British Heart Foundation response to the Department of Health and Social Care's Men's Health Strategy for England: call for evidence

Response to Question 1: Understanding and identifying areas where we can improve support for healthier behaviours

More men live with, and die prematurely from, cardiovascular disease (CVD) than women.[1] Though this is likely due to a combination of risk factors, including physiological influences, evidence indicates that cultural and behavioural factors also play a role in this trend. Men are typically more likely to engage in health-harming behaviours that are also risk factors for CVD, such as smoking,[2] and having a poor diet,[3] particularly if they live in more deprived areas.[4] The impact of these behavioural risk factors on men's cardiovascular health may be exacerbated by men's relatively poor engagement with primary and community healthcare services, compared to women. For example, men in the UK are less likely than women to see their GP.[5] In the most recent GP Patient Survey, 64% of men said they went to the GP in the last 6 months compared to 75% of women.[6] Additionally, in England, fewer men than women are referred to local stop-smoking services,[7] and men are less likely to attend an NHS Health Check.[8] A relative reluctance amongst men to engage with healthcare services may influence their CVD risk and outcomes, because around 70% of death and disability from CVD in the UK is due to modifiable risk factors, which include, high blood pressure, obesity, and smoking.[9] Many of these conditions, like high blood pressure, can be asymptomatic, making regular engagement with healthcare services essential for early detection and management.

Understanding of why men are more likely to engage in health-harming behaviours is rapidly evolving but is incomplete. Though, there is some evidence to suggest that men's motivations may be different from women's. For example, one study exploring smoking cessation motivations in men and women in England found that societal norms and other people's perceptions were a significant motivator for quitting amongst women, but not amongst men.[10] There is a scarcity of research into UK men's motivations for quitting smoking. However, some international research suggests that men are generally more concerned with the health and physiological effects of smoking, rather than social factors, and, additionally, that they may engage more readily with digital cessation services, as opposed to in-person support.[11] [12] These insights may also apply to other health behaviours, but wider research is needed to explore how generalisable these findings are.

Men tend to be employed in more physically demanding and hazardous occupations than women,[13] and the stress, increased physical strain, and exposure to health-harming environments may increase their CVD risk.[14] These types of occupations may also increase the likelihood of engagement in health-harming behaviours, such as smoking, as an attempt to relieve stress.[15] Research is needed to explore this possible link and what interventions could mitigate these behaviours.

Men's engagement in health-harming behaviours may also stem from lower health literacy. One, albeit dated, national survey of UK men found that men were twice as likely to have lower levels of functional health literacy, compared to women, and that this was associated with an increased likelihood of smoking and consuming fewer fruits and vegetables.[16] However, a more recent analysis of health literacy amongst British adults found men scored lower than women on some aspects of health literacy, such as their understanding of health

information, but scored the same, or even higher than women, on other measures, such as their ability to actively engage with healthcare professionals.[17]

Research has also shown deprivation and ethnicity to be a significant predictor of health literacy,[17] suggesting men who live in areas of high deprivation in England, or who belong to a minority ethnic group, may experience a double-disadvantage to their health by experiencing inadequate health literacy alongside a wide range of other barriers to good health. Updated and nationally representative data on men's health literacy across England would be helpful to assess whether there are specific areas within men's health literacy which could be improved to support their physical health. It could also reveal how deprivation and ethnicity interact with, or predict, health literacy and, subsequently, health outcomes amongst patients with CVD. People with lower health literacy are more likely to struggle with their health and wellbeing, use fewer health-promotion services, and communicate less effectively with practitioners.[18]

There is some limited evidence to suggest that interventions designed to improve health literacy can be effective at improving health behaviours and outcomes in both men and women. For example, one systemic review concluded that health literacy interventions, such as small group educational sessions, are generally effective at increasing health literacy and health-protecting behaviours such as smoking prevention, physical activity and health screening attendance. However, the authors note that there is a lack of research focusing on health literacy interventions specific to the prevention of CVD.[19] Whilst we welcome initiatives, such as the National Institute for Health and Care Research's (NIHR) Inequalities Challenge,[20] as a key avenue for building evidence in this area, further Government support to help build the body of evidence around the efficacy of these interventions for supporting patients with CVD, particularly male patients, would be helpful.

There is some evidence to suggest that community-based programmes which seek to increase men's health literacy and confidence to engage with health services may be effective at increasing men's positive health behaviours. For example, a qualitative evaluation of the Men's Sheds initiative in Scotland, a programme which aims to build community-led spaces offering practical and social activities for men, suggests that creating spaces which encourage men to socialise and learn about their health can increase men's health-seeking behaviours. The study found that some Sheds invited health workers and nurses to deliver educational talks about health to the participants, which had a direct effect on the men's health-positive behaviours. In addition, the social support provided through these spaces was found to lead to decreases in alcohol and tobacco intake amongst some participants, as one participant reflected that it was not the 'done thing' to discuss health at other social spaces they engaged with.[21]

Overall, the current body of evidence exploring men's engagement in health-harming behaviours is extremely limited and relies upon only a small amount of international research which has tended to focus solely on smoking behaviour. Further research conducted with men living in the UK is urgently needed to better understand men's motivations for engaging in a wide range of health-harming behaviours, including smoking, diet, and exercise, and how men may, in turn, be effectively supported to engage in health-*protecting* behaviours.

