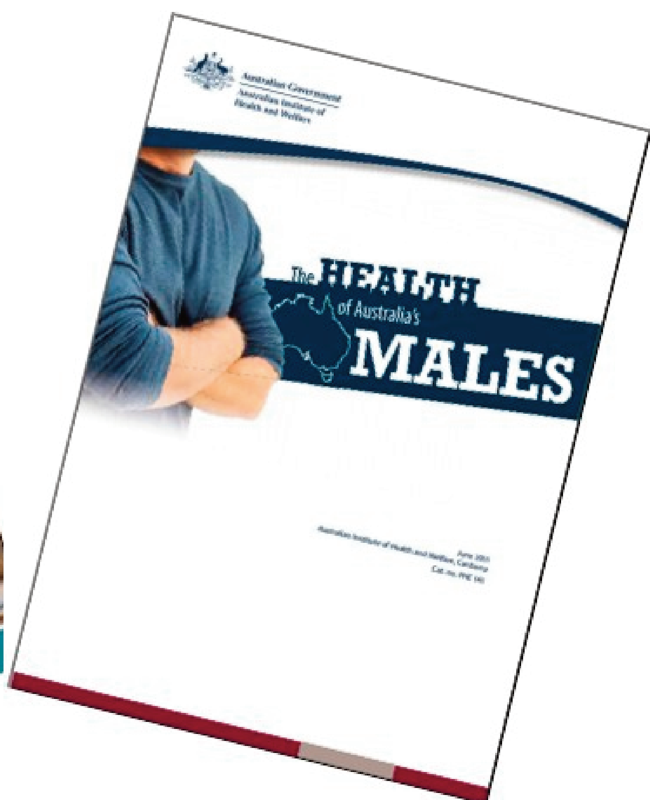

Male Health and Male Health Policy in Australia

Gary Misan

Despite major gains in life expectancy for Australian males over the last century there still remain major disparities in health outcomes between males and females and between different groups of males. In response, in 2010 the Australian Government released the first National Male Health Policy. This landmark policy takes a social determinants approach and advocates for gender equity in dealing with the health needs of Australian males. Its six priority action areas encompass optimal outcomes for males, health equity for subgroups of males and at different life stages and transition points, illness prevention, improved service access and an improved evidence base. The policy rationale, key features, achievements and limitations are described.

Key Words: male health, men's health, male health policy, social determinants, gender equity

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Introduction

June 16, 2013 witnessed the end of another National Men's Health Week (University of Western Sydney, 2013) in Australia and saw the dust settle on over 170 male health advocacy events around the country. With so much apparent enthusiasm for continuing efforts in male health it is perhaps timely to reflect on the status of male health in the 'lucky' country and of the three years since the introduction of Australia's first National Male Health Policy (NMHP) (Australian Government, 2010o).

In so doing we should note that there were attempts to improve male health outcomes well before the introduction of the NMHP. These included the work of a number of male health advocacy groups who despite their often different philosophies have in their various ways inched the male health agenda forward. But as this article demonstrates, there is still much work to do.

How is it then that we ascribe cause and effect to male health policy in Australia? I suggest with some difficulty, particularly at the population level. With the work of local, State and national advocacy groups, the efforts of a plethora of health promotion programs, primary health care initiatives, the national health reform agenda and a myriad of structural changes to national and state health systems, as well as factors external to the health agenda, ascribing changes to the NMHP is likely to be a difficult task. Compounding the dilemma is that population level changes do not happen overnight and it will likely take a decade or two of consistent commitment and funding by successive national and state governments, across a range of sectors in addition to health and importantly changes in sociocultural expectations of men and boys, before we see significant changes in health outcomes for Australian males. Whether the required consistent commitment is forthcoming remains to be seen. Notwithstanding, this article aims to highlight the opportunity that the NMHP holds and what has been achieved over the last three years that can be attributed to the policy.

Male Health in Australia

Life expectancy

The 2011 Australian Bureau of Statistics (ABS) Census estimated the Australian male population on census night at 10,634,013 which represents 49.4% of the population (Australian Bureau of Statistics, 2011a). Of these, 2.5% identified as being of Aboriginal or Torres Strait Islander descent, which is the subgroup with the worst outcomes on just about any measure in Australia, including health. The national median age for males in Australia is 36 years. Approximately 20% of males are under 15 years of age, 68% are aged between 15 and 64 and 12% 65 years and over (Australian Institute of Health and Welfare, 2011a, pp. 9).

