias where men over-report and/or women under-report sexual activity. It is also important to note that reporting a high number of partners does not necessarily increase the risk of transmission because there are specific methods that can be employed to reduce infection during sexual activity.

Used properly, condoms can help prevent infection but most other contraceptives do not do so – indeed, condoms alone are not sufficient to prevent infection from all sexual activities. This is important because the report (Cassell et al., 2006) does not always specify whether the contraceptive used was one capable of preventing transmission of infections. Analysis of first heterosexual experiences in the 2000 Natsal survey (Wellings et al., 2006) is a little clearer because the analysis does include information on condoms. In particular, the survey shows that only slightly more men (83%) than women (80%) used condoms (Wellings et al., 2001). This pattern at sexual debut seems to be reflected in other sexual

encounters, with more men than women reporting using condoms in every age group, with the widest gap found among younger men and women.

Sexual encounters, and particularly decisions to use or not use prophylactics, are much more complicated than can be represented effectively in surveys. In an interview study of 13 men and 43 women aged 16–19 about strategies for ensuring condom use, Coleman and Ingham (1999) found that couples either discussed condom use (verbal) before intercourse or one partner took responsibility without discussion (non-verbal) by, for example, putting a condom on or passing it to their partner. Men were more likely than women to adopt non-verbal strategies whereas women used verbal strategies; it is possible that women feel less able to use condoms without first discussing this with their partner.

Prophylactics require careful use – for example, a condom can slip and break or may not be used for the whole period of sexual activity – which means that it is important to consider how men and women use them. Very little of the research on the use of prophylactics explores gender explicitly. Hatherall et al. (2007) conducted a study of the use of condoms in young people including a wide variety of experiences. Unfortunately, the study does not report all results separately for men and women, but in a discussion of oral sex and the use of condoms Hatherall et al. show that men are less likely than women to use condoms during fellatio. It is notable that men and women may have different reasons for using, or not using, prophylactics: men were more likely to report using condoms during fellatio to avoid STI transmission and to be more hygienic whereas women did so because of taste and to avoid what is termed the ‘spit–swallow dilemma’. It is interesting to note



that men report lower use of condoms for fellatio specifically when they report greater use of condoms for sexual encounters more generally. It is possible therefore that men are more motivated by the possibility that penetrative sex could result in pregnancy than STIs. This suggests that research examining the gendered aspects of the use of prophylactics should take account of how they are, or are not, used; for which sexual activities; and at what point during these activities.

#### 4. Gender and help-seeking behaviour

Examining research on gender and help-seeking behaviour should help us to understand gender differences in how primary care and GUM services are used for sexual health. An integral aspect of help-seeking is the ability to recognise symptoms, but unfortunately there is a dearth of research on this that is relevant for dealing with STIs and HIV in UK primary care and GUM clinics. It is also problematic that many people with STIs may remain asymptomatic. Consequently, an element that could complement symptom recognition would be awareness that a particular sexual activity is risky and justifies seeking support from primary care. The tendency to limit condom use to penetrative sex, as discussed above, suggests that those behaviours considered risky may mainly focus on penile penetration despite the fact that STIs and HIV can be transmitted in other ways. There is also a shortage of research on risk recognition that is relevant to the UK. This makes it difficult to draw firm conclusions about gender differences in the use of primary care either for advice on sexual behaviour or for the treatment of infections.

Once a symptom or risky sexual activity is appropriately recognised, an individual can seek help. The Global Study of Sexual

Attitudes and Behaviors (GSSAB), a large international survey conducted in the late 1990s in 29 countries, looked at sources of help used by those with at least one sexual problem. Moreira et al. (2003) report these findings in a northern Europe cluster, which includes the UK along with Austria, Belgium, Germany and Sweden. Less than one-fifth sought medical help and there was almost no difference between men and women. Indeed, both men and women were more likely to talk to their partner than seek medical help, but about 5% more women than men were uncomfortable talking to a physician. Almost half of both men and women reported doing nothing and waiting to see if the problem went away. Interpretations from GSSAB must be made with caution because the study focuses on the ability to have and enjoy penetrative sex (termed 'sexual function'), although difficulty with sexual function may itself be associated with – and therefore a sign of – an STI (Goldmeier and Leiblum, 2005). The findings from GSSAB also include countries with health and cultural systems that vary considerably, and if we are to better understand how men and women access services for their sexual health then we need research that relates their help-seeking to GUM and primary care services in the UK.

In a survey (Stone and Ingham, 2003) of young men and women attending sexual health services in six NHS districts, the reasons offered by men and women for not attending before their sexual debut differed by gender. While fewer than half of the women had not planned to have sex, around one-quarter had obtained condoms elsewhere and were worried about being too young to attend the sexual health service. For one-third of men, the reason for not visiting the service prior to their sexual debut was having obtained condoms elsewhere,

although a similar proportion had not considered using the service and one-quarter did not think help was necessary before their sexual debut.

An interview study by Dixon-Woods et al. (2001) provides findings that may help direct future research on gender and help-seeking. Dixon-Woods et al. interviewed 37 women attending a GUM clinic for chlamydia screening and found that the main reasons for seeking help were the women's own symptoms and behaviour, their partner's symptoms and behaviour, and 'health maintenance' (including having been traced as a sexual contact of somebody with an infection). If we are to understand better how men and women seek help for their sexual health, then research will need to consider symptom and risk awareness in relation to an individual's own body and behaviour and also in relation to their sexual partner. On this point, some of the women interviewed also reported using smear tests as a legitimate opportunity to raise questions about sexual health. Bilney and D'Ardenne (2001) have found that women are more likely than men to withhold information on their sexual history, and in a survey of 3,184 new patients from four GUM clinics across England, Mercer et al. (2007) found that more women than men continued to have sex while waiting for treatment.

Screening programmes usually actively seek a specific group of people and those who take part get a test result, termed a 'screening outcome'. Because most services do not actively target specific groups, looking at how people view screening outcomes can provide information on how men and women view sexual health. Neale et al. (2008) found that men were less likely to have a chlamydia test despite chlamydia often being asymptomatic (therefore a test being the only way to know). Mills

et al. (2006) found that a positive result from chlamydia screening was a source of amusement for many men whereas women were often worried that they may be perceived as 'dirty' or 'promiscuous'. Men may also be more likely to believe that taking a chlamydia test may be embarrassing, or to experience fear and anxiety because they subscribe to popular misconceptions that the process is inevitably invasive and painful (Wilkins, 2005). It would be useful to examine the implications of these attitudes for help-seeking and treatment as the response from both sexes suggests that people are aware of the risks that chlamydia presents to their health but may be averse to seeking treatment for reasons that differ by gender. Indeed, Scoular et al. (2001) found that women tended to consider GUM clinics as 'the sort of place where filthy men go', and Pearson (2003) found that men thought they were mainly for women.

## 5. Gender and experience of services

Given the gendered dimensions of sexual health, it is likely that men and women have different experiences of services, but there is a dearth of research that is relevant to GUM and primary care services in the UK. The international GSSAB survey found almost no difference in the rate at which physicians in northern Europe would bring up issues of sexual health in routine consultations with men and women, but overall the rate was low at less than one-tenth of consultations. While the GSSAB survey was about sexual function rather than STIs and HIV, it does suggest that health professionals may be reluctant to discuss sexual matters with their patients. Gott et al. (2004) found that GPs and practice nurses reported a broad array of barriers to exploring sexual health with patients. These barriers included the patient being of a different sex from the

clinician, and the patient being from a black or minority ethnic group, middle-aged or older, or non-heterosexual. Furthermore, Robertson and Williams (2005) found that the majority of practice nurses had never examined male genitalia or tested men for chlamydia. While these kinds of findings do not directly provide information about the experience men and women have of primary care services, they do strengthen the suggestion that gender has an effect on how health professionals deal with and respond to male and female patients.

