



LEGISLATIVE ASSEMBLY FOR
THE AUSTRALIAN CAPITAL TERRITORY

Men's and boys' health and wellbeing

**Report No. 2 of the
Standing Committee on Health
and Community Care**

July 1999

RESOLUTION OF APPOINTMENT

The following general purpose standing committees be established to inquire into and report on matters referred to it by the Assembly or, after the Assembly's endorsement, matters that are considered by the committee to be of concern to the community ...

... a Standing Committee on Health and Community Care to examine matters related to health and community care policy, planning and purchasing acute, community health and population health services, hospitals and any other matter under the responsibility of the portfolio minister.

Legislative Assembly for the ACT, *Minutes of Proceedings*, (1998), No. 2, 28 April 1998, pp 15 and 16

TERMS OF REFERENCE

[That the committee] inquire into and report on men's health services in the ACT, with particular reference to:

- (a) the need for specific health services for men in the Territory, including the need for targeting particular groups of men according to age, cultural and linguistic background, socio-economic status, sexuality, and any other relevant factors;
- (b) the availability of men's health services/facilities in the Territory;
- (c) the potential contributing factors to men's health outcomes, including male socialisation, risk-taking behaviours, and violence;
- (d) examples of good practice men's health services/facilities in the Territory;
- (e) the relationship between men's health and wellbeing, and community health and wellbeing; and
- (f) any other related matter.

Legislative Assembly for the ACT, *Minutes of Proceedings*, (1998), No. 13, 25 June 1998, p 101

COMMITTEE MEMBERSHIP

Mr Bill Wood, MLA (Chairman)

Mr Harold Hird, MLA (Deputy Chair)

Mr Dave Rugendyke, MLA

Secretary: Ms Beth Irvin (until 1 April 1999)

David Skinner (from 12 April 1999)

Administrative Officer: Mrs Kim Blackburn

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SUMMARY OF RECOMMENDATIONS

Recommendation 1

4.10. The committee recommends that the Minister for Health and Community Care request the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference to undertake substantive research into men's and boys' health in Australia.

Recommendation 2

4.19. The committee recommends that the Government assist the Belconnen Community Service/men's health service providers working group in collating and disseminating the details of all services available to men in the ACT

Recommendation 3

4.33. The committee recommends that the Government develop a policy framework which takes account of a gendered approach to health and considers the needs of men and women in particular circumstances.

Recommendation 4

4.47. The committee recommends that the Government ensure that health care services provided by the Department of Health and Community Care, The Canberra Hospital and the Calvary Hospital are sensitive to the specific health care needs of men and boys and that health workers receive appropriate training.

Recommendation 5

4.55. The committee recommends that the Government:

(i) explore means of encouraging the ACT Division for General Practice to include men's and boys' health and wellbeing in its Continuing Medical Education program; and

(ii) develop a community awareness program to encourage men to access health services on a timely basis and that the program recognises the cultural imperatives within the community which may act to deter men from accessing health services.

Recommendation 6

4.70. The committee recommends that the Government review its existing health promotion programs to ensure that they include a focus on men's and boys' health.

Recommendation 7

4.76. The committee recommends that the Government:

- (i) implement workplace health promotion programs in the ACT Government Service and encourage the private sector to introduce similar programs; and**
- (ii) initiate a men's health week in the lead up to Fathers Day to promote men's and boys' health issues and the services that are available.**

Recommendation 8

4.105. The committee recommends that the ACT Government endorse the need for a national prostate screening program.

Recommendation 9

4.106. The committee recommends that the Minister for Health and Community Care urgently requests that the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference undertake a prostate cancer screening program.

Recommendation 10

4.107. The committee recommends that the ACT undertakes an energetic and comprehensive promotional campaign to alert GPs and men and women to the need for yearly prostate cancer screening for men aged 50-70 and for men with a family history of prostate cancer.

Recommendation 11

4.110. The committee recommends that the Department of Health and Community Care allocate increased resources to information programs to men and women about prostate problems.

Recommendation 12

4.117. The committee recommends that the Government investigate the demand for nCPAP machines in the ACT, assess the extent to which sleep apnoea sufferers are prevented, by financial constraints, from acquiring or accessing the machines and develop a policy to facilitate acquisition or access for those who are unable to afford the costs involved.

Recommendation 13

4.125. The committee recommends that the Government:

- (i) assess the further need, if any, to ensure adequate accommodation support for men in need of alcohol and drug detoxification and rehabilitation; and**
- (ii) examine measures whereby ACT Housing can reduce the incidence of debt and measures for utilising direct debit facilities.**

Recommendation 14

4.130. The committee recommends that the Government consider the following issues raised during the course of the inquiry:

- (i) domestic violence in gay relationships;**
- (ii) liaison between the Gilmore Sexual Health Centre and Aboriginal Health Services concerning sexual health;**
- (iii) support services (including psycho-social) for men with cancer;**
- (iv) men's high incidence of solar skin damage and skin cancer as a result of occupational exposure;**
- (v) sleep apnoea related to overweight and obesity;**
- (vi) depression and suicide in elderly men; and**
- (vii) support services for men with prostate cancer.**

CHAPTER 1. INTRODUCTION

1.1. The ACT provides a high quality public health system catering for most of the health needs of men. It reaches out into the community offering a wide range of services and support programs. There are good private hospitals and an ample number of highly qualified medical specialists and general practitioners. There is also a range of non-government groups, including self-help groups, actively supporting men in relation to their health and wellbeing. The air and water quality are excellent, there is an extensive array of public and private recreational facilities and the community is recognised as being a highly educated section of the Australian community. As members of the Assembly, the committee knows only too well how well informed Canberrans are.

1.2. The ACT Government accurately states the case:

The ACT has a relatively young and healthy population. Even on an age-adjusted basis, our mortality rates are 16 percent lower than the Australian norm and we also are admitted to hospital and visit doctors at a much lower rate. By most traditional measures, it is possible to say that, on average, the ACT has the healthiest population of any State or Territory. Canberra is, by most standards, a very healthy place to live¹.

1.3. “Why then”, the committee is being asked, “do we need to consider if special attention needs to be paid to men’s health?” The research evidence brought to the committee indicates that some men should do more to improve their health and wellbeing. It seems desirable, too, that health care providers become more aware of the issues of men’s health and treatment. However, amid much comment that men’s attitude to their health is a significant problem, the committee was advised that, ‘there is every reason to believe that attempting to remodel men is folly’.² A view was put to the committee that rather than waiting for one macro-solution to problems in men’s and boys’ health, it is more effective to ‘get started on the problem and refine the solutions as you go along’³.

1.4. The committee recognises that further improvements in men’s health rely in part on changes in attitude and behaviour. But there would be few people in Australia generally who have not absorbed information about diet, or exercise or tension or a whole range of health related matters, yet it seems that many have not responded adequately to those messages.

1.5. The point was well made when the committee was briefed by Healthpact, the ACT Government funding body for health promotion and sponsorship.

¹ Minister for Health and Community Care, Michael Moore MLA. (1998) ‘Setting the Agenda, A Healthy Community - Directions for Health and Community Care in ACT’. p 9.

² Mr Anthony Farr, Submission 21, p 3.

³ Transcript, (Mr Farr), 9 February 1999. p 55.

1.6. Healthpact's funding recommendations are based on sound principles. Officers cited research by a USA epidemiologist, Professor Syme, indicating that targeting behaviours and individuals alone does not work in attempts to reduce diseases and risk taking behaviours. The most effective way to improve health in the long term is to enable people to make effective decisions and to create supportive communities which help people carry out their choices⁴.

1.7. Among other proposals, the committee recommends the development of a framework to advance men's health but it is aware of the considerable task it entails to be really effective in this area.

1.8. There is justification in dealing with men's health. There are improvements that can be made and if we understand the circumstances better we may be able to achieve that goal. This report, focusing on the ACT, attempts to do that.

1.9. In doing so, the committee is emphatic on two points. There is to be no competition for resources with women's health programs, nor does it propose a comparable range of services.

Conduct of inquiry

1.10. The committee sought public input to the inquiry and received 31 submissions. A list of submissions is in Appendix A.

1.11. Public hearings were held on 9 and 10 February and 24 April 1999. The persons and organisations who appeared at the hearing are listed in Appendix B. In camera evidence was taken on 25 February 1999.

Visits

1.12. In order to gain a wider perspective on the issues the committee met with interested parties in the ACT and interstate.

1.13. In Canberra, the committee met with the Murringu Men's Centre, Samaritan House, the Young Men's Support Network at the Woden Youth Centre, the Service Against Male Sexual Assault (SAMSA), the Junction Youth Health Centre and Winnunga Nimmityjah Health Service.

1.14. In NSW, the committee met with the NSW Department of Health and Dr George Burkitt, President of the NSW Men's Health and Wellbeing Association Inc, and the committee also attended an Association workshop.

1.15. Dr Burkitt's medical practice focuses exclusively on counselling men in crisis and the committee met three of his patients.

⁴ Briefing by Healthpact, 24 April 1999.

1.16. At the NSW Department of Health, the committee met with Mr Michael Kakakios and Mr Andrew Gow, who developed the department's discussion paper, *Strategic Directions in Men's Health*.

