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Submission to

the Senate Select Committee on

Men's Health

March 2009

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Submission to the Senate Select Committee on Men's Health

Executive Summary

Men's health, as expressed by death rates, is very substantially worse that women's health.

The health of men in rural and especially remote areas, as expressed by death rates, is measurably worse than the health of other men.

The health of Australia's Aboriginal and Torres Strait Islander men is much worse that the health of other men in Australia.

Causes of death raising the death rate of rural men above that in major cities are cardiovascular disease, emphysema and bronchitis, cancers (including lung and prostate), diabetes, motor vehicle traffic accidents and suicide.

Men (and women) in rural and especially remote areas have measurably reduced access to a range of health services including primary care, diagnosis, life saving hospital procedures (eg coronary artery bypass graft) and mental health care.

Of critical importance to the health of men in rural and remote areas is the environment in which they live. Healthy economies, access to education, work and a range of community or social activities, community resilience and identity, decent housing and services are all keys to good health.

Climate change threatens the viability of primary production, at least in southern Australia, through its impacts on rainfall, evaporation, agricultural productivity, river water flows, bushfire and the prevalence of arboviral disease, amongst others. Reduced agricultural, forestry and fishing yields threaten the economic basis of many of Australia's rural and remote communities.

Climate change also provides opportunities for substantially broadening the basis of economic activity in rural and remote areas, for example through the development of renewable energy and carbon sequestration industries in rural and remote areas.

Prevention should be a major (but not the only) thrust of any strategy to address men's health. Issues including men's lifestyle choices (eg to smoke or not to smoke), attitudes (eg to risk and to seeking help), behaviours, working environments, their critical role and responsibilities for children, and their expectations could all be fruitful areas to explore and address.

In addition, ensuring that men have access to a range of health services and, if possible, services that are man-friendly would provide greater opportunity for men to access primary care. There could be incentives for employers to ensure their workers have an annual health check, and for retired men to obtain checks and screening.

Men start as boys. Healthy development of boys' bodies and minds is critical for the development of healthy, strong, intelligent and industrious men.

Statistical information about men and their health is currently poor, especially for those in rural and remote areas. The Alliance has long argued for increased funding to improve the availability of statistical information about the health of people in rural and remote areas. Key strategies would include ongoing funding for key data agencies (eg AIHW) to continue their work on rural health, the formation of a rural and remote health research institute (a strategic approach to rural health research), regular, independent evaluation of the effectiveness of government rural health programs, and the establishment of a longitudinal study into men's health.

Recommendations

- The Alliance urges the Australian government to implement a longitudinal study of men's health with adequate sampling and sufficient power to report for men in rural and remote areas, for all Aboriginal and Torres Strait Islander men, as well as for males nationwide.

- The Alliance supports development of an Australian men's health policy.

- Improving men's health should be given priority both as a health issue and as one that will improve economic productivity.

- A men's health policy should focus on preventive health (including through workplace measures), improve men's access to preventive services, and encourage men to reduce their personal health risks.

- A men's health policy should address their health by, among other things, improving the formative experiences of boys and their education, particularly in rural and remote areas.

- A men's health policy should also address men's health by creating positive economic environments. In rural and remote areas, diversification of industries, adaptation to climate change, installation of broadband, development of specific infrastructure, healthier town planning and so on, would bolster rural economies, and bolster men's health along with it.

- The Alliance urges the government to establish a rural health research institute to shape a strategic approach to rural health research, including that related to men's health.

Introduction

The National Rural Health Alliance is the peak non-government body concerned with rural and remote health issues in Australia. It comprises 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers. The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, with the specific goal of equal health for all Australians by 2020. (A list of Alliance Member Bodies is at Attachment 1.)

Considerable attention has been given to women's health over the past 20 years since the development of the first National Women's Health Policy[1], and a longitudinal study of women's health[2] commenced in 1996.

Relatively speaking, information about men's health is poor and scarce, although it is clear that men experience worse health outcomes overall than women. Men's health receives about 30 per cent less funding than women's health. The Alliance believes that a longitudinal study of men's health in Australia is overdue and attempts to find funding for such a study are gaining ground[3].

The Alliance is pleased that the Senate is asking questions about men's health. We are also pleased that the Department of Health and Ageing is, for the first time, developing a Men's Health Policy[4]. We hope to make a useful contribution to the development of this policy.

On many measures, men living in rural, regional and remote (hereinafter 'rural') areas generally experience higher death rates, poorer health and are more likely to be psychologically troubled in comparison to their city counterparts. They are more likely to engage in daily smoking, drink excessive amounts of alcohol, have less active lifestyles, suffer injury and disability and be overweight or obese. Also, rural men overall have fewer educational and employment opportunities, lower income, poorer access to healthcare providers, and less choice of recreational and other health promoting activities, while also having lower levels of access to life saving surgical procedures.[5] These points will be discussed in detail in this paper.

Some of this disparity is a reflection of the disadvantage of many of Australia's Aboriginal and Torres Strait Islander men. However, even after accounting for the poor health outcomes of many of these men, the outcome for non-Indigenous men in rural and remote areas is measurably worse than for their counterparts in major cities.

This submission will make some general comments and then briefly address the Committee's specific questions about men's health.

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[1] http://www.health.gov.au/womenshealthpolicy
[2] http://www.alswh.org.au/
[3] http://www.andrologyaustralia.org/pageContent.asp?pageCode=WHATSNEW1600
[4] http://www.health.gov.au/internet/main/publishing.nsf/Content/national+mens+health-1
5 AIHW 2006a. Australia's health 2006. Cat. no. AUS 73. Canberra: AIHW.

Health status of men in rural and remote areas

Judged from death rates, men's health status is very substantially worse than that of women. In addition, and of particular relevance to the Alliance, is the fact that, on average, males in rural areas have worse health outcomes than their male counterparts in metropolitan areas.

Death rates for males can be several times those for women of the same age. Figure 1 compares age-specific death rates for males in broad remoteness regions of Australia, with those for females living in major cities. The only age group in which males have a lower death rate than females is the 80+ age groups (and this is likely to be a statistical artefact).

Figure 1 shows that males have higher mortality than females throughout life, particularly from age 15 to 40 years. The figure also shows that the disadvantage becomes greater with increasing remoteness, such that while 20-30 year old males in major cities have death rates three times those of similar aged females, similar aged males in regional and remote areas have, respectively, a four and six times higher risk of death than females in those areas.

Even though Figure 1 relates to data that are ten years old (the latest for which this analysis has been conducted), we believe that the pattern shown here is unlikely to be very different from the current situation.