Screening is a specific aspect of sexual health services, particularly for STIs and HIV. Primary care services may provide screening or may refer patients to specialist services. As those infected with STIs or HIV are often asymptomatic, screening is particularly useful and can be used on those undertaking high-risk activities. In a study of a primary care trust without specialist sexual health services within its boundaries, Cohen et al. (2006) concluded that too few men and too few asymptomatic women were being screened. It is possible that this primary care trust had a differential policy of dealing with symptomatic women in-house and referring men to other services, but as there were no specialist services available this seems unlikely. Furthermore, Wakley and Chambers (2002) advise that primary care services should be able to test symptomatic women for STIs whereas they only need to assess and refer men to specialist services. Additionally, Clarke et al. (2006) report that there are too few appointments available in GUM clinics to meet current demand in the UK for a maximum appointment waiting time of 48 hours. It seems probable that some investigation would be useful into whether men and women have different needs and expectations in relation to the

balance between primary care and GUM clinics in providing sexual health services.

Again, the study by Dixon-Woods et al. (2001) may be instructive. The women interviewed were attending a GUM clinic for chlamydia screening and their concerns included ensuring that health professionals do not appear judgemental and consideration of the affective elements of screening (many of the women felt nervous and vulnerable). Interestingly, the women noted that they wanted to be well informed and had not been aware that their screening for chlamydia would also include screening for other STIs. It would seem useful to adopt the concept of a 'journey', which is often used in policy and research for cancer services, as a way of understanding people's experiences as they move through the range of different health services necessitated by their condition. Indeed, given the role primary care takes in co-ordinating care between services, the 'sexual health journey' of a patient will be particularly relevant.

## 6. Gender and current policy

Considerations of gender occur frequently in current policy, including the National Strategy for Sexual Health and HIV (DH, 2001b) – most commonly in references to services that are mainly or wholly used by either men or women rather than by both sexes. There are, however, two difficulties with policy-level assumptions about how men and women use services. First, the sexual health of an individual is affected by his or her relationships, both sexual and non-sexual. This means that the use of health services will not only differ between men and women but is likely to be affected by the nature of the relationships within which these men and women find themselves. In particular, heterosexual relationships may put women at a disadvantage relative to

their male partners when it comes to making decisions that impact on their sexual health, such as – as we have seen – whether or not to use a condom. Guidance from the Teenage Pregnancy Unit on how to make services friendlier to men offers an example where services are trying to take more account of the partners of service users and it would be useful to consider the impact of any changes made as a result of this advice for both male and female service users.

Second, it is not always easy to draw conclusions from current data about how men and women use primary care for their sexual health. The UK CGHSS (2006) information on sexual health and HIV infections provides a good example; because it singles out those aspects of sexual health where the risk is highest – in particular, MSM are presented as a discrete category – it is difficult to explore accurately the differences between men and women.

There are a number of actions under way that are attempting to develop materials and services that are relevant for a specific gender. These include, for example, the *FIT* magazine providing health information for men aged 16–30, but of most relevance is work within the National Chlamydia Screening Programme (NCSP). Chlamydia screening is a particularly useful illustration of issues related to STIs because the NCSP, which commenced operations in 2003, is the first mass national screening programme in any area of health to include men. The NCSP relies primarily on an opportunistic approach but it also seeks to encourage people who think they may be at risk to present themselves for screening. Overall, however, the majority of those screened so far have been women (as many as 90% for years one and two). This reflects to some extent the greater number of opportunities for service providers to engage with women

but probably also reflects women's greater concern for their personal sexual health. The imbalance between men and women has been tackled by the development of a specific strategy intended to encourage use of the NCSP by men (HPA, 2007). This strategy is of particular interest because it is believed to be the first national male-specific strategy in any area of health and one of only a very small number of strategies based on an analysis of gender issues. It will be very valuable to evaluate the impact of this strategy not only in relation to its impact on sexual health services but also as a more general example of a gender-sensitive approach.

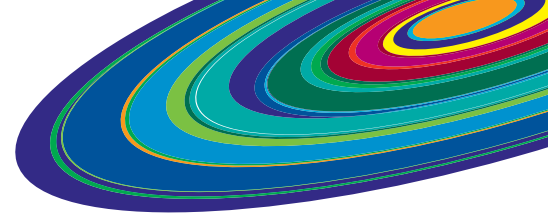
## 7. Key messages

- Primary care is increasingly seen as a key part of the range of services for sexual health.
- Overall, more women are diagnosed with STIs and more men with HIV.
- In recent years, there has been a rise in STI and HIV infections, which has been greater in women than in men.
- Gonorrhoea is the only STI where rates of infection are decreasing and the fall in new infections is greater in women than in men.
- Male homosexual activity has had consistently high rates of HIV transmission diagnoses although there is a larger (four-fold) increase in HIV infection through heterosexual contact.
- Penetrative sex is only one possible means by which STIs and HIV can be transmitted. Men are more likely than women to use condoms for penetrative sex in heterosexual contacts but are less likely to use them for other sexual activities.

- It is likely that sexual health competes with other concerns and that men and women respond differently to their sexual health needs, but there is little research explaining how this occurs that is relevant to GUM and primary care services.
  - There is little research on how men and women experience GUM and primary care services for their sexual health, but there is a suggestion that health professionals deal with and respond to men and women differently.
  - gender differences in attitudes to condom use and the extent to which men and women are willing to use them for different sexual activities; and
  - gender differences in help-seeking behaviours, particularly in relation to symptom and risk awareness.
2. Given the role that primary care takes in co-ordinating care between services, it might be useful to consider adopting the concept of a 'sexual health journey'. This would enable greater sensitivity to differences in attitudes and behaviours between the sexes and enhance the knowledge base in relation to gender and service use.

## 8. Recommendations

1. It is difficult to draw clear conclusions from the information on primary care consultations in relation to STIs and HIV for men and women. An initial step to understanding how men and women use primary care services for their sexual health needs would be to start a new analysis of routine data with information that is specific to the domain of sexual health. Other areas of sexual health in which the knowledge base needs to improve include:



# Chapter 9: Recommendations

There is a group of recommendations at the end of each of the preceding six chapters. These recommendations refer to the specific health policy area under consideration in the chapter concerned and are not repeated here. The following recommendations all refer to overall health policy and are directed at the Department of Health and the NHS. The first four pick up themes that have emerged as common to the recommendations in the specific policy areas. The remaining four are based on our analysis of the issues raised by the generality of this study and on the debate at the Expert Symposium on Gender and Access to Health Services (see Appendices 1 to 3). They also reflect to a lesser extent the debate at the roundtable discussion on men's use of primary care (see Appendix 4).

