Chapter 1

Men's health in Australia

What is Health?

1.1 Definitions of what constitute health range from the narrow - the presence or risk of particular diseases or conditions - to the all-embracing, in which every aspect of a person's or community's life becomes a 'health' issue. A widely accepted definition is that of the World Health Organisation (WHO) which defines health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity."¹

1.2 Such broad definitions are valuable in illustrating that the factors influencing the health of a community or an individual extend far beyond the presence or absence of a particular pathology. It is obvious that diet, housing, the quality of water supplies and sewerage systems are key issues. Determinants of health can range from the social acceptability of the consumption of tobacco, alcohol and other drugs to intangibles such as the social and cultural constructs of 'masculinity'. In the area of mental health many matters, such as the extended experience of drought in South-Eastern Australia, can be powerful influences.

1.3 In evidence to the committee the importance of the impact of social and other factors on health was most clearly demonstrated with regard to road trauma. Land transport accidents are the third biggest cause of potential years of life lost in males, almost double the rate for women.² The general category of injury, which includes road trauma and interpersonal violence, imposes the highest direct and indirect causes on the health system.³ Yet many of the factors which influence the level of road trauma fall outside what is generally considered to be health – road standards and design, vehicle design and maintenance, driver education, attitudes to alcohol consumption and geographic isolation.

1.4 At the same time the WHO definition has been criticised for being too broad and being of little use as a guide to action.⁴ As one writer commented, a "complete ...

¹ WHO. Preamble to the Constitution of the World Health Organization, adopted New York, June 1946.

² Australian Institute of Health & Welfare (AIHW), *Australia's Health 2008*, (2008), p.51, table 2.15. This chapter draws heavily on the AIHW report. The AIHW notes that most of the statistics used in the 2008 Report refer to the years 2006 or earlier. This is a result of the timing of collection patterns and the need to process and verify the quality of data.

³ Royal Australasian College of Surgeons, Submission 14, p.4.

⁴ See, for example, BMJ 1997;314:1409 The world health organisation needs to reconsider its definition of health, Rodolfo Saracci, Director of Research in Epidemiology, National Research Council, Pisa, Italy BMJ 2008;337:a2900, Editorial, How should health be defined?

state of wellbeing corresponds more to happiness than health".⁵ Consideration of allembracing definitions of health is important in that it serves as a constant reminder of the range of factors that contribute to 'health'. However it can also lead to a sense of helplessness in the face of intractable social problems or entrenched cultural attitudes. As a representative of the Royal College of Surgeons cautioned,

You can lose sight of providing good clinical care and dealing with the pointy end of a problem in violence, road safety and so on by focusing too much on the things that are much more removed from the actual illness...⁶

1.5 The challenge for policy makers is to strike the appropriate balance between addressing the broader social determinants of health while ensuring that the research, education and service provision that underpins good clinical care is properly funded and supported.

1.6 In its submission to the committee Foundation 49 provided the following definition which covers both the specific and the general:

...disease[s] or condition[s] unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men.⁷

1.7 In this report the committee has concentrated on those matters which impinge most directly on men's health and the need to support research and provide good clinical care and education and awareness campaigns that seek to improve men's understanding of their health including the social and cultural attitudes that have an impact on it.

1.8 The committee recognises that some health problems may be more amenable to, or conditional on, actions in other areas, for example the impact on mental health of the drought in rural communities or of relationship breakdown and associated stresses which have been referred to in many submissions to the committee. The committee has commented on the need for improved services to respond to these while avoiding the temptation to examine broader contextual issues which fall outside the terms of reference of the inquiry.

Men's Health Status

1.9 Men's health status in Australia, whether measured by the burden of disease and injury or, ultimately, by life expectancy shows distinct differences from that of women. The statistics presented in the rest of this chapter show plenty of opportunities for improving men's health outcomes. However, despite the heated language in some

⁵ Bulletin of the WHO, Bulletin Board, Niyi Awofeso: Associate Professor, School of Public Health and Community Medicine, University of New South Wales, Sydney (accessed 6 May 2009) http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/

⁶ Prof. R. Gruen, Royal Australasian College of Surgeons, Committee transcript, 8 April 2009, p. 11.

