The Senate

Select Committee on Men's Health

May 2009

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Preface

The Senate referred the following matter to a select committee on 13 November 2008:

1. That a select committee, to be known as the Select Committee on Men's Health, be established to inquire into and report by 30 May 2009 on:

   General issues related to the availability and effectiveness of education, supports and services for men's health, including but not limited to:

   i. level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer, and depression,

   ii. adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community,

   iii. prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men's health in general, and

   iv. the extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas.

The committee advertised in the national media seeking submissions. One hundred and thirty-seven were received. A list of these submissions is at Appendix I to this report.

The committee held five days of public hearings in Canberra, Sydney, Melbourne and Adelaide at which forty five organisations and individuals were represented. A list of witnesses and the organisations they represented is at Appendix II.

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Executive Summary and Recommendations

The Commonwealth Government's decision to develop a Men's Health Policy, announced on 8 June 2008, 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.

This committee believes that the issues raised in evidence to it and the contents of this report will make an important and constructive contribution both to the debate on men's health and to the final content of the policy.

Recommendation 1

The committee recommends that the Commonwealth Government give due consideration to the findings of this committee and to the evidence gathered by it in the course of this inquiry in developing the National Men's Health Policy.

Chapter 1

Health is generally defined as much more than the simple absence of a particular disease. To the (WHO) World Health Organisation it is a "…complete state of physical, mental and social wellbeing and not merely the absence of disease or infirmity". While not universally accepted, this definition draws attention to the wide range of social and cultural determinants which may contribute to men's health status; attitudes to masculinity, employment and income for example.

The need to consider men's health as a distinct subject is made clear by the statistics for the morbidity (incidence of disease) and mortality of men in Australia, which are considered in Chapter 1. Australian men are long-lived by world standards but their health status exhibits distinct differences from that of Australian women and is, by most measures, worse.

Chapter 2

The committee received a number of proposals for the creation of an agency to promote men's interests in government, an 'office of the status of men'. The committee does not believe that this is necessary but it does support the view that the impact of legislation and policies on men should be considered by government.

Recommendation 2

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. (2.11)

The lack of a detailed understanding of the various factors which contribute to men's health status have given rise to a demand for a longitudinal study of men's health. A longitudinal study of women's health was established in 1995 and much of the preliminary work for a men's study has already been undertaken under the auspices of Andrology Australia.

Recommendation 3

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. (2.23)

There is a common perception that men are either not interested in their health or careless in managing it. The committee does not accept this. Men do in fact use health services in high numbers and respond positively to education and awareness campaigns. However services need to be provided in ways that acknowledge men's social and economic circumstances and take account of their distinctive attitudes. In addition, boys should be informed about healthy behaviours at an early age.

Recommendation 4

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. (2.43)

Recommendation 5

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. (2.43)

Recommendation 6

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. (2.55)

Indigenous men exhibit the worst health outcomes of all groups in Australian society. Many of these problems are the product of broad social, economic and cultural issues beyond the scope of this inquiry. However some specific steps can be taken to improve the situation.

Recommendation 7

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. (2.80)

Recommendation 8

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. (2.84)

Chapter 3

Depression and other mental illnesses are significant and often poorly recognised problems in Australia. Overcoming the stigma which still attaches to mental illness is a major issue. Depression is a significant problem in its own right. It is also closely linked to alcohol and drug abuse and can also be present as a co-morbidity with major physical health problems such as prostate cancer. It is important that this interconnectedness be recognised in the provision and conduct of treatment services.

Recommendation 9

The committee recommends that the integration of health service provision to recognise the interconnectedness of men's health issues be made a central part of the forthcoming national men's health policy. (3.55)

Recommendation 10

The committee recommends that the Commonwealth Government investigate standardised service models for mental health to facilitate a uniform standard of care throughout Australia. (3.55)

Chapter 4

Prostate cancer is the most commonly diagnosed cancer in Australia. It ranks alongside breast cancer in terms of mortality. The incidence of prostate cancer will increase as the population ages. It is also a highly complicated cancer which requires an increased research effort and greater resources dedicated to treatment. At present the information available to those with prostate cancer and the services to support them are not adequate.

Recommendation 11

The committee recommends that the Commonwealth Government ensure that the Australian Prostate Cancer BioResource is provided with sustainable funding at a level that would enable it to complete its tissue collection and carry out the necessary work in support of prostate cancer research outlined in chapter 4. (4.30)

Recommendation 12

The committee recommends that the Commonwealth Government provide funding to the Prostate Cancer Foundation to ensure that the Prostate Cancer Information Pack program proceeds. (4.53)

Recommendation 13

The committee recommends that the Commonwealth Government expedite funding for the provision of specialist prostate cancer nurses, particularly in rural and regional Australia. (4.58)

Abbreviations

ABS	Australian Bureau of Statistics
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
BEACH	Bettering the Evaluation and Care of Health
BMJ	British Medical Journal
DALY	Disability Adjusted Life Years
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IHBI	Institute of Health and Biomedical Innovation
MATeS	Men in Australia Telephone Survey
MJA	Medical Journal of Australia
NHMRC	National Health and Medical Research Council
OECD	Organisation for Economic Cooperation and Development
OH&S	Occupational Health and Safety
PCFA	Prostate Cancer Foundation of Australia
PYLL	Potential Years of Life Lost
RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
UNSW	University of New South Wales
VPCRC	Victorian Prostate Cancer Research Consortium
WHO	World Health Organisation

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 …

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[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 all-embracing 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

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[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.

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[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 (10th), land transport accidents (14th) and liver disease (15th) 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.

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[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 cancers[24] 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.

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[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 …[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

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[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]

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[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]

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[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

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.…
>
> 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.

Chapter 3

Depression and other mental illness

3.1 Mental health is a hugely significant contributor to the burden of disease in Australia. In chapter 1 the committee described the concept of 'disability adjusted life years' (DALYs) which seek to measure the impact of both fatal and chronic disease in Australia. DALYs measure both years of life lost through premature death and loss of quality of life through living with a chronic condition.

3.2 When these two measures are combined the full impact of mental health is clearly apparent. As a general disease category, mental health ranks third behind cancers and cardiovascular diseases as a contributor to the overall burden of disease.[1] When specific conditions are considered, anxiety and depression rank second behind coronary heart disease.[2] Mental disorders are the largest single component of the non-fatal burden of disease comprising 24.2% of that category.[3]

3.3 Mental health issues show distinct differences between the sexes. Generally men are less likely to experience a mental health problem than women.[4] However, in specific areas and age groups men carry a greater share of the burden of disease. This is particularly clear in relation to substance abuse which is more common among men in all age groups. The incidence of suicide among men is four times that among women.

3.4 Anxiety and depression are less common in men than women but within the 35-44 age group both occur at significant levels. It is estimated that, in this age group, 8.3% of men experience depression or a related condition and 15% experience an anxiety disorder.[5] Surveys suggest that 18% of men experience a mental health problem related to substance abuse or affective disorder (depression) or anxiety at any time.[6]

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[1] AIHW, *Australia's Health 2008*, p.55, table 2.17. The respective proportions are 19%, 18% and 13.3% of total DALYs.

[2] ibid., p.57, table 2.18. Coronary heart disease and anxiety and depression contribute 10% and 7.3% respectively of the total burden of disease.

[3] ibid., p.55, table 2.17

[4] Crisis Support Services, submission 35, p.3. Men account for 47% of the mental illness burden in Australia but only 39% of all mental health-related general practice visits. In 2006-07, only 29% of men that had experienced a mental disorder in the past 12 months sought support services, compared to 46% of females.

[5] *beyondblue*, submission 84, p.2.

[6] ibid., p.4, citing Australian Bureau of Statistics (2008), 2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0). Canberra: ABS.

3.5 The identification and treatment of mental health problems, particularly in men, are made more difficult by a range of factors. Firstly, there is a widespread community perception that mental health is not an important issue and in conjunction with this is a level of ignorance about significant mental health problems. In each of the measures of knowledge of mental illness men were significantly less likely than women to see mental health as a serious issue or to be able to identify specific mental health problems, including depression.[7] In conjunction with research which suggests that men access health services only when they consider it absolutely necessary, this low awareness of mental health inevitably results in failure to seek help.[8]

3.6 Men's attitudes to seeking help and treatment for all health problems are discussed in more detail in chapter 2. Specifically with regard to mental health, the recently published Irish Men's Health policy states that,

> There is considerable evidence to suggest that mental health is highly gendered and requires a gendered focus at a policy and service delivery level. Mental health issues can pose a threat to a man's masculinity, as evidenced by the way many men conceal symptoms, reject help-seeking and rely on more 'acceptable' male outlets, such as alcohol abuse or aggression, to deal with a mental health issue.[9]

3.7 As *beyondblue* has described, men are particularly reticent about seeking help for mental health problems. Research,

> …shows that over 70% of men with a mental disorder do not access services for their mental health problem and that lower rates of men (less than 20%) see their general practitioner for mental health issues than women (30%).

and that a high proportion of men "would feel embarrassed" to talk to their doctor.[10]

3.8 This is compounded by an apparently widely held perception that General Practitioners are not supportive in dealing with depression. Approximately 50% of respondents to a *beyondblue* survey did not feel that their GP would take depression seriously, and significant though smaller proportions held other negative views – that GPs are too busy; that they are likely to prescribe medication rather than engage in a thorough consideration of the problem and that GPs did not view depression as an issue of high importance.[11]

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[7] ibid., p.4

[8] Freemason's Foundation for Men's Health, submission 38, p.6

[9] Republic of Ireland, Department of Health & Children, *National Men's Health Policy 2008-2012*, (Dublin 2008), p. 72, paragraph 83

[10] *beyondblue*, submission 84, p.8

[11] ibid., p.8. The committee reports these as perceptions which may influence patient behaviour, not as fact. The limitations of, and pressures upon, general practice are discussed in chapter 2.

