

Male health in Australia

A call for action...

Prepared by Associate Professor Gary Misan PhD, for and on behalf of The Australian Men's Health Forum. AMHF is the peak national forum promoting a social approach to male health and wellbeing.



January 2016

- Despite three decades of adverse statistics, male health policy or rather the lack of it, continues to fail the Australian male
- Research continues to demonstrate a disproportionate gender differential in death and illness for males in Australia
- The National Male Health Policy (NMHP) released in 2010 lacks endorsement, an action plan or adequate funding by the current Federal Government
- No Australian State or Territory Government has a specific, active male health policy
- Neither the Federal Government or any Australian State or Territory governments have administrative structures that cater specifically for the needs of men and boys. Conversely Offices for Women exist in every State and Territory and at the National level
- Males have a shorter life expectancy, higher rates of death from most non-gender specific causes across all age groups and a higher lifetime risk of many cancers and chronic conditions
- Standardised mortality rates indicate 23,000 excess male deaths per annum compared with women
- The leading causes of male deaths in Australia are ischaemic heart disease, cancers, respiratory system disease, prostate and lymph system disease, cerebrovascular disease, suicide and endocrine disorders, which together account for about 60% of male deaths
- Males account for 93% of all work-related fatalities
- Males account for three quarters of completed suicides nationally
- Those most at risk of premature death and illness include Indigenous males, males from rural and remote areas, those with blue collar backgrounds, males with mental illness, war veterans, gay, transgender and intersex people, males with disabilities, socially isolated and non-English speaking males
- Key risk factors include socioeconomic disadvantage, social isolation, smoking, high blood pressure, overweight and obesity, low levels of physical activity, high cholesterol, alcohol and substance abuse, poor diet, risky health behaviour and occupational exposure to hazards
- About half of males aged over 15 report health concerns, with the leading causes of years lost to disability being anxiety or depression, Type 2 diabetes, adult onset hearing loss, asthma and dementia
- Almost two thirds of males have big gaps in their health knowledge
- Mental illness over the life course affects just under half of the Australian male population; about 1 in 6 males reported experiencing a mental illness in the previous 12 months
- About one third of males report reproductive and sexual health issues
- Sexually transmitted diseases are still common, particularly amongst Aboriginal males
- Males experience 70% of work related injuries
- Government research funding for male health is about one quarter of that allocated for women's health



While the average life expectancy of Australian males is high by international standards, they still suffer from unacceptably high rates of preventable chronic diseases and account for a disproportionate burden of most non-sex specific diseases including mental illness, cardiovascular diseases and cancer. Males account for the majority of deaths from suicide and injury as well as from vehicle accidents and occupationally related causes of death and injury. Selected sub-groups of males fare worse than the 'average' male. Standardised mortality rates point to over 23,000 excess male deaths per year compared with women, most of which are from preventable causes. The watershed 2010 National Male Health Policy has languished with lack of funding and limited endorsement by the current Government means there are precious few policies at State or National level that specifically promote or address the health needs of men and boys. Policy, practice and funding, including for research, is urgently required if there is to be any improvement in the parlous state of male health in Australia in the 21st century.

The policy vacuum

In 1988 the Health For All Australians report noted that:

"Men in Australia die from nearly all non-sex-specific leading causes at much higher rates than do women ..." and that ... *"These differences in health status largely reflect the prevalence of preventable factors."*¹

It seems that despite three decades of statistics, male health policy or rather the lack of it, continues to fail the Australian male².

