

Improving men's health in New Zealand

**A review of the benefits of men's health awareness activities
and a proposal for the development a targeted men's health
programme**

Dr Lannes Johnson
Dr Adrian Field
Paul Stephenson

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Executive summary

The importance of men's health and men's health status

Health is not simply a by-product of economic development, but is a substantial driver of economic development as well. The health of the population affects a country's productivity, labour supply, education levels and capital formation. Healthy people learn better, live longer, and work, earn and save more. In this sense, the health of the population is an important contributor to the health of the nation.

Yet the health status of men appears markedly poorer and their utilisation of health services is lower than that of women's, which questions if men are achieving their potential contribution to the health of the nation. For example:

- In New Zealand, women have consistently lived longer than men: in 2002-04 average life expectancy at birth was 77 years for males and 81.3 years for females.
- There has however been a steady narrowing of the life expectancy gap between men and women, from 6.5 years in 1975-77, to 4.8 years in 2000-02.
- The 2002/03 NZ Health Survey found GP utilisation in past 12 months was lower among men (75.7%) than women (85.5%), yet markers of health status in the survey did not signal that the health of men was better than that of women.

Against a backdrop of a growing awareness of particular issues relating to men's health is an emerging international men's health movement. Although the field remains relatively small, there are notable advances occurring in Europe, the UK, US and Australia, but little co-ordinated activity in NZ.

If greater health equality were to be achieved between the sexes the impact on New Zealand's economic and social wellbeing could be significant. This report reviews the health benefits arising from men's health awareness activities, and identifies options for applying such activities to New Zealand.

Evidence of benefits of men's health activities

The literature reviewed in this study shows a paucity of interventions that have been comprehensively monitored and evaluated, and which in turn have shown clear beneficial impact on men's health. However, the available literature indicates some potential for men health awareness activities to catalyse interest in health and to seek advice or support.

The key benefits of men's health activities identified from the literature are:

- **Raised awareness** of health issues, in both health providers and the public; such awareness is not an end in itself, but creates momentum for either behavioural change or further contact with the health system or support services.
- **Connecting men with health or other support networks** that may be available; however, it is imperative for services to be equipped to deal with

the issues raised in a way that encourages concrete action to take place as a consequence.

- There is also limited evidence of such interventions of **creating behaviour change** around health risk factors, such as cardiovascular disease. Behaviour change can be influenced directly on men, and indirectly through women and families/whanau.

A proposed approach to improving men's health outcomes

New Zealand needs a policy on men's health. A starting point could include clear and simple goals of

1. Men (and women's) life expectancy increases and :
 - The gap in men's and women's longevity closes more rapidly than over the past 20 years.
 - The gap between Maori and Pacific men's longevity and non-Maori non-Pacific men's longevity closes more rapidly than over the past 20 years.
2. Improved men's outcomes for specific disease types including: coronary heart disease; cancer (all types); transport and workplace accidents; and intentional self harm or risk-taking behaviours, including alcohol-related harm.

A five-year programme is proposed to improve men's health. The initiative would seek to achieve measurable improvements in:

- Increasing community and family/whanau awareness of men's health issues
- Improving men's knowledge of their own health issues
- Earlier identification of health risk and disease
- Improved appropriate access of health services
- Improved men's self management of health risks and disease
- Improved health sector response to cancer, heart disease and diabetes screening
- Improved health sector response to guideline-based management of chronic conditions

It is proposed that the year 1 pilot trials a four-phase approach and supports a substantive evaluation. Activities would be based within each of the phases below:

- Phase 1 – Awareness programme, with prompts to 'find out' about their health
- Phase 2 – Improving access to health services and reducing barriers for men
- Phase 3 – Ensuring an effective health system response to men and instituting a systematic, targeted approach in Primary health Care.
- Phase 4 – Evaluation, to proactively learn from the initiative at both a local and national level, to support continuous improvement

The programme design and delivery could be managed by the Ministry of Health or it could be contracted out to another party, such as a PHO or NGO to design and deliver.

Without a detailed costing of the scale and scope of the programme it is impossible to provide an accurate figure. However, it is estimated that a national awareness programme may cost \$1 million per annum to reach 70% of New Zealand men aged 35-64, with at least an extra \$1 million required each year to support a multi-faceted screening programme.

Stakeholder response

A workshop with a broad range of stakeholders was held to gauge public perceptions about men's health issues and to ascertain the level of support for a more proactive approach to addressing men's health.

The stakeholder group included interested parties and opinion leaders, mostly from the Waitakere community. Attendees represented a wide range of organisations and the Maori, Pacific and Asian communities.

- There was strong support in the group for greater recognition of men's health issues, and the need for concrete action
- The key directions outlined in this paper were supported.
- The consensus was that a men's health initiative would receive widespread public support
- Waitakere City Council and local organisations were willing to actively support men's health awareness programmes
- Innovative programmes were needed to communicate with men
- Changes in attitudes will take time and programmes would have to run for many years
- More detailed development of the proposal is required to support the primary care response to a men's awareness campaign.

WDHB PHO Clinical Leaders have expressed enthusiasm in supporting this Men's Health initiative. It is anticipated that all NZ PHOs, ethnic providers and mainstream, will also offer support.

Recommendations

- 1) The Ministry of Health develops a men's health policy for New Zealand.
- 2) There is a five year programme focused on improving men's health awareness and appropriate access to health services.
- 3) Primary care is supported to undertake systematic guideline-based screening of men for selected conditions, in association with awareness programmes.

- 4) The programme is evaluated to identify impact and support continuous quality improvement.
- 5) A pilot programme in the Waitakere District could be considered prior to the development of a national programme.

Introduction

Background to this project

The Ministry of Health has contracted Lannes Johnson to review the health benefits arising from men's health awareness activities, and develop options for the application of such activities in a New Zealand context. Adrian Field and Paul Stephenson of Synergia Ltd are undertaking this research alongside Lannes Johnson.

Specifically, the project aims to:

1. Review published evidence on the health benefits associated with men's health awareness
2. Review the evidence or consensus opinion of the benefits delivered by international and New Zealand experience of men's awareness activities
3. Specify the recommended health outcomes that should be the focus for any nationally co-ordinated activities
4. Consult with appropriate stakeholder groups to establish their perceptions using one or more focus groups or structured interview surveys. Stakeholders must include representatives from the public, public health, and PHO sectors.
5. Outline the estimated benefits and costs of the recommended option.

Chapter one of the report examines the first two components of the project, focusing particularly on the identified benefits of such activities. Chapter two proposes a five-year programme for advancing men's health, and chapter three reports on the findings from stakeholder consultation.

Chapter I - Review of the evidence of benefits arising from men's health awareness activities

Why is health, and men's health, so important?

This introductory section briefly addresses two questions; firstly why is health intrinsically important, and secondly, why is men's health of particular importance?

One answer to the first question would contend that a person's health is a foundation which enables or constrains an individual's lifestyle, social, education or employment choices. A decline in an individual's health has significant ramifications for their employment status, and participation in the workforce. But the idea of health as the foundation of individual wellbeing also extends to the health of a nation.

Health is not simply a by-product of economic development, but is a substantial driver of economic development as well. The health of the population affects a country's productivity, labour supply, education levels and capital formation. Healthy people learn better, live longer, and work, earn and save more (Oram 2006).

The increasing cost of healthcare, fuelled by new technologies and an ageing population, itself places a substantial economic burden. This highlights the importance of improving the overall health status of the population rather than simply extending the average life expectancy of the population – adding life to years, rather than years to life.

If health is important then, what is it about men's health that is worthy of attention? In New Zealand, men comprise 49% of the population and 52% of the labour force (Statistics New Zealand 2006). Building on the above arguments, the health of the male population is therefore a substantial contributor to the health of the nation. Yet, as detailed below, the health status of men appears markedly poorer and their utilisation of health services is lower than that of women's. This does not devalue the importance of women's health, but simply raises the issue that if greater health equality were to be achieved between the sexes the impact on New Zealand's economic and social wellbeing could be significant.

The importance of men's health however is not simply a utilitarian matter of the greater good in relation to the economic health of the country. If health inequalities between social and occupational classes or ethnic groups are considered to be a major issue of equity – or intrinsic fairness – then the poorer health status of men poses a similar challenge (Tsuchiya & Williams 2005). It is difficult to diminish the importance of men's health on the basis of either riskier/unhealthy behaviours, or as a function of occupational roles, when such issues are seen as being important factors to be addressed when confronting other forms of health inequality.

Although in New Zealand addressing inequalities in health is a key focus of health strategy and policy (Minister of Health 2000), men's health does not specifically feature in this regard. Rather, the focus is more on addressing inequalities patterned by ethnicity and deprivation, and issues of men's health within these groups appears at best in the margins.