3.9 Male attitudes to health and seeking health care are exacerbated by the perceived stigma attaching to mental health problems. This is particularly important in regional and rural Australia. It was put to the committee that,

> Both men and women in small communities often seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others.[12]

This was supported by a number of witnesses to the inquiry.

3.10 Community perceptions of mental health also tend to reflect stereotypes, often driven by media representations, which are unrepresentative of the true situation:

> …accounts of mental illness that instil fear have a greater influence on public opinion than direct contact with people who have mental illness. Mental illness is usually depicted through characters that are physically violent toward self or others or people who are simple, lacking in comprehension and appearing lost, unpredictable, unproductive, untrustworthy, and social outcasts.[13]

3.11 Inevitably this leads to a widespread perception that the community at large is unsympathetic to, or ignorant of, the realities of mental illness. The Royal Australian and New Zealand College of Psychiatry (RANZCP) reports that 80% hold these attitudes and that one-third of people "… are unsure how a friend or colleague would treat them after hearing they had a mental illness".[14]

3.12 In the context of men's health the College makes the important point that, "…employment status is a key social determinant in men's mental health and wellbeing", and that fears of "…job loss, being discriminated against at work and falling out with people they had close business and personal relationships with"[15] are major disincentives to seeking early treatment or acknowledging a mental health problem.

3.13 In an area surrounded by so much misunderstanding and anxiety it is perhaps inevitable that confusion also exists about the role of mental health professionals and the treatments available. The RANZCP has commented that,

> With the introduction of the Medicare items allowing access to psychologists, there has never been greater confusion within the wider community regarding the different practitioner roles and treatment options available to consumers.[16]

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[12] Private Mental Health Consumer Carer Network, submission 33, p.1

[13] Royal Australian & New Zealand College of Psychiatrists, submission 14, p.7

[14] ibid., p.9

[15] ibid., p.9

[16] ibid., p.7

The College went on to comment that psychiatry is particularly poorly understood by the community, carrying with it images of "…asylums and forced medication".

Funding and other support

3.14 Expenditure on the provision of mental health services is estimated to be 7.8% of total allocated health expenditure in Australia, which ranks third in terms of expenditure on broad disease categories.[17] This is less than the proportion of the burden of disease which has led some submissions to suggest that funding should be increased to that proportion.[18]

3.15 However as table 8.9 in the AIHW report shows, none of the shares of allocated expenditure on broad disease categories matches the proportion of the burden of disease – the expenditure on cancer and cardiovascular diseases are similarly smaller than their share of the burden of disease, suggesting that such a comparison is not a useful guide to expenditure. To adopt this approach would imply an increase in expenditure on cardiovascular disease from its current 11.2% to 18% and on cancer from 7.2% to 19 %.

3.16 The split of expenditure on mental health per capita between men and women shows that whole of life expenditure on women is slightly higher than on men ($209 compared with $196) but expenditure by age group shows that at some ages expenditure on men exceeds that on women.[19] As noted above, (paragraph 3.3), the incidence of mental health disorders in women is slightly higher than in men.

3.17 However as the College of Psychiatrists commented, "…the pattern of presentation and onset [with mental health disorders] does vary between males and females and there is a marked difference in accessing mental health services depending upon age and social factors".[20] Thus there is a clear need for a better understanding of these patterns and the factors that influence them so that services and interventions can be better targeted.

3.18 The committee received relatively little comment on research into men's mental health. The RANZCP noted that, with regard to depression,

> It is also widely accepted that the understanding of gender specific symptomology of depression is not widely known or understood and could also be promoted in terms of improving men's health.

This conclusion would apply to mental illness generally. Thus providing funding for research into "…gender specific prevention, identification and appropriate treatments

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[17] AIHW, *Australia's Health 2008*, p.4111, table 8.9

[18] E.g. Mental Health Council of Australia, submission 5, p. 3; *beyondblue*, submission 84, p.3

[19] ibid., p.413, table 8.10

[20] RANZCP, submission 14, p.4

of mental illness"[21] should be seen as a priority and would, of course, be of benefit to both men and women.

3.19 A specific area of concern which impinges disproportionately on men's health is the use of alcohol and other drugs and the links to depression. It is now generally accepted that the male brain continues to mature until at least 25 years of age or even older and that the maturing brain can be adversely affected by alcohol. Research suggests that many of the behaviours identified in adolescent males – propensity for risk taking, lack of inhibition and judgement and heightened expression of emotion - which lead to significantly higher rates of accidents and fatalities reflect brain immaturity and that these characteristics are exacerbated by alcohol.

3.20 *beyondblue's* representatives emphasised the importance of recognising and responding to these issues in young people arguing that,

> …the things that affect men most are alcohol and drug related issues, and relationship issues which are terribly profound…and the reason that *beyondblue* was founded was young men dealing with the break-up of relationships.

Drugs, alcohol and depression were described as the "axis of evil' in mental health which imposed "the greatest weight on the condition of men" and consequently needed to be accorded priority in the distribution of limited resources.[22]

3.21 The RANZCP also commented on the need to address mental health issues in young people which "…if unresolved will manifest in adulthood and will become more difficult to manage" and,

> …to ensure that boys learn more positive coping strategies and that aggressive, externalising coping mechanisms are not reinforced in the home or the community.[23]

3.22 The committee considers the mental health of boys and young men to be a key area that must be addressed in the forthcoming national men's health policy. Elsewhere in this report it has recommended the introduction of health-related education programs for school age boys. These must include a component which monitors mental health and identifies emerging problems, permitting early intervention.

3.23 The committee received a large number of submissions about the specific issue of family breakdown and its impact on fathers, who are denied, or have only very limited, access to their children, particularly boys. Clearly, judging from both the individual submissions and those from organisations such as Dads in Distress and Dads4Kids Fatherhood Foundation, this has been a long running issue which, despite

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[21] ibid., p.7

[22] The Hon J. Kennett, *beyondblue*, committee transcript, 9 April 2009, p.3

[23] RANZCP, submission 14, p.7

reforms to the Family Law and to the procedures of the Family Court of Australia continues to cause immense distress.

3.24 With regard to the health of men in this situation, it is clearly important that they are provided with support after the finalisation of their matter before the court. Many men will need to rebuild their lives, to make new living arrangements, sometimes to find new employment and to adapt to the new relationships with their children, no matter how unsatisfactory they may consider their situation to be. These can be demanding and stressful undertakings. It is very important, therefore that they have access to advisory and counselling services that can help them through this period.

3.25 It is well understood that certain groups in society are at greater risk of developing mental health problems. In Australia, in addition to men who have experienced family break down and loss of contact with children, the incidence of mental health problems rises in rural and regional areas, particularly among Indigenous men, among men from low socio-economic backgrounds, and is also particularly prevalent among Defence force personnel who have served in conflict zones.[24]

3.26 With the continuing impact of drought in south-eastern Australia, the impact of the global financial crises on employment, financial security and retirement income and the continuing involvement of Australian forces in conflict or peace-keeping roles in various theatres, the demands on mental health services are likely to rise.

3.27 At the same time service providers need to anticipate this growing demand by putting services in place in preparation. The impact of mental health problems can be significantly reduced through early identification and intervention thus it is vitally important that services are available when and where they are needed. Where at risk groups are readily identifiable, such as members of the forces or the unemployed it is incumbent on the appropriate agencies of government to ensure that at-risk people are monitored or, at the very least, advised as to the availability of mental health support services should they need them.

Education and Awareness

3.28 Improving the community's understanding of mental health is central to making progress in this area. As noted above, men are generally perceived as being unwilling to access medical services and seek help for mental health problems. A

[24] Crisis Support Services, submission 35, p.3. For example, among Korean War veterans studied in 2004, anxiety was present in 31% and depression in 24%, while 59% drank hazardous amounts of alcohol. In 2005, there were 9.5 suicides per 100,000 people in capital cities compared with 12.5 suicides per 100,000 people in rural areas. Indigenous Australians experience rates of self-harm and suicide that are higher; and substance abuse, domestic violence and disadvantage contributed additional risk factors.

significant component of this unwillingness is the stigma attaching to those suffering from such problems.

3.29 Changing community attitudes is extremely difficult as demonstrated by the long term efforts in relation to tobacco use. However the work of *beyondblue* with regard to depression does demonstrate that remarkable progress can be made with well-designed programs. A key aspect of *beyondblue's* success appears to be its ability to get highly visible public figures from a range of backgrounds – politics, business, the theatre, sport - to talk publicly about their problem, to demonstrate that a significant mental health issue can be managed and that it is not a barrier to living a full, productive and rewarding life.

