

Why are men reticent to visit their GP?

What can be done to address this situation?

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**Executive Summary**

It is undisputed in the medical community that men, especially those aged 16 to 44, are in general less likely to visit their GP over medical complaints than women. This inequality poses a serious challenge for those concerned with public health, as an appointment with a GP over a seemingly minor problem can mean early detection and treatment of an otherwise fatal illness.

By using multiple methods of investigation, this report has looked at potential reasons why men are reticent to visit their GP, and has produced several possible policy recommendations and solutions. By using semi-structured interviews, secondary data analysis of national surveys and a comparative case study, we were able to determine the main issues preventing men from visiting their GP and potential solutions.

The main findings were that there were practical reasons preventing men from visiting their GP, such as difficulty in making an appointment outside working hours and the cost of the visit in terms of loss of earnings. The interviews in particular highlighted personal issues, such as the attitude men take towards healthcare and the social expectation of how they should act when ill. Many men also felt that the surgery atmosphere was too feminine, and was designed to meet the needs of women and children.

Secondary data analysis suggested that women are overall less healthy than men, which explains some of the additional GP visits, although this could be an indication that women view less severe symptoms more importantly than men do. It also highlighted the fact that there is a much lower rate of smoking in the UK for men than the EU average, while the rates for women were similar despite more women than men asking and receiving advice from healthcare professionals.

The comparative analysis highlighted the effectiveness of individual interventions for men, as a way to improve their attitude in regards to visiting the GP. The success of mass-media campaigns in emphasizing awareness of men’s health was noted, and the report encouraged these campaigns to continue, especially aimed at young men, as they ultimately improved their attitude and attendance in going to the GPs.

Many healthcare professionals and members of the public felt that changing opening hours of GP’s would help them to make appointments more easily, but there are mixed feelings about how effective drop-in clinics would be because there is a fear they would lead to longer waiting times. Annual check-ups would help to normalise the experience of visiting the GP but the additional spending needed for this is controversial. Health campaigns targeted towards men by their placement in male orientated places and their use of male-specific language were also suggested due to their previous success.

Overall the policy changes recommended will take time to implement, as will changing male attitudes towards healthcare. While policy change is difficult, the importance of men visiting their GP cannot be ignored.

**Rationale**

This report seeks to explain the reasons why men are more reticent than women to visit their GP. Identifying the factors which contribute to this reticence is an important task, as it may help to plan the provision of health services such that men feel more able to access them and catch diseases in their early stages.

Research of this kind is essential to improving the access to medical care by men in the UK, and thus improving the standard of living and life expectancy. The status quo leads to alarming trends in men’s health; for example, despite the higher rate of diagnosis of skin cancer among women, men have the higher mortality rate for the disease (Geoghegan, 2009). Skin cancer is easily treated if diagnosed early, but can be fatal if found later. The differences between men and women demonstrates how late men tend to visit their GP. More men tend to end up in hospital with illnesses which could have been treated by their GP if they attended sooner, a clear indicator of the harm which can be done through waiting to see a doctor, and of the urgency with which this discrepancy must be tackled. More than twice as many working age men than women die each year (European Commission, 2011).

Preliminary research in the subject identified discrepancies between men and women’s health issues. In the UK, until the age of 45, women visited their GPs 66% more often than men in 2005 – in the 16-45 age bracket, the average woman visited the GP five times, while her male counterpart visited only three (Geoghegan, 2009).

Existing research also highlights the differences due to pregnancy and childbirth, a stage of life which only affects women and leads to strong medical involvement. One study claimed that pregnancy affected GP visitation rates among women as much as health status (Polisson, 2011). While this would not affect men, there are higher rates for many risk factors in men, such as obesity (which is more dangerous for men than for women) and tobacco use (European Commission, 2011). Despite this, men are underrepresented at smoking and weight loss support programs (Office for National Statistics, 2003). The fact that men fail to take advantage of the facilities available to reduce their risk of poor health, highlights the need to persuade men to visit the GP.

In many cases, the issues causing men’s reticence were practical in nature. Men often cited the cost of services and the difficulty of accessing services due to their working hours. Men are more than twice as likely to work full-time as women, and men are more likely to make spur of the moment decisions to visit the GP which is undermined by the system of booking and waiting for appointments, especially as men do not understand the process of booking an appointment (European Commission, 2011).

