The problems of accessibility and acceptability in integrated health care for men:

some Australian reflections

Rick Hayes and Simon Barraclough

In recent decades there has been considerable interest throughout the world in the concept of integrated health services or integrated health care. The World Health Organization (WHO) suggests a working definition for integrated health services as:

> *The management and delivery of health services so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of health system. (WHO, 2008: 4)*

However, there are some specific usages of the term 'integrated' and it is often used in reference to 'a package of preventative and curative health interventions for a particular population group' (ibid.: 3).

Much of the impetus for considering integrated health care comes from concerns with the efficiency and effectiveness of services and the manifest problems of fragmented health systems, which often leave clients to navigate their way through diverse health professionals, institutional service providers, funding agencies and regulatory jurisdictions. In principle, integration holds the promise of making better use of scarce resources, providing continuity of care and responding more readily to the holistic needs of clients.

It is timely to consider some of the problems faced by a particular population group whose reluctance to seek curative health care and difficulties in engaging with preventative services is well documented globally. Drawing on several WHO data sets, one report examining the health of men in 17 European nations found that, compared to women, men (White and Cash, 2003: 9–12):

- have a shorter life expectancy
- are at greater risk of all the *major* disease-related causes of death
- are more likely to be injured or to die in accidents at work
- have higher rates of suicide
- are uniformly more likely to be killed as a result of violence
- are more likely to perpetrate violence
- perceive that they have better health

This is consistent with other reports of men's health and their low use of health services (Connell et al., 1998; DHA, 2010a). These particular problems of men have led to the development of men's health policies and of health services specifically for men (Smith and Robertson, 2008; DHA, 2010a). However, not all advocates of men's health and well-being agree about the nature of the problems and possible solutions (Smith and Robertson, 2008).

What might be some of the problems for men in a health system characterised by integration? Two of the elements central to a primary health care approach to health services – accessibility and acceptability – are of particular concern.

Accessibility

Increased accessibility to the resources offered by primary health care has been considered an important goal for several decades (Berman, Gwatikin and Burger, 1987). However, there are diverse aspects to accessibility. For instance, one can ask whether a service or programme can or should initiate and maintain contact with the particular persons for whom it is intended. On the other hand, the issue of accessibility can refer to whether, or to what degree, the members of a particular societal group or of a community can avail themselves of resources as a function of their own initiative.

In terms of initiating contact, it may be wholly inappropriate for certain members of a primary health-care team to do so with persons directly. It may be more appropriate for them to work through a trusted and respected member of the community, as is often the case among Aboriginal and Torres Strait Islander communities in Australia (Wenitong, 2002; Bulman and Hayes, 2011). This is especially true of males who have often been institutionalised at some point in their lives and find interaction with services both intrusive and discomforting (ibid). By contrast, the women of the community often learn to build bridges due to their concern for mothers' and children's health.

Accessing a particular resource might require a community member to have gained the appropriate referral from one service provider to another. Yet, there are any number of reasons why this might be considered inappropriate by the member of the community who has little or no say in the matter. For instance, many refugees are often fearful of engagement with government-funded bodies because of their previous experience of oppression (McGorry, 1995; Sharpe, 1996; Lamb and Smith, 2002). Males may feel particularly vulnerable, as they are often the ones who have been targeted by authorities for interrogation. Flexibility in these matters will greatly enhance the likelihood that access to persons or resources is facilitated.

There is a risk that increased integration of services will create greater inflexibility by reducing diversity within a health system. For instance, research conducted in Australia concluded that 'men in safe, well-facilitated groups associated with their networks' could and would speak about and address their health-related concerns (Hayes, 2001). These networks often include people who have links with community-based services and organisations with greater latitude in the manner in which they relate to various groups

(Kemp, 1993; McGorry, 1995; Fowler, 1998; Wenitong, 2002; Murray and Skull, 2003).

Ironically, integration of service provision can reduce or destroy many natural and diverse linkages that have developed through time and across space to overcome differential distribution of resources (Smith, 1977; 1982). Such linkages often afford access to resources through various family, friendship and work-related networks in age and stage appropriate ways (Bulman and Hayes, 2008; 2010; 2011). The effectiveness and efficiency of these more informal natural networks can be overlooked when decision-making with regard to formal service integration goals, processes and outcomes is undertaken (Smith, 1977; Thomas et al., 2002; Hayes and Williamson, 2007).

The continuity of integrated services by necessity involves clients dealing with a greater number of providers and administrators. This results from a need to have various transition points between one aspect of service provision and another. Navigating such a system might require a higher level of literacy. For instance, a 'men's shed' (an Australian innovation providing a male-friendly space for various activities) might have provided a one-stop programme of outreach where clinical personnel regularly visited the space and interacted with the men informally as a means of providing advice and assessing risk (Hayes and Williamson, 2007; Morgan et al., 2007; DHA, 2010b). Integrating such a service within a larger setting such as a hospital might require the men to be able to navigate a number of physical and bureaucratic pathways to the requisite service.

