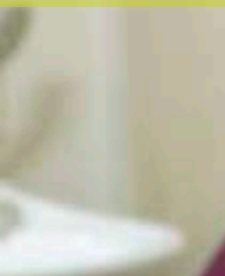
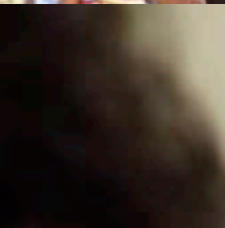




**Australian Government**  
**Department of Health and Ageing**

# National Male Health Policy Supporting Document

**ACCESS TO HEALTH SERVICES**



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# National Male Health Policy Supporting Document

**ACCESS TO HEALTH SERVICES**

The National Male Health Policy has a focus on addressing issues males face in accessing health care, reticence among males to seek treatment, and reducing barriers males experience to accessing health services. This document discusses some of the evidence from the literature about male access to health services. It also considers some of the barriers males experience accessing health services.\*

## What's in this document?

This document first looks at various **issues** to do with access to health services for males:

- Access as part of overall health
- Optimal health outcomes for males
- Services which are accessible by males, and
- Equity between groups of males.

It then looks at **action** that is being taken:

- Government action – policies and initiatives, and
- Community action – working together.

## Access as part of overall health

Access to, and use of, health care services is essential to good health. The World Health Organization (WHO) identifies the provision of universal health care and the equitable distribution of resources, such as health care services, as key social determinants of health. As the WHO report *Closing the Gap in a Generation* states:<sup>1</sup>

Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from health care.

\* Most of the discussion refers to 'males', but on occasions the term 'men' is used to remain consistent with wording used in research papers. Wherever possible, male data is used but, when not available, data has been used for both males and females for particular population groups or issues where inferences for male health can reasonably be drawn.

Concerns about barriers to access were repeatedly raised during the Policy consultations. While most Australians benefit from our universal health care system, equity of access to health care is an issue for males in general, and some groups of Australian males face significant barriers to access.

## Optimal health outcomes for males

Concerns have been raised in Australia, and in other western countries, that males are accessing health care at lower levels than females, and that this may at least partly explain their worse health outcomes and lower life expectancy.<sup>2</sup>

While overall data on health care expenditure and visits show that males are visiting health care services less than females, there is considerable variation of use by age.

An Australian Institute of Health and Welfare (AIHW) analysis of total allocated health system expenditure in 2004–05 revealed that expenditure was higher on males than females for the age groups up to 14 years and for the age groups from 55 years and over.<sup>3</sup> Between the 15–54 age groups expenditure was lower for males, which the AIHW attributed to women's health care costs associated with child-bearing and the genitor-urinary system. Health system expenditure per person was 17 per cent higher for females than males but, when maternal conditions were excluded, expenditure on females was 10 per cent higher than on males.

Analysis of total Medicare Benefit Schedule (MBS) expenditure in 2008–09 reveals a similar pattern. In

2008–09, Australian males accounted for around 41 per cent of total MBS expenditure, including visits to GPs (also around 41 per cent), medical specialist attendances, and treatment for private patients in public and private hospitals.

However, per capita MBS expenditure was higher for males in the 0–4, 5–14, 65–74 and 75–84 age groups, but higher for females in the 15–64 age groups. The 25–34 age group has the peak difference, with male per capita expenditure being only 37 per cent of that on females.

Removing identifiable expenditure on obstetrics (GP visits for obstetrics cannot be identified) brings that figure up to 42 per cent, and total per capita MBS expenditure on males is 80 per cent of that on females.

MBS health assessment item data reveal a similar pattern. Males accounted for around 40 per cent of health assessment items since the introduction of the first health assessments in November 1999, and that males 45 years and older utilised more of these items. Furthermore:

- Child health checks generally show a 50:50 split between boys and girls, including for Indigenous items, and
- The 45–49 Year Old Health Check (for people who are at risk of developing a chronic disease) and the Type 2 Diabetes Risk Evaluation had close to a 50 per cent split in use between males and females.

Of note, too, is that males account for around half or more of the items for refugees and people with intellectual disability.

In summary, from 15 years to around the mid fifties or sixties, health expenditure on males is lower than on females, and considerably lower in the 20–54 age groups. When maternal expenditure is removed, male expenditure is around 8 to 10 per cent lower.

### Gender differences in help-seeking behaviours

Male health attitudes and behaviours, and health outcomes, are the result of a complex interaction of factors, including biological sex, gender, age and a range of other determinants of health, such as education, income, employment, upbringing, and the availability, and type of health services provided.<sup>4, 5</sup>

Sometimes the image males have of themselves is seen as the reason for the lower use of health services by males. The ‘traditional’ stereotype of a strong and self-reliant male is seen by some as preventing some males seeking medical help when unwell, or having regular health checks, for fear of being seen as ‘weak’.