⁷ Foundation 49, submission 10, p.3

submissions about 'shocking' outcomes and a 'crisis' in men's health, Australian men have the second highest life expectancy in the world, bettered only by Japan.⁸ Overall Australia has the third lowest death rate among the membership of the Organisation for Economic Cooperation and Development.⁹

Life Expectancy

1.10 Male average life expectancy at birth is 4.8 years less than that of women – 78.5 years and 83.3 years respectively.¹⁰ Male and female life expectancy declines progressively from urban dwellers, through inner and outer regional and remote areas to those in very remote areas. Men's life expectancy declines from 79 years in urban areas to 72 years in very remote areas, women's from 84 to 78 years.¹¹

1.11 The median age at death (the age at which 50% of deaths occurred before and 50% after) for men in 2005 was 76.8 years compared with 82.9 years for women. Twenty-five per cent of male and fifteen per cent of female deaths occurred at less than 65 years.¹² In 2005 male deaths exceed female deaths in every age-group other than those aged over 85 years. For some age-groups the difference is marked. In the 15-24 cohort there were 274 male deaths for every 100 female deaths and, in the 25-44 group, 208 male deaths per 100 female deaths.¹³ Overall in 2005 the ratio of male deaths to female was 106:100.¹⁴

Causes of Death

1.12 The most prevalent causes of death vary between the sexes, although coronary heart disease is the most common underlying cause of death for both men and women. It also exceeds the next most significant cause in either men or women by a large margin, accounting for 18.5% of male deaths compared with second ranked lung cancer with 7.0% of deaths. For female deaths, coronary heart disease accounts for 17.5% of deaths while the second ranked cerebrovascular disease accounts for 10.8%. Cerebrovascular disease (diseases of the blood vessels in the brain - most commonly stroke) and 'other' heart disease are ranked in the first four leading causes for both sexes. Lung cancer, the second most common cause of death in men ranks sixth for women while dementia and related disorders ranks fourth for women and eleventh for men.

⁸ AIHW, *Australia's Health 2008*, p.28, source, WHO 2007. Life expectancy at birth, 2005. Note that, in the same study women are ranked fifth.

⁹ ibid., p.48, source OECD. The OECD consists of thirty leading developed democracies.

¹⁰ ibid., p.27. Figures for 2003-2005.

¹¹ ibid., p.84, table 3.6

¹² ibid., p.23

¹³ ibid., p.24, table 2.2

¹⁴ ibid., p.24, table 2.2. Note that the ratio of male:female at birth is 105.5:100 (ABS 3201.0 – Population by age and sex, Australian States & Territories, June 2008)

1.13 Prostate cancer and breast cancer are the fifth most common cause of death in men and women respectively and account for almost identical percentages -4.4% and 4.3% of total deaths. The actual number of deaths from prostate cancer in 2005 was 2 946 and for breast cancer, 2 719.¹⁵

1.14 Proceeding down the list of the leading twenty underlying causes of death greater differences begin to appear. Of significance to this inquiry, suicide (10^{th}) , land transport accidents (14^{th}) and liver disease (15^{th}) appear in the male list but not in the female list.¹⁶

1.15 Looking at contributing causes of death – conditions or diseases that played a part in death – the pattern is similar. The three leading contributing causes are coronary heart disease and 'other' heart diseases and cerebrovascular disease and are the same in males and females. They comprise a large proportion of underlying or associated causes of deaths – 70.2% for males and 73.9% for females. It is important to keep these figures in mind. In terms of reducing the male (and female) death rate, action to address heart and cerebrovascular disease must remain a very high priority.

