Parliament of the Commonwealth of Australia

House of Representatives Standing Committee on

Family and Community Affairs

Men's Health

Summary report of a Seminar

November 1997

CONTENTS

Committee Membership	iv
Recommendations	v
Introduction	1
Research and Government funding	2
Conduct of the Seminar	3
Men’s health status	3
Men’s health and the health system - addressing ‘maleness’	5
Strategies to address these issues	11
Recommendations	11

APPENDICES

Appendix A - Seminar program	14
Appendix B - List of participants	15
Appendix C - Overhead presentations from Dr Kuldeep Bhatia	17

COMMITTEE MEMBERSHIP

38th Parliament

Members

Mr John Forrest, MP — Chairman
Mr Harry Quick, MP — Deputy Chairman
Mr Ross Cameron, MP
Ms Annette Ellis, MP
Mrs Kay Elson, MP
Mrs Elizabeth Grace, MP
Mr Harry Jenkins, MP [1]
Mrs De-Anne Kelly, MP [2]
Ms Jenny Macklin, MP
Mr Allan Morris, MP
Dr Brendan Nelson, MP
Mr Peter Slipper, MP [3]
Mrs Danna Vale, MP
Mrs Andrea West, MP

Committee Secretariat

Mr Bjarne Nordin — Committee Secretary
Mr Michael Tynan — Consultant
Ms Bronwen Jaggers — Research Officer
Ms Belinda Shepherd — Administrative Officer

---

[1] Replaced Hon. Duncan Kerr, MP on 17 November 1997.

[2] Replaced Mr Paul Marek, MP on 26 July 1996.

[3] Committee Chairman to 3 September 1997.

RECOMMENDATIONS

1. **An interdepartmental reference group be established at Commonwealth level (including the Departments of Health and Family Services; Primary Industries and Energy; Transport and Regional Development; Employment, Education, Training and Youth Affairs and the Occupational Health and Safety Commission), to investigate how to deal with the issue of 'maleness' in their program development and implementation. This needs to be considerably more than a tokenistic identification of men as a key target group and must deal with issues of maleness in a manner similar to the NRMA's *Like Father, Like Son* initiative, the *Men's night out* initiatives or the HIV/AIDS strategy.**

2. **The Department of Health and Family Services create a policy unit dedicated to the development of men's health policy to provide support to this reference group as they perform a systematic program audit. This policy unit should have a responsibility to ensure consistent data collection of research and treatment based on gender. This may require a substantial education process to address the issue of men's health falling into the 'blind spot' as outlined in the body of this Report.**

3. **The programs identified in the above audit (eg. RHSET, GP Practice Grants, National Drug Strategy, Anti-violence project etc) make men's health a priority area for the next three years, after which a comprehensive review is to be undertaken to evaluate progress in this area. As part of this process, programs should give serious consideration to setting a target for the percentage of their projects which should address men's health. (For example the General Practice Grants Program could set a target of increasing the number of men's health projects they fund from less than 1 per cent to 5 per cent for the next three years.)**

4. **Government departments and the NHMRC harmonise their activities in men's health so that integrated education and treatment strategies are implemented. For example, the current focus on prostate cancer screening should not cause older men's broader health needs (eg. urinary problems and sexual function) to be overlooked.**

5. **In conjunction with all stakeholders, including the States and Territories, Local Government, relevant peak organisations, community health services and men's support services with Commonwealth leadership:**

   - **identify best practice in men's health and develop a strategy to introduce these initiatives systematically across the country;**

   - **undertake a systematic audit of men's support groups and services with the aim of establishing the existence, nature and extent of any possible gaps in services for men in crisis (eg. men experiencing relationship breakdown, self identify as at risk of committing violence or suicide etc.) and develop a comprehensive strategy to support existing services and to address any identified gaps in services;**

   - **ensure that central to the development of men's health policy and identification of best practice initiatives, the different needs of particular groups of men are clearly identified and the differences noted. In particular, Aboriginal and Torres Strait Islander men's health needs must be clearly identified and supported. Other important groups include men from culturally diverse backgrounds, men from rural and remote areas and men from low socioeconomic backgrounds; and**