The Irish National Men’s Health Policy discusses barriers within men themselves, such as lack of awareness about when to use a health service, and not wanting to show vulnerability, as possibly associated with delays in seeking health care. It points out that a key challenge

is to change thinking so that being sick is not seen as personal weakness and seeking help is seen as a responsible choice.<sup>6</sup>

Males displaying stereotypical ‘western’ masculinity are described as viewing themselves as strong and independent and unlikely to be concerned about their health or to seek medical help. Risky and unhealthy behaviours are used to display and prove their masculinity to themselves and others.<sup>7</sup>

However, this is not true for all males. For instance, cultural backgrounds can have an influence. An example of how different cultural backgrounds may impact on help-seeking is provided in an English study that examined the role of masculinity in decisions to seek medical help for chest pain by men with English ancestry and men with Indian or Pakistani ancestry. While the men with English ancestry displayed traditional, western masculine attributes in their reluctance to seek help and to tell others of their symptoms, the men with Indian or Pakistani ancestry valued responsibility for the family and their own health, as well as wisdom and education, as masculine traits, which contributed to seeking medical help.<sup>8</sup>

The same study noted that initiatives such as heart checks at football games, which may be successful in targeting some men, may not be successful in targeting men of Indian or Pakistani decent ‘who do not adhere to Western conceptions of masculinity’.<sup>9</sup>

The notion that men do not care about and are uninterested in their health has also been challenged. For example, a 2008 study found that the men cared about and monitored their health.<sup>10</sup> While a minority of men in the study expressed views about their health in line with the ‘traditional’ view of masculinity, the rest actively monitored their health and made decisions about seeking medical help with reference to a number of factors, including their capacity to maintain regular activities and their perception of the severity of the health issues.

Further, some authors acknowledge that, while male health care access may not be equal to that of women, the majority of males do access health care services, and adapting health care services to facilitate male access, for example by modifying the way GPs communicate with males, will improve the level of engagement by men with general practice.

Further research will show how gender and the other social determinants of health interact and influence male health-related attitudes, use of health services, and health outcomes.

### A faulty system

Some authors emphasise the differences in health outcomes and life expectancies between groups of males, which are greater than those between men and women.<sup>11</sup> Instead of focusing on the individual, the ‘faulty system’ (the social determinants of health, such

as low levels of education, income and employment, the consequences of relationship breakdown, and barriers to health care access) is seen as a key reason for worse male health outcomes.

Barriers in the health care system, such as the cost of health care and services being closed outside normal working hours, are highlighted as the reason for reduced help-seeking. The popularity of 'male friendly' services, such as Pit Stop and MensLine is highlighted as evidence that the nature of services impacts on male help seeking behaviour.

In consultations, participants frequently pointed to factors such as opening hours, long distances to travel to health services, and lack of clear information about when to visit a doctor or other health care provider as factors more likely to influence access rather than 'traditional' male behaviours. The number of males attending the consultation forums clearly demonstrated that males do care about their own health.

## Services which are accessible by males

It is important that males receive information about when to access health care and related health information so that they can enjoy life and fulfil the important roles they play in Australian society.

Males need to know that taking charge of their own health by seeking information, reducing health risk behaviours and seeking help when needed is a strength that enables them to work, support, care, provide and contribute in so many different ways to the health and wellbeing of family, friends and the whole community.

A key way to facilitate male help-seeking behaviour is to design and provide services which address a range of gender-related barriers to health care. The following examples show how to make services more accessible to males.

### Easily accessible after-hours health care

General practices which are open on a flexible or after hours basis are much more accessible to males who work full time, have long commuting times and find it difficult to attend during normal opening hours.

The Australian Government provides incentives for general practices to ensure patients have access to after hours care (any time outside 8am–6pm weekdays and 8am–12noon on Saturday, and public holidays). These aim to encourage GPs to provide quality after hours services.

## A primary health care environment that is comfortable for males<sup>12, 13, 14</sup>

It has been noted that many men 'avoid environments which cause discomfort', including 'waiting room discomfort syndrome', 'a dislike of excessive waiting and women's magazines, and fear of a health system with which they are not familiar'<sup>15</sup>. To address these issues:

- Receptionists can encourage males to phone before leaving work/home to see if the doctor is running late
- A more gender-neutral environment could include a balance of posters and magazines depicting/provided for males and females, and
- Doctors and receptionists could assist men to better understand how the appointment system and Medicare billing works, and inform males of potential out-of-pocket health costs.

### Male-friendly general practitioners

A friendly, affirming approach by general practitioners and the delivery of 'respectful, competent medical services which acknowledge their different needs as health consumers' is important, and 'one bad experience as a consumer can result in avoidance of the particular outlet or provider'.<sup>16</sup> Such an experience may also result in avoidance of health professionals more broadly.