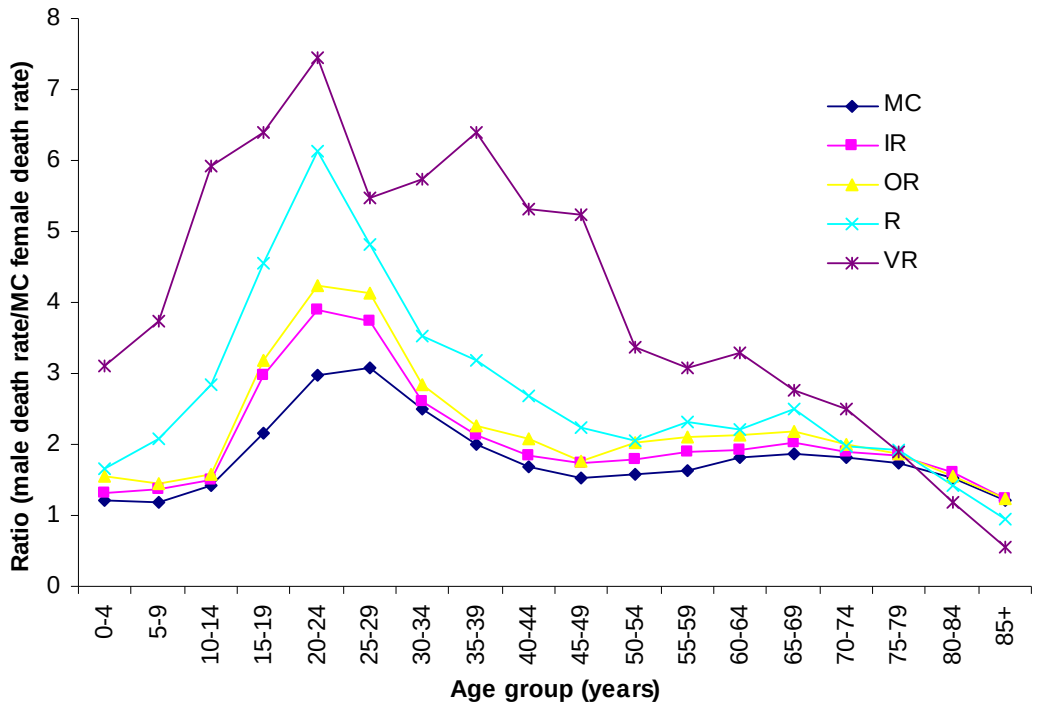

Figure 1: Age-specific death rates of regional and remote area males compared with those for similar aged females in major cities, 1997–1999.

Note: A ratio of 1.0 indicates a death rate identical to major cities women of comparable age. A ratio of 3.0 indicates a death rate for males that is three times that for major cities females.

Source: Derived by NRHA from AIHW data (REF) AIHW 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW.

Death rates for men in rural and remote Australia are between 5–25 per cent higher than in major cities (Figure 2 below) and, for those younger than 65 years in remote areas, nearly three times (200 per cent) higher.

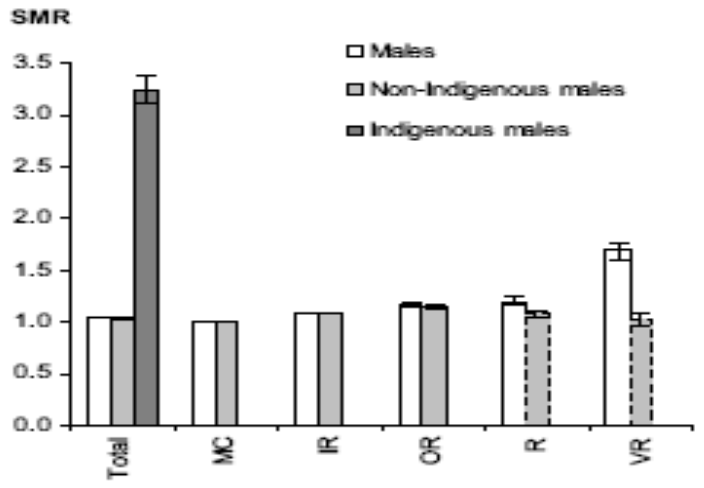

Figure 2: Inter-regional comparison of death rates, 2002-2004

Source: AIHW 2007. Rural, regional and remote health: a study on mortality (2nd edition). Rural health series no. 8. Cat. no. PHE 95. Canberra: AIHW

Overall, the figures show that about 4,400 more people die annually outside major cities areas than if death rates were similar across the board. Of these additional deaths, 65 per cent (2,873) are male.

Indigenous and non-Indigenous men's health

Some of this greater disadvantage, particularly in remote areas, reflects the prevalence of Indigenous people in these areas, coupled with their on average much poorer health outcomes.

A sustained focus on improving the health of Australia's Indigenous peoples must become and remain a high priority for the Australian, State and Territory governments.

Figure 3 below, shows that death rates of non-Indigenous males are similar to those for males generally in the previous figure. It is also clear that average death rates[6] for Indigenous males at almost all age groups are very high compared with any of the other groups.

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[6] We should stress that statistical averages are just that— averages. While it is undoubtedly true that many Aboriginal and Torres Strait Islander men have poor health outcomes, many other Aboriginal and Torres Strait Islander men have much better outcomes. It is our understanding that simply being Indigenous is not the major influence on health outcomes. Aboriginal and Torres Strait Islander men who had healthy childhoods and who have good access to services, jobs, education, good food, sport, and who don't smoke or drink heavily, and who are not overweight etc, will have good health outcomes.

Seventy per cent of all Aboriginal males live in rural, regional and remote areas and death rates for the general population of males (in remote areas particularly) reflect both the numbers of Indigenous males there and their current lower life-expectancy. Death rates for non-Indigenous males are also elevated in regional and remote areas, although not to the same degree as for Indigenous males.

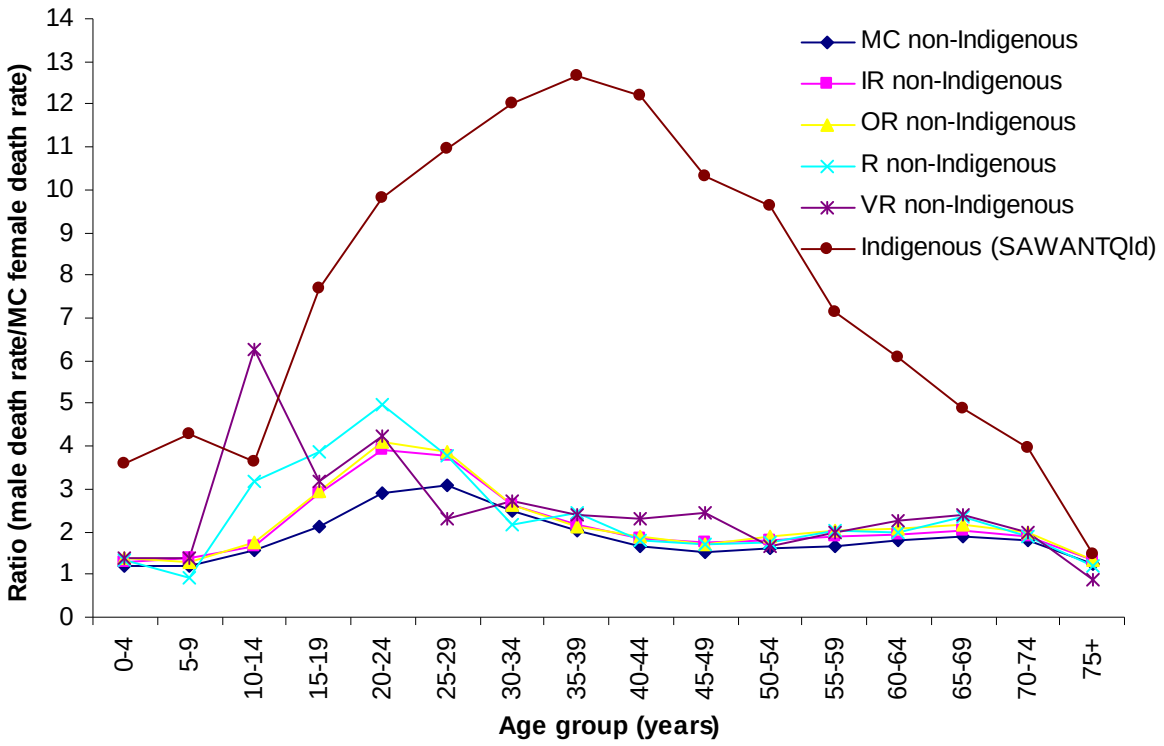

Figure 3: Age-specific death rates of regional and remote area non-Indigenous males and Indigenous males in SA, WA, NT and Qld, compared with those for similar aged non-Indigenous females in major cities, 1997–1999.