## 1. Use and availability of data

Our work has highlighted the very significant differences between men and women in incidence and prevalence rates for particular conditions. We have also drawn attention to differences in help-seeking behaviour including – but not limited to – differences in primary care consultation rates. Although these gender differences vary by balance and degree, the fact of their existence is consistent across all of the six health policy areas that we looked at. We have given less emphasis to details of the treatment 'journey' but it seems probable that there are also differences between men and women in the interventions they receive, their experience of secondary care, the follow-up processes

they are offered and so on. We strongly recommend:

- a comprehensive study of the data held on systems such as the General Practice Research Database, specifically looking at the relationship between gender and the effectiveness of primary care services (see the Introduction for an explanation of why we were unable to do this ourselves);
- that gender-disaggregated data is always used in planning and commissioning processes (for example Joint Strategic Needs Assessments and practice-based commissioning) and in setting local Public Service Agreement (PSA) targets. Where the relevant data is not available because it is not collected in gender-disaggregated form in the first place, then collection processes should be changed; and
- that all data made available to the wider public both nationally and locally (e.g. media releases, public information material and annual reports) should be presented in such a way that they enable people to consider the differences between men and women. This is a relatively small step that has the potential to focus the thinking of health planners; to raise awareness among the general public of the link between gender and health; and to stimulate debate in the media.

Our final observation on data is to draw attention to a technical problem that has become evident to us during the course of this study – that data relating to disease incidence and prevalence are not always

easily compared with data on the use of health care services for those same conditions. This might happen because, for example, data are aggregated differently in relation to specific conditions or because terminologies are not consistent. The result is that it is hard to know whether either men or women are consulting at the right level. It is also difficult to judge how much unmet need there is and whether this varies for women and men by age or in relation to other forms of diversity, particularly ethnicity. It is recommended that this problem is addressed by the data collection agencies.

## 2. Future research

In places we have drawn attention to gender differences in health-related knowledge, behaviours and attitudes. It was not our central objective to examine these issues but it nevertheless is interesting that our searches turned up surprisingly little existing research. Where information did emerge it was often a by-product of work undertaken with other concerns in mind. This perhaps is one reason why (as our study **has** shown) there is currently precious little policy that seeks specifically to redress gender differences. A research programme is needed that pays explicit attention to these kinds of differences and indeed looks at differences in the way in which men and women are viewed by health professionals. As a starting point we recommend that at least one of the leading areas of health policy is made the 'pilot' for developing greater understanding of the relationship between gender and health-related knowledge, behaviours and attitudes. This would involve a much more detailed study of the relevant literature than we were able to undertake. It might also involve the commissioning of new research.

## 3. Gender equality schemes and gender impact assessments

Although these processes are not described here, both are statutory requirements within the Gender Equality Duty (see the Introduction for a summary) and have the theoretical potential, in the long run, to eliminate gender inequalities. We recommend that the Department of Health develops a set of minimum advisory standards to ensure that these processes are carried out thoroughly and comprehensively. Most particularly, the Department of Health should recommend that these processes always include specific actions intended to reduce measurably differences in the use of services between men and women where their need is equal and/or to reduce inequalities in health outcomes where there is no known biological explanation for the difference. Such health-related actions should also be encouraged in non-health gender equality schemes and gender impact assessments (e.g. those relating to crime and disorder reduction partnerships, programmes in schools and colleges, and local authority planning strategies).

It should further be noted that a more developed understanding of gender has the potential to add greatly to our ability to address the other, more familiar, markers of inequality – especially economic status, race and sexuality. The Department of Health is already committed to the development of systems that will enable the inter-relationships between these equality strands to be taken into account within planning processes (i.e. via single equality schemes). It is recommended that policy-making and service-planning processes adopt this broad integrated approach wherever possible, but our concern here would be that gender – for reasons that we have made clear in the

body of this report – may continue to be the element that is most easily overlooked. Vigilance will be necessary to ensure that this does not happen.

#### 4. The potential value of the Quality and Outcomes Framework

A number of the areas of concern that we have highlighted in this report are covered by the Quality and Outcomes Framework (QOF), and many of the existing QOF indicators are potentially subject to variations in effectiveness by gender. The QOF may therefore offer the ideal mechanism to address gender inequities and inequalities where they are associated with patients' face-to-face experience of primary care. It is strongly recommended that – on a trial basis – the awarding of some QOF points is made subject to a test of gender-equitable distribution (for example, the points awarded for recording the body mass index of patients with diabetes could be made subject to the records reflecting the proportions of men and women who have diabetes). If such an approach was successful, it could be applied to any QOF indicators where there was evidence that there were gender imbalances that needed to be redressed.

#### 5. Supporting good practice locally

It is clear from the work we have done that there have been some sterling attempts at local level to redress gender imbalances in the use of services and ultimately in health outcomes. As we have noted, however, much of this work is small in scale, isolated from the other work of the parent agency, subject to unreliable funding and driven by the enthusiasm of particular individuals. Consequently, it is disseminated rarely and sometimes is not even written up before it comes to an end. We recommended the establishment of a national 'Tackling

Gender Inequalities Programme' with the express purpose of supporting, evaluating and disseminating local initiatives that seek measurably to close gaps in service use and health outcomes between men and women and, in doing so, to make local services more cost effective.

#### 6. Influencing health provision outside the NHS

Primary care services often include initiatives intended to promote better health as well as services to treat illness. However, some preventive and health improvement services are delivered outside primary care settings, and indeed some such services are delivered outside the NHS altogether (e.g. in commercial settings such as slimming clubs, or in the workplace via occupational health departments). Likewise some public authorities not directly concerned with health have the capacity to influence significantly health-related behaviour (e.g. transport and planning authorities and education authorities). In the worst cases, these 'non-health' organisations might be actively reinforcing gender inequities in health (e.g. schools that offer a wider range of sporting opportunities to boys, or slimming clubs that concentrate on recruiting women).

We recommended that the Department of Health and local health bodies actively seek to influence these organisations in favour of delivering a more gender-equitable service. Primary care trusts in particular now have a very significant opportunity to make a difference through joint commissioning processes. Contract compliance mechanisms may also be important. Joint Strategic Needs Assessments must routinely use gender-disaggregated data and ensure that gender is always taken into account in local area analyses. The capacity to influence organisations outside the various formal



processes will be more limited, but this should not stop health authorities from looking for opportunities to engage with them on this issue.

## 7. Making primary care more flexible

There is growing awareness that one of the factors governing access to primary care is that the opening hours at local surgeries make it more difficult for certain population groups to gain access to services. Evidence suggests that this may be a particular problem for people who work longer hours – a problem that is a clear issue of gender equity, since men are twice as likely as women to have a full-time job and are more than three times as likely to work over 45 hours per week (ONS, 2008a). It seems probable that people with significant caring responsibilities (a majority of whom are women) may also experience problems of access.

There was broad consensus at the Expert Symposium on Gender and Access to Health Services that inviting patients to attend surgeries (or potentially other healthcare settings) for basic health checks has the potential to cut through gender bias in both the provision of services and in patients' perceptions of primary care. Recently announced forthcoming initiatives like the vascular checks for people aged 40–74 and the LifeCheck scheme will institute this kind of provision to some extent. These initiatives are not inspired by the need to tackle gender inequalities but it will be interesting to look at their uptake by men and women.

It was also suggested at the symposium that developing 'outreach' models of service provision might be effective in reaching groups currently observed to be more reluctant users of primary care. There is very good recent evidence that taking services

out to social settings and workplaces can be effective in reaching men particularly.

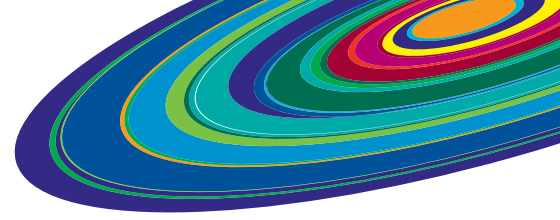
We recommend the local commissioning of initiatives in which the demographic profile and satisfaction levels of patients using primary care services are measured against the following three models of provision, each of which should be 'marketed' in a gender-sensitive way:

- a wider range of opening hours;
- the delivery of some primary care services in non-surgery settings (e.g. workplaces or community settings); and
- invitations to attend surgery (or other healthcare settings) for a 'check-up'.