Potential Years of Life Lost

1.16 Another way of considering causes of death and their impact on society is potential years of life lost (PYLL). This "... is an indicator of premature or untimely death" taking 75 years as a 'normal' life span.¹⁷ Thus a person dying at 60 years is considered to have 'lost' fifteen years. In terms of PYLL the difference between men and women is starker than simply looking at life expectancy or the ratio of male to female deaths in any one year, indicating the significantly higher number of men dying at younger ages. Using this measure "Males lose 75% more potential years of life than females".¹⁸

1.17 The leading contributors to PYLL for males are coronary heart disease, suicide, land transport accidents and lung cancer. For females they are breast cancer, lung cancer, coronary heart disease and suicide. PYLL from all causes are significantly higher for men, 538 985 for men and 306 330 for women. Suicide, which ranks second for men and fourth for women, accounts for 52 998 PYLL in males and

¹⁵ ibid., p.43, table 2.12

¹⁶ ibid., p.43, table 2.12. The six conditions that appear in the male cause of death list but not the female are prostate cancer, suicide, land transport accidents, liver disease, melanoma and oesophageal cancer. Note that breast, uterine and ovarian cancers appear in the female list but obviously not in the male list.

¹⁷ ibid., p.50

¹⁸ ibid., p.50

13 270 in females; land transport accidents account for 42 505 PYLL in men and 12 678 in women.¹⁹

Avoidable Deaths

1.18 Avoidable deaths are those which "...could be avoided either through prevention (a reduction in the incidence of the conditions), treatment (that increases survival) or a combination of these".²⁰ Deaths occurring before the age of 75 are considered avoidable.

Each hour in Australia, more than five men die from conditions that are potentially preventable... Significant numbers of male-related health problems, such as high blood pressure, diabetes, heart disease, prostate cancer, testicular cancer, infertility and colon cancer, could be detected and treated more effectively if men's awareness of these problems was greater.²¹

1.19 The differences between males and females by this measure are, again, marked. The ratio of male to female avoidable deaths is 192:100; that is, almost twice as many male deaths as female deaths are considered avoidable.²² When broken down by age the differences between men and women are even clearer. In the 15-24 and 25-44 age groups the ratio between male and female avoidable death rates are 288 male:100 female and 234:100 respectively. However the overwhelming majority of deaths that are considered avoidable, over 78%, occur in the older age groups, (45 and above).

1.20 The concept of avoidable deaths clearly demonstrates the importance of improving education and awareness programs and service provision to encourage men to monitor their own health, have regular check-ups and seek help at an early stage where they are aware of a problem. Many of the conditions which contribute most to avoidable deaths, particularly in the older age groups, coronary heart diseases and stroke for example, can be managed given early identification and treatment.

¹⁹ ibid., p.51, table 2.15. In terms of the 'breast cancer v prostate cancer' debate that has been mentioned in some submissions to the committee it is worth noting that breast cancer exceeds prostate cancer in terms of PYLL and also in terms of disability adjusted life years – a measure that seeks to estimate the combined impact of loss of 'quality of life' as a result of illness, and early death. The conclusion might be expressed as: Men are just as likely to die of prostate cancer as women are to die of breast cancer however on average male sufferers are likely to be affected at a later age, experience less loss of quality of life while still alive and live to a greater age than women with breast cancer.

²⁰ ibid., p.51. Pages 51-52 provide a detailed discussion of what constitutes an 'avoidable' death.

²¹ Foundation 49, submission 10, p.1

²² AIHW, op cit, p.52. Figures are for 1997-2001

Burden of Disease

1.21 This term refers to the overall extent of health problems in Australia, combining chronic illness and diseases leading to death and is expressed in terms of Disability Adjusted Life Years (DALY).

1.22 Disability Adjusted Life Years seek to express the loss of years of healthy life owing to illness or injury. DALYs have been developed as a tool to enable policy makers and health professionals to make comparisons between a "...common chronic disease that leads to long term disability, but rarely causes death, ...[and]...a disease that is less common but often fatal".²³ In calculating this measure diseases and other conditions affecting a person's health status are given a severity weighting which seeks to quantify the loss of quality of life for a person who lives with a chronic health problem or a disease leading to death. For example, a severe health problem might result in a decade of actual life being equated to three or four years of healthy life. When combined with measures of years of life lost due to premature death DALYs provide a measure of the overall impact of disease and injury.

