If one were to conduct a survey on how men in Australia look after themselves, the near-universal reply would be that they pay little attention to their health, and some even ignore all health issues. Unfortunately, it could be considered a fair statement to say that men’s health has not been a priority of governments, health authorities or even community and lobbying bodies.

It seems remarkable that Australia’s first (and only) national male health policy was launched as recently as May 2010 (Figure 1). It has defined a number of priority areas for action that tacitly admit the shortfalls in male health in Australia (Box 1). This policy has resulted in the publication of The health of Australia’s males and the formation of the Minister’s Male Health Reference Group, instigated by the Hon Warren Snowden MP, who is the Minister for Veterans’ Affairs, Minister for Defence Science and Personnel, Minister for Indigenous Health and Minister Assisting the Prime Minister on the Centenary of Anzac. It is interesting to note that this reference group does not include a urologist, even though that medical group is probably responsible for nearly all male-specific health issues.

**IS THERE AN ISSUE?**

Australian men do not seem to be any different from most men around the world in that they suffer poorer health outcomes than women. There is a well-known difference in illness and mortality between the sexes. Men have a higher mortality from most causes of death, a shorter life expectancy and a higher risk, over a lifetime, for many cancers and chronic health conditions. There are many proposed reasons for this apparent difference in male health status in Australia.
Before we discuss the main health issues for males in Australia, it is worth looking at their use of the health services available. Men certainly utilise health services far less frequently and judiciously than women. There could be several reasons for this – certainly there are many theories. Studies show that men seem to avoid using health services if at all possible, especially those services that are aimed at building intervention. Various reasons for this have been proposed, including:

- limited access outside of work hours
- reluctance to discuss sensitive or emotional issues with a female doctor
- unease with the ‘public’ aspects of the doctor’s appointment, such as the waiting room and stating the reason for the visit in front of others
- the Australian male macho self-image – the self-reliant stoic individual who presented with pain or difficulty.

It is interesting to note that male consultations with the family practitioner are often much shorter than those with women, and are far more likely to refer to physical problems than general and preventative health, mental or emotional issues. This raises the question as to whether men are generally less interested in health than women, and this influences their behaviour in seeking medical attention and addressing health issues in general.

**SOME BASIC FACTS**

According to the Australian Bureau of Statistics, men make up 49.8 per cent of the total population, 70 per cent of whom are under the age of 50. The male population is ageing, as are all populations around the world. In 2010, 12 per cent of Australia’s 11 million men were over the age of 65, compared to just 4 per cent in 1911. The change is reversed in those males less than 14 years of age: this group made up 31 per cent of the population in 1911, compared to just 20 per cent in 2010. Two-thirds of Australian men live in cities, a fact that reflects the steady migration from agricultural to industrial economy.

Males born in Australia now have a life expectancy of 79.5 years, with men aged 65 years having a further life expectancy of 18.9 years, while those at 85 years can expect a further six years of life.

**IMPORTANT ISSUES IN MEN’S HEALTH**

The main issues affecting men’s health in Australia are obesity, exercise, smoking, alcohol, cancer and chronic disease.

**Obesity**

Hippocrates first commented on the association between younger mortality and obesity, so the risk of increased weight is not a new observation. Obesity is associated with increased risk of type 2 diabetes, hypertension, hypercholesterolaemia and erectile dysfunction, to nominate the obvious associated diseases. It is now recognised that body mass index (BMI) is perhaps not as important as waist circumference in allocating risk of significant cardiovascular morbidity. A waist circumference of ≥94cm is associated with an increased risk of chronic disease, with a substantially increased risk at ≥102cm.

Seventy per cent of Australian men over the age of 18 years are overweight or obese, with a higher proportion (80 per cent) in those older than 65 years. Equal proportions of men and women are obese (about 25 per cent), but more men are overweight (42 per cent compared with 31 per cent of women). No comfort can be found in waist circumference either, with 25 per cent of men exhibiting a waist of ≥94cm and 31 per cent ≥102cm.