## 8. Tackling health inequalities

the national programme for action on health inequalities takes a broad view of the contributing factors. The two associated PSA targets, however, focus solely on the link between poorer health outcomes and lower economic status. It is on this issue that much of the effort has been concentrated. This is not problematic for the present in relation to the need to tackle gender-related health inequalities – indeed, although neither of the PSA targets is expressed in gender-specific terms, progress on the life expectancy target is being reported separately for men and for women. In the longer run, however, it is crucial that much more attention is paid to gender as a fundamental determinant of health status. As we have shown in this report, gender remains both an extremely important determinant of health outcome **independently** of economic status and the most significant of the other factors **interacting** with economic status to compound health inequalities.

This means that the national health inequalities strategy must establish a clear intention to tackle gender inequalities. It is our view that many of the actions within the present strategy would benefit from more gender-sensitive planning and implementation. As a starting point we recommend a revision of these actions to ensure that they take account of the issues highlighted in this report. We further recommend that future health inequality PSA targets (i.e. those that follow the expiry of the existing PSA targets in 2010) should explicitly aim to reduce gaps in health outcomes between men and women in parallel with reducing gaps between the least well off and the rest of the population.



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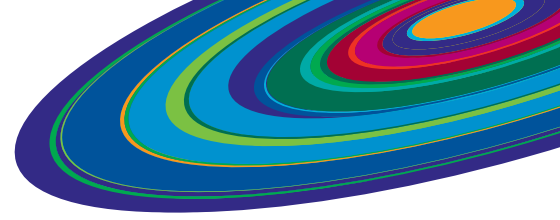
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# Appendix 1: Report of the Expert Symposium on *Gender and Access to Health Services*

Held at the King's Fund, 6 May 2008

The purpose of the symposium was to consider the final draft version of this report. Attendees were invited because they had relevant expertise and had expressed an interest in contributing to the development of the study. Those present included senior Department of Health officials; academics working in the fields of health and/or gender; senior managers from primary care trusts; and representatives of relevant voluntary sector organisations. Thirty-eight people attended out of 52 people who had registered.

All attendees received a copy of the final draft of the report four weeks prior to the symposium. They were asked to read the whole document prior to the event, or at least to read those sections that were relevant to their field of interest plus the definitions of terms, the introduction and the recommendations. The event had an important function in providing a broad review or 'quality control' of the report's content, but it was also intended that the discussion on the day should form *part of the process* of writing the final report. This was made clear to all attendees, both in advance of the event and on the day. It was stressed that we were encouraging comments, observations and recommendations that could be included in the final document.

The programme for the symposium is given at Appendix 2, and a list of attendees is at Appendix 3. The morning session was chaired by Andrea Humphrey, Director of the

Single Equality Scheme at the Department of Health.

The event was introduced by Surinder Sharma, National Director for Equality and Human Rights at the Department of Health, who explained that the study had been commissioned in recognition of the need to ensure that gender was taken properly into account in policy developments arising from *Choosing Health* (DH, 2004b), *Our Health, Our Care, Our Say* (DH, 2006c) and Lord Darzi's continuing review of the NHS. Surinder Sharma said it was also important to recognise gender inequalities in relation to all future national health objectives, and in the development of regional and local NHS policy. The absolute necessity of this was driven both by the Gender Equality Duty and by the requirements of the cross-cutting Public Service Agreement 15, which deals specifically with equality issues.

During the morning session, the symposium heard from each of the authors of this report in turn. Each presentation focused on a specific example from the report highlighting the issues associated with gender as a determinant of health status and access to health services, and explored what a gender-sensitive response might involve in that case. This group of presentations was followed by a panel discussion which gave the audience the opportunity to ask questions directly of the authors.

The afternoon session was given over to an open discussion which allowed participants the opportunity to comment on the draft content of the report, share their own

relevant experiences and explore new ideas for inclusion in the final report – most particularly in relation to recommendations for health policy.

The proceedings of the symposium are not reported separately here, but several chapters of the report have been subject to some revision as a result of the discussions – which also resulted in the addition of one new recommendation to the report and the amendment of others. The ideas most strongly emphasised at the symposium were as follows:

- A more developed understanding of gender has the potential to add greatly to our ability to address the more familiar markers of inequality – especially economic status, race and sexuality. It is important that future thinking and planning take account of these interactions and avoid the 'either/or problem' (i.e that we feel the need to choose between concentrating on one inequality or another).
- Some of the most pressing health problems require solutions in wider society rather than action within the NHS. Social constructions of masculinity and femininity are particularly important in influencing health behaviours. Health policy therefore needs better engagement with the wider social policy agenda if it is to tackle gender differences in health outcomes effectively.
- Some very good work has been and is being done to address gender inequalities in health. Invariably however, this work is small-scale, local, isolated, subject to unreliable funding and driven by the enthusiasm of particular individuals. We will never establish good practice without a dedicated national funding stream tied to proper support and evaluation systems.
- The debate about the value and cost-effectiveness of basic 'health MOTs' is a complex one, but this kind of approach (regular health checks by appointment) has the potential advantage of appearing neutral and objective to the service user, and thus of eliminating gender bias in users' perceptions. It also has the potential to pick up those – perhaps most likely to be men – who otherwise do not make best use of primary healthcare services.
- Similarly, 'outreach' services have the potential to cut through some of the barriers experienced by people who do not use primary care effectively. Health checks – and indeed more complex primary care services – could be delivered in workplaces and community settings. There is already some very good evidence that health services delivered in an occupational setting (as opposed to more traditional occupational health services) have identified pre-existing disease that might not have come to the attention of the patient's GP until symptoms had become much more serious.
- It is ironic that, while many health professionals find the link between gender and health very easy to understand at the level of the individual patient, little policy exists to address the inequalities that result at population level. In contrast, there is a significant amount of policy directed at redressing population-level inequalities associated with differences in economic status, but health professionals may feel that there is little they can do about the issue in individual cases. Either way, there may be a need for improved training for health professionals on addressing inequalities. Additionally, training that helps health professionals take account of the gender differences in help-seeking behaviour might be of value.

- The NHS is the largest employer in the UK. It could set an example by offering good-quality health improvement services to its staff, and by taking account of gender differences in doing so.

We are grateful to all the attendees at the symposium for their support and encouragement, and acknowledge their contribution to the final content of the report.

# Appendix 2: Symposium programme

## Expert Symposium on *Gender and Access to Health Services*

King's Fund, Cavendish Square, London. 6 May 2008

### Programme

**10:00**            **Registration and coffee**

**10:30**            **Chair's welcome**

Andrea Humphrey  
Director, Single Equality Scheme  
Department of Health

**10:35**            **Introduction to the day**

Surinder Sharma  
National Director for Equality and Human Rights  
Department of Health

**10:45**            **Introduction to the *Gender and Access to Health Services Study***

David Wilkins  
Policy Officer  
Men's Health Forum

**11:00**            **Gender, overweight and obesity: the challenge ahead**

Dr Sarah Payne  
Reader in Social Policy  
School for Policy Studies, University of Bristol

**11:20**            **Alcohol misuse and gender: cultural symbols or biology?**

Dr Gillian Granville  
Health Policy Consultant  
Gillian Granville Associates

**11:40 Gender and the diagnosis of cancer**

Dr Peter Branney  
Research Fellow in Men's Health  
Centre for Men's Health, Leeds Metropolitan University

**12:00 Panel discussion**

**12:30 Lunch in the King's Fund restaurant**

**1:30 Open discussion**

Led by David Wilkins

The open discussion will further explore the issues and themes arising from the morning presentations, and will give participants the opportunity to share their own experiences and observations. The objective is to inform the recommendations that will be included in the final report from the *Gender and Access to Health Services Study*, particularly – but not exclusively – those related to health policy.

