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## UROLOGICAL DATA

# The men's health center: Disparities in gender specific health services among the top 50 "best hospitals" in America



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**Abstract** *Objective:* Gender-specific integrated health services have long existed in the arena of women's health care, but men's health centers (MHCs) have only recently emerged as a novel practice model. Here, we seek to evaluate the prevalence and format of MHCs found in the leading academic medical centers in the United States.

*Methods:* The US News & World Report's Top 50 Ranked Hospitals for Urology was used as our cohort. Data were gathered on the presence of MHCs and types of providers and conditions treated. An equivalent search was performed for women's health centers (WHCs).

*Results:* Sixteen of 50 (32%) promoted some type of MHC, compared to 49 of 50 (98%) offering a WHC. Eight of the top 15 ranked institutions (53%) had an MHC compared to eight of 35 (23%) remaining programs. Six of 16 MHCs incorporated providers from a variety of medical disciplines, including urologists, internists, endocrinologists, cardiologists, and psychologists, while another six of 16 MHCs were staffed solely by urologists. Eight of 16 provided services for exclusively urologic issues, four of 16 offered additional services in treatment of other medical conditions, and four of 16 did not specify.

*Conclusion:* A considerable disparity exists between the prevalence of gender-specific health services, with WHCs being much more numerous than MHCs. All but one leading institution

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had WHCs compared to less than one-third having MHCs. Our findings also highlight the heterogeneous nature of men's health programs, as they exhibit great variability in program type and focus, yet are all being marketed under the "Men's Health" banner.

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## 1. Introduction

Major strides have been achieved over the past several decades in the establishment of women's health as a discipline based upon a gender-specific approach towards health care delivery. Unfortunately, the counterpart field of men's health has remained comparatively underdeveloped. Nevertheless, significant health disparities exist between men and women that illustrate the necessity for the provision of male-focused gender-specific care. In general, morbidity and mortality across the spectrum of disease is known to be higher in men than women. Recent United States Centers for Disease Control and Prevention statistics indicate a notably higher male death rate (886.2 male deaths per 100,000 population versus 634.3 female deaths per 100,000 population) and a life expectancy for men (76.2 years) that is about 5 years shorter than that of women (81.1 years) [1]. These discrepancies are likely reflective of a combination of both male lifestyle choices, increased risky behavior, and susceptibility to disease [2]. Men, being typically more averse to seeking medical care than women, are known to underutilize health care resources, with up to 80% of men declining to see a physician without prompting by a spouse or partner [3,4]. In a national comparison of ambulatory care usage between men and women in the US, the rate of primary care visits made by women was 58% higher than that of men, and the rate of visits to outpatient subspecialty departments made by women was 40% higher than that of men, even after excluding women with solely pregnancy-related diagnoses [5]. When coupled with the sociologically masculine tendencies to prioritize self-sufficiency and to adopt riskier lifestyle behaviors [6], the reluctance of men to access the health care system can contribute towards poorer long-term health outcomes.

Among the obstacles that have impeded the establishment of men's health as a universally recognized specialty is the lack of a formal definition for both the composition of the field itself, as well as the identity of the providers serving as its specialists. One of the more frequently cited definitions of "Men's Health" originates from the Men's Health Forum of England, which posits that:

"A male health issue is one arising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level [7]."

The innate breadth in definitions such as this naturally leads to ambiguity in delineating the boundaries of men's health, which in turn obfuscates the determination of which

types of physicians should be responsible for providing this directed care. Today, without a men's health specialist, urologists often end up filling this role by default [8], publicly perceived as the "man's doctor" insofar as the obstetrician-gynecologist serves as the specialist for females. Not all men's health issues are urological in nature, however, with many relevant male health issues fall under the domain of primary care and medical subspecialists, such as cardiologists or endocrinologists. Considering the extent of specialty overlap inherent in such a broad spanning field, questions arise as to who is chiefly responsible for overseeing the practical implementation of men's health as a distinct specialty in today's practice environment.

Perhaps in response to the increasingly realized need for specialized, male-focused health care delivery, recent times have seen the emergence of men's health centers (MHCs) as a novel practice model conceptualized to fulfill this need. While many of these MHCs are still in the process of getting established, in theory, such centers could allow for the centralized provision of integrated, comprehensive, gender-specific health care for men. This additional benefit represents the major strength of MHCs in attracting male patients by offering continuity of care among multiple specialties under a unified location. The ultimate goal would be to enable convenience of access to care and improve streamlined care ultimately leading to an increase in utilization to health care by males.