For others, the issues were more personal; more than half of men reported that they were too embarrassed to discuss their health with anyone, including their doctor. Others said that they lacked the vocabulary to talk about sensitive issues; this is supported by the fact that 73% of GPs said that many male patients tend to have limited vocabularies when it comes to discussing sensitive health issues, and are unable to communicate messages effectively (European Commission, 2011). This is compounded when men find themselves having to explain their health problems to a female receptionist when booking. The inability to communicate effectively can lead to frustration which may put many men off visiting.

Some men found the experience too feminine, reporting problems with the atmosphere. Many men reported feeling that the experience, down to the waiting room, was designed to meet the needs of women and children but not men. GPs’ surgeries are thus seen as more feminine, which may make some men uncomfortable to enter. This feeling that a GP’s office is feminine could be traced to age-old views of women as overreacting (becoming “hysterical”) over illness, while men were expected to remain calm and stoically bear their symptoms (Jeffries & Grogan, 2011). Worse, around 1 in 5 men feel that they would be wasting the doctor’s time (Institute of Cancer Research, 2000). This cause can largely be attributed to a social perception of how men and boys should act; an extended period of time in a non-masculine environment may be seen to be feminising and therefore undesirable.

The EU Commission’s report on Men’s Health (European Commission, 2011) reports that the divide between men and women in visiting GPs is not as large in other European countries; in some EU countries, such as the Czech Republic, the difference in visitation rates is only 5%. This demonstrates that the issue can be resolved; it is not a universal problem, adding further support to the argument that identifying the causes of men’s reticence to visit their GPs is an important task. This is not a universal phenomenon, which suggests that the disparity between men and women can be reduced in the UK as well.

**Methodology**

This report firstly examines existing statistical data in order to quantify the extent of the disparity between the likelihood that men and women will visit their GP. The identification of a gender inequality leads to the research question itself: why are men more reticent to visit their GP than women? The possible reasons for the disparity are identified through primary and secondary research. Throughout this phase, the aim is to identify and explain all the causative factors which make men less likely to visit their GP than women.

The report then attempts to identify potential solutions to this disparity; in other words, to suggest changes to services which would reduce the effect which the causal factors of the disparity have on the uptake of GP services by men. In answering this part of the task, the report firstly looks at whether this disparity is a purely British phenomenon; if the disparity is less apparent in other countries, their methods might provide solutions. Existing solutions, both from abroad and at home, will be outlined to provide ideas for improvements.

Though there are many studies which focus on individual aspects of men’s health, the secondary data analysis in this report focuses on comparative analysis of previous studies, synthesising all the previous studies into a single source document. Previous literature is also often overly-focused on statistical analysis and quantitative research; however, this study took a qualitative approach in surveys by asking open questions to obtain information from healthcare professionals and patients.

To conduct the analysis presented in this report and address the questions, we relied on a methodological triangulation method (ie mixed method research), combining comparative case study analysis, secondary data analysis and semi-structured interviews. These methods complement one another, aiding our understanding of men’s reticence to visit their GPs and allowing us to propose solutions to address this. Furthermore, the combination of data sources meant the strengths and weaknesses of each source were compensated when used together. The aim of this was to improve the validity of our findings.

Secondary Data Analysis

Secondary data analysis was used as a cost-effective method of gaining a broad understanding of the questions. It was also used to aid our design in subsequent primary research, whilst also providing a base to compare the primary data results. The types of information and data used to conduct the secondary analysis allowed us to gain an initial in-depth understanding of the existing evidence on the topic of Men’s reticence to visiting their GP. Moreover, it outlined potential solutions already hypothesized.

National scale survey research has already been conducted on the topic of Men’s health, and was a vital source of secondary data. The survey research used to address the questions, were

The Welsh Health Survey, The Health Survey for England and The British Social Attitudes Survey. Prior to conducting quantitative analysis, each survey was compared and mapped against relevant criteria (table 2 in appendix), to ensure they were appropriate for the topic of men’s reticence to visiting the GP. Surveys were chosen on the basis that they questioned and identified reasons why men are reticent, and would be similar to any questions we would ask if conducting our own survey. The national scale of the surveys gave a large sampling frame, one we could not conduct ourselves in the time and financial restraints of this research.

It was through reviewing, interpreting and cross analysing these surveys that the information gave us an improved understanding of the health of the population, specifically in terms of men’s health and attitudes towards health. Quantitative analysis of the data allowed us to simplify the data presented to us in the form of graphs, and do a cross analysis between each survey to identify trends and consolidate findings.