Methodology

Reviewing the published evidence on health benefits of men's health awareness activities was undertaken through a literature review, drawing on the Medline, PubMed and Google Scholar online databases. Keyword searches were used, with a number of iterations to narrow the literature down to appropriate articles. The main subject 'men's health' was combined in keyword searches with 'health awareness', 'health promotion', 'screening', 'awareness' and 'evaluation'. From this over 100 articles were identified, which were narrowed down to approximately 20 of relevance to this research.

A further search stage identified appropriate literature from the bibliographies of publications selected in the preceding stages. In all, some 30 key sources are cited in this review.

Of note is the extensive work undertaken by McKinlay (2005) and McKinlay et al (2005), in reviewing men's health status, the range of interventions that have been applied, and particular issues in promoting men's health in New Zealand. This work has informed many parts of this report.

The state of men's health in New Zealand and internationally

Health status

In most modern societies, women tend to live longer lives than men. This has often been taken as a given and a reflection of improvements in health services for women over the last century, particularly maternity care, together with the generally higher exposure of men to occupational or environmental hazards. Yet an examination of data on the status of men's health suggests that there are many issues specific to men that should justifiably concern health planners and policy-makers, and for which a systemic or societal response may be required.

In developed countries, the evidence points to a substantial health inequality between men and women (White 2006). For example, a study of 17 European countries found men under 75 years having almost twice the number of deaths as women in the same age group in most disease states, with the exception of diseases of the musculo-skeletal system, skin and connective tissue (White & Cash 2002). A study of men's and women's health outcomes found that more men than women under the age of 44 died prematurely in all the 44 countries examined by the study. Using WHO data, the study found that in many cases the causes of the early deaths were avoidable: the main causes of death in this age group were associated with lifestyle and risk taking, including road traffic accidents, smoking, poor diet and alcohol consumption (Dobson 2006).

The international literature has identified that men tend to have higher mortality rates, but that women tend to have higher morbidity rates, especially at advanced age (Tsuchiya & Williams 2005). It does not appear to be the case however that the

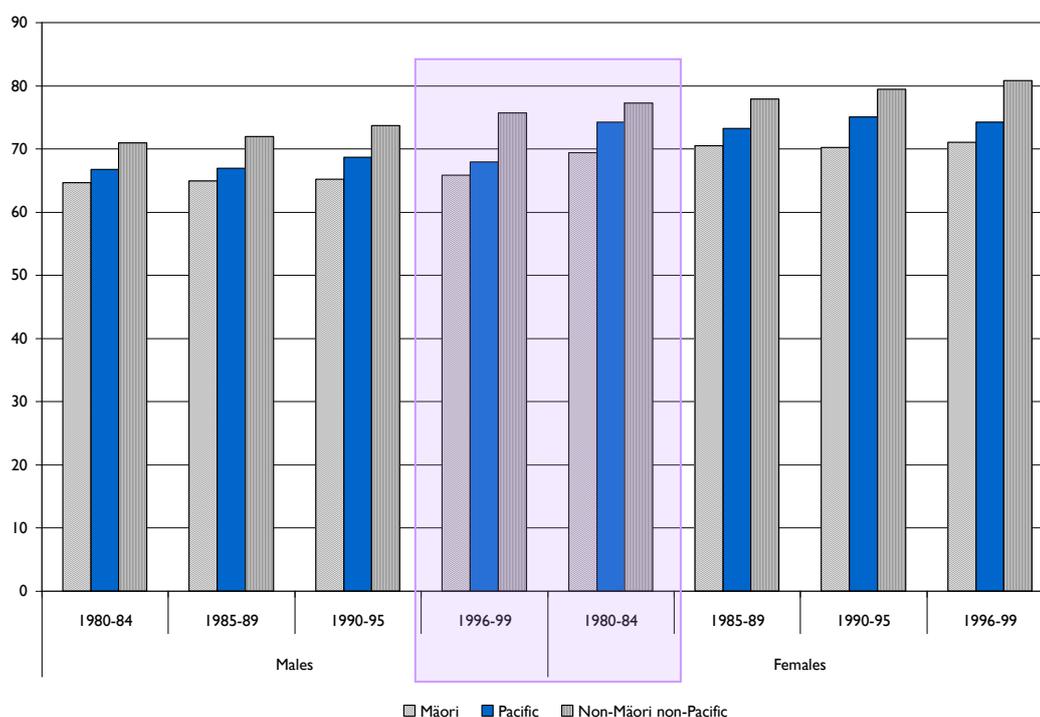
reduced quantity of life on the part of men is offset by the reduced quality of life on the part of women. Rather, the emerging international literature on quality-adjusted life expectancy and disability adjusted life expectancy in developed countries indicates a persisting inequality of poorer lifetime health outcomes among men compared to women in the same community (Tsuchiya & Williams 2005).

These international patterns of inequality are reflected in the New Zealand data. Although life expectancy has increased over the past half-century, women have consistently lived longer than men: in 2002-04 average life expectancy at birth was 77 years for males and 81.3 years for females (Ministry of Health 2005a). Since the 1970s however there has been a steady narrowing of the life expectancy gap between men and women, from 6.5 years in 1975-77, to 4.8 years in 2000-02 (Statistics New Zealand 2004).

The *Decades of Disparity* report focused on widening inequality between ethnic groups over the periods 1980-84 to 1996-99. Yet clear patterns of gender inequality also emerged. For example, life expectancy at birth showed lower life expectancy for males compared to females. More startling was that life expectancy for males in each of the three ethnic groups (Maori, Pacific and non-Maori non-Pacific) in the 1996-99 period was actually lower than life expectancy for females in each ethnic group in 1980-84, 15-20 years earlier (Figure 1 below) (Ajwani et al 2003).

In 1996-99, the greatest life expectancy gap, of 15 years, was between Maori males and non-Maori non-Pacific females. However, the data also indicates a narrowing life expectancy gap between males and females within the Pacific and non Maori non-Pacific groups over the 1980-99 period, of 1.2 years in each ethnic group, and a slight widening of the gap between Maori males and females of 0.4 years.

Figure 1: Life expectancy at birth, New Zealand, 1980-84-1996-99



Source: Ajwani et al 1999

This difference in life expectancy, patterned by gender, is reflected in mortality data for major causes of death. Mortality data indicates males are more likely than females to die of most major causes, including coronary heart disease, cancer (all types), transport accidents and intentional self-harm. Females are more likely than males to die of hypertensive disease and other forms of heart disease (other than coronary heart disease), cerebrovascular disease, pneumonia and influenza, and falls (McKinlay 2005).

Health service utilisation

The literature also points to men experiencing barriers to service, either as a result of apparent reluctance, or potentially systemic barriers. US research has shown men with health problems are more likely than women to have had no recent contact with a doctor, regardless of income or ethnicity. Data from the UK indicates that men tend to visit their general practitioner later in the course of a condition than women, a problem that is compounded by social inequalities (Banks 2001).

Again, a similar picture is evident in New Zealand. The 2002/03 NZ Health Survey found that GP utilisation in past 12 months was lower among men (75.7%) than women (85.5%) (Ministry of Health 2005b). This could suggest men are generally healthier and have less need of seeing a GP. However, there were no conclusive findings in the survey that would support this contention. In terms of prevalence of most chronic diseases, apart from osteoporosis (higher among women), no significant differences emerged. In risk and protective factors, men were more physically active, but consumed fewer fruit and vegetables than men, and there were no significant differences in obesity levels. Alcohol and marijuana consumption was higher among males than females, but no significant difference in tobacco smoking (Ministry of Health 2005b).

However, the data also indicates that a blanket category of men obscures important differences between ethnic and socio-economic groups: Maori and Asian males tend to access GPs less frequently than European/Other, and males in the most deprived quintile were more likely report needing to see a GP but not doing so, than those in the least deprived quintile (although the difference by deprivation was not significant) (McKinlay 2005, Ministry of Health 2005b).

The evidence does suggest though that men do care about health issues, but often find it difficult to engage with health services. This can be for a range of reasons, including

- Lack of knowledge, either of services or of risk factors such as obesity (Banks 2001);
- Lack of motivation, or stoic predispositions (Aoun et al 2002, Courtenay 2000)
- Inappropriate opening times of services (Leishman & Dalziel 2003, McKinlay 2005);
- Inappropriate targeting of interventions or insufficiency of available services (Banks 2001, McMahan et al 2003).

Emergence of an international men's health movement

Against a backdrop of a growing awareness of particular issues relating to men's health is an emerging international men's health movement (White 2006). Although the field remains relatively small, there are notable advances occurring in Europe, the UK, US and Australia. Momentum has been generated and accelerated by the establishment of men's health advocacy organisations in many countries, such as the Men's Health Forum in the England and Wales (www.menshealthforum.org.uk), and the Men's Health Information and Resource Centre in Australia. Organisations such as these have acted as focal points for national and local activity, developing and publicising initiatives, clearinghouses for resources, and health and policy advocacy (Baker 2001).

Conferences on men's health and an international men's health week have also become regular events in many Western countries, providing opportunities to showcase initiatives and advocate for health planning and policy solutions (some examples of such activity are discussed later in this review). Activity in this area has been slower to take off in New Zealand, but a number of localities in 2006 held men's health evenings as part of international men's health week, which were organised by Age Concern.