Andrology Australia has developed a brief guide for GPs on Engaging Men in Primary Care Settings. The guide provides insight into:

- *The GP's role* in effectively engaging men in discussions about their health
- *Factors which influence men's interactions with GPs*, such as the provision of male-friendly environments
- *Factors which affect GPs' interaction with men*, such as the time available for consultation, the GP's knowledge or attitude to discussing sexual or mental health
- *Strategies for GPs to engage men in discussion about their health*, such as communicating in a clear, easily understood, empathetic style
- *How to approach sensitive issues*, suggesting that GPs routinely ask questions such as, 'Are there any other issues you want to talk about ... your relationship, family/work stress, feeling down?'
- *Myths about men's engagement in health services*, such as that men do not talk about their health, and
- *The qualities men value when communicating with GPs*, such as a frank approach, demonstrated professional competence, the use of thoughtful humour to help men feel more comfortable, empathy, and resolving health issues promptly.

The guide is available at [www.andrologyaustralia.org/docs/GPguide\\_11\\_EM.pdf](http://www.andrologyaustralia.org/docs/GPguide_11_EM.pdf)



## Male health care providers

Some males prefer to see a male health care provider for some issues, such as sexual and reproductive health problems.<sup>17</sup> The availability of male health workers is particularly important in some cultures, such as for Aboriginal and Torres Strait Islander males (as outlined in the next section).

There is a range of men's health units and courses provided within the vocational education and training sector, and at the university undergraduate and postgraduate level that maybe undertaken by a range of health workforce disciplines as part of either their core or specialised training programs.

The 2009–10 Australian Government Budget will enable eligible nurse practitioners to provide certain MBS and PBS (Pharmaceutical Benefits Scheme) subsidised services and prescription to the population. The measure will facilitate more efficient use of this workforce, particularly in primary care and rural settings, including eligible nurse practitioners treating men's health issues.

The Government also funds a range of support programs to assist nurses to enter or return to the nursing workforce and to assist nurses to upskill or undertake other continuing professional development activities. More information is available at [www.health.gov.au](http://www.health.gov.au)

## Male health clinics

Male health clinics can be held on an occasional or regular basis by, for example, general practices or community health centres. Such a clinic has been successfully established in Bendigo in regional Victoria.

### Case study: Bendigo Men's Health Clinic<sup>18, 19</sup>

The Men's Health Clinic in Bendigo specialises in men's health and assists men to better understand and manage their own health needs. The clinic promotes men's health and wellbeing and encourages preventative health practices by providing annual check-ups, health assessments, information and support and assisting men to achieve a healthier lifestyle.

A Nurse Practitioner (Men's Health) staffs the clinic. His role includes health education for community groups, development of health promotion resources, and population-based health assessment in a clinic situation and in the workplace.

The clinic has 45-minute initial consultations and 30-minute review consultations. Sixty per cent of clients attend for a men's health check-up, which includes a detailed risk assessment related to their age (e.g. past medical history, lipid and glucose analysis).

In addition, health education requirements and opportunities for action are identified, advice about how to use the health system is provided, and health-related terms, concepts and consequences are explained.

The clinic operates one day per week in the late afternoon/early evening and charges a nominal fee for service.

The clinic states that:

- The Clinic has proven to be very successful, with the number of men seeking primary health services rising dramatically, and the challenge now being managing the increasing demand
- Evaluations consistently demonstrate a high level of satisfaction and suggest a significantly higher uptake of lifestyle modification programs and better outcomes for men within their community
- A 2005–06 evaluation found that 44 per cent of clients had not had a full check-up for more than 10 years and a majority of men had not accessed services for five to 10 years.

Males living in the Bendigo region can make an appointment by calling 03 5434 4330.

## Services provided in settings frequented by males

An obvious solution to difficulties in reaching males is to provide information and services in settings which are frequented by males, such as workplaces (see the *Healthy Workplaces* supporting document for more details), clubs, sporting events, churches, pubs, service stations, rural shows and community centres. The Pit Stop initiative is one such popular example.

### Case study: Pit Stop Men's Health Check

Pit Stop is a men's health screening tool delivered in a variety of rural settings, including field days, shows, car displays and workplaces. Pit Stop invites men to have their roadworthiness (health status) assessed by running through a series of brief stations (health checks), for example:

- Chassis check (hip to waist ratio)
- Fuel additives (alcohol consumption)
- Oil pressure (blood pressure)
- Shock absorbers (coping skills).

If participants fail more than two stations, a 'Work Order' sticker is issued that requires the participant to have a 'tune-up' before being considered roadworthy. Men are encouraged to make lifestyle changes or consult a doctor if needed.

There are over 150 sites throughout Australia including Pit Stop in their health programs. A 2005 evaluation, funded by the Australian Government, found that in rural areas Pit Stop successfully reached men with significant health risk profiles and resulted in nearly half of the men changing their behaviour and/or seeing a health professional.

