

THE AUSTRALIAN MALE POLICY: UNFINISHED BUSINESS

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This comment on the Australian Male Health Policy draws on the framework suggested by Buse, May and Walt which suggests that insights can be achieved by looking at the *content, context, process and actors* involved.¹ As a preliminary step in such analysis, these three elements are briefly looked at. This allows for acknowledgement of some of the strengths of the policy, not least of all its focus on the social determinants of men's health, a framework often applied to other subpopulations, but rarely to men. On another positive note, the policy led to the funding of a national men's health longitudinal study and support for the Men's Shed movement. I also highlight the benefits of the community consultations which occurred, which allowed men from across the country to express their views on men's health needs. Mention is made of the Brazilian Men's Health Policy and the Irish Men's Health Policy and Action Plan from which lessons could be learned.

Walt et al point to the difficulties inherent in the complexities of analyzing any policy while nevertheless highlighting the importance of such analysis:

*Health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes and to plan for future policy implementation.*²

In those words one can see the challenge facing us if we want to have some insights into lessons to be learned from the Australian Male Health Policy promulgated in 2010: what *institutions, interests and ideas* have shaped both the formation of this

policy and what has happened to it since?³ Perhaps non-Australian observers will be better placed to have such insights since this author is immersed in all of these three elements. As such, I can offer some analysis but one which will inevitably be influenced by my own institutional links, interests and ideas. I have been a consultant to this policy and one of the "Men's Health Ambassadors" sent around the country by the government to have a feel of what men in the community felt should be in the document. Accordingly, the opinions expressed in this piece are those of the author alone.

The policy analysis framework is that proposed by Buse and his colleagues acknowledges the importance of looking at the *content, the processes of policy making and how power is used in health policy*.¹ This means exploring the role of the state, nationally and internationally, and the groups making up national and global civil society, to understand how they interact and influence health policy. The complexity both of policies themselves and of the task of analyzing them is developed further by Gilson in a 2012 WHO document. This defines health policy by quoting Buse, May and Walt (2005):

*because health is influenced by many determinants outside the health system, health policy analysts are also interested in the actions and intended actions of organizations external to the health system which has (sic) an impact on health (for example, the food, tobacco or pharmaceutical industries)*¹

CONTENT

The content of the Male Health Policy is predictable: It contains an overview of the state of the health

of Australian males. It must be noted that the word “males” is used in the text to show that the concern is with men *and* boys. This is one instance where the policy acknowledges the Australian indigenous culture, since Aboriginal men insist on this inclusiveness of all ages in their discussion of gender. In its intent, the policy aims at being diverse and at inclusivity.

Although Australian males enjoy one of the highest life expectancies in the world (78.7 years in 2005–07), significant health inequalities exist in Australia... Australian males continue to have a lower life expectancy than Australian females (83.7 years in 2005–07) and are dying earlier of some preventable diseases and injuries.... In 2006, 22 per cent of male deaths occurred in the 25–64 age group compared to 14 per cent of female deaths. Male mortality rates were higher than female rates across all age groups.

It should be noted that the policy was launched in 2010 and of course the data was the most available just prior to that date. However, the trends outlined in the policy have not changed substantially:

*In Australia, a boy born in 2011–2013 can expect to live to the age of 80.1 years and a girl would be expected to live to 84.3 years compared to 47.2 and 50.8 years, respectively, in 1881–1890.*⁴ The Policy does not at this point indicate what most commentators know: there is a *life expectancy gap of four years for males and two years for females between the highest and lowest socioeconomic groups.*⁵ The Australian Government in its “Close the Gap” statements (closing the gap in health and life expectancy between Indigenous and non-Indigenous Australians) targeted the life expectancy gap. Sadly, it must be pointed out that these statistics have not substantially changed and the “gap,” in this case between Indigenous and non-Indigenous men, persists today.

The policy then speaks of causes of years of life lost: it lists these as coronary heart disease, lung cancer and other heart diseases, as well as suicide and points to death by traffic accidents as another major factor in male mortality rates.