3.30 The Director of Communications for the Mental Health Council of Australia looked forward to the day,

> …where, when we look at a football park and we say, 'He recovered from two broken arms and has got back on the field,' we can also say 'Well, that person has had a history of depression or anxiety,' without a stigma being attached to that, and we do it in the same laudatory way of: 'Isn't that great; recovery and resilience.'[25]

3.31 A second component of *beyondblue's* success has been to take its message directly to people where they work, live and relax. It has numerous programs that target rural communities, sporting clubs, organisations and workplaces where a combination of meetings, distribution of educational material and training in how to identify and respond to depression has had considerable success.

3.32 The success of these activities suggests that the generally accepted view that men are not willing to talk about, or seek help for, health problems, specifically mental health issues, needs to be modified. Mr Kennett described to the committee participating in meetings of several hundred people in small communities in rural Australia where there was considerable willingness to talk publicly about problems.[26] Clearly well designed programs which approach men in a manner with which they are comfortable and provide information which they find useful will overcome reticence.

3.33 While progress is being made in encouraging men to acknowledge that they have a mental health problem and to seek treatment, advances in identifying and addressing causes are more difficult. As noted above, the interaction of alcohol, drug use and depression is a major problem, particularly among young people. There is also evidence that drug and alcohol use is related to a high level of 'self-medication' by those experiencing mental health problems.

3.34 Despite recent publicity surrounding alcopops and binge drinking among young women, men remain significantly higher consumers of alcohol than women and alcohol consumption is strongly linked to ideas of masculinity:

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[25] Mr C. Tatz, committee transcript, 26 March 2009, p.90

[26] The Hon J. Kennett, committee transcript, 9 April 2009, p. 5

> It is considered a masculine behaviour. I do not think I have to provide a number of citations for you to realise this. Holding your drink is considered to be a masculine accomplishment…it certainly is embedded in Australian culture…men definitely have a cultural background, an impulse, to drink more, to show that they can drink: to show themselves, not only their friends.[27]

3.35 Research increasingly supports the position that alcohol has a significant negative impact on the immature human brain, leading to recommendations that no alcohol should be consumed before the age of eighteen or even older. However, as has been the experience with changing behaviour with regard to tobacco smoking and drink driving for example, it is extremely difficult to compete with entrenched social and cultural attitudes to the consumption of alcohol, (particularly where they intersect with attitudes to typically 'masculine' behaviour) and the commercial interests that promote it.

3.36 As Dr James Lemon told the committee, attempts to change attitudes that ignore the reality that in the short term drug or alcohol use can make the user feel better will fail and that young people will respond much more strongly to behaviours they see modelled by adults than to messages that are contradicted by people's own experience.

> As long as young men see an advertisement on television telling them that getting drunk is not cool and their experience of getting drunk is that it is cool…they simply say, 'This is a load of codswallop and I'm not going to listen to any of it,' even if the entire remainder of the content is quite sound and would be helpful. [28]

3.37 Alcohol consumption is an area where conflicting messages undermine efforts to educate users about safe behaviour. The known protective effects of regular moderate alcohol consumption tend to confuse the debate about the dangers of alcohol. This emphasises the point that, unless education campaigns are carefully designed they will fail and in failing may discredit the worthwhile messages that they are trying to promote.

3.38 Related to this, the committee heard much comment on the need for thorough evaluation of health-related education and awareness campaigns in general and specifically in the area of mental health. Dr Lemon commented, with regard to advertising campaigns, that,

> …the government does fund a lot of these efforts…It funds the research that devises these interventions, it funds the interventions themselves and it funds people like me. A lot of my job is looking at evaluating these interventions. Very often I end up being a sort of coroner who has to

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[27] Dr J. Lemon, National Drug & Alcohol Research Centre, UNSW, committee transcript, 7 April 2009, p.78

[28] ibid., p.77. It should be noted that, while there have been small variations in patterns of drinking, alcohol consumption in Australia is actually declining overall.

> determine the reason the intervention died and explain this to the bereaved therapist whose intervention has not worked …[29]

The committee has commented further on this in chapter 2.

3.39 The final area of awareness that the committee wishes to emphasise is the link between family breakdown and mental health issues. *beyondblue* identified relationship breakdown as a major contributor to mental health problems. The College of Psychiatrists similarly identified family circumstances as one of the most important social factors affecting men's mental health.[30]

3.40 The committee also received a number of submissions from individuals and organisations specifically concerned with the impact of family breakdown on men and on the children of a relationship who found themselves without regular contact with their father. These submissions referred to both the damage to men's mental health and the impact on boys of growing up without a father providing a male role model. The committee has commented on the need to provide support to men experiencing this process at paragraphs 3.23-3.24 above.

3.41 In terms of addressing the causes of depression and other mental health problems, some effort needs to be put into educating young men (and women) about the responsibilities that they will take on when entering into long-term relationships, particularly where they become parents, with the object of reducing the incidence of relationship breakdown. A second group that should be targeted is parents whose relationship has failed, to assist them in minimizing the adverse impacts on children of behaviours which inappropriately limit contact between the child and both parents, or worse, involve the children in a conflict with the estranged partner.

3.42 In terms of reducing the incidence of family breakdown and addressing a source of depression in both men and boys the committee supports the proposals put forward in the submission from the Family Action Centre at the University of Newcastle on the need to increase awareness among fathers of the issue of post-natal depression and also the related issue of the incidence of depression in new fathers, which can have damaging effects on the whole family.[31]

3.43 The committee notes that the Commonwealth Government has announced the National Perinatal Depression Plan[32] which "…aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and

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[29] ibid., p.76

[30] RANZCP, submission 14, p.4

[31] Submission 7

[32] Approximately 16% of mothers experience problems related to perinatal depression. See *beyondblue* Media Release, 26 November 2008

treatment for expectant and new mothers experiencing depression".[33] The program will involve screening of all pregnant women for depression prior to and two months after the birth of a child. The program will also include some information and advice for men as to how they can help their partner and also where they can get advice.

3.44 While the incidence of depression in new fathers may not be high enough to justify a universal testing program, the committee suggests that the screening program for mothers could be extended to include contact with the father to ensure that he is fully aware of the issue and that he is given an opportunity to raise any problems he may be having.

Improving the quality and accessibility of services

3.45 Removing the stigma attached to mental health, promoting open discussion and encouraging men to seek help for mental health problems will not have significant impact on morbidity if the services cannot respond appropriately to demand.

> Improving health professionals' capacity and willingness to recognise and manage depression and anxiety may be a key factor in improving the help seeking behaviours of both Australian men and women.[34]

3.46 General practice is the first point of contact for the majority of men seeking help for a mental health problem,[35] despite the perception noted above in paragraph 3.8 that it is not a sympathetic environment in which to discuss depression. The committee is aware of the demands on general practitioners and does not wish to criticise them but there do appear to be structural problems which militate against the men concerned about their mental health seeking treatment from a GP.

3.47 The standard short consultation is not appropriate to the identification of depression or anxiety. Yet reliance on the short consultation is largely driven by demand (the doctor's waiting room is full) and cost (the gap between the Medicare rebate and the GP's fee is obviously greater for longer consultations).

3.48 There are also training issues in relation to general practice because GPs may not be particularly well-equipped to identify a mental health problem, especially where the patient presents with another complaint and does not volunteer the information that they have an additional problem. Here again we see the interaction of men's behaviour, a reticence to talk about mental health and a preference for practical advice in relation to a visible problem, with the realities of general practice. Research suggests that most GPs deal with only one problem at a time.[36]

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[33] Department of Health and Ageing; http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/perinatal-depression-3 (accessed 25 May 2009)

[34] *beyondblue*, submission 84, p.8

[35] ibid., p.8

[36] Freemasons Foundation, submission 38, p.7

3.49 In recognition of this problem *beyondblue* is supporting research to "…enhance general practice's capacity to identify depression and suicidal risk factors".[37] The committee has also considered this matter in chapter 2 and made recommendations to improve the situation.

3.50 An important aspect of the incidence of depression is co-morbidity, where depression occurs in conjunction with, and as a result of, a physical disease such as prostate cancer. The committee has discussed this at some length in chapter 4. There is a clear need for general practitioners and specialists to consider the mental health implications of major physical diseases or trauma. The committee notes that the Prostate Cancer Foundation of Australia (PCFA) and *beyondblue* have collaborated in a number of activities to increase awareness of this problem, particularly the successful Movember campaign which acts as both a fund- and awareness raiser.[38]

3.51 A more general problem exists as a result of the rigid division between services which are, in practice, often closely related. This is most apparent in the areas of drug and alcohol problems which are often associated with mental illness, particularly among men, given the incidence of self-medication. *beyondblue* explained to the committee that there is a need for much better integration of services to ensure that people are not turned away if they approach the 'wrong' service.