Pit Stop is a WA Country Health Services initiative. In 2006/07, the Australian Government provided funding to Gascoyne Population Health Regional Health Services to update and reprint the Pit Stop material and develop the Pit Stop website.

For more information contact your local Community Health and Public Health Services, Division of General Practice or Medical Health Service or visit [www.wacountry.health.wa.gov.au/default.asp?documentid=613](http://www.wacountry.health.wa.gov.au/default.asp?documentid=613)

## Anonymity, confidentiality and convenience

Male health telephone help lines, such as MensLine, and internet websites have proved popular, indicating that males are willing to seek help from services which offer confidentiality, anonymity and convenience. It is important to ensure that medical information is accessed from reliable sites such as Foundation 49.

### Case study: Foundation 49 Online Men's Health

Foundation 49 aims to 'reduce the number of males dying from preventable conditions through raising health awareness and encouraging regular check-ups with a doctor'.

Its Online Men's Health website ([www.49.com.au](http://www.49.com.au)) aims to help men play a more active role in their health, and to help men of all ages, their families, and doctors make more informed decisions about men's health. It encourages men to:

- Find a GP and have an annual check-up ([www.healthengine.com.au](http://www.healthengine.com.au) is provided to help find a GP)
- Know your body and promptly check out changes with your GP, and
- Know the health risks for your age group, and what to do to reduce them.

The website provides (including for different age groups and in a range of languages):

- Health and lifestyle information
- An online men's health check
- An online medical dictionary, and
- A Workplace Men's Health Program – a comprehensive health check for male employees in the workplace, which can be booked by calling 03 9508 1567.

The website receives approximately 100,000 hits per year and is continuing to grow.

Foundation 49 is overseen by a Medical Advisory Committee made up of medical specialists and experts in the field of men's health. Foundation 49 also has an online consumer reference group of about 1600 men who contribute to a growing body of knowledge on or about men's attitudes to health, the barriers and motivators to accessing health services, and what their concerns and priorities are.

Foundation 49 is a Cabrini Health initiative, located in Victoria, but with a national focus. It is funded by donations, fundraising activities and philanthropic grants.



## Equity of access between groups of males

During the Policy consultation process, additional barriers to accessing health care and information were frequently raised, with particular significance for the groups of males at risk of poorer health. These barriers are part of the living conditions (the social determinants) of the lives of males which can lead to health inequalities.

### Aboriginal and Torres Strait Islander males

The *Expenditure on Health for Aboriginal and Torres Strait Islander People 2006–07* report estimates that recurrent, per-person health expenditure on Aboriginal and Torres Strait Islander people was 31 per cent higher in 2006–07 than for non-Indigenous Australians. However, Aboriginal and Torres Strait Islander use of the major primary care programs, the MBS and the PBS, was only 59 per cent that of non-Indigenous Australians. Primary care expenditure was still well below that for other Australians when Australian Government expenditure on programs such as Aboriginal Community Controlled Health Services was included.<sup>20</sup>

In addition, only 17 per cent of Aboriginal and Torres Strait Islander males accepted the invitation to be participate in the National Bowel Screening Program, compared to 40 per cent of non-Indigenous males. Lower levels of access to preventive screening and primary care partly explains why Aboriginal and Torres Strait Islander Australians are twice as likely as other Australians to present at hospital outpatient/casualty services, and why state and territory government expenditure for Aboriginal and Torres Strait Islander Australians is 2.3 times that for other Australians.<sup>21</sup>

Revised Principle 7, 'Access and Support', of the *National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males* emphasises the importance of recognising:

the need for local, regional, state-wide and national support structures to empower Aboriginal and Torres Strait Islander males to take leadership, ownership, and responsibility to access and use new and existing support programs. This leadership, ownership and responsibility is in the context of endorsed individual rights to equitable access to gender-specific and culturally appropriate mainstream and Aboriginal and Torres Strait Islander community-controlled health and health-related services across geographical, institutional, and custodial settings.

See the supporting document *National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males Revised Guiding Principles*.

### Males in rural and remote areas

People living in rural and remote areas use hospital emergency departments for primary care more than those living in major cities.<sup>22</sup> In 2008–09, per capita MBS

expenditure on GP services reduced with remoteness (\$193 for males living in major cities, \$162 in outer regional and \$139 in very remote areas). A 2009 analysis of the use of health care services by males in South Australia found that in 2004–05 male (and female) use of GP services declined with increasing remoteness, and was 21 per cent lower in very remote areas, compared to major cities.<sup>23</sup>

In addition, only 24.7 per cent of males living in very remote areas and 32.3 per cent of males living in remote areas accepted the invitation to participate in the National Bowel Screening Program, compared to 39.7 per cent of males in inner regional, 36.9 per cent in outer regional and 35.1 per cent of men in major cities.

