Chapter 2

Men's Health Issues

Why Men's Health?

2.1 Men's health has emerged as a public issue in recent decades for a number of reasons, principally the weight of statistical evidence that shows that men's health outcomes in Australia, whether measured by mortality or morbidity, are distinctly different from, and in some cases significantly worse than, those of women.

2.2 The success of the feminist movement of the last forty years in focussing attention on the roles and needs of women in society has, among other things, demonstrated the significance of gender as an influence on, and determinant of, health outcomes. This has encouraged approaches to education, research and treatment which consider gender as an important factor. It has also become clear that gender issues in health are not simply matters of specifically male or female pathologies – prostate and breast cancer for example - but also the different impact of non-specific pathologies on the two sexes and also the characteristics and behaviour of the different sexes that contribute to their health status.

2.3 Women's health programs such as breast and cervical cancer screening, improved treatments, particularly the development of a vaccine to protect against cervical cancer, and the success of the longitudinal study of women's health, (established in 1995), in informing research and treatment, are often contrasted with the lower levels of effort and attention devoted to specifically male health problems, particularly diseases of the prostate and other disorders of the male reproductive system.

2.4 This has resulted in a growing awareness that more can and should be done to address health issues in men. Thus, recent years have seen the emergence of men's health organisations engaged in research, health promotion and advocacy such as the Prostate Cancer Foundation, Andrology Australia, the Australian Prostate Cancer Collaboration, the Australian Prostate Cancer BioResource and Foundation 49 – Men's Health. In addition, organisations such as *beyondblue* have focussed attention on depression as a men's health issue.

2.5 The reasons for male over-representation in certain conditions which are common to both sexes have also come under increasing attention.[1] Men's health status is affected by a range of factors that influence behaviour, attitudes to health and utilisation of health services. Increasing attention is being given to social and cultural constructions of masculinity and the extent to which they drive these behaviours and attitudes.

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[1] For example, men are disproportionately affected by HIV/AIDS, cancers of the bladder and the oesophagus, melanoma and trauma related to road accidents and self-harm.

2.6 Men, particularly young men, are more prone to engage in risk-taking behaviours and activities, such as contact and 'extreme' sports and in relation to driving, which is reflected in the much higher incidence of injury and death in the age groups from the mid-teens to middle age. Men tend to be disproportionately represented in employment categories that have a higher incidence of workplace accidents (and may be less likely to take Occupational Health and Safety matters seriously). The excessive use of alcohol and other drugs and of cigarettes have a direct impact on health and are also more prevalent among males.[2]

2.7 One of the most obvious and most distressing causes of death in which men are over represented is suicide. The whole issue of anxiety, depression and other mental health problems in men is one of the most difficult to deal with in that identifying a problem and seeking help or treatment comes into conflict with what appears to be an entrenched aspect of masculinity, resistance to admitting weakness, seeking help and talking openly about emotional matters.

2.8 Attributing male health status to behaviours and attitudes that militate against maintaining good health has been characterised as the 'male deficit model' of men's health. Put more crudely it is a view that men are to blame for much of their adverse health outcomes by adopting risk-taking or other irresponsible behaviours and by failing to seek advice, support or treatment at an early stage where a health problem is apparent. The committee does not believe that such a characterisation is either sufficient as an explanation or useful as a guide to action.

2.9 Clearly, individuals need to take responsibility for their own health as far as is practical. However the capacity to take that responsibility and act appropriately does require understanding and awareness of the issues involved and access to, and ease with, the services that might provide support. It also depends on an appreciation of the social and cultural norms which define male behaviour.

2.10 Thus it is essential that policies are designed on the basis of sound research about male attitudes and behaviour. Service provision and education and awareness campaigns must be designed to engage constructively with men and services must have regard to men's attitudes and the realities of their lives, particularly family responsibilities and employment.

2.11 The committee notes that the Office of the Status of Women has, for many years, provided a 'gendered' input to public policy, promoting the interests of women in the Commonwealth sphere. The committee does not favour the creation of yet another bureaucratic structure, an 'office of the status of men', as was suggested in a number of submissions. However it does believe that it is important to ensure that the

[2] Lung cancer remains a significant cause of death and ill-health among both men and women as do conditions such as stroke and heart disease, to which smoking is a contributory factor. However the incidence of smoking has been declining steadily in response to legal restrictions on use, cost increases and public health and education campaigns. Thus mortality and morbidity from this source is also declining.

potential impact of legislation and policies on men as well as women across all government departments and agencies is assessed as a normal part of the legislative and policy development process.

The committee recommends that legislative drafting instructions and administrative procedures applying in all Commonwealth Government departments and agencies include a mandatory requirement that they consider the impact of legislation and policies on men as well as women.

2.12 The Commonwealth Government's decision to develop a Men's Health Policy is an acknowledgement that men's health requires specific attention. A program of consultation throughout Australia is currently underway and it is expected that the policy will be completed by the end of 2009.

2.13 The committee has not set out to duplicate or pre-empt that process. However it trusts that the issues raised in evidence to it and the contents of this report will make a constructive contribution both to debate and to the final content of the policy.