Australian males live long lives by international standards. When compared with other developed countries the life expectancy of Australian males at birth ranks third only to Japan and Hong Kong and after age 60, males rank top equally with Japan, New Zealand and Canada (Australian Bureau of Statistics, 2012a). There is however an almost 5 year disparity between life expectancy for Australian males and females (Australian Bureau of Statistics, 2011c) and this gap has widened over the last century (Australian Bureau of Statistics, 2011c). Between 1900 – 1910 the survival gap between males and females was 3.6 years but by 2004 – 2006, the difference had increased to 4.8 years. This increase is despite improvements in public health infrastructure, immunisation programs, better living standards, the eradication of common infectious diseases and better access to health services, suggesting other factors are at play.

The average Australian male life expectancy at birth is 79.7 years compared with 84.2 years for females (Australian Institute of Health and Welfare, 2013b). People living in regional, rural and remote areas, including Aboriginal Australians, die on average about 3 years earlier than their urban cousins, primarily due to socioeconomic disadvantage, lifestyle factors and lesser access to medical care (Australian Institute of Health and Welfare, 2012b, Australian Institute of Health and Welfare, 2011a). In remote and very remote areas, the average male life expectancy is about 4 years less (Australian Institute of Health and Welfare, 2007). Additional subgroups, including those with mental illness, war veterans, gay men, socially isolated and blue collar men, all have lower life expectancy

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than the average male (Australian Institute of Health and Welfare, 2007). For Indigenous males the picture is much more sombre. The ABS estimates that Indigenous males born in the period 1996-2001 have a life expectancy at birth of 59.4 years. Revised estimates from 2005-2007 put this figure at 67.2 years. Depending on the source this suggests Indigenous males can expect to die between 10 – 20 years sooner than their non-Indigenous counterparts and about 6 years less than Indigenous females (Australian Bureau of Statistics, 2011b, Australian Institute of Health and Welfare, 2008a) Whichever figures you choose to believe, the differential is significant and warrants specific strategies targeting Indigenous males.

Mortality and morbidity

While life expectancy figures suggest all is well with the Aussie male, not all is well in terms of quality of life and there are sub-groups of males that do less well than the 'average'. 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 (Australian Institute of Health and Welfare, 2011a, pp. 28) which collectively account for approximately 60% of all male deaths (Australian Institute of Health and Welfare, 2012c).

Mortality rates for males for most non-sex-specific causes of death are higher than for females across all age ranges (Draper et al., 2004b). The national standardised death rate for males is 2.2 deaths per thousand higher than for females (Australian Bureau of Statistics, 2008). Nationally, this represents approximately 22,400 additional male deaths per year compared with female deaths. All-cause death and injury rates are highest in the 15-24 year (163% higher), 65 -74 years (85% higher) and 25-64 year (81% higher) age groups (Draper et al., 2004b, pp. 16-29). The greatest contributors to these figures are suicide, motor vehicle accident and other injury in the 15 -24 year age group, respiratory and circulatory disease in the 65-74 year olds and circulatory system and lung cancer in the 25-64 year olds (Draper et al., 2004b, pp. 16-29).

Death rates for males less than 25 years of age are nearly twice that of females the same age. For males 25 years and older, the leading causes of death are coronary heart disease followed by lung cancer (Australian Institute of Health and Welfare, 2013a). Males in the 15-29 years age group have higher death rates from injury than other age groups. Vehicle accidents are the major cause of death for males less than 25 years old, and males are almost three times more likely to die from vehicle accidents than females with younger men accounting for 60% of deaths (Draper et al., 2004b).

Although IHD is the most common single cause of death, when the different cancer death statistics are combined, malignant neoplasms are the leading cause of death for Australian males. In 2007, males accounted for 57% of all cancer related deaths and 57% of all newly diagnosed cancers (Australian Institute of Health and Welfare, 2011a, pp. 33). Prostate cancer, bowel cancer and skin cancer are the most commonly diagnosed male cancers with lung cancer, prostate and colorectal cancer the leading causes of cancer death (Australian Institute of Health and Welfare, 2011a, pp. 33). Death rates from prostate cancer exceed the mortality from breast cancer in Australian women.

Burden of disease

About half of the male population over 15 years of age report health concerns; and reports of ill-health increase with age reflecting the increased incidence of chronic disease as men age (Australian Institute of Health and Welfare, 2012a). In the most recent ABS Health Survey, only 56% of Australian males aged 15 years and above rated their health as very good or excellent. Self-reported health status generally declines from 65 years of age and is generally worse for disadvantaged groups (Australian Institute of Health and Welfare, 2012a, pp. 107).

Males die from avoidable causes 85% more often than females and rates for conditions such as diabetes, heart, stroke and vascular disease are significantly higher. These findings highlight the need for more male-specific disease prevention and early intervention strategies as key components of male health policy (Leahy K et al., 2009).