Hospitalisation rates for people living in rural and remote areas are higher for some conditions, including conditions that could have been 'prevented through the provision of non-hospital services and care'.<sup>24</sup> Hospitalisation rates for people in very remote areas are significantly higher than for Australians living in urban areas. Higher hospitalisation rates may partly be due to lower levels of access to primary care, and later presentation for treatment may result in poorer outcomes.

### Males from disadvantaged backgrounds

Socioeconomically disadvantaged Australians reported a higher use of doctors, and hospital outpatient, accident and emergency services, but were less likely to use preventive health services.<sup>25</sup>

Per capita MBS expenditure on GP attendances in 2008–09 on males in the most advantaged group was 82 per cent of those in the most disadvantaged group.<sup>26</sup> The 2009 South Australian study, mentioned above, found that in 2004–05 males in the most socioeconomically disadvantaged areas had a 30 per cent higher use of GP services than males in the areas of most socioeconomic advantage.<sup>27</sup> Use of community health services also increased with disadvantage, with use by males living in the most disadvantaged areas being nearly six times higher.

Participation by males with the most disadvantaged socioeconomic status in the National Bowel Screening Program was lower (34 per cent) than males with the highest socioeconomic status (38 per cent).<sup>28</sup>

### Males with a disability and males born overseas

While data is generally not collected on the use of GP and hospital services by males with a disability or by males born overseas:<sup>29</sup>

- More males (38.9 per cent) with a severe or profound activity limitation accepted the invitation to participate in the National Bowel Screening Program, compared to 33.5 per cent of males with no severe or profound limitation, and

- A significantly lower level of males who preferred to correspond in a language other than English accepted the invitation to participate in the National Bowel Screening Program (25.4 per cent), compared to 38.2 per cent of males of those who did not.

### Barriers to access<sup>30, 31, 32, 33, 34, 35, 36, 37</sup>

Barriers to accessing health care services, and prevention initiatives, in addition to those identified above, may include:

- Shortages of GPs, specialist medical services, Aboriginal health services and workers, and a range of other health services, particularly in rural and remote areas but also in some urban areas
- Shortages of male health care professionals, including Aboriginal and Torres Strait Islander service providers
- Cost of health care services
- Low levels of literacy
- Low levels of health literacy; for example, in 2006 men living in inner regional and outer regional/remote areas were 22 per cent less likely than men in major cities to possess an adequate level of health literacy, and
- Complex health care needs which require case management assistance to navigate the health care system.

Additionally, in relation to Aboriginal and Torres Strait Islander males and males born overseas, barriers include:

- A lack of culturally appropriate services and information
- A lack of interpreter services and information available in other languages (17 per cent of men in Australia mostly speak a language other than English at home). The majority live in major cities but 31 per cent of males in very remote areas speak mainly Indigenous languages
- Living in a culture with limited knowledge of how to access appropriate health services, and with limited family and social networks
- Racism
- Feelings of shame and embarrassment in the area of reproductive and sexual health, and
- For Aboriginal and Torres Strait Islander males in particular, a lack of male specific 'spaces' or services, specific 'skin' relationships to clinic staff, having to attend city hospitals and die away from 'country', and the biomedical model which focuses on curative rather than holistic health and an Aboriginal and Torres Strait Islander sense of healing.

Of particular relevance to men living in rural and remote areas, including Aboriginal and Torres Strait Islander males, are:

- Distance to health care services and lack of affordable transport, particularly in rural and remote areas but also in outer urban areas
- Staying away from home to receive treatment often without family support and with increased financial costs, and
- Perceived lack of privacy and confidentiality in rural and remote areas.

Of particular relevance to males with a disability are:

- Inaccessibility of buildings and services, including parking, entrances, toilets and examination tables
- The need for information to be made available in accessible formats
- The need for information to be distributed direct to the males and, for example, through disability organisations, support workers, service providers, and carer networks, and
- Communication and language difficulties, for example, as experienced by males with hearing or intellectual disabilities.

## Government action – policies and initiatives

The Australian Government currently funds a wide range of programs which aim to provide equitable access to health care for all Australians. In addition, the Government is undertaking a significant health care reform agenda which includes addressing major access and equity issues that affecting Australians.

### Improving health care services for all Australians

In 2008, the Australian Government commissioned three reports to provide recommendations on reforming the health system to meet the challenges of the future, the:

- National Health and Hospitals Reform Commission's report, released in July 2009, which recommended a re-design of the health system to create a more agile, responsive and self-improving system
- Draft National Primary Health Care Strategy, released in August 2009, which argued that a strong and efficient primary health care system is critical to the future success and sustainability of the health system, and
- National Preventative Health Strategy which put forward 35 areas for action tackling obesity, tobacco and alcohol as key drivers of chronic disease, and the resultant health system and social costs.

The Government used the recommendations made in these reports as the basis for 103 consultations held around the country with doctors, nurses and the users of the health system – the general public. A recurring theme from these consultations was that the health system needs to be more responsive to the needs of individuals and of local communities.

