



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

## SENATE

SELECT COMMITTEE ON MENS HEALTH

**Reference: Availability and effectiveness of education, supports and services for men's health**

WEDNESDAY, 8 APRIL 2009

MELBOURNE

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**SENATE SELECT COMMITTEE ON  
MEN'S HEALTH**

**Wednesday, 8 April 2009**

**Members:** Senator Bernardi (*Chair*), Senators Cash, Lundy, Sterle, Troeth and Williams

**Senators in attendance:** Senators Bernardi, Cash and Lundy

**Terms of reference for the inquiry:**

To inquire into and report on:

General issues related to the availability and effectiveness of education, supports and services for men's health, including but not limited to:

- (i) level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer, and depression,
- (ii) adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community,
- (iii) prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men's health in general, and
- (iv) the extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas.

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**Committee met at 9.01 am****GRUEN, Professor Russell, Fellow, Royal Australasian College of Surgeons****McLORINAN, Mr Andrew George, Manager, Fellowship Services, Royal Australasian College of Surgeons**

**CHAIR (Senator Bernardi)**—I declare open this public hearing of the Senate select committee in relation to its inquiry into men's health. The committee's proceedings today will follow the program as circulated. These are public proceedings. The committee may also agree to a request to have evidence heard in camera or may determine that certain evidence should be heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee.

If a witness objects to answering a question, the witness should state the grounds upon which the objection is to be taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time. A witness called to answer a question for the first time should state their full name and the capacity in which they appear, and witnesses should speak clearly and into the microphones to assist Hansard to record proceedings. Mobile phones should be switched off. With formalities over, I welcome everyone here today, and in particular I welcome representatives from the Royal Australian College of Surgeons. Thank you very much for coming along today. We have received your submission as submission number 13. Do you wish to make any amendments or alterations to the submission as received?

**Mr McLorinan**—No.

**CHAIR**—I invite you to make a brief opening statement.

**Mr McLorinan**—Thank you for hearing our submission. The college represents 6,000 surgeons. We work, as a lot of colleges do, on training and equipping those surgeons. We maintain three committees of particular interest to this discussion. They are the trauma, rural and Indigenous health committees. Our submission is focused on two principal male health challenges: they are land transport accidents or car accidents typically, and also trauma amongst the male Indigenous population. We want to stress quite strongly today that land transport injuries are highly preventable and are the main cause of loss of potential years of life in men. Although trauma is not traditionally seen as a disease, it is certainly a disease that is preventable and it deserves a lot more attention.

The cost of the disease is enormous. Estimates by Access Economics put the cost at about \$19.4 billion across men and women, but men are the biggest contributors to that cost. When you look at the cost of a 20-year-old having some sort of disabling injury, the costs to sustain that 20-year-old for the rest of their life accumulate and are enormous. Remember that for every one death from a car accident, there are hundreds of injuries. All of those injuries have accumulative impact for the community.

What can be done? A lot is being done, but certainly the creation of what are called safer land transport systems, so a safe systems approach, which is behaviour, road design, car design, enforcement—all of those things. In particular, the Commonwealth has a role on car standards, so continuing to raise the bar in terms of the standards of cars. In rural areas, we have a growing problem with all-terrain vehicles, and men are over-represented in the trauma statistics associated with farm accidents, so that is something on which we can do more.

We also draw your attention to the fact that there is no national trauma database. There are individual state trauma databases. Databases provide us with a wealth of information for research and prevention. There is an informal trauma database operated in Queensland. However, we see a Commonwealth role for the creation of a national trauma database.

We also think the Commonwealth has a role in terms of setting standards for outcomes in trauma departments. Hospitals are the biggest growth area in the health budget. I think they take 40 per cent of the Commonwealth budget, and trauma, which is the surgical part of an emergency department, is a huge cost. So we should be driving continuous improvement in those areas, and the Commonwealth has an emerging role in setting standards through Commonwealth-state health agreements.

Turning to the Indigenous male population, our report highlights that it is a combination of alcohol, incompetent driving, overloaded cars, and bad roads—all of this is a disaster for men's health, particularly in rural and remote areas of Australia. It is also a problem for the wider male community in regional and rural Australia. A problem which is not just a male problem, interpersonal violence, also is a significant impact in Indigenous communities. One of our fellows notes that Alice Springs Hospital, which serves a population of about 50,000 people, has 2.6 times the number of stab injuries per annum as the Royal Prince Alfred Hospital in Sydney. That is a shocking statistic. Our discussion to you is that the closing-the-gap agenda is within a generation. That is 25 years of terrible loss of life, and surgeons say, 'Can we have that and also save lives in the next 25 years?'

With regard to solutions, we think the Commonwealth needs to work out where it is going on workforce solutions. The combination of these challenges in regional Australia plus the loss of surgical and other medical talent in rural Australia is a terrible combination of events. We also propose perhaps a remote area trauma system. So, if you are in the east of Western Australia, your closest trauma department may not be Royal Perth Hospital. Something that would be multijurisdictional would deal with trauma patients from pavement to rehab, which is what we define as a trauma system, might be something that the Commonwealth wants to look at, particularly for Central Australia.

We need more data availability and quality which underpins improvement of Indigenous health in particular, and that is something on which Professor Gruen may wish to expand. That is all I wanted to say today. Thank you for your time. We just want to conclude by saying that injury is a very preventable particularly male disease, and it needs more attention. In particular, better quality trauma systems which deal with the results of a car accident and in particular save lives and ultimately restore lives, so that is a benefit for the individual as well as the Commonwealth. If we can be of any assistance, we would love to engage with the Commonwealth on those subjects. Thank you for your time today.

**CHAIR**—Thank you.

**Senator CASH**—Thank you for your submission. I am from Western Australia, so in relation to the rural and Indigenous issues I am absolutely on board with what you are saying. Could I take you back to basics, to the very, very beginning? One of the issues that have been raised with us by a number of witnesses is what we mean when we say men's health. What would you like to see, or what would you recommend, a definition of men's health actually encompass as a starting point?

**Mr McLorinan**—I will defer to the professor. With respect to my observations, I am from a management and public policy background. Men have a shorter life expectancy than women for all sorts of reasons. We have drawn attention to some of them. I think perhaps it is that we see more comparability in that—that there is a closing of the gap, as it were, on life expectancy so that men's life expectancy is as long as that of women in Australia.

**Prof. Gruen**—I think you are getting to the crux of it being the things that are distinctly male, whether identified by others as being male or perhaps more importantly identified by men as being issues that are peculiar to maleness in improving a very holistic view of health. So, prevention of ill health, mental wellbeing; social, job and financial security might even impact what is otherwise a narrower, clinical focus on male health.

**Senator CASH**—That is one of the issues that has been raised, that men's health is not just the absence of disease; it is that holistic view, the overarching statement encompassing social, economic, et cetera, and then from there looking at what issues actually do arise. Would you agree that it actually needs to be a much broader statement than just the absence of disease?

**Prof. Gruen**—I think the focus on Indigenous men's health in our submission actually targets that very clearly, where if there is a group in Australia that has a much broader understanding of health, it would be the Indigenous people, because it permeates every aspect of their lives and what they do, and they do not separate the concept of clinical illness from the other aspects of their life. Do you mind if I give a little bit of my background here?

**Senator CASH**—Absolutely; please do.

**Prof. Gruen**—I am now Professor of Surgery in Public Health at Monash University and Director of the National Trauma Research Institute and a trauma surgeon at the Alfred Hospital. I spent five years living in the Northern Territory and doing a PhD on the delivery of surgical services to remote Aboriginal communities, in which time my wife, who is a GP, and I spent three years living in western Arnhem Land in a community called Oenpelli which has 1,500 Indigenous people and a small handful of non-Indigenous people and is very typical of many remote Indigenous communities throughout the country. It experiences a high degree of injury, related both to transport accidents and interpersonal violence where substance abuse was a major problem, where gainful employment was scarce, where a number of community initiatives have been tried and failed and, above all, not sustained.