1.17. The committee visited the Victorian centres of Daylesford, Ballarat, Bendigo and Shepparton in the company of Mr Bernard Denner, Project Manager at the Centre for Advancement of Men's Health. Mr Denner developed the Men's Awareness Network (MAN) model which endeavours to improve men's and boys' health and wellbeing through a partnership approach between men and boys, general practitioners, community health workers and schools.

1.18. The committee met with local general practitioners and representatives from the Hepburn Health Service, Victorian Department of Health, Hepburn Shire Council, LaTrobe University and Ballarat City Council.

1.19. The committee also visited: the Works Depot of the City of Ballarat Council to observe a workplace men's health program and a session presented by a urologist; staff and former students at the Whitehills Secondary College in Bendigo to talk about the Lifeskills Program for Adolescents; board members and staff of the Goulburn Valley Community Health Service to discuss their men's health initiatives; the Rumbalara Football and Netball Club, an Aboriginal sports club used as a vehicle to improve Aboriginal health and wellbeing; and the Rumbalara Community Health Centre.

1.20. The committee was accompanied on the interstate visits by Mr Simon Rosenberg, Manager, Health Strategies Development Unit, Health Outcomes Policy and Planning Group, ACT Department of Health and Community Care.

CHAPTER 2. THE STATE OF MEN'S HEALTH AND WELLBEING IN THE ACT

2.1. This chapter draws heavily upon material provided by the Health Status Monitoring Epidemiology Unit, ACT Department of Health and Community Care⁵ and the Government submission to the committee.

Demographics

2.2. The 1996 Census found the population of the ACT to be approximately 308,000 of which 49.6 percent were males. Most of the population was under 75 years old. However, the proportion of people aged 65 or more was predicted to nearly triple between then and 2051, compared with doubling for the States and the Northern Territory.⁶

2.3. More males are born than females but higher male death rates result in a larger number of women in the higher age groups than men.⁷

2.4. The male median age in the ACT was 30.9 years in 1997, with the median age for all persons being 31 years.⁸

Cultural and Linguistic Diversity

2.5. The ACT is very culturally diverse, with approximately 25 percent of its residents born overseas (nearly 50 percent of these are from Europe or the former USSR and 20 percent from Asia).⁹

2.6. In 1996, 17 percent of the population spoke a language other than English at home. The most common languages were Chinese, Italian, Croatian, Greek, Spanish and German.¹⁰

Employment

2.7. In 1995-96 the labour force participation rate in the Territory was 74 percent compared to the national average of 64 percent.¹¹

2.8. The participation rate for males in the labour force was 81 percent, which is 7 percent higher than the national rate, while the participation rate for females was 76 percent, 13 percent higher than the national rate. Eighty-seven percent of employed

⁵ Carol Kee, *The Health Status of Males in the ACT*, Monograph No. 1, ACT Department of Health and Community Care, Canberra, August 1998

⁶ *ibid*, p 3

⁷ ACT Government, *Submission*, p 4

⁸ Carol Kee, *op cit*, p 3

⁹ ACT Government, *Submission*, p 4

¹⁰ *ibid*

¹¹ *ibid*

men and 61 percent of employed women worked full time and 25 percent of the labour force worked part time (with the majority of these being women).¹²

Health Status

2.9. Men appear to be more at risk of poor health because they are less likely to make use of primary health care services. Low income families report more serious chronic illnesses for children (0-14 years) than high income families. Similarly, people aged 25-64 years in low income families report worse self-perceived health than those in higher income families.

2.10. The Government submitted that:

People on low incomes are also more likely to have lifestyle risk factors such as smoking, risk drinking, overweight or obesity and lack of exercise.

Groups identified as being at risk of poverty in Australia include the homeless, indigenous people, sole parent families, young and older single people (especially those who do not own their own home), people who are unemployed or not in the workforce, very large families, recent migrants from non-English speaking backgrounds and many rural families who may be asset rich but cash poor.¹³

2.11. Indigenous Australians suffer higher morbidity rates and die younger than non-indigenous Australians. Indigenous men live 16 to 18 years less than non-indigenous men and infant mortality rates are three to five times higher than non-indigenous Australians.¹⁴

Health risk factors

2.12. Risk factors have varying impacts on individuals, their health and life quality. Major behavioural risk factors include smoking, excessive alcohol consumption, other drug abuse, poor diet and nutrition, inadequate physical activity, unprotected sexual activity, and excessive sun exposure. Major physiological risk factors include overweight and obesity, high blood pressure, and high blood cholesterol levels.¹⁵

Risk taking behaviour

2.13. It appears that risk-taking is predominantly a male behaviour that is linked to low socio-economic status. For instance, young, under-educated men are more likely to be involved in motor vehicle accidents than other demographic groups and in 90 percent of vehicle accidents human behaviour is a contributing factor.¹⁶

¹² *ibid*

¹³ *ibid*, pp 4 and 5

¹⁴ *ibid*, p 5

¹⁵ Carol Kee, *op cit*, pp 3 and 4

¹⁶ *ibid*, pp 4 and 5

Mortality

2.14. At 17 percent below the national rate, the ACT's standardised death rate is the lowest for any State or territory. In 1995 male death rates exceeded female death rates in all ages except in the under one year age group.¹⁷

2.15. The major causes of death for males, both in the ACT and Australia are circulatory disease (mainly ischaemic heart disease and cerebrovascular disease (stroke) and malignant neoplasms (cancer)). In 1996 approximately 31 percent of male deaths were due to cancer and 23 percent were due to ischaemic heart disease.¹⁸

2.16. While life expectancy for all ages has improved, it is lower for males (76.7 years) than for females (81.5 years).¹⁹

Morbidity

National Health Survey

2.17. The Australian Bureau of Statistics conducts a National Health Survey every 5 years. The 1995 survey found 87 percent of men in the ACT rated their health to be excellent or good overall.²⁰ This self reporting survey suggests a high level of confidence by men in their health.

Hospital utilisation

2.18. Length of stay in hospital is a reasonable measure of the acuteness of diagnosed conditions. Males' hospital activity increases as their age increases, but this trend decreases from age 65 years, probably because there are fewer males in the older groups.²¹ The committee received evidence indicating that other factors are also involved.²²

2.19. The age category for males with the highest number of hospital separations is the 45-74 age range. Reasons for hospitalisation include diseases of the digestive (12 percent) and circulatory (9 percent) systems, neoplasms (8 percent) and injury and poisoning (8 percent).

Projections of morbidity for selected causes to the year 2001

2.20. The number of separations due to digestive system diseases is expected to decline by the year 2000-01. Circulatory system disorders are predicted to rise by the year 2000-01 and injury, poisoning and neoplasms are projected to increase slightly

¹⁷ ACT Government, *Submission*, p 6

¹⁸ Carol Kee, *op cit*, p 7

¹⁹ ACT Government, *Submission*, p 6

²⁰ Carol Kee, *op cit*, p 8

²¹ *ibid*, pp 10 and 11

²² Professor Jorm

but constantly. Separations for injury and poisoning are expected to exceed separations for circulatory diseases by the year 2000.²³

Cardiovascular disease

2.21. Mortality rates for cardiovascular diseases have declined significantly over a ten year period (1984-93). Mortality rates from coronary heart disease (ischaemic heart disease) and cerebrovascular disease (stroke) have declined by over 50 percent in males and females. However, there were no major changes in other heart disease mortality rates.²⁴

2.22. The ACT male standardised rate for cardiovascular disease is 257 per 100,000 compared to 265 for Australia as a whole, the ischaemic heart disease rate is 151 per 100,000 compared to 161 for Australia as a whole, and cerebrovascular disease is 54 per 100,000 compared to 52 for Australia as a whole.²⁵

Cancer

2.23. Approximately one in four people will develop a cancer during their life time and, even though not all cancers are fatal, cancer is the major cause of premature death in Australia. The most common cancers for younger men are leukaemia and melanoma, and colon and prostate cancers for older men. Lung, colo-rectal and prostate cancer are the leading cancers causing death in males.²⁶

Injury

2.24. Injury is the fourth most common cause of death in the ACT with the majority of injuries occurring in the 15 to 44 age group. Suicide, self-inflicted injury and motor vehicle accidents were responsible for the majority of male deaths due to injury in 1996.²⁷

Mental health

2.25. With regard to mental health, the ACT data suggests a worrying situation:

- all male age groups in the ACT have higher rates of anxiety disorders compared to male age groups across Australia;
- ACT males with substance use disorders were nearly double the Australian rate in the 18-34 and 55-64 year age groups; and
- ACT males had higher rates of all mental disorders than Australian males in all age groups.²⁸

²³ *ibid*, p 13

²⁴ *ibid*

²⁵ *ibid*, p 14

²⁶ *ibid*, pp 14 and 15

²⁷ *ibid*, pp 15 and 16

²⁸ ACT Government, *Submission*, pp 8 and 9

Men and women

2.27 Witnesses pointed to the differences in the way that men and women sought medical assistance. A general view among those who contacted the committee was that men were reluctant to attend to their health needs. This was exemplified by the comment that fewer men than women visit their GP, that they do so less frequently and that they tend to wait until serious problems have arisen rather than take preventative action.²⁹

2.28 The committee was advised that women use health services more frequently because of their reproductive function and associated organ structures. Nevertheless, men may well present later than they possibly should, tending to wait until there is an emergency, while women tend to present at the first sign of an illness.³⁰

2.29 The committee was advised that a longitudinal study of the health of elderly people in Canberra and Queanbeyan which began in 1990 showed, among other things, that men who attended their general practitioner less frequently tended to have poor social support. The study also showed that one of the reasons why some very sick men do not go to the doctor is probably because those who are in good health earlier in their life do not get into the habit of visiting their general practitioner and as they age and develop chronic diseases this habit continues.³¹

2.30 The committee was informed that on a number of health measures the pattern of men's visits to general practitioners was quite different from women's - those in the worst health tended to be those who never went.³²

2.31 This high quality research has important messages for those planning health policy and delivery services.

²⁹ Transcript (Mr Orkin), 9 February 1999, p 11

³⁰ Transcript (Dr Richards), 9 February 1999, p 47

³¹ Transcript (Professor Jorm), 10 February 1999 pp 89, 90 and 91

³² *ibid*, p 90

CHAPTER 3. ACT HEALTH SERVICES FOR MEN AND BOYS

ACT health services for men

3.1. Health services for men and boys in the ACT are typically provided in three ways:

- comprehensive provision by the ACT Government;
- private medical practice and hospitals; and
- non-government community based bodies.