Further sources of secondary data used to answer the research questions were the Office for National Statistics, the Men’s Health EU report, the ICR (Institute of Cancer Research), the NHS, WHO and the CDC (National center for health statistics). One of the major challenges of using secondary data is the assessment of its quality and validity. In order to assess this, we followed a series of steps to ensure a high standard of quality.

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| Topic Area | Focus | Target Group | Scale | Processes/strategies |
| Alcohol | Mesa Grande Project and Project Match in the US.  | Individuals with alcoholism | Individual level. | Brief intervention and psychotherapy.  |
| Smoking  | NHS Wirral campaign.  | General population | Mass level.  | TV advertising campaign.  |
| Prostate Cancer | Prostate cancer UK.  | Male population.  | Mass level.  | Posters, stamps, TV advertising campaign.  |

Firstly, we determined the original purpose of the data collection, in order to discern the potential level of bias (Novak, 1996). Then we attempted to ascertain the credential of the sources of the information, identifying their past experience. Key questions asked when using each piece of secondary data, was the date of publication, the intended audience and the referencing of the document. We identified these as key features to ensure our secondary data would be of high quality.

In order to assess the surveys in particular, we placed them in table 2 (see appendix) to identify whether the methods used were sound, who answered the survey and the purpose of the survey. This allowed us to review each survey and ascertain the quality of the research.

The advantage to using this method was the ability to carry it out relatively quickly, particularly saving us time using the good quality surveys and avoiding duplication of effort. The ability to complement primary data collection was also a positive. Whilst it may be a disadvantage in the extent to which it questions *why*, we plan to question this in our semi-structured interviews. Ensuring quality may also be difficult, however the steps taken should omit any potential error in this.

Table 1

Case Study Comparison

A case study approach was used to describe and analyse a selection of approaches and initiatives to allow us to identify transferable learning on attitudinal, behavioral, and policy change. Halperin and Heath (2012, p.207) state; “Case studies are an incredibly powerful tool for examining whether concepts and theories travel, and whether they work in the same way in cases other than where they were originally developed.” It is for this reason this method was chosen, as it enabled us to see whether successes in other health related campaigns, can be transferred to the specific case of Men’s reticence to visiting their GP.

This case study analysis is a particularly appropriate method for examining activities which are implemented in ‘real-life’ settings and which involve multiple, complex and sometimes unpredictable processes and outputs, such as in the case of Men’s reticence to visiting their GP (Keen and Packwood, 1995) Unlike more traditional evaluation methods, the case study is particularly concerned with the processes by which activities are implemented and through which change occurs. It therefore has the potential to yield relevant learning for this particular study on Men’s reticence.

Five campaigns were identified. Table 1 shows the selected topic areas, and how they were mapped against relevant criteria. We attempted to identify case studies that were both thematically appropriate to Men’s Health and which used strategies and processes that may result in transferable learning and solutions for Men’s reticence to visiting their GP. These included individual campaigns (brief intervention, psychosocial treatments) and mass-level campaigns (television, radio and print materials). A most similar systems design was then used to identify the similarities and crucial differences to make the comparative analysis (see table 3 in appendix).

This comparative research is, however, based on a small N sample of five cases. Whilst this allows for the deeper in depth analysis of the case study and can be vital for generating new ideas, the issue is that the incorrect selection of cases can lead to a selection bias, omitted variable bias and an ultimately misleading hypothesis. To reduce the significance of this issue, data and information on the five campaigns was collected from the available literature where a general strategy was devised to keep a relatively consistent approach to five diverse topics. An analysis framework was used to assess and review each case study, followed by an overall analysis of each case study’s analysis framework, to identify similar themes across each case, for example, on discussing behavioural change outcomes of the individual.

Semi-structured Interviews

Semi- structured interviews were used to question *why* the evidence is happening, and to follow up on the findings from both the comparative case study analysis and the secondary data analysis, allowing us to extract a deeper assessment of the solutions we proposed comprehensively.

This interview structure was used to question both health-care professionals and men, as a follow up on the evidence already found.

Prior to doing the interviews, we planned some initial questions (see appendix). Whilst there was flexibility in structuring these questions, these focused our interviews and kept us on topic. The practice of building rapport was also vital, and allowed us to use sensitive questions.

A purposive sample, type of non-probability sample, was used in the semi-structured interviews for both samples of healthcare professionals and men. The main objective of this was to produce a sample; “logically assumed to be representative of the population” (Battaglia in Lavrakas, 2013). The resource constraints for this research meant it more practical for qualitative data to be captured purposively. Both types of respondents for these interviews were chosen because they enable detailed exploration into men’s reticence from the perspective of both the professional and men themselves.