Note: A ratio of 1.0 indicates a death rate identical to major cities non-Indigenous women of comparable age. A ratio of 3.0 indicates a death rate for males that is three times that for major cities non-Indigenous females.

Source: Derived by NRHA from AIHW data. AIHW 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW.

Specific diseases and trauma

With the data available, it is difficult to compare rates of disease in regional and remote areas with those in major cities, but it is possible to compare rates of death due to these causes.

During the period 2002–2004, the main contributors (Figure 4) to the annual 2,873 extra deaths of males outside major cities were a raft of chronic diseases - coronary heart disease

(19 per cent), other circulatory diseases (excluding stoke) (13 per cent), emphysema and bronchitis (COPD) (10 per cent), cancers (strongly featuring lung and prostate cancers) (18 per cent), and diabetes (as primary cause of death) (4 per cent). Injuries were responsible for much of the rest of these extra deaths, with motor vehicle accidents (10 per cent) and suicide (6 per cent) featuring strongly.

National surveys provide limited information about health in regional areas, and very little about health in remote areas. Hospital data reflect the availability of services and admission patterns as well as clinical need. Mortality data remain one of the best means of comparing health across the areas, notwithstanding their disadvantage as a blunt tool.

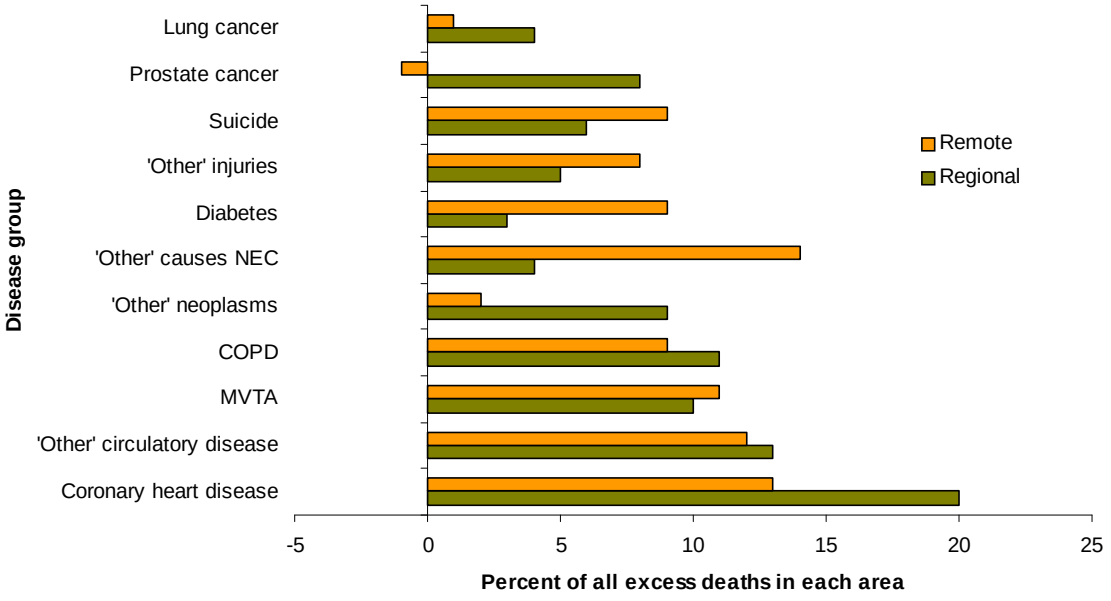

Figure 4: 'Excess' male deaths in each area by cause, 2002-2004

Note: Total of 92 per cent and 87 per cent of all excess deaths identified for males in regional and remote areas respectively. Note that 'Other circulatory disease' excludes stroke. Stroke is an important cause of death across the board, but rates were very similar in major cities, regional and remote areas.

Source: Derived by NRHA from AIHW data (REF) AIHW 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW.

Death rates due to coronary heart disease and 'other' diseases of the circulatory system in regional and remote areas are typically 10 per cent to 90 per cent higher than in major cities. This is not surprising given the poorer risk profile (eg smoking, overweight and lack of exercise), the lower rates of preventive medical procedure (eg coronary angioplasty) undertaken and the lower access to health services generally (including to primary health care) for people living in these areas.

Death rates for males in regional and remote areas due to motor vehicle accidents are roughly twice as high as in major cities, and five times as high in very remote areas.

Death rates for males in regional and remote areas due to suicide are 1.3–1.7 times those in major cities, and 2.6 times higher in very remote areas. The bulk of the excess in very remote areas is a consequence of the suicide of young Indigenous men.

The incidence of new cases of many cancers (eg lung, prostate and melanoma) in rural and remote areas is not only higher than in major cities, but also the 5-year cancer survival rates are significantly lower than in the major cities. One of the likely explanations of lower cancer survival in regional and remote areas is the greater extent of the disease at diagnosis (broadly analogous to the later stage of the cancer at diagnosis)[7].

The NSW Cancer Council has recently commented that distance can also reduce access of rural patients to cancer treatments involving radiotherapy[8]. Lung cancer death rates for males in regional and remote areas are 1.05 to 1.3 times those in major cities. Prostate cancer death rates in regional areas are about 1.2 times those in major cities.

The incidence of melanoma due to sun exposure is higher in regional areas than in metropolitan areas and has been steadily rising over the last 20 years. While melanoma was responsible for about 1,300 deaths annually, and was only the tenth most common form of cancer death in 2005, it was responsible for 42 per cent of all excess new cases of cancer in regional areas[9]. UV exposure may be greater outside major cities and it may also be that men are not protecting themselves as effectively as they might or being diagnosed early enough, or they may not be receiving adequate treatment because of difficulties accessing services.

Death rates for males in regional and remote areas due to chronic obstructive pulmonary disease are 1.2–1.4 and 1.6–2.3 times the rates in major cities.

Death rates for males in regional and remote areas due to diabetes are, respectively, 1.05–1.3 and 1.9–3.3 times rates for males in major cities. This differential is largely influenced by mortality of Indigenous men (although rates are still elevated for non-Indigenous men in outer regional and remote areas).

Why do rural men have such poor health outcomes?

A discussion of the health of men in rural and remote areas would be incomplete without first discussing the context in which they live.

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[7] http://www.aihw.gov.au/publications/can/cspia-cdf-82-04/cspia-cdf-82-04.pdf Australian Institute of Health and Welfare, Cancer Australia & Australasian Association of Cancer Registries 2008. Cancer survival and prevalence in Australia: cancers diagnosed from 1982 to 2004. Cancer Series no. 42. Cat. no. CAN 38. Canberra: AIHW.

[8] http://www.nswcc.org.au/html/aboutus/media/mediareleases/mar0309_radiotherapy_callin.htm

[9] http://www.aihw.gov.au/publications/index.cfm/title/10519 AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Rural Health Series no. 9. Cat. no. PHE 97. Canberra: AIHW.

Ill health does not develop in a vacuum, nor does it resolve itself in one. There may be a number of positive benefits to living outside major cities, but available statistics point only to the negatives, some of which are quite substantial.

The reasons why men in rural and remote areas have worse health than their peers in major cities fall into a number of broad categories.

Environment

- Riskier occupations.
- More dangerous driving conditions, frequently at higher speeds.
- Locational issues related to remoteness and population density.

Socio-economics

- Average lower income and education.
- More likely to be Indigenous.