In 2003, it was estimated that Australians lost more than 2.6 million healthy years of life due to disease and injury of which approximately 52% was attributed to males (1.4 million DALY) (Aus-

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tralian Institute of Health and Welfare, 2011a, pp. 30). The five leading causes of years of lost life (YLL, i.e. mortality burden) for the male population were ischaemic heart disease, lung cancer, suicide, stroke and colorectal cancer. The five leading causes of years lost to disability (YLD; i.e. non-fatal burden) were anxiety or depression, Type 2 diabetes, adult onset hearing loss, asthma and dementia (Australian Government, 2011). When taking into account the combined YLL and YLD, Ischaemic Heart disease and Type 2 diabetes account for the leading burden of disease for Australian males (Australian Government, 2011).

Chronic conditions — those lasting six months or more that can lead to death — are responsible for the majority of death and injury experienced by men and women and impose the greatest burden on health and wellbeing. About one third of Australian men report common chronic conditions (Australian Institute of Health and Welfare, 2011a, pp. vi) the leading causes of which include heart and circulatory problems, arthritis, asthma, diabetes, cancer and osteoporosis. High rates of overweight and obesity in males are a significant contributor to morbidity and mortality from chronic disease such as Type 2 diabetes, CVD and cancer (Government of South Australia, 2006).

Similarly, long term conditions — defined as those lasting 6 months or more but that don't generally cause death — are reported more often than chronic conditions and together with chronic conditions, place a substantial financial, resource and social burden on individuals and communities. For Australian males the most commonly reported long term conditions include visual problems such as long and short sightedness (23% and 20%), back pain and spinal disk problems (14%), and hay fever and allergic rhinitis (14%) (Australian Institute of Health and Welfare, 2011a, pp. 32). In 2007 – 08, 15% of males across all age groups reported developing a long term condition caused by previous injury (Australian Bureau of Statistics, 2010). Eighteen percent of males over the age of 25 report a core activity limitation affecting mobility, self-care or communication (Australian Institute of Health and Welfare, 2013a).

Mental health

About half of Australian males are affected by mental illness over their life course (Australian Institute of Health and Welfare, 2011b). A national survey conducted in 2007 found that approximately 48% of males aged 16-85 years reported experiencing a mental disorder sometime in their life with an estimated 1.4 million reporting illness in the year prior to the survey. The most commonly reported disorders were anxiety and depression, substance use disorders and affective disorders. Males account for 68% of substance abuse disorders (Australian Institute of Health and Welfare, 2011b). Men with mental illness die up to 16 years earlier than the general population and for those with drug or alcohol related co-morbidities, the gap is some 20 years (Norton, 2013).

Males in regional and remote areas are more likely to show high to very high levels of psychological distress, and males living outside major cities are significantly more likely to experience depression (greatest in the 45-64 years age group). Prevalence rates are generally higher again for Aboriginal males (Australian Institute of Health and Welfare, 2008b).

The rate of suicide in Australian males is of particular concern. Approximately 4 males kill themselves in Australia every day. Suicide is the leading cause of death in males in the 15 – 44 year age group (Australian Bureau of Statistics, 2013a) indicating that mental health disorders in males are under-recognised, under-diagnosed and under-treated (Australian Government, 2010i, pp. 7, Begg S et al., 2007). Suicide rates are highest in men 85 years and older and in the 25-49 year age groups (Australian Bureau of Statistics, 2013a, pp. 5, Australian Government, 2010i, Australian Bureau of Statistics, 2013b). In 2007, men accounted for 77% of suicides nationally (Australian Government, 2010i, pp.5). Males in rural and remote regions, particularly young men, are more likely to commit suicide than their urban counterparts (Australian Institute of Health and Welfare, 2005b, Australian Institute of Health and Welfare, 2007, Caldwell TM et al., 2004) and are less likely to have sought professional help prior to the event (Caldwell TM et al., 2004, Steel Z et al., 2006). Farmers and farm workers suffer the highest rate of suicide of any occupational group and those at highest risk are males aged 30 -50 years.

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Sexual and reproductive health

Of the four most prevalent Sexually Transmitted infections (STIs) in Australia, Chlamydia is the most common among males, followed by gonorrhoea, infectious syphilis and HIV with all except the latter being more common in Aboriginal males. Australian males carry the major burden of new cases of HIV and infectious syphilis with more than 90% of new cases diagnosed in males, compared with 41% of new cases of Chlamydia (Australian Institute of Health and Welfare, 2011a, pp. 42).

Australia wide, over a third of men report experiencing at least one reproductive disorder, with frequency increasing with age (Australian Institute of Health and Welfare, 2011a, pp. 38). The disorders most commonly reported include low testosterone, erectile dysfunction, lower urinary tract symptoms and prostate disease (Australian Institute of Health and Welfare, 2011a, pp. 39).