The structure of the interviews allowed us flexibility in asking questions and the ability to probe extra details. It permitted us to discuss the more emotional aspect of the issue, further comprehending men’s reticence. An advantage of this method, was the fact that it was much less intrusive and confirmed our evidence found, whilst also provoking opportunity to learn more.

However, a precaution that we took into consideration was the extra information which could surface throughout interviews, causing differences in responses (fao.org). In order to reduce the impact of this, we did a brief, informal content analysis of the interviews, identifying frequencies of words and looking at trends. (Halperin and Heath, 2012). The unobtrusive nature of content analysis was also a huge advantage in comparing the nature of the two interviews.

**Findings**

Secondary Data Findings

* Both healthcare professionals and members of the public interviewed all indicated that they and their male relatives were registered with a GP, suggesting direct access to GPs did not impact the reticence of men to visit their GPs.
* An important reason for men’s reticence to visit their GPs highlighted in the research was working hours, which corroborated with the findings from the literature review. The majority of healthcare professionals felt that working hours were a “significant” factor affecting GP visitation. Many of the non-health care respondents indicated that their working hours did not prevent them from going to the GP, but this could be explained by the sample used including a large proportion of students, who have flexible timetables.
* Healthcare professionals mentioned the attitude of men towards health; many answers mentioned a sense of male “stoicism” or that men simply do not visit as often as women “because they say there is never anything wrong with them”. It is perceived that men do not want to know if anything is wrong, and more than one respondent postulated this was because men are “in denial” of their health. One could therefore ascertain that due to (perceived) socially constructed norms of men being seen as “macho” and that their health is “not always [a] priority”, men are more reticent than women to visit the GP. This is validated by the secondary data research, which indicates that female smokers are more likely to seek some sort of help about quitting smoking, and more likely to ask their GP specifically for help (ONS 2009: 33-34).
* A clear majority of both interview groups agreed that men preferred to “tolerate” illness rather than get it checked out, again referencing the perceived social expectation of almost invulnerable masculinity. Again, this is corroborated by the secondary survey data that suggests women are more likely to visit a doctor for symptoms associated with minor illnesses (NCCSDO 2005). Furthermore, the healthy life expectancy of women is increasing at a greater rate (UKHS 2010), which suggests women are more likely to get their symptoms checked by a doctor earlier.
* Both sets of interviewees think men are poorly informed about preventative care and their health in general. However, many healthcare professionals felt that some men had been well informed by health campaigns although these had not reached everyone. 50% of the members of the general public had been to see their GP after it had been suggested to them by their mum.
* None of the people interviewed had been to see their GP because of a media campaign, but 20% of men mentioned they were more aware of the symptoms of prostate cancer and would be more likely to visit their GP because of information gained in a prostate cancer media campaign. This suggests that these campaigns can be helpful in spreading information.





GP’s views of how informed men are about their General Health (%)

Source: surveys of healthcare professionals

GP’s views of how informed men are about preventative health care (%)

Source: surveys of healthcare professionals

* In Wales women had lower physical and mental health than men, there was a greater proportion of women taking prescribed medication, and above the age of 35 a higher percentage of women reported that their daily activities were limited by poor health (Statistics for Wales 2011), Suggesting that women experience worse health than men. The increased visitation to the GP can partially be explained by this, particularly as being prescribed medication means a patient has to undergo regular check-ups.
* Many interviewees argued that men “find it difficult to discuss medical problems”, and that this is due to “keen embarrassment” and “nervousness”, which supports the initial research found from the European Commission (2011).
* Respondents generally found the attitudes of GPs positive, but some felt they could have been friendlier when dealing with embarrassing problems, particularly sexual health. One interviewee mentioned having a particularly bad experience dealing with a female receptionist to get an appointment. This is supported by secondary NHS data, which indicated that the second highest number of written complaints by subject area were those concerning the communication or attitude of GPs (The Health and Social Care Information Centre 2012).
* Female smokers are more likely to seek some help about quitting smoking, and are more likely to ask their GP specifically for help. However, this may be because more female smokers than male smokers receive advice on quitting smoking from healthcare professionals without asking for it (ONS 2009: 33-34), and therefore already associate the concept of quitting with those providing health care



Smokers who sought no help in quitting

Smokers who asked their GP for advice on quitting smoking

Smokers who were given advice about quitting smoking without asking

% smokers

* The smoking rate for men in the UK is further below the EU average than the respective rates for women. Despite having less advice from GPs than women, men in the UK outperform their EU counterparts and rates of smoking in the UK have decreased faster for men than women (ONS 2010 in ONS 2012). Additionally, only 37% of smokers who quit received advice from their GP (ONS 2009), which suggests that GPs are not the most useful tool men use when stopping smoking.