Even in the three years that we were there, we saw programs start, falter and disappear. I think that is enormously depressing for Indigenous communities to see and get their hopes up about something happening, and then to have it falter. There access to the sorts of services that we all

take for granted is far from the reality. The Royal Darwin Hospital, which is 350 kilometres away, is the nearest tertiary hospital where there were specialist surgeons apart from me, which was an aberration obviously for them. For four months of the year the roads are impassable because of flooding, and the only way in and out is by a small light aircraft which may or may not be able to land. So you are really dealing with a very, very different health system to deal with a major problem.

As I am sure you know, Indigenous males have a median life expectancy in Australia of 57, and it is a bit more for females, but in the community where we were, it would have been much closer to 50, and that means half of all men in that community died before the age of 50. The predominant cause was not chronic disease in that community; it was injury and injury-related harm. For me, when I think of Indigenous injury, it is a male problem. It is both affecting males and perpetrated by males, so women who suffer injuries usually have it inflicted by male partners, and it is usually related to the complex social issues of unemployment and substance abuse, so it is a very holistic thing, as you were talking about, and I am sure you are aware of in your jurisdiction.

**Senator CASH**—Absolutely. I will actually follow on from a point you made that is also set out at page 8 of your submission. You say:

For example patients in the east of Western Australia may be better served by either Royal Darwin or Alice Springs Hospitals than Royal Perth.

From a federal government perspective, what can we do to facilitate that and why should we do it?

**Mr McLorinan**—This idea was put forward by two of our fellows who are based at Royal Darwin Hospital. The idea of a trauma system probably needs a little bit of explanation. In a number of jurisdictions, particularly Victoria and now Queensland, but also in the midlands of New Zealand and most of Europe, a trauma system is the integration of the ambulance service, the coordination of their activity with the receiving surgical team, basically the whole patient journey from pavement to rehab, rather than treating them as a sequence in a pass the parcel; here, you take the patient now, we have dealt with them, and treating them as a team.

There is a history there, but in some jurisdictions, for example in New South Wales, there is not what we would call a trauma system, so that is being contemplated under the Garling inquiry. Recommendations were made that they concentrate their trauma activities in certain hospitals. The advantage of that is that the more you do trauma surgery, the better you get at it, and the expensive equipment infrastructure gets used more appropriately. In some places like Perth there may only be one what we would call a level 1 hospital, or I think in Adelaide there is development on a hospital now.

So a trauma system combines ambulance, triage—all the way through to rehab. How would that work in Central Australia? A decision would be made not on the jurisdiction of the patient. So, you are in eastern Western Australia, we are going to take you to Perth because you are in the state of Western Australia; we will take you to the nearest suitable appropriate hospital. I forget the terminology, but it is something like the right patient goes to the right hospital at the right time. It might be more appropriate that a patient goes to a base hospital in Northern Territory. I

do not know my geography too well there, but it could be somewhere in South Australia, so it would be that sort of decision.

How that would work together with perhaps Aboriginal controlled community health organisations and other elements of the health system would need to be worked through. That was the thinking. Then you have Medivac issues as well, so it is quite a complex system that you are managing. The relationship between the pick-up of the patient and the receiving hospital is also something that is very important in a trauma system.

**Senator CASH**—Has this been looked at previously? Is there anything that you can refer us to in terms of a report that has already been done, or will this literally be the first time that what you are putting forward has actually been looked into? I do not mean it is the first time it has actually been discussed?

**Mr McLorinan**—There is an article in this magazine which we may have forwarded with our submission. It is of an injury symposium that was convened by Professor Gruen, and in it is a proposal for a Commonwealth trauma system across jurisdictions. The Commonwealth is already involved, for example, with the Royal Flying Doctor Service in that sort of multijurisdictional service delivery, so it would at least have a logical role as coordinator of those different jurisdictions.

**CHAIR**—Would you table a copy of that magazine which we have, subject to our acceptance of that?

**Mr McLorinan**—Yes.

**Senator CASH**—Thank you very much.

**Prof. Gruen**—There are a couple of other documents that I have been involved in developing. One is the proposal for a Northern Territory trauma system; the other is the development of the National Trauma and Critical Care Response Centre, which I largely wrote, and which was funded by the federal government in 2004 in the wake of the Bali bombings and Darwin's involvement in responding to those bombings. There is a document that I could easily get to you which was a stakeholder analysis of how a national trauma and critical care response centre might look.

**Senator LUNDY**—Yes, please.

**Senator CASH**—Absolutely. Definitely, thank you.

**Prof. Gruen**—It has been implemented variably from the original proposal, but the results are of a lot of discussion in that.

**Senator CASH**—That would be greatly appreciated.

**Prof. Gruen**—I will come back to your question of why this is a Commonwealth issue? I come to that from a couple of directions. The first is, if we think of it as a remote health issue, the remoteness, the bush, is something distinctly Australian. So just from a sort of fearing point

of view, it is a national issue; it is not a state-owned thing about getting services to the bush. As Mr McLorinan said, the Royal Flying Doctor Service is something that the Commonwealth has had involvement in maintaining. It is a very Australian organisation.

The second thing is from an Indigenous perspective; Indigenous health is a national image problem. It is a national disgrace, if you want to go so far as to say that. The Commonwealth has proven that it does Indigenous issues, including health, best, and the states I think have pretty much proven that they do it badly when it comes to health matters. The recording of Indigenous status, the ability or perhaps even the willingness of states to invest in remote area services and so on has often fallen short of what I think has been necessary. The Commonwealth has frequently come to the fore and delivered where states have been unwilling to.

I will give a specific example of that. I refer to the program that formed the basis of my PhD, which was the specialist outreach service in the top end of the Northern Territory and which has subsequently been embodied in the medical specialist outreach assistance program more nationally, and not Indigenous focused, whereas the former was Indigenous focused. There were initiatives to get specialist medical practitioners, not just surgeons, out to remote areas to provide consultations and minor procedures and so on on site, where the states had failed to provide adequate access to specialist level care for people in rural and remote areas. So they were Commonwealth funded schemes, Commonwealth maintained schemes, and very effective schemes.

My PhD was an evaluation of those services in the Northern Territory, and we proved benefits in terms of access, in terms of health status, in terms of efficiency of service provision and so on. I think the problem of Indigenous men's health needs a whole-of-country solution for all of those reasons. That is why I think the Commonwealth is both the appropriate and the most capable body to steer and deliver that process.

**Senator CASH**—If we had a wish list and we could make three recommendations that would actually make a difference in combating the issues in relation to Indigenous health, what would those three recommendations be?

**Mr McLorinan**—We can only speak from a surgical perspective, and this is essentially our brief. We would recommend that you look at workforce issues because, as I say, in the generation before we close the gap, there will be horrendous loss of life, and that in a way may not be preventable, but it calls on surgeons' skills to cure. I would say dealing with workforce issues is number one. The whole array of surgical workforce proposals are with the Office of Rural Health at the moment while they review what happens with rural workforce. We will not know until May whether many worthy projects in rural workforce are acted on.

The second initiative I would say is once again on the cure side, because the prevention side is a medium-term achievement to do with housing, employment, et cetera. I believe that trauma systems then have to deal with the results of our failure of the past to prevent Indigenous trauma. Better trauma systems would be appropriate, and we are starting to see a focus on continuous improvement from the National Health and Hospitals Reform Commission, which is well regarded. They note that we do not have a systemic approach to improvement in hospitals. It seems implausible, but that is what they say, and I agree: so having better trauma systems, with respect to both the system and the continuous improvement of a trauma department's

performance, so that the Commonwealth can have a role there in terms of setting objectives and being an aggregator of the information.