So, the policy lists male health problems but speaks also of action to address these: *The National Male Health Policy provides a framework for improving male health across Australia – with a focus on taking action on multiple fronts*

The document lists six priority “areas for action”:
*Optimal health outcomes for males, Health equity between population groups of males, Improved health for males at difference life stages, A focus on preventive health for males, particularly regarding chronic disease and injury, Building a strong evidence base on male health and using it to inform policies, programs and initiatives and Improved access to health care for males through initiatives and tailored healthcare services, particularly for male population groups at risk of poor health.*³

The emphasis on equity is clear in the policy and mention is made of the LBGT community and its needs, as well as those of migrants. Special attention is paid to the situation of Aboriginal and Torres Strait Islander men who tend to die 10 – 15 years younger than non-Indigenous men.

There is also an emphasis on prevention and improved access, thus reflecting the international literature on Primary Health Care for populations in general.⁶ The policy lists priority areas for action, as well as general statements concerning optimal health outcomes for males, the need to focus on prevention and improved access for men; it also promoted and has funded a national men’s health longitudinal study. This has been initiated by Melbourne University (University of Melbourne and recently handed over to the Australian Institute of Family Studies).

So, as regards content here is little to fault in the policy. But content can mean words alone and this indeed is largely the case with the Male Health Policy. Apart from funding the national men’s health longitudinal study, called Ten to Men since a study of children was already under way, and funding for the Shed Movement (the movement gathers men, often after retirement and clearly benefits their health) there is no evidence of allocation of funds to the “priority areas” mentioned in the document. The Brazilian Men’s Health Policy (dealt with elsewhere in this issue) may have its critics but has the advantage of having allocated 26 pilot projects for men’s health, one for each state in the country as well as the Federal District of Brasilia and 1,000 cities in the country. Such an infrastructure is missing in Australia.

Similarly, the Irish Men’s Health Policy is embedded in the national health policies of that country.⁷

This “mainstreaming” of men’s health allows us to think that initiatives in both Ireland and Brazil will have continuity. Sadly, no such optimism is warranted in Australia.

CONTEXT

One of the other elements highlighted by Buse and colleagues in their discussion of the analysis of policy is *context*.¹ An important dimension of the context which is relevant here is the global perspective or narrative in the English speaking world concerning men’s health. Men’s health has been receiving considerable attention in the past decade, Brown and Macdonald,⁸ Robertson, Zwolinsky and Day,⁹ and Macdonald,¹⁰ are just some examples of this interest, and the Australian Medical Association has recently published a document on men’s health.¹¹ There are indications of this in Europe¹⁵ and in other continents, for example the *Asian Men’s Health Report*.¹⁶ Australia is not the only country to have a national men’s health policy. There are two other national policies: the Irish National Men’s Health Policy¹⁷ and the Brazilian National Male Health Policy.

Most commentators on men’s health agree on male-specific pathologies as outlined above. Where commentators differ, either explicitly or otherwise, is in the interpretation of the causes of these male health issues: why do men die earlier than women? Why do they often access help later than is in their interests? Why are they more susceptible to injury-related illness and even death more than women? This debate forms a major part of the international narrative which can be seen as playing an important role in the context of the Australian Male Health Policy, in terms of its formation and its reception by the Australian public and policy makers.

Globally, there is an influential stream of thought which has an explanation for the relatively poorer health of men. As Macdonald puts it

There is a very large body of writing about men and their health rooted in sociological theories of “masculinity” (e.g. Garfield, Isacco, & Rogers, 2008; Mahalik, Burns, & Syzdek, 2007; Philbrick, 2015) which tend, perhaps without deliberate intent, to focus on what men are doing wrongly: they not only do not attend the doctor frequently enough, in addition, they do not get in touch

*with their feelings, they tend towards competition and violence, and take unnecessary lifestyle ‘risks’. These “masculinity” traits are seen to be injurious to their health and often the health of others.*¹⁰⁻¹³

The theorizing around masculinity owes much to the scholarship of Professor R Connell¹⁸ who says of masculinity that it consists of ‘the configuration of gender practice which ... guarantees ... the dominant position of men and the subordination of women.’¹⁹

Another author, Courtenay, contends that in the USA masculinity-shaped behaviour is the main reason for the poorer state of men’s health compared to that of women and holds that men are more likely than females to engage in over 30 behaviours that increase the risk of disease, injury and death. In other words, the bulk of illness in men should first of all be attributed to “men behaving badly.”²⁰

This perspective has influenced a considerable amount of Australian academic writing on men’s health, for example the article of Schofield and her colleagues who argue that only a “gender-relations” perspective should be used to understand men’s health.²¹