Men in all age groups also report sexual related difficulties ranging from lack of interest in sex to concerns about sexual performance and achieving orgasm (Australian Institute of Health and Welfare, 2011a, pp. 39).

Work Health and Safety

Work health and safety (WH&S) also remains a key area of concern (Safe Work Australia, 2011b) and males experience 70% of the national burden of disease related to injury (Australian Bureau of Statistics, 2012b). Nationally, 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 (Linacre S, 2007, Australian Bureau of Statistics, 2006). In 2009 – 10 there were nearly 73,000 claims for serious injury resulting in fatality, permanent or temporary incapacity; there were 170 work related deaths. Males aged 25-64 accounted for 55% of claims (Australian Institute of Health and Welfare, 2013a). In addition to occupational fatalities, there are many other deaths related to occupational exposure to hazardous substances that occur each year, mostly in men (Fritschi L and Driscoll T, 2006, Safe work Australia, 2011a).

Social determinants

In Australia as elsewhere, the most likely determinant of health is where a man is situated on the social gradient with males appearing more adversely affected by lower socioeconomic status (SES) than females (Leahy K et al., 2009, Turrell G et al., 2006, Misan and Ashfield, 2011). Premature mortality for males in the most socially advantaged group of the population is higher than that for females in the most socially disadvantaged group; and the rate for males from the lowest SES group is nearly double that of the most socially disadvantaged females (Leahy K et al., 2009, Misan and Ashfield, 2011). Males with lower SES, living in disadvantaged areas, with lower levels of education and employed in blue-collar jobs generally report the poorest health and are more likely to make poorer lifestyle choices and to work in dangerous, health-damaging occupations (Leahy K et al., 2009, Turrell G et al., 2006, Misan and Ashfield, 2011). Male blue-collar workers experience significantly higher death rates for all causes and for most specific causes (Australian Institute of Health and Welfare, 2005a). Socioeconomically disadvantaged men are more likely to report chronic disease or adverse health indicators or associated risk factors and are less likely to be able to access health services [11, 33, 34].

Geography is another key male health determinant with males who live in regional and remote areas more likely than metropolitan males to report fair or poor health. The prevalence of chronic disease and injury is generally higher and increases with remoteness (Australian Institute of Health and Welfare, 2008b, Misan and Ashfield, 2011). Males in rural and remote areas have higher prevalence rates of diabetes, bronchitis, arthritis and some cancers, compared with city counterparts. They are more likely to show high to very high levels of psychological distress and to experience depression (greatest in the 45–64 years age group) and these rates are generally higher again for Aboriginal males (Australian Institute of Health and Welfare, 2008b). Males living outside major metropolitan centres are more likely than their urban counterparts to exhibit poor health behaviours including drinking alcohol, smoking, illicit drug use, exhibiting sedentary behaviour, being overweight or obese, and consuming a poor diet. Rural and remote men are also more likely to have lower education attainment, have lower socioeconomic status, undertake dangerous work, work with dan-

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gerous equipment or be exposed to hazardous chemicals and also to have less access to health services [(Misan and Ashfield, 2011)32, 33].

Social inclusion, as well as social control and cohesiveness, are additional determinants of social and emotional wellbeing, health and longevity (Misan and Ashfield, 2011). There is a causal association between the prognosis of coronary heart disease and social isolation, and the lack of quality social support and depression. Also, the risk of death due to the absence of social relationships and networks is comparable to the well-known risk factors of smoking, alcohol, high cholesterol, poor diet and lack of exercise (Baum F, 2008, Holt-Lunstad J et al., 2010, Seeman TE et al., 2001, Marmot M, 2001, Bunker SJ et al., 2003).

Health Service Utilisation

In Australia, adult males are about 15% less likely to have seen their GP than females although on the positive side, 75% of men report visiting a doctor in the previous 12 months. Rates increase with increasing age, reflecting an increase in the incidence of chronic disease in older age groups (De Kretser et al., 2006, Australian Bureau of Statistics). Data from the 2011 annual BEACH survey of 1000 Australian GPs found that there were 43,000 GP encounters with males accounting for less than half (43%) of all the GP consultations that year (Australian Institute of Health and Welfare, 2011a, pp. 51 and 56, Britt et al., 2010). Males aged between 45 – 65 accounted for over half of these visits. The top 5 complaints managed by the GP's were respiratory conditions (15%), general concerns (19.7%), cardiovascular problems (18.8%), skin conditions (18%) and musculoskeletal problems (16.4%) (Australian Institute of Health and Welfare, 2011a).