Personal characteristics

- Poorer personal health risk factors.
- Possibly riskier cultural characteristics, including attitudes and behaviours.

Access

- Less availability and greater barriers to accessing primary health care, sub-acute and acute care services.
- Longer retrieval times after trauma.

Environment

Many men in rural and remote areas contribute strongly to Australia's export earnings through their engagement in the agriculture, forestry, fishing and mining sectors. These sectors are among the most hazardous in which to work.

Road travel, especially between towns, can add to risks. People in rural and remote areas are exposed to higher speeds, animals on roads, gravel roads, increased elapsed time (to inform, respond and retrieve) after accidents, and large distances that induce tiredness and may decrease the options to 'take a cab' after drinking, and may encourage people to drive home while intoxicated.

Distance and remoteness reduce people's access to a range of health-supporting services, not just health services.

Isolation and the opportunity to be alone can increase the opportunities to attempt suicide. Greater access to more lethal means (eg firearms) can increase the opportunity for violent interventions and completed suicides.

Greater exposure to the natural environment can increase the risks of arboviral diseases (eg Ross River Virus) and zoonoses (eg Q fever).

Ironically, access to fresh fruit and vegetables can be constrained in some rural areas, and they are sometimes unavailable (or unaffordable) in some remote areas. Conversely, processed foods that are high in fats, salt and sugar, and cigarettes, are generally readily available.

The quality of town planning affects opportunities for exercise, recreation, healthy living and a sense of joy. Without a pleasant or safe environment in which to walk, play sport, swim, cycle or socialise, the options for a healthy lifestyle are limited.

People in rural and remote areas also have substantially poorer access to the internet, and especially to broadband. This reduces their opportunity to access services and to participate more broadly in the life of the nation.

The quality of housing for many of Australia's poorest people, and for many of our Indigenous people, is a national scandal. Overcrowding and poor sanitation provide excellent opportunities for the development and spread of infectious diseases, frequently among children, greatly reducing their opportunity for a healthy and long (or even average) life. A major compounding issue is that reducing opportunities for good health also reduces opportunity for education and economic productivity, which in turn reduces the opportunity for decent living conditions, and so the cycle continues. Whereas less than three per cent of households across the nation are considered to be crowded, 14 per cent of households in very remote areas are crowded, and up to 40 per cent of Indigenous households are crowded.[10] As stated, among other disadvantages, crowding increases the spread of infectious disease.

Socioeconomics

Income and cost of living

Incomes and educational levels in rural and remote areas tend to be lower on average compared with major cities.

For example, about 35 per cent of people in major cities live in Australia's least disadvantaged areas, compared with about 10 per cent of people in regional and remote areas and 2 per cent of people in very remote areas. Conversely, 20 per cent of people in major cities live in Australia's most disadvantaged areas, compared with about 30 per cent of people in regional and remote areas, and about 55 per cent of people in very remote areas[10].

While rents and mortgages in regional and remote areas tend to be 0.6-0.8 times what they are in major cities, prices for commodities tend to be higher (eg food prices in very remote areas are 15-20 per cent higher than in major cities)[10].

Education

Access to education in rural areas tends to be poorer for a number of reasons. The demand in rural and remote areas for highly educated workers is less than in major cities. This tends to limit the expectations of youth attending schools in rural and remote areas, which acts as a

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[10] http://www.aihw.gov.au/publications/index.cfm/title/10123 AIHW 2005. Rural, regional and remote health—Indicators of health. AIHW Cat. No. PHE 59. Canberra: AIHW.

disincentive to high school completion. Ironically, a well-educated workforce is a key to attracting more sophisticated industry to rural areas[11].

Most teachers, like other professional groups, prefer to work in major cities or in coastal regional areas than in inland regional or remote areas. Currently, State Education Departments offer incentives, whereby new teachers can eventually 'earn' a position at a school in a 'desirable' area by serving time in regional and especially remote areas. Consequently, schools outside major cities may be less likely to have experienced and capable teachers than those in major cities.

Schools in smaller regional and remote areas tend to face greater challenges in terms of the 'critical mass' of educational skills required to offer a wide range of quality educational opportunities for children.

A lower prevalence of role models in specialised employment (ie employment requiring further education) also reduces the motivation for children in rural and remote areas to further their education. Also, it can be difficult for children in rural and remote areas to go on to higher education because while students whose parents live in major cities can 'live at home', those whose parents live outside major cities are unlikely to be able to do so, and will need to pay for accommodation – a very real economic impediment to young people from rural and remote areas attending university. Furthermore, young people from rural and remote communities face major challenges in the long transition to successful living without their support networks of the local culture and environment and the companionship and support of family and friends.

Industry

Rural economies do not rely entirely on farming and mining. The bulk of the workforce in rural and remote areas is employed in other industries (eg government, retail, service, etc). However, a downturn in agricultural production or in commodity prices has a large impact on the viability of many of the businesses in rural areas, and on the welfare of people living in those communities.

Further diversification of the rural and remote economy can only serve to bolster the welfare of people in rural and remote areas against the uncertainties of climate, especially in a time of climate change. However reduced access to broadband limits the opportunities for people in rural and remote areas to diversify their income base, as well as reducing access to education, information and services.

The development of new infrastructure and industries in rural and remote areas (such as renewable energy power stations, carbon sequestration plants, fast rail, broadband internet, and so on) would strengthen the resilience of the economy outside major cities.

Indigenous Australians

Aboriginal and Torres Strait Islander people constitute over 40 per cent of the population in very remote areas, and 2-5 per cent of the population in regional areas. The health and

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[11] http://www.ers.usda.gov/AmberWaves/May07SpecialIssue/Features/Policy.htm 'Policy Options for a Changing Rural America', Amber Waves, May 2007. Economic Research Service, US Department of Agriculture.

welfare of Australia's Indigenous people would be well served by a range of programs, but central, in the Alliance's opinion, is the opportunity for Indigenous people to have good housing and decent access to law and order, health services, education and jobs.

Personal characteristics

A range of rural men's characteristics make them more likely to experience worse health outcomes compared with their major city counterparts. These are discussed below.

Personal health risk factors

A large proportion of the mortality due to diseases and injuries mentioned above is potentially preventable. Assisting men to quit tobacco, drink more moderately, better protect themselves at work, seek and accept help when they need it (or for rural men – at least to be able to access help) may measurably improve their health outcomes.

Table 1: Self-reported risk factors for men versus women, and in rural/remote areas versus major cities, 2004/05

Behavioural risk factors	MC M/F crude prevalence ratio	MC	IR	(OR+Rem)	Reg+Rem
		Age standardised prevalence ratio			
Tobacco smoking	1.35	1.00	1.11	***1.26**	***1.17**
Hazardous/harmful alcohol consumption	1.26	1.00	***1.19**	***1.41**	***1.27**
Sedentary levels of physical activity	0.89	1.00	***1.16**	***1.39**	***1.25**
Consume reduced fat milk	0.76	1.00	***0.90**	***0.84**	***0.88**
Consume 2+ serves of fruit per day	0.78	1.00	1.01	***0.90**	0.97
Consume 4+ serves of vegetables per day	0.77	1.00	***1.58**	***1.66**	***1.61**
Experienced food insecurity in past 12 months	0.85	1.00	1.14	1.12	1.13
Personal risk factors					
High blood pressure	1.88	1.00	1.09	1.08	1.08
High cholesterol	1.06	1.00	0.85	0.86	***0.85**
Obese/overweight	1.38	1.00	1.03	***1.13**	***1.07**
Changes (1995-2004/05)					
Smoking		***0.83**	0.95	0.94	0.95
Alcohol		***1.39**	***1.40**	***1.40**	***1.40**
Sedentary		***0.93**	1.01	***1.12**	1.05
Obesity		***1.13**	***1.15**	***1.24**	***1.19**

Source: Derived by NRHA from AIHW[9]

As one might expect, men were worse than women on most risk factors. For example, they were more likely to smoke, and to drink excessively, less likely to eat well, and more likely to self-report high blood pressure and being overweight (but were less likely to report being sedentary).