*Tea will be served during the discussion at 3:00.*

**4:00 (latest) Close**



## Appendix 3: List of symposium attendees

### **Shahnaz Ali**

Associate Director of Equality and Diversity  
NHS North West

### **Dr Ian Banks**

President  
Men's Health Forum

### **Peter Baker**

Chief Executive  
Men's Health Forum

### **Carolyn Bodnar**

Pfizer Inc

### **Dr Peter Branney**

Research Fellow in Men's Health  
Centre for Men's Health  
Leeds Metropolitan University

### **Richard Chester**

Director of Equality and Human Rights  
Leicester City Primary Care Trust

### **Paul Deemer**

Equality and Diversity Officer  
NHS Employers

### **Dr Alan Dolan**

Associate Professor  
School of Health and Social Studies,  
University of Warwick

### **Tim Elliott**

Team Leader: Cancer Screening  
and Male Cancers  
Department of Health

### **Dr Marion Gibbon**

Assistant Director for Public Health  
Lewisham Primary Care Trust

### **Nick Gradwell**

Policy Manager  
Equality and Human Rights Commission

### **Dr Gillian Granville**

Health Policy Consultant  
Gillian Granville Associates

### **Caroline Gunnell**

Co-Director, Essex and Hertfordshire  
Comprehensive Local Research Network  
West Essex Primary Care Trust

### **Geoffrey Henning**

Public Affairs Manager  
Roche Products Limited

### **Pamela Holmes**

Head of Healthy Ageing  
Help the Aged

### **Andrea Humphrey**

Director, Single Equality Scheme  
Department of Health

### **Heather Hunt**

Policy Officer  
Equality and Human Rights Commission

### **Professor Kate Hunt**

Head of Programme: Gender and Health  
Medical Research Council Social and Public  
Health Sciences Unit, Glasgow University

### **Melanie Lee**

Equality and Diversity Strategy Manager  
Macmillan Cancer Support

### **Barbara Limon**

Policy Manager  
Equality and Human Rights Commission

### **Matthew Maycock**

Development Manager  
Men's Health Forum

### **Gillian Mayo**

NHS Equality Advisor  
Equality and Human Rights Group  
Department of Health

**Karen Moore**

Policy Officer  
Women's Resource Centre

**Dr Sarah Payne**

Reader in Social Policy  
School for Policy Studies, University of Bristol

**Colin Penning**

Parliamentary Officer  
Men's Health Forum

**Balraj S Rai**

Programme Lead: Pacesetters  
NHS West Midlands Strategic Health  
Authority

**David Robertson**

BME Men's Mental Health Project Officer  
Men's Health Forum

**Dr Steve Robertson**

Senior Research Fellow  
Families, Children and Life Course Research  
Group, University of Central Lancashire

**Surinder Sharma**

National Director for Equality and  
Human Rights  
Department of Health

**Angy Smith**

Policy Manager  
Department of Health

**Angus Somerville**

Chief Executive  
Orchid

**Clem Turner**

Member, Equality and Diversity Steering  
Group, Suffolk Primary Care Trust

**Dr Su Wang**

Group Head of Health  
Royal Mail Group

**Sue Waterhouse**

National Lead for Gender Equality and  
Women's Health  
Care Services Improvement Partnership

**Professor Alan White**

Professor of Men's Health  
Centre for Men's Health  
Leeds Metropolitan University

**Suzannah Wilcox**

Equality and Diversity Lead  
East of England Ambulance Service

**David Wilkins**

Policy Officer  
Men's Health Forum

**Lydia Yee**

Programme Director, Equality Legislation  
Department of Health

*Apologies were received from:*

**Joy Adamson**

Lecturer in Epidemiology  
Department of Health Sciences  
University of York

**Susan Crane**

Director of Operations  
Women's Health Concern

**Sarah Lee**

Associate Director  
Mandate Communications

**Jo McCullagh**

Health Promotion Specialist –  
Tobacco/Men's Health  
Sefton Health Improvement Support Service

**Erick Savoye**

Director  
European Men's Health Forum, Brussels

**Patrick Shervington**

Chief Executive  
Women's Health Concern

**Dr Justin Varney**

Consultant in Public Health Medicine  
Barking and Dagenham Primary Care Trust

# Appendix 4: Report of the round table discussion on men's use of primary care

Held at the Department of Health,  
21 February 2008

## Background

This round table discussion was organised by the Men's Health Forum at the request of the National Director for Primary Care, Dr David Colin-Thomé, who also chaired the meeting. The idea arose from long-standing concerns that men have higher rates of premature mortality than women and higher rates of morbidity for many serious conditions – yet at the same time, they seem to make less use of primary care services. These general observations are, of course, explored more fully throughout the rest of this report.

The planning of the round table pre-dated the commissioning of the present study, and the round table was therefore not originally intended to form part of the study process. Given the coincidence of the timing and the relevance of the subject matter, however, it was decided at the round table to include a report of the discussion in the present document.

Because the round table was specifically about *men* rather than gender more generally, we had some anxieties that the inclusion of this appendix could unbalance the content of the report. At the same time, men's use of primary care is clearly one of the central themes of the present study and, as might be expected, much of the discussion at the round table took account of the wider context. It is not really possible, for example, to speak about men's use of health

services without drawing comparisons with women's use of health services. Likewise any discussion of men's health behaviours is bound to recognise that the subject is inseparable from broader socio-cultural ideas about men's and women's roles and attitudes.

Furthermore, the attendees at the round table (listed in full at the end of this appendix) were people with a high degree of experience and understanding of the issues. It is rare to bring people of this kind together in this way, and this debate is not so widely aired that we can afford to pass up the chance of drawing on so much expertise. Our solution therefore has been to present a report of the round table discussion that focuses on the wider issues wherever possible – and to caution that the broader, overall objectives of the study should be borne in mind when reading it.

## Introduction

In opening the round table, Dr Colin-Thomé and Peter Baker, Chief Executive of the Men's Health Forum, observed that many of the most commonly held beliefs about the problems associated with men's use of primary care are effectively no more than assumptions. In some cases there is strong anecdotal evidence for these assumptions, of course; there is even some research evidence here and there, although this is rarely comprehensive enough to be conclusive. This absence of good evidence is a problem in itself; one of the purposes of the round table was to establish what was known for sure and to identify the

gaps that needed addressing. Where there was evidence, the round table might begin to frame recommendations for action to tackle the problems. Important issues that the discussion needed to cover included the following:

- It is known that men use primary care services less frequently than women. It is unclear, however, whether that is the same as using primary care services less **effectively**. How can this question be addressed?
- It is also well established that, on the whole, men have poorer health outcomes than women – but it is not known to what degree men’s less frequent (or less effective) use of primary care is a contributing factor to this.
- It is almost universally held by clinicians and other health professionals that men tend to present later than women in the progress of disease (i.e. with more advanced symptoms). Is this true – and if so, is there a connection between that and health outcomes for men?
- What is known about interventions that work with men? How might these interventions fit within the current model of commissioning services and the current structure of primary care?