Evidence of benefits of men's health awareness activities

In reviewing the available literature, it is clear that the evidence base of the benefits of men's health awareness programmes is sparse, reflecting its relatively recent emergence as a field of activity. The published literature does however point to some benefits of activities that are targeted at men's health. What is clear though is that there is no one programme that will cater to the needs of men across all ethnic or social groupings. Rather, programmes need to be developed according to the particular ethnic, social or geographical circumstances within which men live.

National Men's Health Week and other events/resources

The international Men's Health Week provides an opportunity for men's health groups and advocates in different countries to showcase local and national initiatives and hold one-off events that draw attention to men's health issues. Men's health week is marked in countries across Europe and the UK, as well as Australia and the US, and as noted earlier, to a lesser degree in New Zealand.

There is a paucity of evaluation evidence of these events, and none that would signal their health benefits. It is important however not to evaluate such events in terms of their possible health benefits, which would be very difficult to disentangle from the effects of any number of other policy or service interventions. It would be more appropriate to assess impact on their more immediate aims of motivating action and raising awareness.

The Men's Health Forum in England and Wales publishes an annual evaluation of the activities taking place under the banner of National Men's Health Week. The findings

in 2005 were mixed, signalling some plateauing of the momentum that had built up rapidly in previous years. Over the first three years from 2002 to 2004, registrations for National Men's Health Week grew tenfold, but dipped slightly in 2005. The evaluation was able to point to a continuing diverse range of local grassroots activities, considerable enthusiasm on the part of those leading such activities, and the creation of a unifying brand or concept to draw the activities together. However, media coverage of the event in 2005 appeared lower than the previous year. Whether these signal deficiencies in planning or reduced public and media interest are not clear (Men's Health Forum 2005).

The Men's Health Forum has tapped into an innovative way of raising awareness of men's health issues. The organisation has worked with Haynes, a company that publishes owners' car maintenance manuals, to produce a series of manuals using the analogy of maintaining a car with a man maintaining his body. Over 100,000 copies of the original 'Man Manual' were sold through mainstream bookshops and other outlets. Other manuals focus on different aspects of health from a male perspective, including a 'HGV' (Heavy Goods Vehicle) Manual for overweight men (European Men's Health Forum 2005).

A review of men's health activities in Scotland drew attention to the success of the Scottish Men's Health Forum in raising the profile of men's health within the Scottish political sphere over a brief period of time. However, as a young organisation, the report also indicated there remains work to be done to raise the profile of organisation among local authorities, voluntary health organisations and NHS staff (Johnson & Rafferty 2004).

Men's health clinics/centres

Internationally, there are a growing number of men's health clinics or centres targeted at men. Such centres incorporate a range of innovative approaches in attracting men to attend. These included operating outside normal working hours; using appointment systems for comprehensive assessments rather than brief 'drop-ins'; advertising of services locally; and targeting at particular cultural or socio-economic populations (Ekundayo et al 2003, Leishman & Dalziel 2003, Price 2006).

The limited published evidence indicates that these can be effective in connecting men with health services when tailored to the needs of their local populations. A review of a wide range of men's health activities in Scotland (commissioned by the Scottish Office) found such clinics or centres can provide an effective form of outreach and demonstrated ways in which it is possible to communicate with men from a range of social groupings and geographic areas:

'Through clinics and projects encouraging and giving men the time to disclose concerns about their health, practitioners appear to be promoting behaviours that challenge the archetypal and widely held perceptions that men aren't interested in their health and tend only to present to services when their health is in crisis. If such health promotion approaches to men's health care continue this has potentially wider implications in terms of the economics of

health care provision, placing an emphasis on education, prevention and early detection rather than treatments and cures.’ (Johnson & Rafferty 2004)

Men’s health evenings

Evening events where men are able to meet in local community centres are a further awareness-raising activity that has been widely employed. In New Zealand, six such events were held during international men’s week in 2006 (June 12-18), in Whangarei, North Shore, Kapiti, Wellington, Napier and Hastings (<http://www.ageconcern.org.nz/?/menshealth>).

Such events often take the format of a local doctor or guest health professional speaking on various topics and with time for audience questions or discussion, either directly to speakers or in smaller groups (McKinlay 2005). Very limited evidence is available on the benefits associated with these events. A rural and suburban study in Victoria found such sessions successfully tapped into the concerns of many older men, raised awareness of health issues and enhanced their motivation to visit a GP. The sessions tended to attract older men of higher socio-economic status, suggesting different types of interventions are needed to draw in other groups (Verrinder & Denner 2000). The fact that in New Zealand most of these events were organised by Age Concern indicates a similar demographic group would be receptive to these initiatives.

Workplace interventions

A number of projects targeted at men in workplaces have shown positive benefits in terms of raising awareness, and connecting men to health services, particularly men from the blue collar workforce who are often less likely to make use of health services.

A Western Australian intervention in diabetes education and risk assessment targeted men aged 40-65 years in 27 organisations. Data from the study showed that 76% of men were identified as high-risk of developing diabetes and were referred to their GP (Aoun & Johnson 2002). A brief evaluation of a health promotion campaign on prostate health, using posters, leaflets and nurse visits in the British Post Office found increased awareness of prostate health issues (by as much as 24 percentage points pre- and post-intervention), and high levels of willingness to discuss such issues at work and to seek advice from the occupational nurse (Summer et al 2002). It is not clear whether this actually translated into help-seeking behaviour. A New Zealand workplace health promotion programme targeting dietary behaviour used nutrition displays and on-site workshops over six months. The study showed low intensity workplace events such as these can improve reported health behaviours and nutrition knowledge, although the changes in objective measures of risk were more variable (Cook et al 2001).

These studies point to the potential effectiveness of workplace-based programmes in connecting people with health services for ongoing follow-up. However, the Australian study also showed that the GP referrals were not endpoints in themselves. The lifestyle advice that men received once referred to their GP was

often not enough to act upon. What was needed was concrete advice with specific, attainable recommendations with co-ordinated management. (Aoun et al 2002).

Primary health care

Primary care has often emerged in the literature cited above as an important endpoint in many men's health interventions. Having raised awareness of men's health issues, a success factor of such initiatives is that men will then consult their GP. However, as noted above in an Australian study, primary care is often not equipped to provide effective health promotion activities in the course of GP or nurse consultations (Aoun et al 2002).

Once again, there are few evaluated interventions focusing on men's health promotion in primary care. An Irish study of men's health promotion provided men with health education and consultations on cardiovascular screening, cancer screening, stress management or general lifestyle advice. The study found some successes in motivating changes in health behaviours over the short term, but stressed that adequate training and resources are needed for primary care to be effective in this role (McMahon et al 2003).

The literature also points to a range of approaches that primary care can take to be more 'men-friendly'. These include offering services at 'work-friendly' hours, setting up health checks targeting at-risk men, offering choice of female or male health professionals, using more information or communication technology such as email or texting, and encouraging primary care staff to work in wider community initiatives (McKinlay 2005). Personal approaches used by health professionals have also been reviewed to ensure a primary care environment that is more responsive to men, including the waiting room ambience, the health promotion resources on offer in surgeries, avoiding language that is negative about masculinity, following up family difficulties and avoiding judgemental attitudes (Banks 2001, McKinlay 2005).

Screening can have positive outcomes other than the early detection of disease, such as forming a relationship with a health provider. Opportunistic health screening by GPs is suggested as a means of ensuring routine screening checks are undertaken regularly. However, as men do not attend GPs regularly, opportunistic screening can be difficult to address within a routine appointment, and there is debate as to whether patients approve of such screening. There is also significant debate about the efficacy of prostate screening in particular (McKinlay 2005).

Within New Zealand, there is emerging evidence that population health screening, through health checks in primary care, can identify those at risk in the population of cardiovascular disease and diabetes. This initiative, implemented by the HealthWest PHO in Waitemata, has successfully reached many whose risk levels were previously undetected, and who now received ongoing follow-up through primary care

A qualitative study based in Wellington on the experiences of men in primary care, and the experiences of primary care practitioners in men's health, indicated a wide range of issues. The male consumers interviewed wanted access to public information about the range of general practices and their services. Interviewees

sought good communication skills from their GP, and that GPs should initiate conversation/assessment about the wider aspects of men's life. Of note was the appeal to many men of the 'warrant of fitness' analogy for accessing health services to receive a health check (McKinlay et al 2005).

Primary care practitioners in the study indicated men were less likely to look after themselves than women, but also identified systemic barriers to men accessing primary care. These include the clash with working hours, the cost of consultation, and environments that were not 'male-friendly'. Practitioners also considered the lack of health promotion material in New Zealand on men's health minimised perceptions of men's health as an important issue. The lack of evidence on the effectiveness of men's health promotion activities in primary care was also cited as a barrier to undertaking men's health initiatives. Those participating in workplace-based health care were enthusiastic about its effectiveness and efficiency, particularly in reaching people who would not otherwise link with the health system.