2.14 This chapter deals with a range of issues raised in evidence taken at public hearings and elsewhere and focuses on the establishment of a longitudinal study, health services for men, education and awareness raising and men's networks. Given the volume and depth of evidence received on the subjects of depression and the prostate, the committee has presented its findings for these subjects in chapters three and four respectively.

Longitudinal Study of Men's Health

2.15 Even a short summary of men's health status such as presented in chapter 1 underlines the importance of attitudes and behaviour as contributors to men's health outcomes and demonstrates that men's health is hugely influenced by social factors. Further, the determinants of health whether pathologies, behaviours or social factors are inextricably interlinked. Throughout this inquiry the committee has heard a great deal of comment on these topics, some of it evidence-based, much of it simply asserted and some of it little better than suburban myth.

2.16 This underlines the importance of health policy and service delivery being based on sound research, not simply into biomedical issues but also into all these complex interactions.

> While men's health is an emerging field, the evidence-base in men's health in Australia is relatively lacking with respect to health and social policy and associated initiatives. This is a potentially limiting factor in the implementation of appropriate and effective strategies and interventions to improve the health and quality of life of Australian men of all ages and backgrounds…[3]

[3] Andrology Australia, submission 18, p.5

2.17 An important contribution to the evidence-base would be made by a longitudinal study into men's health. A longitudinal study into women's health was established in 1995 and has made a considerable contribution to women's health since that time:

> …women's health has been on the agenda for a much longer period and there is in place, as you know, an impressive longitudinal study of women's health. I think it is fair to say that we know more about women's health than we know about men's health, including in rural areas.[4]

2.18 This has been a priority of Andrology Australia since its foundation in 2000.

> Enhancing the men's health evidence-base within Australia through the funding support of a national men's health longitudinal study would provide a better understanding within an Australian context of the associations of biomedical, behavioural, genetic, environmental and social determinants.[5]

2.19 The proposal for a longitudinal study was supported by virtually every witness with whom the matter was raised. Professor Risbridger,[6] Professor Marshall, [7] and Mr Andrew Phillips[8] all spoke in support of the establishment of such a study. Mr Phillips suggested that it should have been set up ten years ago.

> Why is it that men are the way they are? Is it the environment they are in? Is it something to do with the way they have developed? Is it something to do with their genetics about the way they respond to certain issues?[9]

2.20 The Commonwealth Department of Health and Ageing, while being careful to stress that funding for such a study was a decision for government, "…acknowledge[d] the usefulness of the data in the women's longitudinal study" while noting that "…one of the key principles of the development of the [men's health] strategy that the minister has articulated,…is a strong and emerging evidence base".[10]

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[4] Mr G. Gregory, Executive Director, National Rural Health Alliance, Committee transcript, 26 March 2009, p.27

[5] Andrology Australia, op cit., p.5. For a full discussion of the proposal for a longitudinal study of men's health, see Andrology Australia, *Men's Health Longitudinal Study-a Missing Chapter in Australia's Health Narrative*, May 2008.

[6] Prof. G. Risbridger, Head Researcher, Victorian Prostate Cancer Research Consortium, committee transcript, 9 April 2009, p.52

[7] Prof. V. Marshall AC, Centre Director, Freemason's Foundation Centre for Men's Health, University of Adelaide, committee transcript, 30 April 2009, p.46

[8] Mr A. Phillips, Policy Adviser, National Rural Health Alliance, committee transcript, 26 March 2009, p.38

[9] ibid.

[10] Ms Jennifer Bryant, First Assistant Secretary & Mr David Learmonth, Deputy Secretary, Department of Health and Ageing, committee transcript, 26 March 2009, p.14

2.21 Much of the groundwork to establish a men's health longitudinal study has already been undertaken under the aegis of Andrology Australia. A steering group was established in 2002 and a full proposal for the study has been under development since 2006. As envisaged by Andrology Australia the study would combine a "…focus on physical, mental and reproductive health" with an investigation of "…the social determinants of men's health". In addition, a range of collaborators would be engaged,

> …to ensure that the study outcomes contribute evidence beyond reproductive health issues and include the broader socio-economic and psychosocial issues that significantly impact on men's health.[11]

2.22 Andrology Australia has also tested the feasibility of such a study with its Men in Australia Telephone Survey (MATeS) which demonstrated the willingness of men to be involved in a long term epidemiological study. The proposal is now at the stage where, once resources are available, it can move forward to a development phase where all the necessary structures for the study can be put in place. It is estimated that this would take about two years.

2.23 The establishment of a longitudinal study is not conditional on the finalisation of the Commonwealth's men's health policy. Given the importance of this work and the time frames involved, it should proceed immediately.

The committee strongly recommends that a Longitudinal Study of Men's Health, building on the work already undertaken by Andrology Australia and other stakeholders be established and funded by the Commonwealth Government.

Health Services for Men

2.24 There is a great deal of evidence showing that men make less use of health services than women. For example, in the use of GP services women account for 57% of visits and men for 43%.[12] The committee notes in chapter 3 that 70% of men with a mental health problem do not seek medical advice and that 20% of men (compared with 30% of women) see their GP for a mental health problem.