Data from the ABS showed that in 2007-08, men accounted for 49.2% of the total GP consultations and 52% of the Emergency Department (ED) visits, indicating a lack of access to primary health care services and a higher usage of emergency services which may also reflect the less flexible opening hours of GP surgeries compared to ED. Emergency department service use varied across age cohorts with men aged 15-24 years having the highest proportion of visits (28%) whilst those aged 65 years and over accounted for 17% (Australian Institute of Health and Welfare, 2011a, pp. 55). The higher incidence of emergency department use is attributed to the lower use of preventative health measures and higher rates of trauma as a result of traffic accidents, occupational mishaps and violence (Malcher G, 2005). The higher use may also reflect the extended opening hours not available in general practice, particularly in rural areas.

The data is similar for hospital admissions where for people under the age of 55 years, men are less likely than women to be admitted to hospital, even when figures are adjusted for gynaecological and obstetric services (Australian Bureau of Statistics).

Australian Male Health Policy

Rationale

That an Australian national male health policy was well overdue is evident from the 1988 Health for all Australians report (The Health Targets and Implementation (Health for All) Committee, 1988) which 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.' It would seem not much has changed in 30 years. In fact much of the premise for the NMHP is based on these statements.

So how does Australia's Male Health Policy rate and what changes have there been in the three years since its release?

It is clear from the above data, including some subsequent to the policy release, that Australia's male health policy needed to target a number of key areas – prevention, early detection and treatment, service access, health promotion and research – from the outset (Misan and Ashfield, 2011, Smith and Bollen, 2009). Moreover, a social determinants approach combined with a focus on gender equity was critical to ensure factors influencing male health, risk factors and behaviours, health knowledge, health seeking behaviour and health service utilisation — in particular the health

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differentials between males of different occupational, socio-economic and cultural backgrounds, males at different ages and males from marginalised or vulnerable populations — were properly considered. Furthermore, due to limited empirical data regarding the above factors it was important that the NMHP support research regarding socioeconomic and related determinants to improve the evidence base that would inform future male health policy.

Factors that influence differential health outcomes for males compared with females and the conditions that account for the majority of the burden of chronic disease, were and are deserved priority areas. A dearth of empirical evidence for the former highlights the necessity for increased research (Collins et al., 2011). In addition, subgroups of males who are most at risk deserve special consideration. The common modifiable risk factors for chronic disease needed to be addressed as are strategies to target male suicide, young male drivers, mental health, social isolation and work safety, each of which contribute to considerable morbidity and mortality for Australian males (Misan and Ashfield, 2011).

For the broader group of males, additional policy requirements were for strategies that encouraged male health service utilisation, particularly for younger men. This might be achieved by facilitating an increase in the numbers of male health workers, by offering male-specific clinics, making existing services more male friendly and up-skilling health professionals to work more effectively with men, including addressing the lack of men's health education in undergraduate and postgraduate nursing and allied health curricula (Holden et al., 2010, Collins et al., 2011, Australian Medical Association, 2005, Macdonald, 2006). There was also a need for an inter-sectorial approach to address the broader socioeconomic and related determinants of male health which lie outside the domain of health departments; a multi-sector approach on workforce capacity; and a need to embed any policy into whole of government frameworks to increase the resilience of the policy to changing government priorities (Misan and Ashfield, 2011, Collins et al., 2011).

With these complexities one could be forgiven for wondering why despite more than three or more decades of stark evidence, that it took so long for Australia to produce a Male Health Policy. Life expectancy aside, mortality rates; measures of years of life lost; of potentially avoidable deaths; of unacceptably high suicide rates, occupational injury and death; and a range of other indicators of health inequity between males and females, should have been clear enough reason of the need for health and other policy targeting Australian males (Draper et al., 2004a, Woods M, 2005). However, these difficulties should not have been an excuse because by way of contrast, there has been a National Women's Health Policy since 1989 and since that time an Office for Women or equivalent has been established in every State and Territory as well as at the national level. Three years after the release of the NMHP, Australian males are still bereft of administrative structures in any state that cater for their specific concerns!

Overview

Notwithstanding, May 2010 was a watershed point in Australian policy history following the release of the National Australian Male Health Policy: Building on the Strengths of Australian Males (Australian Government, 20100). The policy was hailed as a landmark document, testament to efforts of a number of male advocacy groups over many years and was the second (after Ireland) national male policy document published worldwide (Government of Ireland, 2008).

This policy, long overdue and arguably 15 years in the making, evolved from the first national men's health conference in 1995 and followed the release of statements on male health from several professional medical colleges about a decade later (Australian Medical Association, 2005, Royal Australian College of General Practitioners, 2006) together with strategy documents from at least two Australian States (South Australia Department of Health, 2008, NSW Government, 2009) and a briefly lived attempt at a third which was dramatically withdrawn following a change in the Victorian state government (Victorian Government, 2010).