That brings me to my third point: I think we do not have all of the information that we need or the quality of the information that we need about Indigenous trauma, and that would lead me to recommend a national trauma database. This would be the aggregation of all the state trauma bases and then that information informs decisions about policy and funding for national Indigenous trauma.

**Prof. Gruen**—I think my three points were the same. I wrote them down completely separately. If I think of Indigenous men's health and rural men's health from a surgical point of view, injury features number one as the key issue. In terms of preventable morbidity and mortality for Indigenous people, injury is the top one. It is the primary cause of 20 per cent of the burden of disease and injury. It is the main waster of young productive years of life lost. To minimise injury occurring, to understand where it does occur and to allow a targeted improvement of both injury prevention programs and trauma services and care delivery, we need data collection. We absolutely and completely need good data collection. What we have in Victoria is an outstanding model of a trauma registry that is probably the best in the world. The Victorian State Trauma Registry is very good at rural areas, but we do not have the major challenges that are faced by the rest of the country. There is a real hotchpotch of data collection around the rest of the country. Some states have a reasonable system; other states have virtually nothing in terms of knowing where injury occurs and being able to follow it through from when the patient gets injured to the outcomes of the treatment. Without that, we do not know anything about what to do, about what the magnitude of the problem is, about where to invest, about what the maximum bang for buck is going to be.

**Mr McLorinan**—Would it be true that most of the trauma registries do not record ethnicity?

**Prof. Gruen**—And Indigenous identification is a major problem.

**Mr McLorinan**—We do not know the ethnicity in the trauma registries.

**Senator CASH**—Which is quite basic.

**Mr McLorinan**—It is a basic piece of information. It is very present in the American national trauma database.

**Prof. Gruen**—Investing in something that seems relatively small and would be a very modest investment, but getting a national standard of data collection and investing in the ability to collect that data is the first key part of this process. I think everything else is built from that. The development of a trauma system that serves first and foremost rural people and remote areas is a great proposition, and I think we have done a lot of the work within the college and with the Commonwealth previously in getting those ideas together. We are part of the way there, but we need to do something more, and we need to support the people like the guys in Alice Springs who provide a fantastic service.

The third thing I have down is to be able to bring together the sorts of people like the college has, like government has and like other interested men's groups that relate either to farming and

rural or to Indigenous people, to have a coalition of people that will make addressing men's health in rural and remote areas a priority who are well connected and able to be advocacy bodies using good information, good data, and being able to create targeted solutions. I do not think we have that yet in Australia, and I think there is a lot of ground that can be made by bringing together well intentioned, well informed people who have the levers that can act to make a difference.

**Senator CASH**—Thank you, gentlemen.

**Senator LUNDY**—Those questions ended up going in the direction that I wanted to pursue, which was about the national database. What are the management and organisational requirements that you think would make that work best?

**Mr McLorinan**—The matter of a national trauma database has been discussed, and it has basically been cobbled together with the support of, I think, the Motor Accident Insurance Commission of Queensland through a body called CONROD. Professor Gruen is the new chairman of the Systems Improvement and Performance Committee, and the national trauma database is part of the domain. It has basically been cobbled together from different jurisdictions. I think ultimately you would want to arrive at what is called a national trauma dictionary, so that we are all using the same terms and that, when we send our data, it all works together.

**Senator LUNDY**—Is there a standard that you are aware of?

**Mr McLorinan**—There is a trauma dictionary that is fairly mature.

**Prof. Gruen**—There are a couple of groups internationally working on this. The Americans have a national trauma data bank which is a voluntary system that does not address remote issues well because of the voluntary nature of it, and it is coordinated by the American College of Surgeons. The Canadians have a national trauma registry funded by the Canadian Institute of Health Research, a national body, maintained on a province basis and overseen by a national board that includes surgeons, public health practitioners, government, et cetera. I can certainly get more information about that for you. I know personally the chair of that committee, so I am happy to do that.

**Senator LUNDY**—I encourage you to do that, but can you say what you think would be the best model for the operation of such a database in this country? What would you like to see based on all the observations you have made of the international models about what does and does not work? What would you like to see?

**Prof. Gruen**—In Victoria we have the expertise to be able to manage that. There needs to be a central body with a hub and spoke oriented local coordination of data collection, and I anticipate that Queensland and New South Wales would be involved in the dedicated collection oversight of rural and remote areas in particular, because that is where it is hardest to get. We are not just getting the data out of urban centres; we are getting it out of rural centres.

**Mr McLorinan**—One of the challenges, as I understand it—and this is from discussions with experts in the field—is the definition of the quality of data at the state level. Different states have different sources for their trauma data. Some of it will be the actual clinicians who are dealing

with the trauma patient in the trauma ward, and some of it will be entrance data, or as the patient is received by the hospital. Some of that data is not as strong as the data that is related to the clinician's handling of the patient through the patient journey. Some of the jurisdictions will be loath to move to that more demanding source of data because they have something already and it is roughly good enough. It is the rubbish in, rubbish out line of thought, that the better the quality of data going into the system, the better the results at the end.

There is a whole other piece to do with continuous improvement, comparability between jurisdictions and research, so if you do not have that base you cannot measure it or manage it, to use the cliché. This is where we start with trauma systems, to really understand what is working, who is doing really well on their morbidity and mortality and the time it takes to get from A to B in a patient's journey. If you can get a really solid strong base of information, you can do amazing things.

**Senator LUNDY**—Is the NHMRC a potential candidate to perhaps support such a national initiative to try to align the data collection and the creation of a trauma database, regardless of who ends up managing it and driving it forward?

**Prof. Gruen**—What I anticipate would happen is that there would be a body of professionals from different avenues—the College of Surgeons is a key player but not the only player here—who would manage it—

**Senator LUNDY**—I am thinking of the NHMRC as perhaps the funding source.

**Prof. Gruen**—The vehicle for funding could well be NHMRC, and that could be through a competitive grants scheme or through a targeted initiative of other sorts. One of the problems has been that this has not been coordinated together at a national level and put to a national funding body, like NHMRC, previously, or the department for that matter. There is no reason why this could not be funded by the Department of Health and Ageing.

**Mr McLorinan**—I think the National Health and Hospital Reform Commission interim report really highlights quality assurance, practices and data collection as critical to improvement of the system. There is an impermanent body—I think it is called the national quality something, but I forget the acronym—that is flagged as a future leader in this area. We are not qualified to judge which body would be best, but somebody needs to take a multijurisdictional view of quality and process improvement. The college is involved in that area. We do what is called trauma verification, so it is like quality assurance for a trauma system.

**Senator LUNDY**—The quality assurance system could be the accurate recording of trauma incidents.

**Mr McLorinan**—It is. It is in our verification process. We look at the collection mechanisms for data and their own continuous improvement mechanisms.

**Prof. Gruen**—The college has a long history of development of these methods, but the funding could go through NHMRC primarily as a competitive grants process. It could go through the department or the Australian Commission on Safety and Quality in Health Care as a targeted funding initiative. Why are resources required? Clearly the resources that are needed

are, first, to facilitate data collection; secondly, to get the right data agreed upon to start with, so there is some development work that would need to go up front; and thirdly, to maintain the national registry and make it available so it can be useful for people, to make sure that that data is then used for developing the right services—

**Senator LUNDY**—To de-identify data for statistical analysis?

**Prof. Gruen**—Absolutely.

**Mr McLorinan**—That is right. Some of the jurisdictions have thrown up privacy and confidentiality issues as reasons not to proceed, but when you scratch underneath those—

**Senator LUNDY**—Sophisticated software can deal with those things.

**Mr McLorinan**—That is correct.

**Prof. Gruen**—They are able to be overcome everywhere, and Victoria has led the way in showing how to do that.

**Mr McLorinan**—As you say, you can de-identify. It is really for the benefit of the jurisdictions that they know where they stand in terms of best practice.