% of smokers

Source: Office for National Statistics (2009)



* One reason for this could be the high rates of information concerning smoking. 83% of smokers who wanted to quit said it was because of at least one health reason, and 71% said it was to improve their general health (ONS 2009). Mass media campaigns can indeed be successful, as proven by a controlled trial of a TV advertising campaign. It was found to be effective in reducing smoking by 1.2 % in 18 months (NHS). This evidence is further supported by the NHS Wirral campaign for decreasing smoking.

Source: European Commission (2011), Office for National Statistics (2009)



People who used the NHS Wirral campaign

% of smokers

* More young women than young men are now regular smokers (Health and Social Care Information Centre 2011), suggesting that media campaigns and information have affected men more than women.

Case Study

**Case Study A: Health Related Behaviour at the Individual level and Alcoholism**

Overview

* Intervention of health related behaviour at the individual level

includes an analysis of brief intervention and psychotherapy (Miller and WIlbourne, 2002). . ‘Brief intervention’ is a form of advice giving, with obvious brevity (Miller and Wilbourne, 2002). Psychotherapy’ includes individual therapies “designed to bring about change by enhancing insight and awareness or uncovering underlying dynamics” (Miller and Wilbourne, 2002).

Mesa Grande Project and Project Match, USA.

* This study revealed that “brief preventive interventions…are shown to be effective in reducing alcohol consumption for up to two years” (Raistrick and Heather et al, 2005, p.35). Moreover, psychosocial treatments with “clear structure and well-defined interventions have favourable effects” (Raistrick and Heather et al, 2005, p.35). It was found in Project Match in the USA that “briefer treatment was no less effective than two more intensive treatments” which is vital, as there were claims prior to Project Match that effectiveness of brief interventions would only be successful amongst individuals who were not deemed to have a serious problem (Raistrick and Heather et al, 2005).
* Brief intervention and psychosocial treatments can have a positive impact within healthcare behaviour. Harris and Mason et al (2011) also found “trends have shown increased effectiveness in men and even very brief interventions were found to be effective in reducing negative alcohol-related outcomes”. The fact that ‘men’ as a group have been highlighted as having been positively affected by these individual intervention types suggests that individual intervention may be a suitable approach to increase men’s awareness of the vital importance of going to the GP and the implications of not doing so.

**Case Study B: Health Related Behaviour at the Mass level and Smoking**

* The idea of Mass Media campaigns is to “change knowledge, awareness and attitudes”, (NHS, 2004) all aiding the ultimate goal to change behaviour. Evidence that such campaigns can be successful was proven by a controlled trial of a TV advertising campaign. It was found to be effective in reducing smoking by about 1.2 % in 18 months (NHS, 2004).
* The particular NHS Wirral campaign emphasised individuals choosing their own approach to quitting while also offering incentives to do so. These benefits were offered in conjunction with ASDA. Advertising played a key role, with a branded mobile trailer that visited various locations, personal quit kits and support through phone, text and other means. When evaluating the campaigns success it found 28% of those who had been involved went on to quit smoking. Furthermore, 57% of continuing smokers attempted to quit again within 6 months (corporate culture, 2010). Overall 81% of the people who visited the campaign trailer stated that they had been encouraged to quit and 75% recommended the service to another. 84% of users who received the self-help quit kit felt that it made quitting easier to consider (corporate culture, 2010). Following a positive pilot period in February 2010, the campaign was continued until March 2011 (corporate culture). This campaign demonstrates the strengths of targeting a large segment of the population (of which men are), offering sufficient incentives and maximising awareness through advertising.