The context of men’s health policies and this includes the Australian policy is indeed one where the national narrative is generally framed as a gender-relations issue; the feminist movement has been at the forefront of promoting gender equity in all areas, including health, and provides the context in which the Australian Male Health Policy was born. It is, however, of note, that the Australian Male Health Policy is entitled “Building on the strengths of Australian males” and does not start from the position that “masculinity-shaped behaviour is the main reason for the poorer state of men’s health”. Rather it endorses a “social determinants of health” and an evidence-based perspective. The Centers for Disease Control (USA) describes the social determinants of health of all populations in the following way: *Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).*²² The Australian Male Health Policy lists examples of the social determinants of health affecting men: Income, Education, Employment, Injustice experienced by Aboriginal and Torres Strait Islander people, Relationships, including fathering, social

networks, and violence. It is of interest that the social determinants of health approach have been applied to many populations but only infrequently to men.²³

There is, therefore, a tension in the Australian context of men's health, not so much at the grass roots but rather at the policy and academic levels, just as there is always a tension between a narrower bio-medical approach and a more sociological perspective.

The longitudinal study of men's health which stems from the policy is, for the first time, providing Australian health planners with reliable longitudinal data on male mental and physical health. Until this initiative, planners of programs for men's health had to rely on assumptions about men, not all of which were positive. As Macdonald¹⁰ says, drawing on Englar-Carlson and Kiselica, *The perspective is often one focused on the pathological, what needs to be fixed. For instance, in the context of counselling, Englar-Carlson and Kiselica in their overview of the literature on males and masculinity conclude that:*

*Many of the central assumptions advanced by existing research on men and masculinity support the notion that males are defective and damaged, need to be fixed, and are at fault for the problems they bring to counselling.*¹⁰

Rather than focusing only on male pathologies, men's contribution to society is acknowledged in the policy: *Males play varied and important roles in Australian society, including as fathers, partners, providers, carers, sons, brothers, grandfathers, uncles, friends and role models. They contribute in a wide range of community activities, such as the arts, sports and spiritual endeavours, and in the paid and unpaid workforce*³; these remarks may seem inconsequential, but in fact they represent a move away from such other Australian male health policies often influenced by the "masculinity" focus already mentioned. An example is the Doctors' Reform Society (DRS). In their still unchanged Gender policy, this progressive group of doctors (they have been vocal in their support of affordable medical care for the whole population) have this to say:

The DRS recognises that there are particular issues for men which affect their health. These issues can arise from the process of socialisation to compete and dominate in social and political spheres which can foster violence. As a result of this, many men experience

*a number of psychological difficulties, a reluctance to acknowledge and address their own health issues and diffidence in approaching health services.*²⁴

The Australian policy document, by endorsing a social determinants of health approach, adopts a more holistic view while acknowledging that the orientation of "Building on the strengths of Australian Males" was at least in part due to the fact that the lead up to the policy consisted of a series of nation-wide consultations with stakeholders, rather than drawing first of all on the academic literature.

PROCESS

The policy could easily have been formulated by academics. Most probably it would then have taken a different shape with different emphasis. In fact, as mentioned, the government appointed an "expert panel" to go throughout the country to speak to men's groups and get an idea of what men were saying about their health and their health needs:

In 2009, to gain a picture of attitudes to male health across Australia, 26 public forums were conducted in each state and territory, with more than 1300 people – health experts, government and nongovernment organisations, peak bodies and males themselves – involved. More than 90 public submissions were also received. (Australian Government Department of Health)

The social determinants approach came directly from the consultations with the community. As the document says about the findings of these consultations: *During the public forums, males consistently said that they view health holistically. All aspects of life impact on their health and wellbeing, including family and social circumstances, income levels (and) where they live.*³ In other words, a real attempt was made in the lead up to the issuing of the policy to consult with the community. Partly as a result of this, and an attempt to address the diversity in the country, the document has this to say:

Other males also have poorer health outcomes as raised in consultations and submissions for this Policy, particularly gay, bisexual or transgender males, and intersex people. Other groups with poorer outcomes include males with disabilities, males with mental health issues, servicemen or veterans, and males who

are socially isolated. Males who are in the criminal justice system also have particular health issues. (Australian Government Department of Health)

There is evidence, then, of the policy's attempt to acknowledge diversity and disadvantage, an essential dimension of the social determinants approach²⁵:

Social and economic disadvantage is directly associated with reduced life expectancy, premature mortality, injury and disease incidence and prevalence, and biological and behavioural risk factors A recent study found a 32 per cent greater burden of disease for the most disadvantaged population as compared to the least disadvantaged, due to higher rates of burden for most causes, particularly mental health disorders, suicide, self-harm and cardiovascular disease (Australian Government Department of Health).

