

1. Introduction

Aim of the report

Over the years, it has been asserted that men do not access health services as early as they should from a perspective of illness and disease prevention, or engage in health promotion activities that may reduce the risks of illness and injury (1, 2). Furthermore, comparisons are often made with women's greater use of illness and injury prevention health services. Further evidence and a better understanding of men's health service use are needed to provide a stronger base for public policy and to better inform popular discourse.

To this end, the South Australian Department of Health (SA Health) commissioned this report to address the following question,

'Are there populations of South Australian men who underutilise a range of health services, particularly primary health care services, and, as a consequence, experience a disproportionate burden of disease?'

Thus, the aim of this report is to provide an analysis of South Australian men's health and medical service use by age and socioeconomic status; and to indicate likely directions for improving men's health across the population, through targeted public policy.

The objectives of the report are:

- i) to describe South Australian men's health service use through the analysis of significant, available data sets;
- ii) to disaggregate South Australian men into sub-populations including by age, social gradient and remoteness to describe service use by these populations;
- iii) to analyse and discuss service use and health and wellbeing outcomes by sub-populations of men by assessing under-utilisation (or over-utilisation) of health services by different groups of men and comparing their health outcomes; and
- iv) to provide commentary about causes of (over- or under-) utilisation based on men's health literature and the research project findings, with a view to optimising service utilisation.

The report uses South Australian data to describe men's use of health services and their health status and some health risk factors, with an emphasis on geographic variations in use, in particular, variations related to socioeconomic status.

Variations by age, socioeconomic status and remoteness are shown, wherever possible, for both men and women, to highlight variations in the use

of services, allowing these to be compared with variations in socioeconomic status and in health outcomes.

The services covered include:

- Community health and community mental health services;
- Other community-based services, such as those supplied by the Royal District Nursing Service and Domiciliary Care;
- Dental services;
- GP services (provided under Medicare);
- Accident and Emergency Department attendances; and
- Hospital inpatient admissions.

The health status data presented provide details of:

- Estimates of the prevalence of selected chronic conditions;
- Incidence of cancer;
- Estimates of the prevalence of profound and severe disability; and
- Premature and avoidable mortality.

The health risk factors included are:

- Smoking; and
- Overweight and obesity.

Background

Gender is increasingly being recognised as a significant determinant of health. Not only are there obvious differences in the health of men and of women, but these are also apparent within subgroups of men themselves - boys, young adults, older men, Aboriginal men, and so forth (3). (Note that, throughout this report, the term 'Aboriginal' also includes those of Torres Strait Islander origin).

Men's health issues are defined as those that affect men's health and wellbeing. This definition extends beyond the purely biological aspects of health, as gender influences men's understanding and experiences of health itself, their use of health services and their health outcomes. Beliefs about masculinity and manhood are deeply rooted in culture (8). They are reinforced by social institutions and community values, and play a part in shaping the behaviour patterns of men in ways that have negative consequences for their health (6).

The growing awareness of men's health has arisen from observations that men often ignore the symptoms of poor health, and consequently, do not seek timely health care. Men are also seen to have less interest in their general health than women and may be harder to target through health education and promotion strategies. From existing data, it is evident that Australian men are more likely to become unwell and die from serious health problems than women, and have an average life expectancy of five years less than women (4). For Aboriginal men, their life expectancy is significantly less than their non-Indigenous counterparts, and six years less than Aboriginal women (5).

These patterns of poor health in men are evident from early life: boys are more likely to be injured than girls, young men die more often from accidents, suicide and substance abuse than their female counterparts; and older men die from heart disease and cancers at a higher rate than older women. Men, particularly younger men, tend to act as if they were invulnerable, and may be socially patterned to do so (6). This can lead to destructive, risk-taking behaviours such as drug or alcohol binges, and reckless driving. The suicide rate for men aged between 15 and 24 years has tripled in the past three decades (7). While these rates are declining, they have remained higher than those for women.

As men get older, work becomes an important determinant of their health, with its counterparts of unemployment and under-employment. Relationship issues are also significant influences on men's health and wellbeing. When men are in their later years, some may find themselves in the role of homemaker rather than bread winner, which can bring with it an uncertainty of status, after many years of providing financially for their families.

Risk factors and the health of men

By international standards, Australian men enjoy high life expectancies. However, they tend to utilise health services at a lower rate than Australian women, and die more often from chronic diseases such as cardiovascular disease, cancer, and injury including suicide (4). Men also experience higher rates of hospital admission due to work-related injuries (4).