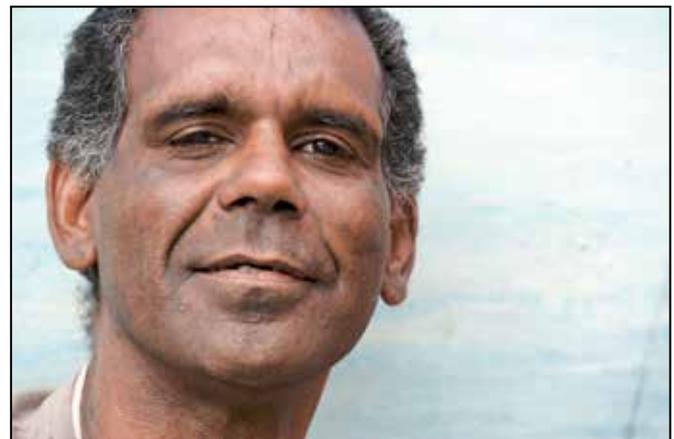
Moreover, five years after the release of the 2010 National Male Health Policy (NMHP), Australian males are bereft of administrative structures in any State that cater for their specific concerns. Conversely, an Office for Women or equivalent exists in every State and Territory as well as at the national level.

Although a watershed for male health at the time, the NMHP now languishes due to lack of endorsement, planning and funding by the current Federal Government. Moreover, at the time of writing, no Australian State or Territory Government has a specific active male health policy. These circumstances leave a clear, distinct policy vacuum at State and national level to address the health needs of men and boys.

Health determinants

Non-biological factors are fundamentally important determinants of male death and illness.^{3,4,5}

There is a complex interplay of factors including socioeconomic, cultural, ethnic, educational, environmental, occupational, psychological and social elements.



At the practical level, the most telling determinant of a man's health is where he is situated on the social gradient. Increased affluence is generally associated with better health outcomes.

Males from low-income households living in disadvantaged areas with lower educational attainment and employed in blue-collar jobs generally report the poorest health. They are more likely to report chronic disease, be overweight or obese, smoke and drink to excess, have a diet poor in fruit and vegetables, exhibit poor health behaviours and have lesser access to health services.²

Almost two thirds of males have deficiencies in health literacy, with males from poorer backgrounds generally demonstrating the lowest levels.^{6,7,8}



While changing the socio-economic circumstances of the most disadvantaged in the community is no easy task, many of the risk factors common to both fatal and non-fatal disease are preventable and susceptible to intervention. Smoking, high blood pressure, overweight and obesity, low levels of physical activity, high cholesterol, alcohol, poor diet, risky health behaviour, social isolation and occupational exposure to hazards, are all amenable to change.⁹ These are areas where concerted, male-oriented action is warranted.

The not so average male

Although the life expectancy for Australian males is high by international standards, there remain significant differences in life expectancy for different groups of males.

Australian males living in regional, rural and remote areas die on average about 3 – 4 years earlier than their urban cousins, primarily due to socio-economic disadvantage, lifestyle factors and lesser access to medical care.^{6,8,10}

Indigenous men have a life expectancy at least 11 years less than non-Indigenous men, mostly as a consequence of significant socio-economic disadvantage, drug and alcohol abuse, cultural dislocation and poor service access.¹¹

Other groups of males at high risk of premature death and early onset of chronic disease include those with mental illness, war veterans, gay, transgender and intersex people, socially isolated men, men from blue collar backgrounds and non-English speaking males.^{2,6} The NMHP advocates a social determinants approach and health equity for subgroups of males. However, apart from support for Men's Sheds, a few reports on the status of men's health and overdue funding for a longitudinal study of male health, its rhetoric is not matched by specific action or funding at National or State levels.

Excess death and ill health

Research consistently demonstrates a disproportionate sex differential in death and illness for males in Australia. Males have a shorter life expectancy, higher rates of death from most

non-sex specific causes across all age groups and a higher lifetime risk of many cancers and chronic conditions.^{8,12,13} Standardised mortality rates point to over 23,000 excess male deaths per year, most of which are from preventable causes.

The leading individual causes of Australian male death are ischaemic heart disease (IHD), cancer, respiratory system disease, prostate and lymph system disease, cerebrovascular disease, suicide, and endocrine disorders.⁸ These causes account for approximately 60% of all male deaths¹⁴ and point to potential priority areas for male health policy and planning.