It can easily be forgotten that even signage requires interpretation skills that many people will not have mastered. Forms that were once filled out with the assistance of trusted others become a barrier to those whose ability to read and write is inadequate to the task (Hayes and Williamson, 2007; Bulman and Hayes, 2011). Higher levels of learning difficulty and lower functional literacy levels among males can make this problematic (Wenitong, 2002; Bulman and Hayes, 2008; 2010; 2011; DHA, 2010b).

Men might also perceive increased levels of interaction as threatening their anonymity (Wenitong, 2002; DHA, 2010b). Integrated services will require extensive data recording, which might be seen as intrusive by some men, especially those confronting mental or physical conditions that they do not wish others to know about. Men will also be expected to engage with services biased towards the needs of women and children (White, Fawkner and Holmes, 2006; Holden, Allan and McLachlan, 2010; Bulman and Hayes, 2010; 2010). It is often the case that signage and other messages that make the space safe and welcoming for women are both off-putting and, sometimes, discomforting to men (Bond, 2000; DHA, 2010b).

Service providers in an integrated setting must also recognise the time constraints of men. Centralised service provision may require travel with its consequent costs in time and loss of wages. Concerns with accessibility require careful thought about the 'gatekeeper' of any integrated system. Should physicians be the gatekeepers or is this likely to alienate some men from engagement? Men may resent a perceived medicalisation of their health concerns and dominant role for the doctor. Should there be multiple points of entry?

Acceptability

A related issue is that of acceptability. There are a number of components to acceptability, including whether the goals, processes and potential outcomes of a programme or service are both welcome and valued by a particular groups. For instance, many prenatal programmes and services that seek to involve fathers fail to consider what outcomes and processes would make them feel valued and safe.

Australian researchers have found that men can avoid involvement in fathering roles and fail to access important services for a variety of reasons including 'negative attitudes to services in their current format, mothers who act as 'gatekeepers' of childbirth and child-rearing knowledge, and, on a broader scale, negative stereotypical images of men as nurturers' (Fletcher, Silberberg and Galloway, 2004: 20). However, Fletcher, Silberberg and Galloway (loc. cit.) have also have identified a number of programme-related reasons for a father's dissatisfaction with and consequently disinclination to access such services:

- ambivalence about increasing father involvement
- little focus on men's roles
- a failure to recognise fathers in family-service settings
- lack of skills for engaging men
- few opportunities for men to relate to other men
- a preoccupation with medical rather than fathering information
- the timing of classes where information is not presented when most needed.

As the Attorney-General of New South Wales discovered (Donovan Report, 1998), it is vital that those providing services for men are enthusiastic to do so on the 'terms and turf' of those men. The counselling needs to be located in a manner that supports the men, and this may not be the most 'cost-effective' location. Moreover, Aboriginal and Torres Strait Islander males often prefer support services with minimal signage to avoid stigma (Bulman and Hayes, 2010; 2011).

It is important that men perceive the location of service delivery as 'safe' for them to communicate their concerns (Hayes, 2001, Hayes and Williamson, 2008). Programmes dealing with domestic violence often have signage that *implies* that males are the sole perpetrator. Yet, in some areas, for a significant minority of *reported* cases of domestic violence, or intimate partner abuse, it is the female who is the perpetrator. Implicit failure to acknowledge that this may be the case reduces the possibility of greater reporting and more effective engagement of the issues (Tilbrook, Allen and Dear, 2010).

Those providing services must also have the relevant experience to allow them to connect with men, as well as the expertise than can be drawn upon by men when they feel that it is useful for them (Donovan Report, 1998). Integrated services that require staff to take many different interrelated roles within the organisation may fail to ensure that people with appropriate life experience and expertise deal with male-related issues and trauma and may reduce the likelihood of men continuing to use services (McGorry, 1995; DHA, 2010b).

For instance, insisting that older males see the duty social worker in community health services before being referred to an appropriate service area may mean that female workers with views and experiences less sympathetic to males accessing the service act as gatekeepers (Thomas et al., 2002). Many males are sensitive to the

issue of being scrutinised and *implicitly* shamed as a means of social control and they are often unlikely to tolerate more than one attempt at accessing a service (McArthur et al., 2006). They may also misinterpret bureaucratic processes as directed at them personally as a result of the contestation that they have often experienced in the workplace.

Concluding observations

The WHO recognises that 'supporting integrated services does not mean that everything has to be integrated into one package' (WHO, 2008: 6) and that single-issue-style provision may be appropriate for specific client groups. In deciding which path to take with men's health services, policy makers need to pay particular attention to accessibility and acceptability and may benefit from considering some of the issues canvassed in this brief discussion.

References

Berman, P.A., Gwatkin, D.R. and Burger, S.E. (1987). Community-based health workers: head start or false start towards Health for All? *Social Science & Medicine*, 25(5): 443–59.

Bond, G. (2000). *'I'd sooner talk to someone...': improving young men's access to health and welfare services*. Melbourne: Moreland Community Health Service.

Bulman, J. and Hayes, R. (2008). 'Promoting Indigenous participation in health promotion education through community-based participatory research'. *Aboriginal and Islander Health Worker Journal*, 32(3): 10–13.