3.2. The public and private health services are well established and comprehensive in the ACT, delivering a high standard of care. They lack nothing in comparison with provisions elsewhere in Australia. There is no need to detail these services, but the committee has been interested in the health care provided by the non-Government sector and wishes to comment on its range and quality. A list of such groups and services appears in Appendix C.

3.3. Research cited by Healthpact that people should be enabled to make the decisions in support of their choices, aroused the committee's interest, especially in the activities of a range of community based groups which have a whole or partial focus on the health and wellbeing of men.

3.4. The purpose of these groups varies widely and in total their activity amounts to considerable effort on behalf of men's health. Some by nature are directive, others are less structured with some focused strongly on personal development.

3.5. The common thread is the provision of services not generally offered by the Government and sometimes related to men's wellbeing. Often these services are in part or whole purchased by government. The variety of services is important since the range of men's problems is diverse and there is no one way to deal with issues concerning men's health and wellbeing.

3.6. Groups vary from self-help and mutual support to men's rights, gay support as well as groups concerned with specific medically related issues and rehabilitation following drug and alcohol use.

3.7. Since 1997, the Belconnen Community Service has been active in conducting programs specifically for men. Its services have been varied to provide on an individual basis, men only workshops, parenting programs and anger management workshops.³³

³³ *ibid*, (Ms White) p 76.

3.8. The Service made the point:

...it is important to be in touch with community need and maintain a flexible, multifaceted approach to service delivery in order to respond effectively and maximise access to service.³⁴

3.9. As a broad based service, Belconnen Community Service works in this way. Other groups have a narrow focus. Typically for men there is much attention to drug and alcohol addiction. A number of community or church based groups work in this area, funded by government.

3.10. There are men's rights groups offering advocacy and advice and support groups for gay people.

3.11. Of considerable interest to the committee was the activity of groups working with men who may be estranged, who may be experiencing personal difficulty for a number of reasons. The committee notes the growing interest in this area – a necessary response when the “strong silent male” runs into difficulty.

3.12. Travelling to Sydney the committee observed the private practice of Dr George Burkitt who specialises in counselling men. The evening of the visit was spent observing and participating in a men's self-help group.

3.13. In printed information for his clients, Dr Burkitt states:

Traditional ways of looking at us as men are becoming less and less relevant. We need to find new ways.

3.14. The committee understood Dr Burkitt to argue that the mature, healthy notion of manhood needs to include in it an acceptance of responsibility, adjustment to masculinity and the ability to find meaning in life.

3.15. Among other considerations, Dr Burkitt stressed the importance of the concept of initiation into adulthood – a transition not generally recognised in modern society, suggesting the need for mentoring programs.

3.16. In the ACT, a similar theme was expressed by Murringu, a men's self-help group:

Boys do not grow up with encouragement to think about what it means to be a male ... This means that we have a lot of men around who do not talk to each other seriously about being men, which includes not talking much about their health either ... not acknowledging or taking seriously their own risk taking behaviours.³⁵

3.17. Murringu has been functioning since 1992, is established in premises in Narrabundah and receives a small grant to operate on a part-time basis.

³⁴ ibid

³⁵ Transcript (Mr Aldridge) 9 February 1999, p 41

3.18. Murringu expresses a familiar view, that the most powerful influence on men's attitudes to health are the values learned from an early age - to be strong, not to show feelings, not to be weak, competing is good, winning is best.³⁶

3.19. Murringu is functioning to provide mutual support, to find ways of improving 'services for all men and ... [ways] of getting men to be motivated ... about themselves'.³⁷

3.20. The committee believes that there is an important role for such groups and that they are worthy of continuing government support.

3.21. Working in a specific area, the Service Against Male Sexual Assault (SAMSA) advises of the need for discrete services and works effectively in this area. While arguing that most health and support services should be available for men through mainstream services, the service argued that:

Issues such as sexuality, sexual assault, torture and trauma need to be addressed through discrete services accounting for the needs of men from diverse cultural and linguistic backgrounds, gay and bisexual men, indigenous men and young men.³⁸

3.22. The quality of services and the organisational competence of the specific groups working in the field of men's wellbeing have impressed the committee.

Conclusions

3.23. From the foregoing, there can be little dispute that improvements in the attention directed towards men's and boys' health and wellbeing are desirable.

3.24. The committee is concerned that in light of all the evidence, including statistical data showing higher death rates for men than for women, it is time to focus more attention on the overall standard of men's and boys' health.

3.25. In the ACT, there is no policy framework addressing men's and boys' health and wellbeing issues and not all men are aware of the resources and services available to them. Greater coordination would be beneficial. A large number of existing health services may not target men appropriately and consequently men do not access the available services as often as they might.

3.26. This situation needs to change and the committee makes a number of recommendations to achieve this. In doing so, the committee recognises that men are not one group, they are diverse in their needs, age, culture, language, social and economic status and sexuality.

3.27. Accordingly, the committee has deliberately taken into consideration the broader issues (such as male socialisation, men in relationships, men's coping

³⁶ *ibid*

³⁷ *ibid*, p 43

³⁸ SAMSA Submission 23, p 7.

methods and risk-taking behaviours) without getting bogged down in the detail.

3.28. To some extent the committee has been obliged to be broad brush in its approach to the reference. This is because of a lack of specific data about men's behavioural characteristics and a paucity of research covering the range of health issues which impact on men. And it is particularly the case that the complexity of men's behaviours and responses to them require a study beyond the resources of this committee.

3.29. Part of the evidence taken by the committee has been anecdotal which has given the committee valuable 'grassroots' insights into some of the problem areas in men's and boys' health. The committee is especially appreciative of those organisations and individuals who have taken the time and trouble to give the committee the benefit of their hands-on experience. The community owes a great deal to those who work in this area. It would not have been possible for the committee to provide a useful contribution to the overdue and necessary debate on men's and boys' health without the assistance of these individuals and organisations.

Cooperation

3.30. The committee also considers that there is much to be gained from closer cooperation between the ACT health authorities and those practitioners identified in this report who have undertaken pathfinding initiatives in the development of men's health programs. Not all have formal health services qualifications, a point recognised by the Department of Health and Community Care.³⁹

3.31. The committee considers there is scope for a renewed effort to get things moving with men's health. There is a need for consultative mechanisms with men's organisations and for public education to advance men's health services. Indeed, there is a need for a process of continuous improvement directed towards best practice and assessing new initiatives in health.⁴⁰

³⁹ Transcript (Mr Rosenberg), 9 February 1999, p 1

⁴⁰ Transcript (Mr Farr), 9 February 1999, p 55

CHAPTER 4. ISSUES FOR CONSIDERATION

4.1. This report does not attempt to solve difficult and complex issues but rather attempts to provide a framework to begin the process of encouraging improvement in men's and boys' health.

4.2. In that context, a number of important issues arise, namely:

- (i) the lack of substantive research;
- (ii) the lack of a policy framework for men's and boys' health;
- (iii) budgetary factors;
- (iv) gender competition for resources;
- (v) whether specific male health services should be established;
- (vi) focused health services;
- (vii) education and personal responsibility;
- (viii) health promotion;
- (ix) workplace health;
- (x) male-specific medical conditions; and
- (xi) supported accommodation.

4.3. These matters are considered in more detail below.

Research on men's and boys' health

4.4. The committee's attention was drawn to a lack of research into men and boys' health, with comments such as "why don't men access their GP often or soon enough?", "how does men and boys' socialisation affect their health and wellbeing?", "why do some diseases affect men and women differently?" and "how do men access information?"

4.5. The committee noted with considerable interest a comment that:

Research into health matters that are relevant to men has been piecemeal and fragmentary, often more on an illness by illness basis. Men's health needs are not seen in this way because men have not been looked at in the health system as a particular group in the way, for example, migrants or Aborigines or women or people with disabilities have been. Although much medical research has been conducted into diseases that afflict men, the patient as a man has been almost invisible. The health system's approach

has traditionally been the treatment of a bunch of organs that just happen to be inside a man's body.⁴¹

4.6. The committee was advised that the impact of men's and boys' health problems are not systematically understood and responded to, and community awareness of these issues remains dismally low. The view was put that the process of collecting statistics, demographics and doing epidemiological studies is essential for use in the health system, but the problem of getting this information to the men who need it must be addressed. Many men are not listening to health warnings and advice, and they tend only to respond when a problem has been ignored long enough for it to become a crisis.⁴²

4.7. In the absence of targeted research into men's and boys' health, policy makers and health workers are only guessing at the nature of possible solutions. This may lead to fragmentation and inefficient use of resources.