   - **develop a detailed research agenda to investigate these issues. As part of this the NHMRC should make men's health a priority area for research funding over the next three years. This should particularly apply to the public health/health promotion side of its activities.**

6. **This partnership could be coordinated at the intergovernmental level through the National Public Health Partnership, with men's health forming a key element of their workplan, with subsequent endorsement of any strategies developed at the appropriate Health Ministers' conference.**

7. **All these activities be pulled to together under a coherent national policy framework based on broad consultation with all relevant stakeholders. While the responsibility for the development of this policy lies with all stakeholders, the Commonwealth should take a leadership role. This policy development process should therefore be coordinated by the policy unit in the Department of Health and Family Services.**

SUMMARY REPORT

Men's Health Seminar

Introduction

1. The House of Representatives Standing Committee on Family and Community Affairs has responsibility for monitoring the portfolio areas of health and family services, immigration and multicultural affairs, social security and veterans' and youth affairs. As part of this responsibility, Members of the Committee identified men's health as an issue that requires more public discussion by being debated by the Parliament through the work of the Committee.

2. The *Men's health seminar* was convened on 29 September 1997, in order to gather information from a range of academics, general practitioners, health workers and other experts to give Committee Members a broad overview of the complex issues involved. The seminar also provided an opportunity for peak health, community and men's support organisations to exchange information and contribute to the discussion on key issues that need to be addressed in this area. A program of the day's events is at Appendix A. A list of all participants is at Appendix B.

3. The Committee recognises that despite an increase in focus on men's health issues in recent years, there is no coherent policy context or direction at the national level. Therefore, highlighting the issues to the Federal Parliament provides a unique opportunity to identify key future directions in a bipartisan manner.

4. While a number of participants spoke of the increasing acceptance of men's health as a legitimate area of study and health promotion in recent years, it was stressed that there is still a significant way to go. Until recent years, identification of men's health was seen as irrelevant in many health and academic circles.

5. Mortality statistics provide a stark illustration of the disturbing state of men's health. Males experience higher mortality rates at all ages compared to females, rising to a peak of 2.65 male deaths for every female death in the 15-24 age group. Men also have higher mortality rates for all the major causes of death. For example working aged men (aged 25-64) have death rates of 3.53 times those for cardiovascular disease, 1.94 times for cancers and 3.28 times for injury than working aged women. The summary of Dr Kuldeep Bhatia's presentation at paragraph 14 provides more detail on men's health status.

Research and current Government funding

6. The Committee welcomes the significant increase in focus on men's health issues in recent years, particularly at the community level, through a range of innovative initiatives such as men's health nights in rural areas and a wide range of men's support groups.

7. Federal, State and Territory Governments have also recognised men's health as an issue through the funding of the first National Men's Health Conference in 1995 and by supporting the second National Men's Health Conference in October this year. New South Wales and West Australia are in the process of developing men's health policies or strategies.

8. In the past it has been assumed that men's issues were addressed adequately through general interventions. Recently however, there have been a range of initiatives and research targeted specifically at men. Perhaps the best known and documented are initiatives for gay and other homosexually active men under Australia's highly successful HIV/AIDS strategy. A number of speakers noted that the success of this strategy might have a number of lessons for the broader men's health movement, a point which will be discussed further in the report.

9. Other initiatives include the *Healthy Activity for Working Men* project (aimed at encouraging male tertiary students to exercise regularly), various projects under the General Practice Grants program such as the *Men's night out* programs in rural Victoria, the development of a men's health database and web site and the development of a men's health training manual for health professionals under the Rural Health Services Education and Training (RHSET) Program.

