Chapter 3
Health-Seeking Behavior and Meeting the Needs of the Most Vulnerable Men

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Introduction

Men seek and ask for help in many different ways compared to women when it comes to their health. It has been well documented that men are less likely to have a usual source of healthcare and are less likely to utilize healthcare services, even when they have access to these services. For minority men (African American, Hispanic, and Latino), these healthcare-seeking behaviors are worse and are often structured by socioeconomic factors, which increases their risk for morbidity and mortality from preventable diseases. Men who are missing from healthcare settings may avoid these settings because they do not acknowledge their risk for chronic diseases, may experience challenges with navigating through healthcare settings (e.g., making appointments, transportation issues), or have difficulties with establishing trusting relationships with their providers. For minority men, their engagement with healthcare settings may be further diminished as a result of

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experiences of discrimination within these settings. Men who are engaged, have trusting relationships, and feel confident about managing their health are more likely to be adherent to treatment plans and exhibit positive health behaviors and health outcomes. To improve men's healthcare-seeking behaviors, researchers, practitioners, and clinicians will need to consider individual, economic, and social determinants of men's healthcare-seeking behaviors and relevant barriers toward improvement.

Men's health remains a relatively recent area of study compared to women's health in the United States (USA) and internationally [1–3]. Men's health has gathered momentum around the world since the late 1980s and early 1990s due to gaps in health status and health-seeking behavior between men and women. Men are more disconnected from healthcare compared to women. The W.K. Kellogg Foundation noted in the early 1990s "a growing concern, and now with alarm, the absence of men of all ages in the waiting rooms of clinics and other healthcare providers" [4]. From 1997 to 1998, doctor visits for annual examinations and preventive services were 100 % higher for women than for men [5]. This problem with men accessing healthcare has persisted decades later as men are 24 % less likely than women to have visited a doctor within the past year, but are 32 % more likely to be hospitalized [6]. However, minority men are least likely to access healthcare and their health outcomes are even more dire than their Caucasian counterparts [7]. African American (AA) men's health is considerably worse than other race-gender groups, with AA men disproportionately suffering from preventable diseases, being disproportionately disabled by them, and suffering disproportionately higher mortality, relative to European American (EA) men [1].

Research suggests that male gender socialization teaches men that they are invulnerable to illness or that asking for help, such as for medical problems, is a sign of weakness and continues to persist, particularly in AA men [8–10]. Avoidance of healthcare providers by men has been offered as a partial explanation for the increased mortality rates from several chronic diseases and the persistent disparities that have been observed in hypertension, heart disease, diabetes, and lung, colorectal, and prostate cancers when compared to Caucasian men [10–13]. Disparities in healthcare and health outcomes have been identified across race/ethnicity with minority men faring the worst on many health outcomes [14–16]. Overall, minorities are less likely to participate during the medical encounter and AA and Hispanic men are less likely to self-advocate during the medical encounter [17, 18]. Furthermore, AA and Hispanic men are less likely than Caucasian men to effectively manage their chronic condition [19–21]. AA men also have a shorter life span than any other group in the USA [11]. The Affordable Care Act (ACA) lays the foundation for a partnership with patients as health outcomes are linked to physician payment [22]. In particular, the ACA encourages shared decision which is associated with better health outcomes [23–26]. The literature shows that overall the health of AA, Hispanic, and Latino men lags behind that of Caucasian men and AA men's health is at a crisis point due to the disparate burden of the diseases.

Root Causes of Disparities in Healthcare

The collective experiences of AA men appear to be distinctive from Caucasian men and AA women—this is partly attributable to race- and gender-based differences in economic and social life, health burden, and experiences of inequity in the healthcare system—which could impact AA men's healthcare utilization and perceptions of healthcare [27–30]. In addition, studies have shown various barriers to improving men's health behaviors [31]. Men often express fear of diagnosis, stress and role strain, lack of awareness and access to good information (from self and peers), medical mistrust, and relationships with healthcare providers [32]. One factor that promotes use of preventative health services is having a usual source of care, which can improve routine screening and care. As a result of many men in the USA lacking insurance, they are less likely than women to have a usual provider and usual source of care.