4.8. The committee is concerned about the lack of profile of men's and boys' health in the community and would be pleased to see the issues considered by the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference. This would have the added advantage of enabling the States and Territories to work together by sharing information and experiences. The committee is also mindful that, given the current economic climate in Australia, it would make sense if the States and the Territories worked collaboratively on men's and boys' health needs.

4.9. The committee was encouraged to learn that Western Australia, South Australia, New South Wales and Tasmania have either developed or are developing policies or discussion papers on men's health.⁴³ The committee also understands that two national men's health conferences have taken place with a third conference planned for later this year.

Recommendation 1

4.10. The committee recommends that the Minister for Health and Community Care request the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference to undertake substantive research into men's and boys' health in Australia.

The policy framework

4.11. The Government acknowledged that there is no policy or strategy addressing men's (or for that matter women's) health in the ACT⁴⁴ and that the Department of Health and Community Care was awaiting the committee's report on this matter. The committee was advised that in the meantime the department has been keeping a

⁴¹ Transcript (Mr Aldridge), 9 February 1999, p 41

⁴² *ibid*

⁴³ ACT Government, *Submission*, p 11

⁴⁴ *ibid*

watching brief on the considerable activity in other Australian jurisdictions and was targeting men's health issues through other departmental strategies (for example, its youth suicide prevention strategic plan and sexual health and blood-borne diseases strategic plan).⁴⁵

4.12. The committee notes that the Department of Health and Community Care's *Setting the Agenda* document sets out the overall framework for health care advancement in the ACT. The department noted that the document:

places an emphasis on client focus and a greater emphasis on health promotion, prevention and primary care, and also [looks] at making sure we have an evidence base to our interventions and emphasising partnerships and service delivery.⁴⁶

4.13. On the specific issue of men's health there is doubt as to whether this framework alone is adequate to result in improved outcomes for men. The committee was advised of both research and anecdotal evidence that has shown there are a number of factors which contribute to poor or inadequate health care for men. One witness advised the committee that these include:

... a lack of, or inappropriate, service provision; poor use of existing services, a lack of community awareness or understanding of the issues for men, and societal pressures on men, and often perpetrated by men, not to seek assistance.⁴⁷

4.14. The specific health services for men that are available seem to be fragmented and uncoordinated. The men's health sector does not appear to know what services are available for men. This is partly because it is a relatively new sector and not well funded.

4.15. It was put to the committee that it would be very beneficial to map what services do work with men to get an indication of what is happening in the community. It was submitted that an exercise of this type may allow existing services to be better co-ordinated.⁴⁸

4.16. The committee agrees with this view. Desirably, this work should also involve an appropriate consultation process and a subsequent feasibility study leading to, firstly, the provision of services specifically designed to address the needs of men in the ACT and, secondly, the provision of opportunities to enable men to take responsibility for their own health and wellbeing.

⁴⁵ Transcript (Mr Rosenberg), 9 February 1999, pp 8 and 9

⁴⁶ Transcript (Mr Rosenberg), 9 February 1999, p 1

⁴⁷ Transcript (Ms Purtell), 9 February 1999, pp 25 and 26

⁴⁸ Transcript (Ms Callen), 9 February 1999, p 32

4.17. The committee understands that part of a mapping exercise is being undertaken through the Belconnen Community Service and a number of men's health service providers which have formed a working group to collate and disseminate details of all services available to men in the ACT. The committee strongly recommends that the Department of Health and Community Care assist this group, particularly with the mapping exercise.

4.18. Given the difficulty the committee had in identifying men's health services, it believes that details of services available to men in the ACT should be published and distributed to health care workers (such as general practitioners, psychologists, counsellors and community health workers) and other relevant organisations where men may seek help.

Recommendation 2

4.19. The committee recommends that the Government assist the Belconnen Community Service/men's health service providers working group in collating and disseminating the details of all services available to men in the ACT

A gendered approach to health

4.20. The committee was cautioned about creating a competitive environment between the sexes.⁴⁹

4.21. The Women's Centre for Health Matters suggested that such competition could be avoided by an approach to gendered health which does not revolve around data based on sex difference alone. The centre noted that gender specific is different from gendered health.⁵⁰

4.22. The centre advised that a philosophical discussion looking at gendered sensitivity as well as comprehensive data, including the current social, political and economic context has the potential to advance the effectiveness of health care services for both men and women. The Centre noted that this discussion must go beyond the natural tendency to see it just as an issue of equivalence and acknowledge that the wider context provides a more universal approach to the health agenda and is therefore best for both men and women.⁵¹

4.23. The committee understands that gender specific health focuses on one gender to the exclusion of the other without consideration for the social and cultural aspects of gender. This approach can lead to the notion of one service for women and a parallel service for men. Thus, if there is a breast screening program for women then there should be a prostate screening program for men. If health centres are established for

⁴⁹ For example: submissions 14, 16, 17 and 23; and transcript (Mr Lawton and Ms Polites), 10 February 1999, pp 59 and 84

⁵⁰ Transcript (Ms Polites), 10 February 1999, p 84

⁵¹ *ibid*

women then health centres should be established for men. A gender specific approach does not take into consideration issues such as how men and women access health services, what services are needed, whether those services will be used or whether the program/service is effective. This approach can lead to a competitive environment between the sexes.

4.24. On the other hand a gendered health approach does take into account the social aspects of gender. An example of this approach could be heart disease where the physical aspects like blood pressure, cholesterol and other lifestyle factors are considered as well as the way men have been socialised to behave and the cultural practices of masculinity. This approach takes into account the ideas that men have about themselves and the ideas society has about what it means to be a man – “men don't ask for help”, ‘men should be in control”, “men don't admit to being sick or feeling weak”.

4.25. A gendered health approach does not stereotype men and women. Rather it has a less rigid view of what gender means, providing a more fluid environment in which to be a man or woman. It does not presume that because of a person's sex other things follow as a matter of course.

4.26. The Department of Health and Community Care supported a gendered approach, advising the committee that it is easy to get bogged down in the specifics of particular men's health conditions and the impact on individual men. While this is important, health policy should better conceptualise men. One way of doing this is to look at health in the way it impacts on men and women, as well as the social experience and the social determinants of health outcomes.

4.27. The department pointed to cancer as an example where a gendered approach might look at the fact that skin cancer is more predominantly a men's ailment. Often it is men who work outside without sun protection.⁵²

4.28. The department further advised that there are a range of other variables such as socio-economic status, age, indigenous status, and ability or disability, which impact on gender. It is not a matter of taking either the gendered approach or these other variables, but often looking at the interactions between them. One example is indigenous health where the overall rates for life expectancy are worse for men than for women, as it is in the general population, but for all indigenous people life expectancy is worse than for the general population.⁵³

⁵² Transcript (Mr Rosenberg), 9 February 1999, pp 1 and 2

⁵³ Transcript (Mr Rosenberg), 9 February 1999, p 2

4.29. The committee notes that the ACT Government prefers a framework which is partly based on a NSW Health Department model.⁵⁴ The model divides men's health into four streams:

- (i) biological, where conditions which are essentially men's or women's are addressed (such as prostate or testicular cancers)
- (ii) particular diseases or risk factors where men have high rates of morbidity (such as HIV/AIDS and excessive drug and alcohol use in certain age groups)
- (iii) social practices which affect men's behaviour and health (viz, violence and sexual assault)
- (iv) conditions such as asthma which are not seemingly gender related, but men and women may need different treatment options because of their different socialisation and experiences (for example the way men and women play sport).⁵⁵

4.30. With regard to this evidence, the committee supports a policy framework using the gendered health approach where the needs of men and women in particular circumstances are taken into account.

4.31. The committee's view is that gendered health theory takes a considered approach to the provision of health services. Rather than simply being even handed (which is the gender specific approach), the gendered health approach flows from a careful assessment of the prevailing social, political and economic circumstances.

4.32. In developing a policy framework a number of other pertinent issues were raised in submissions and evidence. In particular, the Service Against Male Sexual Assault made a number of comments about the need to address several issues in any attempt to achieve best practice in men's health care. These issues include:

- working cooperatively with and accountably to women's health services;
- employing a community development model that seeks input directly from men into the planning, development and evaluation of the service delivery model;
- responding in a timely manner to emerging men's health needs with innovative and creative service models and programs;
- adopting an holistic view of health service provision that acknowledges that individual health needs impact on men's entire health and wellbeing and cannot be viewed or addressed in isolation, and that men's health needs exist in a context of family and other social relationships, socio-

⁵⁴ NSW Health Department, *Strategic Directions in Men's Health - A Discussion Paper*, NSW Health Department, Sydney, August 1998, p 10

⁵⁵ Transcript (Mr Rosenberg), 9 February 1999, p 2

economic status, cultural and linguistic communities and economic climate.⁵⁶

Recommendation 3

4.33. The committee recommends that the Government develop a policy framework which takes account of a gendered approach to health and considers the needs of men and women in particular circumstances.