1.23 This measure shows that cancers²⁴ and cardiovascular diseases continue to have the largest impact, with early death rather than reduced quality of life contributing a high proportion of DALYs. However by measuring 'disability years' this process also shows the impact of mental disorders, neurological and sense disorders, injuries and chronic conditions such as respiratory diseases and diabetes, which have a significant impact on quality of life without necessarily leading to early death.

1.24 When these calculations are reduced to reasonably specific conditions then the greatest number of DALYs are attributed to coronary heart disease, anxiety and depression, type 2 diabetes, stroke and dementia.²⁵

1.25 The most common non-lethal long-term health problems of both men and women were long and short-sightedness, back pain and disc problems and hay fever and allergic rhinitis. Back pain and disc problems were more commonly reported among men while hay fever was more common among women. Lower ranked conditions showed a greater variation between the sexes; for example men reported a significantly higher incidence of deafness while women reported a higher incidence of migraine.

²³ ibid., p.52. The method of calculating DALYs is explained in detail in *Australia's Health 2008*.

²⁴ AIHW, *Cancer in Australia: an overview*, 2008, p.4-5. "Based on 2005 data, the risk for a male of being diagnosed with cancer before age 75 was 1 in 3, and before age 85 was 1 in 2." "Almost all cancers occur at higher rates in males than females, with an overall male-to female ratio of 1.4, that is, the male rate is 1.4 times the female rate."

²⁵ AIHW, Australia's Health, op cit, p.57, table 2.18

Health Status

1.26 Generally, Australians rated their health status to be 'Good' to 'Excellent'. Though this rating declined with age, more than 60% of those over 75 years were in this group. AIHW notes that self-ratings "...were similar for males and females".²⁶

Trends

1.27 The AIHW report warns against comparisons over time because of changes to methodology, however some trends with regard to the burden of disease can be discerned.

1.28 There was a significant reduction of some 15% in the burden of disease between 1993 and 2003 as measured by DALYs. The main contributors were the reduction in the impacts of cardiovascular diseases, cancers and injury and the reduction was predominantly in the fatal component of DALYs, i.e. years of life lost through early death. The non-fatal component, i.e. loss of quality of life through chronic illness, did not fall as much and in some cases, for example diabetes, it actually increased.²⁷

Regional & Rural Australia

1.29 As noted above, life expectancy declines as one moves away from major cities through inner and outer-regional Australia and into remote and very remote Australia. This pattern also shows up with some, but not all, indicators of health. For example perinatal mortality and, of significance to this inquiry, risky behaviours in relation to smoking and alcohol consumption, increase with remoteness. However in other cases, for example the incidence of cancer, while there is an increase in regional areas when compared with major cities, the incidence is not statistically significant in remote areas and actually declines in very remote areas.

1.30 In considering poorer outcomes in regional and remote areas it is important to recognise that many of the social determinants of health that contribute to adverse outcomes are more prevalent away from major cities. AIHW summarises it thus:

Australians living in rural and remote areas generally have less access to primary health-care ..., more driving risks ..., longer patient transport times, and more jobs with higher risks \dots^{28}

1.31 To these should be added a disproportionately high number of the lowest socio-economic areas and, particularly in very remote areas, the high proportion of Indigenous people whose poor health status and early deaths when compared with national population averages have a significant impact. At the same time AIHW warns

²⁶ ibid., p.29

²⁷ ibid., p.57

²⁸ ibid., p.83

against easy generalisations, pointing to significant variations within and between urban and non-urban areas.