10. Recent and current research initiatives include the NHMRC report *Unintentional Injury in Young Males 15-29 years,* and *The Men and Mental Health Report,* as well as studies relating to male specific health problems such as prostate cancer and lower urinary tract infection. The Public Health Division of the Department of Health and Family Services is funding a range of studies such as the *Young Men and Drug Use* research project, as well as developing an evidence based research agenda to guide policy and planning for men's health in the longer term for health promotion and disease prevention around the five national health priority areas.[1]

11. While these initiatives are significant, it is clear that their overall sparsity indicates the infancy of a specific and much needed focus on men's health issues. Dr Brian Richards referred to the Department of Health and Family

[1] The five national health priority areas are cardiovascular disease, cancer, injury, mental health and diabetes.

Services summary of all the General Practice Divisional projects between 1993-96. Only one page out of 125 (each page summarises about 12 projects) deals specifically with men's health. It is also indicative of the need for all areas of health promotion and primary health care to become increasingly sensitive to the issues of gender in their work.

Conduct of the Seminar

12. In order to provide the Committee and other participants with a comprehensive appreciation of men's health issues, the seminar, chaired by Committee Chairman, John Forrest MP, was divided into a number of sessions. The seminar commenced with two presentations aimed to give a broad picture of men's (and boy's) current health status and an overview of how men's heath has developed as a practice in Australia. This was followed by two sessions with five and four presenters respectively giving short presentations on the initiatives that they were involved in. The large number of presenters was necessary to attempt to capture the diversity and breadth of men's health activity in Australia. The majority of the afternoon was dedicated to discussion by the presenters and the participants to facilitate the development of recommendations to the Government.

13. The major outcomes of the day’s proceedings provided:

- a clear description of men's poor health status which extends beyond standard health measures to broader aspects of men's wellbeing and quality of life;
- a clear articulation as to the 'neglect' of the health system to systematically identify and address the impact that 'maleness' has on the full range of important men's health issues; and
- a range of constructive strategies to support and strengthen the existing responses to these problems at the community, regional, State and national levels.

Men's health status

14. Dr Kuldeep Bhatia gave a detailed statistical overview of men's health status. As well as addressing mortality statistics, he focussed on a wide range of risk factors and analysed many of the indicators on a regional basis (capital cities, other metropolitan areas, large, small and other rural, remote centres and very remote areas). A full copy of Dr Bhatia's overhead presentation is at Appendix C. Some of the following discussion is also supplemented by data presented by other speakers and is detailed in the transcript of proceedings.

15. The sex ratio at birth is 106 boys for 100 girls. However, males have higher perinatal death and congenital malformation rates, thereby reducing their early numerical advantage.

16. The earlier contribution of biological factors is progressively overtaken by environmental influences which makes it difficult to determine the precise impact of biological determinants of behaviour. Even in areas such as accidental drowning, the rate for young boys is much higher than for young girls.

17. Figures for alcohol consumption indicate that men consume more than women. While a similar picture emerges for smoking, the key difference is the significant public health gains made in this area. Men's smoking rates in recent years are now converging with those of women.

18. Obesity, a key risk factor in heart disease (the major cause of death in Australia) again reveals significantly higher rates in men. Diabetes also has a higher prevalence in the male population, despite the significantly lower proportion of men reporting themselves as having the disease in the 1995 national health survey.

19. This lack of recognition by men of their health problems is exemplified by their lower consultation rates with GPs compared to women. Whereas 6.1 per cent of attendances for women are for health promotion services (eg. screening or immunisation) this compares with 2.8 per cent for male visits. In fact, male utilisation of medical services is lower in all areas except injury.

20. The higher prevalence of risk factors and lower utilisation of health services inevitably results in higher mortality and disability. While mortality rates are higher in rural areas than the cities and higher still in remote areas, these differentials are much higher between men and women than they are regionally.

21. In extending this analysis to particular groups of men such as Aboriginal and Torres Strait Islanders, the male female differential is evident, although, in this case, it is overshadowed by the huge differential between indigenous and non-indigenous Australians. For example, indigenous men have death rates eight times the general population for some age groups.