A common theme through all interviews (from consumers and practitioners) was that primary care could improve service delivery through reminders of appointments (by post or email/text), flexible opening hours and where possible, more timely appointments.

Cost is also often cited as a barrier to accessing primary health care, and is a major focus of the Primary Health Care Strategy in New Zealand. However, among men, the 2002/03 New Zealand Health Survey did not show a consistent relationship between seeing a GP and level of deprivation. The survey did find males in the most deprived quintile were more likely report needing to see a GP in the past 12 months, but did not do so, than those in the least deprived quintile, but the difference was not significant (Ministry of Health 2005b). It has yet to be seen if the phased introduction of low-cost GP access via PHOs is contributing to improved rates of GP attendance by men.

Multifaceted community programmes

A range of multi-faceted community programmes using comprehensive models of health promotion and health care have been established to improve men's health. Unlike the single initiatives discussed earlier, these draw together a range of projects targeting men under a single umbrella and are not necessarily time limited (McKinlay 2005). Such programmes, undertaken in the UK, Ireland and Australia weave together many strands of men's health issues, such as health and identity among adolescent boys, antenatal sessions for fathers-to-be, support groups for male sexual abuse survivors, heart health and professional development for GPs.

There are also examples in the US of comprehensive men's sexual health programmes that take action on a number of fronts, in many cases to tackle the growing syphilis epidemic. Approaches include print, radio and television media, expanded access to men's health services, and professional and community training (Schmitt et al 2005, Taylor et al 2005).

The underlying approaches are founded on an evidence base of the importance of multi-faceted interventions, which draw on a wide range of stakeholders and sectors. Unfortunately however, there are few published evaluations of such interventions. There is little available evidence to assess how these and other interventions discussed in this report have impacted on the lives of men involved or their families or loved ones, beyond raised awareness and intentions to contact GPs (Sternberg & Hubley 2004).

One exception is the evaluation in New Zealand of PHARMAC's 'One Heart, Many Lives' campaign, a programme aimed at increasing awareness of cardiovascular disease, particularly among Maori and Pacific men, increasing uptake of statins, and increasing the uptake of the Green Prescription programme. The programme had three components:

- A social marketing campaign based around the theme of *One Heart Many Lives*, reflecting the way in which heart disease affects not only men aged 35 and over, but also their family and friends, and their roles within their family/whanau, their relationships and responsibilities;
- Community provider projects in Porirua and Gisborne in 2005, which involved screening men in the priority group and enrolling them in risk reduction programmes aimed at improving nutrition, increasing physical activity and reducing smoking; and
- A third, ongoing phase collaborating with DHBs in implementing their cardiovascular risk reduction strategies, including support for primary care training and screening, and using the *One Heart Many Lives* social marketing package (Sinclair 2006).

Although it has an emphasis around primary care activities, the programme also has significant elements of community-based interventions. The programme evaluation found an increase of 27% in statin prescribing in the social marketing intervention areas, compared with a national average increase of 20%. Statin prescribing rose in both the intervention and control areas, as well as for each of the population groups assessed (Maori, Pacific and Other) over the 16 months surrounding the *One Heart Many Lives* launch, most notably for Pacific men. However, rates of statin prescribing in the intervention areas remained substantially below the national average. The increase in statin prescribing for Maori and Pacific people in the pilot areas was greater than in control areas, but the increase in statin prescribing for the population as a whole was the same in the pilot and control areas. In addition Green prescription referrals increased significantly in the Gisborne area and a number of church groups have set up group exercise sessions (PHARMAC 2006, Sinclair 2006).

The research for the social marketing campaigns found improved awareness and recognition of the personal relevance of cardiovascular disease to men, but no improvement in understanding of cardiovascular disease or progress from awareness to action. It was also not possible to ascribe the equivocal prescribing changes found to the social marketing campaign. In relation to cardiovascular disease risk factors, the research found:

- Men are generally reluctant to change, but responsive when important aspects of their self-perception and lives are at risk.

- Men are more responsive to assistance when it is offered and supported, rather than taking the initiative themselves.
- Women play important roles in men's state of health, through their nutrition, and level of activity, as well as influencing men's health behaviours, social interactions and social roles (Sinclair 2006).

The report concluded that the third approach of the programme, based on collaboration with DHBs and support for primary care training and screening, accompanied by social marketing activity, is more likely to provide better results for PHARMAC's investment than either separate social marketing campaigns or directly funding community-level projects.

Also of relevance are evaluations that have taken place of multi-faceted community interventions around cardiovascular disease. These have not been targeted specifically of men, but do reflect a health issue which has a particular burden among men. Unfortunately, reviews of these interventions have not been conclusive, and while evaluations of some have been positive, most have not been able to demonstrate sustained reduction in cardiovascular disease risk or incidence (Sinclair 2006).

Overview of benefits associated with men's health activities

The literature presented above reveals a paucity of interventions that have been comprehensively monitored and evaluated, and which in turn have shown clear beneficial impact on men's health. However, the available literature indicates some potential for men health awareness activities to catalyse interest in health and to seek advice or support.

The most commonly cited benefit of men's health activities is the **raised awareness** of health issues. There are also many ways of approaching activities to improve awareness and understanding of men's health, suggesting significant potential for tailoring interventions for particular target populations. Such awareness is not an end in itself, but creates momentum for either behavioural change or further contact with the health system or support services.

The second key benefit of such activity is **connecting men with health or other support networks** that may be available. Many studies showed men either having the intention to or directly making contact with health services as a result of awareness raising activities, either through clinics, events or workplace initiatives. However, it is imperative for services to be equipped to deal with the issues raised in a way that encourages concrete action to take place as a consequence. A key deficiency of some health service interventions was the provision of generic advice that was not useful or sufficiently specific to the particular issues of the individuals concerned.

There is also limited evidence of such interventions of **creating behaviour change** around health risk factors, such as cardiovascular disease. Behaviour change can be influenced directly on men, and indirectly through women and families/whanau. The evidence available so far only points to short term changes, but these nevertheless

suggest some potential for well-designed and targeted men's health activities to contribute to improvements in health status.

HealthWest – a case study of primary care capability and the potential of primary care based systematic screening

This case study is presented as an example of how a PHO can support targeted systematic screening of a population.

HealthWest PHO covers West Auckland; it has an enrolled population of 140,000, and with 29 practices as members. The HealthWest population includes a significant high-need population of approximately 12,000 people (Maori, Pacific and high deprivation deciles based on Services to Improve Access priority criteria). 39% of Waitakere's population are in Quintile 4 and 5.

HealthWest PHO has approximately 80% of Waitakere population enrolled and 99% of that population is registered with an accurate NHI number. 100% of practices are computerised and all have clinical decision support tools for the Guidelines Implementation Project (GIP).

In 2004, HealthWest PHO decided to proactively support systematic screening for CVD risk using on-line clinical decision support tools, supported with a repository of collected data to enable process and outcome evaluation. Patients are separated into 3 groups; low risk (<10%); medium (10-15%) and high (>15%). The latter two groups are referred to Green Prescription for lifestyle care, and all high risk must see the GP for pharmaceutical management.

The progress of the screening programme over subsequent years is shown in the figures 2 and 3 below.