Recommendation: Government should support further research to better understand why men are more likely to engage in health-harming behaviours, and how these motivations may vary across men from all socioeconomic, ethnic and cultural backgrounds. Broadly, this research should include longitudinal studies which aim to

assess a wide range of men's behavioural motivations for engaging in health-harming behaviours, as well as funded pilot services and evaluations of male-targeted interventions to improve health literacy and uptake of health-protecting behaviours.

Response to Question 2: Improving outcomes for health conditions that typically, disproportionately or differently affect men

Over four million men in the UK are currently living with cardiovascular disease (CVD), and millions more are living with the risk factors that can cause it, making tackling CVD critical to improving men's overall health outcomes.[22] In order to effectively improve cardiovascular outcomes for men, Government must adopt a multi-pronged approach to improving service uptake and sustained engagement with services for men across primary and community care. Although a man is more likely to receive the appropriate diagnosis and treatment for a cardiovascular condition than a woman in England,[23] [24] the premature death rate from CVD is significantly higher for men than for women.[22] As outlined in our response to the previous question, this is the result of a multitude of physiological, behavioural and cultural factors.

Qualitative research conducted by BHF suggests that cardiac services, from diagnosis to aftercare, are not consistently meeting men's needs. Male heart patients have shared frustrations with us around inadequate, or insufficiently personalised, follow-up care for CVD, as well as challenges around managing their mental health following a diagnosis.[25] Indeed, insufficient support for men's mental health following a CVD diagnosis or a cardiovascular event is consistently raised as a key issue amongst BHF patient groups. Patients often report experiencing feelings of shame or distress related to living with CVD, and that tailored mental health support for cardiac patients is inaccessible. For example, speaking with BHF about their mental health challenges, one patient reported, 'My mental health is [my] biggest challenge – my family would say 'you should go and speak to someone', and I was getting very angry and frustrated and was probably suffering from depression, but was in denial and had probably been depressed since my diabetes diagnosis' [65, male, Black British background, with high blood pressure and diabetes, England].[25]

BHF insights also suggest there are actions Government can take to improve cardiovascular service delivery for all patients, including men. For example, our focus groups have revealed the majority of male and female participants have experienced having to chase GPs and specialists in order to get an appointment, as well as having to constantly push for the care they need due to long waiting times and unclear communication.[25] Based on these insights, it is likely that addressing many of the systemic issues within the healthcare system that currently impact patients' outcomes such as, continuity of care, waiting times and provision of mental health support, would significantly improve outcomes for male and female patients alike.

However, targeted action to support specific groups of men who experience disproportionate barriers in accessing treatment for CVD and its risk factors, such as men from lower socioeconomic and minority ethnic backgrounds, must be prioritised. The absolute difference in premature mortality from CVD between the most and least deprived areas of the UK is particularly large for men.[26, 27] Similarly, evidence suggests that access to care for CVD and its clinical risk factors can be more limited for men from Black ethnic groups, compared to their White counterparts.[1] Qualitative analysis of discussions about cardiovascular health and treatment, commissioned by BHF, suggests that experiences of racial discrimination directly impacting the CVD care received by patients from minority ethnic background are commonplace. Dismissal of symptoms, reduced access to necessary

devices for managing CVD, and racially inappropriate diagnostic criteria are common experiences amongst patients from minority ethnic backgrounds.[28]

Recommendation: Universal improvements to the cardiac treatment pathway are likely to improve outcomes for most patients. However, Government should also work to improve available data on inequalities in men's health outcomes, and experiences of the health system, due to socioeconomic status or ethnicity by implementing the Movember Institute's call for a men's health index, and, incentivise primary care services to make better use of already available population data tools, such as CVDACTION.

Response to Question 3: Men's access, engagement and experience of the health service

The current body of evidence exploring why men are less likely to engage with health services for CVD is limited, and Government should seek to better understand men's unique barriers to engagement through commissioning new research and local pilot services. Alongside general barriers to engagement across all men, this research should seek to understand where particular groups of men experience disproportionate barriers to engaging with available services, such as those living in more deprived or rural areas, and minority ethnic communities.

There is some research into men's engagement with broader health services which has suggested that men's relative reluctance to seek help from health services may be driven, at least in part, by ideals of traditional masculinity, and health being seen as a more feminine concern.[29] Though evidence from the UK is limited, a study from the US found that 65% of men report that they avoid seeking medical attention for as long as possible, citing several reasons, one being feelings of weakness.[30] This is supported by further research from the US which found a negative correlation between higher levels of adolescent and young adult men's 'male gender expressivity (MGE)', and a diagnosis and treatment for hypertension.[31] However, whilst this evidence provides some indication that culturally-held beliefs around masculinity may negatively impact men's engagement with health services, research conducted within the UK is needed to verify whether this applies to UK populations.