Men's health and the health system - addressing 'maleness'

22. Mr Richard Fletcher's presentation focussed on the 'blind spot' in addressing men’s health issues in recent decades. He spoke of the surprise of health workers when he contacted them in 1990, in an attempt to develop a men's health policy in the Hunter area. This was an indication of the failure to recognise men’s health as a significant issue.

23. While health workers were aware of the differences in life expectancy of men they were genuinely shocked at the excessive gender differentials, particularly in the younger population, in relation to preventable issues such as road accidents, suicide and drowning. There was an assumption by many that biological determinants would be more prominent in the differentials (these differences are illustrated in the graphs at Appendix C).

24. An illustration of the blind spot in the health system was provided by the national drug strategic plan in 1990 which highlighted priority groups such as prisoners, Aborigines and women. Men were not included. This seems to imply that there are issues in relation to female drug use, such as the use of minor tranquillisers. A similar case could be argued that there are issues about being raised as a 'bloke' in our culture which affects, for example, the quantity of alcohol men drink.

25. Other examples include:

- A 1990 publication on Crime and Justice by the Institute of Criminology which included a list of groups overrepresented in prison and failed to mention men despite the fact that men represent 50% of the general population and make up 97% of the prison population.[2]

- In 1990, the NSW Consultative Committee on the Ageing issued a fact sheet stating that old age was an important women's issue because women make up two thirds of those aged 75 and over.[3] From a men's health perspective this a remarkably odd way to characterise issues relating to ageing. Is ageing a women's health issue because most of the men are dead? Clearly we do not promote similar arguments in respect of indigenous health.

26. The apparent assumption that men's health issues are adequately addressed by existing services is perhaps encapsulated by the comments of the Chief Planning Officer of the Victorian Health Department in relation to the famous case where Dr Alex Proudfoot tried to close down the Canberra Women's Health Centre on the basis of discrimination against men. When asked about the process of planning services for men and women he said that health planners assumed that services are meeting the needs of someone and because

---

[2] Mukherjee S, Neuhaus D and Walker J; *Crime and Justice In Australia*, Australian Institute of Criminology, Canberra, 1990.

[3] Factsheet No. 1, NSW Consultative Committee on the Ageing, 1990.

they are not working for women, therefore they are presumably working for men.[4]

27. In contrast to these views, many health workers have realised how poorly men are catered for and have developed local level initiatives to address men's health needs. More often than not these health workers have been women, particularly nurses, which demonstrates a clear difference from the development of women's health as a grass roots mobilisation of women. For example, it was a nurse and mother who developed the testicular screening pamphlet taken up and promoted by Apex. It was also a community nurse in rural Victoria who developed the first *Men's night out* program.

28. The points raised were supported by a range of presentations from the other speakers. Ms Pam Leicester, from the NRMA, pointed out that despite the fact that young men are five times as likely to be killed in motor vehicle accidents as young women and have twice the rate of serious accidents, there has been little attention given to this group or to their fathers. Recently however, focus groups have been conducted with fathers to explore the relationship they have with their sons in relation to driving.

29. There was a general consensus from the focus groups that fathers worry about their sons and that they perceive their role in teaching their sons to drive as important. The association of boys with cars was a constant theme in the discussions. For example comments included 'A man likes to drive' and 'I found my male child was more interested from an earlier age in driving' which suggested an association between gaining a driver's license and a male rite of passage.

30. Another issue that became apparent was the lack of opportunity fathers have to talk about these issues with other fathers. As a result, the research provided the basis for the NRMA launching a booklet entitled *Like Father. Like Son*, which has a number of suggestions for fathers and affirms the role they have to play in road safety with their sons.

31. Men's health consultant Mr Bernard Denner also talked about the importance of particularly targeting men through a partnership with local GPs, community health services, hospitals, councils and other health services. Getting GPs out of their consultation rooms to address large gatherings of men at a *Men's night out* - an informal gathering of men including light entertainment and refreshments - have been particularly effective, attracting

---

[4] Human Rights and Equal Opportunity Commission 1992 cited in Fletcher R; "An outbreak of men's health: the history of a welcome epidemic" in the *Proceedings from the First National Men's Health Conference*, Commonwealth of Australia, 1996.