Men in rural and remote areas tend to be more likely to smoke, to drink more than they should, to be overweight, to be sedentary, and so on (Table 1) compared with those in major cities. This tendency to 'do the wrong thing' increases with remoteness. At least they are more likely to be eating their vegetables (although these may be chips)!

Knowledge of blood pressure and blood cholesterol concentration relies on a test having been performed. People in rural and remote areas have lower levels of access to health services, and so they are less likely to be aware if they have either high blood pressure or high blood cholesterol. Consequently the inter-regional comparison for these issues may understate the disadvantage for men in rural and remote areas.

In major cities, the prevalence of smoking amongst men has clearly fallen; however such a decrease has not been evident in regional and remote areas. While sedentary behaviour in males has declined in major cities, it has increased in regional areas. For males, obesity has increased across the board, as has alcohol consumption (Table 1).

Other characteristics, including attitudes and behaviours

Do men in rural and remote Australia have a set of personal characteristics that predisposes them especially to risk? Characteristics that spring to mind include stoicism, a tendency not to discuss health issues, a perception that being large is an advantage, a tendency not to consult with a doctor but to 'tough it out', tendencies to take greater risks, to see themselves as the 'breadwinner' and work longer hours, and so on. Anecdote suggests that this is the case, but we are unaware of any research that clearly describes or demonstrates the veracity of this. A longitudinal study would be very useful in providing this sort of information in the future.

Access to services

Access to primary healthcare services for both males and females in regional and remote areas is worse than in major cities. On top of this, men are also less likely than women to visit a GP, less likely to be voluntarily admitted to hospital and more likely to discharge themselves against medical advice 'at their own risk'.

Although there is little hard evidence, it is very likely that retrieval times for victims of trauma (eg injury and heart attack) are greater in rural and remote areas simply because of the distances involved and the time required to 'raise the alarm', find the patient and then transport them to appropriate care.

Lower levels of access to hospital procedures

While we are not aware of any evidence to suggest that males have lower rates of hospital procedures compared with females, AIHW has published data comparing rates of hospital procedures for people living in regional and remote areas with those living in major cities[10]. For example, people in rural and remote areas are between 0.6 and 0.9 times as likely to have a coronary artery bypass graft and coronary angioplasty as people living in major cities. As stated earlier in this paper, death rates due to coronary heart disease are appreciably higher outside major cities. This suggests that for males, as well as females, living in regional and remote areas reduces the opportunity for life saving surgery.

Lower access to GPs

In 2005 the BEACH survey reported that males constituted only 40 per cent of GP encounters, while females constituted the remaining 60 per cent.[12]

The 2004–05 National Health Survey reported that "females were more likely to consult health professionals than males. For example, 20 per cent of males had consulted a doctor in the previous two weeks, compared with 26 per cent of females. Proportions consulting other health professionals were 11 per cent for males and 16 per cent for females."[13]

Lower access to Medicare mental health items

Men (and women) in rural and remote areas of Australia have lower levels of access to the new MBS mental health services.

Late in 2008 and under the COAG Mental Health Reform, the Mental Health Council of Australia reported[14] that:

"Distribution of services remains an issue, with people not living in urban areas facing real disadvantage in terms of access to care under the new MBS items. Per capita service figures reveal the extent to which Australians not living in cities have less access to the new measures."

From this report, the rate of access:

- in regional areas is 40-90 per cent of that in major cities, while
- in remote areas, it is 10-30 per cent of the rate in major cities.

The report also comments that "women are twice as likely as men to have received some care under the Better Access Program. This trend tends to mirror the pattern of total GP presentations and may reflect broader patterns of help-seeking behaviour across genders but seems more exaggerated for these mental health items. Further, we know the risk factors for adverse outcomes, such as suicide, are significantly higher for men than for women."

Lower use of Medicare

Males access Medicare 0.7 times as frequently as females. In some age groups (20 to 35 years), use is as low as 40 per cent of the rate for females, though much of this difference likely reflects increased use of GP services by females seeking help for reproductive health issues (Figure 5). By their late 30s, men have 57 per cent of the number of consultations of

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[12] http://www.aihw.gov.au/publications/index.cfm/title/10171 Knox S, Britt H, Pan Y, Miller GC, Bayram C, Valenti L, Charles J, Henderson J, Ng A, O'Halloran J 2005. Locality matters: the influence of geography on general practice activity in Australia 1998–2004. AIHW Cat. No. GEP 17. Canberra: Australian Institute of Health and Welfare (General Practice Series No. 17).

[13] http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3B1917236618A042CA25711F00185526/$File/43640_2004-05.pdf ABS. National Health Survey: Summary of Results. Cat No 4364.0. 2004– 05.

[14] http://www.mhca.org.au/documents/publications/COAG%20MBS%202nd%20Report%20Sept%202008.pdf Mental Health Council of Australia 2008. Mental Health and the new Medicare Services: 2nd Report November 2006 – August 2008. September 2008

similar aged women, 'narrowing the gap' in their early 60s to 84 per cent of the number of consultations by similar aged women.

Unfortunately, the Alliance has never been successful in accessing Medicare data in a format suitable for comparing the use of Medicare services in major cities, regional and remote areas, and consequently is unable to advise the committee as to the effect of remoteness on men's use of Medicare services. We can only assume that use is significantly less because medical practitioners are less prevalent in regional and remote areas. We are hopeful that AIHW (or another statistical agency) may be successful in accessing Medicare data and be permitted to publish their findings in the future so as to inform debate.

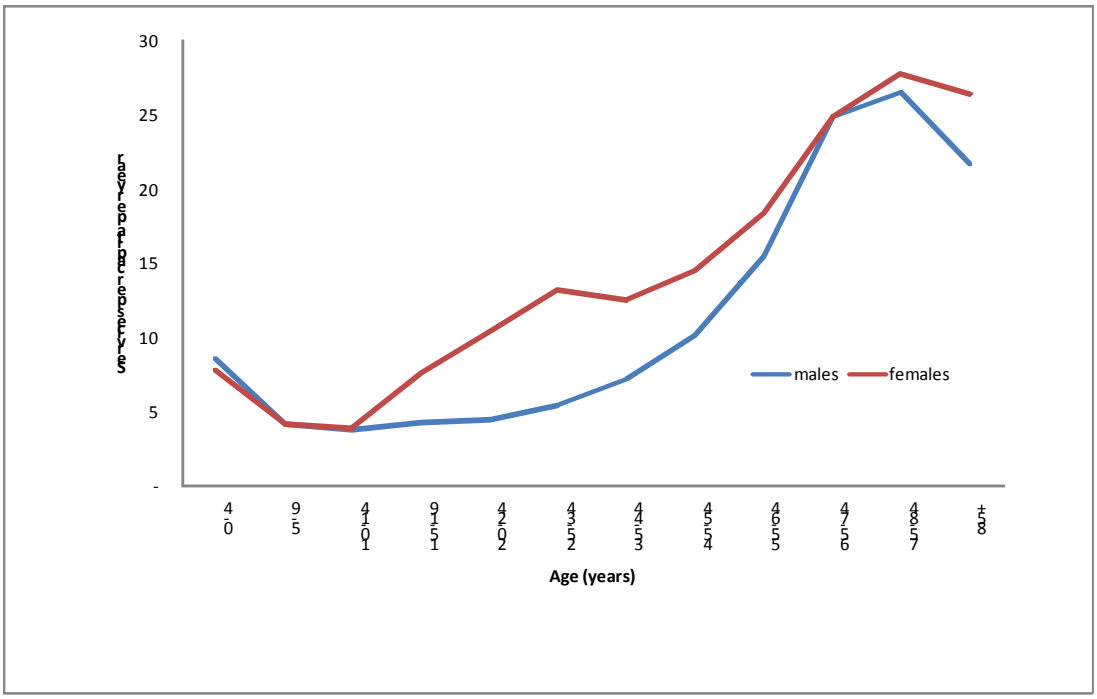

Figure 5: Age specific annual Medicare services per capita, 2004/05

Source: NRHA derived from Medicare data[15]

Other considerations

As well as what has been discussed above, there are a number of other aspects of life in regional and remote areas which may impact on the health of males.