**Case Study C: Prostate Cancer UK Mass Campaign**

* The important aspect of this mass campaign is its ability to lobby Government for change. The ‘Pledge for Prostate Cancer’ campaign placed pressure on MP’s to reduce inequalities and improve services for prostate cancer (prostatecancer.org, 2013). This was ultimately successful in advancing the PSA (prostate-specific-antigen) test for men, as men became aware of the option to take the test thus allowing them to make informed decisions about it. This also influenced and impacted the attitude of healthcare professionals themselves, who did not promote tests and screening for prostate cancer prior to this campaign.
* Evidence suggested; “inconsistent practice amongst GPs prevents many of the men who are not aware of prostate cancer from receiving information about the test” (prostatecancer.org, 2013). The ability of the campaign to lobby the UK national screening committee consultation led to informed GP knowledge and persuasion in GP informing men of the pros and cons of the test.  This reveals the ability of this campaign to improve knowledge of not only men, but also healthcare professionals. By targeting MPs and political reform towards health, it allowed the campaign this success in targeting different audiences. Its particular ability in informing men and provoking change in their knowledge and attitude is a particular success that could be used and adapted to reducing men’s reticence to visit GPs. Similarities between this campaign for prostate cancer and men’s reticence to visiting the GP lie in the attempt to improve awareness about an issue and prevent fatalities, suggesting transferability in the use of this campaign to improving men’s visitation of GPs.

Solutions

* Individual intervention would be a good method to improve the attitude of particularly older men who have been socialised to perceive visiting the GP as a weakness or lack knowledge of the importance of visiting their GP. The particular effectiveness of this individual intervention for men makes this approach appealing for the problem of men’s reticence.
* Further success of campaigns at the mass level in changing attitudes and awareness is also an important tool for men’s reticence to visiting their GP. This would be a particularly useful tool as men make up a large proportion of the population, therefore in order to influence and target the majority a mass campaign is necessary and has the ability to influence men of younger ages specifically. If younger men are brought up with these campaigns, then this has the ability to adapt the social conventions and attitudes surrounding men going to their GP and ultimately improve this attitude and influence their attendance.
* 70% of respondents from the general public thought that annual check-ups would be a good idea, but there were concerns raised that it would be an unnecessary cost to the NHS.
* Because there is often a lot of confusing health information on the internet, 80% of interviewees thought a direct improvement of the most visited health sites would be a good idea.
* There were mixed results from members of the public about how useful a drop in centre would be; 60% said they would be keen to use it, but many worried it would lead to longer waiting times.

Policy Recommendations and Implications

From the survey we discovered that healthcare professionals believed that much more could be done by the NHS to help increase male attendance to the GP. Firstly a common solution was to advertise in more male oriented places such as pubs, leisure centres, garages and men’s magazines. Furthermore it was important that these advertisements were specifically targeted towards men, this could be achieved through the use of lexicon that would increase understanding, in addition to this the use of role models such as sportsmen or celebrities in awareness campaigns may increase male attendance to clinics. A crucial problem identified by the majority of men interviewed, is the lack of flexibility of opening times at surgeries, with males missing out due to working hours and job roles, therefore longer opening hours and an internet booking system may aid participation. This could be solved by more drop in centres, but there is a worry this would increase waiting times. Additionally the provision of services in non-medical settings such as workplace and social venues, may allow men easier access to medical services. It was suggested by NHS professionals that men should partake in a yearly scheduled body M.O.T’s which would be a general health check up addressing any minor problems and perhaps helping reduce the possibilities of diseases whilst still increasing attendance. This system is already used in Germany and the US, so could perhaps be copied in the UK and achieve similar success. It was also found that men would prefer a male receptionist rather than a female as it would increase their confidence in surgeries, therefore male only clinics with male staff could aid participation levels to the GP.

From the secondary survey analysis it was seen that the general public were dissatisfied with the service they received at GP practises with only 58% satisfaction rate (NatCen, 2012), this could be addressed by increasing efficiency, reduction of waiting times, more nurses and easier appointment system. From the data gathered it was also seen that 68% of the population surveyed wanted additional spending focused on the NHS in 2011, this would contribute to the training of professionals, the increase of access to healthcare, purchasing equipment, new technology and consequently the reduction of waiting times  (NatCen, 2012). This is supported by the fact that 87% of respondents expressed a need for change in the NHS and the way in which it is managed and operated (NatCen, 2012).  This could be due to the fact that the increase in expectations has been disproportionate to the increase in the quality of service of the NHS and other explanation that was suggested is that the media tends to criticize the NHS and this has an indirect effect on social attitudes. It is a common view that the NHS budget needs to be increased year by year to keep up with current demand and respondents believed that a proportion of the spending should be decided by healthcare professionals such as GP’s as this would allow them to be more decisive in what is required at a local level.