Figure 2: Total HealthWest CVD Screened Population, December 2004 to June 2006

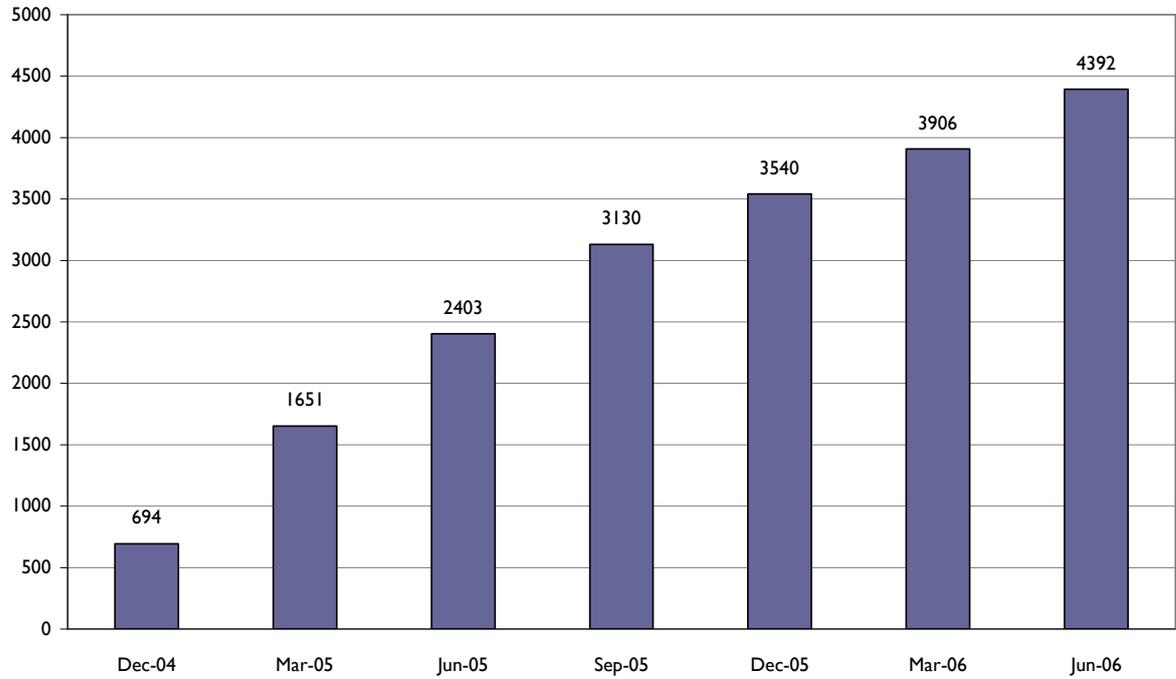
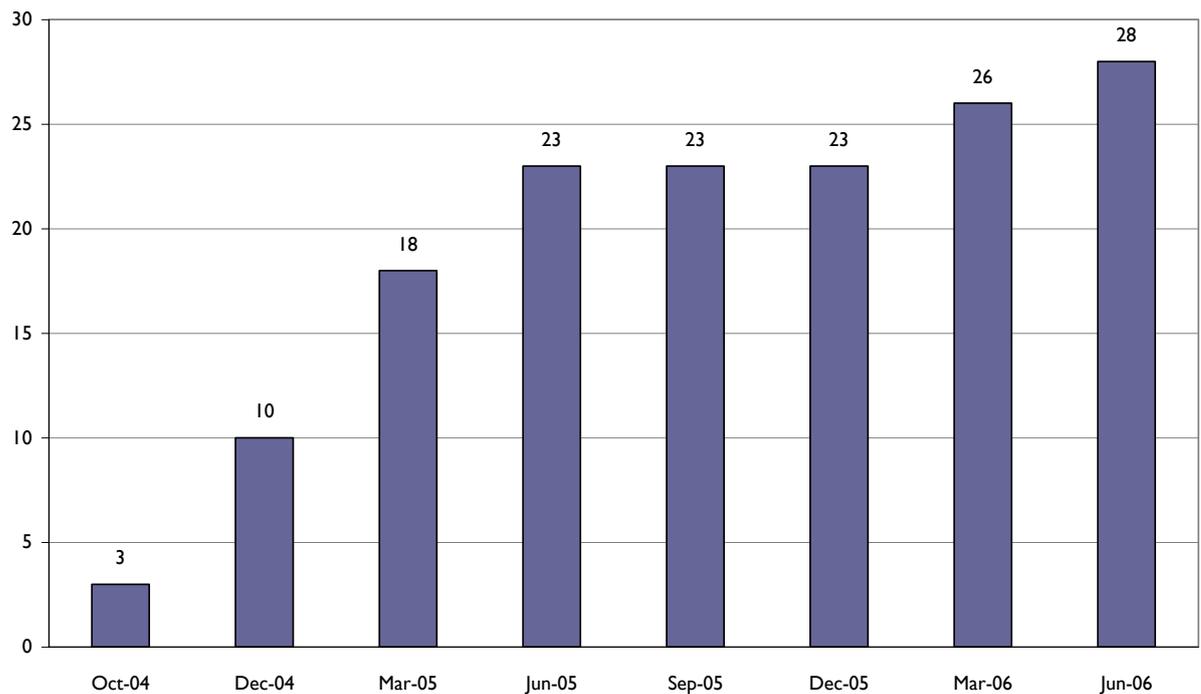


Figure 3: Uptake of HealthWest Practices commencing screening, October 2004 to June 2006



To date (June 2006), 11% (4,392) of the target population (as defined by New Zealand guidelines) has been screened since December 2004. Of the 12,000-strong SIA sub-target group, 3,489 (29%) had been screened by June 2006.

The aim is to screen 75% of SIA patients, where the 'hard to reach' reside, by the end of 2007. As indicated above, data to date shows HealthWest is tracking towards achieving the goal.

The project is an example of a 'targeted systematic population' approach and results indicate the screening has reached the high risk populations and the male populations. For example, Maori and Pacific peoples are 7% and 12% respectively in the NZGG population group, yet of those screened 18% are Maori, and 34% are Pacific peoples. In each priority subgroup, males consistently outnumber females, by 15% among Maori, 7% among Pacific, and 18% among Quintile 5 patients.

Further detail on this programme is in Appendix I.

A recent worksite was visited with the outreach bus. This was a manufacturing company, with approximately 100 employees. Of these, 89 agreed to be screened; most had not visited their GP nor were able to attend the laboratory (blood tests were performed on-site). Of the 89 risk assessed, over 10% were above 10% risk, in a relatively low age group (30-40s).

Potential directions for future initiatives and sector planning

It is clear from this review that New Zealand has been slow to follow the lead of other countries in implementing men's health awareness activities in a comprehensive manner. Men's health does not feature in policy and planning as an issue of inequity, with the exception to some degree of some intra-ethnic considerations.

It is also clear that comprehensive evaluation of men's health activities is lacking, not only in New Zealand, but also internationally. Without a stronger level of evaluation than has occurred to date, it is difficult to learn from the experiences of existing interventions and prevent the same problems cropping up repeatedly. Any new or pilot men's health initiatives need a foundation of evaluation to support their ongoing development. This also suggests much potential for investment in men's health research from research funders in New Zealand.

A further consideration is the difficulty to apply a blanket "men's health" label to health issues or interventions to deal with them. This is particularly so in the New Zealand context, where ethnic diversity, considerations of indigenous populations, and differences in age structures of these sub-populations add considerably more complexity to designing interventions.

This issue of diversity also signals the need to develop interventions that are tailored to particular sub-populations, such as different ethnic groups, age groups and sexual orientation, rather than adopt a 'one size fits all' approach.

The review also notes that the New Zealand primary healthcare sector, with its enrolled populations, PHO structures with their “blanket” of primary care management, high level of computerisation, and sophisticated decision support tools is well placed to provide systematic support for national programmes that target particular populations.

Based on the available evidence, there are three broad approaches that appear likely to be successful in engaging men on health issues, with flow-on through to improved health outcomes. There could be significant potential in taking a selection of these forward through pilot initiatives at local level, supported by appropriate evaluation.

1. Improved focus on health promotion and disease prevention among men

The studies and interventions examined here indicate that men are interested in health issues and are responsive to health messages, when they are tailored appropriately to their needs, cultures and circumstances. With this in mind, health promotion activities could be developed focusing specifically on men’s health, including the following:

- Increasing the range of activities and settings to raise awareness of men’s health issues, with approaches tailored to different male audiences and different geographic communities.
- Promoting change in men’s thinking about their health through social marketing, linked with other activities to directly engage men in health promotion and primary care. Such activity should build on and ensure linkages with national programmes such as *One Heart Many Lives*, led by PHARMAC, and local initiatives such as *Let’s Beat Diabetes* in Counties Manukau.
- Utilising the influence that women and families/whanau can have in influencing men’s nutrition, physical activity, and men’s health behaviours, social interactions and social roles.
- Related to the above suggestion, developing health promotion communications in a variety of media around critical areas of men’s health amenable to change. These could include such areas as cardiovascular disease and diabetes, cancer, occupational health, depression, and alcohol-related harm.

2. Improving access to health services for men

The literature signals on the one hand, lower levels of health service utilisation by men, and on the other hand, willingness of men to make use services when made more accessible. There is therefore potential for health services to identify and implement initiatives that are more patient-centred around men’s health needs, and to reach men in less traditional settings or means of contact. This could include:

- Expanding the range of opportunities for health services to target male health. These could encompass settings or times where men indicate they may be more likely to access health services, such as workplaces, community settings, or clinics held outside working hours.
- Exploring with DHBs and PHOs the appropriate use of opportunistic or population screening processes in primary care for men’s health for major causes of morbidity and mortality such as cardiovascular disease and diabetes.

3. Improving the health promotion function of primary care in relation to men's health

Traditional primary care settings may not be perceived as 'friendly' to men, and men have expressed difficulty in finding support through primary care that meets their health needs. There is potential for primary care to tap into what may be a previously under-utilised market in their population health function, but to do so could require some reconfiguration to make primary care more relevant to men.

The literature suggests the following activities may be of benefit:

- Extending training of health professionals' around the effective provision of lifestyle advice to men, in conjunction with appropriate medication, and ways of discussing sensitive health procedures with men.
- Improving information on availability of services within PHOs and DHBs relating to men's health.
- Reviewing and potentially expanding or improving the resources available through primary care to the general public on men's health issues.
- Identifying and raising awareness of support networks that may be available for men.

Having identified the benefits of men's health activities, and potential areas for action, the next component of this report puts forward a potential framework and five year implementation programme for developing men's health awareness in New Zealand.