Budgetary factors

4.34. Other men's health issues need to be addressed including the roles of government and the general community as to the extent to which government should fund community activities. The Department of Health and Community Care noted that this work needs to be on two levels. The first involves interventions, for example, getting men to visit doctors. The second would involve a strategy on a broader level, that is, a framework for mapping the needs that are not met properly and looking at planning for future needs.⁵⁷

4.35. In considering support for a specific framework for men's health, the committee has taken into account budgetary constraints and the need to avoid competition between men and women for the health dollar.

4.36. The committee considers there is much to be gained by services working collaboratively to avoid duplication and achieve economies of scale. As an example, the committee notes the successful collaboration between the Service Against Male Sexual Assault (SAMSA) and the Canberra Rape Crisis Centre.

4.37. The committee is also aware that there is a willingness to work together within the community sector. The Women's Centre for Health Matters advised that it would be happy to have a male staff member in the community development area or maybe two or three hours a week on the information line and advertise that service.⁵⁸

4.38. The Murringu Men's Centre suggested that a solid working partnership between key stakeholders in the ACT health services and the men's sector needs to be established, and become standard practice with ongoing support for any strategic planning to address men's and boys' needs in the ACT.⁵⁹

4.39. The committee considers that there is a need for a facilitator to encourage partnerships and collaboration in the community sector. It appears appropriate for the

⁵⁶ SAMSA submission 23, pp 4-4

⁵⁷ Transcript (Mr Rosenberg), 9 February 1999, p 4

⁵⁸ Transcript (Ms Polites), 10 February 1999, p 85

⁵⁹ Transcript (Mr Aldridge), 9 February 1999, p 42

Government to take on this role by allocating an appropriate level of resources and by encouraging collaboration and partnerships through contracting arrangements.

Specific health services

4.40. The committee found diversity of opinion as to whether specific health services need to be established for men and boys.

4.41. One view is that most of the health services in the ACT are open and accessible to men, the issue is not whether they discriminate against men but how to get men to access health services when they are in need.⁶⁰ At the practising medical level there was no support for a stand-alone men's health practice. The view was put that the benefits of men accessing the existing health system should be emphasised and men should be encouraged to access existing medical services in a more timely and appropriate manner.⁶¹

4.42. Another view is that existing health services do not adequately address the needs of men and that men's under-utilisation of mainstream health and community services would appear to support this.⁶² This view was echoed by groups working closely with homeless, needy or lonely men. One group advised the committee that a separate facility would provide a starting point for men to deal with the significant issues of health⁶³, another noted that most health workers are women and this raises a cultural barrier for some men, especially elderly men from non-English speaking backgrounds.⁶⁴

4.43. Others supported the establishment of health services for target groups such as men from diverse cultural and linguistic backgrounds, indigenous men, gay and bisexual men, men on low incomes and young men.⁶⁵ The comment was made that most health and support services should be available for men through mainstream services. However, a view was put that 'the health needs of many men could be met through better targeting of existing resources, needs-based planning, and consideration of the different accessibility issues for men'.⁶⁶

4.44. The committee notes an offer by Calvary Hospital to establish a comprehensive and integrated men's health service which would be accessible out of normal hours and which would target lifestyle risk factors associated with the leading causes of

⁶⁰ Transcript (Mr Lawton), 10 February 1999, p 59 and submissions 3,13,17,23

⁶¹ Transcript (Dr Richards), 9 February 1999, p 52

⁶² Transcript (Ms Purtell), 9 February 1999, p 26

⁶³ Transcript (Mr Cockayne), 9 February 1999, pp 33 and 35

⁶⁴ Ainslie Village, Centacare, *Submission*, p 3

⁶⁵ *Submissions* 16 and 23.

⁶⁶ Service Against Male Sexual Assault, *Submission*

death in men. It would be planned and evaluated using a consumer participation model.⁶⁷

4.45. While the committee acknowledges the concerns expressed above by those who advocate the establishment of health services which are specific to men's medical needs, on balance it is not persuaded that a dedicated men's health service would be in the social and economic interests of the ACT, nor that it would necessarily be beneficial to men.

4.46. The committee considers the existing medical services infrastructure is capable of meeting most community needs. However, there is room for ensuring that medical services are more effective in addressing the needs of men in particular. Accordingly, the committee supports:

- (i) where necessary, training and refresher training of all health workers on the specific health issues relevant to men and boys;
- (ii) a review of health care services provided by the Department of Health and Community Care, The Canberra Hospital and the Calvary Public Hospital to ensure that they are male friendly;
- (iii) the Department of Health and Community Care developing a policy framework which takes account of a gendered approach to health and considers the needs of men and women in particular circumstances; and
- (iv) a community health awareness program to encourage men in particular to access health services on a more timely basis.

Recommendation 4

4.47. The committee recommends that the Government ensure that health care services provided by the Department of Health and Community Care, The Canberra Hospital and the Calvary Hospital are sensitive to the specific health care needs of men and boys and that health workers receive appropriate training.

Focused health services

4.48. General medical practitioners are the first points of contact for most people seeking health services. An ongoing relationship with a general practitioner provides continuity of care and a coordination point for other services which may be required.

4.49. The committee was advised that men who suffer substance abuse, that is, alcohol and drug abuse, are less likely to seek medical assistance than are women who are similarly afflicted. The point was made that with men's

⁶⁷ Calvary Hospital, *Submission*, p 4

health, the tendency is to say that there is some failing in the men, but the adequacy of medical services needs to be examined.⁶⁸

4.50. In an effort to address this situation the committee was advised that some general practitioners are employing male receptionists, extending their operating hours to late evening and opening on Saturdays and Sundays.⁶⁹

4.51. Concern was expressed to the committee about the relationship of general practitioners to their male gay patients with one witness commenting that, 'a lot of [gay] men who go to their GP in the suburbs and try to raise [gay] issues get a very negative response'.⁷⁰

4.52. The committee acknowledges the view that men have traditionally been socialised to be self-reliant and that health providers need to understand ingrained male attitudes and match their services to accommodate them. In other words, health providers need to be aware of such social attitudes, particularly with older men, and develop means of engaging them.

4.53. The committee understands that the ACT Division for General Practice runs a program called Continuing Medical Education (CME) for medical practitioners and sees value in the local Division including men's and boys' health in its CME program if possible.

4.54. The committee also considers that there needs to be recognition of those cultural differences within the community which may act to deter men from accessing medical services, and that strategies should be developed by the Department of Health and Community Care to address perceived problems in this area.

Recommendation 5

4.55. The committee recommends that the Government:

(i) explore means of encouraging the ACT Division for General Practice to include men's and boys' health and wellbeing in its Continuing Medical Education program; and

(ii) develop a community awareness program to encourage men to access health services on a timely basis and that the program recognises the cultural imperatives within the community which may act to deter men from accessing health services.

⁶⁸ Transcript (Professor Jorm), 10 February 1999, p 91

⁶⁹ Transcript (Dr Richards), 9 February 1999, pp 49 and 52

⁷⁰ Transcript (Mr Lawton), 10 February 1999, p 65

Education and personal responsibility

4.56. The Victorian Men's Awareness Network (MAN) model utilises a partnership approach between men, general practitioners and other health workers. It aims to empower men to take responsibility for their health as well as assisting health workers to more effectively relate to men.

4.57. The committee examined the work of the network in provincial Victoria and was very impressed with its program and the results it has achieved.

4.58. It is clear that the network has been very successful in raising the level of interest by men in their health.

4.59. This outcome was ensured by the high degree of energy driving the program, the cooperation with available medical services and, importantly, the effective techniques employed to gain the attendance of men.

4.60. The committee found the MAN model to be an excellent example of a community development emphasising sustainability and capacity building so that skills for men's health development are spread broadly throughout the health profession and relevant community agencies. The model is simple, cost-effective and is able to draw large numbers of men to health nights and information sessions.

4.61. The results of the evaluation of the model appear quite promising. The *GP - Client Relationship: Men in the Country Interim Report* notes that:

once men have been to a health night and begun to understand that they may still be at risk, despite being careful with lifestyle choices, they are much more keen to have a medical check up. More than 80 per cent of men to date who have participated in the surveys have indicated they would be more likely to visit their doctor in future.⁷¹

4.62. The committee considers the MAN model could be used effectively in the ACT. To do so would require a partnership between the Department of Health and Community Care and the ACT Division of General Practitioners. The committee considers that as with all MAN model programs it would need to be evaluated.

4.63. The committee discussed the introduction of the MAN model in the ACT with the Minister for Health and Community Care and is pleased that he endorsed the model. The committee welcomes the 1999/2000 budget allocation to establish programs using the model and is pleased to report that the Minister was receptive to the committee's views. The committee understands that the ACT Division of General

⁷¹ Bernard Denner and Dr Michelle Gibson, *The GP - Client Relationship: Men in the Country*, Interim Report, Centre of Research for the Advancement of Rural Health, La Trobe University, Bendigo, December 1998, p 7

Practice is in the process of negotiating with Mr Bernard Denner, developer of the model, to implement the model in the ACT.