2.25 This is attributed to a range of factors:

- men are considered to be more neglectful of their health or less informed about health matters than women;
- men are more likely to seek help for a condition once it is unavoidable whereas women are more likely to take a preventative approach;
- constructions of masculinity emphasise putting up with discomfort, not making a fuss;

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[11] Andrology Australia, *Men's Health Longitudinal Study-a Missing Chapter in Australia's Health Narrative,* May 2008, p.5

[12] AIHW, *General Practice Activity in Australia 2007–08- the BEACH Program,* p.36, figure 6.1

- the traditional male role as provider and the place of work in the male identity incline men to defer dealing with health problems in case they jeopardise those roles; and more prosaically,
- medical services, particularly general practice, are not 'men friendly' environments.

2.26 There are elements of truth in all these generalisations and, to the extent that they do have an influence on men's behaviour, they should be acknowledged and catered for in the development and provision of services.

2.27 At the same time it is important not to exaggerate this situation. About 88% of Australians of both sexes visited a GP at least once in 2005-2006.[13] This tallies with the findings of the MATeS study which looked at the health behaviours of men over the age of 40. That study returned the same finding, that 88% of its randomly selected group of men had visited a GP in the 12 months preceding the study.[14]

2.28 This proportion varied with age, ranging from 81% in the 40-49 age group to 98% among the over 70s. Survey results published by the AIHW show that while older age groups comprise a higher proportion of those consulting a GP, the differences are not dramatic. 21% of total consultations were by people under the age of 25 rising to a peak of 28.1% in the 45 to 64 age group. Female consultations exceeded male in all groups except those under the age of 15.[15]

2.29 Thus a significant proportion of men (although lower than the proportion of women) do in fact have contact with a medical practitioner in the course of a year. A Foundation 49 study, on a smaller sample but taken across all adult age groups, found a rather lower rate - 55% of men had had a health check in the year preceding the survey.[16]

2.30 The presumed lack of interest in health is also difficult to sustain. The MATeS study, which involved a 20 minute interview by telephone, had a 78% response rate. This is supported by quantitative evidence from other sources. The survey by Foundation 49 had a similarly good response rate and also found that 82% of respondents would have an annual health check, if it was organised through their workplace.

2.31 This is borne out by the experience of other organisations engaged in education and awareness-raising on health matters. *beyondblue*, for example, reported very high rates of participation in, and satisfaction with, its training program, *Don't*

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[13] ibid., p.1. Based on BEACH data for 2001-02, Australians on average spent 83 minutes with a GP compared with 56 minutes in New Zealand and 30 minutes in the USA. There may be differences in methods of service provision which affect the validity of this comparison.

[14] Holden et al, Men in Australia Telephone Survey (MATeS), *The Lancet*, vol 366, July 2005, p.220

[15] AIHW, BEACH data, op cit, p.35

[16] Foundation 49, submission 10, p. 8

Beat about the Bush, and of attendance by men at public meetings to raise awareness of the issue of depression.[17] The high level of calls to services such as Mensline also indicate a degree of willingness to seek advice and help that is at odds with the male stereotype. Andrology Australia reported that "…our website receives 1.2 million hits a month, 50,000 visitors a month, and 30,000 pdf downloads of information…a month".[18]

2.32 Taken together, all this suggests that neither lack of interest nor lack of contact with the health system is the primary problem but rather that men are not getting the best value out of the contact that occurs. For a range of reasons, contact with the health system is not addressing the underlying factors affecting men's health. The Royal Australian College of General Practitioners has characterised male use of general practice as follows:

> …Bettering the Evaluation and Care of Health (BEACH) data indicates that men…have briefer consultations later in the course of illness, and tend to leave significant issues unaddressed.[19]

Thus the task would be better viewed as encouraging men to make better use of their contact with general practice and other parts of the health system – to go seek medical advice earlier and to engage in more open communication.

2.33 The AIHW describes general practice as a "useful intervention point for health promotion",

> GPs, through ongoing professional education, have substantial knowledge of population health, screening programs and other interventions. They are also in an ideal position to advise patients about the benefits of health screening, and to counsel patients about their lifestyle choices on an individual basis.[20]

2.34 The committee received a number of suggestions for changes that might enhance the role of general practice in addressing men's health issues. The full potential of general practice could be realised if a program of annual health checks was introduced in which men were reminded by the practice that their check–up was due. As part of that check–up a questionnaire addressing symptoms of mental disorder and other areas which men are generally unwilling to discuss, such as reproductive health, should be used. It has been put to the committee that, while men are often unwilling to initiate discussion on a range of significant issues, they will respond to specific questions.

2.35 The Medicare schedule already provides for long consultations, more than 40 minutes, which would be required for such a comprehensive check-up. The Commonwealth Government should consider creating a specific item for this type of

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[17] *beyondblue,* submission 84, p.4 & the Hon. Jeff Kennett, committee transcript p.2.

[18] Prof. R. McLachlan, Andrology Australia, committee transcript, 8 April 2009, p.13

[19] Royal Australian College of General Practitioners, *Men's Health Policy Statement*, 2006, p.3

[20] AIHW, BEACH data, op cit, p.91

consultation, and funding it completely so that there is no patient contribution and no financial disincentive to undertaking the check-up.[21] The benefits of early identification and intervention would offset the costs over time.