From the comparative study of health care campaigns it was found that individual intervention, in particular, would be a good method to improve the attitude of older men who have been socialized to perceiving visiting the GP as a weakness or simply don’t understand the need to visit their GP. The particular effectiveness of this individual intervention found in men makes this approach appealing for the specific case of men’s reticence. If younger men are brought up with these campaigns, then this has the ability to adapt the social conventions and attitudes surrounding men going to their GP and ultimately improve this attitude and influence their attendance. This emphasizes again, that mass and individual interventions both have aspects useful to this case of men’s reticence.

One of the main implications that could prove to be a constraint on the above solutions is government spending on the NHS, the efficiency of solutions is all dependent on whether enough funding is available to make them cost effective. With budgets being cut for the past three years following the recession, it is difficult to see whether the British government will be feasibly able to increase the NHS budget. Therefore it may be required to keep costs low, a way in which this could be achieved is by reducing waste by giving GP’s more power over what to spend the money on so that only the necessities are bought. Money implications can be overcome by encouraging sponsors to partake and organise male orientation campaigns, for example a brewery sponsoring a campaign about alcohol awareness campaign.

Secondly, the solutions above would be subject to political agendas. Favourable spending on the NHS would require perhaps a more left wing Government; changes cannot be made to such an entrenched healthcare system without the approval of those in power.  For these solutions to be successfully implemented, it is important that the increase in male attendance at GP practices is a top priority due to the fact that male attendance is currently so low. Furthermore, it seems to be viewed as a given that men’s life expectancy is lower than women’s life expectancy in the current age, this should not be the case. Due to the fact that the NHS is such a broad system covering the healthcare of the nation it is obviously impossible for them to solely focus on men. Political parties are unlikely to focus on just men as they are elected to be responsive to the entire voting population. The constant re-election of governments means political agendas are ever changing, this would cause tension between the NHS and the government as each new party tries to implement new ideas. Perhaps less political intervention is required so that solutions can be implemented to a successful degree and are not just adapted to the agendas of politicians. Moreover, with a nationalized health care service, such as the NHS, the organization is tied amongst politics, which could provide an operational burden. Harrell (2009) reported how ‘British politicians display how a socialized medicine system can be shielded from market forces’ and that ‘Politicians know the NHS is incredibly popular, so they wouldn't dare propose cuts this close to an election, even though debt will eventually force the Government to either raise taxes or cut public services or both’. The views and health of the people should be more important than any political goals that the government wishes to achieve.

The complex structure of the NHS means that it takes time and money for new ideas to come into use, this often causes friction and disorganisation. Moreover, a time lag exists between the drafting of solutions, the implementation of solutions and the effects of the solutions. It is not clear whether health care policies will have a definite positive effect until they are left to progress for many years and so this needs to be taken into consideration.

We would recommend further research to test out the solutions we recommend. The research we have gathered has shown support for many of the solutions. We would also recommend research of a larger sample size and the comparison of male resistance to visit the GP across different geographical locations such as rural and urban areas, economically deprived and economically advantaged cities. Furthermore another interesting area to expand on would be that of health scares and whether these encourage frequent visits to the GP for males aged 16-44. .

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**Table 2** – Used to assess surveys on their relevance and validity to answer the research questions

**Appendix**

|  |  |  |  |
| --- | --- | --- | --- |
| Survey | Purpose | Who Answered | Problems with methodology? |
| Welsh Health survey | Covers issues such as Health status and illnesses, Health related lifestyle and Health service use.  | Taken in 2011, 16,000 adults participated. Adults selected randomly from a list of postcodes. Only adults in private housing.  | Bias in data as a result of the fact that adults in public housing were omitted. Data also collected through self-completion questionnaires, individuals answered based on how they interpreted the question.  |
| The Health Survey for England  | Variety of issues: E respiratory health and lung function·      Sexual health and contraception·      Kidney disease·      Dental health·      Obesity·      Alcohol consumption and smoking·      Fruit and vegetable consumption | 8420 adults and 2692 children. Sample derived using random probability method, ensuring a representative sample of private households. Face to Face interviews conducted on participants upon consent.  | Some participants refused to answer questions or were unable to and when this was the case the missing values were not included in the analysis. Participants were only those in private households, potential bias in the data. The survey also used weighting procedures and this resulted in standard errors being higher than they would otherwise be.  |
| British Social attitudes survey  | Survey collects data based on social, political and moral attitudes.  | A representative sample of adults over and including the age of 18. The full sample included 3311 respondents. Sampling frame was the Postcode Address File and only included private households.  | Public institutions not included, therefore the sample wasn’t as representative as it could have been.  |