1,200 men over the last 15 months across rural Victoria. Other initiatives include health screening in pubs and farm safety projects for primary school children to educate them to address the complacency of their fathers, uncles and grandfathers in relation to safety practices on the farm.

32. Dr Tony Jorm, from the NHMRC Social Psychiatry Research Unit, pointed out recent research showing different patterns of GP usage by elderly men and women. The pattern for women was that those with significant sicknesses saw their GP regularly while those that were well saw the GP far less frequently. In contrast, there is a large group of very sick elderly men who do not go to a GP at all, despite the preventable nature of many of their complaints.[5]

33. Clearly there is an underlying set of reasons closely linked to 'maleness' or what it means to be a man in modern Australian society. Dr Carole Pinnock's research with elderly men looked at the social factors associated with men growing up in the 1930s, 40s and 50s. The dominant male role was that of provider and protector, with the complementary role of one's wife as homemaker and nurturer. While that role may have served very well over the last 40 years, it carries a lot of risk factors into older age. As breadwinners, men feel they cannot afford to be seen as weak and symptoms of sickness may be interpreted as such. If a man's identity is tied up with work, then retirement can be a risk factor, as can be unemployment, which may result in the loss of identity and support groups. Also the skills of homemaking and nutrition can be lost through separation or loss of a partner.

34. Dr Garry Egger's research related to the development of the Gutbuster Program - a waist loss program for men. His presentation indicated three main barriers to men's health. First, biology - most animal species have lower life expectancies for males. Secondly, lifestyle factors related to biology - the excess of testosterone in males leads to high-risk lifestyle behaviours. Thirdly, there are attitudes that men have which are culturally and socially conditioned such as:

- resistance to displaying weakness amongst males;
- the desire for social proof; and
- 'the paradox of male company' - that men desire the company of other men but they do not want to show this, as it can be seen as a sign of weakness.

---

[5] Jacomb P et al; "GP attendance by elderly Australians: evidence for unmet need in elderly men" in *Medical Journal of Australia*, Vol 66, pg 123.

35. These issues are of significant importance when it comes to designing health promotion programs for men because they need to meet men on their own terms to be effective. Therefore, the Gutbuster program does not focus on alcohol consumption, weight control or health per se. It focuses on 'waist loss' - as research clearly showed that men were concerned about the size of their bellies. The program employs reflective strategies whereby male participants take control of the process instead of being passive participants. Follow up research indicates that men's interest in their own bodies by reducing waist size, results in reduced drinking and smoking behaviour.

36. A significant reference of many of the speakers at the seminar was the notion of 'wellbeing' as a central concept which is broader than 'health'. A number of the speakers argued that we need to address underlying issues about men's sense of wellbeing - their happiness in their relationships, work and the community - if we wish to achieve longer term benefits in the area of health status.

37. The relevance of these points was also illustrated in the General Practice context by Dr George Burkitt, who runs a practice exclusively for men in crisis. His 'male friendly model' involves a converted garage (known as the 'men's shed'), an informal atmosphere and no women's magazines. His consultations often run for an hour, which is very difficult to fund on current Medicare rates which penalise long consultations. The patients originate from all occupational backgrounds, over a wide age range and consultations focus primarily on relationship difficulties, breakdown and separation, family law, depression, substance abuse, work and financial stress and sexual problems.

38. Dr Burkitt noted the higher risk of suicide for separated men than for married men, whereas separated women do not have an increase in suicide risk. He argued that there is a real gap in funding for crisis services for men, particularly in the area of relationship difficulties and breakdowns. This is the major cause for establishing a range of men's telephone counselling services by volunteers in Brisbane, the Gold Coast, Lismore and Sydney.

39. Dr Brian Richards, Executive Director of the ACT Division of General Practice, talked of how GPs tend to orient and market their practices to be women and child friendly, a process that is likely to increase as female GP rates increase. This is exacerbated by the greater preponderance of practices near homes rather than near men's places of work. Some of the other speakers referred to the male reluctance to go to community health centres and other services that they perceive are designed particularly for women. Clearly issues of targeting health services in a 'male friendly' manner and addressing structural issues such as access are a key to improving men's utilisation of services.