2.36 The committee notes that 97% of general practices already have electronic systems and more than 80% use them for prescribing, billing and record keeping.[22] Thus a patient tracking and reminder system should be able to be incorporated into existing systems with a minimum additional workload for the practice.

2.37 Greater use could also be made of practice nurses in carrying out appropriate parts of the general check-up. The BEACH data shows that more than 70% of GPs work in practices that employ a practice nurse[23] and comments that results of the survey suggest that practices make "…very little use of the…preventive check practice nurse [Medicare] items".[24]

2.38 The committee was particularly impressed by the work being done through the Bendigo Community Health Service which, uniquely, employs a men's health nurse practitioner. This enables the Service to follow three distinct approaches:

> men's health promotion,…engaging with men in the setting that they work, play or live,…[and] establishing a men's health and wellbeing clinic within our general practice.[25]

2.39 The service's men's health program is built around annual health checks involving a 45 minute consultation which is supported by a system of reminders to encourage men to attend. The check-up involves taking a proper history of the patient and then working through a long list of conditions and risk factors which are relevant to the particular patient:

> To get through all those questions is difficult and you need 45 minutes, so it cannot possible be done in 10 minutes. The guys love it because they have the time to discuss their mental health and their sexual health. We bring up those topics, and that is a really effective way to engage with a guy.[26]

2.40 The particular strengths of this program appear to be that it has a dedicated and qualified men's health nurse practitioner,[27] that the practitioner takes the initiative

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[21] Such a 'free' consultation item could be made available to men and women once per year only.

[22] AIHW, BEACH data, op cit, p.28

[23] ibid., p.25

[24] ibid., p.89

[25] Ms K. Riley, Bendigo Community Health Service, committee transcript, 8 April 2009, p.94

[26] Mr P. Strange, Bendigo Community Health Service, committee transcript, 8 April 2009, p.96

[27] The terms 'nurse practitioner' and 'practice nurse' are used at various places in this report. Note that a nurse practitioner is a trained nurse with post-graduate qualifications, in this case in men's health, and a practice nurse is a nurse employed to carry out simple procedures in a medical practice.

in seeking information about a range of health problems rather than relying on the patient to raise them and that the service goes to the patient as necessary:

> Yesterday we were out at a place with a population of 100. It has a bush nursing centre that has no doctor. They are farmers who are 50 minutes out of Bendigo and they will not come in and have an annual check-up or come in again for the results. We go out to them and I offer that annual check-up out there.[28]

This program seems to embody most of the features of good men's health practice that should be part of the forthcoming National Men's Health Policy.

2.41 The committee was impressed by the evidence from a number of sources, particularly the Foundation 49 study referred to above in paragraph 2.30, which indicated that a high proportion of men would be willing to participate in a program of regular health checks if it was delivered through their workplace. This would address a common reason men put forward for not seeking health care – lack of time and opportunity, particularly because it addresses the common complaint that general practice is inaccessible for many men in full-time employment.

2.42 The Commonwealth Department of Health and Ageing representatives also stressed the importance of taking health care to people:

> Certainly people have talked about a need to involve men in their workplaces, and we clearly need to look more at the settings in which we can reach people. As you are aware, the national partnership on preventive health very much has a settings based approach. So we look at how we can engage people in terms of preventive health activities in the community setting, in the workplace setting and in schools and other places where you can reach children and families.[29]

2.43 Studies conducted in the workplace by Foundation 49 – in a major brewery and in the Victorian Police - indicated high levels of undetected disease.[30] This suggests that there should be a commonality of interest between government's responsibility for health services and employer's responsibility for occupational health and safety (OH&S). OH&S has tended to emphasise 'safety', however the incidence of disease and the loss of productivity through poor health suggest that more emphasis on health is required and the cooperation of employers should be forthcoming.

The committee recommends that the Commonwealth Government investigate the feasibility of introducing a structured, comprehensive annual health check for men. The proposed health check should be designed to be carried out in a range of contexts - general practice, the workplace and through community health programs. Consideration should also be given to providing a specific Medicare item which provides adequate time for the consultation and minimises the cost to the patient.

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[28] Mr P. Strange, op cit, 8 April 2009, p.97

[29] Ms J. Bryant, op cit, 26 March 2009, p.13

[30] Foundation 49, submission 10, p.11

The committee recommends that the feasibility of offering incentives to nurses to undertake training as men's nurse practitioners be investigated by the Commonwealth Government.

2.44 The information generated by a comprehensive system of health checks could, with proper regard for privacy issues, provide a valuable source of data for the longitudinal study on men's health recommended above.

2.45 There are many other ways of reaching out to men and providing the opportunity to undergo a health check in a friendly environment. The committee received many positive comments about the *Pitstop* program for example, which is provided through the Divisions of General Practice in regional and rural areas, and offers basic health checks at functions such as country shows.

2.46 If such 'outreach' programs are to be successful they do need to be properly supported. There is little point in getting a man to undergo a general health check if the resources to act on the findings are not readily available in his community. Ensuring that back-up medical services, whether it be a practice nurse or perhaps a temporary additional GP, are available in a community after a *Pitstop*–type program should be an integral part of the process.