In addition to deaths, about half of the male population over 15 years of age report health concerns. Reporting rates increase with age, corresponding with increasing incidence of chronic conditions as males age.¹⁵



The leading causes of years lost to disability (i.e. non-fatal disease burden) are anxiety or depression, Type 2 diabetes, adult onset hearing loss, asthma and dementia.¹⁰ The causes of these conditions are largely preventable and therefore amenable to targeted intervention.



The leading causes of years lost to disability (i.e. non-fatal disease burden) are anxiety or depression, Type 2 diabetes, adult onset hearing loss, asthma and dementia.¹⁰ The causes of these conditions are largely preventable and therefore amenable to targeted intervention.



Mental health

Poor psychological health is associated with increased risk of chronic disease,¹⁶ poorer lifestyle choices, higher rates of physical illness, lower education attainment, lower productivity and income, poorer personal relationships, social isolation and general reduced quality of life.^{16,17}

Men suffer a significant burden of mental illness, which over the life course affects just under half of the Australian male population; about 1 in 6 males report experiencing a mental illness in the previous 12 months.¹⁸ The most commonly reported disorders are anxiety and depression, substance use disorders and affective disorders.¹⁹ Males account for three quarters of completed suicides nationally which equates to about four suicides per day, a continuing and alarming statistic.

Males in rural and remote regions, particularly young men, are more likely to commit suicide than their urban counterparts^{20,21} and are less likely to have sought professional help prior to the act.^{22,23} This suggests that mental health disorders in males may be under-recognised, under-diagnosed and under-treated.²⁴ Accordingly mental health remains a key target for improvement with regard to men's health.



Social isolation

The male experience of social inclusion as well as social control and cohesiveness are also important determinants of social and emotional wellbeing, health and longevity. There are a number of studies demonstrating that the absence of meaningful social relationships poses health risks comparable to factors such as smoking, alcohol, high cholesterol, poor diet and lack of exercise.^{44,45,46,47} Links have been demonstrated between low social support and rates of depression and suicide. Older, retired, single (including separated and widowed men) and rural men are at particular risk. Screening for indicators of social isolation and strategies that promote socialisation for at-risk men (e.g. through service clubs, men's sheds) may be just as important a strategy for improving male health as are medical interventions.^{25,26,27,28,29,30,31}

Sexual & reproductive health

About one third of males report at least one sexual and reproductive health issue with erectile dysfunction, lower urinary tract symptoms and prostate disease being the most common.³² Prostate cancer is the fourth leading cause of death for males and the second leading cause of cancer, yet many men have limited awareness of the prostate, its function or the range of conditions affecting it.^{33,34,35} There is still much public (and clinician) confusion regarding the utility of screening, investigation and treatment of prostate cancer; significant research is still required.^{36,37}

Sexually transmitted diseases are still common and responsible for significant long-term morbidity and mortality, mostly in males and particularly Aboriginal males. Sexuality, demographic and socio-economic characteristics together with frequency of other risky behaviours are key contributors.^{8,38}

Possible strategies to address sexual and reproductive health issues include education directed at the general public and health professionals; opportunistic enquiry about reproductive health as part of a general health assessment, including with older men; and encouraging general practitioners to initiate discussions with older patients about sexual health.



Work health & safety

The most dangerous, deadly and health-diminishing work in Australia is overwhelmingly performed by men, so it is no surprise that males experience 70% of the burden of disease related to work related injury.³⁴ Although the incidence of work related fatalities has decreased by about 25% over the last decade or so, nationally about 15 serious workplace injuries occur every hour and at least one work-related death occurs every other day with males accounting for 93% of all work-related fatalities.³⁹ Clearly more needs to be done to correct this parlous state of affairs.

Health service utilisation and health seeking

Gender (masculinity) and gender socialisation (manhood) affords males a different experience of health and serves to both prescribe and limit their lives. For many, the gender-based characteristics of strength, resilience, independence, self-reliance, need for control, and problem-solving act as barriers to health-seeking. Cultural stereotypes also augment male reticence for seeking out screening and preventive health care.