Chapter 2 – A proposed approach

Introduction

The previous chapter describes a national and international pattern in which men's health "appears markedly poorer, and men's utilisation of health services is lower, than women's".

A review of policies and programmes also suggests New Zealand lags behind other similar countries in proactively responding to men's health issues (McKinlay et al 2005).

It is noted that while other countries have tried various combinations of men's health awareness programmes there is not strong evidence as to the effectiveness of such programmes.

There is good information supporting the thesis that a healthy population is more productive and that health programmes should be seen as an investment in improved economic outcomes and not simply a cost.

With the issue of men's health we, therefore, find ourselves in a situation that is common for population health programmes; having identified a need, being able to point to various overseas examples of interventions but without clear guidance from evidence as to how we should construct a response and which approaches provide the best cost-benefit.

In this situation, we can be guided by general principles of good practice in population health programmes and to build from specific promising examples of overseas interventions. We should also build from current strengths in the New Zealand system and learn from our own activity.

Below we outline a proposal for improving men's health outcomes.

Long term vision for Men's Health in New Zealand

New Zealand needs a policy on men's health. A starting point could include clear and simple goals.

Proposed goals:

- 1) Men (and women's) life expectancy increases and:
 - The gap in men's and women's longevity closes more rapidly than over the past 20 years.
 - The gap between Maori and Pacific men's longevity and non-Maori non-Pacific men's longevity closes more rapidly than over the past 20 years.

2) Improved men's outcomes for specific disease types including:

- Coronary heart disease and diabetes
- Cancer (all types)
- Transport and workplace accidents
- Intentional self harm or risk-taking behaviours, including alcohol-related harm
- Depression assessment

Proposed five-year programme to improve men's health

It is proposed that the Government 'in principle' commits to an initial five-year national programme to improve men's health.

The five year programme would be based around an annual men's awareness week, which would act as a focus point for developing more systemic changes to support improved men's health outcomes.

Over five years, the initiative would seek to achieve measurable improvements in:

- Increasing community and family/whanau awareness of men's health issues
- Improving men's knowledge of their own health issues
- Earlier identification of health risk and disease
- Improved appropriate access of health services
- Improved men's self-management of health risks and disease
- Improved health sector response to cancer, heart disease and diabetes screening
- Improved health sector response to guideline-based management of chronic conditions

The men's health awareness week would be structured around improving a whole system response to men's health.

Activities would cover four key areas:

- Improving awareness/knowledge - with prompts to 'find out' about their health
- Making access to the health system easy – reducing barriers for men
- Ensuring the health system responds effectively when men present.
- Proactively learning from the initiative at both a local and national level, to support continuous improvement.

The primary healthcare response to the national awareness programme should include clearly defined evidence-based cost-effective interventions, which may include:

- CVD risk assessment

- Diabetes screening
- Depression scores
- Prostate health
- Alcohol and possibly gambling harm assessment.
- ACC accident reduction guidelines

The development of the five year programme needs to be strongly influenced by evaluation. The learnings from the first year should inform the design of the initiative in the second year – and so on.

It may be that in subsequent years, the men’s health awareness focuses on particular issues – or it could retain a more general focus. A more detailed list of key men’s health issues will need to be developed and the evidence and cost:benefit of focusing on various issues will need to be debated. For example, one year there could be a focus on diabetes, or cancer, or self harm. Evaluation from the first year may inform whether a more general or focused approach is desirable.

As discussed in chapter one, it is crucial that activity in this area builds on and has strong linkages with national programmes such as *Healthy Eating Healthy Action*, *One Heart Many Lives*, and local initiatives such as *Let’s Beat Diabetes* in Counties Manukau. Developing linkages with these existing programmes will minimise resource duplication, ensure consistency of messages, and maximise the added value of a campaign targeted at men’s health awareness.

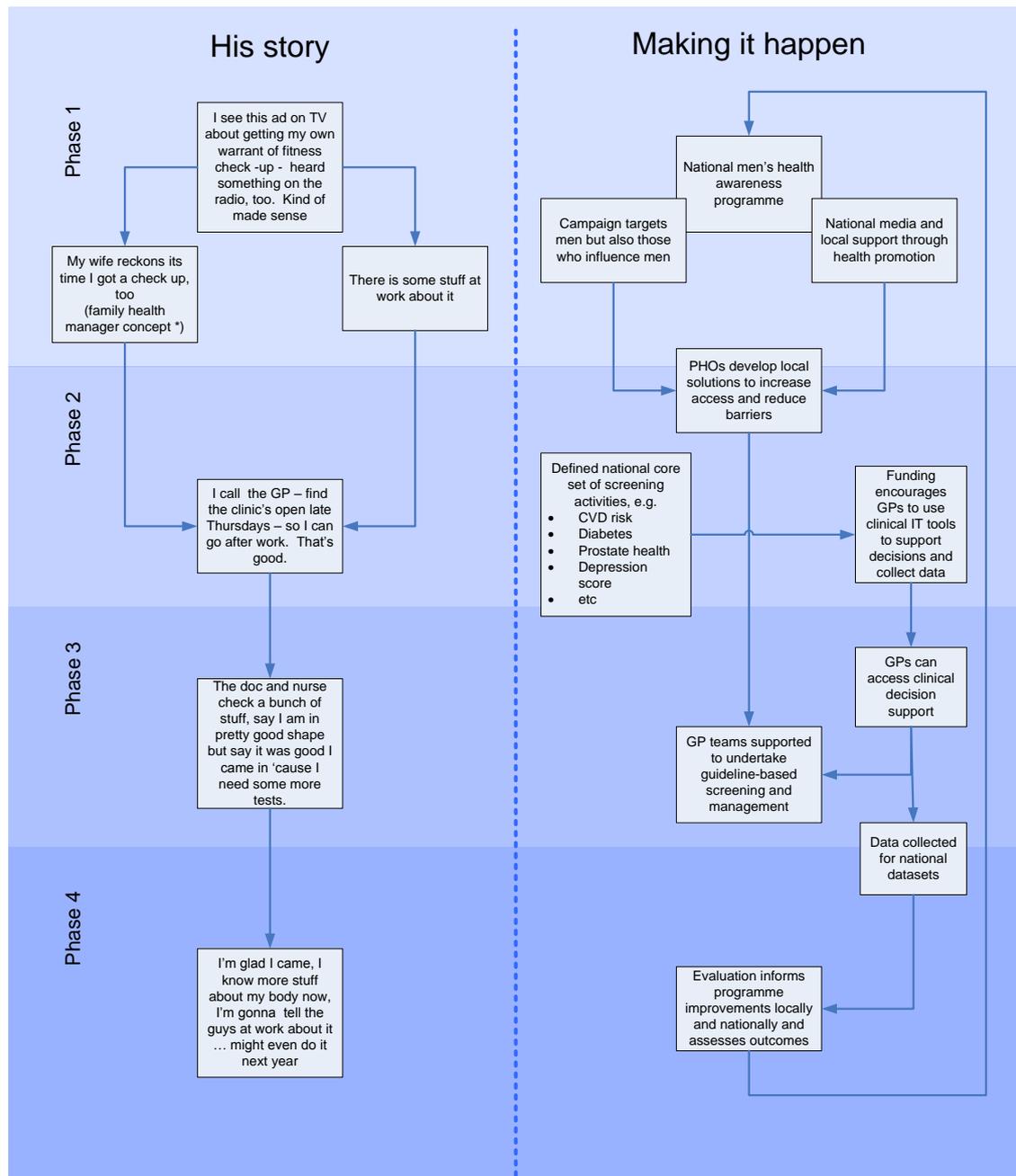
Proposed Year 1 programme

It is proposed that the year 1 pilot trials the four-phase approach outlined above and supports a substantive evaluation.

The core concept being proposed is outlined in the graphic below – which shows a possible pathway and set of reactions from a man in the left column – and the required programme design in the right column.

The activities are laid out to show how the four phases of the project are linked.

Concept



(* note the 'family health manager' concept is introduced above to note that in different communities it may be different people who assume the role of looking after the family's health. For example, for older males it may be the oldest daughter in some communities). It is proposed that the year 1 programme supports a general focus on men's health as a concept and on the "warrant of fitness/check-up" approach that has been tried in other countries (European Men's Health Forum 2005, Johnson & Rafferty 2004, Leishman & Dalziel 2003, Price 2006) and supported by research in New Zealand (McKinlay et al 2005).

This approach has the advantage of examples of overseas programmes in the literature to learn from and it can provide information about key health issues and promote a check-up call-to-action all within a 'warrant of fitness' message.

Phase 1 - Awareness programme

A national awareness programme is proposed that would be based on the warrant of fitness concept. The message can be promoted using images and humour that is likely to engage men from high risk communities. A subset of messages may reinforce that their health is important for their families as well as themselves.

The national campaign should be promoted through the lens of the Maori and Pacific community, rather than a mainstream view. This is consistent with the approach taken in the *One Heart Many Lives* campaign (Sinclair 2006). The proposal is based on the relative greater need of Maori and Pacific men and the observation that even targeted programmes seem to influence mainstream New Zealanders.