> …if you have a drug problem and an alcohol problem you may not even get into the one service. If you have mental illness as well, you will not; you will be turned away because ‘we do drugs here’ or ‘we do alcohol here’ or ‘we do mental illness’[39]

and concluded,

> …there is an absolute need for identifying issues and working together in an integrated way across drug, alcohol and mental health services. Regardless of the point at which you come in, you should not to be turned away…There is a strategy for everything, but they are not integrated. In fact, the person is often excluded from services because of that. [40]

3.52 The College of Psychiatrists also commented on two aspects of service provision:

- The variable standards of care across the various jurisdictions in Australia, and
- the range of services which are often required in the treatment of mental illness and the need to bring them together,

> There is also a need to better coordinate and connect other relevant community supported services needed by patients with severe mental

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[37] *beyondblue,* op cit, p.3

[38] ibid., p.5

[39] Ms L. Young, CEO, *beyondblue*, committee transcript, p.7

[40] ibid.,p.7

> illness and complex needs with their clinical care (e.g. general health care, financial support, housing, substance abuse, rehabilitation etc).[41]

3.53 This can be particularly true for patients from rural or regional Australia who have had to move 'out of area' to receive treatment.

3.54 The importance of recognising the range of services that a person with a mental health diagnosis may need cannot be over-emphasised. It is a common occurrence, particularly for a person being released from institutional care to be left without adequate support. The pressure on acute care beds is such that many mental health units have to discharge patients somewhat earlier than is ideal:

> Adequate discharge planning and follow-up of patients should become mandatory for all patients discharged into the community from hospital settings. Acute inpatient units increasingly discharge people with severe illness into crisis accommodation or "no fixed address". In communities that do not have the service structures and operating systems to support people with mental illness to live safely or rehabilitate in the broader community, people with mental illness will not receive adequate follow-up treatment and often end up being readmitted following a worsening of their condition.[42]

3.55 There is overwhelming evidence of the interconnectedness of men's physical and mental health issues. It is important that this be recognised in the provision and conduct of treatment services. Therefore,

The committee recommends that the integration of health service provision to recognise the interconnectedness of men's health issues be made a central part of the forthcoming national men's health policy.

The committee recommends that the Commonwealth Government investigate standardised service models for mental health to facilitate a uniform standard of care throughout Australia.

3.56 Given men's attitudes to seeking help for mental health problems and its higher incidence in rural and remote areas, and the lower level of trained and specialist services in those areas, telephone counselling services play an important part in providing initial contact and advice on mental health and in providing crisis support.

3.57 The Commonwealth must ensure that services such as Mensline Australia, SuicideLine Victoria and the *beyondblue* Information Line are adequately funded and that the services they provide are widely publicised, particularly to known at-risk groups. These services also have specific advantages for men particularly in:

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[41] RANZCP, submission 14, p.9

[42] ibid., p.8

> Providing services that allow men to access help without have to confront perceived social obstacles; [and]
>
> Devising gender-specific information and disseminating it through media that are appropriate for men;…[43]

and the potential to expand them should be investigated.

Suicide

3.58 Men are four times more likely to commit suicide than women. It is the tenth most common cause of death for men, ranking above such things as melanoma and land transport accidents.[44] Suicide is highest in the 30-45 age group but is high, above 20 per 100 000, in every age group from the late teens through to late middle age. It also increases in older men above the age of 75.[45]

3.59 The reasons why men commit suicide are, perhaps inevitably, unclear and there is no clear linear progression from a 'negative life event' to suicide. It is known that having a diagnosed mental illness is an increased risk factor for suicide and that relationship breakdown leading to anxiety and depression is correlated with attempted suicide in men.[46] The increasing incidence of suicide in rural Australia has been linked to economic and social stresses related to the extended drought. It is also conjectured that men are particularly ill-equipped to cope with the sense of failure that may come from the loss of a property of or job.

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[43] Crisis Support Services, submission 35, p.4

[44] AIHW, *Australia's Health 2008,* p. 43, table 2.12. The comparable rates are: men 16.6 per 100 000; women 4.4 per 100 000

[45] *beyondblue,* submission, p.3

[46] ibid.

Chapter 4

The Prostate

4.1 Submissions and other evidence taken by the committee concentrated overwhelmingly on two matters - diseases of the prostate and depression. In this chapter the committee considers the issues with regard to the prostate – research and research funding, diagnosis (including testing and screening issues), treatment and education and awareness.

4.2 The prostate gland is found only in males. It surrounds the urethra where it leaves the bladder and produces a fluid which is a component of semen. The prostate is vulnerable to a number of diseases – particularly acute and chronic prostatitis, prostatic enlargement and cancer. Chronic prostatitis and benign prostate enlargement are considered later in this chapter.

Prostate Cancer

4.3 Cancer of the prostate is a significant health problem and, with the ageing of the population it is likely to become the leading cause of death from cancer in men in the near future.[1] Prostate cancer is the most commonly diagnosed cancer in Australia,[2] the fifth largest cause of death among men, and, after lung cancer, the second most common cause of death from cancer. It is predicted that the rate of prostate cancer will rise by 3.1 per 100 000 males or 939 extra cases per annum.[3]

4.4 Over the age of 51 prostate cancer becomes the most common cancer for the remainder of a man's life. [4] Regrettably, despite the incidence of this disease there has been a tendency to dismiss it as an inevitable part of the process of ageing:

> …there is a concern amongst clinicians that treat prostate cancer and researchers that because it can be labelled as a disease of old men it is not as important. Firstly, younger men can develop prostate cancer, with devastating consequences. That comment still occurs and it is an ageist comment. … As a practising clinician I do not consider anyone in their 70s to be elderly but have an expectation that men will not lose years of their

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[1] The Victorian Prostate Cancer Research Consortium (VPCRC) estimates that diagnoses of prostate cancer will double by 2020. VPCRC submission, p.1. With the decline in smoking, the mortality from lung cancer in men is declining.

[2] AIHW, *Cancer in Australia: an overview, 2008*, p.4. "The five most common cancers were prostate cancer (16,349 cases), colorectal cancer (13,076), breast cancer (12,265), melanoma of the skin (10,684) and lung cancer (9,182). These five cancers accounted for over 61% of all diagnoses."

[3] ibid., p.16

[4] AIHW, *Cancer in Australia, op cit,* p.vii

lives or have the morbidity that can occur from disseminated prostate cancer.[5]

4.5 In this context it is important to remember that, for the purpose of medical statistics, 75 is considered a 'normal' life span, that male life expectancy is now 78 years and that a decision to raise the retirement age to 67 has just been announced. Thus prostate cancer is, and will remain, a significant health issue for men of working age.

4.6 The committee believes that the case for secure long-term funding for research into diseases of the prostate is beyond dispute. The incidence of prostate cancer and its projected increasing incidence is sufficient justification in itself for a considerable research effort and enhanced treatment and support services.

4.7 The benefits that can flow from research which provides for a better understanding of a disease and hence earlier diagnosis and better treatment can be shown by the declining mortality rates for a number of 'common' cancers. Colorectal cancer mortality has fallen by about 40% since the 1980s largely due to improved early diagnosis and treatment; cervical cancer mortality has declined by some 75% since the 1960s since the introduction of the pap smear and deaths from lung cancer in males has fallen by nearly 40% from its peak around 1980 as a result of the reduction in smoking and improved treatment.[6]

4.8 It is difficult to estimate the level of funding for research into prostate cancer because it comes from a range of sources. Specifically with regard to funding through the Commonwealth's principal funding body for medical research, the National Health and Medical Research Council (NHMRC) prostate cancer research has lagged behind breast cancer research. In the years 2000-2008 funding for prostate cancer was $44.5 million compared with $88.9 million for breast cancer.[7] Given that the death rates from these two cancers are similar, that the incidence of prostate cancer is actually greater and that projections for the increased incidence are, by some margin, higher than for any other type of cancer[8] there is a very good case for an increase in funding in this area.

4.9 Prostate cancer remains relatively poorly understood and thus presents particular problems of both diagnosis and treatment. As an internal organ, changes to

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[5] Prof. J. Best, Chair, Victorian Prostate Cancer Research Consortium, committee transcript, 9 April 2009, p.41

[6] AIHW, *Australia's Health*, op cit, pp. 45-46

[7] NHMRC funded research into cancer and other malignant neoplasms 2000 – 2008, the Cancer Dataset, http://www.nhmrc.gov.au/grants/dataset/disease/cancer.php (accessed 14 May 2009). In making this comparison the committee does not wish to engage in any 'men v women' debate. The similarity of death rates from the two diseases and a range of other matters makes this a valid comparison.

[8] AIHW, *Cancer in Australia*, op cit, p.16

the prostate are not immediately obvious and, at present, no definitive test short of a biopsy (which extracts tissue samples from the prostate for examination) is available.

4.10 The committee was told by a number of witnesses at its hearings that, where a cancer does exist, the nature of that cancer is also difficult to determine. Prostate cancer can be largely passive or very slow growing and have no noticeable affect on a patient (hence the saying that more men die with it than of it). Alternatively the cancer can be aggressive and metastasise (grow beyond the prostate itself) leading to serious illness and death.

4.11 At present the ability to determine which type of cancer a patient has is limited:

> The disease is highly variable. You can have two cancers that look alike down the microscope. One of them will be quite indolent and the other one will be quite aggressive. …and we have got no marker for that at all.[9]

4.12 This problem is compounded by the fact that cancer may be dispersed throughout the prostate and have different characteristics:

> The thing is that it is a multifocal disease. It is, to a large degree, in the periphery of the prostate but there are different cancer foci and it is believed that they probably arise independently and therefore may have different propensities for aggressive progression of the disease.[10]

4.13 The difficulties associated with diagnosis flow on into treatment. At present there are limited treatment options, particularly for non-invasive therapies.