The Australian Government's policy response to these reports and the consultations includes:

- Establishing a National Health and Hospitals Network:
  - comprising networks with small groups of hospitals governed by professional Governing Councils, with funding based on the services they provide and reflecting the health needs of rural and regional communities
  - where local professionals with local knowledge determine the services needed to meet the needs of the community, with national safety and quality standards ensuring patient safety, and
  - bringing numerous health systems into one, thereby delivering better hospital services.
- \$5.4 billion to invest in the Health and Hospitals Network over the next four years including:
  - \$1.6 billion for subacute care delivering over 1,300 beds including palliative, rehabilitation and mental health care
  - \$1.75 billion for improvements for waiting times for elective surgery emergency treatment
  - investing \$643 million in the health workforce – which will, amongst other things, bring on-line 1,375 more general practitioners by 2013 and 680 more specialist doctors within a decade
  - providing \$436 million to fund better integrated care for individuals with diabetes – to improve their management and make sure they stay healthy and out of hospital
  - taking full financing and policy responsibility for aged care, including investing an additional \$739 million – which will fund an additional 5,000 places or beds and 1,200 new packages of care, and
  - \$174 million to improve our mental health system including 30 new youth-friendly services, more nurses and early intervention services.
- Taking full responsibility for primary care, including establishing primary health care organisations, also funded nationally and run locally – coordinating general practitioner and allied health professionals services, ensuring they are better integrated and more responsive to the needs and priorities of patients and communities.

These investments will help improve the health of males in Australia, by:

- Funding additional hospital and aged care services
- Building the workforce – including in rural and regional areas, which were identified as a priority area in this policy
- Ensuring that health services are planned and managed by clinicians – which will allow tailoring for the needs of males, including those of Indigenous and culturally and linguistically diverse backgrounds and those of lower socioeconomic status, and
- Funding integrated care for diabetics – males experience higher rates of diabetes than females (5 per cent compared to 3 per cent), are less likely to report using medication to manage the disease,<sup>†</sup> and are more likely to be hospitalised for diabetes.<sup>‡</sup>

### Australian General Practice Training Program

The Government has made a significant investment in general practice training by increasing the number of training places on the Australian General Practice Training (AGPT) program. In March 2010, the Government announced an expansion to the program to provide 1200 places per annum by 2014. Combined with previous investments, the Government will have doubled the AGPT program from 600 to 1200 over the period 2008 to 2014.

These increases will continue to assist in meeting the demand for vocational training associated with the increased number of medical students coming through the system. As GP registrars provide services while they train, the additional training places will help to tackle the nationwide GP shortage and provide improved access to health services. The Government will continue to ensure that the increasing number of medical graduates is supported to work in areas where they are needed most.

### Action in rural health

In response to the health needs of rural and remote Australians the Australian Government has:

- Made a significant commitment to rural health programs and services through the 2009–10 Budget which provided \$206.3 million over four years – on top of existing funding of \$834.4 million for these programs
- In recognition of the enormous challenge for rural and remote communities in attracting and retaining a skilled health workforce, the rural health Budget package includes \$134.4 million over four years for the Rural Health Reform – Supporting Communities with Workforce Shortages measure to improve rural and remote health workforce shortages, and

<sup>†</sup> ABS, National Health Survey 2007–08 – Summary of Results. Cat 4364.0.

<sup>‡</sup> AIHW, Diabetes: Australian Facts 2008.

- Invested significantly in Indigenous health – funding has increased substantially in the last few years. Funding of almost \$1 billion has been allocated in the 2009–10 Budget for health programs specific to Aboriginal and Torres Strait Islanders, including new Indigenous-specific Medicare items, hearing services, aged care, population health and prevention programs. This equates to a 57 per cent increase in Indigenous health funding since the 2007–08 Budget.

Initiatives with a men's health focus include:

#### The Medical Specialist Outreach Assistance Program

- Since its inception in 2000, the Medical Specialist Outreach Assistance Program (MSOAP) has been highly effective in delivering medical specialist services to people living in rural and remote communities,
- Over 100 speciality disciplines and sub-specialities are supported under MSOAP, including surgical urology services, which specifically relates to men's health. In 2008–09 more than 1,430 MSOAP services were provided to a range of rural and remote locations throughout Australia, and
- Cardiovascular diseases are responsible for nearly a third of the elevated male death rates outside Major cities. In 2008–09 there were over 60 physician-cardiology services provided nationally through the MSOAP (to both men and women).

#### The Rural Primary Health Services Program

- The Rural Primary Health Services program provides primary and allied health services to rural and remote Australia. In support of the mainstream primary health care services, there are a range of projects within the program to support men's health. These projects include developing and preparing resources and investigating needs of the community in order to address particular men's health issues including mental health issues, health and safety, and general health awareness.