Health promotion

4.64. The World Health Organisation defines health promotion as:

the process of enabling individuals and communities to increase control of the determinants of health and thereby improve their health. It ... represent[s] the need for change in both the ways and conditions of living in order to promote health. [It is] a mediating strategy between people and their environments, combining personal choice with social responsibility for health to create a healthier future.⁷²

4.65. Health can be promoted through media campaigns, the mobile immunisation service, various awareness weeks, grants and sponsorships under Healthpact to organisations such as the ACT Cancer Society or to sports, arts, cultural or recreational organisations, Active Australia, Health Promoting Schools, the Health Awareness Program run by the ACT Fire Brigade, posters, pamphlets and workplace health promotion programs.

4.66. The committee was advised that the ACT Division of the National Heart Foundation accesses men through sports and arts groups that receive funding from Healthpact. These groups are required to promote a Heart Health message such as “Be ACTIVE for Life”, “Eat More Fruit’n’Veg”, “SmokeFree” and “Be Your Best”. The aim is to change lifestyles which increase the risk of cardiovascular disease. The groups which promote these messages include ACT Bowls, Dance Sport Championships, ACT Orienteering, ACT Australian Football League and the Royal Canberra Show.⁷³

4.67. The committee noted a number of health promotion ideas, including:

- (i) a campaign to warn the community, particularly young men, about the dangers of intravenous drug use;⁷⁴
- (ii) health promotion and education programs (including screening) to improve men’s health to reduce the risk factors associated with the leading causes of death for men;⁷⁵
- (iii) a campaign about the health needs of older men;⁷⁶

⁷² Healthpact Strategic Plan 1996-97 to 1998-99

⁷³ ACT Division of the National Heart Foundation, *Submission*

⁷⁴ Assisting Drug Dependents Inc, *Submission*

⁷⁵ Calvary Hospital, *Submission*, p 1

⁷⁶ Council of the Ageing (ACT), *Submission*, p 7

- (iv) health messages communicating that it is not a sign of weakness to use health services;⁷⁷
- (v) workplace health promotion programs;⁷⁸
- (vi) information channels accessible by men, including workplaces, pubs and clubs, sporting amenities and TV networks;⁷⁹
- (vii) fathers and sons health information nights, advertised primarily through schools;⁸⁰
- (viii) special in-schools projects to help boys develop positive identities linked to early intervention campaigns about alcohol and drug use, smoking, diet and exercise, emotional wellbeing, dealing with conflict, and sex and relationships.⁸¹

4.68. The committee is aware that Healthpact provides financial support for Men Mentoring Men and notes that this support has resulted in increased community awareness of the need to address young men's health issues.⁸²

4.69. The committee considers health promotion to be an efficient and cost effective tool in raising health awareness and improving the health and wellbeing of the community.

Recommendation 6

4.70. The committee recommends that the Government review its existing health promotion programs to ensure that they include a focus on men's and boys' health.

Workplace health

4.71. The committee was urged to recommend that an audit of workplace health promotion programs be undertaken and comprehensive programs be introduced into the workplace.⁸³

4.72. With this in mind, the committee visited a workplace men's health promotion program at the Works Depot of the Ballarat City Council. All staff involved in the project felt that the program had raised awareness of health issues, had increased morale and that the men were taking more responsibility for their health.

⁷⁷ ACT Division of General Practice, *Submission*, p 3

⁷⁸ *ibid*

⁷⁹ Transcript (Mr Aldridge), 9 February 1999, p 42

⁸⁰ *ibid*

⁸¹ *ibid*

⁸² Healthpact Annual Report 1997/98, p 12

⁸³ ACT Division of General Practice, *Submission*, p 3

4.73. The committee noted that the NSW Health Department's *Strategic Directions in Men's Health Discussion Paper* recognises the value of workplace health promotion programs. The discussion paper noted that the [NSW] Department will:

- promote existing examples of good practice in workplace health and safety programs that include healthy lifestyles, such as the Alcoa workplace program;
- continue to develop and promote partnerships and projects with private industry, unions, sport and recreation clubs and relevant Government departments to improve men's health in key areas such as use of drugs and alcohol, injury and nutrition; [and]
- promote and develop culturally appropriate health screenings and health promotion campaigns to be delivered in sites men most access, such as workplaces.⁸⁴

4.74. The committee considers that workplace health promotion programs could be a useful tool in improving the health and wellbeing of men.

4.75. The committee notes that the NSW Health Department held a men's health week in the lead up to Fathers Day in 1998. The committee considers this to be an excellent means of raising community awareness of men's and boys' health issues and the services that are available.

Recommendation 7

4.76. The committee recommends that the Government:

(i) implement workplace health promotion programs in the ACT Government Service and encourage the private sector to introduce similar programs; and

(ii) initiate a men's health week in the lead up to Fathers Day to promote men's and boys' health issues and the services that are available.

Prostate cancer

4.77. It has become apparent to the committee that issues relating to women's health focus heavily on female medical issues such as breast cancer.

4.78. In contrast, much of the committee's attention has been drawn to the societal and behavioural factors behind men's health.

4.79. Testicular and prostate cancers, however, are purely male related. In deliberating on the issue of prostate cancer and noting all the debate around the subject, the committee points out that benign enlarged prostate (Benign Prostatic Hyperplasia : BPH) is much more the common health problem for men. Most men

⁸⁴ NSW Health Department, *Strategic Directions in Men's Health op cit*, p35

who suffer from BPH will not develop prostate cancer though they may have anxieties about it. BPH is relatively simple to treat. This part of the report focuses on prostate cancer, although the committee acknowledges that men need to be informed about other likely prostate problems.

4.80. The Australian Health Technology Advisory Committee (AHTAC), a standing committee of the National Health and Medical Research Council, has effectively established the national policy on the contentious subject of screening for prostate cancer. Its report has been endorsed by the Federal Minister for Health and Aged Care.⁸⁵

4.81. In its report, AHTAC claims the following factors are important in considering the health significance of prostate cancer:

- prostate cancer is an important health problem;
- prostate cancer is the most common male cancer in Australia and the second most common cause of cancer death among Australian men;
- the disease has low virulence, which means that the majority of individuals who have prostate cancer will die with the disease rather than of it;
- the incidence of prostate cancer increases with age - it is rare in men under the age of 50;
- the reported incidence of prostate cancer in Australia is rapidly rising but mortality rates do not reflect this trend; and
- a major reason for this rise in reported incidence is thought to be more intensive medical surveillance following the introduction of prostate specific antigen (PSA) testing.⁸⁶

4.82. Evidence to the committee has disputed the claim that the disease has low virulence.⁸⁷

4.83. The AHTAC report itself reveals this difficulty. It makes an apparently contradictory statement: 'The impact of prostate cancer on health varies. In some cases, the cancer may spread rapidly resulting in premature death'.⁸⁸

4.84. About as many men die of prostate cancer in a year as women die of breast cancer⁸⁹. However, the committee notes Australian Institute of Health and Welfare

⁸⁵ Commonwealth Department of Health and Family Services, AHTAC (1996) 'Prostate Cancer Screening' foreword

⁸⁶ *ibid*, p 15

⁸⁷ Transcript, (Dr Hughes), 24 April 1999. p 2.

⁸⁸ *ibid*, p 5

figures showing that female breast cancer mortality rates are substantial in the younger age groups, this is not the case with prostate cancer. This translates to a much higher number of 'potential years of life lost' for breast cancer than for prostate cancer.⁹⁰

4.85. However, the incidence of prostate cancer related mortality in younger men is not insignificant and the committee considers that there is a strong argument that some measure of screening for early identification is necessary.

4.86. The committee's deliberations on this issue were guided by the evidence from members of the very informed and articulate ACT Prostate Cancer Support Group. The committee heard evidence from members of the group indicating that if some form of screening had been in place, life might have been prolonged for sufferers. When the committee talked to men in this situation it was difficult to accept the notion that a national screening program is not justified.

4.87. The group noted that, 'When men in the 45 - 60 age group develop prostate cancer it tends to be an aggressive form, with 75% of those dying of their cancer. Therefore early detection is essential'.⁹¹

4.88. Dr P.D Hughes, a Canberra urologist, provided emphatic evidence in his submission to the committee. Disputing the AHTAC claim of low virulence he stated that, 'my experience is that carcinoma of the prostate is not of low virulence'.⁹²

4.89. Expanding on his views in a public hearing, Dr Hughes noted that during his 40 years as a urologist he had been watching men in their prime under the age of 65 dying from cancer of the prostate.⁹³

4.90. He further cited a comprehensive 1997 Swedish study, noting that, 'the massive effort involved in conducting this study over 23 years revealed that when a man is diagnosed with carcinomas of the prostate under the age of 70 years, the risk of dying from cancer of the prostate is 66%, and if diagnosed before the age of 60 years the risk of dying from carcinoma of the prostate is 80%'.⁹⁴

4.91. Dr Hughes emphasised the fact, conceded by AHTAC but not acted upon, that prostate cancer is slowly progressive in some cases but is rapidly progressive in others.⁹⁵

4.92. To conduct a sound public health policy, particularly for men, the committee asserts that this fact has to be recognised and appropriate policies implemented.

⁸⁹ Australian Institute of Health and Welfare, Mortality Database 1986 –1997, mortality data on Malignant Neoplasm of Female Breast and Malignant Neoplasm of Prostate.