The purpose of our study is to evaluate the prevalence and practice formats of MHCs found amongst the leading academic medical centers in the US. By examining the variation between the different MHCs, while also assessing the availability of concurrent women's health services at the same institutions, we hope to gain valuable insight into the state of this newly emerging practice model.

Based on the ambiguity found within the field of men's health, we hypothesized that there is considerable variation in formats and practice patterns among MHCs established in the US. We expected to see a diversity of different specialists and generalists involved in providing men's health care, resulting in vastly varied setups between the centers. We also suspected WHCs were far more common than MHCs in the US.

## 2. Materials and methods

To form our study's cohort of academic medical centers, we utilized the US News & World Report's annually published "Best Hospitals" rankings, and selected the Top 50 Ranked Hospitals for Urology [9]. We elected to use the urology category of rankings, as the majority of men's health offerings have been traditionally concentrated in this area.

The institutional websites for each of the 50 identified centers were then queried with the search term “men’s health” in order to detect the presence of an MHC. Included within the definition of MHC were any type of publicized men’s health clinic, men’s health program, or men’s health services which specified the provision of male-focused health care. For each identified MHC, data were collected on the types of providers staffing each center, as well as the variety of medical services advertised by each MHC. A concurrent search for women’s health centers (WHCs) at each of the 50 institutions was conducted using the search term “women’s health” in order to obtain a controlled comparison between the male-specific and female-specific health services offered by the institutions. The equivalent inclusion criteria were adopted for the WHC query.

Prism Software (version 6; Graphpad Software, Inc., La Jolla, CA, USA) was used to calculate a z-score and *p*-value using a two-tailed test. Data were considered statistically significant if *p*-value was less than 0.05.

### 3. Results

Of the medical centers assessed in our study, 16 of 50 (32%) advertised some form of an MHC. In contrast, 49 of the same 50 institutions (98%) advertised some form of a WHC ( $p < 0.05$ ). Half of the identified MHCs were found among the top 15 ranked institutions, with eight of 15 (53%) having an MHC, compared to eight of the remaining 35 institutions (23%) having an MHC ( $p < 0.05$ ).

Looking more closely at the characteristics of the 16 identified MHCs, six of 16 (37.5%) were staffed solely by urologists, while another six of 16 (37.5%) incorporated a variety of specialists in a multidisciplinary practice arrangement. These multidisciplinary MHCs were staffed by a combination of providers from disciplines such as internal medicine, family medicine, cardiology, endocrinology, and psychology, in addition to at least one urologist. Of the remaining four MHCs, one was staffed exclusively by physical therapists, one was a research-based center, and two did not specify their providers.

With regards to the assortment of medical services provided by each MHC, eight of 16 centers (50%) advertised services in treatment of exclusively urologic conditions, including erectile dysfunction, low testosterone, benign prostatic hyperplasia, and male infertility. Alternatively, four of 16 centers (25%) also incorporated treatment for medical conditions that fall outside the traditional purview of the urologist, such as cardiovascular disease, diabetes mellitus, musculoskeletal injuries, and preventive care. The remaining four MHCs did not specify the types of services provided.

With regards to the assortment of medical services provided by each WHC, all but a few offered care in the fields of internal medicine, obstetrics and gynecology, breast surgery, and psychiatry. Treatment at these WHC included female sexual dysfunction, infertility, obstetrics, pelvic organ prolapse, and gynecologic and breast cancer.

### 4. Discussion

With nearly all of the queried medical centers advertising a WHC and only a third of them offering an MHC, our findings

highlight a marked disparity between the availability of male-focused and female-focused health care centers. To be sure, the women’s health movement has had significantly more time to flourish, borne out of a confluence between economic motivations and social interests during the late 20th century. As the healthcare market began to saturate in the 1980s, hospital administrators adjusted their marketing strategies to target women, who were thought to be the health care decision makers for their whole households, while also utilizing medical services more than men [10,11]. Meanwhile, in the wake of the feminist movement that spanned the 1960s and 1970s, women were growing increasingly dissatisfied with the limited scope of mainstream medicine and vocalized a desire for changes to existing models of care to better accommodate their needs [12,13]. The US government responded by establishing the Office on Women’s Health within the Department of Health and Human Services in 1991 [14]. In the late 1990s, this agency went on to spearhead the Centers of Excellence in Women’s Health program, a governmental initiative to establish and fund nationally recognized centers for women’s health within designated academic medical centers [13,15]. These Centers of Excellence were designed to foster the advancement of women’s health through intra-institutional collaborative efforts in research, education, and clinical care. By comparison, far less attention has been afforded to the equivalent promotion of men’s health over the years, and the notable fact that no counterpart Office on Men’s Health exists within the US Department of Health and Human Services is testament to that lack of recognition. In an effort to address this disparity, a bill was introduced to the US House of Representatives in 2009 under the title of the “Men and Families Health Care Act of 2009”, which endeavored to establish an Office of Men’s Health while initiating and promoting programs to improve the state of men’s health nationwide [16]. However, the bill ultimately languished on the House floor and died in congressional subcommittee.