40. Issues of wellbeing are also central to male GPs' own health as well. They work an average of 51.6 hours per week compared to the female GPs' 35 hours per week and there are four per cent of male GPs (compared to 1.6 per cent of female GPs) working over 80 hours per week.

41. Other talks focused more on issues that are specific to particular groups of men. Mr Paul Briggs, a Yorta Yorta man from Shepparton, Victoria, spoke of the lack of infrastructure suitable for use by Aboriginal communities to address issues of emotional and spiritual wellbeing. Aboriginal communities often operate in a hostile environment where they are isolated culturally, socially and politically.

42. The infrastructure they do have tends to be focussed around crisis intervention, such as the medical and legal services available. In contrast, the broader community has services such as the RSL, Rotary, Apex, sporting and professional bodies. Without a similar range of infrastructure, this tends to make Aboriginal people isolated from the mainstream and meaningful communication to address problems is very difficult.

43. The advent of the Rumbalara Football and Netball club is an attempt to bridge this gulf. It is far more than a social venue. It provides the infrastructure whereby athletes and their families and friends congregate as a community, thereby providing an opportunity to run health promotion initiatives addressing substance abuse, family violence, nutrition, diabetes and so on. It has also provided a bridge to the broader community in the provision of these health promotion initiatives.

44. The Committee noted the relevance of Mr Briggs' presentation to its current inquiry into Indigenous health.

45. Mr Peter Jager spoke of the range of initiatives undertaken by ALCOA to keep their workforce and their families well. ALCOA has a comprehensive program addressing issues at three levels, namely at work, in the family and in the broader community.

46. In the workplace, ALCOA has a comprehensive training program relating to occupational hazards, the correct use of safety equipment and routine health screening. They actively involve employees in hazard identification and risk assessment as well as in emergency response training such as fire and rescue skills. They run seminars for workers and their families in relation to coping with shift work, such as adjusting diet and social life. Security issues can also be a concern with the worker absent at nights resulting in strategies such as linking up with other neighbours whose husbands/partners are shift workers.

47. Health in the community includes strategies such as defensive driving courses. While ALCOA has had no fatalities on site, there have been some deaths while commuting to work. They also run a range of sporting competitions, some in conjunction with the National Heart Foundation as well as providing gym equipment in the workplace.

48. Health in the family involves providing beepers to the worker in case of sickness in the family, providing cars for transport to the hospital or childcare if a mum is sick. They also provide flexible working hours on occasions such as parent/teacher interviews as well as conducting a range of courses around nutrition, quitting smoking, drug abuse and testicular cancer screening. A highlight in this area is their award winning home health and safety program, instituted when they realised absenteeism resulted more from injury at home than at work.

49. Mr Eamonn Murphy from the Department of Health and Family Services gave an overview of Australia's response to HIV/AIDS, which has been internationally acclaimed for its effectiveness. Of particular relevance to the broader issues of men's health is the campaign's effectiveness in mobilising the gay community to embrace health promotion messages. A significant part of this process has been a partnership approach between all vested interests in addition to breaking down stereotypes of masculinity around caregiving, individuals taking responsibility for their own health and dealing on an informed basis with service providers. These are key areas where men have taken on a positive role for themselves.

Strategies to address these issues

50. Mr Richard Fletcher was asked by the Chairman to attempt to summarise the day's proceedings. The following is part of the statement which provided the basis for discussion in the last session:

> In view of the evidence of men's poor health status that we have heard today, in view of the wide array of social, cultural and spiritual factors which are determinants of men's health outcomes and in view of the unprecedented activity a local, regional and State level, including innovations in research, education, prevention of ill health, promotion of wellbeing and treatment services. In view of these things, our goal would be to have as much success in the men's health area as we have had in the HIV/AIDS area. What we would like to say some time in the future is 'Well

look how well we did this. Look at the amazing consensus we achieved around this difficult messy area'.