**Prof. Gruen**—There is good evidence internationally of the effectiveness of both trauma registries and trauma systems based on those registries that use that data to change practice in improving injury mortality, quite dramatically.

**Senator LUNDY**—All of which are critical objectives to make our health system more efficient and be able to plan well for the future.

**Prof. Gruen**—Right.

**Mr McLorinan**—Absolutely. I could not have said it better.

**Prof. Gruen**—At an excitement level, this is something Australia has the potential to do the best in the world. With a small investment in doing this, we would have the best trauma registry data system that addresses rural issues, of which men's health issues are major, better than anywhere. Personally, at an academic and a clinical level, and as a representative of the College of Surgeons, I find that very exciting.

**Senator LUNDY**—Thank you very much.

**CHAIR**—In your earlier remarks, you mentioned your experience in the Indigenous community where you said injury was a far greater cause of death than chronic disease for men under 50. Could you hazard an estimate of the proportion of deaths were caused by injury?

**Prof. Gruen**—I can go back to national figures or territory-wide figures which put the burden of disease and injury, which is a measure based on productive years of life lost and mortality, at 20 per cent of all of those related to injury. I can reflect on the relative rates of injury, Indigenous

versus non-Indigenous people, so motor vehicle crash related deaths are three times higher for Indigenous people. Interpersonal violence related deaths are 4½ times higher for Indigenous people. Hospitalisations for injury related issues are 12 times higher for Indigenous people. The acute and chronic effects of injury compound the disadvantage that Indigenous people face in all aspects of their lives. As to saying what proportion of the community that I lived in suffered injury as a cause, I cannot give you a figure, but it was a daily event that people would come to the clinic, after closing time at the club, with lacerations, broken bones or a head injury. It was a several times a week event that people would be evacuated by aeroplane to Royal Darwin Hospital as an emergency following an injury. It was probably a monthly, maybe two or three-monthly, event that someone would die from an injury related issue, and that is in the community of 1,500 people in a small country town.

**CHAIR**—We heard lots of evidence yesterday about the societal pressures that contribute to men's health issues. It would appear that you are reinforcing that in some ways—that substance abuse impairs judgement and unlicensed motor vehicle driving and things of that nature all impact on it. Yet we heard yesterday that, if we had a perfect world where there were no societal contributors such that diet was fine and substance abuse was removed, that would only account for about 30 per cent of men's health deaths. I think it was—and we will have to check the *Hansard* record—that 70 per cent were actually revolving around illness and disease development through ageing or something like that. Your experience in Indigenous communities is obviously very, very different.

**Prof. Gruen**—Yes. I can only speak from that personal experience. Again it comes back to this whole of life course, whole of health view, that clearly some of their upstream factors, the socioeconomic determinants of health, are really important and they are accentuated in Indigenous people. You can lose sight of providing good clinical care and dealing with the pointy end of a problem in violence, road safety and so on by focusing too much on the things that are much more removed from the actual illness, such as education, diet, et cetera. The whole spectrum needs to be addressed and, as to where the balance lies, you have probably heard of somebody doing some modelling of where investments should be made. I am not qualified to say where that balance lies necessarily.

**CHAIR**—In your submission you note that Australia's first Indigenous surgeon was welcomed into the college in 2006. Are there any implications for Indigenous people in that? What are they? Is he or she practising in a remote community? Is there some opportunity there? Do you have an opinion on whether Indigenous people actually respond to Indigenous physicians or medical practitioners better than they do to white practitioners?

**Prof. Gruen**—Kelvin Kong is an ENT surgeon who works in Sydney. He grew up in Sydney. He has never lived in remote areas, but he is a very Indigenous man and he is identified as being such by the whole Indigenous community. He has been a very effective leader of the college's Indigenous health subcommittee. Like all Indigenous medical professionals, he becomes pretty quickly overburdened with responsibilities and tasks of everything that people want of him. I guess he does have very much a national stage on Indigenous health issues.

My own experience of working with Indigenous people is that, while they do like to identify and celebrate Indigenous health professionals, they want kind, caring, competent doctors, nurses and health workers. It does not really matter if their doctor is a balanda, a white doctor, as long

as they have a good manner and are able to deal effectively with Indigenous people respectfully and capably. Rather than aiming to be like New Zealand and having 20 per cent of our workforce being Indigenous, I think that is a really unrealistic goal at this point in time in Australia. Maybe one day in the future it will not be, and I would love it not to be, but Aboriginal people are only 2 per cent of the population, and their educational attainment levels, particularly in rural areas, are low.

At the moment we will not see too many Indigenous doctors. While we should foster the ones that we have, perhaps more pressingly we need to make sure that people who are working with Indigenous people are appropriately trained and skilled. To that end, a couple of years ago within the college and again funded by the Commonwealth, we ran the Australian Indigenous Health program to train particularly overseas trained doctors who were being sent to remote parts of Australia as areas of need in Indigenous health, cultural, behavioural, communication issues and particular aspects of Indigenous health care which were especially challenging, of which injury and violence was one, some women's health aspects were others, consent issues were major, and so on.

**CHAIR**—Do Indigenous men respond better, or is there a difference in how they respond, to male medical advice versus female medical advice—because a concern has been raised not in relation to Indigenous men but that men generally respond better to male doctors?

**Prof. Gruen**—I would say it is very much more the case with Indigenous men. My wife was the only GP in Oenpelli, but men would often try to talk to me.

**CHAIR**—Thank you very much. Unfortunately we are out of time. On behalf of the committee I do appreciate not only your submission but also your appearing today.

**Prof. Gruen**—Thanks very much.

**Mr McLorinan**—Thank you.

[9.47 am]

**HOLDEN, Dr Carol, Chief Executive Officer, Andrology Australia**

**McLACHLAN, Professor Robert, Director, Andrology Australia**

**CHAIR**—Welcome, and thank you for coming along and talking with us today. I thank you for your submission, which we received as submission number 18 early in the piece. Do you have any amendments or alterations to your submission before we go to questions?

**Prof. McLachlan**—No, we do not. We have some additional information by way of some of our publications and educational material.

**CHAIR**—Are you seeking to table that information for us?

**Prof. McLachlan**—We would like to table that for you.

**CHAIR**—Thank you; I am sure that will be received. I invite you to make a brief opening statement.

**Prof. McLachlan**—Thank you very much. I would like to make a few introductory comments. Just for the background, Andrology Australia was supported in the year 2000 with funding by the Department of Health and Ageing. It is administered through Monash University. We bring together health and educational experts across Australia to develop collaborative strategies to improve community and professional education and research in disorders of the male reproductive system and associated conditions. We have an annual budget of about \$1 million a year, which is about 90 per cent of our funding. By any measure, we have achieved great success with this limited funding, but that success is largely due to the generous in-kind support, commitment and motivation by experts in the biological, medical, public health and social science sectors who volunteer their services. We coordinate and disseminate programs across the nation in a cost-effective fashion.

Over the past 10 years I think we have become fairly recognised as the peak national authority covering a range of specific men's health issues and their associated conditions. Many governmental and community organisations now refer to and utilise our materials, including the one that is currently being promoted by the department in relation to the men's health policy resource kit, which I will also table for your pleasure. Our education programs of course are at no cost.

I will present now some facts and figures. At the moment our website receives 1.2 million hits a month, 50,000 visitors a month, and 30,000 pdf downloads of information facts a month. Clearly we are seen to be the major unbiased quality and evidence based source of information. We have distributed about 160,000 specifically related booklets, which again you also have before you, and we obviously work with many organisations as a lead information partner; for example, in Men's Health Week in June, 700 organisations used our materials and support. We have some key special interest groups that we relate to heavily, like the cancer councils, PCFA

and, as we will get to later, certainly ethnic and Indigenous groups are some where we are also very active.

