

1 Introduction

Men's health has been defined as "any issue, condition or determinant that affects the quality of life of men and/or for which different responses are required in order for men (and boys) to experience optimal social, emotional and physical health"¹. This definition highlights the fact that men's health encompasses not only health issues that are male-specific but also those common to both sexes.

Recently, men's health has received increased attention because there is epidemiological evidence of inequality in health outcomes between the sexes¹. Compared with Australian women, Australian men have higher death rates at all ages, and a shorter life expectancy by 6 years². Further, men tend to suffer from more serious diseases than women³.

The health of an individual or of any group of people is thought to be due to multiple factors. Turrell and Mathers⁴ developed a model of the complex framework of external (e.g. social, political, environmental) and internal (e.g. psychological, physical, occupation) factors that shape the health of an individual or group. According to this framework, the state of men's health could be seen to be caused by a complex mixture of socioeconomic and physical factors^{1,5}.

The Centre for Advancement of Men's Health⁵ and the NSW Department of Health¹ both acknowledge in their publications that the best way to provide the most appropriate health education and health services to men is not known. It has been suggested that part of a future action plan could be to encourage a change in the perspective and values of influential people in the health system and to model future male health strategies on existing male perspectives and customs⁶. Fletcher⁶ suggested that there may be a danger in replicating the strategies of the women's health movement without regard for the differing illness experiences and health needs of men. General practitioners (GPs) can play a role in improving men's health by recognising that it needs to be approached with the aim of achieving both social and organisational change^{1,5,7}.

Cardiovascular disease is the most common cause of death for men and women in Australia, accounting for 39% of deaths in 2000. However, the rate of mortality is greater in males (255.7 per 100,000 persons) than in females (172.9)². It has been hypothesised that this difference is partially due to a natural biological protection in females (until menopause) against build-up of cholesterol⁸, and to the male behavioural factors that increase their risk factors for cardiovascular disease. However, this difference in prevalence may be partially explained by the lack of health strategies targeted specifically towards men¹.

The risk factors that are linked to cardiovascular disease are also risk factors for many other diseases. The value of examining the prevalence of risk factors is that they are preventable and can be targeted in future health strategies.

The 2001 National Drug Strategy Household Survey used self-reported data to describe drug-related behaviour in the Australian population. It included questions about tobacco, alcohol and illicit drug use in Australians aged 14 years and over. The results showed that smoking was more prevalent in males (21.1%) compared with females (18.0%). Levels of alcohol consumption defined as being 'risky' and of 'high risk' to health in the long term (according to the National Health Medical and Research Council Guidelines⁹) were found to be more common in males (10.2%) than females (9.4%). In addition, in the previous 12 months 39% of males (compared with 30% of females) consumed alcohol at levels considered to be 'risky' or of 'high risk' to their health in the short term. Illicit drugs were

found to be more recently used (within the previous 12 months) by males in every age group compared with females.

The 1999–00 Australian diabetes, obesity and lifestyle study (AusDiab) found that two in three males were overweight or obese compared with one in two females aged over 25 years (as reported in *Australia's Health 2002*).

Men have a propensity to spend time engaging in risky behaviours such as over-eating (leading to obesity), smoking, and excessive alcohol consumption³. These behaviours are explained, at least in part, by the male gender role in society and the detrimental impact it has on men's health⁷. Sabo and Gordon¹⁰ defined male gender behaviour, also known as masculinity and maleness, as behaviour that is regarded by a particular culture to be acceptable for men. Male gender behaviour displays four groups of behaviours: the denial of emotions; achieving success, status and power to maintain control of situations; denial of any problems that show weakness; and risk taking¹¹. These four groups of behaviour encompass several masculinity traits identified by other authors^{1,7,12-14}. The male gender role means that the illness experience for men is different from that of women^{7,12,15}. Masculinity has a different effect on males of different ages¹. In particular, during adolescence and early adulthood men struggle to find an identity that fits within the culturally acceptable role of an Australian man. This struggle causes health risk behaviour that has serious implications for future health¹².