> A diagnosis of prostate cancer also impacts on quality of life, due to the current inability to determine and advise the sufferer on the likely course of his disease. This leads then to a combination of clinical and psychosocial impacts….[11]

Research Priorities

4.14 It was put to the committee by the Institute of Biomedical Research and Innovation that the priority areas for research into prostate cancer are:

- Development of new predictive and diagnostic tools to identify men at increased risk of developing PC and enhance early detection of the disease;
- Development of new prognostic markers to distinguish between aggressive and nonaggressive cancers to inform treatment options and minimise impacts on patient quality of life; and

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[9] Associate Prof. D. Horsfall, National Project Manager, Australian Prostate Cancer BioResource, committee transcript, 30 April 2009, p.4

[10] ibid., Prof. D. Horsfall. p.8

[11] Australian Prostate Cancer BioResource, submission 22, p.1

- Development of new therapeutic options that target the genetic and biomolecular factors that underlie specific prostate cancer types.[12]

These priorities were reflected in other submissions from professional groups.

4.15 If significant advances are to be made in the identification and treatment of prostate cancer, research must be supported over the whole spectrum of relevant activities. Professor James Best summarised these as:

> …biomedical laboratory-based discovery research; clinical research, which goes out of the laboratory to involve patients in the research; population based research, where we might look at the prevalence of prostate cancer and whether it is increasing, decreasing et cetera; and finally health services research, which is how is prostate cancer treated and how might we improve the treatment.[13]

4.16 The committee strongly supports continued and increased funding for organisations engaged in research and other activities, such as health promotion and public education across all these areas.

The Australian Prostate Cancer BioResource

4.17 Underlying progress in all these areas is a need for research material, specifically tissue collected from prostate cancers.

> Medical researchers will undoubtedly uncover the secrets of prostate cancer variability that give rise to this complex disease. Discoveries will come from studying the biology, pathology and clinical outcome of tissues from a large number of men with the disease,… More importantly, the more cases studied the more likely we will unravel the full spectrum of disease…[14]

4.18 Only by being able to examine a large number of tissue samples and follow the progress of the disease over a period of ten to twenty years will researchers be able to make progress:

> … prostate cancer tissues really form the basis for all of Australia's prostate cancer research, into biomarkers of diagnosis, prognosis—that is, outcomes—and therapeutic response.[15]

4.19 A further reason for the importance of human tissue in prostate cancer research is that the use of laboratory animals does not provide a practical alternative:

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[12] Queensland University of Technology, Institute of Health and Biomedical Innovation (IHBI), submission 52, p.1

[13] Prof.J. Best VPCRC, op cit, p.41-42

[14] Australian Prostate Cancer BioResource, submission 22, p.1

[15] Prof. D. Horsfall, op cit, 30 April 2009, p.2

> The reason that biobanks and specimens taken from men are so important to a biomedical researcher in prostate cancer is that you do not have mouse models to work with. Mice do not get prostate cancer. You can make them do that if you genetically manipulate them, but it is not something that occurs spontaneously.[16]

4.20 The importance of being able to follow the development of a disease in individual patients is a product of the currently unpredictable nature of the disease:

> …approximately 30 per cent of men operated on will fail that treatment. Their cancer will have already escaped the prostate by the time they are operated on. We cannot pick these people. Those patients will relapse in about three to seven years after the operation.[17]

4.21 The principal prostate tissue collection in Australia is the Australian Prostate Cancer BioResource, established in 2004, which currently collects tissue samples from more than 10 hospitals throughout Australia.[18] The committee is particularly concerned to ensure that this BioResource receives secure, long-term funding to enable it to carry out the full range of activities in support of research. It was initially funded by the Commonwealth Bank of Australia, Prostate Cancer Foundation of Australia and Andrology Australia and has received funding from the NHMRC. The NHMRC grant runs until 2009 and renewal is currently under consideration.

4.22 The committee is advised that the BioResource faces a number of limitations imposed by resources which prevent it achieving its full potential. Financial constraints act at both the collection and research stages. Consent of patients to participate in the program has to be obtained and tissues have to be collected and stored according to uniform procedures. At present the BioResource relies,

> …on the goodwill of the institutes, the medical schools that are associated with the institutes and the pathologists who are doing things for us gratis, although they are very busy.[19]

4.23 As a result of practical arrangements within hospitals, the scheduling of operations and availability of pathologists for example, tissue is not collected from a proportion, up to 30%, of men who have consented to participate in the program.[20]

4.24 The BioResource needs to maintain the current rate of tissue collection until at least 2014 to ensure that there is a sufficient number of tissue samples and that these samples have been followed over a long period of time.

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[16] Prof. G. Risbridger, Monash Institute for Medical Research, committee transcript, 8 April 2009, p.28

[17] ibid., p.4

[18] Other collections are held by researchers in Victoria and Western Australia.

[19] Prof. D. Horsfall, op cit, p.7

[20] ibid., p.3

4.25 At the research stage the BioResource would be much more effective if it could produce a greater range of blood and tissue products to supply to researchers. As described in its submission the production of,

> serum and plasma extracted from blood, DNA from blood cells and prostate cancer tissue, RNA from prostate cancer tissue, and micro-arrays of tissue cores of selected prostate pathologies and disease outcomes. These materials are used for the discovery of markers of diagnosis, prognosis and therapeutic response, and for determination of cancer-related mutations and predictive genetic variations.[21]

4.26 In addition to these research activities the BioResource requires an accessible web-linked database which would enable researchers to "… view the collection on the database online to determine which patient tissues are relevant to their research study…".[22]

4.27 The committee is advised that the current level of funding,

> …provides part of [the Project Manager's] salary and the salaries of four tissue collectors, one at each node, and a small amount of maintenance for each of those nodes. It is really only about half what we want.[23]

4.28 It should be noted that staffing of the BioResource has been delayed and the National Project Manager only works part-time to try end ensure that existing funding can be made to last until the end of 2009.[24]

4.29 The question of some element of self-funding of the BioResource through cost-recovery was raised in the committee's hearings. This raises the conflict between putting a price on a product to ensure that users value it appropriately and discouraging its use by setting a price that is a disincentive to use. The committee was advised that it does not charge university and other non-profit institutions. At present it does not supply the private biotechnology industry but should it do so in the future then the issue of charging for tissue will be reviewed.[25]

4.30 The committee does not wish to make a recommendation with regard to a precise level of funding for the BioResource; that is a matter for government and the relevant professional funding bodies. However the committee would wish to endorse the importance of the BioResource as fundamental to the conduct of the very necessary research into prostate cancer.

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[21] Australian Prostate Cancer BioResource, submission 22, p.3

[22] ibid., p.3

[23] Prof. D. Horsfall, op cit, p.7

[24] ibid., p.7

[25] ibid., p.11

The committee recommends that the Commonwealth Government ensure that the Australian Prostate Cancer BioResource is provided with sustainable funding at a level that would enable it to complete its tissue collection and carry out the necessary work in support of prostate cancer research outlined in this chapter.

4.31 An important aspect of research is the translation of that research into better patient outcomes. It was explained to the committee that the institutional pressures of attracting research funding and building a professional reputation can come into conflict with the need to engage with the general community either by publishing in non-specialist media, working through groups such as Andrology Australia and the Prostate Cancer Foundation or through community groups such as Rotary. At present the incentives, for example the ranking of publications in journals, tend to favour the former activity.[26]

4.32 The committee has no ready answer to this problem. However it does emphasise the need for continued support for organisations such as the prostate Cancer Collaborations, Andrology Australia and the Prostate Cancer Foundation as vehicles for bringing together researchers from different areas, facilitating coordination of research and providing the lay reader with accessible information on technical matters such as prostate cancer testing and screening.

4.33 It would also be valuable if 'community outreach', which is encouraged by research institutions, could also be given more weight in ranking researchers and making funding decisions.

Screening and Testing[27]

4.34 This is a key area for research into prostate cancer. An effective screening program can have a significant impact on the morbidity and mortality of a disease. The three national cancer screening programs operating in Australia at present are for breast cancer, cervical cancer and colorectal cancer. Deaths from each of these diseases have been reduced considerably since the introduction of screening programs - cervical cancer deaths have halved from 4.0 deaths per 100,000 women in 1991 to 1.9 deaths per 100,000 women in 2006; deaths from breast cancer have decreased from 31 per 100,000 in 1991 to 22 per 100,000 in 2006.[28] The national screening program for colorectal cancers is too recent to have yielded significant results.

4.35 As indicated above prostate cancer can take a number of forms with widely varying prognoses. The ability to diagnose the disease at an early stage and to

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[26] This issue is considered in more detail in the committee transcript, 8 April 2009, pp.32-34

[27] The committee has used the term screening to refer to the surveying of populations who have no symptoms but are selected on the basis of some general factor such as sex or age group, for example taking a pap smear or carrying out mammography, and testing to refer to a test administered to a patient showing symptoms.