In providing our input today, we acknowledge the fact that there are many other groups and organisations in this field, and that is certainly very different from 10 years ago when this landscape really developed from our point of view. We are involved with many of them in some way or another, and we acknowledge their efforts. We hope to demonstrate pivotally today that male reproductive health is a very important part of the men's health sector. To begin with, diseases of the prostate, erections, fertility and so on are important in their own right. Some 80 per cent of men are worried about their reproductive health, and almost all men will undergo a problem in one of these areas. Critically, men's reproductive health is a window of opportunity into a broad range of men's health issues and allows a really holistic view of men's health generally, accessing through the reproductive aspect. We always avoid any temptation of a siloed approach or a one-dimensional view of a problem.

The simple fact that is that does not fit the disease model and the biological and social determinants. Take, for example, erectile dysfunction, a very much talked about activity. This is a leading health concern which is influenced by medical factors such as heart disease, diabetes or smoking; by social factors such as health seeking behaviour; access to care, cultural and social norms; and, of course, by psychological relationship and mental health issues as well. All of these come together and can present with erectile problems. It is certainly an indicator of impending vascular ill health, and this is something that demands review from medical practice always, and that is a key feature of our educational process.

Because these issues are important to men, it actually provides a mechanism by which to engage them in broader discussions and, put simply, a diabetic man is likely to pay increased attention to his glucose control in the knowledge that, as part of that, he will get benefit or protection of his erectile function, so the two synergise very well. Thus it provides a marvellous opportunity for public health innovations and in engaging men in the health system for chronic disease, quality of life and relationship matters.

The next point is research and policy. Men's health policy must be informed by both biomedical and social aspects. Existing data is very limited, and this obviously limits the government's ability in a policy framework to implement effective strategies and to improve health. So large and significant is this knowledge gap that we believe that men's health research should become a national research priority. Andrology Australia has a strong academic base that effectively translates evidence into community and professional programs. Issues such as the recent PSA screening debate is an example where you need to have someone with the clarity to understand the whole area.

In terms of research programs in a more basic aspect, we also foster where needed such research, and I think you will hear about the prostate bio-bank today from Gail Risbridger. In the public health context, which I would like to really highlight, we performed the internationally acclaimed Men in Australia Telephone Survey a few years ago now which provided the first ever prevalence data on 6,000 Australian men representative of the population. It did not exist prior to that study. We showed this very high prevalence of reproductive health disorders and associated concerns of middle aged and older men, and the role of co-morbidities and modifiable lifestyle

factors. The study also provided information about their health seeking behaviour, their knowledge and their attitudes to health.

This study, really from the get-go, was considered a pilot study for the longitudinal men's health study which I understand you have heard a little bit about already. This is a very important study because it could impact across a broad range of biomedical, genetic, environmental and social determinants over a long period of time and give invaluable data. Such a powerful study would complement the women's and children's studies which are already up and going and supported by the Australian government that effectively translate research into evidence based policy and best practice on a backdrop of an ageing population.

Specifically included are rural men, migrant men and Indigenous men—groups that we know have demonstrated the poorest health outcomes as recognised by governments for particular attention and targeted health policy. Unique to this study, it would incorporate both biomedical and social determinants to ensure that the findings can directly feed into broader preventative health strategies. I note your comment at the end about the biomedical and social impacts on health outcomes. You cannot ignore one. They always go together. It also would provide, by virtue of being able to have add-on studies well into the future, an extraordinarily powerful piece of national research infrastructure. We see this project as key to improving men's health and comes across a broad range of portfolios.

The next thing we highlight is removing the barriers to seeking information and treatment. Our analysis of men's health seeking and information needs highlights the fact that they want to have quality and evidence based information they can trust because they know the source and be able to demonstrate that they can talk about these matters comfortably with health professionals, another key issue. So, our strategy is to try to normalise otherwise very sensitive health concerns and overcome reluctance in the community and in the profession to talk about them. I always say you have to engage both sides of the consulting table in which to be able to ask, and they also have to be able to be heard.

Programs must obviously be adaptable across different populations to ensure their widest dissemination. Greater support and understanding of education requirements and workforce capabilities is needed to provide a coordinated and multidisciplinary service and support for men across their lifespan and in different settings. A growing number of voices in the community is a great thing, but there is also the issue of fragmentation and mixed messages that might develop. I think there is a need for coordination in health information provision so that everybody is, if you like, on the same page. This really represents a very great challenge for policy development and implementation, because the government response has to cover across a large range of portfolios.

With respect to workforce capability and strengthening the community, we have to ensure that all men have ready access to professional skilled care. Yet there is a serious deficiency in this area in the male reproductive workforce. A lack of focus on men's health over the past few decades means that fewer young health professionals are entering this area. We are working with Australian universities to encourage them to incorporate men's health in their curriculum status in a similar way that they already do to women's and children's care. At the same time, we are continuing our professional development programs across sectors including general practice, nursing and OH&S officers. We continue to support the development of capable and sustainable

local community workplace initiatives that raise awareness of men's health, and an excellent example is the Bendigo Community Health model, which I think you will hear about today.

Finally, we are developing a men's health education module for male Aboriginal health workers with our Aboriginal and Torres Strait Islander male reference group that we have had in place for many, many years. This seeks to provide those young men with the knowledge, skill and support that they need to initiate activities in their local community, and this requires particular attention. Thank you again for your interest and for the opportunity to talk about our activities and the role of Andrology Australia and in men's health more broadly. Our key proposition is that male reproductive health provides a window of opportunity in which to engage men in a very broad fashion.

**CHAIR**—Andrology Australia is funded by the government—

**Prof. McLachlan**—The department of health.

**CHAIR**—with about \$1 million per year?

**Prof. McLachlan**—Yes.

**CHAIR**—Do you have an ongoing commitment from the department for that, or is it based on a particular cycle?

**Prof. McLachlan**—Yes. We received initially a four-yearly funding cycle, times two. Some 18 months ago, at the time of the last election, we went to a yearly funding cycle, where we currently reside. Our funding extends to the end of this financial year. Of course, we hope it continues. We always seek obviously for longer-term funding, because clearly it assists our long-term planning.

**CHAIR**—How do you measure your success? You have 1.1 million hits, you have 30,000 pdf downloads, and 50,000 visits to your site; they are big numbers. How else do you measure your success?

**Prof. McLachlan**—I think we measure our success with those hard parameters, but also by the range of organisations and the number of people, who utilise our materials, which we cannot actually track in the sense of knowing how they then disseminate them, but we know who is using them and how much interest they show and how we are relied upon. That is one parameter. I guess you are also asking how we know, for example, that we have influenced in a favourable way a group of general practitioners in a particular region to change their behaviours. This is universally a very difficult area to study, how you actually monitor translation or effect on health practice.

**Dr Holden**—Our GP education programs, for example, do have an inbuilt evaluation as part of the program. So we are looking at that on an ongoing basis. We did also conduct an international review, so we had international experts actually review the program over a two-year period, and they actually identified that really there was nothing like this program in the world in relation to having a balance between both professional and community education, and the strong underpinnings of research and evidence. That really demonstrated to us that we were

on the right track, and as Professor McLachlan has already mentioned, we are seeing this growing and continuously growing increase in awareness about our program and the request for resources has just not yet plateaued, and that is now nine years into the program.

**CHAIR**—In your opening statement, you mentioned two documents. Are you seeking to table those documents for us as well?

**Prof. McLachlan**—I have tabled the information sheets. I wish to table also the kit which is being promoted by the department in relation to the men's health policy.

**CHAIR**—Dr Holden, you mentioned about some of the research and communication with GPs. We have heard some evidence and some suggestion that men are not going to their doctors and their GPs. That is not entirely consistent with some of the material that is in your submission. You have conducted a telephone survey.