The different gender-based reactions to and perceptions of sickness and health for men⁷ are evident in the results of the 1995 National Health survey which found that men had a less critical view of their health³. It also reported that the top three self-reported reasons for visiting a doctor were common to both men and women. These were respiratory conditions, check-ups and musculoskeletal conditions. Although these reasons were common to both sexes, males tend to visit doctors less frequently^{2,16} and report more serious illnesses (measured by higher rates in 10 of 18 serious disease groups)³ than do females.

Medicare-funded services include general practice (45% of services), pathology, specialists and diagnostic services¹⁷. Men's use of Medicare-funded services in both 1993–94 and 1997–98 was lower than for women. In 1993–94 males used, on average, 8 Medicare items of service per year whereas females used 12¹⁷. In 1997–98 men again used fewer Medicare-funded services, at an average 8.7 services per year, compared with women, who used 12.4 services per year¹⁶.

GPs are the point of entry to the health care system for most people¹⁸. The level of general practice service utilisation is less for males than females in every age group, except among children. For the first 14 years of life, males and females have similar rates of use, but from 15 years onwards males have a consistently lower usage of Medicare funded services¹⁷.

It has been suggested that the lower rate of health care utilisation by men may be due to the male gender role, which attaches illness to weakness¹⁵. There has been a call for health services to be made more male-friendly based on the hypothesis that men feel intimidated by community health centres and the general practice setting, because these are more oriented toward the needs of women and children^{1,5}. The results of a small localised Australian study of the opinions of 15 GPs, showed that GPs felt that men were reluctant to use their services because of lack of accessibility, work commitments and cost^{19,20}. The masculinity traits and stereotypes of male GPs have also been identified as possible barriers to the provision of effective health care for men^{7,20}. It could be hypothesised that because men take a less critical view of their health (discussed earlier), they do not regard health care as a priority²⁰ and hence do not utilise health care services.

Men spend more years in the workforce than women and are more likely to do hazardous jobs (e.g. mining), exposing them to more stress, physical activity, dangerous materials and injury^{1,3}. By interviewing GPs, Woods et al.²⁰ identified that the need to continue working was a primary reason for men to attend GPs.

GPs reported in focus groups, interviews and opinion articles that male patients tend to have a tangible physical condition when they attend a GP^{7,20,21}. These views are supported by a survey of male ($n = 80$) and female ($n = 204$) patients, between 20 and 45 years of age in London, in which Corney²² found that men attended health care providers primarily with physical symptoms. If men did attend a GP because of conditions or concerns other than physical problems, they were observed by GPs to be indirect or ambiguous in explaining their reason for the encounter^{7,20,21}. Again these findings were supported by Corney²² who found that women found it easier than men to divulge personal information (especially regarding social or psychological problems) to GPs.

The influence of women on men's health behaviours and their social standing in relation to health has been widely recognised^{5,6,15}. On the basis of findings from a series of GP focus groups, Tudiver and Talbot²¹ suggest that men use women, rather than the health care system, as their support network for health concerns. Norcross et al.²³ studied the effect of women on men's utilisation of general practice in San Diego, America. From this study of 314 consecutive general practice patients, the authors recommend involving women in men's health, because they appear to play a critical role in the social network and health behaviours of their partners.

This poses a problem for men without women in their lives. Norcross et al.²³ recommended that men should be better educated to assume greater responsibility for seeking health care services in an appropriate and timely manner. An increase in male self-responsibility for their health has also been recommended by GPs^{15,19,20,24}. Huggins¹² supports this call for greater responsibility; however, he also suggests that the community is responsible for the cultural definition of what it means to be a man and the health outcomes of this¹².

Men do not approach health preventively^{5,25-27}. For this reason, health education, the assessment of risk factors and the delivery of preventive care should take place at all contacts with GPs regardless of the reason for encounter^{28,29}.