By and large, the NMHP delivers on most of the key imperatives outlined previously. The key strength of the policy is that it saw a departure from the notion of male health outcomes as stemming from primarily biomedical or behavioural factors to one that acknowledged socioeconomic and cultural factors as key determinants. The policy acknowledges the positive role of males in so-

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ciety, in both family and community life and aims to build on those strengths. The policy acknowledges the gender disparity in health status between males and females; that there are subgroups of males at heightened risk of ill-health; that even within these groups not all males have the same health outcomes (e.g. Aboriginal and Torres Strait Islander (ATSI), rural and remote, migrants, socially disadvantaged, veterans, prisoners); that at different life stages, males have different needs; and that there is a need for collaboration between government, health services, communities and individuals to effect change. The NMHP exhorts a gender equity approach to health—in which males and females have equal opportunity to achieve good health (World Health Organization, 2001) and acknowledges that health and wellbeing require positive change to economic, social and health-minimising conditions that adversely affect health outcomes.

There are six priority action areas: optimal health outcomes for males; health equity between population groups of males; improved health for males at different life stages; preventive health for males; building a strong evidence base on male health, and improved access to health care for males. The priority areas are supported by nine supplementary documents that provide useful additional detail, exemplars, case studies and statistics (Australian Government, 2010f, Australian Government, 2010n, Australian Government, 2010k, Australian Government, 2010l, Australian Government, 2010j, Australian Government, 2010i, Australian Government, 2010m, Australian Government, 2010g, Australian Government, 2010h).

In tandem these priorities take a broad brush to the health of Australian males. While they lack specificity — and rely on the good will of states, regions, government and other health services, other government departments and other agencies — they call for health programs that specifically target male health and target those in greatest need, in particular males who suffer the most health disadvantage.

There is advocacy for improved health promotion strategies, acknowledging groups of males who are at risk of poorer health; recognising transition points across the life course that require special interventions, services or information; valuing the important role that older males have in mentoring and caring for younger generations; and recognising that, to effectively engage males, prevention programs need to be tailored in content, format and delivery settings to better reach the target groups (Misan and Ashfield, 2011).

Throughout NMHP there are tables associated with each of the priority areas that describe useful strategies and the relevant stakeholders who might implement them. Case studies that mirror these strategies are also sprinkled throughout the document as well as through the nine supplementary supporting documents. However, there is little information describing who will be responsible for implementation and co-ordination or of time frames for delivery.

The policy also acknowledges the need for more research targeting biological and social determinants of male health, of primary care and health promotion approaches that better engage males and of improved monitoring of workplace hazards. The policy encourages approaches that aim to address social isolation; that result in improved service delivery models more responsive to the barriers to service access for males; for consideration of policy or service impact for males at different life stages or from different socioeconomic and cultural backgrounds, and for consideration of and for changes to language used in health promotion programs and materials.

The policy is somewhat diminished by repeated reference to the 'men behaving badly' paradigm, which emphasise the need for men to change a range of so-called 'risky' behaviours rather than taking into account the reasons underpinning those behaviours. In both the NMHP and its supporting documents there is little discussion of gender and social constructs of masculinity and manhood that affect the male experience of health. There is need for better understanding of how 'masculinity' influences men's health and considerations and what needs to happen (including at political, industry and societal level) to improve men's health outcomes (Saunders and Peerson, 2009).. Also while acknowledging workplace risks, NMHP suggests only the need for continued monitoring rather than addressing key risks. Finally, there is little reference to the need to train health workers how to more effectively engage with men.

Unlike its Irish equivalent that did not quarantine funding for implementation, the NMHP

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offers specific, if modest financial support (AUS$16.7 million over 3 years) for several of the policy initiatives; the majority however remain unfunded. Those that receive funding do target several of the priority areas. These include support the Australian Men's Sheds Association; to develop health promotion resources for men's sheds; to provide fatherhood support and services to Aboriginal and Torres Strait Islander males; to build an evidence-base in male health including establishing a national longitudinal study in male health; and to commission regular statistical bulletins on male health. The need for additional research is also acknowledged.

As for funding the myriad of other policy recommendations the NMHP makes reference only to its complementing other government policy initiatives including the broader health reform, primary health care, preventative health and social inclusion agendas, none of which make little reference to male specific strategies. This concern is reinforced by a number of statements in the 2010 Australian Government's Response to the Report of the Senate Select Committee on Men's Health (Australian Government, 2010a, Commonwealth of Australia, 2009), which confuses sex discrimination with gender equity; which calls for boys to take responsibility for their health and wellbeing rather than calling for system change; makes reference to either current or future mainstreaming approaches to a number of men's health initiatives (e.g. annual health checks, men's nurse practitioners, prostate cancer nurses) as the response to male health issues rather than calling for male specific strategies. That these responses contradict some of the rhetoric in the NMHP does raise question about consistency in policy direction and puts at potential risk future outcomes. Notwithstanding the above, there have been some significant outcomes resulting from the NMHP that are discussed below.