An Institute of Medicine (IOM) report described how the social hierarchy that exists in the USA plays an important role in explaining differences in the quality of care provided to minorities [33]. These differences occur in the context of historical and contemporary social inequities; are impacted by a variety of sources, including conscious or unconscious stereotyping; and are not explained by racial and ethnic differences in treatment refusal rates [33]. How people of different racial, ethnic, cultural, and gender groups are perceived remains part of a growing body of literature focusing on racism and bias within public health and healthcare [34–36]. That is, healthcare organizations are beholden to societal institutions and forces through funding streams, government mandates, and the practices of individual staff members [37–39]. For example, public health departments are constrained by government bodies that confer legal authorization to function and that provide their funding. Funders of health can structure the values and operating principles by which staff are evaluated and promoted which may influence the quality of care delivered and the resulting health outcomes of patients in those facilities. At the same time, as the conduits to resources and providers of critical services, health departments can have the capacity to control AA communities' power, agency, and ability to access resources and services [39–41]. Hence, an essential starting point for appreciating the complexity of institutional racism in today's healthcare system is to recognize the existence of inequities in the delivery and quality of healthcare [42].

Navigating Healthcare Systems

Racial disparities in quality of healthcare may involve one or more of several factors. Possible explanations include organizational factors within facilities and health plans or systems, including complex appointment or referral systems or long waiting times, simple lack of providers within any reasonable traveling distance or time,

and poor understanding of how best to mobilize local community organizations that principally serve African American residents. Other matters, such as the racial and ethnic concordance (or lack thereof) between patients and clinicians, may have effects on patient care-seeking behaviors or satisfaction with care (101–104). Moreover, cognitive and decision-making processes may differ by culture and ethnic group, meaning that choices and preferences may not be mutually understood or acted upon [43]. Research has also demonstrated that poor health literacy may be a key intermediate variable, since poor health literacy is differentially distributed among racial and ethnic groups and is associated with difficulty obtaining appropriate care [33, 44].

Health-Seeking Behaviors and Barriers

When men do not seek help, or healthcare, they can burden the healthcare system [45]. There are many factors that contribute to men's health-seeking behaviors that are shaped by male socialization and the lack of socializing males to and within the healthcare system. Many men exhibit treatment fears and help-seeking stigma that are fueled by psychological factors such as restricted emotional expression and not expressing negative emotions [45–47]. There are four central areas related to men and healthcare-seeking behaviors: access, awareness of their health needs, inability to express their emotions, and lack of social networks [45]. Our focus is largely on health behaviors here. Health behavior is a function of health status [48]; hence, it is important to understand the health beliefs and behaviors of men across race and ethnicity in order to improve their health outcomes.

For example, abuse of alcohol and illegal drugs is more common among men than women, and research has demonstrated that alcohol use among various populations is associated with the presence of masculine attitudes [13, 49]. Substance abuse may occur as a response to stress, physiological addiction, difficult life circumstances, and other environmental factors [50]. These life challenges may be further magnified by the fact that men are socialized to value economic independence. Low-income men may be at increased risk for substance abuse because of the daily stresses they face and the socially sanctioned nature of substance use as a coping strategy for men. Men with limited educational and employment opportunities may turn to alcohol and other drugs as an escape from their inability to live up to one of the major tenets of male gender socialization in our society [51].

AA men in their middle-adult years often evaluate their sense of manhood against their ability to fulfill their roles as provider, husband, father, employee, and community member [46, 52, 53], and often to maintain this sense of manhood, many men engage in unhealthy behaviors. Avoidance of healthcare providers by men has been offered as a partial explanation for the increased mortality rates from heart disease among men [10, 12, 13]. However, what further complicates this story is socioeconomic position. Men in lower socioeconomic positions also may conform more to traditional male role norms, which allows them to diminish their

vulnerabilities [54]. As noteworthy, trust appears to benefit men's health-seeking behavior and adherence to their treatment plans [55].

Mistrust of the healthcare system remains an important issue with men, particularly AA men in the southern US states, due to the history of unethical mistreatment and racial discrimination which at times were highly prevalent (e.g., Tuskegee syphilis experiment) [56]. Racial and ethnic minorities are more prone than Caucasians to distrust the healthcare establishment, and historically minority men have had less access to culturally competent providers [57–59]. Southern US AAs are more likely than Caucasians to report perceived racial barriers to care [60] and AA men are more likely than AA women to report perceived discrimination [61–65]. Perceived discrimination and mistreatment are associated with poorer medical adherence and delays in seeking healthcare [66–69]. In addition, higher levels of trust in the healthcare system are associated with better adherence to recommended care, greater patient satisfaction, and better outcomes [70–73].