In the last 7 years there has been an international groundswell in activities relating to the improvement of men's health. In Australia the (then) Commonwealth Department of Human Services and Health developed a draft national men's health policy in 1996, although no further action on the development of this policy has occurred³⁰. The Standing Committee on Health and Community Care submitted a report to the Legislative Assembly on men's health services³¹. The Commonwealth Government has funded a series of national men's health conferences, the fourth of which was held in September 2001³². Additionally, the Commonwealth Government has funded four national male strategic initiatives: development of a database of activities in men's health; the development of a men's health research agenda; a centre for excellence in men's sexual and reproductive health; and a forum on men and relationships³³.

Current activities are numerous and reflect a growing community interest in men's health.

- The second world congress on men's health was held in Austria in October of 2002³⁴.
- America has legislation in place for an annual men's health week (to occur prior to Father's Day) to increase community knowledge of men's health issues³⁵. The international men's health week coincides with the American men's health week³⁵.
- The *British Medical Journal*³⁶ and the *Australian Family Physician*³⁷ have both released special editions devoted to male health issues.

- The sixth National Rural Health Conference recommended that the Department of Health and Aged Care (DHAC) (now the Department of Health and Ageing, DoHA) fund research on men's health similar to the Australian longitudinal study on women's health and develop a National Men's Health Policy³⁸.
- In September 2001 the Department of Family and Community Services established a men's phone line as a result of the Commonwealth Government's men and family relationships initiative³⁹.
- The Men's Health Information and Resource Centre based at the University of Western Sydney offers advice on policy, research and evaluation for projects working with men and boys. This centre takes an active role in organising the national men's health conferences⁴⁰.
- The NSW Health Department¹, the Queensland Epidemiology and Health Information Centre,⁴¹ and the South Australian Department of Human Services⁴² have released reports on men's health.
- The Centre for Advancement of Men's Health, established in Australia in 1995, developed the MAN model to promote men's health through men's health nights and GP education⁵. Men's health nights create a male-friendly environment and aim to develop a pathway for male education and empowerment. In turn this may help men deal with health needs preventively, by reducing risky behaviour patterns and by encouraging them to seek regular check-ups and to adopt healthy lifestyle practices.
- A local General Practice Division in Western Australia developed a male-friendly health promotion program to deliver preventive health check-ups using the analogy of a health pit stop, with oil pressure being a blood pressure check, exhaust being smoking and so on⁴³.
- The men's health tune-up program developed by the pharmaceutical company Pfizer uses the racing personality Dick Johnson in its promotions. The service offers free 'tune-up nights' and a mobile unit providing free health information and health assessment⁴⁴.
- Newspapers educate men about their health needs using a non-threatening channel of information⁴⁵⁻⁴⁷.
- There has been an expansion in the number of internet sites that cater for men's health. Examples include:
 - www.menshealthandwellbeing.org.au
 - www.menshealthweekaustralia.org/mhirc.htm
 - www.menshealthforum.org.uk
 - www.menshealthnetwork.org
 - www.mannet.com.au.

In summary, we know that men have shorter life expectancy and higher death rates in every age group compared with women. Data from the National Health Survey and other patient surveys rely on self-reported data from the male and female participants involved to reach conclusions. Other hypothesised patterns in men's health and their use of GPs have come from GP opinion articles and research conducted using GP focus groups and interviews.

There is very little evidence that the hypothesised behavioural differences between men and women are true. Further, there is very little information about what problems men do take to the GP (except by self-report) and the way in which these problems may be different from those of women.

The BEACH (Bettering the Evaluation and Care of Health) study provided an ideal opportunity to examine GP encounters with male patients at a national level to determine men's reasons for seeing GPs, the types of morbidity reported and the management of these problems.

1.1 Aims

The primary aim of this study was to:

- describe morbidity and its management at GP encounters with male patients and to compare these to encounters with female patients.

Other aims were to:

- describe the characteristics of male and female patients at GP encounters
- compare the extent of use of GP services by male and female patients
- describe the health risk behaviours of males at GP encounters
- examine the pattern of morbidity managed by GPs for males in different stages of their lives.