Achievements

Reference group

A Male Health Reference Group, that reports to the Minister responsible for male health was established in 2011. This group meets about three times a year and comprises leading academics, practitioners and other stakeholders and provides expert advice on broader male health priorities as well as issues relating to the implementation and monitoring of male health programs that support the Policy (Australian Government, 2010e).

Evidence base

Ten To Men or the Australian Longitudinal Study on Male Health was commissioned in 2011 as a key element of the NMHP Policy to build on the evidence base on male health and to inform future policy. The study — that will cost $6.9 million over 4 years — plans to follow up to 50,000 males aged 10 – 55 years in three cohorts (boys aged 10-14 years; adolescent males 15-18 years; and adult males 19-55 years), over time to investigate social, economic, environmental and behavioural factors that affect the morbidity and mortality; men's health and risk behaviour, health service use and health across the life course, and to identify policy opportunities for improving the health and wellbeing of males at key life stages, for example when leaving school, commencing work, becoming a father and retirement. The first wave of data collection commences in the second half 2013 and data will be linked to administrative and health databases for epidemiological purposes. Follow-up waves are anticipated every three years to monitor changes over time. Data will be available to researchers and other interest groups on application (Australian Government, 2010b).

Although not a direct result of the NMHP, since 2004 a further $5million in competitive research funding has been made available through the National Health and Medical Research Council (NHMRC) for prostate cancer research and a further $15 million for the establishment of two prostate cancer research centres to improve diagnostic tests, screening and treatment for prostate cancer (Australian Government, 2010a, pp. 20).

Evidence dissemination

A further $400,000 over 4 years has been committed by the Australian Government to prepare regular statistical bulletins regarding male health. To date four reports have been prepared. The first providing key general statistics on male health and subsequent reports examining separate groups in

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more detail: five population groups at risk of ill health; males less than 25 years old, and males 25 years and older (Australian Institute of Health and Welfare, 2011a, Australian Institute of Health and Welfare, 2012b, Australian Institute of Health and Welfare, 2013a, Australian Institute of Health and Welfare, 2013b).

Men's Sheds

The community men's shed is a relatively recent grass-roots phenomena originating in Australia in the late 1970s and now seeing growing interest overseas. There are an estimated 900 community sheds around Australia catering for an estimated 40,000 members. In contrast to the backyard shed where men retreated to get some time away from the world, the community shed is a place where men go to enjoy the company of other blokes, doing what men do – talking while building or fixing things, sharing experiences over a cup of coffee, enjoying a laugh, sometimes teaching others or learning from others and sometimes even do nothing.

In Australia, the community men's shed generally cater for older, retired men and are thought to offer social, emotional and other benefits to men who participate in them. These include gaining a sense of purpose, enhanced self-esteem, decreased social isolation, and friendship. Sheds offer an environment conducive to men's learning, including health knowledge and also offer positive effects for partners, families and communities (Misan, 2008, Misan G and Sergeant P, 2009).

These benefits of the social network of the men's sheds were recognised in the NMHP through the allocation of $3million over four years to develop national infrastructure aimed at ensuring the growth and future sustainability of men's sheds. This funding is managed by the Australian Men's Sheds Association (http://www.mensshed.org) and includes $250,000 per annum (for 3 years) available through a competitive application process as small grants to individual sheds to fund tools and equipment, building maintenance and development and shed activities (Australian Government, 2010d).

Funding was also made available for the development of a DIY Health Toolbox to be distributed to Men's Sheds. The Toolbox is a health promotion initiative to encourage men to give more consideration to their health. The Health Toolbox was developed in consultation with the Male Health Reference Group and Men's Shed organisations to ensure the items and health promotion messages in the toolbox were appropriate and useful in the shed environment. The toolbox contains items including tape measures, carpenter's pencils, magnetic clips together with note books featuring positive health messages and referral pathway information (Australian Government, 2010c).

Aboriginal and Torres Strait Islander Fathers

The NMHP provided $6 million over three years for support and services to Aboriginal and Torres Strait Islander males in their role as fathers and partners, grandfathers and uncles, and to encourage them to actively participate in their children's and families lives, particularly in the antenatal period and in the early childhood development years.

Challenges

No single policy document can hope to address the plethora of influences on male health but as a first attempt the NMHP, with its background papers and supporting documents provides a useful blueprint for improving the health of Australian males. Key challenges though do remain in the transition from policy development to longer term implementation.