It was observed that this is a crucial time for health policy in respect of this matter. NHS bodies must begin to address gender issues more effectively in order to meet the requirements of the Equality Act 2006, and the Equality and Human Rights Commission has highlighted men’s underuse of primary care services as an important example of the kind of inequalities that it wants to see tackled. The current debate about general practitioner (GP) opening hours is relevant; there is some evidence that opening hours

limited to the working day are more likely to disadvantage men.

Recent developments in health policy could also have an impact. For example, the fact that men use pharmacy services much less than women is problematic given the current emphasis on the role of pharmacy in increasing the range and availability of primary care services. The recent Health Work Wellbeing strategy has proposed an enhanced role for occupational health services, which have more contact with men than with women by virtue of men spending more time in the workplace. And the review of the NHS by Lord Darzi had been asked to give priority to problems around access and inequality, both of which are central to men’s use of primary care services.

Finally by way of introduction, Men’s Health Forum policy officer David Wilkins explained that the round table needed to be seen as part of a wider and continuing programme of events at which men’s health issues are being debated. The Men’s Health Forum has held symposia in the past two years on cancer in men, overweight and obesity in men, and long-term conditions in men. Other events are planned in the future looking at the role of the workplace as a setting for improving the health of men, and possibly at health literacy in men. David Wilkins also explained the potential of the round table to contribute to the Gender and Access to Health Services Study as outlined in the ‘Background’ section above.

It was acknowledged by all participants that the research base in relation to the connections between gender and use of health services is currently very poor. There was consensus that more research is needed. In particular it was felt that a proper analysis of the General Practice Research Database (GPRD) would be very useful, as would a

comprehensive literature review examining issues of help-seeking behaviour.

## Presentation

The open discussion was preceded by a presentation from Professor Alan White of the Centre for Men's Health at Leeds Metropolitan University.

The statistics in relation to use of primary care are fairly clear. Women use GP services more frequently than men overall, even once allowances are made for visits associated with reproductive health and childbirth. Within that overall picture, it can be seen that men visit their GP less frequently than women up to age 45. From that point onwards, the pattern is more even until age 75, at which point women become more frequent users again.

A major Danish study following lifetime use of GP services nationwide suggests that men are less likely than women to visit their GP but are equally likely, or at some ages more likely, to require hospital admission. Broadly this suggests that men tend not to see their GP often enough and/or that they present for help later in the development of disease. Although there is no comparable UK study, and the analysis of hospital admissions in this country is much less detailed, it is also the case in the UK that men are more likely than women to be inpatients, especially in childhood and after the age of 45.

The categorisation of disease used within the GPRD (categorisation decided by the GP) suggests that, while women are more likely to consult with 'minor' and 'intermediate' conditions, men are more likely at all ages to consult with 'serious' conditions. It is possible to speculate that women with more serious conditions may be being picked up opportunistically because they are more likely to have presented with minor conditions that

give some indication of their degree of risk. However, more detailed work is needed on these data before conclusions can confidently be drawn.

There is, furthermore, some conflicting evidence about the stage of disease at which men present with symptoms; men have higher rates of virtually all cancers (excluding sex-specific cancers), but their five-year survival rates are pretty much equal to those of women. This tends to suggest that they have not been diagnosed later in the development of the disease (which would reduce their chances of survival).

In some respects the crucial age group is between the ages of 15 and 45. Men have very much higher rates of injury and suicide than women in early adulthood, and by early middle age they have higher rates of cancer and heart disease. If there were strategies to target men in this age group, could disease that will become potentially life-threatening be picked up earlier?

Looking at the data on a large scale can also give a misleading impression – particularly about subsets of both men and women. Women are very much more likely overall to present in primary care with mental health problems, for example, but more detailed consideration of the data reveals an important social class differential; despite the overall picture, men in lower social classes are much more likely than women in higher social classes to be diagnosed with mental health problems. Similarly, separated and divorced men are more likely than married women to be diagnosed with mental health problems.

The large-scale 'Twenty-07' study in Scotland found no statistical difference between men's and women's willingness to seek help for health problems. However, qualitative

data suggest that some differences in help-seeking behaviour between men and women might be attitudinal. Men are more likely, for example, to say that they will go to see their GP only when they believe they are actually 'ill'. Women may be more likely to go for routine reasons (e.g. contraception) or for health advice. Qualitative studies suggest that even men with severe chest pain may delay seeking medical help in case they are 'wrong' about what is happening (i.e. they are not really ill). This suggests that socialisation may account for part of the difference between men and women – men perhaps have learned to feel that they should not 'give in' to illness. Further evidence that cultural attitudes play a part may be inferred from a study finding that men's attitudes may be different in South Asian culture, where 'being a man' may mean being prepared to seek help when you need it. These potentially deep-seated cultural and attitudinal explanations for men's less effective use of health services suggest that simply making opening hours more convenient will not be enough on its own to bring about a change.

Finally, we should not overlook that failure to recognise symptoms may be the biggest cause of delay in help-seeking for both men and women.

## Discussion

The ensuing discussion was wide-ranging, and it has proved most practical to group the observations and opinions of participants under a number of different headings rather than trying to report the discussion in the precise order that it happened.

### Alternative forms of provision

Finding alternative ways of engaging with men may be a very important part of the solution. Quite apart from anything else, the

routine 10-minute appointment is simply not long enough for a GP to pick up the wide range of health problems that a man – especially an older man – might have if he doesn't see a health professional very often. A man may be encouraged to attend for a 'check-up' but this will take longer in itself, and longer still if particular health problems are identified. That is why community-based outreach (or health services delivered in the workplace – see later) may be more effective. Services delivered in community settings may also help overcome some of men's other reservations, such as only going to see the GP when one is 'ill'. Community settings are also well suited to focusing on particular groups of men (e.g. those with lower incomes or from black and minority ethnic communities) rather than all men.

NHS walk-in centres may be more successful for men. There is some data suggesting that younger men in particular may use walk-in centres in greater proportion than they tend to use primary care. That, however, raises the question of why men do not make better use of pharmacies, which are situated in all communities and offer a form of walk-in service. The answer is probably that pharmacies are perceived as a predominantly female environment from a consumer's point of view (since they sell cosmetics, toiletries, baby products and so on). This could perhaps be addressed in the longer run. Interestingly, 50% of people using smoking cessation services delivered in pharmacies are men, as are 40% of weight-loss programme users. This compares very favourably indeed with similar services offered in other health settings.

NHS Direct has the potential to offer services with more appeal to men. It would be interesting to carry out a detailed analysis of NHS Direct user data to see what the gender-related differences are. The advent of NHS

Choices also offers the opportunity to deliver advice and information targeted at particular sectors of the population – indeed, NHS Choices may have the potential significantly to improve NHS engagement with men, especially those who are computer-literate. NHS Choices should be flexible enough to offer a very wide range of services specific to particular population groups. In the long run, technological innovation of all kinds has the potential to make services more effective with men, e.g. through e-mail consultations and electronic booking of appointments.

### **Policy and practice that could be implemented quickly**

There is enough historic data for us to be able to say that there is a legitimate concern about men's poorer health outcomes, especially in the middle years, and there is a strong case to be made for implementing some pilot programmes immediately to address this issue. Outreach programmes of the kind that have been used in Preston, Bradford, Falkirk and Knowsley have been successful. The problem is that such schemes have been subject to short-term, time-limited funding and vulnerable to the loss of individual local 'champions'. It was agreed at the round table to produce a short report summarising the generalisable core components of programmes like these, with a view to arguing for properly funded and evaluated pilot programmes based on this kind of model. The use of social marketing techniques and joint working with local authorities will be key to the success of such programmes in the future.