|  |  |  |  |
| --- | --- | --- | --- |
| Data on Written Complaints in the NHS 2011-2012 | This survey was taken to identify complaints related to NHS organisations, this in includes walk in clinics and the NHS Direct service. | Data is collected from all NHS organisations, however 29 failed to respond. | The collection of data was not absolute. It is unclear whether GP surgeries who claimed to have had zero complaints were telling the truth. Currently it is compulsory for organisations funded by the NHS to collect complaints, this is vital for the success of finding solutions as without this, problems would not be identified. It also needs to be stressed that the collection of complaints needs to cover nationwide because if there is no data for some practices, it is not totally comprehensive as it is possible that the worst practices did not submit their complaints (Health and Social Care Information Centre, 2012). |
| Health Expectancies at Birth and at Age 65 in the United Kingdom, 2008-2010 | To collect information on health expectances so that they can be used to assess health inequalities, to recommend ways in which one can live a healthier life, | N/A | N/A |
| Smoking-related behaviour and attitudes, 2008-09 | To summarise attitudes and behaviours towards smoking | 1200 adults (aged 16 and above) who lived in private households in Great Britain. The sample frame is the Postcode Address file | The sample frame included some households in which private residents were not living because they were empty or new. |
| Smoking, drinking and drug use among young people in England in 2011 | This survey was created to monitor smoking, drinking and the use of drugs from pupils aged 11-15. | Pupils in years 7 to 11 that are in secondary school, 52 schools in each English Strategic Health Authority were selected, on average 35 pupils in every school participated. | There is worry that students may not have been honest when answering the survey because they wanted to conceal certain things about themselves or because they wanted to impress their peers. |

Most Similar System Design --**Table 3**

|  |  |  |
| --- | --- | --- |
| Mesa Grande Project  | NHS smoking campaign.  | Prostrate cancer UK. |
| A | A | A |
| B | B | B |
| C | C | C |
| D | D | D |
| E | E | E |
| F | F | F |

**Overall similarities:**

 A = Aims in changing health-related behaviour

 B= Raising awareness

 C= Increasing Knowledge

**Crucial Differences:**

D= Scale of intervention

E= Successes in changing behaviour

 F= Methods- One involving face-to- face intervention and others using visual tools such as television and posters.

Hypothesis: The differences in scale, successes and methods affect changes in behaviour and attitudes of individuals to a differing extent. One may either be more suitable to men’s reticence than the other method and this will become evident through comparison.

- Each of these Case Studies were male oriented in their implementation and had male-specific findings, therefore could be easily transferred to address men’s reticence to visit their GPs.

Semi Structured Questions

**Semi-structured questions for Healthcare Professionals:**

Are you registered with a GP?

Do you think men go the Doctors less often than women do?

What might prevent men from going to the doctors?

Do you think men are informed about preventative care?

Do you think men are informed about health care in general?

In what ways do you think the NHS can include more men and encourage them to visit their GPs more often?

**Semi-structured Interviews for members of the public:**

1.       Age:

2.       Gender:

3.       Working hours (full time/part time/ student/unemployed/night shifts etc.):

4.       Are you registered at a GP?

5.       How often do you visit your GP?

6.       A) In the past 2 years has anyone else ever suggested that you should visit your GP?

B) Who suggested it?

C) Did you visit your GP?

        D) if not, why not?

        E) Have you ever suggested to someone else that they should visit a GP?

        F) were they male or female?

        G) Did they follow your advice?

 Have you ever been prevented from going to the GP because of your working hours?

A) Have you ever been to see your GP because of information you saw in a media campaign?

B) What kind of campaign was it? (TV, internet, magazine etc.)A) Would you rather visit a drop-in clinic where you didn’t have to make an appointment?

B) If there was a drop-in clinic close to your workplace would you be more likely to visit it than your GP?

C) If there was a drop-in clinic close to a place that you socialise (Pub, football stadium etc.) would you be more likely to visit it than your GP?A) Would you like there to be a system of regular check-ups (rather than only visiting your doctor when you are unwell?)

B) If you were sent an invitation by your GP to attend a health event or check-up, how likely would you be to attend?

 Would you find improved medical information on the internet helpful? A) How do you find the attitude of the staff at your GP?

B) Would you be more likely to visit if the attitude was different? Is there anything else that would improve your experience of GPs?