Of primary import is that there is no additional specific state or national funding allocated to implement aspects of the policy not otherwise funded in the initial policy offerings. Neither are there clear lines of responsibility, accountability or indeed timeframes described for policy implementation in general or for specific elements of the policy (except for those already funded). There are no formal processes, and no central points of co-ordination for ensuring cross-departmental or inter-sectorial support for elements of the policy that require input or co-ordination from outside the health sector (Richardson and Smith, 2011). Key, relevant and measurable male health indicators together with an independent evaluation framework remain to be established so that the outcomes

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and impact of the NMHP can be properly monitored (Andrology Australia, 2013). There also remains a need to determine how to embed policy elements within an uncertain and still developing broader gender mainstreaming framework (Richardson and Smith, 2011, Saunders and Peerson, 2009, Smith et al., 2010). Indeed, it also remains unclear specifically if and how the NMHP will interdigitate with the broader government health and social reform agenda, and key partnership agreements or who will be responsible for co-ordinating this process (Richardson and Smith, 2011, Andrology Australia, 2013). Some suggest that there is also a crucial a need for open dialogue and further research to examine how changing notions of gender and masculinity together with the societal, cultural and other factors that shape them interplay to influence male health (Saunders and Peerson, 2009).

Summary and conclusion

The health of Australian males is critical to their individual wellbeing as well as to that of their families, their communities and to Australian society; and males have special and unique needs within the health system that are different from females.
Despite major gains in life expectancy for Australian males over the last century there still remain major disparities in health outcomes between males and females and between different groups of males. Largely preventable diseases including ischaemic heart disease, cancers, respiratory system, prostate and lymph system disease, cerebrovascular disease, suicide and endocrine disorders account for almost two thirds of male deaths. The greatest contributors to the male non-fatal burden of disease are anxiety or depression, Type 2 diabetes, adult onset hearing loss, asthma and dementia.

Males die from preventable causes almost twice as often as females and death rates are greater across all age groups. Death and injury rates are highest in the 15-24 year age group due mainly to suicide, motor vehicle accident and other injury. Aboriginal and Torres Strait Islander males, those from disadvantaged, marginalised or non-English speaking backgrounds, or from rural and remote areas, together with older males, socially isolated males, returned service men, non-heterosexual males and those with mental illness, suffer the worst health outcomes. While biology is an obvious contributor (e.g. prostate disease), socioeconomic disadvantage, cultural factors, limited health knowledge, risky behaviours, delayed health seeking, and reduced access to health services are the key determinants.

In response, in 2010 the Australian Government released the first National Male Health Policy and became only the second country in the world to do so. There are nine supporting documents. This landmark policy takes a social determinants approach and advocates for gender equity in dealing with the health needs of Australian males. The policy promulgates strategies for primary and secondary illness prevention together with health promotion and targets at risk groups. Its six priority action areas encompass optimal outcomes for males, health equity for subgroups of males and at different life stages and transition points, illness prevention, improved service access and an improved evidence base to inform future policy. A total of $16.7million over four years was allocated for implementation.

While demonstration of population level health improvements will likely take decades, in the three years since its introduction the NMHP has been responsible for a number of positive outcomes. A key outcome has been the establishment of a Male Health Reference Group comprising experts and other stakeholders to advise the Minister on male health priorities as well as to the implementation and monitoring of the policy. To increase the male health evidence base the Australian Longitudinal Study on Male Health – Ten to Men was commissioned in 2011. Further funding was allocated for the preparation of key statistical reports on male health of which four have been published to date.

To address the impact of social isolation as a contributor to poor male health outcomes the policy also provided funding to support the development of national infrastructure for community men's sheds as well as making available small grants to individual sheds for tools, equipment, building maintenance and other activities. Funding was also provided to develop a DIY Health Toolbox which apart from containing some basic tools for men's sheds, also included a range of health promotion materials for use in the men's shed setting. Finally the NMHP also provided funding for an Aboriginal and Torres Strait Islander initiative encouraging male family and community engagement.

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A number of challenges remain. These include the need for funding security by national, state and other agencies for a number policy initiatives and the need for training of health professionals in strategies that better engage males at different ages, from different backgrounds and of different occupational and social standing. There is little evidence of co-ordination between different government departments or between complementary policy portfolios to implement broader and cross-departmental agenda and strategies. As yet the policy does not outline roles or responsibilities of departments or other agencies, a timeframe for implementation, delineation of outcome indicators, or framework for evaluation. Finally there is a lack of detail regarding the development of a whole of government gender equity framework that is truly cognisant of male health.

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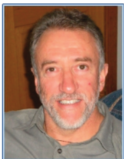

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