⁹⁰ *ibid*

⁹¹ Transcript, in-camera evidence, 25 February 1999, p 11

⁹² Dr Hughes, *submission*, p 2

⁹³ *ibid*

⁹⁴ Gronberg et al (1997) volume 49, pages 374-378 cited in Dr Hughes *op. cit.* p 2

⁹⁵ *ibid*

4.93. The established AHTAC policy is now being reviewed by the Medical Services Advisory Committee's supporting committee on prostate cancer screening. At the time of writing its report had not been released.

4.94. The Assembly committee argues that screening is necessary. A number of tests are available as a means of assessing the likelihood of prostate cancer. The Prostate Specific Antigen (PSA) test and digital rectal examination (DRE) are generally used for initial testing.

4.95. Dr Hughes pointed out that, 'the advent of the ... PSA was a huge breakthrough and following that we have seen patients diagnosed early because the raised PSA has drawn attention to the probability of cancer in the prostate'.⁹⁶

4.96. Although an elevated PSA test is not a specific indication of the presence of cancer cells⁹⁷ and an elevated PSA does not necessarily mean cancer, the test appears to be a reasonable precautionary screening measure.

4.97. While there has been a good deal of publicity given to prostate problems, it does not follow that men will of their own initiative act in good time to protect their health. Indeed, the often-cited factor of men generally being less willing to seek medical help is a factor in failing to check their condition. This inclination is exacerbated by the very personal nature of the necessary medical examination and general practitioners too don't always indicate the importance, even the urgency of attention.

4.98. A member of the Prostate Cancer Support Group graphically illustrated the problem:

So we had the blood test and ...[the doctor] called me in the following week and said, "Oh, look, it's raised, ... - your reading is 13." He told me what my reading was at the time, but he did not tell me what it should be. It should have been 3.4 or thereabouts. And he said, "Well, don't worry too much. I'll give you a referral to a urologist." Now, I carried that referral to the urologist around in my diary for nine months because I was too busy to do anything about it. What I feel he should have said is, "Look, I think you should see the urologist. I'll make the appointment for you now", knowing the way men are.⁹⁸

4.99. The witness acknowledged that he should have been proactive, but it is obviously difficult to be proactive if a person does not have all the appropriate information to make effective choices.⁹⁹

⁹⁶ Transcript, (Dr Hughes) 24 April 1999, p 2

⁹⁷ AHTAC op. cit. p 33

⁹⁸ Transcript, in-camera evidence, 25 February 1999, p 2.

⁹⁹ *ibid*

4.100. Screening, by use of the PSA, is now widespread, but a program needs to be officially established and promoted. With an official federal government endorsed policy against screening, it is not surprising that there are GPs reluctant to promote this activity.

4.101. The Federal Department of Health has been conducting a campaign to general practitioners discouraging screening for prostate cancer. This has got to the stage where some general practitioners are refusing to carry out a prostate specific antigen (PSA) test when requested by a patient.¹⁰⁰

4.102. Reflecting the experience of some members of the Prostate Cancer Support Group, one witness noted, 'that is very typical of the experience of men who have had prostate cancer in the support group. Although in that case the doctor did end up supporting it, a number of our members have in fact requested PSAs, and have been talked out of it by their GPs. The GP has not been supportive of it, and they actually had to persist.'¹⁰¹

4.103. Though men are using the PSA test in increasing numbers, to the extent that it has been claimed that a defacto screening program is in place¹⁰², the committee is emphatic that in the ACT men should have access to a comprehensive screening program as soon as possible.

4.104. The committee is optimistic that the review of national policy by the Medical Services Advisory Committee will result in a recommendation which will enable the Federal Government to introduce such a program, which is clearly a national responsibility.

Recommendation 8

4.105. The committee recommends that the ACT Government endorse the need for a national prostate screening program.

Recommendation 9

4.106. The committee recommends that the Minister for Health and Community Care urgently requests that the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference undertake a prostate cancer screening program.

Recommendation 10

4.107. The committee recommends that the ACT undertakes an energetic and comprehensive promotional campaign to alert GPs and men and women to the

¹⁰⁰ Dr Hughes, *submission* 30, p 4

¹⁰¹ Transcript, in-camera evidence, 25 February 1999, p 6

¹⁰² David P Smith and Bruce K Armstrong (1998) 'Prostate-specific antigen testing in Australia and association with prostate cancer incidence in New South Wales' in *Medical Journal of Australia* vol 169, p 17

need for yearly prostate cancer screening for men aged 50-70 and for men with a family history of prostate cancer.

Education

4.108. Such a promotional campaign as mentioned above is itself an important part of an education program. It is important that men should be well informed about likely prostate problems, for example, about symptoms and that an enlarged prostate or even an elevated PSA does not mean cancer. If men are to be widely screened it is essential that as they are there is clear and specific information provided to them.

4.109. The committee is aware that the Department of Health and Community Care conducts information nights about prostate problems. While the information and presentation are excellent, it appears that the lack of resources to publicise the program has resulted in a relatively small number of men attending.

Recommendation 11

4.110. The committee recommends that the Department of Health and Community Care allocate increased resources to information programs to men and women about prostate problems.

Support

4.111. The committee has been very impressed by the quality of evidence from the Prostate Cancer Support Group. The group developed as its members sought more information about their condition after diagnosis of prostate cancer. Indeed the group provides much more than support, offering the benefits derived from their own experiences and their extensive research. In an in-camera hearing, members of the group expressed views that the medical profession was inclined rather perfunctorily to recommend options that required acceptance of the condition, perhaps including radical prostatectomy, but did not consider a wider range of treatment options. The committee heard that members had of their own initiative sought and received beneficial advice from medical oncologists and one was participating in research programs which he believed had prolonged his life.¹⁰³

4.112. The committee is aware that attention to research in Australia about prostate cancer is growing and acknowledges that men in the prime of their life will want to explore every option. The committee makes no recommendations in this regard but points out that it is essential for men with prostate cancer to be fully informed by the medical profession of all treatment options and the progress made by research.

¹⁰³ *ibid* p, 9-10

Sleep Apnoea

4.113. The committee was advised that anywhere from 4 to 15 percent of Australians are affected by sleep apnoea and up to 6,000 people each year die from it or related conditions and that men are affected to a greater degree than women.¹⁰⁴

4.114. Sleep apnoea sufferers may experience daytime sleepiness, restless sleep, morning headaches, memory lapses, irritability, slight disorientation, personality changes, impotence, obesity and incontinence.¹⁰⁵ The committee was made aware of Government concern that sleep apnoea related to overweight and obesity can lead to socialisation problems and a sense of alienation, that it impairs work performance, and is a major factor in some road accidents.¹⁰⁶

4.115. Those suffering from the condition require a nasal Continuous Positive Airway Pressure (nCPAP) machine and approximately 50 percent also require a humidifier. However, the machines are costly and beyond the financial reach of many sufferers.¹⁰⁷

4.116. The committee was advised that most, if not all, states have either introduced, or have approved in principle, a means tested program for providing the machines.¹⁰⁸

Recommendation 12

4.117. The committee recommends that the Government investigate the demand for nCPAP machines in the ACT, assess the extent to which sleep apnoea sufferers are prevented, by financial constraints, from acquiring or accessing the machines and develop a policy to facilitate acquisition or access for those who are unable to afford the costs involved.

Supported accommodation

4.118. A number of organisations expressed concern about the shortage of supported accommodation for men in crisis or long-term care, especially for those recovering from alcoholism or drug addiction.¹⁰⁹ The committee is concerned by the reported large unmet need in this area.

4.119. The committee noted that Samaritan House, run by the St Vincent De Paul Society, offers short-term crisis accommodation and assistance for up to 12 men over the age of 18. The majority of those seeking accommodation at Samaritan House have problems with drug and/or alcohol addiction, mental illness, gambling, domestic

¹⁰⁴ Sleep Apnoea Association, *Submission*

¹⁰⁵ *ibid*

¹⁰⁶ ACT Government, *Submission*, p 15

¹⁰⁷ Sleep Apnoea Association, *submission*

¹⁰⁸ *ibid*

¹⁰⁹ For example submissions 4, 5, 27 and 29

violence or are itinerants. Staff provide counselling to help these men identify and resolve their needs.¹¹⁰

4.120. With regard to alcohol and drug detoxification, the committee was advised that clients usually wait one week to be placed in a detoxification facility and three to four weeks to be placed in rehabilitation accommodation. The committee was informed that in the absence of continuing accommodation clients usually move to where the drug influence is heavy.¹¹¹

4.121. The committee was advised that ACT Housing provides short-term accommodation in places such as Burnie Court but prospective tenants cannot access government housing if they have a previous debt. As a result, some men have difficulty in finding long-term accommodation and this exacerbates the strains on short-term relief accommodation such as Samaritan House.¹¹²

4.122. The committee notes that the Alcohol and Drug Foundation (ADFACT) runs two halfway houses for men with alcohol or drug addiction but was advised that the program turns away a significant number of clients because of a lack of bed space. Further, ADFACT is unable to include men on methadone or benzodiazepine reduction.¹¹³

4.123. The committee is concerned about the shortage of supported accommodation for men with alcohol and drug addiction problems.

4.124. The committee is aware of the significant cost of providing the accommodation that is reported as being needed and expects that the Government will deal with the matter progressively as needs emerge.