Workplace-based programmes also have a good track record. For example, Royal Mail has offered health checks for its male manual workers in partnership with Southwark Primary Care Trust. These have been successful beyond expectations, and

Royal Mail believes that there is a strong business case for continuing with such initiatives; in the longer run it would like to see some primary care services delivered in the workplace. Half the men who attended the Royal Mail health checks needed referral to their own GPs (for hypertension, high cholesterol levels and so on).

### **'Changing men'**

The objective for the immediate future must be to focus on changing services, not on changing men. There is no doubt that some of the dominant notions of masculinity are unhelpful. Men may feel restricted in their capacity to admit vulnerability or to seek help. But we need to recognise that we have to engage with men 'as they are'. This does not mean that we should not address these wider issues of unhelpful male attitudes in the longer run, but it does mean that they should not be our starting point. It was suggested by some participants, however, that in engaging with men 'as they are' we should aim not to reinforce (and thereby help to replicate) any aspects of masculinity perceived as potentially detrimental to health.

Changing the way that services are provided is itself a step towards helping men to become more interested in their personal health. The more we can engage with men, the more opportunity we have to encourage them to develop more effective help-seeking behaviours. NHS Choices may well have a role to play here. Work with boys in schools would also be very useful, and it would be a significant step forward if there were more gender-sensitive provision within the personal and social education (PSE) curriculum.

Another important issue to be aware of is the link between prevailing ideas of masculinity and the health of particular groups of

men. In other words, certain models of masculinity may be more common in certain male populations, and may be part of the explanation for the differences in health status between population groups.

### Ways in which primary care might change

Putting aside discussion of GP opening hours, which was discussed briefly in the introduction to this chapter, it was observed that there are two elements to the delivery of services in a GP surgery – the organisation and the consultation. It is clear that the organisation can and should change the way it markets itself and is perceived by its male users. However, the consultation itself is rarely considered – despite there being some evidence that the dynamics of the interaction between GPs (and other health professionals) and their patients vary significantly according to social factors. More is known about social class in this context, but there may be scope for developing a better understanding of the relationship between gender and the quality of the consultation. Do GPs have different expectations of male and female patients, for example? And does it make a difference to men whether the doctor is male or female?

### Cautionary notes

It is easy to assume that comparisons between men and women over the numbers and proportions using services are the main issues, but in fact they are a red herring. As far as gaining access to the most effective treatment is concerned, recognising symptoms and seeking help at the right time are the crucial factors. Likewise, in qualitative studies both men and women identify anxiety about wasting doctors' time as an obstacle to seeking help. These factors may vary by degree between men and women – indeed, it seems probable that they do – and may require different solutions for men and women, but they are altogether more

important issues to address than simply the numbers who are using services.

It is easy to fall into the trap of assuming that, just because men do something, it follows that women don't (and vice versa). Similarly we should not lose sight of variations within groups of men and women which may sometimes be greater than the variations between the genders. This does not mean that we should not compare men and women; such a comparison is one way in which we can measure progress for both sexes. The mortality gap between men and women varies across Europe, for example – in Norway men live almost as long as women.

### Summary, conclusions and recommendations

The crucial issue – and an argument still to be won – is the need to have gender-related variations in the use and effectiveness of services, and discrepancies in health outcomes between men and women that are thought not to have a biological explanation, recognised as **inequalities** in the same sense as inequalities associated with (for example) racial origin and social class. We can then begin to make real progress in tackling these inequalities. Proper implementation of the Gender Equality Duty by health bodies is an important part of this, but there is also work to be done in convincing politicians and policy-makers. The current inquiry into inequalities in health by the House of Commons Health Select Committee will be important, as was the Darzi review. Encouraging better interdepartmental co-operation at the Department of Health would also be helpful.

It is also important to think more widely than just about disease. The round table's attention was inevitably rather concentrated



on treatment services because its remit was to discuss men's use of primary care services. Other issues central to improving men's health include the need to address violence in men (as both perpetrators and victims) and the need to promote mental well-being in a way that will engage men.

In terms of developing a focus for policy, it would probably be useful to concentrate in the first instance on a particular group of men. The high level of mortality among men in the middle years of life is a powerful argument for looking at the needs of that group, but younger men also have particular problems. The current policy aim of greater choice and more flexibility in NHS services could be helpful here – a 'personal' NHS is one that recognises all important facets of the patient, including his or her gender.

It was agreed that the following actions are needed in the short term:

1. A brief document outlining the key components of the programmes and interventions that are known to have been successful with men so far. It was agreed that the Men's Health Forum would try to pull this document together in the near future.
2. A research programme intended to redress the present paucity of data on men's health and men's engagement with services. Such a research programme should consider the following questions:
  - Do men and women use health services differently (not just GP services but also NHS Direct, outpatient services, walk-in centres, pharmacy, dentistry etc)? This question should also include consideration of variations in rates and methods of use between men and

women, and severity of need at the point of seeking help.

- What do we know about why these differences occur?
- Where there is excess mortality in men, especially in the middle years, can this be attributed to less effective use of services?
- What can be done about problems that are identified?

### Attendees at the round table

#### **Dr David Colin-Thomé OBE (Chair)**

National Director for Primary Care  
Department of Health

#### **Peter Baker**

Chief Executive  
Men's Health Forum

#### **Dr Ian Banks**

President  
Men's Health Forum

#### **Jonathon Carr-Brown**

Involvement and External Affairs Lead  
NHS Choices

#### **Dominic Cowieson**

Account Manager  
Clinical Solutions

#### **Caroline Gunnell**

Research Governance Co-ordinator  
West Essex Primary Care Trust

#### **Richard Holford**

Public Health Development Manager  
Knowsley Primary Care Trust/Knowsley  
Metropolitan Borough Council

#### **Professor Kate Hunt**

Head of Programme: Gender and Health  
Medical Research Council Social and Public  
Health Sciences Unit,  
University of Glasgow

**Professor Mike Kirby**

Centre for Research in Primary and  
Community Care, University of Hertfordshire

**Gopa Mitra MBE**

Director of Health Policy and Public Affairs  
Proprietary Association of Great Britain

**Dr Sarah Payne**

Reader in Social Policy  
School for Policy Studies, University of Bristol

**Graham Phillips**

Council Member  
Royal Pharmaceutical Society of Great Britain

**Professor Mike Richards CBE**

National Cancer Director  
Department of Health

**Dr Steve Robertson**

Senior Research Fellow  
Department of Nursing, University of Central  
Lancashire

**Howard Stoa MP**

Member, House of Commons Health Select  
Committee

**Dr Su Wang**

Group Head of Health  
Royal Mail Group

**Professor Alan White**

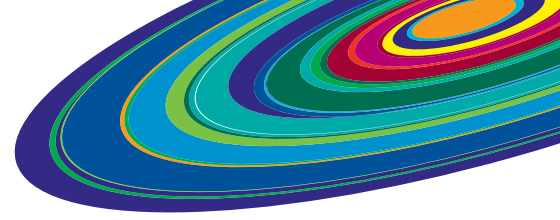
Professor of Men's Health  
Centre for Men's Health, Leeds Metropolitan  
University

