

'mutual respect and support', which was in evidence throughout. The format included leading speakers on men and boy's health and wellbeing—such as Richard Fletcher and Professor Faith Trent—as well as presentations, panels, and workshops covering a diverse range of men's health issues. These included physical, mental, and emotional health; men and workplace issues; health of socially disadvantaged groups of men such as indigenous, rural, and homeless men; fathers and parenting; and men's use of health services.

By adopting a social perspective of health, the conference highlighted the diversity of issues and factors that contribute to men and boy's health and wellbeing.

#### **Older men and health**

In partnership with *Older Men: New Ideas* (OMNI)—a social group for older men—the MHIRC conducted a number of research focus groups where older men were encouraged to discuss their perceptions of health and wellbeing. Older men are a group of potentially marginalised men who are significant users of health services. These older men saw good health as encompassing more than physical wellbeing. Health was seen as a combination and an interaction of different aspects of health, including physical, mental, emotional, 'economic health', and spiritual health. The results of this research are incorporated into a discussion paper written by the MHIRC for the NSW Committee on the Ageing, *Keeping the Balance—Older Men and Healthy Ageing*.

The discussion paper is being used as a starting point for reflection and action by state health agencies and community groups. Copies of the discussion paper may be obtained from the NSW Committee on the Ageing by telephone (02) 9367 6860.

#### **Fostering developments in men's health**

The MHIRC has been active in helping to establish the Confederation of Men's Organisations (COMO). This confederation aims to provide a forum for people working with men and boys—a place to exchange views and keep up to date with the latest information and developments in the area of men's health and wellbeing. COMO also seeks to empower men and boys and their organisations to become better advocates of men and boys' health and wellbeing.

#### **THE FUTURE**

In the eighteen months since the establishment of MHIRC as a dedicated Centre for men's health, the range of activities is constantly growing—networks, publications, and research projects—as MHIRC pursues its goals. MHIRC is evolving to meet identified needs, and is already contributing to the improvement of men's and boy's health in NSW.

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## **MEN'S USE OF GENERAL PRACTITIONER SERVICES**

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The use, or rather the non-use, of health services by men is currently one of the main concerns in men's health. The *Health of the People of NSW—Report of the Chief Health Officer, 2000* notes that men access health services (that is, hospital and general practitioner services as well as other providers such as naturopaths and telephone counselling services) at a lower rate than females.<sup>1</sup> It also notes that men use preventive health services at a lower rate than women (although there are fewer preventative and screening services directed at men).<sup>1</sup> Given that men show a higher level of serious morbidity, and have a lower life expectancy in all age groups, this comparatively low usage of services is surprising. Men's use of the major form of primary health care, general practitioners, is estimated to be at least 15 per cent lower than that for women. For example, a recent Australian study shows that

men use general practitioner services on 42 per cent of all occasions of service.<sup>2</sup> This article examines possible explanations that emerge from the literature for this pattern of usage, and describes the findings of a recent study of general practitioners (GPs) undertaken in Sydney.

The literature offers two main types of explanation to account for this lower usage rate of GP services by men, and these explanations are likely to be relevant to considering questions of men's use of other health services. The first focuses on how culture influences individual behaviour. This explanation suggests that our culture conveys different values regarding health to each gender, and that men have not been encouraged to place the same premium on health that women do.<sup>3,4</sup> For example, a study by Jones of a sample of men in rural Queensland indicated that health only became a priority for men once it is under threat from illness or injury.<sup>5</sup> These men equated health as 'being able to work'. This relative undervaluing of health by men in Australia can also be seen to be reflected at the level of health policy, planning and provision, in the lack

of male-specific services, or services overtly sensitive to the issues and needs of men.

The second type of explanation locates the problem of under-utilisation in the nature, location, accessibility, convenience, and relevance (or 'male friendliness') of the health services themselves. This approach draws on the history of the women's health movement, which highlights the fact that gender-sensitivity by service providers influences both satisfaction with, and degree of use of health services. Alan Wright, a general practitioner in Perth, surveyed men in Western Australia regarding their perceived barriers to the use of GP services.<sup>6</sup> His sample indicated that the main reason why men were reluctant to access GP services was the amount of time spent in waiting rooms. Lesser reasons noted in the survey included: negative perceptions of GP knowledge and skills; feeling 'uncomfortable'; cost; time spent and restricted surgery hours. These findings are supported in a further Australian study by Aoun and Johnson.<sup>7</sup>

A study by Woods, Macdonald, and Campbell—which is the subject of this article—was conducted by the Men's Health Information and Research Centre, together with the Hawkesbury Division of General Practice.<sup>8</sup> It aimed to elucidate possible reasons for the seeming paradox of men's morbidity–mortality levels and the use of GP services. The study focused on both the perceptions of the GP of the main health concerns of men who use their services, and the factors that they believed influenced men's willingness (or not) to use their services.

The study involved lengthy interviews with GPs. The findings regarding men's use of services support a view that incorporates both postulated explanations—that is, the rate of use was believed to be affected by cultural learning in combination with systematic problems of access, location, and nature of service provision. Some findings were that:

- men seem to be using 24-hour medical services in preference to the more traditional general practitioner services. The 24-hour services have the advantage of easy access and rapid service, but may lack the benefits of continuity of care (such as concerns with screening, regular check-ups, awareness of life, context, etc.) provided by traditional general practice;
- patterns of general practitioner usage by men varies depending on age and educational level. Older men and better educated men were more likely to use services; self-employed men tended to avoid general practitioner's until their health problem interfered with work performance; young men, especially those who are unemployed and at greatest risk of psychological problems, rarely access GP services; and men did not tend to use GPs as a means to deal with psychological issues, but focused on physical ailments.

These findings are, with some variations, largely supported by a similar study conducted by Tudiver and

Talbot in the United States.<sup>9</sup> Their study concluded that men's health-seeking behaviour is determined by a combination of:

- systematic barriers (time, access, and non-availability of a male service provider);
- psychological variables (perceived vulnerability, fear, and denial);
- social factors (male learning of social roles that militate against appropriate help-seeking behaviour).

Both the Australian and American studies indicate that effective primary care services for men (and probably preventative services as well) will require two changes in their current arrangements. First, a greater degree of sensitivity to male help-seeking behaviour (location, provider, hours of operation etc) is needed to ensure that males do use services. Second, and a greater challenge, is the need to encourage men and boys to place a higher premium on their health. This cannot be achieved simply by exhorting males to change their social values. We must convey the message to males, and especially boys, that their wellbeing is a matter of broad social concern, and that services are available and responsive to their needs.

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