**Dr Holden**—That is right.

**CHAIR**—I have some questions about that, with respect to the number of people who were contacted and to some of the findings. Also, I refer to the statement:

... younger men express high levels of concern about developing reproductive health problems in later years.

That is inconsistent with what we have been told—that young men generally do not go to their doctor.

**Dr Holden**—The study was conducted with men over the age of 40. I suppose we do see in an ageing population an increased prevalence of a range of disorders. We saw that about over 80 per cent of men were attending their GP, but what they were not talking about was sexual and reproductive health problems, and that was particularly evident in groups such as rural men, who would not talk to their local GP necessarily about those issues. Those men are the ones that particularly identified at being very concerned about their reproductive health. We also know from that study that about 12 per cent of men are actually infertile, and a small proportion of those are voluntary infertility, and that is the same across studies in younger men as well. I suppose we are extrapolating back that men in their older ages are not concerned about their reproductive health, but a lot of young men do not know what might happen in their younger years that might actually impact on reproductive health in the future. There is just not an awareness of issues that can extend across the lifespan.

**CHAIR**—We are talking about a different categorisation of younger men. I like the younger men than 40; I am with that.

**Prof. McLachlan**—I am sure that a 23-year-old does not think about erectile dysfunction but men in their 40s and 50s do.

**Dr Holden**—You are correct in saying that younger men between 20 and 30 may not necessarily go and see their doctor for a range of issues, but try to engage them into the health system at that younger age, because there are a lot of issues that perhaps they need to be thinking about that they will take on in their middle age as well. It is important to engage young men, and

these can be completely different things from the things we are talking about. Maybe there should be more of a focus on mental health issues, the use of alcohol and drugs, for example, and even in the younger age group, in the adolescents, issues about puberty. This is a group of young males that can get completely forgotten about, and it is the time when they are developing behaviours that will then be shown in later life in different ways.

**CHAIR**—From looking at some of your material here, it is designed for men; I can see that immediately. It catches the eye; the language is male oriented, or it seems to be. You refer to puberty, but it does not seem that great resources are available for boys. Often they feel very uncomfortable in talking about it with their parents. There are books available, but boys tend not to pick them up. I wonder whether there is a transition into an adulthood issue that stops boys and young men from actually engaging with some physical health issues.

**Dr Holden**—When the program started, we were very aware that in all of these areas there was very little information across the board. I suppose we took the stance initially to try to get information out to people who were affected by the conditions, and most of those conditions are not infertility so much but most of them do affect middle-aged and older men. That was where our focus was. Now that we have really developed those resources, we will look in the future at trying to be developing more in relation to younger men and trying to engage younger men into the health system, not specifically on reproductive health but just generally getting them to understand what they have to do to make an appointment, to see their doctor and who they need to see. Anecdotally we get a lot of emails just asking, ‘Who do I need to see about this problem?’ There is just a lack of information.

**Senator CASH**—I have a follow-up question to the chair’s question. From your perspective, are there any innovative or effective initiatives or campaigns that have succeeded in raising the profile of men’s health and getting men to ask the right questions and go and see their doctors?

**Dr Holden**—I am not sure whether it is really about asking doctors, but if you take the campaigns in relation to smoking and road accidents I suppose are intended to be targeted at younger men, so there are probably a lot of lessons learnt there about how to raise the awareness of the issues. How you then translate that into actually seeing your GP, I think it would probably need a lot of people to sit around a table to work out the best strategy.

**Prof. McLachlan**—We have tried a range of synergies in which we have utilised the services of Merv Hughes in various promotional activities. That has been terribly successful at the local community level. We have all attended or participated in those sorts of town hall meetings, and they are terribly effective in getting people out, often with their partners, of course, because the female role is incredibly important in getting men to seek care. Virtually everything we have tried has seemed to get a very good response. I think that reflects the community awareness and willingness to participate in this now. People will get up and state very personal things about themselves in a public forum because, once they are given permission to talk, they are willing to do so. It has been quite fruitful.

**Senator CASH**—How do we get that to the next level where it translates into that greater awareness of men’s health issues on an ongoing basis?

**Prof. McLachlan**—That is why we have such a diversity of programs, from occupational health and safety, through industry, through GP programs, to public campaigns such as with Merv Hughes, so I think you have to take a very broad brush because you are not going to get everybody with the single magic communication bullet.

**CHAIR**—Your submission talks a lot about a longitudinal study. This is common across many, many submissions, and it seems to be that there is a universal desire for this to take place. How would you anticipate such a study should be conducted, and over what period of time?

**Prof. McLachlan**—This has been really one of our cardinal activities, ever since we began. The MATeS study was really a pilot study for the longitudinal study. That focused on men after the age of 40. Our longitudinal study, you will note, is proposed to include men after the age of 20, so we are looking at the transition from young adulthood to middle age, middle age to older age and then older age and beyond. We see it as being something that we must develop in a collaborative fashion with a number of partners. Andrology Australia has done two things: first, it formed a working party in conjunction with Monash University to develop a discussion document, which we are very happy to send to you if you would like to see it.

**CHAIR**—I would like to see it, actually.

**Prof. McLachlan**—Our pleasure. Last year, in June, we had a national meeting with many, many partners—100 or more people—at Government House in Victoria, and again it was very strongly supported. It evolved further, and we now have a social determinant subgroup working in conjunction with the main group. What we are trying to do here is to scope a longitudinal study for the department. So, if the department does decide to go ahead and try to actuate that, it will have what will be an internationally competitive piece of research on its own, and a piece of infrastructure which will allow not only reproductive health but all sorts of health issues, including mental health and everything from social determinants onwards, able to be accessed. Yes, we have had a lot of support for it. It is still in a developmental phase, and it will take a couple of years for that final scoping exercise to be complete.

**CHAIR**—Your intention would be to submit that to the department and seek funding?

**Prof. McLachlan**—Our understanding is that the department would, if it decided it was an important activity, put this to a tender process.

**Dr Holden**—We see it as an important component of the national men's health policies, so we are hoping that it becomes part of that framework.

**Senator CASH**—Just going back to local community initiatives in relation to raising issues of men's health, I am from Western Australia and we actually have a number of local initiatives because of the extent of our rural population and our Indigenous population. One of the comments that was made in a hearing in Canberra was that whilst people are arguing for a national approach, we would not want it at the expense of state based initiatives that are actually successful. One of the examples that has been given is the Pit Stop approach. What is your comment on other local health initiatives that are successful and that you would see as beneficial for the federal government to support?

**Dr Holden**—In our role, Andrology Australia actually tries to support those types of community activities, and the kit that we have tabled actually provides some tips and information about how to actually run an event, and also presentations about a range of men's health issues. We have seen over the last eight or nine years this growing awareness in the communities, and we really believe that by supporting the community and providing that sort of local capacity and resources, they can essentially run a program that meets the community's needs and obviously be more sustainable in the future. We have seen that growing awareness.

We are familiar with some programs. The Bendigo Community Health program has been very successful in raising the awareness in that local community, and I think that is because of the collaborative approach. I strongly support that as a way of moving forward. Another program that we are familiar with is the Sustainable Farm Families project over in the west Hamilton area, and that has been running for some time. It actually engages the farming families in health. Indirectly it supports men, in looking after their health, to support their farm. But there are a number of examples. The Men's Sheds program is one that you have probably heard about as well. There are Indigenous Men's Sheds popping up as well. There is a need to support communities, and they are pushed forward by some very passionate people in the local community, and giving them the resource support to actually allow that to happen is very important. Having an overarching sort of framework to ensure that those people are actually getting the right information to give out within the community is very important, so that they are getting those same messages.

**Senator CASH**—That is a very good point, ensuring that those people get the right information. How do we do that? How do we get the right information to those people?