**Exercise**

The logical progression from obesity is the association of exercise and physical activity with health. It is well recognised that regular exercise is necessary to maximise an individual’s health. Exercise has always been one of the first tools utilised if a person is determined to lose weight. As a preventative measure, moderate physical activity has been shown to be of benefit, not only in battling obesity, but with better health outcomes in diabetes, lipid disorders, hypertension, cardiac disease, osteoporosis, immune function and ageing. Appropriate construction of the exercise regimen is important, as the risk of a cardiovascular incident is increased from 5- to 50-fold, depending on its intensity.

Physical activity in Australia was surveyed by the Bureau of Statistics in 2010 in its multipurpose household survey. It was reported that 65 per cent of males >15 years of age had participated in some form of physical activity during the preceding 12 months – 28 per cent in some form of organised sport and 52 per cent in other activities. Naturally there was a marked variation according to age, with 86 per cent of males in the 15- to 17-year age group participating, compared with 50 per cent in those older than 50 years.

As with the rest of the world, the overall levels of physical activity are decreasing – more men have a sedentary job, households have more motor vehicles (therefore less walking), emails and mobile telephony result in less walking and effort for communication, stairs are often not available for general use in public buildings (for safety reasons) – the list goes on.
There has been a push to increase the levels of physical activity in males of all ages by health and government bodies, but the success of such programmes has not been well established to date.

**Smoking**

There is no need to outline the health risks associated with tobacco use. The risk of cardiovascular disease, lung cancer and respiratory diseases, to mention a few, is increased in those who smoke. It is probably the most preventable cause of poor health and death throughout the world — certainly Australia is no different.

Australian men are smoking less than previously. The percentage of men older than 50 years who have never smoked is 40 per cent, compared to 90 per cent in those aged 14–19 years. The highest rate for smoking among men is in those aged 20–29 years; males smoke more than females in all age groups except those aged 14–19 years. Daily smokers decreased from 27 per cent of males >14 years in 1991 to 18 per cent in 2007; ex-smokers also increased from 25 per cent to 28 per cent.2

There has been a concerted effort at advertising the risks of smoking across all media, as well as banning tobacco advertising on television and during sporting events, which seems to be paying dividends on the basis of these figures.

**Alcohol**

It has been stated that alcohol is the second biggest drug problem, in that there are a number of well-recognised health issues that have alcohol as the root cause. Of course, there is also the direct effect of acute alcohol intoxication — accidents, trauma, violence and inappropriate behaviour, with sequelae that have a significant impact on an individual’s health, the health of others and on community resources that must deal with the consequences.

Australian men are renowned worldwide as ‘great beer drinkers’. More than half of all males (58 per cent) older than 14 years consume alcohol on a daily or weekly basis — those >60 years are more likely to be daily drinkers. Six per cent of men drink at levels that put them at risk of long-term consequences.2 There has been a steady increase in the consumption of wine over the past ten years or so, mainly as a result of the relative glut of good-quality wine in Australia, its relatively lower price and social acceptance of wine and its appreciation as a part of the local culture.

Cancer Cancer remains one of the most common causes of death around the world. It seems that in the ten most common cancers that affect both men and women, mortality rates are higher in men. The reasons for this are unclear, and do not necessarily relate to higher rates of risk behaviour with regards to health (eg smoking, alcohol consumption). Having said this, there is a tendency for the overall cancer mortality to be slightly higher in younger females (mainly because of breast and genital cancers), which is overwhelmingly reversed after the age of 50 in men.2

A study in the Lancet in 20066 stated that 37 per cent of risk factors associated with cancer deaths came from: smoking, alcohol use, diet, obesity, physical inactivity, urban pollution, indoor smoke. The association with male-related behaviour is obvious.