Growing up and then living in a small town may be challenging for young homosexual men. Anonymity would be harder to maintain, while the attitudes of peers may be more antagonistic than in major cities. It might be that this raises suicide rates amongst young gay men in rural communities.

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[15] http://www.drinkingnightmare.gov.au/internet/main/publishing.nsf/Content/medstat-dec05-tables-d or http://www.health.gov.au/internet/main/publishing.nsf/Content/medstat-dec05-tables-d

Employment in rural towns is more exposed to market forces than in major cities. A change of job because of redundancy, business failure or for career advancement, will frequently mean moving town and a consequent impact on the family, schooling, social networks and spouse's work.

Rural economies are more exposed to the vagaries of the weather than those in major cities. This exposure is expected to increase with the roll out of climate change, likely further exposing rural people to natural disasters (eg drought), reduced agricultural production and the impact of these on physical and mental health.

Bureaucracies (and frequently parliaments) are based in major cities. Policy makers tend to view city models of operation as 'normal', while models that are effective outside major cities tend to be seen as 'abnormal' and therefore prone to being replaced by those that are effective in cities (but not necessarily in rural and remote areas). The provision of primary care services may be a case in point, with rural and remote populations saddled with city-centric models of care.

Specific Issues

Social and emotional wellbeing

Over the past few years, drought has not only ravaged the land, depleted stock, upset yields and disrupted lifestyles, it has also increased the prevalence of depression among those who work the land and whose businesses are reliant on a buoyant rural economy. A likely future impact of climate change is for further climate destabilisation and increased likelihood of drought in many current farming areas with its inherent economic and human costs.

There has been much speculation about the impact of drought on mental health and suicide in regional and remote Australia. The so-called Drought Bus toured country areas to provide financial relief to struggling farmers and revive the sagging spirits of depleted rural communities. Anecdotal evidence from those who staffed the bus suggests that drought has a substantial effect on the mental health of men in the bush.

Unfortunately, our statistical knowledge of the mental health of men in the bush is poor. ABS National Health Survey data suggest similar or slightly worse mental health, but the survey relies on self-reported data, while sampling in rural areas results in wide confidence intervals and in remote areas sampling is essentially non-existent. What we do know, however, is that suicide death rates for these men are higher than for men in major cities.

This is an area where a longitudinal study on men's health, with adequate representation in rural and remote areas, would provide an insight into a currently poorly understood issue.

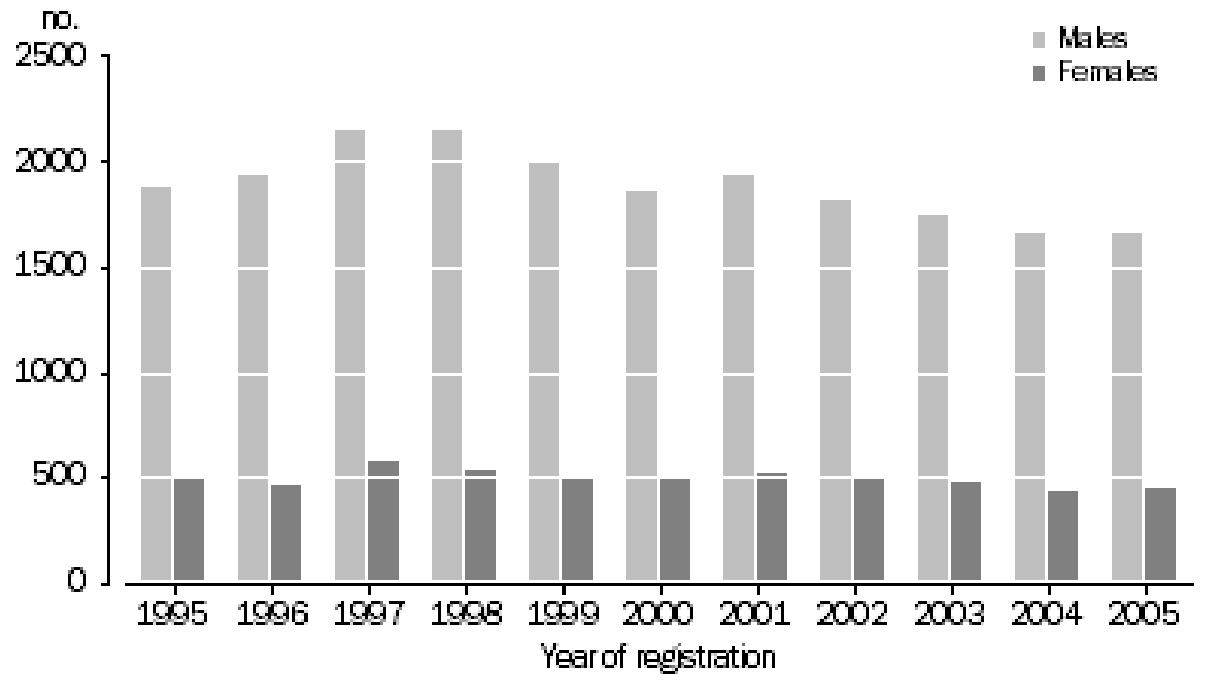

Figure 5: Suicide: Total number of deaths in Australia, 1995-2005

Source: Australian Bureau of Statistics 2005. Suicides. Cat.no. 3309.0. Canberra: ABS

The Australian Bureau of Statistics reports that 2,101 suicide deaths were registered in 2005, of which almost 80 per cent were men. Further alarming statistics are that male farm owners or farm managers commit suicide at almost twice the rate of the national average[16] and young Indigenous men commit suicide at between 4 and 6 times the rate of their non-Indigenous counterparts[9].

It may be that suicide rates are higher in rural and remote areas because mental health is worse in those areas or is less well treated, or it may be that the environment exacerbates mental illness, or that the environment is more lethal. As discussed earlier, measures of mental health in rural areas are of poor quality, so mental health status in these areas is somewhat unclear. A more lethal environment may be one in which there is greater access to lethal means (guns) and disinhibitors (alcohol), greater opportunity to commit suicide through being more alone (eg sheds and paddocks), and an attitude or culture that fails to protect individuals from suicide.

16 Australian Centre for Agricultural Health and Safety. NSW Farmer's blueprint for maintaining the mental health and wellbeing of the people on NSW farms.