Education and raising awareness

2.47 Education and awareness programs have two key and interlinked roles to play – informing men about health issues and encouraging them to seek medical advice. As suggested above the stereotypical view of men as being uninterested in their health is not borne out by experience but that lack of knowledge of health issues and unwillingness to seek advice and help is a real problem.

2.48 Andrology Australia suggested that men are much more comfortable to engage with health professionals if they already have some understanding of issues:

> Our analysis of men's health seeking and information needs highlights the fact that they want to have quality and evidence based information they can trust because they know the source and be able to demonstrate that they can talk about these matters comfortably with health professionals.[31]

2.49 Social determinants, attitudes, behaviour, socio-economic status and levels of knowledge, are critical to men's health outcomes. Many submissions commented on risk-taking and unhealthy behaviours such as dangerous driving, smoking, excessive alcohol consumption or poor diet and their influence on men's health outcomes. A significant proportion of the relatively poorer outcomes for men's health when compared to women's health in Australia can be attributed to these factors. Thus the importance of providing men with accessible and reliable information on broader influences on their health is central to any successful health program.

[31] Prof. R. McLachlan, committee transcript, p.15

2.50 The committee does not wish to comment on the content or impact of particular awareness campaigns. However as Dr Lemon advised the committee many campaigns in his field of drug and alcohol use fail because they are poorly designed or targeted.[32] A number of other witnesses also spoke of the need to evaluate education and awareness programs, campaigns and material much more systematically to find out what actually works.[33]

2.51 Confusing or conflicting information will merely exacerbate problems and may lead to demands for services which are inappropriate or unnecessary, as has been the case to an extent with the debate over prostate cancer screening using the PSA test. Thus cooperation between the various groups involved in a particular area is to be encouraged. The committee noted an impressive level of joint effort that seems to exist in the area of men's health, particularly among the groups that provided evidence to it.

2.52 Evaluation should be built into every program, including service delivery, to ensure that the unsuccessful are discontinued, the effectiveness of those that work can be enhanced and the lessons learned are disseminated. Programs supported by the Commonwealth do have a requirement for evaluation. Representatives of the Commonwealth Department of Health and Aging advised the committee that various types of evaluation are undertaken:

> It just depends on the scale of the program. If it is a small program that is being delivered by an NGO, we will have an evaluation, we will talk to them about it and we will reflect the relevant changes in something like the negotiation of the contract for the next funding cycle, to make sure it is tweaked in a way that makes it better.…
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> At the other end of the scale you have got things like the BreastScreen Australia evaluation, which is going on as a major Commonwealth-state activity, and the outcomes of that will be considered by health ministers in due course.[34]

2.53 In terms of encouraging and supporting healthy behaviours and attitudes, it is obviously easier to do so in young people before unhealthy behaviours are established than to alter such behaviours in older people. The long term efforts that have been put into altering behaviours with regard to smoking and drinking and driving illustrate the difficulty of changing entrenched behaviours all too clearly, even where confronting information is combined with severe penalties, restrictions on use and cost pressures.

2.54 A number of witness groups and submissions emphasised the need for general health education for boys at schools which would:

- seek to promote healthy behaviours with regard to diet and exercise, and

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[32] See chapter 3, paragraph 3.38

[33] See for example Andrology Australia, committee transcript, 8 April 2009, pp16-17; Australian General Practice Network, submission 77, p.1

[34] Mr D. Learmonth, op cit, 26 March 2009, p.13

- offer advice on particular conditions which boys and young men may be subject to, for example, testicular cancers.

2.55 The committee is aware of the problems of 'curriculum overload' but this is a very important area and most school systems in Australia already have a personal development component in their curriculum.

The committee recommends that the Commonwealth Government initiate discussions with its State and Territory counterparts with the object of introducing, as appropriate, programs that encourage boys to take responsibility for their health and wellbeing.

Men's networks

2.56 This chapter of the report has, so far, concentrated on the capacity of government and major non-government organisations to promote and deliver health services and to conduct research. However in terms of the dissemination of information and the provision of support to those with a health problem there is a range of less formal, and indeed informal groups in the community that can and do make a considerable contribution in this area.

2.57 The committee received overwhelmingly positive evidence supporting the networks that are created through involvement in structured activity, such as sport and other physical activity, through the traditional community organisations such as the churches, Rotary, and Apex or through other groups such as the Men's Shed movement. Such involvement has two main benefits; the protective effect of being part of a community which is well-understood (isolation is a proven risk factor) and the opportunity to share information and provide support. There is the added benefit for those involved in sport or other physical activities of the protective effects of regular exercise.