Research suggests that many males have a functional view of health, not seeking help until the problem is shown to clearly impact on physical function. Many are disposed to self-monitoring, seeking information from different sources before coming to an informed decision about whether to seek help. They often display indirect health information seeking, viewing friends, partners and other repositories as sources of health advice until function is clearly impaired, when they then seek professional help.^{40,41,42,43,44}

A common consequence is lesser engagement with illness prevention and health promotion programs.^{43,44,45,46,47,48} and lower utilisation of health services, particularly for chronic disease, sexual and reproductive health and mental health.⁴⁰





Research spending

Government research funding for male health lags significantly behind that for female health. Since 2003 NHMRC funding for research relating to men's health has been about a quarter of that provided for women's health.⁴⁹ Building the evidence base on male health is crucial. Identifying the determinants (individual and social) and the causal pathways for good and poor health in males in general and in specific sub-groups of males will allow resources and effort to be dedicated to activities where the most benefit can be gained. To accomplish this will require dedicated inter-disciplinary and multi-method research into male health, but also require undertaking evaluation of both current and future projects and interventions.

What next ?

The aforementioned draw attention to some of the key issues affecting the health of Australian males. The persistence of these issues warrants as a priority the re-affirmation of the National Male Health Policy together with development, promulgation and funding of commensurate State and Territory policies. Moreover, and in keeping with the key tenets of gender equity in health, health and research resources corresponding to the demonstrable needs associated with poor male health should be made available by policy makers, planners and service providers alike.

Rather than the general "one-size fits all" approach to addressing these issues, male-specific prevention strategies that take into account men's differential vulnerabilities, including for sub-groups of males at special risk, are more likely to be effective than those that do not.^{25,26,43}

In order to address issues regarding health service use and perceived barriers to male health-seeking, we need a better appreciation – including through research – of the factors that act as obstacles to male health-seeking and health service utilisation. Moreover, policy, health services and health promotion programs need to better accommodate the differing social constructs for males and acknowledge the factors influencing their health-seeking behaviour.^{40,41,44,50}

Strategies need to actively encourage health service utilisation by legitimising health-seeking behaviour as fundamental to perceptions of male health and illness. There is a need for health promotion programs that are male orientated and which specifically target males.

Health services and providers need to be cognisant of particular physical, sexual and mental health issues that concern men as well as the social, geographic and cultural barriers that sometimes limit their engagement with health services.

Health professionals also need a better understanding of factors influencing male health and health seeking behaviours and guidance in how to better structure clinical and management practices to encourage engagement of males.

Clinicians should be attuned to differences in the way males express health concerns and the different symptomatology associated with certain conditions. They need to be more opportunistic in exploring sensitive issues, including sexual and reproductive health and mental health, particularly in the case of marginalised groups of males.

If there are to be strategies that address the socio-economic determinants most responsible for poor male health, a wider and more strategic commitment from departments other than health is required. When the siloed structures of government institutions limit cross-sectorial change, interventions need to be broken down into more manageable initiatives that fit within existing government departmental boundaries and capacity.⁵¹