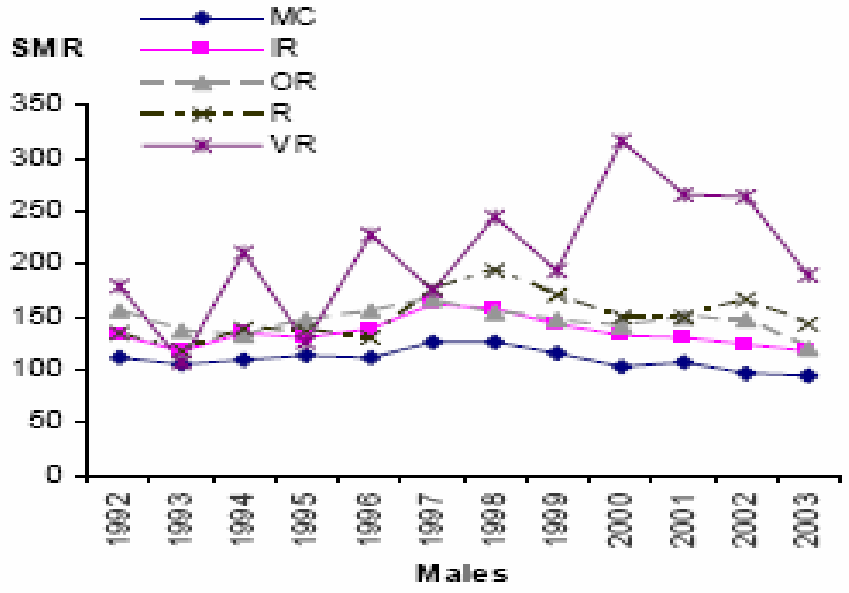

Figure 6: Trends in suicide mortality, 1992-2003

Source: AIHW 2006. Rural, regional and remote health—Mortality trends 1992–2003. AIHW Cat. No. PHE 71. Canberra: AIHW (Rural Health Series no. 7).

Rates of suicide death for men are 30 per cent higher in the least remote rural areas, increasing to almost 400 per cent higher in the most remote areas. Many of these men are Aboriginal. Worryingly, while the rate of suicide appears to be declining elsewhere, the rate of suicide in remote areas appears to have been increasing since the early 1990s.

Awareness and access to counselling and support

The harsh environment and weather conditions, including drought, floods and bush fires, relative lack of services and geographical expanse, are all regular reminders of the difficulties men and women face in regional and remote Australia. Many of those living and working in rural Australia experience these stresses in addition to the general stresses that people experience (eg financial concerns) in daily life.

We believe that rural men are significantly more likely to be under psychological stress than those in major cities. They engage in more physically demanding work which is generally less safe as they regularly work in isolated areas or on their own.

Living in a rural area has been linked to reduced help-seeking behaviour and rural men are less likely to have visited a doctor in the previous 12 months[17]. The limited access to health services[18] in rural areas may be an involuntary barrier to their use by rural men.

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17 Holden CA 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; 218-24

Warr D, Hillier L. "That's the problem with living in a small town": privacy and sexual health issues for young rural people. Aust J Rural Health 1997; 5: 132-139.

18 Johnston G, Wilkinson D. Increasing inequitable distribution of general practitioners in Australia, 1986-96. Aust N Z J Public Health 2001; 25: 66-70

More research is needed to better understand the barriers (health literacy, cost, time, culture, distance, low availability etc) that exist for rural men when accessing health services. For example, while the prevalence of prostate cancer is similar across geographical regions, prostate cancer mortality appears to be higher in rural areas than in major cities[19]. As suggested earlier, the higher mortality rates in rural areas may be due to rural and remote patients being diagnosed later in the course of the disease[20]. However, further research is needed to better understand such disparities and how diagnostic and treatment services can be improved. A sound evidence base is essential for creating informed policy and approaches to improving men's health in specific and most disadvantaged population groups. Again, a longitudinal study of men's health would be very useful here.

Seeking help for reproductive health concerns

When rural men do access health services, their level of specific enquiry and treatment for more personal and sensitive health issues, such as reproductive health disorders, are minimal[3]. Anonymity may not exist in relationships in rural locations as it does in many urban settings. Living in a small community may limit men's discussion of sensitive issues as their GP may be known personally to them.

A recent study found that rural men are less likely to speak to their GP about erectile dysfunction[21]. While not life threatening, erectile dysfunction can be highly emotionally traumatising and a sign of chronic disease, such as diabetes or heart disease.

Rural men may not be accessing treatment for sexual and reproductive issues because there is less opportunity for discreet patient-doctor visits in smaller communities[3]. Other major reasons for men not seeking medical help may be the belief that the problem is a result of medication or due to other issues that do not concern the GP (eg relationship or other sexual difficulties), or the inability to talk openly about erections or other sensitive health problems.

Sexually transmitted infections can also be more common in rural and remote areas than in major cities. For example, rates of syphilis are over 12 times as high in remote areas as in major cities. While the pattern in previous years has been similar, the absolute rates and regional differences have declined substantially since the early 1990s.

Similarly, rates of Chlamydia were 4 times higher in remote areas than in major cities in 2001. This pattern of higher rates outside major cities is typical of the pattern in previous years.

Apart from the disease implications for men, a pool of STIs in the male population provides a source of infection or reinfection for women and their children.

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19 http://www.aihw.gov.au/publications/phe/rrrh-ihsdh/rrrh-ihsdh.pdf Australian Institute of Health and Welfare 2008. Rural, regional and remote health: indicators of health status and determinants of health. Rural Health Series no. 9. Cat. no. PHE 97. Canberra: AIHW.

20 http://www.aihw.gov.au/publications/can/cspia-cdf-82-04/cspia-cdf-82-04.pdf AIHW, Cancer Australia & Australasian Association of Cancer Registries 2008. Cancer survival and prevalence in Australia: cancers diagnosed from 1982 to 2004. Cancer Series no. 42. Cat. no. CAN 38. Canberra: AIHW.

21 Warr D, Hillier L. "That's the problem with living in a small town": privacy and sexual health issues for young rural people. Aust J Rural Health 1997; 5: 132-139.

Communicating with men in rural areas about their health

Men in rural areas live within a different cultural setting than men living in major cities. For rural men, talking about health is not considered a 'normal' pastime, visiting health professionals may be seen as a last resort, and being overweight or a 'big bloke' can be seen as a sign of strength, rather than a sign of poor health[22]. Education strategies for health professionals working with men in rural areas need to recognise the impact of such attitudes and beliefs on help-seeking behaviours, particularly for more sensitive health issues[21].

The situation could be improved with some specific training for health professionals to make health services more appealing or less off-putting to men, eg though the use of more appropriate language, and through reconsideration of the settings in which services are delivered.

Challenges facing health workers in rural areas

A recent Australian Government audit of the health workforce in rural and regional Australia confirmed that there are not enough rural health workers to provide health services to people living in rural areas. In fact, per capita, people in remote areas have less than half the number of GPs as people in major cities[23].

In addition to their professional isolation and undersupply of staff, rural health service providers are also challenged by a lack of specialist staff and services in rural areas. Specialist referrals may require men from rural communities to travel long distances into major cities for specific treatment, which has cost and workplace implications. Particularly where a rural man owns or manages a farm or other local business, time away may mean less productivity and cause difficulties in having to find a replacement. People in rural areas have less than half the access to clinical psychologists as city people, and men use their services at less than half the rate of women[24].

Community action to improve men's health in rural areas

Australia is a large country with vastly different living environments. Similarly, the specific health needs of each community vary significantly and depend on the wide a range of social and environmental conditions. Compared to health service provision for men in major cities, provision of health services and programs for men in rural areas carries additional challenges of acceptability, availability, accessibility and affordability due to remoteness and financial limitations.