[28] AIHW, *Cancer in Australia*, op cit, p.viii

distinguish the various types of cancer and treat them appropriately is vital. The current inability to do so leads to a situation where,

> …men [are] being over-treated for cancers that they do not need to be treated for, but we have at least 3,000 men a year who are not getting treated, because they are dying from it. They probably could have been saved if we knew more about what sort of cancer they had and that they needed radical treatment. That is the number one need…[29]

4.36 The question of population based screening for prostate cancer using the Prostate Specific Antigen (PSA) has been the subject of considerable research and debate both in Australia and internationally. An editorial in the *Medical Journal of Australia* (MJA) commented "A particular characteristic of the debate has been the polarisation of views…to the point where, at times, constructive debate has been constrained".[30]

4.37 Tests which provide a reliable indicator of the presence of cancer and enable clinicians to distinguish aggressive from indolent cancers would have a significant impact on prostate cancer treatment. To be effective the method of screening should have a high level of sensitivity, meaning that it indicates positive results with a high level of reliability (and yields a low level of 'false negatives' which result in cases of the disease being missed). The method should, ideally, also have a high level of specificity; that is it should identify those who do not have the disease with high reliability and thus avoid 'false positives' – indicating that people who are in fact disease free have the disease which may lead to further, unnecessary invasive testing or treatment.

4.38 The MJA editorial referred to above identified the problems as arising from,

> …the fact that PSA is not a test for prostate cancer and has no threshold level providing a high sensitivity and specificity…a raised PSA level often commits men to the invasive procedure of transrectal ultrasound (TRUS) guided biopsies.

and concluded that,

> If the diagnostic process were non-invasive and treatments with curative intent were not associated with significant unwanted effects, few would quibble about whether it is appropriate to be tested.[31]

4.39 Two recent studies, one in the United States and the other in Europe, have produced conflicting results and interpretations and as a consequence, did not provide

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[29] Dr C. Hovens, VPCRC, committee transcript, 9 April 2009, p.43-44

[30] Medical Journal of Australia, 2007; 187(9):501-502

[31] ibid.

conclusive results that might have settled the debate.[32] Andrology Australia drew three conclusions from the results of these studies:

- The results of these studies are relevant to Australian clinical practice and provide the best evidence to date that there is a significant level of uncertainty about the use of PSA test as a population-wide screening marker for prostate cancer;
- Both studies highlighted the issue of over diagnosis as a result of screening and the consequent interventions (and side effects) that would not occur otherwise;
- The studies highlight that newer and more specific prostate cancer markers are needed before an effective population-wide prostate cancer screening program could be recommended or implemented.[33]

4.40 As will be discussed further below, treatment for prostate cancer can be invasive and carries with it a number of risks. Thus when evaluating the utility of a screening program it is necessary to compare the outcomes of unnecessary treatment, which may result either from false positive results or from over-treatment in the absence of a clear understanding of the particular cancer being treated, with the benefits of mass screening.

4.41 At present it is the general consensus among medical scientists and the Cancer Councils in Australia is that the PSA does not meet these criteria and that, consequently, population screening using the PSA would not be justified.

4.42 Developing a better understanding of the relationship between PSA results and prostate cancer was given as an example of the sort of research that would be facilitated by the proposed longitudinal study on men's health. "One of the biomedical parameters that we would undoubtedly collect in that longitudinal study could be PSA levels from these men. Then that would give you exactly the information that you would need and it would be informative for people to know what does happen to people's PSA levels and what did happen to those men in terms of their tumour".[34]

4.43 However testing for prostate cancer where a man has general symptoms or a family history or simply a desire to monitor their own health status should be encouraged. Testing currently relies on a combination of a PSA test and digital rectal examination. Should these tests indicate the presence of an abnormality of the prostate

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[32] See discussion of these studies at, *Doubts raised over US study on prostate cancer screening test*, Urological Society of Australia and New Zealand, 24 March 2009; Prostate Cancer Screening, ABC Health Report, 23 March 2009 http://www.abc.net.au/rn/healthreport/stories/2009/2520425.htm (accessed 14 May 2009)

[33] *Jury still out on PSA testing*, Andrology Australia, 3 April 2009, http://www.andrologyaustralia.org/pageContent.asp?pageCode=WHATSNEW1742 (accessed 14 May 2009)

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

then the patient would be referred for a biopsy, which is the only definitive test for prostate cancer that is currently available. The Prostate Cancer Foundation recommends that all men,

> …from [age] 50 onwards would go to his GP and have a conversation about prostate cancer. If they are concerned about prostate cancer, they should have the blood test, the PSA, and they should also have a physical digital rectal examination to feel whether there is any growth on the prostate.[35]

4.44 The committee endorses the efforts of the Cancer Councils, Andrology Australia and the Prostate Cancer Foundation to make men aware of the importance of seeking medical advice should they have an indication of a problem with their prostate or any of the risk factors, such as family history, which might suggest an elevated risk.

Treatment

4.45 The significant variations in the behaviour of prostate cancer and the difficulty in identifying the probable behaviour of the cancer in the individual patient lead to considerable difficulties with treatment; "The issue for prostate cancer is that we do not know which men to treat…, because we do not have markers that are prognostic."[36] This can lead to confusion and anxiety for patients and their families and may contribute to people undergoing unnecessary or inappropriate treatment.

> …we were seeing too many patients coming into our clinics not knowing what their treatment options are. We work in a urology department, so we offer surgery and that is all we offer. Unfortunately, men were coming into the clinic and not being aware that they could have a whole plethora of other treatment options, including radiotherapy and cryoablation—a whole range of different things.[37]

4.46 The committee is not qualified to canvass the relative merits of various treatment options. However it did receive a considerable volume of evidence about the impact on patients of having to make decisions on treatment when faced with a range of options and in many cases insufficient support and advice:

> …there are a large number of treatment options available for prostate cancer patients and, from a psychological point of view, this can be a very daunting task. Patients are often asked to make their treatment decision themselves, so without specific guidance from their treating urologist or doctor. Often patients and their families can feel a sense of paralysis around which decision to make.[38]

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[35] Mr A. Giles, Prostate Cancer Foundation of Australia, committee transcript, 8 April 2009, p.84

[36] Prof. G. Risbridger, committee transcript, 8 April 2009, p.35

[37] Dr. A. Wootten, Department of Urology, Royal Melbourne Hospital, committee transcript, 8 April 2009, p.41

[38] ibid., p.37

4.47 A second source of anxiety is the range of morbidities which can result from treatment including:

> failed cancer control, incontinence of the bladder or the bowel, sexual dysfunction and psychological trauma. These morbidities seem to have a very big impact in terms of patient quality of life later on down the track and also how they cope with these difficulties psychologically.[39]

4.48 In evidence to the committee representatives of *beyondblue* made a similar but more general point:

> We are now doing a lot more work in the areas of cancer, such as prostate cancer, and major operations….The surgeon does a good job but no-one is looking after the mind of the person. …We are not very sophisticated in the holistic medical approach as opposed to dealing with specific individual issues. I think that is an area where we have to make a great deal of inroad in the years to come.[40]

4.49 This is a major health issue. The committee heard that a large survey of patients in NSW found that over 50% of patients had some psychological support need and that just under 50% had a need for support relating specifically to changed sexual functioning after treatment for prostate cancer.[41] Prostate cancer sufferers also suffer from depression at 2 to 3 times the community average and general psychological disorders are present in between 25% and 47% of cases. Some studies also indicate that suicide is more prevalent among older men with prostate cancer, perhaps as much as four times more common.[42]

4.50 Support for patients and their families both at the time of a diagnosis of prostate cancer and in the longer term as they undergo treatment and live with the results of it is clearly an area requiring much greater attention.

> …in our work running support groups for men with prostate cancer that there was consistent feedback from men saying that they did not have enough support around the time of diagnosis, they did not know about the different support agencies, they did not know that there were different treatment options, they did not know that there were treatment options for sexual dysfunction or where to get pads—a whole range of different things that they just felt they were not being provided information about.[43]

4.51 The efforts of the various organisations which seek to promote public awareness of all these problems have made a significant difference. The quality of

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[39] ibid.

[40] The Hon. J. Kennett, op cit, 9 April 2009, p.3

[41] Dr. A. Wootten, op cit, p.38. These findings come from a NSW Cancer Council study.

[42] Prostate Cancer Foundation of Australia, *National Prostate Cancer Information Pack, Pilot, Final Report* (April 2009), p.7. The introduction to this report provides a useful summary of recent research into the psychological impact of prostate cancer.

[43] Dr. A. Wootten , op cit, p.41

information that is available is excellent as are the links to support groups. However more needs to be done to reach all prostate cancer patients and to maintain contact with them.

4.52 During its hearings the committee was advised that a pilot project to test a National Prostate Cancer Information Pack was underway. This is an initiative of the Prostate Cancer Foundation and of practitioners in the field. The pack was modelled on the Breast Cancer Foundation's *My Journey* kit which is distributed to all patients at the time of a diagnosis of breast cancer. The purpose of the pack is to provide "…credible, non-biased and consistent information about treatment options and ongoing quality of life issues in the context of localised prostate cancer".[44]

4.53 The report of the pilot project indicates almost unanimous support for the pack among patients and a strong support for the major components. To be effective approximately 18 000 Packs would have to be distributed every year.[45]

The committee recommends that the Commonwealth Government provide funding to the Prostate Cancer Foundation to ensure that the Prostate Cancer Information Pack program proceeds.