### Action to address the social determinants of health

The Government's funding action across the social determinants of health, including the social inclusion agenda (see the *Social Determinants of Health* supporting document), will address some of the underlying causes of health problems, such as poverty, unemployment and a low level of education, and enable some people to overcome barriers to accessing health care.

## Community action – working together

### Toll Holdings Second Step Program

The Toll Holdings Second Step Program offers a supported employment program for people who find themselves marginalised as a result of previous drug, criminal record or incarceration issues. Toll Holdings

employs people for 12 months, with assistance from a range of community-based partner organisations that ensure candidates are 'work ready'.

With the support of these partners, 'Second Steppers' are provided with individual case management. The partners work with the employers to help Second Steppers:

- Arrange secure and appropriate accommodation
- Establish support networks
- Attend to physical or mental health or drug and alcohol issues
- Undergo appropriate training, and
- Make use of community resources that may benefit other aspects of their lives.

Second Steppers are provided with time to attend necessary counselling during the course of the working week.

Second Step has enabled more than 170 people to obtain or retain employment and avoid returning to criminal activity or dangerous drug use. The benefits to Toll Holdings include:

- Loyal employees
- Workplace supervisors whose people management skills are developed and extended to the broader workforce, and
- Business-wide enthusiasm for assisting with a community-wide issue.

Benefits for the Second Steppers, their families and communities include:

- Re-establishing themselves in the working world
- Developing strategies for coping with difficulties in daily life, and
- Gaining skills, experience and a solid reference for future employment.

The cost of the program is minimal, involving the Second Steppers' salaries and the participation of existing members of the workforce. The case management services provided through the partners are already available in the community.

For more information contact [secondstep@toll.com.au](mailto:secondstep@toll.com.au).

### Men's Resource Centre (Albany, WA)

The Men's Resource Centre is a non-government, consumer-based not-for-profit organisation located in prominent shopfront premises in the Albany CBD.

The centre is committed to encouraging males to take responsibility for their mental and physical health in a proactive rather than reactive manner. It delivers innovative and effective services in the area of men's health promotion (including physical and mental health) throughout the Great Southern Region of WA. It runs



community men's health forums across the region and works closely with health professionals and government agencies in the specific areas of men's health education, early intervention and promotion.

The centre is regarded by many as the first point of contact for information and referrals concerning men's health and welfare, and it is able to respond quickly and effectively to specific needs (e.g. a spate of male suicides in the region, crisis accommodation needs, or intimate partner violence).

The centre has developed a range of resources, such as the free booklets *Depression Management for Men* and *Anger Management for Men*, and a rural men's health website. A set of workplace men's health programs is currently being designed.

Since 2006 the WA Department of Health has provided core funding. Other funding is provided by a range of sources such as the Australian Government, the City of Albany, Healthway, Lotterywest, the business sector, and public donations.

More information is available by calling 08 9841 4777.

### Men's Educational Rural Van (MERV)

MERV is a mobile men's health check and information service. The modified van travels to men's workplaces and community sites within a 50km radius of the NSW town of Mudgee. The service was established with the assistance of an initial men's health funding grant from the NSW Department of Health and continues to be supported by the Greater Western Area Health Service and local businesses.

The health check includes a review of blood pressure, blood glucose and cholesterol levels. Health education is provided on topics such as heart disease, alcohol consumption, smoking, prostate cancer, bowel cancer, sexual health, testicular self-examination, healthy eating, exercise and mental health. Men are referred to health professionals if needed.

Local observations identified that men were often reluctant to access health facilities. MERV addresses these barriers by offering a versatile, flexible, male-specific health service. MERV has created substantial local interest, which in turn has increased the profile of men's health. This flexible service has improved men's access to health information. For more information visit [www.gwahs.nsw.gov.au/index.php?select=Media&option2=Release\\_1023&search=merv](http://www.gwahs.nsw.gov.au/index.php?select=Media&option2=Release_1023&search=merv)