1.32 AIHW also examines what it calls 'excess' deaths outside major cities, i.e. the deaths above what would be expected if rates in regional and remote Australia were the same as in major cities. This shows that the most significant contributors to excess deaths are coronary heart disease, other diseases of the circulatory system and motor vehicle accidents. Of particular relevance to this inquiry is that suicide and prostate cancer appear among the leading causes, both contributing 4% of excess deaths.²⁹

Indigenous Australians

1.33 The poorer health status of Indigenous Australians is well known. Life expectancy for Indigenous men in 1996-2001 was 59 years.³⁰ 71 % of Indigenous Australian deaths in 2001-2005 occurred below the age of 65 compared with 21% for the non-Indigenous population.³¹

1.34 Death rates from all causes are markedly higher in the Indigenous community; for males the Indigenous rate is three times that of the non-indigenous. Looking at the most common specific causes the rate for deaths from diseases of the circulatory system is more than three times higher than for non-Indigenous Australians. For accidents, assaults and self harm it is slightly less than three times and for cancers, one and one half times. The ratios are much higher for other significant causes of death, with the rate of deaths as a result of diabetes being nearly eleven times higher for Indigenous men compared with non-indigenous men (the comparable rate for women is 14.5)

1.35 In terms of the gap between Indigenous and non-Indigenous health outcomes, while there has been some improvement in the infant mortality rate, the decline in Indigenous death rates did not match that for non-indigenous Australians leading the AIHW to conclude that "...the gap in mortality between Indigenous and non-Indigenous Australians is widening".³² It also observes that only one of the five leading causes of death among Indigenous people – diseases of the circulatory system - showed an improvement in the period 1997-2005.

1.36 The committee acknowledges the efforts of successive governments to address these problems but despite these efforts, it cannot but agree with the conclusion of Professor Gruen, "Indigenous health is a national image problem. It is a national disgrace." 33

²⁹ ibid., p.85, table 3.7

³⁰ ibid., p.69

³¹ ibid., p.75. Note that these figures are derived from data for Queensland, South Australia, Western Australia and the Northern Territory which are considered to have the most reliable statistics.

³² ibid., p.78

³³ Prof R. Gruen, Royal Australasian College of Surgeons, committee transcript, 8 April 2009, p.12

1.37 The need to adopt a 'social determinants of health' approach is most pressing in Indigenous communities particularly those in regional, remote and very remote areas. Issues such as low consumption of fruit and vegetables, sedentary lifestyles, overcrowded housing and lack of access to clean water supplies and proper sewerage systems are major factors in the poorer health outcomes experienced by Indigenous Australians.

1.38 For Indigenous men the problems are compounded by the disempowerment experienced by Aboriginal men:

As a reaction to the social dysfunction that exists in many Aboriginal communities, all Aboriginal Males, as a group, have been targeted and convicted as the cause of this dysfunction. This approach is wrong, adding further burdens and causing greater pain within the community and to individuals. "Aboriginal men have been targeted as if they were the only perpetrators of child sexual abuse in communities. This is inaccurate and has resulted in unfair shaming, and consequent further disempowerment, of Aboriginal men as a whole".³⁴

1.39 Although some of the factors bearing on Indigenous men's health are similar to those affecting non-indigenous men, including risk-taking behaviour, injury, road trauma, alcohol and other drug consumption (including cigarette smoking) and eating habits leading to obesity, the health status of Indigenous men is not a 'worst case' example of the state of men's health in Australia generally but is to a large extent the product of factors relating to the destruction of traditional societies and cultures, the breakdown of traditional social roles and alienation from, and disempowerment by, the Australian mainstream which are distinctly different from the experience of men in the wider society. Indigenous health requires a separate and complementary approach. It is inextricably linked, "...not just [to] the physical well-being of an individual but... to the social, emotional and cultural well-being of the whole Community".³⁵

1.40 Thus the committee believes that it requires a distinct approach and therefore supports the recommendation of the Aboriginal Torres Strait Islander Social Justice Commissioner in his submission to the committee that:

...a national Aboriginal and Torres Strait Islander men's health strategy is developed and integrated with a national plan of action towards achieving Aboriginal and Torres Strait Islander health equality by 2030.³⁶

³⁴ Central Australian Aboriginal Congress, submission 129, p.1; quoting Anderson & Wild, Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, 2007:57

³⁵ National Aboriginal Community Controlled Health Organisation, submission 134, p.1

³⁶ Aboriginal and Torres Strait Islander Social Justice Commissioner and Race Discrimination Commissioner, submission 135, p.1