4.54 Outcomes for patients diagnosed with prostate cancer vary considerably depending on place of residence and income. Patients in rural and regional areas have a 21% greater mortality than those in capital cities. Mortality is also related to income, with significantly higher mortality rates from prostate cancer among socially disadvantaged men.[46] These figures reinforce the need for improved services to be provided throughout Australia.

4.55 Health services in regional and remote Australia generally suffer from "…larger client capture areas, smaller populations, fewer general and specialist medical professionals per population, and fewer services".[47] While the provision of advanced hospital based services can only be addressed by improving patient transport and support services to ensure that they receive high quality treatment, local services providing education and awareness programs to encourage men to seek medical advice and better support services, post-diagnosis should be provided through regional hospitals, health centres or general practice.

4.56 The committee notes, and fully supports, the Commonwealth Government's support for a program to place specialist breast cancer nurses in health centres predominantly in rural and regional Australia. The program, developed in collaboration with the McGrath Foundation, is to provide:

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[44] *National Prostate Cancer Information Pack*, op cit, p.4

[45] This figure is based on the number of prostate cancer diagnoses per year.

[46] Prostate Cancer Foundation of Australia, submission 72, p.2

[47] AIHW, *Australia's Health*, op cit, p.87

> …specially trained registered nurses…[to] provide vital information, care and practical and emotional support to women diagnosed with breast cancer, their families and carers.[48]

4.57 The Prostate Cancer Foundation has been providing scholarships to nurses undertaking training in the treatment and support of prostate cancer patients for some years but there is no program to appoint prostate cancer nurses nationwide. The committee is advised that PCFA is undertaking a study of the viability of such a program.

4.58 In view of the various factors discussed in this chapter; incidence, mortality, difficulties surrounding diagnosis and treatment, the psychological impact on patients and their families and regional variations in outcomes, it is clear that a similar need exists among prostate cancer sufferers and their families. A program to appoint specialist prostate cancer nurses should be established.

The committee recommends that the Commonwealth Government expedite funding for the provision of specialist prostate cancer nurses, particularly in rural and regional Australia.

Non-cancerous diseases of the prostate

4.59 Benign prostate enlargement is a very common but not life-threatening condition. It is estimated to affect 25% of men in their 40s increasing to some 75% in their 70s. It can be little more than a source of discomfort but if left untreated may affect the functioning of the bladder and, in extreme cases, kidneys.[49] Various treatments are available, ranging from drug therapies to surgery depending on severity. Bacterial prostatitis is the result of infection and, again, can be treated with drugs or surgery depending on the severity of the condition.

4.60 Chronic prostatitis, non-bacterial inflammation of the prostate, is poorly understood in Australia, even by doctors and is certainly under-reported. Evidence to the committee suggests that "…awareness of the condition and its treatment is still poor, despite its prevalence and severity"[50] and affects between 10 and 20% of men in Australia.[51]

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[48] The Hon Nicola Roxon MP, Minister for Health and Aging, *New Breast Cancer Nurses for Regional Australia*,13 October 2008. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr134.htm (Accessed 18 May 2009) The committee notes that the Prostate Cancer Foundation and the Cancer Council of Victoria already offer scholarships to encourage registered nurses to undertake a training course specialising in prostate cancer care.

[49] Andrology Australia, *Prostate Enlargement or BPH*, 2006 http://www.andrologyaustralia.org/pageContent.asp?pageCode=PROSENLARGE (accessed May 2009)

[50] Prof. J. Best, submission 30, p.1

[51] Prof. J. Best, committee transcript, 9 April 2009, p.53

4.61 In extreme cases it can be the cause of severe pain and leave its sufferers leading 'lives of quiet desperation'. It may be a result of inflammation of the prostate or of muscle tension in the pelvic area and can be alleviated to some extent by anti-inflammatory drugs or physiotherapy.

4.62 All of these conditions are susceptible to treatment and benign prostate enlargement and bacterial prostatitis can become serious problems if left untreated. They are much more common than prostate cancer. However men may be discouraged from seeking medical advice when experiencing symptoms because of a fear of a cancer diagnosis. This emphasises the importance of greater awareness of the various diseases that may affect the prostate both among the general public and general practitioners and of encouraging men to seek medical advice at an early stage.

The committee wishes to thank all those who made submissions to this inquiry and participated in the committee's public hearings.

Senator Cory Bernardi
Chair

Appendix 1

Submissions, tabled documents and additional material received by the committee

Submissions

1	Mr David Hughes
2	Mr Bernard Denner
3	Mr Michael O'Meara
4	Victorian Government
5	Mental Health Council of Australia
6	Public Health Association of Australia
7	The Family Action Centre, The University of Newcastle
8	Men's Health Services, NSW
9	Men's Wellbeing Matters Inc
10	Foundation 49, VIC
11	Mr Tony Bowring, TAS
12	Mr Michael Coleopy
13	Royal Australasian College of Surgeons
14	Royal Australian & New Zealand College of Psychiatrists
15	Scarlet Alliance, NSW
16	Monash Institute of Medical Research
17	Name Withheld
18	Andrology Australia
19	Ms Margo Saunders
20	McKesson Asia-Pacific
21	Wamba Niglee Burru Ngardu Aboriginal Corporation
22	Australian Prostate Cancer BioResource
23	Royal Melbourne Hospital
24	Name Withheld
25	Pharmaceutical Society of Australia
26	Catholic Health Australia
27	National Drug and Alcohol Research Centre, University of New South Wales
28	Mr Kenneth Newton

29 Northern Territory Mental Health Coalition

30 Professor James Best

31 Relationships Australia (Tasmania)

32 Victorian Prostate Cancer Research Consortium (VPCRC)

33 Private Mental Health Consumer Carer Network (Australia), SA

34 Northern Territory Government Department of Health and Families

35 Crisis Support Services, VIC

36 Survivors of Suicide Bereavement Support Association

37 Mr Graham Fazio

38 Freemasons Foundation Centre for Men's Health

39 Health Consumers of Rural and Remote Australia Inc

40 Dr Gideon Polya

41 Mr Bob Such MP, Member for Fisher, SA

42 Dr Greg Malcher, School of Rural Health, University of Melbourne

43 Dr Kim Hames MLA, Deputy Premier of Western Australia and Minister for Health and Indigenous Affairs, WA

44 Richard Hillman Foundation

45 Australasian Sleep Association

46 FamilyVoice Australia

47 Australian Health Promotion Association (AHPA)

48 Dads in Distress Inc

49 South Australian Government Minister for Health

50 National LGBT Health Alliance

51 College of Clinical Psychologists, Australian Psychological Society

52 Institute of Health and Biomedical Innovation

53 Mental Health Coordinating Council

54 Gay Men's Health

55 Carers Australia

56 Sydney Men's Network

57 Men's Health Information and Resource Centre, NSW

58 Mr John Miller

59 Mr Bill Muehlenberg

60 Australian Federation of AIDS Organisation Inc

61 Men's Advisory Network, WA

62 Mr Jonathan Pearson
63 Bendigo Community Health Services
64 Royal Australasian College of Physicians
65 Sexual Health information networking and education SA Inc (SHine SA), SA
66 Pastor Eric Trezise
67 Shared Parenting Council of Australia, NSW
68 Dr Elizabeth Celi
69 Dads4Kids Fatherhood Foundation
70 Mensheds Australia
71 Mr Ross Mitchell
72 Prostate Cancer Foundation of Australia
73 Name Withheld
74 Dr Alex Brown, Dr Mick Adams & Dr Mark Wenitong
75 ACON, NSW
76 South Australian Men's Health Alliance
77 Australian General Practice Network
78 Tasmanian Men's Health & Wellbeing Association
79 Mr Luke Bain
80 Mr Stuart Innes
81 Australian Mens Shed Association
82 GlaxoSmithKline
83 Non-Custodial Parents Party (Equal Parenting), NSW
84 BeyondBlue
85 MWC Media
86 Ross Stewart
87 Confidential
88 Mr Ken Thompson AFSM
89 Lifeline Australia
90 Western Sydney Men and Family Relationship Network
91 Council of the Ageing
92 Australasian Mens Health Forum
93 Mr Nick Sivertsen
94 Mr Phillip Pettet
95 Mr Brad Flynn

96 Mr Philip Noonan
97 Mr James Adams
98 Mr Hugh McGonigle
99 Mr Peter Hunter
100 Dr Stan Jeffery
101 Mr Craig Murray
102 Mr Adam Cashmore-Brooke
103 Mr Graham Parish
104 Mr Geoff Thorley, NSW
105 Mr Francis Barram
106 Mr Peter Gregory
107 Mr Sean Slaven
108 Mr Chris Cooper
109 Mr Simon Styles
110 Mr Dallas Bentley
111 Mr Mark Millard
112 Rev Graham Guy
113 Mr Wes Carter
114 Mr Richard Holloway
115 Mr R S Thomas
117 Mr John Kingsmill
118 Mr Adrian Smyth
119 Ms Babette Francis
120 Mr Ian Smith
121 Mr Johaan Ernest
122 Confidential
123 Confidential
124 Confidential
125 Osteoporosis Australia
126 Lara Giddings MP, TAS
127 Lone Fathers Association of Australia (LFAA)
128 National Rural Health Alliance, ACT
129 Central Australian Aboriginal Congress
130 Department of Health and Ageing