From birth, morbidity and mortality rates are higher for males, with greater incidences of heart disease, cancer, accidents and injuries. Men participate in 'risky' behaviours more readily than females, with heavier alcohol and tobacco consumption, dangerous driving, participation in more contact sports, and work in stressful and laborious jobs

thereby increasing the likelihood of illness and/or injury.

Interpersonal violence is also commoner amongst men, and they are more likely to commit violent crimes such as assault, and to be the victims of most assault offences, with the exceptions of sexual assault and abduction.

In the first decade of life, deficits in many of the determinants of health, such as enriching early childhood environments, educational achievement, quality of family relationships and parental employment, can facilitate the development of poorer adult health and wellbeing. For example, national literacy assessments indicate school-aged boys perform less well than their female counterparts across all socioeconomic groups, especially those most disadvantaged (54). There is also an association between boys' play interests and behaviours and patterns of risk-taking behaviour when they are older (6).

In adolescence, many unhealthy habits are fostered by increased experimentation and risk-taking, and the cessation of regular consultations with health practitioners. During this period, the difference between men and women's death rates increases, with injury, a major cause of death in young men.

Occupational and family stresses and a reduction in physical activity may also occur during this time, all of which can impact negatively on an individual man's health.

By adulthood, men once again revisit their general practitioners with health problems that are often already established, as the poor health habits of their youth emerge as conditions such as diabetes, heart disease and obesity. Relationship and employment issues, mental health issues, sexual health problems and prostate cancer are additional health concerns of adult men.

Role adjustment in the later stages of life may also cause mental health difficulties for older men, who may find themselves retrenched or retired, socially isolated or caring for a frail or unwell partner.

Men – historically and socially shaped

As indicated earlier, men's health is largely determined by our cultural perspectives of men. It is commonly believed that men neglect their health and do not regard their health with a high sense of priority; that men in Australia are less likely to take an active role in maintaining their own health, compared with women; and that they are also less likely to seek professional help for health problems when these occur.

Historically, 'masculinity' and 'male' characteristics have shaped attitudes towards health and caring for one's health. Many of the social factors that shape men's health are first encountered in childhood. Men are encouraged by our culture to 'be tough', and many believe that complaining about an illness or visiting the doctor undermines their masculinity or is 'a waste of time,' unless they are acutely unwell or injured. Men interact and communicate differently to women, which may create difficulties for them in voicing their health concerns - they may feel that is a sign of 'weakness' to seek help. As a result, men may not be conditioned to value good health.

The role of a man today is not as clearly defined as it was last century; men have a socially designated role as providers and protectors, yet they are also now expected to be caring and sensitive fathers and partners - in tune with their emotions, yet needing to display stoicism (9).

Women are more likely to have regular contact with doctors because of reproductive issues such as medically prescribed contraception, pregnancy and childbirth. Men do not have a biological role that requires them to see a doctor regularly, and are less likely to take action at the first sign of illness.

While the poorer health of many men may be partly due to certain attitudes, ill health is also the result of the social environment in which we live, as health is largely influenced by factors such as socioeconomic status, income, employment and one's level of education. Men from low socioeconomic backgrounds make up one of the sickest population sub-groups in Australia (4).

Socially, for many men, the role of provider is intrinsically linked with self-worth. Unemployment, therefore, puts great financial and emotional strain on a family, which in turn can make men feel guilt and stress for not fulfilling the expected role of provider. Men without sufficient education or training or a skilled trade are more likely to experience periods of unemployment, when work in unskilled positions falls short. Unemployment can also foster feelings of helplessness and a lack of control over one's life, meaning that physical and mental health needs may also be neglected. Depression in men is associated with an increased risk of physical health disorders, such as cardiovascular disease and diabetes.

Stressful life issues - such as the death of a spouse, separation, divorce or unemployment - can trigger serious depression in men more often than in women (10). Men are also more likely to resort to destructive behaviours in an attempt to deal with depression. Depressed men are twice as likely as their female counterparts to misuse alcohol and drugs.

Mortality in men

Men in the 15 to 29 year age group experience higher death rates from injury compared with males of other ages, and with females in the same age range and across all ages. Self-inflicted injury and injury from external causes result in death more often for men than women and overall, men experience higher hospital separation rates compared with women. Aboriginal men also have higher overall rates of death from injury than non-Aboriginal men (11).