With a growing awareness of men's health across Australia, many regional and remote communities have taken the initiative to undertake activities to raise the awareness of men's health in their local community. This can take the form of simple displays in libraries, community health centres and other general settings, or a whole community approach with a range of programs and services targeted at local men. An understanding of the local context is necessary for developing a program that specifically meets the health needs of the local community. While often driven by passionate individuals, such community commitments to

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22 O'Kane G, Craig P and Sutherland D. Riverina men's study: An exploration of rural men's attitudes to health and body image. Nutrition & Dietetics 2008; 65: 66-71.

23 Australian Government Department of Health and Ageing. Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra.

24 Mental Health Council of Australia, Second report on mental health and new medical services, November 2006-August 2008.

men's health recognise the longer-term benefits in supporting men and their contribution to the local economy and community life.

While there are many examples of successful community approaches to men's health across Australia, different models exist that reflect the needs of the local community. For example, the Bendigo Community Health Service focuses on the provision of a men's health clinic, workplace assessments and significant men's health promotional activities, resulting in increased help-seeking by men within the local area.

In contrast, the Sustainable Farm Families initiative of the Western District Health Service in Hamilton, Victoria, aims to address health, wellbeing and safety issues specifically facing the farming industries by integrating farming family health indicators into farm management quality business reporting. With men being significantly represented in the farming industry, this program indirectly invests significantly in the health of local men to achieve both improved health outcomes and productivity.

Over the past few years, the Men's Sheds initiative has evolved across Australia where community-based 'sheds' or community groups have been established to help connect men, especially those who may be socially isolated, to their community. The type of activities being undertaken at each Men's Shed are many and varied but aim to reflect local community needs and setting.

The variety of innovative programs developing across rural Australia highlights the creativity of many communities and their self identified need to support local men.

Support required by rural communities to improve the health of men

Over recent years, the growing popularity of running men's health events, particularly in rural areas, has helped raise the awareness of a range of men's health issues. Men's health events are a great way to disseminate health information locally to men and their families. However, ensuring that consistent and evidence-based health messages are communicated can be difficult when there is a lack of local resources (eg funding and dedicated personnel).

As awareness of men's health issues increases in local communities, the challenge will be to develop and maintain specific programs and services that incorporate men's perspectives on health and provide ongoing support for their health needs. Building the men's health network through local communities across Australia will help co-ordinate and support sharing of knowledge about public health interventions and education and practice models that effectively engage men in local communities, being mindful that different approaches will work differently in different settings.

A free Men's Health Education kit has been developed by Andrology Australia, together with a range of education resources for communities and professionals. These can help equip local community members with information and resources to effectively run a seminar as part of a local men's health event. Simple tips are also offered to help those running a men's event to engage community members to lend their support.[25]

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[25] Individuals and communities wishing to hold an event can order the kit online at www.andrologyaustralia.org.

The future for the health of men living in rural Australia

As part of the Government's commitment to the health of people in rural communities, significant financial support is allocated to a range of workforce programs - particularly for general practice - that increase the range and access to health services in rural and remote Australia.

The establishment of the Office of Rural Health within the Department of Health and Ageing has been welcomed by the Alliance as a potentially useful measure for the improvement of health outcomes for those people, including men, living in rural, regional and remote Australia.

The Alliance has recently made several supportive submissions to the National Health and Hospitals Reform Commission which has also recognised the need for a much stronger rural focus.[26]. The adoption by government of many of these reforms would enhance men's health in rural areas.

In conjunction with a greater focus on health promotion through a National Preventative Health Strategy, the development of a National Men's Health Policy should ensure that priority attention is given to this issue – including in particular to its rural, regional and remote dimensions.

Statistical information is critical, as is effective evaluation of services (including successful innovations). Without these it is likely that efforts to improve men's health will be hit and Miss.

Climate change provides both threats and opportunities for rural economies and rural men. How government approaches climate change will have a major impact on the health of men (and women) in these areas.

The health and wellbeing of Indigenous people is a critical issue for Australian society, now and into the future. Greatly improved access to health services, good food, education, meaningful work, decent housing, and sanitation for Indigenous communities are all terribly important. Education, training and other fundamental human rights are part of what is needed to allow people to help themselves. Imposed 'wellness regimes' are very unlikely to be effective and Indigenous people, like all others, need to be able to direct activity and do it their way.

It may be that a new approach to advertising at, for example, sporting activities would help improve men's attitudes to drinking, eating and activity levels.

The need for research

In our opinion there are a number of research priorities:

- a longitudinal study of men's health;
- on what is working and not working in men's health now; and

[26] http://nrha.ruralhealth.org.au/cms/uploads/publications/nhhrc%20submission%20final%204%20june.pdf

- on men's attitudes, behaviours and practices and how they relate to men being 'compliant', responsible and proactive regarding their own health.

Much is known about the more extreme outcomes for men's health (eg death rates), but relatively little about rates of illness, knowledge, attitudes, behaviours, practices and access to services. Integral to accomplishing better health for men in general, and for men in rural and remote areas specifically, is a better understanding of men's experiences with, and attitudes towards, health, health risks and health infrastructure. A longitudinal men's health study could greatly benefit men's health by filling in some of the information gaps.

Consequently, the National Rural Health Alliance strongly supports the establishment of a longitudinal study of Australian men's health. Without such a study, we believe that progress on men's health will be greatly handicapped.

Because the health of rural men (and particularly of Indigenous men) is so much worse than that of other men, it is important that the sample is sufficient to allow reporting for men living in rural, regional and remote areas, and particularly for Aboriginal and Torres Strait Islander men in those areas.

In addition to a longitudinal men's health study, we believe that research relating to what's working and not working in men's health now, and dissemination of that information, would be particularly helpful.

Research relating to the barriers to men better managing their own health and to seeking help would be very useful. Among other things, it would throw light on the extent to which men's reluctance to attend health services is due to them being 'less responsible' as distinct from the services being 'man-unfriendly'.

Response to Senate questions

The Alliance believes that the level of Commonwealth, State and other funding addressing men's health, including prostate cancer, testicular cancer, and depression, is insufficient. Greater clarity about the causes and nature of men's health and ill health would enable additional investments to be well-targeted and a longitudinal study would soon prove very valuable in this respect.

There is the strong impression (although very little empirical evidence) that existing education and awareness campaigns regarding men's health, for both men and the wider community, are currently inadequate. There are some high-profile and effective practitioners in the area, and well-known interventions (such as the pit-stop program[27]), but the field is small and widely spread. We need to know much more about what works for men and why it does.

It is almost certain that the prevailing attitudes of many if not most men towards their own health and sense of wellbeing has an adverse effect on their health. To rectify this will require years (possibly generations) of gradual cultural change, involving education, modelling and mentoring. The Alliance believes that government programs and public campaigns (including public health campaigns) can contribute to the desired change, and that the establishment and

[27] http://www.healthblitz.com.au/programs/pitstop1.html

operation of a new men's health strategy will provide a framework and some direction for such public contributions to what is largely a personal, family and community issue.

As with many other health and health-related services, the extent, funding and adequacy of treatment services and general support programs for men's health are seriously deficient in rural, regional and remote areas. Some of the required investment will have national reach and will assist men in need wherever they live, but much will need to be specially targeted at the particular characteristics of men in rural and remote areas and the local communities in which they live and work.

Attachment 1:

Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Rural Sub-Committee of the Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association of Australia
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Members Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
RDAA	Rural Doctors' Association of Australia
RDN of the ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service of Australia
RHWA	Rural Health Workforce Australia
RIHG	Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
RPA	Rural Pharmacists Australia - Special Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health