131 Cancer Council, NSW

133 Grenfell Men's Shed Inc

134 National Aboriginal Community Controlled Health Organisation

135 Aboriginal and Torres Strait Islander Social Justice Unit
Australian Human Rights Commission

136 Mr. Adam Henry

137 Royal Australian College of General Practitioners

Tabled Documents

Supplementary information on specific proposals for policy and program action, tabled by the National Rural Health Alliance Inc (NRHA), Canberra, 26 March 2009

Evidence by Mr Philip Bell, Mental Health Carer, tabled by Mr Philip Bell, Canberra, 26 March 2009

Presentation by Ms Margo Saunders, tabled by Ms Margo Saunders, Canberra, 26 March 2009

Assorted reading materials, tabled by the Pharmaceutical Society of Australia, Canberra, 26 March 2009

Assorted reading material, The Family Action Centre, Faculty of Health, University of Newcastle, NSW, tabled by The Family Action Centre, 7 April 2009

Healthy Men, Healthy Families, Healthy Nation (literature and materials), tabled by Dads4Kids Fatherhood Foundation, Unanderra, NSW, 7 April 2009

Regular Joe Vs Mr Invincible (2007, book), Dr Elizabeth Celi, tabled (with other materials) by Dr Elizabeth Celi, 8 April 2009

Men's Health Promotion Forum, Newcastle (conference program), 3 August 2008, tabled by the Prostate Cancer Foundation of Australia, Melbourne, 8 April 2009

Assorted reading material, Prostate Cancer Foundation of Australia, Melbourne, tabled by the Prostate Cancer Foundation of Australia, Melbourne, 8 April 2009

Assorted reading material, Andrology Australia, Melbourne, tabled by Andrology Australia, 8 April 2009

Injury - International Journal of the Care of the Injured, UK, December 2008 tabled by the Royal Australasian College of Surgeons, Melbourne, 8 April 2009

Prostate Cancer Research is Underfunded (graphs), tabled by Professor Gail Risbridger, Centre for Urological Research, Monash Institute of Medical Research, Monash University, 8 April 2009

Expansion of Mensline Australia, tabled by Crisis Support Services, Melbourne, 9 April 2009

Advertisement (on a CD), MWC Media, Melbourne, tabled by MWC Media, 9 April 2009

SHine SA Annual Report 2007-2008 (and other materials) - tabled by Sexual Health Information Networking Education (SHine SA) Inc, Adelaide, 30 April 2009

Additional material received by the committee

Strong Men Deadly Groups (DVD) provided by the Men's Health Information and Resource Centre, University of Western Sydney, NSW

Men in Australia Telephone Survey (article, July 2005), several authors, provided by *Beyondblue,* Melbourne

Colleague – the Royal Australian College of General Practitioners, April-May 2009 newsletter, provided by David Helmers, Australian Men's Shed Association

Media segment relating to Men's Sheds (DVD), provided by David Helmers, Australian Men's Shed Association

Assorted further materials relating to active ageing, provided by the Council on the Ageing, South Australia

Assorted further information, Pharmaceutical Society of Australia, Canberra

Improving the information resources provided to localised prostate cancer patients and their families: pilot of a national information and resource pack – Final Report, April 2009, provided by Dr Addie Wootten, Department of Urology, Royal Melbourne Hospital

Appendix 2

Public hearings

Thursday, 26 March 2009 – Canberra

Department of Health and Ageing

Mr David Learmonth, Deputy Secretary

Ms Jennifer Bryant, First Assistant Secretary

Ms Andriana Koukari, Assistant Secretary

Mr Philip Bell, Private Capacity

Carers Australia

Ms Joan Hughes, Chief Executive Officer

Health Consumers of Rural and Remote Australia

Ms Margaret Brown, National Chair

Mr Jeffrey Wearne, Executive Officer

National Rural Health Alliance

Mr Gordon Gregory, Executive Director

Mr Andrew Phillips, Policy Adviser

Ms Lexia Smallwood, Business and Policy Adviser

Public Health Association of Australia

Adjunct Professor Michael Moore, Chief Executive Officer

Ms Melanie Walker, Health Policy Officer

Pharmaceutical Society of Australia

Mr Bryan Stevens, Chief Executive Officer

Mr Paul Mackey, Director, Policy

Australian General Practice Network

Ms Liesel Wett, Deputy Chief Executive Officer

Ms Rachel Yates, Director Policy

Ms Margo Saunders, Private capacity

Mental Health Council of Australia

Mr Simon Tatz, Director of Communications

Tuesday, 7 April 2009 – Sydney

Lifeline Australia

Mr Alan Woodward, General Manager National Services

Dads4Kids Fatherhood Foundation

Mr Warwick Marsh, Chief Executive Officer

Dr Tim O'Neill, Medical Policy Adviser

Mr Ron Brookman, Relationships Policy Adviser

Dads in Distress Inc

Mr Tony Miller, Founder

Family Action Centre, Faculty of Health, University of Newcastle

Dr Richard Fletcher, Senior Lecturer and Team Leader, Fathers and Family Research Program

Cancer Council Australia

Professor Ian Olver, Chief Executive Officer

Mr Paul Grogan, Advocacy

National Drug and Alcohol Research Centre

Dr James Lemon, Research Fellow

Men's Health Information and Resource Centre

Mr Michael Woods, Co-Director

Mr Greg Andresen, Researcher

Mr Rick Welsh, Aboriginal Men's Health Project Officer

ACON

Ms Stevie Clayton, Chief Executive Officer4

Mr Nicholas Parkhill, Director Community Health

Royal Australasian College of Physicians

Dr Anita Sharma, Researcher

Australian Men's Shed Association

Mr David Helmers, Executive Officer

Wednesday, 8 April 2009 – Melbourne

Royal Australasian College of Surgeons

Professor Russell Gruen, Fellow

Mr Andrew McLorinan, Manager, Fellowship Services

Andrology Australia

Dr Carol Holden, Chief Executive Officer

Professor Robert McLachlan, Director

Monash Institute of Medical Research, Monash University

Professor Gail Risbridger, Director, Centre for Urological Research

Royal Melbourne Hospital

Dr Heather Siddons, Clinical Psychologist, Department of Urology

Dr Addie Wootten, Clinical Psychologist, Department of Urology

Dr Elizabeth Celi, Private capacity

Foundation 49

Professor Gary Richardson, Chairman

Prostate Cancer Foundation of Australia

Mr Andrew Giles, Chief Executive Officer

Mrs Jo Fairbairn, National Community Partnerships and Health Promotion Manager

Mr Bill McHugh, Consumer Consultant

Bendigo Community Health Service

Ms Karen Riley, Chief Executive Officer

Mr Peter Strange, Nurse Practitioner, Men's Health

Thursday, 9 April 2009 – Melbourne

beyondblue

The Hon. Jeff Kennett, Chairman

Ms Leonie Young, Chief Executive Officer

The Royal Australian and New Zealand College of Psychiatrists

Professor Kenneth Kirkby, President

Dr Mirco Kabat, Deputy Chief Executive Officer and Director, Corporate Services

Crisis Support Services

Dr Nicholas Foster, Manager, Partnership Development

Mr Randal Newton-John, Mensline Australia Call Back Service Team Leader

Victorian Prostate Cancer Research Consortium

Professor James Best, Chair

Ms Soula Ganiatsas, Chief Executive Officer

Associate Professor Christopher Hovens, Head Researcher

Professor Gail Risbridger, Head Researcher

Professor James Best (Private capacity)

Australian Psychological Society

Mr Jeffrey Kelly, College of Clinical Psychologists

MWC Media

Mr Mike Chapman, Company Director

Mr John Emmerson, Senior Account Manager

Relationships Australia

Mr Maxwell Bessell, Tassie Male Men's Support Worker and Family Drought Support Worker

Mr Herman Morris, Coordinator, Tassie Male Program (South Tasmania)

Thursday, 30 April 2009 – Adelaide

Australian Prostate Cancer BioResource

Associate Professor David Horsfall, National Project Manager

COTA Over 50s

Mr James Giles AM, Chair, Policy Council, COTA Seniors Voice

Ms Jane Fisher, Manager Policy

Wamba Nilgee Burru Ngardu Aboriginal Corporation

Mr Garth Robertson, Coordinator

Private Mental Health Consumer Carer Network (Australia)

Ms Janne McMahon, Independent Chair

Mr John Kincaid, South Australian Delegate

Mr Michael O'Hanlon, Victorian Representative

Freemasons Foundation Centre for Men's Health, University of Adelaide

Professor Villis Marshall AC, Centre Director

Ms Anne Hayes, Chief Executive Officer

Central Australian Aboriginal Congress

Dr John Boffa, Public Health Medical Officer

Mr John Liddle, Male Health Officer

Institute of Health and Biomedical Innovation

Professor Ross Young, Executive Director

Sexual Health Information Networking Education (SHine SA) Inc

Ms Kaisu Vartto, Chief Executive Officer

Dr Bob Such (Private capacity)