The impact of disadvantage

The RACGP health inequalities study clearly demonstrated the much higher high mortality rates for males compared with females across the socioeconomic spectrum (55).

Utilising the Index of Relative Social Disadvantage (IRSD), one of the Socioeconomic Indices for Area (SEIFA) developed by the Australian Bureau of Statistics, a strong social gradient is apparent across the health of the SA population (47). Men living in socioeconomically advantaged areas are more likely to be educated about health issues, are more likely to have access to health services and are able to afford health care costs. There is also a strong association between occupation and mortality, as some occupations are more hazardous to health than others, and the geographical distribution of some occupations varies. For example, farmers suffer higher rates of injury and death than office workers.

The participation by men in health screening activities varies widely according to the risk factor considered. Not only does unemployment contribute to behavioural risks such as smoking and poor nutrition - which can lead to cardiovascular disease, respiratory disease, and hypertension - it also affects psychological wellbeing (6). Low levels of psychological wellbeing can lead to depression and suicide, and the effect of unemployment on physical and mental health problems tends to increase with the duration of unemployment (7).

Men in rural and remote areas may face disadvantage because of their geographical isolation and relative lack of access to health services. Accessing a health service often requires travel and time away from work. Rural employment may be detrimental to men's health, with exposure to hazardous machinery, chemicals, long and laborious hours often the nature of the work. Farm work-related deaths occur every three days on Australian farms, highlighting the substantial associated health risks (9).

Aboriginal men

Aboriginal men suffer a greater burden of illness and disease than the rest of the Australian population. In particular, they are generally not employed in the planning and delivery of health services, which results in a lack of an Indigenous male focus in health services and programs. Aboriginal men's health issues are perceived differently to those of non-Aboriginal men, in that they reflect issues relating to the whole male community, rather than to each individual as a separate entity (2).

Socioeconomic disadvantage, poor housing, lack of services, less education, unemployment and under-employment, and racism and discrimination are compounding issues across all areas of Aboriginal men's health (5).

The cultural identity and role of Indigenous men in their communities and families changed dramatically after colonisation, forced removal from their traditional lands, and later policies of assimilation and the removal of children. The cumulative effects of these events resulted in disempowerment, despair and loss of language and culture, which in turn was increasingly associated with substance misuse, ongoing trauma and violence, depression, and family breakdown (5).

Efforts to improve the health and wellbeing of Aboriginal men are unlikely to be successful without the acknowledgement of past injustices, the provision of opportunities to regain dignity and acquire skills and meaningful work, reconnect with land and culture, take ownership of health issues, and have Aboriginal control of the planning and delivery of appropriate health services, relevant to local need and circumstances (12).

The role of health providers

General practitioners (GPs) are the first port of call in the Australian health care system and around 80% of Australians visit a GP at least once in any year. However, researchers from the Bettering the Evaluation and Care of Health (BEACH) program reported that men attended their GP less often, compared with women (13).

Men need to be better informed about the health issues that affect them, and services should be delivered in a manner that makes them readily accessible to men. Health planners and service providers also need to acknowledge that men's health warrants greater attention.

Different groups of men have particular health issues and needs, and therefore, a range of approaches will be necessary to meet them.

As stated in *Moving Forward in Men's Health*, in order to promote and improve men's health, and make health services more responsive to men, further research is required into men's health, taking a community-wide and intersectoral approach, so that all areas of the community can work together (46).

2. Overview

Background

It is widely held that Australian men's health and, equally, their attitudes to their health, are poor. Comment is frequently made about the lower rate of use of health services by men, when compared with women; and that their lesser use contributes to poorer health and earlier mortality (14). Further, not all men have the same health experience: for example, rates of premature mortality vary by 70% when examined by socioeconomic status (see page 137).

This report seeks to inform those responsible for policy development and strategic planning for, and the delivery of services to, men by analysing the available data to determine:

- how men's health and use of services varies by age, socioeconomic status of area of residence; and
- the extent and nature of their different use of services compared with women.

The approach taken in this report is to examine the available datasets that describe men's health and wellbeing and their use of a range of health and welfare services. Similar data on women are included in order to provide a comparator. The datasets are limited to those with a geographic element, which allow for analysis by socioeconomic status and remoteness.

The data used in this report were supplied by a range of agencies: see Table A3.

Summary information

What do the data show? Table 2.1 indicates overall numbers and rates of clients and use of selected services for men and women. These are described in more detail later in the report. Table 2.2 provides data for some of the main diseases and

health risk factors; and Table 2.3 provides data from the 2006 Population Census of the population reporting limitations with certain activities, to the extent that they are classified as having a profound or severe disability, and two measures of mortality.