The campaign would be promoted through television and radio. The call to action would be to see your family doctor for a check up. PHOs and GPs may be able to support the call to action with their own information or letters to patients.

Phase 2 - Improving access to health services

PHOs will need to be engaged into the men's health initiative and to work with their constituent GPs to develop ways of making access easier for men.

PHOs know their own populations and primary care teams best and should have the flexibility to try different approaches to encouraging men to have a check up.

Ideas to improve access could include:

- Reduced co-payments
- Longer opening hours
- Changed 'check up' venues (such as workplaces, sports clubs, Marae, Pacific churches)

PHOs may be able to use local advertising to support a national initiative to advise men on their specific local response. As noted earlier, where PHOs are already part of a district-based programme, men's health awareness may best be integrated into an existing initiative.

Phase 3 - Ensuring an effective health system response

A national approach should be developed for an agreed minimum specification of a men's health check up.

The minimum specifications should focus in the first instance on those interventions for which there is the best evidence around screening and subsequent management.

Further work is required to define the minimum specification for a men's health screening, but candidate areas include CVD risk, diabetes, prostate health, depression scores, alcohol use review and potential review of gambling and workplace safety.

PHOs would have to be engaged to work with local GPs to resolve the practical issues associated with the programme. For example, if men receive their check up by someone who is not their GP or at a venue that is not their local clinic, how will the information get back to their GP? How are the payment issues managed? How will SIA, Health Promotion and Care Plus funds be applied to support the initiative?

There should be thought given to supporting GPs with clinical decision support tools that can help accurate advice and care and simultaneously provide data to national datasets to support policy development and evaluation of quality and programme outcomes.

An example of the linkage of a clinical intervention with national data exists in the Diabetes Get Checked programme. A similar approach could be taken for a 'Blokes Get Checked'.

Government may need to incentivise GPs to undertake the extra activity required.

Phase 4 - Evaluation

An evaluation approach should be developed in parallel to the programme design. The evaluation should focus on processes and outcomes.

The year 1 programme will need to be evaluated at multiple levels, with areas of interest including:

- project design and delivery
- awareness
- PHO/GP uptake
- check-up uptake from men
- what was offered and delivered by GPs

Programme design, governance and management

The programme design and delivery could be managed by the Ministry of Health or it could be contracted out to another party, such as a PHO or NGO to design and deliver.

The programme will require detailed design and considerable project management. GPs, PHOs and DHBs will need to be on board as well as other groups such as employers and opinion leaders.

Risks

There are a number of risks for the project, some are fundamental risks of design and others are risks of delivery.

- Given that all of the components of the proposed design are not based on high grade evidence, there is a risk the whole initiative will be ineffective and will not result in improved outcomes.
- There is a risk that primary care will not be engaged and will not respond effectively to men's needs. A poor response in year 1 may reduce options in following years as men or primary care providers may not want to repeat a poor experience.
- A focus on men's health issues could prompt negative comment from those promoting women's health (although, as stressed in chapter one, the intention is not to devalue the importance of women's health, but to confront health inequity from a different starting point).
- A one week programme may not be an effective way of designing an awareness campaign – there may not be opportunity in one week to answer the call to action.
- The provision of effective electronic systems to support the primary care screening processes may reduce a number of risks associated with the programme, but there are costs and risks associated with IT development and roll out.

Costs

Without a detailed costing of the scale and scope of the programme it is impossible to provide an accurate estimate. However, it is estimated that a national awareness programme may cost \$1 million. The table below is an initial attempt to estimate a possible costing model to incentivise GP participation in the programme.

'Blokes Get Checked' ball park costs to incentivise GP uptake

	Population reach/ costs based on 2001 Census	Assume 10.3% increase in population 2001- 2006
NZ population men aged 35-64	687,684	758,515
Aim to reach 70% of that group over five years	481,379	530,961
Achieved 20% of 70% each year	96,276	106,192
If 20% of the 20% each year were in quintile five	19,255	21,238
If a PHO was paid \$50 for each man in quintile five	\$ 962,758	\$1,061,922

The table is self explanatory and looks at figures based on 2001 and estimated population growth since then.

It assumes that extra payments are focused on quintile five patients to incentive an appropriate response. This 'finger-in-the-wind' estimate of cost would be \$1 million to support a targeted the local response. If the decision was to incentivise screening and follow up for Quintile 4 and five, the cost doubles to \$2 million.

There may be a further developmental cost associated with information technology developments and roll out. This cost is outside the scope of this report and could be seen as a general investment in sector capability and not a defined 'men's health' cost.

A total budget is proposed of \$2 - \$3 million a year, with funding aimed at incentivising GP participation as described above, social marketing activities, programme planning and evaluation.

Chapter 3 – Stakeholder response

I. Stakeholder consultation

A workshop with a broad range of stakeholders was held to gauge public perceptions about men’s health issues and to ascertain the level of support for a more proactive approach to addressing men’s health.

The stakeholder group

The stakeholder group included interested parties and opinion leaders, mostly from the Waitakere community. Attendees represented a wide range of organisations and the Maori, Pacific and Asian communities.

Attendees included:

Person	Position/representing
Dr Ekramul Hoque	President Asia:NZ Foundation, School of Population Health, Asian health research
Gary Thompson	Maori Health, Waitemata DHB
Ken Eagle	Manager, Western Leader newspaper
Rod Oram	Journalist
Maurice Reid	Lions
Mal Lange	Clinical Manager, Man Alive
Barry Earl	Freemasons
Matt Anderson	Branch Manager ACC, Henderson
Kay Lindley	HealthWest PHO
John Tamihere	Te Whanau o Waipareira Trust
Lannes Johnson	GP and Clinical Director, HealthWest PHO
Fraser Bruce	Educationalist
Bob Harvey	Mayor, Waitakere City
Roger Smart	Pharmacist
Tom Clarke	Promoter of Men’s Health
Barry Peihopa	Health Promotion in schools
Moera Grace	Pacific health consultant
Paul Stephenson	Facilitator

The stakeholder workshop was hosted by Bob Harvey, Mayor, Waitakere City and was held in the council chambers.

The group was provided with a presentation by financial journalist Rod Oram on the importance of good health to our nation’s economic wellbeing. Paul Stephenson then provided an overview of the men’s health paper and the proposed direction for men’s health.

The workshop discussion was based loosely around the following questions.

1. Is male health an issue in New Zealand?
2. Whose issue is it?
3. What do you think about the document and proposal?
4. Should men only be targeted (what about the “everybody” argument)?
5. How does a men’s health focus fit with the health inequalities agenda?
6. If this programme is announced tomorrow, what do you think will happen?
 - How would the community respond?
 - How would the health sector respond?

2. PHO consultation

All 6 PHO Clinical Leaders, of the Waitemata District Health Board, were consulted on 2.11.06 at a meeting with Clinical leaders:

Dr Jill Calveley - Harbour PHO

Dr Lannes Johnson - HealthWEST PHO

Helen Chan and Dr Alex Chan - Te Puma PHO

Dr Siobhan Trevallyan - Waiora PHO

Dr Chris Boberg - Procure North PHO

(Dr Tim Malloy - Coast to Coast PHO, was absent from the meeting, but has verbally offered support)

Although a formal approach to PHO CEOs and boards, for agreement to participate in a National (or Local WDHB) Men's Health promotion with subsequent management, will need to be made, (as with other NZ PHOs and DHBs), it is anticipated subject to funding arrangements, that all parties in the Primary Health Care sector will be enthusiastic in supporting this Men's Health initiative.

Conclusions

- There was strong support in the groups for greater recognition of men’s health issues, and the need for concrete action.
- The key directions outlined in this paper were supported.
- The consensus was that a men’s health initiative would receive widespread public support

- Waitakere City Council and local organisations were willing to actively support men’s health awareness programmes
- Innovative programmes were needed to communicate with men
- Changes in attitudes will take time and programmes would have to run for many years
- More detailed development of the ideas is required to support the primary care response to a men’s awareness campaign

Discussion

I. Men’s health as health and a political issue

The group felt strongly that raising the profile of men’s health and developing a well articulated government response would receive strong community and political support.

There was little risk of a negative response. “Low risk, no fallout”, was one comment. It was felt some groups may raise points and critiques about men’s health programmes, but these would be within a constructive context. It was seen that the statistics on men’s health outcomes and poor access to health services, created a legitimate context for a men’s health policy.

There was discussion about whether women would see a focus on men’s health as competing with women’s health issues and also on whether it would be seen as cutting across the inequalities agenda.

Women members of the group felt that men’s health would be supported by women. It was seen that a men’s health awareness programme would help women, who have difficulty in getting men to take their health seriously.

Maori representatives did not perceive that men’s health would contradict a focus on inequalities. “If it is good for Maori men it is good for whanau”.