**Dr Holden**—First, I suppose it is knowing who is actually—

**Senator CASH**—We do not want the wrong information.

**Dr Holden**—Absolutely.

**Senator CASH**—I say that quite seriously.

**Dr Holden**—Our approach is always to take the evidence based approach, and that is a very strong component of the resources that we develop. We also try to make sure that they will be used by people so, like Senator Bernardi noticed, we do test them to the extent that they will be things that men will actually pick up. An example of that is there was a lot of work in actually getting the person on the front cover to be the right person so that people will actually pick up the brochure and not offend either younger men or older men. There needs to be a lot of work around that sort of testing of information. Knowing who is actually running such programs is really important, and also evaluating those programs to make sure that they are actually effective and, like you mentioned before, seeing that men are actually going to see their GP after they have been to an event. That would be part of that intervention.

**Senator CASH**—Is there an information gap there at this present point in time in terms of the community efforts that are successful? Is that data then given to a central body so that you can actually evaluate the success of those programs?

**Dr Holden**—We would know the number of communities that are running events, purely because they request resources from us. We ask them to do an evaluation of the event as part of obtaining the resources, and that is really to help us to then improve the resources and provide different types of support. In fact, the kit was a result of getting previous evaluations from men's health weeks that demonstrated that they needed more in relation to capacity support. I suppose that information is then fed to the department through our own progress reporting, et cetera.

**CHAIR**—My question is in a related area, and it goes to marketing of men's health issues and getting men to engage with it. You have made reference to the fact that it could lead to men being over-prescribed treatments that have no proven benefit.

**Prof. McLachlan**—Yes. This is one of the reasons we are so passionate about ensuring that that information is unbiased and available, and it is promulgated through every avenue. If there is a void of information, particularly in issues that are sensitive and men are perhaps not likely to feel willing to discuss with other people, they might seek out information and be vulnerable to exploitation through commercial activities. The information void or misinformation, which is of course always hard to control, is something that concerns us greatly. That is why every time our booklets go out or our hits go up, we know that at least someone is now getting information that we know in our heart of hearts is correct. Men are vulnerable.

**CHAIR**—Do you have any particular billboards in mind?

**Prof. McLachlan**—I do not have any particular billboards that I would like to specify, but I think everybody is aware that there is a vulnerability in sensitive issues for men to be able to be led off the pathway that they should be following, which is to seek skilled professional advice, usually through their local doctor, who is well and truly armed. The point about this, as I said, is that each side of the consulting table has to be on the right page. The patient has to know that when they go and see their doctor he or she will be happy to talk about it, and the doctor needs to have at their disposal information that they need. We are working on both sides of the table. If there are external factors that have big budgets and big opportunities to influence behaviour, we are not in a position to block them; we can only try to make sure that the right course of action is available. We are dancing around the table.

**CHAIR**—Can I give you an example of the PSA test for prostate cancer? We heard evidence yesterday that to have a widespread marketing that all men should undertake a PSA test may actually be counterproductive, given that only one in 40, according to the evidence that was given to us yesterday, would actually be at dangerous levels, and the treatment of the other 39 may in fact create a range of other issues for men that are unnecessary. Do you have a comment on that?

**Prof. McLachlan**—Yes. We are currently updating our position statement on that particular issue in conjunction with other bodies such as the Urological Society of Australia. It is one of the most contentious and most difficult issues to address because what you are really saying is that the evidential basis for widespread promotion of it as a lifesaving procedure is just not to hand, yet we know that many men are already being tested, and in fact our MATeS study indicated that the majority of the adult male population is undergoing some form of testing at some stage. The truth is that it is already occurring to a large extent. So that means that both the gentleman and his medical attendants need to be well informed about what is currently known about the test in

terms of what the options might be and what the outcomes might be. It is a question of balance. We do not have definitive information; we have a widespread application already. That is the reality. Therefore, both the patient and the doctor need to have the best information to decide what they will do with the test.

**CHAIR**—Is it fair to say that any promotion or awareness that is drawn to male health issues that results in their picking up the phone and engaging with their doctor, with your service, through the internet, or even with some of the commercial services, is a positive step forward even if the outcome—

**Prof. McLachlan**—I was almost going to agree with you except when you used the word ‘commercial’ at the end.

**CHAIR**—That is why I put it in.

**Prof. McLachlan**—What we are talking about, the PSA issue is being pursued by us, the PCFA and many other very respectable bodies who are trying to make sure that men get the right information. It is not a commercial issue; it is a care issue. Everybody wants to ensure that we know the best things available to that particular man, because the second senses are different. If, for example, you are a young man with a family history of prostate cancer, that is quite different from being a 75-year-old man, et cetera. There are issues about how it is applied and how the information is received. That is not a commercial issue. When I referred to commercial services before, I was referring particularly to the erectile dysfunction area where men are potentially able to be led—that is the billboard thing that you referred to.

**CHAIR**—Yes. Obviously there is lots of advertising about that, but is it better for men to actually make that phone call and admit they have an issue, as it might be their first port of call because they get no satisfaction?

**Prof. McLachlan**—Seeking care for your erectile dysfunction is an important step, and that is always a good point to come to. Where you get the care is critical, because as I said to you before, it is not just about their erectile dysfunction; erectile dysfunction is the canary in the coalmine for cardiovascular disease. It indicates a much higher risk of underlying diabetes, hypertension and so on that you may not be aware of. Therefore, whoever you speak to about the erectile dysfunction has to not only address that question but to look at your care in a holistic way; not just look for diabetes and everything else but ask about your relationship or your mental health. Depression, for example, is a very marked indicator of risk for erectile dysfunction. Just picking up the phone and saying, ‘I’ve got erectile dysfunction’, is step one. What you have to see beyond that is a review of the man in total to work out what that is telling you about his health. That is best done through the local doctor. That sort of service is usually not done through other facilities. That is the silent approach that I am trying to avoid.

**CHAIR**—If you are advertising yourself as a medical institute, it does not mean there is any requirement to have a medical practitioner providing the advice?

**Prof. McLachlan**—It does not necessary mean that you will have a full medical evaluation of all the issues that I have mentioned.

**CHAIR**—But it would be a doctor at the other end of the phone?

**Prof. McLachlan**—I do not wish to speak about the actual—

**CHAIR**—Okay.

**Prof. McLachlan**—I understand that there is doubt about some of that.

**Senator CASH**—Just to follow on, I have a question in relation to the beginning of page 10 of your submission where it states:

There is a myth that men don't visit their doctor, whereas in fact most men over the age of 40 years have visited a doctor in the last 12 months<sup>22</sup>. But compared to women, men visit the doctor less often, have shorter consultations and see their GP later in the course of their illness.

Following on from what you have just said, suppose I go to the doctor and raise an issue as a man. What is the gap there between what I raise and what the GP themselves then needs to discuss with me? Is there a gap in training at a GP level? Is it a communication gap? I have gone to you; I clearly have an issue. How as the GP do I get all of the information from you?

**Prof. McLachlan**—What you are referring to there is facilitating positive encouragement to discuss problems with the general practitioner. For example, with respect to the man with long-standing diabetes, the GP needs to bring up: 'Well, Craig, many men in your situation may have a problem with erections. Is that something that is on your mind?' You facilitate it and, if it is there, it will come out. They may not want to broach it. Yes, some men will be forthcoming and say, 'This is my problem', but other times you have to encourage them to declare their concerns by asking, 'What is on your mind? What is worrying you?'

**Senator CASH**—Do you find that doctors do that? As a woman, I go to a doctor, and you almost end up having a general chat; that is the nature of a woman with her doctor. Do you know if that is something that doctors do with men or do not do?

**Dr Holden**—A very nice study was published recently through the Florey Adelaide Male Ageing Study, with James Smith as the author, which showed there are some characteristics, I suppose, of a GP that men preferred and felt more comfortable with when discussing in particular the issues that we are talking about. Knowing that they have good levels of knowledge about an area, for example, and that they were quite frank about their approach were important things. I suppose there is a range of barriers that might exist that would stop men actually asking about things.