In sections 5 to 12, these topics (use of services, prevalence of chronic disease and associated risk factors, disability, mortality and burden of disease) are explored in more detail, and analysed by sex, age, socioeconomic status and remoteness.

In order to provide a context for these data on use of services and health and wellbeing, Section 4 describes the demography and socioeconomic status of men as a group, highlighting variations within the population.

A separate section was planned to present data about Aboriginal males, because they are a substantially disadvantaged group, with the poorest health when compared with other males in Australia. However, there were little State data available at a small area level and with sufficient numbers to map. Therefore, where possible, comparisons made are with Aboriginal men in other population groups, with Aboriginal women, with the total population, or with non-Indigenous men.

Men's use of community health services was substantially lower than that of women (a rate ratio of 0.44, 56% lower) (Table 2.1). Their use of general medical practitioner and specialist medical practitioner services was also lower than of women (rate ratios of 0.73 and 0.89, respectively; or 27% and 11% lower). Community mental health services were utilised slightly (8%) more by men than by women (a rate ratio 1.08).

Table 2.1: Use of selected services, by sex, South Australia, early 2000s¹

| Variable | Males | | Females | | RR M:F ² |
|--|-----------|-------------------|-----------|-------------------|---------------------|
| | No. | Rate ³ | No. | Rate ³ | No. |
| Community health service clients ⁴ | 5,413 | 987.7 | 13,330 | 2,337.7 | 0.42 |
| Community mental health service clients Child and Adolescent Mental Health Service (CAMHS) clients | 8,824 | 1,147.0 | 8,347 | 1,062.2 | 1.08 |
| General medical practitioner services | 12,074 | 4,036.1 | 9,836 | 4,861.7 | 0.83 |
| Accident and emergency attendances | 3,225,724 | 423,422.8 | 4,487,690 | 578,589.1 | 0.73 |
| Hospital admissions | 153,503 | 28,009.8 | 153,880 | 26,986.2 | 1.04 |
| | 232,461 | 30,759.6 | 26,5154 | 34,372.6 | 0.89 |

¹ Community health and community mental health services are for 2005/06; general medical practitioner services, 2004/05; hospital admissions, 2003/04, CAMHS 2004/05-2006/07

² RR M:F is the ratio of the rate for males to that for females

³ Rate is the average annual number of clients or services per 100,000 population

⁴ Figures for residents of Metropolitan Adelaide only

⁵ Includes consultations with specialist medical practitioners funded under Medicare

Data for selected chronic diseases, risk factors and self-assessed health status are shown in Table 2.2. These are self-reported data, collected by the Australian Bureau of Statistics in the 2004/05 National Health Survey: that is, they are not based on actual measurements. As such, they do not necessarily reflect the true situation. For example, as people age, they tend to understate their weight and overstate their height. Thus, when the calculation is made to assess whether they are overweight, or obese as measured by the Body Mass Index, these mis-statements result in an understatement of overweight and obesity. Similarly, when people are asked if they have ever been told by a doctor or a nurse that they have diabetes, it appears (from evidence in other studies involving measurements), that the self-report figures are below the 'true' level. However, for the purposes of this report, the self-report data are useful for comparing men with women, and making comparisons between various population groups of men.

Male rates for diabetes and heart, stroke and vascular disease were higher than for females (rate ratios of 1.27 and 1.10, respectively); however, rates of respiratory system diseases (including asthma) and circulatory system diseases overall were lower than for women (rate ratios of 0.90, 0.76 and 0.80, respectively).

Consumption of alcohol at levels considered to be of high risk to health was substantially higher among men, being more than twice the rate of that for women (a rate ratio of 2.32). Smoking rates were also markedly higher for men (a rate ratio of 1.39). However, rates of physical inactivity were similar for both men and women.

There was little difference between men and women assessing their health as 'fair' or 'poor' (compared to 'excellent', very good', or 'good'). However, rates of 'high' or 'very high' psychological distress (measured by the K-10 – see Glossary) were 32% lower than those reported by women (a rate ratio of 0.68).