Prostate cancer remains the most common cancer in men, a fact further exacerbated by the ageing population and the increase in diagnosis that followed the advent of prostate-specific antigen measurement and transrectal ultrasound-guided biopsy. In 1998 there were 128.3 new cases of prostate cancer diagnosed per 100 000 males; in 2007 this had risen to 182.9 per 100 000. It is interesting to compare these figures with the other important male cancers (Table 1). Mortality rates do not follow the same pattern. Survival would appear to be improving (Table 2). Apart from testicular cancer, the death rates were highest in those older than 80 years.2

**Chronic disease**

In 2007–08, 31.4 per cent of men reported that they had a chronic condition.7 The most common conditions were long-and short-sightedness, followed by back problems and allergic conditions; these conditions mostly have a relatively low impact on male quality of life. However, figures concerning the higher impact conditions give some indication of where initiatives into improving the health of Australian males might be directed (Table 3).2

**WHAT IS BEING DONE FOR MEN’S HEALTH IN AUSTRALIA?**

The health of Australian males has recently been a matter of interest to governments and health authorities. With the imperative that the ageing populations around the
world are ever imposing on our governing bodies, it is only prudent that every effort should be made to improve health or prevent diseases that can impact on the quality of life and the ability to live independently. The cost saving to government alone would be worth the effort.

Australia now has a national male health policy, with its declared priorities and associated Minister’s Male Health Reference Group. It is hoped that this will be a continuing stimulus to pursue measures across all aspects of male health. Some significant programmes have already been initiated.

**Men’s sheds**
These are community-based initiatives where men can talk to each other about issues of concern, while working together on traditional ‘shed’ projects such as restoring furniture, small community construction, etc. The informal environment plus the associated ‘camaraderie’ will hopefully encourage and allow subjects to be addressed that men might otherwise avoid.

<table>
<thead>
<tr>
<th>Chronic condition</th>
<th>No. (000)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart and circulatory</td>
<td>1557</td>
<td>15.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1321</td>
<td>12.9</td>
</tr>
<tr>
<td>– osteoarthritis</td>
<td>604</td>
<td>5.9</td>
</tr>
<tr>
<td>– rheumatoid arthritis</td>
<td>159</td>
<td>1.6</td>
</tr>
<tr>
<td>Asthma</td>
<td>910</td>
<td>8.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>464</td>
<td>4.5</td>
</tr>
<tr>
<td>– type 2 diabetes</td>
<td>416</td>
<td>4.1</td>
</tr>
<tr>
<td>Cancer</td>
<td>190</td>
<td>1.9</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>125</td>
<td>1.2</td>
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<tr>
<td>Any chronic condition</td>
<td>3227</td>
<td>31.4</td>
</tr>
<tr>
<td>Total males</td>
<td>10,261</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Table 3. Prevalence of selected chronic conditions among Australian males, 2007–08*  

**Pit stop**
This is a men’s health screening tool delivered in non-medical settings throughout rural areas. It uses a mechanical theme and a series of stations to deliver non-invasive medical tests. The ‘health mechanics’ discuss the participants’ chassis (hip to waist ratio), oil pressure (blood pressure), fuel additives (alcohol consumption), exhaust (smoking), spark plugs (testicles) and shock absorbers (coping skills). Evaluations in Western Australia suggest that it is having a positive effect on male health.

**Movember**
This programme started as a fundraising exercise to raise awareness about prostate cancer. It has blossomed into an international initiative raising awareness of men’s health issues. In Australia it supports charities such as the Prostate Cancer Foundation of Australia and Beyondblue (a programme to help raise awareness of issues surrounding depression).

Other more formal government initiatives have also been established, such as Andrology Australia – Centre of Excellence in Male Reproductive Health, which leads the way in increasing men’s awareness of issues that affect their health and what they can do about them.

**FINALLY**
Now that the importance of the separate and specific issues that affect male health has been recognised, it is our responsibility to take matters forward. Hopefully family practitioners, cardiologists, endocrinologists, urologists and sexual health physicians can form a co-operative network to create an environment that encourages men to take an active role in their own health. Such co-operatives could provide a ‘cross-referral’ of measures that work in a wider health frame – for example, ‘heart health = prostate health’. Australia has been slow with men’s health but it can go forward and perhaps lead the way in the future.

**Declaration of interests:** none declared.

**REFERENCES**