2.58 The committee believes that these less formal networks have considerable potential as vehicles for getting health messages out to the community. It was put to the committee by a representative of the Council of the Ageing that:

> Given that access to accurate—not inaccurate—information is an important aspect of men's health, as it is, there may be the possibility of supporting those male friendship networks in some way to make information available. I am sure this would be more effective than the rather dreary brochures you see in GPs' waiting rooms and certainly better than that dreadful ad on SBS about prostate cancer.[35]

2.59 By definition informal networks cannot be created by an act of government; in fact they may well be destroyed by being drawn into direct or formal relationships with government. However, where they exist they can be supported by providing the accurate information to which Mr Giles refers. That information is already out there

[35] Mr J. Giles AM, COTA, committee transcript, 30 April 2009, p.14

through the agency of the Prostate Cancer Foundation or Andrology Australia for example

2.60 The committee believes that existing websites particularly the Health*Insite* web site[36] maintained by the Commonwealth Government but including *beyondblue*, Andrology Australia and the Prostate Cancer Foundation, provide an excellent range of community based and professional information and are a good way of promoting a positive men's health message. However, websites such as these might further maximise their reach if they provided a prominently identifying ***Men's Health*** button as part of the homepage or within the web address itself.

2.61 Access through a single, extensively promoted, Government portal would have the advantage of limiting the confusion that can arise when a search for 'men's health' in the internet produces both professional health information sites and commercial sites such as men's magazines or pharmaceutical promotions.

2.62 Community involvement may be a particular problem in rural areas. While we tend to assume that community life is a particular strength of rural and regional Australia, it was put to the committee that isolation and uncertainty are major issues:

> …there is an issue here just logistically for rural people who have fewer connections, and also it is intuitively certain that rural people, not just farmers but others as well, have less control over their lives, over what the Fates bring to their life. This is a real determinant of health, not just speculation.[37]

2.63 Isolation or lack of facilities and services in rural areas is often compounded by privacy concerns. People know each other and deal with the local doctor or pharmacist socially as well as professionally and may be inhibited as a result from seeking advice or treatment particularly for conditions that they find embarrassing or are perceived as carrying a social stigma.

2.64 The opportunity that social networks provide to 'get' to men in environments in which they are comfortable is already well understood. *beyondblue* has a program promoting awareness of depression designed specifically for Men's Shed coordinators and facilitators which takes advantage of the fact that a "Men's Shed can…be a safe space where men feel confident in gathering in a gender friendly environment that encourages discussion and sharing of information".[38]

2.65 *beyondblue* and others make use specifically of sporting organisations as a means of disseminating information.[39] Sporting clubs are particularly useful points of

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[36] http://www.healthinsite.gov.au/index.cfm

[37] Mr G. Gregory, op cit, 26 March 2009, p.40

[38] *beyondblue*, submission 84, p.5

[39] *beyondblue*, ibid., p.6, describes the cooperative work being done with the Professional Golfers Association, the AFL and the Australian Cricketer's Association.

contact because they give access to young men and play an important part in community life, particularly in rural areas.

2.66 It was argued by a number of witnesses to the committee that the ethos of community-based sporting clubs was particularly suited to getting health and wellbeing messages out to men:

> …they are around other people that are there for a common purpose. They are naturally supporting each other. They work as a team. They help each other out. There are informal chats that go on. Often there are easier chats going on…that are very profound conversations that help men go off and think…[40]

2.67 The representative of the Mental Health Council of Australia agreed:

> Sport and recreation are absolutely critical. I cannot overstate how important sport is for young men, particularly for mental health. We have seen it in Indigenous communities. The Act Belong Commit campaign is about that. It is not just organised sport; it is participatory sport… where it helps with substance abuse and alcohol and kids going off the rails.[41]

2.68 The Commonwealth is currently reviewing the role of sport and Mr Learmonth, the Deputy Secretary of the Department of Health and Ageing, commented that,

> The review is not just about high-performance sport but also about participation—so that nexus between organised sport, participation and healthy activity. That will be another area where the government looks to policy…[42]

2.69 In addition to the obvious physical benefits of participation in sport or regular physical exercise, engaging in physical exercise has been shown to reduce the symptoms of depression by significant margins. Some research suggests that exercise can be just as effective as treatments with antidepressant drugs.[43]

2.70 An important aspect of good education and awareness programs is that in their absence ignorance or exploitation will flourish. Many readers will be familiar with the advertising for private services promoting treatment for erectile dysfunction and other sexual health 'services'. The committee is advised that these services generally rely on a 'telephone consultation' which may not even involve a qualified medical practitioner. Various drug therapies of questionable efficacy are then prescribed, at considerable expense to the patient, to deal with the problem.

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[40] Dr E. Celi, committee transcript, 8 April 2009, p.62

[41] Mr C. Tatz, Mental Health Council of Australia, committee transcript, 26 March 2009, p.86-87

[42] Mr D. Learmonth, op cit, p.13

[43] *beyondblue*, Depression & Exercise, http://www.beyondblue.org.au/index.aspx?link_id=9.697 (accessed 25 May 2009)

2.71 Erectile dysfunction is a genuine health issue. It is often a symptom of serious underlying health problems ranging from cardiovascular disorders to depression. It should not be 'treated' over the phone where there is no opportunity for even the most simple test such as taking the patient's blood pressure.

Indigenous Men's Health

2.72 The committee outlined in the previous chapter the statistics in relation to Indigenous men's health which show that the burden of disease and life expectancy are significantly worse for that community (both men and women) than for Australia as a whole. The committee also argued that the health of Indigenous men should not be viewed simply as a 'worst case' example of general men's health issues. It requires a distinctive approach which addresses health issues in their social and cultural context.