51. He then articulated a range of practical strategies arising from the seminar which were then discussed and supplemented by other participants.

52. After having considered all the evidence presented, the Committee has identified the following as key issues to be progressed, and therefore recommends that the following be adopted as key principles for the development of strategic directions in men's health:

- **An interdepartmental reference group be established at Commonwealth level (including the Departments of Health and Family Services; Primary Industries and Energy; Transport and Regional Development; Employment, Education, Training and Youth Affairs and the Occupational Health and Safety Commission), to investigate how to deal with the issue of 'maleness' in their program development and implementation. This needs to be considerably more than a tokenistic identification of men as a key target group and must deal with issues of maleness in a manner similar to the NRMA's *Like Father, Like Son* initiative, the *Men's night out* initiatives or the HIV/AIDS strategy.**

- **The Department of Health and Family Services create a policy unit dedicated to the development of men's health policy to provide support to this reference group as they perform a systematic program audit. This policy unit should have a responsibility to ensure consistent data collection of research and treatment based on gender. This may require a substantial education process to address the issue of men's health falling into the 'blind spot' as outlined in the body of this Report.**

- **The programs identified in the above audit (eg. RHSET, GP Practice Grants, National Drug Strategy, Anti-violence project etc) make men's health a priority area for the next three years, after which a comprehensive review is to be undertaken to evaluate progress in this area. As part of this process, programs should give serious consideration to setting a target for the percentage of their projects which should address men's health. (For example the General Practice Grants Program could set a target of increasing the number of men's health projects they**

fund from less than 1 per cent to 5 per cent for the next three years.)

- **Government departments and the NHMRC harmonise their activities in men's health so that integrated education and treatment strategies are implemented. For example, the current focus on prostate cancer screening should not cause older men's broader health needs (eg. urinary problems and sexual function) to be overlooked.**

- **In conjunction with all stakeholders, including the States and Territories, Local Government, relevant peak organisations, community health services and men's support services with Commonwealth leadership:**

  - **identify best practice in men's health and develop a strategy to introduce these initiatives systematically across the country;**

  - **undertake a systematic audit of men's support groups and services with the aim of establishing the existence, nature and extent of any possible gaps in services for men in crisis (eg. men experiencing relationship breakdown, self identify as at risk of committing violence or suicide etc.) and develop a comprehensive strategy to support existing services and to address any identified gaps in services;**

  - **ensure that central to the development of men's health policy and identification of best practice initiatives, the different needs of particular groups of men are clearly identified and the differences noted. In particular, Aboriginal and Torres Strait Islander men's health needs must be clearly identified and supported. Other important groups include men from culturally diverse backgrounds, men from rural and remote areas and men from low socioeconomic backgrounds; and**

  - **develop a detailed research agenda to investigate these issues. As part of this the NHMRC should make men's health a priority area for research funding over the next three years. This should particularly apply to the public health/health promotion side of its activities.**

- **This partnership could be coordinated at the intergovernmental level through the National Public Health Partnership, with men's health forming a key element of their**

workplan, with subsequent endorsement of any strategies developed at the appropriate Health Ministers' conference.

- **All these activities be pulled to together under a coherent national policy framework based on broad consultation with all relevant stakeholders. While the responsibility for the development of this policy lies with all stakeholders, the Commonwealth should take a leadership role. This policy development process should therefore be coordinated by the policy unit in the Department of Health and Family Services.**

John Forrest, MP
Chairman

19 November 1997

APPENDIX A

PROGRAM - MEN'S HEALTH SEMINAR

Friday 26 September 1997
Committee Room 2R3, Parliament House, Canberra

9.00am Assemble

9.15am Opening Statement - Mr John Forrest MP (Committee Chairman)

9.30am Session 1 *Demographic Background*

Dr Kuldeep Bhatia, Head, Population Health Unit Australian Institute of Health and Welfare
Presentation 20 minutes; Questions by Committee Members 25 minutes