Table 2.2: Selected chronic disease, associated health risk factors and self-reported health status, by sex, South Australia, 2004/05¹

| Variable | Males | | Females | | RR M:F ² |
|---|------------|------|------------|------|---------------------|
| | No. ('000) | % | No. ('000) | % | |
| Chronic diseases | | | | | |
| Diabetes | 34.3 | 4.6 | 27.2 | 3.6 | 1.27 |
| Respiratory system diseases | 233.4 | 31.5 | 264.0 | 35.1 | 0.90 |
| Asthma | 74.4 | 10.0 | 97.5 | 12.9 | 0.76 |
| Circulatory system diseases | 130.7 | 17.6 | 165.0 | 21.9 | 0.80 |
| Heart, stroke & vascular conditions | 33.3 | 4.5 | 31.0 | 4.1 | 1.10 |
| Risk factors | | | | | |
| Smoking | 148.6 | 26.2 | 110.9 | 18.9 | 1.39 |
| Alcohol - high risk consumption | 53.7 | 9.5 | 24.3 | 4.1 | 2.32 |
| Physical inactivity | 195.1 | 34.6 | 204.6 | 34.8 | 0.99 |
| Overweight | 223.5 | 39.7 | 146.5 | 24.9 | 1.59 |
| Obesity | 105.2 | 18.7 | 97.6 | 16.6 | 1.12 |
| Self assessed health status | | | | | |
| Fair or poor health ³ | .. | 16.5 | .. | 16.6 | 0.99 |
| High/ Very high levels ⁴ of psychological distress | 54.3 | 4.7 | 86.0 | 7.5 | 0.68 |

¹ ABS National Health Survey 2004/05

² RR M:F is the ratio of the rate for males to that for females

³ Respondents' general assessment of their own health, against a five point scale from 'Excellent' through 'Very good' and 'Good' to 'Fair' and to 'Poor' – 'fair' or 'poor' being the two lowest in the scale

⁴ Derived from the Kessler Psychological Distress Scale-10 items (K-10), which is a scale of non-specific psychological distress based on ten questions about negative emotional states in the four weeks prior to interview. 'Very high' distress is the highest level of distress category (of a total of four categories).

Source: ABS National Health Survey: Summary of Results, 2004-05, (ABS Cat. No.4364.0).

There were 18% fewer men than women whose responses to questions in the 2006 Population Census indicated they had a profound or severe disability (see box opposite), but only 5% fewer who were living in the community (i.e., excluding people living in long-term residential accommodation in nursing homes, accommodation for the retired or aged (not self-contained), hostels for the disabled and psychiatric hospitals) (Table 2.3). The equivalent proportions for the population aged 65 years and over were 32% (total) and 20% (living in the community).

Death rates for males at ages 0 to 74 years (referred to as premature deaths) are 68% higher than those for females. The differential in avoidable mortality rates is even greater, at 85% – this indicator comprises those causes of death (before 75 years of age) that are potentially avoidable at the present time, given available knowledge about social and economic policy impacts, health behaviours, and health care.

Estimates of profound or severe disability

This indicator was developed by the ABS from responses to questions on Core Activity Need for Assistance in the 2006 Population Census: the responses to these questions were used to estimate the number of persons with a profound or severe disability. People with a profound or severe disability are defined as those people needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication because of a disability, long term health condition (lasting six months or more), or old age.

Table 2.3: Selected health status measures, by sex, South Australia, 2004/05

| Variable | Males | | Females | | RR M:F ¹ |
|--|--------|-------------------|---------|-------------------|---------------------|
| | Number | Rate ² | Number | Rate ² | |
| Estimated number of people with a profound or severe disability | | | | | |
| All ages | 32,495 | 4.4 | 40,906 | 5.3 | 0.82 |
| All ages, living in the community ³ | 28,063 | 3.8 | 30,639 | 4.0 | 0.95 |
| 65 years and over | 14,039 | 13.7 | 26,362 | 20.2 | 0.68 |
| 65 years and over, living in the community ³ | 10,631 | 10.4 | 16,868 | 12.9 | 0.80 |
| Mortality | | | | | |
| Premature mortality (deaths before 75 years of age) | 13,047 | 1,833.5 | 7,654 | 1,088.6 | 1.68 |
| Avoidable mortality | 10,326 | 272.8 | 5,612 | 147.2 | 1.85 |

¹ RR M:F is the ratio of the percentage for males to that for females

² Rate is per 100,000 population

³ Figures for 'Living in the community' exclude people living in long-term residential accommodation in nursing homes, accommodation for the retired or aged (not self-contained), hostels for the disabled and psychiatric hospitals

Source: Australian Bureau of Statistics 2006 Population Census (unpublished).

This page intentionally left blank