Increasing the response to existing health services was seen as potentially a very efficient way of improving outcomes – especially for Maori, Pacific and Asian people. Asian males were described as having a level of ‘denial’ about their health issues and low access to services.

One of the potential issues that did arise was the low interest from men in men’s health.

It was noted that for men, health was not an issue until they were ill. Men were seen to have low knowledge about their health risks and that increasing knowledge was one of the first things that needed to happen to change men’s behaviour.

Information should also lead to a call to action to understand the need for regular tests and improve early detection of diseases.

There were comments that the programme would be seen as politically positive if the issue of men's health was raised and a solution was then found.

It was noted that there was a lack of a men's health champion at a national level, therefore, there was not a focus for the issue. It was felt that national champions could support the emergence of local champions for men's health.

Discussion was undertaken in reference to the paper and also to local issues and infrastructure. Points made in a general sense about the paper were often taken up and developed in relation to the local Waitakere City context.

The discussion reflected a strong desire to 'get things moving' locally, which could be interpreted as a sense of readiness from institutions to support men's health issues. Local government, health providers and community organisations all wished to see action as a result of the presentation of this paper to the Ministry of Health.

This 'readiness' to respond to men's health issues may be specific to Waitakere City or it may represent a broader societal view.

Waitakere City offered to support men's health awareness programmes and pointed to a number of practical measures it could support. Community service groups such as Lions and Freemasons were enthusiastic about improved identification of risk and disease in older men and supportive of more proactive programmes for younger men. The Waitakere City Mayor thought that there would also be support from other territorial authorities for supporting men's health.

The group noted that if the government wanted to pilot a men's health programme, Waitakere City would 'put up its hand'.

One comment was : "We use the example of Waitakere – really make it work and we can demonstrate to the rest of the country how to make it work."

The group suggested that any change in knowledge and behaviour would take a long time. The long term policy framework proposed in the men's health paper was supported. An effective men's health programme would require sustained messages over years to many age groups.

The evaluation approach was also supported. It was noted that an investment should be aligned with improved data that would allow for impact analysis.

2. Issues with the development of men's health programmes

The group was cognisant of the scope of activities outlined in the paper and the need for more detailed work to ensure that any programme was properly thought through and had well designed programmes and supportive infrastructure:

Comments pointed to the need for:

- Improved understanding of costs and risks
- Better understanding of the target groups and the types of strategies needed to access particular groups
- Need to develop ownership from health providers
- Programmes must be developed in such a way to meet the needs of men
- Providers needed capacity to respond

One of the Maori providers noted the need to properly prepare, saying that it could not cope if there was to be an awareness programme without the proper development of response capacity.

It was noted that in Auckland Asian health providers have limited capacity and the health status of many new Asian immigrants is actually decreasing since they have arrived in New Zealand. There is a need to develop strong Asian health providers.

There was considerable discussion about the difficult nature of engaging with the male population.

There was a strong call around the importance of ‘knowing the man’ and the off-putting nature of health services that did not have continuity of information.

The need for improved information systems was discussed, with a proposal that people should be able to carry their core health information on a card so that it could be retrieved by any relevant health professionals.

The use of innovative methods for accessing men was discussed. Suggestions included:

- Working with businesses that target men
- Accessing men at natural places of gathering, such as sports games
- Use of technologies, such as texting
- Building on the ‘warrant of fitness’ concept, with opportunities for a man-check at the same time as a vehicle warrant
- Use of the family as a trigger for men to act – proposed as particularly effective for Asian men
- Support for peer-based programmes

Appendix I – The HealthWest CVD/diabetes screening project – An example of systematic targeted screening¹

Five Thousand CVD risk screenings – results from the HealthWEST project

GIP, as it is known (Guideline Implementation Project) began in October 04 after a 12 month development period involving training, preparation and motivating HealthWest's 29 practices. To date, over 5,000 cardiovascular risk assessments, with subsequent appropriate management, have been performed. The inspiration for GIP came from realisation that HealthWest could seriously decrease mortality and morbidity from CVD/diabetes in Waitakere City, by simply implementing the evidence-based New Zealand Guidelines Group guideline (released by Annette King in December 03).

The HealthWest PHO population is 140,000, the target population as per the NZGG guideline is 40,000 and our priority sub-target of the SIA (Services to Improve Access – Maori, Pacific and Quintile 5) is 12,000 (approximate figures). The aim is to screen 75% of these SIA patients, where the "hard to reach" reside, by end 2007. Project data to date indicates considerable progress has been made towards this.

HealthWest has taken the practice tool, *Predict* and added software (developed by Enigma) before and after to develop a 'PHO management tool'. All information is recorded electronically in a web-based database, independent of the PMS (Practice Management System). From this system, HealthWest can identify who has not been screened and the progress of each practice.

Recently an 11 metre bus has been electronically equipped allow an outreach free screening service, to community centres and work places. The decision support module has also been added to MedTech, Profile, Next Gen and Mac practices.

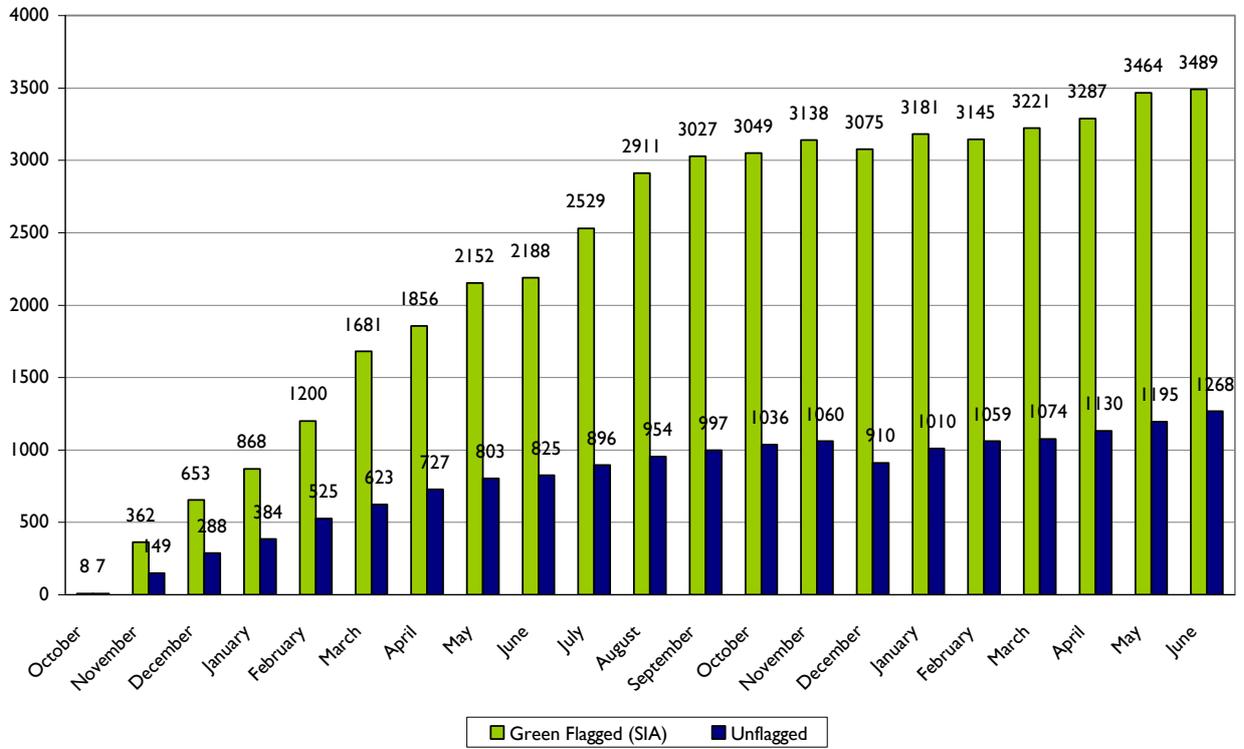
Patients are separated into 3 groups; low risk (CVD Risk less than 10%); medium (10-15%) and high (greater than 15%). The latter two groups are referred to Green prescription for life-style care, and all high risk patients must see the GP for pharmaceutical management. The project is an example of a 'targeted systematic population' approach and results support the targeting. For example, Maori and Pacific peoples are 7% and 12% respectively in the NZGG population group, yet of those screened 18% are Maori, and 34% are Pacific peoples. In each priority subgroup, males consistently outnumber females, by 15% among Maori, 7% among Pacific, and 18% among Quintile 5 patients. Next year HealthWest will publish in detail, including later clinical outcomes.

Figure 4 below shows the accumulated totals per month, from October 2004 to June 2006. The green bars are the SIA target group. So far, near 40% of all are high risk,

¹ This is adapted from a report submitted to the New Zealand Medical Journal in 2006.

this is however, skewed as practices call in those that know may be at risk preferentially.

Figure 4: Cumulative total of HealthWest CVD screening patients (based on NZGG criteria)



Dr Lannes Johnson
 Medical Director
 HealthWEST PHO Ltd.

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