10.15am Morning Tea

10.30am Session 2 *National overview of developments in men's health*

Mr Richard Fletcher, The Men and Boys Project University of Newcastle
Presentation 20 minutes; Questions by Committee Members 25 minutes

11.15am Session 3 *The practicalities of dealing with men: views from different backgrounds*

1) Men in distress - the need for counselling and other support services - Dr George Burkitt, President, Sydney Men's Health and Wellbeing Association
2) Is General Practice designed for men? - Dr Brian Richards
3) Rural men's health, The Men's Awareness Network - Mr Bernard Denner, Men's Health Consultant
4) HIV/AIDS and men - Mr Eamonn Murphy, Public Health Education Unit, Department of Health and Family Services
5) Aboriginal men's health; Sporting and healthy lifestyle initiative - Mr Paul Briggs, Koori Resource Centre, Shepparton

Short presentation of 10 minutes each
Questions by Committee Members 25 minutes

12.30pm Lunch

1.30pm Session 4 *Youth, working and older men: health education strategies*

1) Road Safety: Like father, like son - Ms Pam Leicester, NRMA
2) Alcoa of Australia - Workforce Health Program - Mr Peter Jager, Occupational Health and Safety Officer
3) Getting to the 'hard to reach' male audience - Dr Garry Egger, Gutbusters
4) Older men's health - Dr Carole Pinnock, General Repatriation Hospital

Short presentations of 10 minutes each
Questions by Committee Members 25 minutes

2.30pm General discussion of issues by all participants

3.30pm Afternoon tea

3.45pm Concluding session and summing up

5.00pm Close

Appendix B

LIST OF PARTICIPANTS

Mr Brooke Alexander—Consumers' Health Forum of Australia

Dr Kuldeep Bhatia—Australian Institute of Health and Welfare

Mr Paul Briggs—Koori Resource Centre, Shepparton

Dr George Burkitt—President, Sydney Men's Health and Wellbeing Association

Mr Sam Choucair—FECCA

Ms Kirsten Cross—Australian Medical Association

Mr Bernard Denner—Men's health consultant

Ms Fidelma Doran—Department of Health and Family Services

Mr Barry Duncan—Jumbanna, CAISER

Dr Garry Egger—Gutbusters

Ms Denise Ericson—Producer, *The Problem with Men*

Mr Richard Fletcher—The Men and Boys Project, University of Newcastle

Mr Allan Huggins—Curtin University

Mr Peter Jager—Occupational Health and Safety Officer, Workforce Health Program, Alcoa of Australia

Dr Anthony Jorm—NHMRC Social Psychiatry Research Unit

Ms Pam Leicester—NRMA

Mr Michael Kakakios—NSW Department of Health

Dr Graeme Killer—Department of Veterans' Affairs

Mr John Lemaire—Family Court of Australia

Mr Bradley Lewin—Young Men's Support Network

Ms Sue McHutchison—Department of Veterans' Affairs

Mr Eamonn Murphy—Department of Health and Family Services

Mr Joseph Murphy—Department of Health and Family Services

Dr Harry Nespolen—Australian Medical Association

Dr Robert Pegram—Department of Health and Family Services

Dr Carole Pinnock—General Repatriation Hospital

Ms Helen Rankin—Department of Health and Family Services

Mr Ian Rankin—AFAO

Dr Brian Richards—ACT Division of General Practice

Mr Dave Rugendyke—Australian Federal Police

Mr Donald Thomson—Us Too Australia

Mr Alan Thorpe—Department of Health and Family Services

Mr Peter Vogel—Editor, *Certified Male*

Ms Ros Walker—ACT Cancer Society

Dr Peter West—University of Western Sydney Nepean

Mr Lincoln Wood—Aboriginal Health Conference

Lieutenant-Colonel Donald Woodland—Salvation Army

Appendix C

OVERHEAD PRESENTATIONS FROM
DR KULDEEP BHATIA
are not available in PDF format, please contact the Secretariat if you wish to obtain copies