Recommendation 13

4.125. The committee recommends that the Government:

(i) assess the further need, if any, to ensure adequate accommodation support for men in need of alcohol and drug detoxification and rehabilitation; and

(ii) examine measures whereby ACT Housing can reduce the incidence of debt and measures for utilising direct debit facilities.

¹¹⁰ Discussions between the committee and staff at Samaritan House on 3 February 1999

¹¹¹ *ibid*

¹¹² *ibid*

¹¹³ Alcohol and Drug Foundation, *Submission*, p 2

Boys

4.126. The committee was disappointed that it did not receive more submissions concerning boys' health and wellbeing and is concerned that there may be insufficient advocacy on behalf of boys and young men in the Canberra community. As a result, the committee did not explore the issue in-depth, which would in any case require a separate study.

Other issues

4.127. The Government's submission noted that the following issues warrant further attention: domestic violence in gay relationships; liaison between the Gilmore Sexual Health Centre and Aboriginal Health Services concerning sexual health; support services (including psycho-social) for men with cancer; men's high incidence of solar skin damage and skin cancer as a result of occupational exposure; sleep apnoea related to overweight and obesity; depression and suicide in elderly men; and support services for men with prostate cancer.

4.128. Ms Purtell from the YWCA commented that:

... there are ... very few services in the ACT for men who wish to address their violent behaviour and there are even fewer services run and designed by men for men in the area of domestic violence. This has far-reaching implications for us in our effort to achieve safety and a quality of life for the women and children with whom we work.¹¹⁴

4.129. The committee did not investigate these issues during this inquiry. However, the committee believes that the Government should examine these issues in detail.

Recommendation 14

4.130. The committee recommends that the Government consider the following issues raised during the course of the inquiry:

- (i) domestic violence in gay relationships;**
- (ii) liaison between the Gilmore Sexual Health Centre and Aboriginal Health Services concerning sexual health;**
- (iii) support services (including psycho-social) for men with cancer;**
- (iv) men's high incidence of solar skin damage and skin cancer as a result of occupational exposure;**
- (v) sleep apnoea related to overweight and obesity;**

¹¹⁴ Transcript (Ms Purtell), 9 February 1999, p 25

- (vi) depression and suicide in elderly men; and**
- (vii) support services for men with prostate cancer.**

Chair
Date

APPENDIX A: LIST OF SUBMISSIONS¹¹⁵

1. Professor Jorm, NH&MRC Psychiatric Epidemiology Research Centre, Australian National University.
2. Mrs Lorraine Turl.
3. Mr Bernard Denner, Project Manager, Centre for Advancement of Men's Health.
4. Mr Chris Jennar, Coordinator, Men's Halfway House Program, Alcohol and Drug Foundation, Australian Capital Territory Inc.
5. Mr Rollo Brett, Co-Ordinator, Samaritan House, Society of St Vincent De Paul.
6. Mr Jim Purcell, Executive Director, Council on the Ageing (ACT) Inc.
7. Mr Jack Zinn, Project Manager, Council on the Ageing (NSW) Inc.
8. Ms Gillian Phillpot, Cancer Information and Support Team Leader, ACT Cancer Society Inc.
9. Mr Denis Hardiman.
10. Ms Liz Gaukroger, Healthpact Sponsorship Co-ordinator/Health Promotion Officer, National Heart Foundation, ACT Division.
11. Mr Neil Dewhurst, Honorary Secretary, Sleep Apnoea Association Inc (ACT).
12. Ms Julia Nesbitt, Acting Executive Director, YMCA of Canberra.
13. Dr Brian Richards, Executive Director, ACT Division of General Practice Inc.
14. Ms Libby Bell, Co-Ordinator, Women's Centre for Health Matters Inc.
15. Ms Gail Aiken, Manager, TenFit.
16. Mr Stephen Lawton, Senior Education Officer, AIDS Action Council of the ACT Inc.
17. Mr Stephen Lawton.
18. Mr John Franklin, Murringju Men's Centre.
19. Ms Maureen Cane, Executive Director, Assisting Drug Dependents Inc.
20. Mr Jon Postill, Group Leader, ACT Prostate Cancer Support Group.

¹¹⁵ Listed by the date of receipt within the Committee Office

21. Mr Anthony Farr.
22. ACT Government.
23. Mr Tim Bavinton, Coordinator, Service Against Male Survivors of Sexual Assault (SAMSA).
24. Belconnen Community Service Inc.
25. Mr Gerry Orkin.
26. Dr Robert Griffin, Director Medical Services, Calvary Hospital.
27. Ms Cheryl Oostermeyer, Senior Case Manager, Ainslie Village, Centacare.
28. Mr Andrew Champion, Sails Program, Centacare.
29. The Rt Revd Richard Randerson, Chair, Anglicare.
30. Mr Stephen Lawton.
31. Dr Peter Hughes

APPENDIX B: PUBLIC HEARINGS - LIST OF WITNESSES

Tuesday, 9 February 1999

Department of Health and Community Care

Mr Simon Rosenberg, Manager, Health Strategy Development Unit

Mr Gerry Orkin

YWCA of Canberra

Ms Julia Nesbitt, Deputy Executive Director

Ms Sue Purtell, Director, Family Housing and Outreach Program

Ms Michelle Callan, Director, AXYSS and CYOSS Youth

Anglicare

Chaplain Ken Batterham

Canon Michael Cockayne

Murringu Canberra

Mr Peter Campbell, Vice President

Mr Greg Alderidge, Secretary

ACT Division of General Practice

Dr Brian Richards, Executive Director

Mr Anthony Farr

Wednesday, 10 February 1999

Mr Stephen Lawton

ACT Prostate Cancer Support Group

Mr John Postill, Group Leader

Belconnen Community Service

Ms Serena Scarlett, Community Worker and Co-ordinator "For Men Only"
Workshops

Ms Felicity White, Deputy Executive Director

Women's Centre for Health Matters

Ms Philia Polites, Manager

Professor Anthony Jorm

Wednesday, 24 April 1999

Dr Peter Hughes, Urologist

APPENDIX C: EXISTING COMMUNITY BASED MEN'S AND BOYS' HEALTH AND WELLBEING SERVICES IN THE ACT

4.131. The committee has been able to identify the following specific community based services for men in the ACT. However, it is not an exhaustive list, there might be services which the committee has not identified. A number of these services receive funding from the ACT and/or Federal governments.¹¹⁶

- Young Men's Support Network - provides advocacy, support, one-to-one counselling and outreach education programs to high schools and colleges. The focus is around issues of sexual assault, violence, self-injury and relationships. The network runs a young father's and young men's group.
- Murringu Men's Centre - men's support network which provides a support and advisory service enabling men to meet life's challenges. It offers drop-in advisory and information sessions and workshops.
- MensLine (Domestic Violence Crisis Service) - for men troubled by violent and/or abusive behaviours and their effect on themselves and those that they love.
- Service Against Male Sexual Assault - supports men recovering from sexual assault and childhood sexual abuse and assists men who seek to eradicate sexual violence against men, women and children. The service is aimed at men of all ages, backgrounds and lifestyles.
- Mancare Community (Salvation Army) - long term residential alcohol and other drug related rehabilitation program.
- Samaritan House (St Vincent De Paul Society) - offers short-term relief accommodation and assistance for men over the age of 18.
- Lone Fathers Association - ACT - self help group, lobbying for equal rights in all family law issues. Its membership is open to any person interested in their children regardless of custody status and women are also welcome as members. The association runs the Men's and Children's Crisis Accommodation Service and Men's Information and Referral Service.
- Health Services for Men - a men's clinic for sexual problems concerning impotency.
- Mary's Place (Residential and Proclaimed Place) - provides medium to long-term accommodation for men moving to a stable life-style following times of difficulty, such as jail, drug dependency, unemployment or family conflict. It also has a

¹¹⁶ The description of each service has been obtained from CONTACT which is produced by the Community Information and Referral Service of the ACT Inc

proclaimed place, overnight accommodation for men (by referral only if under the influence of alcohol or other drugs).

- ACT Cancer Society Prostate Cancer Support Group - provides practical and emotional support for men with prostate cancer through the Prostate Cancer Support Group and Hospital and Home Volunteers.
- Kaidesh (Emmaus Ministries) - seeks to provide a cross-denominational Christian short and medium term accommodation service for men.
- Gay Information and Counselling Service - telephone counselling, information and referral service for gay and bisexual men and men who have sex with men in the ACT region.
- Gay Youth (AAC) - support service for young gay people with monthly activities.
- George Lloyd House (Lasa Youth Centre) – long-term residential service for up to four males aged 16 to 20 years. Occupants must be enrolled in independent living skills program.
- Mature Age Gay Network - social and support group for mature aged gay and bisexual men.
- St Benedicts Home of Compassion - crisis accommodation for men over the age of 18, a night shelter providing short-term accommodation and meals.
- Halfway Houses for Men (ADFACT) - offers accommodation, counselling and support for men aged between 18 and 35 years old with alcohol problems.
- Haemophilia Foundation ACT Inc – self-help group providing support, education and counselling.
- Man to Man - telephone counselling, information and referral service for men who have sex with other men in the ACT region. It provides safe sex information.

4.132. The committee is also aware that various churches and religious groups run men's groups.

4.133. The committee understands that there are a large number of existing general services such as Relationships Australia which provide services targeted at men.