To the Senate Select Committee on Men's Health, from Dr Greg Malcher

The Senate has established a Select Committee on Men's Health to inquire into general issues related to the availability and effectiveness of education, supports and services for men's health.

Comment: Men consume health differently from women, and it is unreasonable to expect men to utilize a health system designed for women and children. Many men are intimidated by "the system" and at times they and we readily swallow the old wisdom that they are not especially interested in their health. But recent evidence (James Smith in Adelaide, and Prof Barry Golding , men's sheds expert, in Ballarat) confirms that their health is a major concern to many men.

But a range of practical barriers and learned responses result in suboptimal uptake of existing services.

Practical barriers include

- difficulties accessing services in-hours (for many men the process of getting time off work, or accessing an after-hours appointment is either seems impossible or is so complicated they just give up, until the problem become undeniable)
- cost issues (for many men their role as provider takes precedence over their health needs: when money is short many men will avoid/defer going to the doctor if they know that they will be expected to pay a gap or the costs of medication). And of course the lower socio-economic group of men with the highest level of financial pressure is subject to the highest level of disease, disability and disease-inducing lifestyle behaviours.

Learned responses which have an impact on health behaviour can include:

- men modelling their behaviour on other men, often their fathers or older males. If their mentor's approach to their health has involved avoidance/denial/deferment then this is likely to be passed on.
- men typically avoid environments which cause discomfort. This includes 'waiting room discomfort syndrome' characterised by a dislike of excessive waiting and women's magazines, and fear of a health system with which they are not familiar (one well-educated man said in bewilderment to me "so I pay the gap…OK. And then the cheque make out to the doctor gets posted to me, and then I (thinking)… post it to him….Why not just send the cheque to the doctor? Who invented this system, a politician?"
- previous failure of provision of respectful, competent medical services which acknowledge their different needs as health consumers (as we all know, one bad experience as a consumer can result in avoidance of the particular outlet or provider)
- according to many men there is a large variation in health professional's skill and attitudes in dealing with men and their health issues. Unlike specialist

practitioners for whom the complaint has often already been identified and compartmentalised (cardiologists are not expected to deal with skin problems) general practitioners and others in primary care often deal with both undifferentiated problems and up to five or more health issues in one consultation. Men's health does not appear to feature strongly in the considerations of those responsible for GP training. Also there are very few men's health practitioners (GPs or nurses with specific interest and extra training in men's health) in primary care, especially in rural and remote areas.

Some of the ways we could modify our existing primary health care system are

1. Getting receptionists to help the health care system engage men. They can

- Encourage men to phone before leaving work/home to see if the doctor's running late
- Help men understand how the appointment system works (be honest!)
- Take their work requirements into account when making appointments, and let them know this is happening
- Warn men of potential out-of-pocket health costs
- Teach men how medicare billing works
- Encourage more man-friendly reading material in the waiting room (fishing, cycling, golf magazines; newspapers)
- Be men recruited into a typically female job

2. Changing the hours of operation of health services: this might require offering incentives to those working unsocial hours, as currently medical practices booking patients into after-hours clinics do not receive any subsidy for this.

3. Offering some extra subsidisation of pharmaceutical costs to those on low non-HCC incomes.

4. Offering better training in men's health to general practitioners. My recent survey of workshop teaching of men's health to GPs-in-training by 4 Victorian Regional Training Providers indicates that the time allocated to teaching men's health varies significantly, from 1.5 hours to 16 hrs (mean 5.9 hrs, compared with women's health 8.2 hrs). The wide variation suggests that some RTPs' men's health teaching may be inadequate. A number of key areas, including intimate partner abuse and post-natal depression, appear to be ignored. Currently ACRRM, the alternative to RACGP in GP training, has no specific Men's Health component to its curriculum. There should be adequate resources dedicated to improving the training of GPs in Men's Health.

5. Establishing specific training programs for men's health practitioners, such as men's health nurse practitioners (of which there is only one in Australia, Mr Peter Strange in Bendigo, Vic, to my knowledge).

6. A key watershed area for men is parenthood. There is a need to change maternal and child health centres to Parent and Child Health Centres, in function as well as name. They require adequately resourcing to deal with multiple parenting roles and to provide help for new fathers' and mothers' problems including perinatal depression in either parent. At present support services are virtually non-existent for fathers with partners with PND, or who have PND themselves.

7. Indigenous men are clearly a group who the health system has failed to engage, in part because their cultural norms (despite several centuries of fragmentation) still involve a marked separation of men and women. Even in Broome, when I worked their last year, the Aboriginal Medical Service does not offer a separate mainstream men's health clinic, due to physical, financial and staffing constraints. Yet there is evidence that mainstreamed separate services for men can have an impact on a broad range of issues including health, educational activity and violent behaviour.

However I believe that only changing our existing system of service provision is insufficient to achieve the outcomes required. Health service providers need to move beyond the walls of their clinics and health centres. And health should be regarded as a key issue in the workplace and educational venues.