In addition to evidence suggesting that beliefs around 'traditional masculinity' impact men's engagement with healthcare services, research has also found these stereotypes to influence the way men are *treated* by healthcare professionals. For example, polling of 1500 men living in the UK, commissioned by the Movember Institute, found nearly half of men (42%) have experienced gender bias from their healthcare practitioner, with the proportion for some groups of men being much higher. For example, 72% of men who are underemployed, meaning their salary is below the national average for their professional industry, reported experiencing bias from a healthcare professional.[32] These experiences included feeling that the communication they received from a healthcare professional lacked empathy, feeling as though their healthcare practitioner overlooked or minimised their health concerns, and feeling misunderstood or unwelcome.[32]

In addition to reducing the likelihood that men will engage with healthcare services, stereotypes around male and female health may negatively impact NHS service delivery for men. For example, qualitative research conducted with men referred to an NHS weight-loss service in south-west England found that many men felt self-conscious and embarrassed about attending services that are primarily tailored to the needs and preferences of women, suggesting services designed to support men to engage in health-positive behaviours must

be sensitive to men's specific needs and preferences.[33] An example of such a service was developed by the Queen's Institute of Community Nursing in 2018, and piloted at the Eagle House Surgery in Dorset for nine months. The pilot invited men aged 45-64 living with obesity to an individualised service which included screening, education and support for their mental and physical health. By the end of the programme, 86% of the participants had lost weight and 89% reported an improved understanding of blood pressure control and cholesterol targets. Feedback from the participants revealed they preferred a fact-driven approach, with one-to-one support, indicating that services tailored to men's preferences can be highly effective at supporting men to manage their own health long-term.[35]

However, though some evidence shows an association between traditional masculine ideals and a lack of engagement with health services, it is unlikely that perceptions of traditional masculinity are the only barrier to men engaging with the healthcare system; it is likely there are a wide range of internal and external barriers to men engaging with health services. For example, a systematic review conducted in 2016 by researchers at the University of Sheffield and Leeds Beckett University concluded that men experience a diverse array of barriers and facilitators to engaging with health screening. The barriers observed included their relative level of knowledge about health, the fear of being diagnosed with the condition and views held around masculinity, whilst the facilitating factors included, social support system, and the accessibility and affordability of services.[34] The authors conclude that interventions which target more than one of the key barriers, such as sending personalised letters to men coupled with an appointment reminder system and supplemented by asking partners to encourage men to attend health screening, are likely to be more effective at increasing men's engagement than methods which only target one barrier.[34] Fear of diagnosis was also identified as a barrier to men engaging with healthcare services by a small qualitative insights project commissioned by the Queen's Institute of Community Nursing and carried out by Darwen Health medical practice in Lancashire in 2018. Men who had been invited to attend an NHS Health Check at their local practice but had declined the invitation on three separate occasions, were asked why they had chosen to not attend. The conversations revealed that the fear that blood pressure checks could expose an underlying health problem was a significant barrier to men's attendance.[35] These insights suggest that preventative services, including screening services, *may* be able to overcome a key barrier to men's engagement by targeting men's fear of diagnosis. For example, highlighting the long-term health benefits of attending screenings may enable men to focus on the positive outcomes of attending regular screenings. However, further research is needed before concrete solutions can be implemented.

Interventions that aim to 'meet men where they are', in existing community spaces, such as barbershops, have shown success in supporting men to talk more about their health, and engage with health services, such as screenings. For example, an analysis of targeted blood pressure interventions at barbershops in the US found a significant reduction in customers' blood pressure after six months, following the intervention.[36] In the UK, a similar pilot was developed by London South Bank University (LSBU) in 2021, and offered customers free blood pressure checks at a selection of barbershops across South London. Following the success of the 2021 pilot, which saw 230 individuals receive blood pressure tests, it was repeated in 2024 and expanded to offer longer term support for men with hypertension.[37] [38] Improving men's engagement with health services as early as possible through community-based interventions is likely to lead to long-term cost savings for the healthcare system. One analysis of cost-savings from improving detection and management for cardiovascular risk conditions in England concluded that £68 billion could be saved, 4.9 million quality

adjusted life years (QALYs) gained, and 3.4 million cases of CVD could be prevented over 25 years if all individuals in England with one or more conditions that are a risk factor for CVD were diagnosed and subsequently managed.[39]

Recommendation: Government should pursue a comprehensive approach to improving engagement between men and the health service, as part of a cross-Government action plan to improve men's health, as recommended by the Movember Institute. This action plan should be headed by a Men's Health Ambassador for England, equivalent to the role of the Women's Health Ambassador for England. This plan must detail how Government plans to increase men's engagement with, and experiences of, the health system in England with measurable and time-bound ambitions.

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