Self-Management and Self-Advocacy

Self-management positively influences health outcomes by increasing persons' involvement in the control of their health conditions [74]. Negative emotional states, social factors, and chronic life stressors have been found to hinder men's ability to manage their health [75]. Additionally, there are significant racial/ethnic differences in perceived difficulty with self-care behaviors [76–78], which, for men, is significantly influenced by self-confidence [79]. Self-confidence refers to the belief that one is capable of performing those behaviors required to attain a certain outcome and could be applied specifically to beliefs about self-care behaviors [80]. Research has also found that men with high levels of self-confidence were able to engage in more health-promoting and health-monitoring behaviors. Confidence in self-management is influenced by patient empowerment [81]. Higher levels of self-confidence in men as measured by self-efficacy were associated with being more likely to report better medication adherence and hypertension control. Higher self-efficacy has been closely linked to active participation in cardiovascular disease risk-reduction strategies in minority populations [82], positive behavior change [83], patient empowerment [84], and chronic disease management. Men as patients can become empowered as they gain new knowledge about their health. This knowledge may come as a result of better relationships and communication with their providers and their own search for information. As men gain new knowledge, they may also acquire new skills and capacities to manage their chronic conditions which will make them co-participants in the healthcare encounter. As providers improve communication, build rapport, engage patients, and develop accountability systems to monitor patient outcomes, patients and providers will improve their relationships.

Another important factor to better manage and increase men's confidence to manage their health is involvement. The positive benefits of patient involvement

extend beyond the medical encounter [23, 24, 26, 85–88]. Patients who are well informed are more capable of monitoring their health, coping with their illness, and adhering to treatment [89]. Self-advocacy extends beyond patient involvement; it encompasses gathering and using information to advance health [90]. Health information seeking has increased in the USA, and it is associated with patient empowerment, positive health management, patient follow-up, and patient treatment decision making [91, 92]. Rooks and colleagues found health information seeking was associated with changing approach to managing health and better understanding of how to treat illness [93]. However, studies have found racial and ethnic minority men are less likely to use the health information sought during the medical encounter [18, 94].

Health information is an important factor contributing to the poor health status of the most vulnerable men; however, access to culturally appropriate information is important as well (NCI 2006). Possible explanations for poor access to culturally appropriate health information include organizational factors within facilities and health plans or systems, including complex appointment or referral systems or long waiting times, simple lack of providers within any reasonable traveling distance or time, and poor understanding of how best to mobilize local community organizations that principally serve African Americans. Other matters, such as the racial and ethnic concordance (or lack thereof) between patients and clinicians, may have effects on patient care-seeking behaviors or satisfaction with care [95–98].

Literacy levels of men remain a significant predictor in determining how appropriate health information is for AA men and other high-risk men to improve patient awareness of diseases and treatments [99]. AA men obtain health information using the Internet, television, and print media such as magazines, pamphlets, and books [100] and prefer to receive health messages from effective speakers who embody characteristics they can model such as clergies, community leaders, active community members, and health professionals [101]. As a result, studies have found that identifying and developing culturally appropriate health promotion messages for AA men would be beneficial toward improving the health outcomes of African American men [99–102].

Next Steps to Improve Health-Seeking Behavior

Improving the health-seeking behavior of the most vulnerable men will require a comprehensive approach. Traditionally, patients with multiple comorbidities are identified as complex patients [103–114]; however, this definition might be too restrictive [115]. Safford and colleagues [115] contend that complexity extends beyond having multiple comorbidities, proposing that it includes socioeconomic, behavioral, cultural, and environmental factors [115]. Safford and colleagues propose that patient complexity is a function of "the interactions between biological, cultural, environmental, socioeconomic, and behavioral forces" (Vector Model of Complexity). The health-seeking behavior of men is complex, and if healthcare

providers address only one facet, as we have seen, the result is likely to be less than optimal for men [116]. Thus, to improve health-seeking behavior of men and the most vulnerable men (minority), one must address all the vectors that impact health-seeking behavior in men and how men interface with the healthcare system. The aforementioned remains somewhat difficult because men's health remains understudied and systematically underfunded. However, the Patient Protection and Affordable Care Act (ACA) is a step in the right direction in addressing men's health. The ACA emphasizes preventive care and population health partnered with primary health. This type of partnership is absolutely necessary to improve health-seeking behavior in men as it addresses matters outside of the medical encounter that challenge health-seeking behavior for men. Lastly, one of the critical inclusions in the ACA is the role of accountability for physicians. With increased accountability and monitoring of patient outcomes, we will expect that we will see an increase in men's use of preventive healthcare services, as well as their engagement in the healthcare system in meaningful ways that will reduce their burden of disease and minimize costs to the healthcare system.

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