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## Endnotes

1. World Health Organization Commission on Social Determinants of Health (2008) *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health, Final Report of the Commission on Social Determinants of Health*, Geneva
2. Smith J, Braunack-Mayer A, Wittert G & Warin M (2008) "It's sort of like being a detective": Understanding how Australian men self monitor their health prior to seeking help or using health services, *BMC Health Serv Res*, 8(56)d
3. Australian Institute of Health and Welfare (2008) *Australia's Health 2008*, cat. no. AUS 99, Australian Institute of Health and Welfare, Canberra, p.412
4. WHO Commission on the Social Determinants of Health (2008) *Key Concepts*, Geneva
5. Marmot M (2004) *The Status Syndrome: How Your Status Standing Affects Your Life and Life Expectancy*, Bloomsbury, London
6. Department of Health and Children (2008) *National Men's Health Policy 2008–2013, Working With Men in Ireland to Achieve Optimum Health and Wellbeing*, Brunswick Press Ltd, pp.68–9
7. Richardson N (2004) *Getting Inside Men's Health*, South Eastern Health Board
8. Galdas P, Cheater F & Marshall P (2007) What is the role of masculinity in white and South Asian men's decisions to seek help for cardiac chest pain? *Journal of Health Services Research and Policy*, 12, 223–229, p.228
9. *ibid*
10. Smith J, Braunack-Mayer A, Wittert G & Warin M (2008) "It's sort of like being a detective": Understanding how Australian men self monitor their health prior to seeking help or using health services, *BMC Health Serv Res*, 8(56)d
11. Men's Health Information and Resource Centre (2009) submission to the Senate Select Committee on Men's Health
12. Malcher G (2009) Submission to Senate Select Committee on Men's Health
13. Andrology Australia, *Engaging Men in Primary Care Settings*, [www.andrologyaustralia.org/docs/GPguide\\_11\\_EM.pdf](http://www.andrologyaustralia.org/docs/GPguide_11_EM.pdf)
14. Royal Australian College of General Practitioners (RACGP) (2009) submission to Senate Select Committee on Men's Health
15. Malcher G (2009) submission to Senate Select Committee on Men's Health
16. *ibid*
17. Andrology Australia, *Engaging Men in Primary Care Settings*, [www.andrologyaustralia.org/docs/GPguide\\_11\\_EM.pdf](http://www.andrologyaustralia.org/docs/GPguide_11_EM.pdf)
18. [www.bchs.com.au/services/HealthPrograms/HealthyComm/index.aspx](http://www.bchs.com.au/services/HealthPrograms/HealthyComm/index.aspx)
19. Bendigo Community Health Services (2009) submissions to the National Men's Health Policy and Senate Select Committee on Men's Health

20. Australian Institute of Health and Welfare (2009) *Expenditure on Health for Aboriginal and Torres Strait Islander people 2006–07*, Health and Welfare Expenditure Series no 39, cat. no. HWE 48, Australian Institute of Health and Welfare, Canberra
21. Australian Institute of Health and Welfare (2008) *Australia's Health, 2008*, cat. no. AUS 99, Australian Institute of Health and Welfare, Canberra
22. *ibid*
23. Leahy K, Glover J & Hetzel D (2009) *Men's Health and Wellbeing in South Australia: An Analysis of Service Use and Outcomes by Socioeconomic Status*, Public Health Information Development Unit, p.44
24. Australian Institute of Health and Welfare (2008) *Australia's Health, 2008*, cat. no. AUS 99, Australian Institute of Health and Welfare, Canberra, p.87
25. *Ibid*, p.65
26. Department of Health and Ageing
27. Leahy K, Glover J & Hetzel D (2009) *Men's Health and Wellbeing in South Australia: An Analysis of Service Use and Outcomes by Socioeconomic Status*, Public Health Information Development Unit, p.44
28. Australian Institute of Health and Welfare (2008) *National Bowel Screening Monitoring Report 2008*, Cancer Series no.44
29. *Ibid*
30. Boustany J (2000) *Health Access Problems Facing the Aboriginal Community*, [www.medicinea.com](http://www.medicinea.com)
31. Ansari Z (2007) 'A review of literature on access to primary health care', *Australian Journal of Primary Health*, vol.13, no.2, August
32. World Health Organization (1998) *Health Promotion Glossary*, p.10
33. Australian Institute of Health and Welfare, *A snapshot of men's health in rural and remote Australia*, March 2010, AIHW.
34. [www.chp.org.au/parity/articles/results.html?filename\\_num=00249](http://www.chp.org.au/parity/articles/results.html?filename_num=00249)
35. Wenitong M (2002) *Indigenous Male Health, a report for Indigenous males, their families and communities, and those committed to improving Indigenous male health* <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-malehealth.htm>
36. Federation of Ethnic Communities Councils of Australia Submission to the Department of Health and Ageing
37. Australian Institute of Health and Welfare (2007) *Aboriginal and Torres Strait Islander Health Performance Framework 2006*, cat. no. IHW 20, Australian Institute of Health and Welfare, Canberra
38. A National Health and Hospitals Network for Australia's Future and A National Health and Hospitals Network: Further Investments in Australia's Health, accessible at [www.health.gov.au](http://www.health.gov.au)

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**Note:**

This document provides links to external websites and contact information for various organisations. The external websites and contact information listed are provided as a guide only and should not be considered an exhaustive list. All contact details were correct at the time of publication, but may be subject to change. The Commonwealth of Australia does not control and accepts no liability for the content of the external websites or contact information or for any loss arising from use or reliance on the external websites or contact information. The Commonwealth of Australia does not endorse the content of any external website and does not warrant that the content of any external website is accurate, authentic or complete. Your use of any external website is governed by the terms of that website.