References

1. The Health Targets and Implementation (Health for All) Committee. Health for all Australians: Report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference. Canberra, ACT; 1988: Australian Government Publishing Service; 1988.
2. Misan G, Ashfield J. Male health: facts, determinants and National and South Australian policy responses. South Australia Public Health Bulletin. 2011;8(18):33-41.
3. Turrell G, Stanley L, de Looper M, Oldenburg B. Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use. Health Inequalities Monitoring Series No 2. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare; 2006.
4. Harvey PW. Social determinants of health - why we continue to ignore them in the search for improved population health outcomes! Aust Health Rev. 2006 Nov;30(4):419-23.
5. Marmot M. Inequalities in Health. The New England Journal of Medicine. 2001;345(2):134-6.
6. Australian Institute of Health and Welfare. The health of Australia's males: A focus on five population groups. Canberra: AIHW; 2012.
7. Australian Institute of Health and Welfare. A snapshot of men's health in regional and remote Australia. Canberra: AIHW; 2010.
8. Australian Institute of Health and Welfare. The Health of Australia's Males. Canberra: AIHW; 2011.
9. Australian Bureau of Statistics. Australian Health Survey: First results 2011-12. Canberra 2012; Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012011-12?OpenDocument>.
10. Australian Government. Burden of Disease and Injury. Canberra 2011 [cited 2012 December]; Available from: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc~womens-health-policy-key~womens-health-policy-key-burden>.
11. Australian Institute of Health and Welfare. Mortality and life expectancy of Indigenous Australians: 2008 to 2012. Cat. no. IHW 140 In: AIHW, editor. Canberra, Australia 2014.
12. Draper G, Turrell G, Oldenburg B. Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1 AIHW Cat No. PHE 55. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare; 2004.
13. Australian Institute of Health and Welfare. Australia's Health 2010. Australia's health series no. 12. Cat. no. AUS 122. Australia's health series. Canberra: AIHW: AIHW 2010.
14. Australian Institute of Health and Welfare. Male health: health status. Canberra, Australia 2012 [cited 15/09/2015]; Available from: <http://www.aihw.gov.au/male-health/health-status/>.
15. Australian Institute of Health and Welfare. Australia's Health 2012. Australia's health series no. 13. Cat. no. AUS 156, Canberra: AIHW 2012.
16. Australian Government. National Male Health Policy Supporting Document: Healthy Minds. Canberra 2010.
17. Friedli L. Mental Health, Resilience and Inequalities WHO Regional Office for Europe, Denmark 2009.
18. Australian Bureau of Statistics. National survey of mental health and wellbeing: Summary of results. Canberra, Australia 2007.
19. Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW; 2011.
20. Australian Institute of Health and Welfare. Rural, regional and remote health - Indicators of health. Canberra: AIHW Contract No: PHE 95; 2005
21. Australian Institute of Health and Welfare. Rural, regional and remote health: a study on mortality. Canberra Contract No: PHE 95; 2007
22. Steel Z, McDonald R, Silove D, Bauman A, Sandford P, Herron J, et al. Pathways to the first contact with specialist mental health care. Australian and New Zealand Journal of Psychiatry. 2006; 40(4):347-54.
23. Caldwell T, Jorm A, Dear K. Suicide and mental health in rural, remote and metropolitan areas in Australia. Medical Journal of Australia. 2004;181(7):S10-4.
24. Misan G. Male health and male health policy in Australia. New Male Studies. 2013; 2(3):104-19.
25. Ostlin P, Eckerman E, Mishra US, Nkowane M, E W. Gender and health promotion: A multisectoral policy approach. Health Promotion International. [Gender equity in health but only in reference to females; mainly related to developing countries]. 2006;21(1):25-35.
26. Victorian Government. Men's health and wellbeing strategy background paper. Melbourne, Australia: Victorian Government; 2010
27. Milligan C, Dowrick C, Payne S, Hanratty B, Neary D, Irwin P, et al. Men's Sheds and other gendered interventions for older men: Improving health and wellbeing through social activity. A systematic review and scoping of the evidence base: A report for the Liverpool-Lancaster Collaborative (LiLaC) and Age UK; 2013
28. Misan G, Sergeant P. Men's Sheds - a strategy to improve men's health. Proceedings of the 10th National Rural Health Conference, Cairns, Qld, Australia. 2009.
29. Cordier R, Willson NJ. Community-based Men's Sheds: promoting male health, wellbeing and social inclusion in an international context. Health Promotion International. 2013: doi:10.1093/heapro/dat033.
30. Wilson NJ, Cordier R. A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and wellbeing. Health & Social Care in the Community. 2013;21(5):451-63.