Bulman, J. and Hayes, R. (2010). Yarning spaces: dealing with depression and anxiety among Aboriginal and Torres Strait Islander males the 'proper way'. *The CAPA Quarterly* (Journal of the Counsellors and Psychotherapists Association of NSW), 1: 24-28.

Bulman, J. and Hayes, R. (2011). Mibbinbah and spirit healing: fostering safe, friendly spaces for Indigenous males in Australia. *International Journal of Men's Health*, 10(1): 6-25.

Connell, R.W., Schofield, T., Walker, L., Wood, J., Butland, D.L., Fisher, J. and Bowyer, J. (1998). *Men's health: a research agenda and background report*. Canberra: Commonwealth Department of Health and Aged Care.

DHA (2010a). *National male health policy: building on the strengths of Australian males*. Canberra: Department of Health and Aging.

DHA (2010b). *National male health policy supporting document: access to health services*. Canberra: Department of Health and Aging.

Donovan Report (1998). *Men's counselling research: report to Attorney General's Department, Family Services Branch*. Canberra: Attorney General's Department.

Fletcher, R., Silberberg, S. and Galloway, D. (2004). New fathers' postbirth views of antenatal classes: satisfaction, benefits, and knowledge of family services. *The Journal of Perinatal Education*, 13(3): 18–26.

Fowler, N. (1998). Providing primary health care to immigrants and refugees: The North Hamilton experience. *Canadian Medical Association Journal*, 159(4): 388–91.

Hayes, R. (2001). *Men's health promotion: developing an intersectoral strategic framework*. Melbourne: Victorian Health Promotion Foundation.

Hayes, R. and Williamson, M. (2007). *Men's sheds: exploring the evidence for best-practice*. Melbourne: La Trobe University.

Hayes, R. and Williamson, S. (2008). Men's health. In Kirch, W. (ed.), *Encyclopedia of public health*. Berlin: Springer-Verlag, pp. 903–06.

Holden, C.A., Allan, C.A. and McLachlan, R.I. (2010). 'Male friendly' services: a matter of semantics. *Australian Family Physician*, 39(1/2): 9–10.

Kemp, C. (1993). Health services for refugees in countries of second asylum. *International Nursing Review*, 40(1): 21–4.

Lamb, C.F. and Smith, M. (2002). Problems refugees face when accessing health services. *NSW (New South Wales) Public Health Bulletin*, 13(7): 161–3.

McArthur, M., Zubrzycki, J., Rochester, A. and Thomson, L. (2006). 'Dad, where are we going to live now?' Exploring fathers' experiences of homelessness. *Australian Social Work*, 59(3): 288–300.

McGorry, P. (1995). Working with survivors of torture and trauma: the Victorian Foundation for Survivors of Torture in perspective. *Australian and New Zealand Journal of Psychiatry*, 29: 463–472.

Morgan, M., Hayes, R., Williamson, M. and Ford, C. (2007). Men's sheds: a community approach to promoting mental health and well-being. *International Journal of Mental Health Promotion*, 9(3): 50–54.

Murray, S. and Skull, S. (2003). *The Victorian Immigrant Health Program (VIHP)*. Melbourne: Department of Paediatrics, University of Melbourne.

Sharpe, I. (1996). Refugees and torture: the new global epidemic. *Australian Nursing Journal*, 4(6): 18–19.

Smith, D.M. (1977). *Human geography: a welfare approach*. New York: St. Martin's Press.

Smith, D.M. (ed.) (1982). *Living under apartheid: aspects of urbanization and social change in South Africa*. London: George Allen & Unwin.

Smith, J.A. and Robertson, S. (2008). Men's health promotion: a new frontier in Australia and the UK? *Health Promotion International*, 23(3): 283–89.

Thomas, S., Foreman, P., Hayes, R. and Moran, J. (2002). *Older men's access to health and welfare services, For Aged Care and Mental Health Branch*. Melbourne: Lincoln Gerontology Centre, La Trobe University.

Tilbrook, E., Allan, A. and Dear, G. (2010). *Intimate partner abuse of men*. Perth: Edith Cowan University (a research project commissioned by the Men's Advisory Network (MAN).

Wenitong, M. (2002). *Indigenous male health: a report for Indigenous males, their families and communities, and those committed to improving Indigenous male health*. Canberra: The Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Aging.

White, A. and Cash, K. (2003). *A report on the state of men's health across 17 European countries*. Brussels: European Men's Health Forum.

White, A., Fawkner, H.J. and Holmes, M. (2006). Is there a case for differential treatment of young men and women? *Medical Journal of Australia*, 185(8): 454–55.

WHO (World Health Organization). (2008) Integrated health services – what and why. Technical Brief No.1. Geneva: WHO.

Dr Rick Hayes and **Dr Simon Barraclough** are, respectively, Head of Department and Associate Professor in the Faculty of Health Sciences at the School of Public Health and Human Biosciences, La Trobe University, Australia. Dr Hayes has a longstanding involvement with men's health research and programmes and has worked with Indigenous male health projects in Australia, while Dr Barraclough researches and teaches health policy.