2.73 The impact of weakened communities and cultural breakdown and, particularly for men, the loss of positive roles are profound determinants of health that cannot be fixed by the treatment of pathologies. They are long term and intractable issues certainly beyond the scope of this committee to address.

2.74 The Central Australian Aboriginal Congress, in evidence taken by teleconference explained that:

> These issues are in no particular order but they are the main ones that affect Aboriginal people all over Australia. The first one is substance abuse, and that includes alcohol, cannabis and, at that time, petrol sniffing. The second is access to cultural gender appropriateness and privacy. Then there is health education and compliance; violence and family breakdown; environmental health; suicide, self-harm and mental health, and sexual health; youth issues; parenting and youth activities; employment; nutrition; and chronic diseases, especially diabetes and heart disease.[44]

The committee has already quoted Professor Russell Gruen's comment that attempts to deal with long-term and underlying social determinants should not divert attention from the importance of providing good clinical care to address immediate health issues.45 Thus this section of the report summarises the practical proposals put forward in evidence to it that should be applied at the 'pointy end' to improve services to Indigenous Australian men.

2.75 As a starting point the Australian General Practice Network recommended that better identification of Indigenous men in general practice is important particularly because it will enable the "…development of culturally appropriate care,

[44] Mr J. Liddel, Male Health Officer, Central Australian Aboriginal Congress. committee transcript, 30 April 2009, p.51

[45] Prof. R. Gruen, op cit, 8 April 2009, p.11.

including the development of a culturally appropriate lifestyle modification programs".[46]

2.76 Indigenous men are also resistant to seeking treatment and it appears are much less comfortable about talking about their health with female doctors or other health professionals. Thus the training of male health workers and their location in Indigenous communities are key issues that should be pursued as a matter of urgency.

2.77 The submission and evidence from Royal Australasian College of Surgeons (RACS) concentrated on the issue of trauma as a result of transport accidents and violence in Indigenous communities. The College estimates that 25% of the gap in health outcomes between Indigenous and other Australians is attributable to injury.[47] This is a very serious issue:

> … Turning to the Indigenous male population, our report highlights that it is a combination of alcohol, incompetent driving, overloaded cars, and bad roads—all of this is a disaster for men's health, particularly in rural and remote areas of Australia. It is also a problem for the wider male community in regional and rural Australia.[48]

2.78 The submission also commented on levels of interpersonal violence

> One of our fellows notes that Alice Springs Hospital, which serves a population of about 50,000 people, has 2.6 times the number of stab injuries per annum as the Royal Prince Alfred Hospital in Sydney. That is a shocking statistic.[49]

2.79 However there is scope to improve the treatment of trauma victims. The RACS commented that the trauma systems used in the smaller and more densely settled jurisdictions are inappropriate for central Australia and recommended the creation of a regionally based system that ignored state and territory jurisdictions and used the nearest suitable hospital:

> For example patients in the east of Western Australia may be better served by either Royal Darwin or Alice Springs Hospitals than Royal Perth. Equally as argued by Plani and Carson given the prominence of Indigenous men's trauma in the overall remote health challenge in Central Australia, a community based trauma system may be the answer.[50]

2.80 Garth Robertson, Coordinator of the Wamba Nilgee Burru Ngardu Aboriginal Corporation in Derby, WA, made a similar point with regard to Indigenous people

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[46] Ms L. Wett, Deputy Chief Executive Officer, Australian General Practice Network, committee transcript, 26 March 2009, p.66

[47] RACS, submission 13, p.6

[48] Mr A. McLorinan, Manager, Fellowships, RACS, committee transcript, 8 April 2009, p.2

[49] ibid., p.2

[50] RACS, submission 13, p.8

living in northern Western Australia where Darwin might be a closer and more convenient option for those in need of hospitalisation.

The committee recommends that the Commonwealth Government take the initiative in conjunction with the States and Territories in examining strategies for improving trauma treatment in Central Australia.

2.81 Modifying behaviour through the provision of information and promotion of good examples is particularly difficult in more isolated communities. The organisations that are trying to do this need better support, particularly to allow them to concentrate on their core activities:

> The volunteer Aboriginal men's groups, because they are not incorporated or grant funded…seem to be overlooked. But they do a lot of work in communities. They run everything from doing counselling sessions with blokes to mentoring youth, young males.[51]

2.82 Mr Robertson also described to the committee the amount of time and resources that small organisation working with Indigenous communities were required to devote to applying for relatively small amounts of funding:

> …I am spending more time looking for grants applications. In the case of the one that we put in to the Office of Aboriginal Health, they asked for grant applications, gave a date of the funding round. We put the application in and the reply came back, 'We have no money.' It was a total waste of time. I realise that not everybody will be successful, but to say, 'We don't have the money'—if you do not have the money, why waste my time by having me put in my application?[52]

2.83 Clearly more needs to be done to identify groups working in Indigenous communities and to support them in ways that does not take up disproportionate amounts of time complying with bureaucratic requirements.

2.84 The committee is aware that there are numerous sources of funds for health programs and related services at different levels of government which impose a serious burden on applicants in finding the appropriate program which might support their activity.