**David Wilkins**

Policy Officer  
Men's Health Forum

**Lynn Young**

Primary Healthcare Adviser  
Royal College of Nursing



## Appendix 5: Transgender people's health

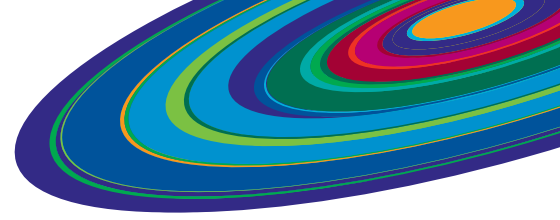
The Government is committed to ensuring fair and equal health outcomes for transgender people, who are also covered by the Gender Equality Duty. Transgender people have the same rights to healthcare as any other member of the community. Because this report is specifically about differences in access to health services between all men and women, it does not seek to address specific transgender issues beyond the extent that transgender people are men and women. However as part of the work of the Department of Health, a number of separate resources have been commissioned and/or published over the last two years, including:

- *Trans: A practical guide for the NHS;*
- *An Introduction to Working with Transgender People;*
- *Bereavement: A guide for transsexual, transgender people and their loved ones;*
- *A Guide for Young Trans People in the UK;*
- *Transgender Experiences – Information and Support;*
- *A Guide to Hormone Therapy for Trans People;*
- *Medical Care for Gender Variant Children and Young People: Answering families' questions;*

- A video resource, *Real Stories, Real Lives: LGBT people and the NHS* to support healthcare organisations in developing local strategies to promote equality and eliminate discrimination for LGBT people; and
- *Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People: Briefings for health and social care staff.*

All of these resources are available under the heading 'Sexual orientation and gender identity' on the Department of Health website at:

[www.dh.gov.uk/equalityandhumanrights](http://www.dh.gov.uk/equalityandhumanrights)



## Appendix 6: The *Gender and Access to Health Services* study team

**Dr Peter Branney**  
**Research Fellow in Men's Health**  
**Centre for Men's Health,**  
**Leeds Metropolitan University**

Peter Branney is a researcher concerned with critically exploring contemporary issues around gender and health while developing and evaluating methods for doing so. His doctoral thesis, *Deconstructing Domestic Violence* (University of Leeds, 2006), argues that a critique of public policy needs to be able to imagine its own policies and ways of realising them. Current research includes analyses of domestic violence policy, male-targeted health service provision and issues for postgraduates who teach.

Before taking on his first postdoctoral position as a research fellow in the Centre for Men's Health, Leeds Metropolitan University, Peter held an Economic and Social Research Council studentship at the University of Leeds and was a visiting doctoral student at Massey University, Aotearoa/New Zealand. He holds a BSc in psychology and philosophy, an MSc in psychological approaches to health and a PhD in psychology from the University of Leeds.

*Dr Peter Branney wrote the chapters on cancer and sexual health. He also compiled the statistical data in relation to primary care consultations for the report as a whole.*

**Dr Gillian Granville**  
**Health Policy Consultant**  
**Gillian Granville Associates Ltd**

Gillian Granville is the Director of Gillian Granville Associates, a company that seeks to translate policy and research into practical solutions at a local level in order to improve health and reduce inequalities. She works across a range of organisational systems within the NHS, local authorities and the third sector to improve services and encourage the spread of innovation in practice.

Gillian worked at the Health Development Agency managing a national programme from the NHS Plan and the National Service Framework for Older People to improve the health of men and women aged over 50 in deprived communities. Following this, at the request of the Deputy Chief Medical Officer, she moved to the Department of Health to support the implementation of Choosing Health, and was responsible for the initial setting-up of the Health Trainers programme and life checks.

Gillian is a visiting Senior Research Fellow at the Centre for Research on Ageing, University of Southampton, and has a doctorate in women's health. She has undertaken studies on gender and ageing in relation to health, including for Age Concern England, and recently produced an evidence review for Help the Aged on older men, work and health. She is a registered nurse and health visitor with grass-roots experience of working in the voluntary and community sector.

*Dr Gillian Granville wrote the chapter on alcohol abuse and undertook a series of background interviews with Department of Health officials designed to help inform the content and direction of the report.*

**Professor Kate Hunt**  
**Head of Programme: Gender and Health**  
**Medical Research Council Social and Public Health Sciences Unit,**  
**University of Glasgow**

Kate Hunt obtained her MA in Human Sciences from Oxford University, her MSc for research on the long-term effects of hormone replacement therapy from the Faculty of Clinical Medicine at Oxford University, and her PhD on gender and health from Glasgow University. She works at the Medical Research Council Social and Public Health Sciences Unit where she leads a programme of research on gender and health.

In 2006 Kate was appointed Honorary Professor in the Division of Community Based Sciences at the University of Glasgow, and since 2005 she has also had a part-time secondment to the Alliance for Self-Care Research, Department of Nursing and Midwifery, University of Stirling where she is a Professorial Fellow.

Kate's current research interests include gender and health; social inequalities in health; health, illness and disability in late mid-life and early old age; media and health; and lay understandings of coronary heart disease, cancer, mental health, and other chronic diseases.

*Professor Kate Hunt acted as critical reviewer for most of the content of this report.*

**Dr Sarah Payne**  
**Reader in Social Policy**  
**School for Policy Studies,**  
**University of Bristol**

Sarah Payne is a Reader in the School for Policy Studies, University of Bristol. The School has a multidisciplinary staff of experts working on theory, policy and practice in a multidisciplinary, research-intensive environment.

Sarah's main research in recent years has been in the area of sex and gender influences on the health of men and women, with projects funded by the Department of Health, the World Health Organization, the Equal Opportunities Commission and Leverhulme. Recent research has focused on sex and gender influences on mental health, suicidal behaviour and non-communicable diseases, and policy issues including the care of women in secure psychiatric hospitals, the prevention of suicide, and mental health services. Sarah was also part of the research team funded by the Joseph Rowntree Foundation to look at poverty and social exclusion in Britain; her particular focus was the relationship between poverty and social exclusion and mental health. Her recent publications include *The Health of Men and Women*, published in 2006 by Polity, together with journal papers on suicide and colorectal cancer.

She also co-authored, with colleagues from the School for Policy Studies, two reports on gender and health for the Equal Opportunities Commission: *Public Service Agreements: A gendered analysis* (2006) and *Promoting Gender Equality in Health* (2004).

*Dr Sarah Payne wrote the chapters on cardiovascular disease, obesity and mental health. She also reviewed the content of some of the other chapters and contributed to the co-ordination of the study.*

**David Wilkins**  
**Policy Officer**  
**Men's Health Forum**

David Wilkins has worked for the Men's Health Forum (MHF) since 2002. He was responsible for the MHF's overarching policy document *Getting It Sorted*, and has written policy papers on several specific aspects of male health including men's sexual health, men's mental health, men and cancer, and overweight and obesity in men.

From 2002 to 2005 David managed the MHF's Men and Chlamydia Project, which has been influential in the debate about improving men's sexual health. During 2005 he also managed the Gender Equity Project, which looked at local health services' preparedness for the introduction of the Gender Equality Duty. He is currently leading the three-year Bowel Cancer Project, which is funded by the Department of Health and aims to redress the balance between men and women in uptake of the National Bowel Cancer Screening Programme. David was the author of *Tackling the Excess Incidence of Cancer in Men*, the proceedings document from a 2006 expert symposium held at Leeds Metropolitan University.

David previously worked for 11 years in the NHS, for the last three of which he was Lecturer/Practitioner in Health Promotion on a joint appointment with Bournemouth University. His prior work experience includes local authority social services and youth work, and several years as a community worker. David writes frequently on men's health issues.

*David Wilkins co-ordinated this study and edited the report, for which he also wrote the introduction, definitions of terms, recommendations and Appendices 1 and 4.*



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