WORKPLACE: Many men define themselves via their work, often feeling more comfortable there than in health-oriented settings such as community health centres, hospitals, maternal and child health centres and general practices. There is a profound need for research in workplace-based health care programs. There is good evidence that workplace-health programs both engage men successfully and lead to establishment of GP relationships, as well as fostering reduced absenteeism, higher productivity, higher workforce retention rates and healthier employees with better home lives. Given the enormous potential benefits for all men, but especially for high risk groups of men (those in the lowest socio-economic strata), it would seem sensible for a number of trials to be funded to identify successful models for national roll-out.

EDUCATION: In our education systems, right from pre-school to TAFE/university there should be a sustained focus on the differences between boys and girls, both educationally and socially.

A range of structured male initiation activities, such as the Pathways to Manhood program of the Pathways Foundation, challenge cultural sterotypes relating to masculinity. They can help young men, with their fathers, step beyond the stereotypes and to find ways of positively expressing their masculinity while reducing exposure to potentially lethal risks or separating themselves from health allies.

There has been, to our young men's detriment, limited uptake of a range of school-based interventions (primary and secondary) designed to support boys and young men at high risk of disengagement. Richard Fletcher in Newcastle is a real leader in this field and resources should be provided to roll-out his and similar programs on a national basis.

In particular, we are asked to comment on :

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

Comment: It is of concern to me that the only expansion of the traditional "prostate and testicles" view of men's health is in regard to depression. Clearly there should be adequate resourcing (=$$) of programs related to sexual and mental health.

But just focusing on these areas misses a number of points, as men regard their health as being about much more than sexual and mental health. For them there is a range of issues including

- work-life balance (not just the philosophy but the practicalities of balancing where to live and work, hours of work if they can choose, debt, travel times and costs, time for them to spend with their kids, working to keep their key relationship healthy, finding time to exercise),
- workplace risks,
- family history (heart disease, bowel cancer, prostate cancer)
- establishing a relationship with a GP which suits them.

The vast majority of men who attend health-related services attend GPs who should be well-trained in men's health, as well as all the other aspects of general practice.

Both the AMA position statement on men's health, and the RACGP men's health policy, emphasise the broad nature of men's health, asserting that men's health is so much more than sexual and reproductive health.

In my opinion the time is right for the development of a National Men's Health Institute, adequately-resourced to bring together many of the multiple strands of men's health (educational, sociological, medical). While it is important to set some boundaries in an area in danger of making itself too diverse, we would do Australia's men a disservice to limit it to a medical model.

In women's health for instance the Jean Hailes Foundation and the Key Centre for Women's Health in Society provide excellent models for a National Men's Health Institute. In men's health the Men's Health Information and Resource Centre and Andrology Australia provide leadership in the sociological and reproductive health areas respectively.

Andrology Australia's brief is as a centre of excellence in male reproductive and sexual health (with its board and management group heavily weighted towards expertise in urology and endocrinology) and it does world-class work in this area. It should continue to be resourced to do its work in this area.

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

Comment:

Education and awareness campaigns should take into account the following:

- They should reflect a national men's health policy
- They should be part of a national men's health program which features long-term planning and resourcing over 5-10 years
- They should reflect that men consume health, and think about health, differently to women and target men in ways which take this into account
- They should be evaluated to identify their effectiveness in regard to better outcomes for men
- Government should direct its attention to a range of messages to which men are subject that may be in conflict with national health priorities (eg KFC sponsoring our national cricket team in the middle of an obesity epidemic; and VB being another sponsor while binge-drinking is a national health issue). We cannot hope to win the health battle unless we play to win. VicHealth has provided some important examples of how we can approach health marketing.

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

Comment:

I repeat my comment expressed previously: Men consume health differently from women, and it is unreasonable to expect men to utilize a health system designed for women and children. Many men are intimidated by "the system" and at times they and we readily swallow the old wisdom that they are not especially interested in their health. But recent evidence (James Smith in Adelaide, and Prof Barry Golding , men's sheds expert, in Ballarat) confirms that their health is a major concern to many men.

It is crucial that men's needs are acknowledged, in particular that they want ownership of their health: that is, they want to be able to discuss it on their terms, in places they feel comfortable. It times this will involve them voluntarily disempowering themselves (eg getting someone else to make an appointment for them if they feel that person is better skilled at doing it), but this does not mean that this is a bad thing for their health. While this contrasts to some extent with the feminist model of health, it actually owes much to this model.

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

Comment:

One could argue that the further away from capital cities men are, the more resourceful they are. There is some truth in this, especially when the man has made the choice to be there.

But many men have no great choice, if they are born or raised in rural or remote areas. Even those who move there find that there are fewer doctors and allied heath workers, whose average age is higher, and who work longer hours. Waiting lists are often longer, and distances travelled to access services are often significant.

If they require capital city treatment their families can experience major problems in keeping in contact, and capital city outpatient appointment systems rarely seem to take their isolation into account.

In rural and remote areas men's health outcomes are generally significantly worse that their city counterparts, and the per capita Medicare expenditure is lower. They "enjoy" fewer health resources and fewer choices.

Many would rather die than go to live in the cities, and they do this earlier too than their city cousins.

Thank you,

Dr Greg Malcher, Rural GP, Daylesford Victoria