The committee recommends that the Commonwealth Government take the initiative, in cooperation with the States and Territories, to reduce complexity and simplify the application process for health related grants.

2.85 As with the broader community sport is,

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[51] Mr R. Welsh, Aboriginal Men's Health Project Officer, Men's Health Information and Resource Centre, committee transcript, 7 April 2009, p.85

[52] Mr G. Robertson, Coordinator, Wamba Nilgee Burru Ngardu Aboriginal Corporation, committee transcript, 30 April 2009, p.26

> …a fantastic opportunity for young men to take out their frustrations in life and maybe also their inability to mix with other people…We get Aboriginal community football teams travelling for miles to compete in local football competitions.[53]

2.86 Sport "…provided a reason for young blokes to stop smoking and start to actually take some more interest in their health. That reason would not have been there if it were not for sport. They did not have any other reason to do it at the time".[54]

2.87 The committee is aware that the enthusiasm for sport is limited by the cost of equipment and travel in remote areas. Given the potential of participation in sport to improve Indigenous men's health and the potential of sporting clubs as a way into communities to provide information and increase awareness of health issues, the committee would encourage health services and particularly those government and non-government bodies involved in health promotion to strengthen links with Indigenous sporting organisations.

Older men

2.88 The health of older men is considered at various stages throughout this report. However there are two issues with regard to this group that need to be emphasised.

2.89 Increased life expectancy means that men (and women) will, on average, live much longer post-retirement than was the case in the past. This can result in older men finding themselves increasingly isolated as the networks related to employment are removed. Isolation has been shown to make a significant contribution to poor physical and mental health and to have an impact on the probability of seeking treatment.

2.90 The committee has referred to the excellent work done by organisations such as men's sheds in bringing older men together and acting as a vehicle for increasing health awareness and providing support. However it needs to be acknowledged that many men may not be involved, or wish to be involved, in such groups. Thus it is extremely important that when men have contact with health services (and a very high proportion of older men do in fact attend general practitioners) the opportunity is taken to address older men's circumstances more generally, particularly in relation to their social situation.

2.91 A specific example that is of concern is where an older man may find himself acting as carer for his partner who has a significant health problem, for example dementia. Caring for someone else in these circumstances can impose a major burden on the carer and may put that person's own health at risk.[55] The committee recognises

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[53] Mr J. Liddle, committee transcript, 30 April 2009. p.59

[54] Dr J. Boffa, committee transcript, 30 April 2009, p.60

[55] It was put to the committee that carers generally have "…the lowest health and wellbeing in the community". Ms Joan Hughes, CEO, Carers Australia, committee transcript, 26 March 2009, p.16

that carers can be of almost any age and that both sexes discharge this responsibility, however it is a particular issue for older people.

2.92 Earlier in this report the committee stressed that men's health is not just about the diseases specific to men but to all conditions that bear on men's health. A particular example which illustrates this is osteoporosis. This condition, a loss of bone density commonly found in older people, is discussed almost exclusively in terms of its impact on women post-menopause where the progress of the condition is much more rapid than in men. However it is also a significant men's health issue driven by the same process of changing hormonal levels with age.

2.93 In its submission to the committee Osteoporosis Australia stated that one in three men over the age of sixty will suffer a bone fracture due to osteoporosis and that the risk of dying after a hip fracture is higher in men than in women. Osteoporosis can be diagnosed with a simple test and can be managed.

2.94 The committee notes, and supports the recommendations of Osteoporosis Australia with regard to the need for testing of older men or where a man has a family history of the condition or has a range of other conditions or exhibits any of a number of indications.[56]

Gay men

2.95 The committee received some comment on the health of gay men, which has both similarities to and distinct differences from that of the broader community. Gay men are significantly more likely to smoke and use drugs and to exhibit symptoms of anxiety and depression. Gay men also have a higher incidence of HIV/AIDS, various sexually transmitted diseases and some cancers.[57]

2.96 Submission representing the views of gay men also claimed that the disincentives to seeking treatment that men experience particularly in relation to privacy are compounded for gay men, especially in smaller communities and that service providers, both general practice and hospitals are not considered gay-friendly environments. A further cause for concern is that much of the educational material on men's health is aimed solely at heterosexual men. [58]

2.97 It was also put to the committee that the consultative material supporting the development of the National Men's Health Policy makes no mention of gay men as a distinct group whose needs should be considered in the policy.[59]

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[56] Osteoporosis Australia, submission 125. This issue is discussed generally in the submission and page 4 considers the question of who should be tested for the condition.

[57] ACON, submission 75, p.5-8

[58] ibid., p.5-7

[59] Gay Men's Health, submission 54, p.1

2.98 It should be remembered that the constructive and cooperative response of the gay community to HIV/AIDS enabled Australia to respond to that health threat quickly and effectively with the result that HIV/AIDS has been managed very successfully in this country. This illustrates that engaging with a community and encouraging individuals to take responsibility for a health problem can make a significant difference to health outcomes and suggests that properly presented education material and services which meet the needs of the gay community will have an impact on the health problems of that community. The committee trusts that the specific concerns of gay men will be reflected in the National Men's Health Policy.