Nevertheless, the significant strides achieved in the arena of women’s health care can serve as a model for contemporary efforts to further develop and organize men’s health. The well-established state of WHCs has provided the necessary infrastructure for studies to assess their overall impact on their delivery of women’s health care. A large, multi-center study of quality of care at the aforementioned Centers of Excellence in Women’s Health demonstrated significantly higher patient satisfaction ratings among women who received care at a WHC as opposed to non-gender-specific, traditional medical practices [15]. The study also reported higher utilization rates of preventive services, including Papanicolaou tests, breast examination, mammograms, cholesterol screening, colon cancer screening, and routine physical examination, in addition to increased usage of counseling services for smoking cessation, exercise, alcohol and drug use, domestic violence, and sexually transmitted infections, among WHC patients. A similar study investigating WHCs established within the Veterans Affairs hospital system likewise revealed consistently higher patient satisfaction ratings from women who attended a WHC versus a traditional clinic, with the authors concluding that WHC attendance was a positive predictor

for increased patient satisfaction with privacy and comfort, provider communication, comprehensiveness of care, and arrangements for follow-up care [17]. The evident improvements in women's health care delivery afforded by WHCs could conceivably be extrapolated onto efforts to improve men's health care with the continued development of MHCs.

The results of our study also underscore the notable degree of variation between the practice models currently implemented by extant MHCs with regards to both the types of providers staffing and the range of medical services offered by the centers. The division between MHCs operated exclusively by urologists and those incorporating a variety of medical specialists is reflective of the general ambiguity and fragmentation within the organization of men's health as a discipline. The adoption of a more integrated, interdisciplinary approach to gender-based care may confer several inherent advantages with the potential to address some of these issues. Having multiple specialists co-localized in one setting makes it easier for patients to see providers from different specialties as their individual needs dictate, and increases the likelihood of appropriate referral, patient follow-up, and coordination of care. Looking again to the progression of WHCs for corroboration, a pilot study conducted by Johnson et al. [18] involved the restructuring of a medical practice to adopt an interdisciplinary, women-based approach to care. The practice redesign implemented a collaborative, team-based arrangement, with providers working in one of four specialty-specific teams [gynecology, primary care, internal medicine subspecialties (cardiology, endocrinology, gastroenterology, and rheumatology), and mental health] out of a shared ambulatory center. The investigators then surveyed the provider participants and found improved provider satisfaction as a consequence of the cross-specialty collaboration and streamlining of care.

In recent times, providers have begun to recognize an increased public appetite for such dedicated services [19], and this growing demand may be contributory to the contemporary trend of emergent MHCs. Physicians have also begun to acknowledge the benefits of multidisciplinary models of care, as the American Urological Association's Committee on Male Health has stressed the need for urologists to learn to practice collaborative care with other specialists in order to fully meet the health care needs of their patients [3]. The implementation of such cross-specialty ventures can be ably optimized by MHCs.

Our current study does have limitations. For one, our small sample size limits our ability to generalize our findings to the medical community as a whole. We are also limited by the information that was able to be obtained online. It is possible that there are newer MHCs at these institutions that were not adequately advertised on their respective websites leading to an under-representation of these facilities. Also, by limiting our search to the top Urology programs in the country we are preferentially looking at programs which we believed would have a higher likelihood of offering integrated MHCs. Even with this bias, there remained a significantly higher number of WHCs at these institutions with a much smaller number of MHCs. In comparison, if we searched the top 50 hospitals in the US, we would expect this disparity to be similar or even greater.

## 5. Conclusion

As the discipline of men's health continues to develop, health policy and governmental initiatives promoting men's health could aid in increasing public awareness of men's health issues. Professional development opportunities for men's health providers are paramount to sustaining the growth of the field, and professional associations such as the newly launched American Society for men's Health are needed to organize providers and provide a forum for the evolution of the discipline. Prospective studies of established MHCs could provide invaluable data to elucidate the effects of this practice model on men's health care delivery. These all will be instrumental in the advancement of men's health and its establishment as a specialty within the medical community.

## Conflicts of interest

The authors declare no conflict of interest.

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