ACTORS

The actors in the case of this policy are similar to those in the formation of any policy: a combination of Department of Health workers, some men's health specialists (there are few in the country beyond the biomedical world) politicians and people's organisations. The department, as indicated, initiated and carried out the community consultations, without which there might have been no policy or a policy very different from the existing one. Such players are, of course, often influenced by relevant politicians. Governments can change every three years in Australia; it was the Labor Party when in opposition which promised a policy and when in government launched it in 2010. The government of that time had a "Minister's Male Reference Group." With a change of government this has since been discontinued. The Australian government is at the time of writing is a Coalition Government (of the conservative Liberal and National Parties) and has continued to support the Men's Shed movement, a grass root nation-wide organisation offering, among other things, social support to men after retirement. The Shed movement is mentioned in the policy and receives financial support from the government which continues to honour the funding of the longitudinal study. It is to be hoped that these two commitments will continue whichever Party is in power.

The other "actors" are organisations promoting men's health, notably the Australian Men's Health Forum,²⁶

which runs the National Men's Health Conferences or Gatherings and has been lobbying for a policy and a longitudinal study for some time. Members of the Men's Health Information and Resource Centre at Western Sydney University were consultants to the department during the process of compiling the policy and, among other things, run the National Men's Health Week. The Centre continues to promote the ideas of the policy.

UNFINISHED BUSINESS

The Australian National Male Health Policy has much to commend it. When compared with, for example, the Brazilian Male Health Policy and that of the only other country to have such a policy, Ireland, (the contexts of both, of course, are in many ways different), the Australian policy can be seen to be stronger in several senses: Australia has initiated its national longitudinal study of male health, thus providing evidence-based data that has been lacking so far. Moreover, it strongly endorsed the social determinants of health approach, thus laying the foundation for possible new approaches in policy and practice. It has to be said, however, that these new approaches are not yet much in evidence. In addition, the Australian policy endorsed and thereby led to government support for the National Men's Shed Movement and the work of that organisation in building the health of older men, a group vulnerable to physical and mental health issues. It has provided this support without medicalizing the Sheds, a practical way of endorsing a social determinants of health approach. There is much which other countries might learn from these initiatives.

However, the Brazilian Policy can be seen to have more teeth than the Australian version. It has a national infrastructure to implement its policy, Money has been spent in implementing programs directly flowing from the policy: *In 2013 for instance, PNAISH financed 80 projects in local municipalities, with each municipality receiving approximately US\$12,540 for that given year.*²⁷

Indeed, both in terms of financing male-specific programs (including fathering programs) and having a national infrastructure to promote the policy, the Brazilian Policy has much that could be learned from. Spindler concludes her assessment of that policy with

words which could count for all men's health policies, including the Australian one:

The Brazilian Men's Health Policy (PNAISH) *provides a toolbox full of strategies, considerations, complexities, and lessons learned that can help guide other policy makers globally. Chile and Paraguay are among a number of countries with governments now looking to PNAISH as they begin developing their own men's health policies. They are joining the growing movement, affirming that men's health matters.*²⁸

The Brazilian Men's Health Policy is integrated into the National Health structures and plans and its implementation is monitored; some accountability is built in. In a positive sense, it is "top down." The Australian policy, on the other hand, grew out structures which do not have their origin in government-structures, like the Australian Men's Health Forum. There is little indication of "top-down" implementation or target setting even of the actions called for in the policy, unlike the Irish policy, which calls for explicit actions. This points to weakness in the Australian policy and it is to be hoped that whatever government is in place in future it can work towards mainstreaming and funding actions highlighted in the policy. Otherwise we are left with largely unfinished business. The call for a "Men's Health Strategy" by the Australian Medical Association must be welcomed.¹¹ However, it should be noted that it makes no reference to the Australian Male Health Policy of only eight years earlier.

It is clear that Australia has made many good steps in the development men's health programs and policies but there is a lot of road ahead. Let's hope that the renewed interest in the National Male Health Policy is the beginning of a new phase in the development of more sophisticated policy responses to men and boys' health.

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