References continued...

31. Golding B. Older men's wellbeing through community participation in Australia. *International Journal of Men's Health*. 2011;10(1):26-44.
32. Holden C, McLachlan R, Pitts M, Cumming R, Wittert G, Agius P, et al. Men in Australia Telephone Survey (MATEs): a national survey of the reproductive health and concerns of middle-aged and older Australian Men. *Lancet*. 2005;366:218-44.
33. Australian Bureau of Statistics. Men's health. Canberra: ABS; 2010.
34. Australian Bureau of Statistics. Underlying Causes of Death (Australia). Canberra 2012; Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02010?OpenDocument>.
35. Australian Government. National Male Health Policy Supporting Document: Healthy Reproductive Behaviours. In: Department of Health and Ageing, editor. Canberra 2010.
36. Hoag NA, So AI. The confusion surrounding prostate cancer screening faced by family physicians. *Canadian Urological Association Journal*. 2012;6(3):194-5.
37. Murphy DG, Ahlering T, Catalona WJ, Crowe H, Crowe J, Clarke N, et al. The Melbourne Consensus Statement on the early detection of prostate cancer. *British Journal of Urology International*. 2014;113:186-8.
38. Australian Bureau of Statistics. 4102.0 - Australian Social Trends, Jun 2012. Sexually transmissible infections. Canberra 2012
39. Australian Bureau of Statistics. Work related Injuries 2005-06. Canberra, Australia; 2006
40. Smith JA. Beyond Masculine stereotypes: Moving Men's health promotion forward in Australia. *Health Promotion Journal of Australia*. 2007;18(1).
41. Smith JA, Braunack-Mayer A, G W. What do we know about men's help-seeking and health service use? *The Medical Journal of Australia*. 2006;184(2):81-3.
42. Smith JA, Braunack-Mayer A, Wittert G, Warin M. "It's sort of like being a detective": Understanding how Australian men self-monitor their health prior to seeking help. *BMC Health Serv Res*. 2008;8:56.
43. Misan G, Oosterbroek C. Practitioners' Guide to Effective Men's Health Messaging, Men's Health Resource Kit 2 Penrith: MHIRC, University of Western Sydney; 2014.
44. Witty KR, White AK, Bagnall A, South J. Male frequent attenders of general practice and their help seeking preferences. *Journal of Mental Health*. 2011;8(1):21-6.
45. Boman EKO, Walker GA. Predictors of Men's Health Care Utilization. *Psychology of Men and Masculinity*. 2010;11(2):113-22.
46. Addis ME, Mahalik JR. Men, Masculinity, and the contexts of help seeking. *American Psychologist*. 2003;58(1):5-14.
47. Evans J, Frank B, Oliffe JL, Gregory D. Health, Illness, Men and Masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Mental Health*. 2010;8(1).
48. Courtenay W. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Soc Sci Med*. 2000;50: 1385-401.
49. Dunlevy S, Cornish L, Scarr L. Men die earlier but women's health gets four times more funding. News Corp Australia Network; 2014 [5/10/2015]; A SPECTACULAR gender gap has resulted in men's health problems being allocated a quarter of the funding women's health research gets, ranked just ahead of parasitic infections.]. Available from: <http://www.news.com.au/lifestyle/health/men-die-earlier-but-womens-health-gets-four-times-more-funding/story-fneuzlbd-1226794504245>.
50. Smith JA, Robertson S. Men's Health Promotion: a new frontier in Australia and the UK? *Health Promotion International*. 2008;23(3).
51. Carey G, Crammond B. Taking action on the social determinants of health. Insights from politicians, policymakers and lobbyists. *Social Determinants of Health Alliance*; 2014.



Australian Men's Health Forum is the peak national forum promoting a social approach to male health and wellbeing

www.amhf.org.au admin@amhf.org.au
PO Box 741 Richmond NSW 2753
Phone 0414 950 902