**Senator CASH**—What are those barriers?

**Dr Holden**—I suppose one of them might just be a feeling of time or that they might be embarrassed about their issue and, if it is not brought up, they will not actually offer that information unless they are prompted. There are obviously difficult issues when you are talking about men in rural areas of actually accessing GPs, but just when they actually get there, knowing that their GP is knowledgeable and that he is comfortable also about talking about the issue is important.

**Prof. McLachlan**—I would like to make one other point which is really quite striking to us. There is a condition called Klinefelter's syndrome. It affects one in 600 men. It is a chromosomal disorder. It would affect many thousands of men across the country. The evidence—and it is good evidence—is that the majority are never diagnosed for their entire life. That is striking for one reason. You can diagnose this condition if you actually examine an adult male. I have a little visual—I will not table this, but I have to show you. This is a series of elliptical beads which show the size of a human testis across puberty, leading to adulthood. So, before puberty, the little ones, and when you grow up to be big boys, you have bigger ones. The condition I am talking about, which affects one in 600 Australian men, as I say, the testes size is that big as opposed to the median for the population which would be about that big. So you will see a distance that, if you bothered to examine the male, you could tell the diagnosis. What this tells us up until now is that routine examination of a male does not occur in many settings, presumably in general practice. So those men who go to the local doctor do not actually get a general examination. There is a reluctance, and in fact, in our scoping of Australian universities, it seems that the men's health systematised approach to men's health issues is not inculcated in the curriculum. So, as well as our GP education program, where we provide these to the GPs along with an active learning module and how to examine the male, we are also going to the other end of life and going to the students and saying, 'Listen, this is something you need to do.' I think it is an education issue. I do not think these days it is really an issue of embarrassment for the doctors. I think it is just that they have not been taught; they have not had it inculcated in their routine practice.

**Senator CASH**—So it is actually taking it back to looking at the curriculum?

**Prof. McLachlan**—Yes, you have to.

**Senator CASH**—Looking at what is taught on a practical level?

**Prof. McLachlan**—Yes. It is quite in contrast to the approach to female health, where one could not imagine an examination that did not include the breasts.

**Senator CASH**—Exactly. Dr Holden, you mentioned rural health issues. Evidence to us in Canberra suggested that one of the reasons that men in rural communities do not want to go to the doctor is that it is the local doctor; everybody knows the local doctor and God forbid I should be seen walking into the doctor's surgery. How do we overcome that issue?

**Dr Holden**—I think a lot of it is about normalising the issues, particularly sensitive issues. So, if men do have an erectile problem, it could be because of their diabetes or for some other warning sign. I think that is the first stage. As Professor McLachlan mentioned, people now talk about this in open forums quite readily, whereas initially it was not something that they would raise at all. I think that is the first step. It will always be hard to actually address those barriers, but I think again supporting the GP so that they are knowledgeable in the area as well, that they can slowly sort of start discussing these issues with men, and hopefully one day people will feel comfortable in talking to their GP about it, irrespective of their relationship with them on a personal level.

**Senator CASH**—One of the potential solutions that was canvassed was the idea of a locum doctor visiting on a Thursday: I know that I can nip in quietly and nip out. Obviously the

problem that that raises is: do I then actually follow up with the person? Do you have any comments on that type of approach?

**Prof. McLachlan**—No, I have not given that any consideration. There are some specialists who go to regional areas on an infrequent basis. A colleague of ours goes to Bairnsdale once a month and he is an expert in male reproductive health. Presumably people may already be using his facility because they know there is some distance between him and the local community. It is a very perplexing problem. It is a real manpower problem. We have already mentioned that the trained manpower in reproductive health in the cities is low, but in the country it is a particular challenge. All we can do is grow the workforce. That is why going through local health workers and practice nurses, for example, is another initiative we are thinking about, because many places have a practice nurse, and they may also be able to deliver some of the basic information and care. It happens in the diabetes model; it could also happen in some aspects of reproductive health as well. Not all men are by any means reluctant to discuss problems with females. I stated earlier that I do not think it is a given that they necessarily always prefer a male care giver.

**Senator LUNDY**—I am interested in the forum of the internet or the web as a way of communicating with men particularly about their reproductive health. What is your organisation's experience with that, and what opportunities do you think exist for further using that as a forum either through video conferencing and so forth for their health?

**Dr Holden**—I suppose particularly through education, and particularly to rural areas, being able to provide support and education would be very important. It is very difficult to get that information out to GPs unless you are doing it through the internet. That is one area. As we have already indicated, we provide information primarily through the internet, and we are surprised how many people actually contact us through email having requests seeking information about their disorders. We always point them back to a GP. It would be good if they were with some kind of system where you could really point them to the right people in their location, because the trouble with email is that you do not know where they are coming from, so that is very difficult. Probably as a first step, education for health professionals would be a really important way of getting information out. Having discussion forums, et cetera, could be included as part of an internet program. With the Klinefelter's syndrome, for example, we know that a lot of men contact us, and there is very little support for Klinefelter's men. We actually do suggest that there is a discussion group in the states that they can engage in, and some of them actually do that. They are some of the activities.

**Prof. McLachlan**—We see ourselves as a portal of entry for information. We provide a lot ourselves, and our website is quite interactive, and we try to update it and keep it interesting and topical. Where there is extremely good information available elsewhere, for example, we will link through. With respect to puberty, for instance, there is a very good statement about circumcision through the college of paediatric urologists that we refer people to, so we do not reinvent the wheel. As I said before, one of the issues is that you have to try to be cost effective. We do not need to redo a lot of stuff that has already been done by excellent bodies, but there are so many gaps; we have never been short of a task to find another gap to fill. We are always looking for new ideas.

**Senator LUNDY**—That is the main thing. I just want to explore it a little further. Apart from providing resources to health professionals and so forth, what about new forms of direct support

to men to get around this problem of them presenting with their health issues to doctors; what kinds of higher level of health information can be delivered to men as a first point of their inquiry in the future? Have you thought about the opportunities there or about that as a strategy to try to encourage men?

**Prof. McLachlan**—To just get across the threshold with their doctor?

**Senator LUNDY**—Yes, I think so. I understand your point about referring people on to their GP, but I guess I am thinking of something further than that.

**Prof. McLachlan**—We have a very small budget and a small staff, and the actual service delivery or facilitating direct access to care is not something that has been in our brief.

**Senator LUNDY**—That is okay.

**CHAIR**—We are out of time. Professor McLachlan and Dr Holden, thank you very much for your submission and your appearance today. It has been very interesting.

**Proceedings suspended from 10.43 am to 10.47 am**

**RISBRIDGER, Professor Gail, Director, Centre for Urological Research, Monash Institute of Medical Research, Monash University**

**CHAIR**—I welcome the officer representing the Monash Institute of Medical Research. Thank you for coming along and talking with us today. We have received your submission. Are there any alterations or amendments to that submission that you would like to advise us of?

**Prof. Risbridger**—No.

**CHAIR**—I invite you to make a brief opening statement.

**Prof. Risbridger**—I thank you for allowing me to make this submission that relates to your first terms of reference on the level of Commonwealth and state funding for prostate cancer research and men's health. I am here in my capacity as an expert in biomedical prostate cancer research. I have worked in the field of men's health research for more than 30 years and I have outlined to you in the submission my credentials in that area.

To come back to the terms of reference that I have addressed, I could make many statements. I have chosen in fact to give you four of my recommendations that relate to my opinion about basically infrastructure for prostate cancer research or for the development of the workforce. The first two are infrastructure, and the last two relate to people. The main question that drives me is: how can funding for prostate cancer biomedical research deliver greater benefit to patients with prostate cancer? That is the driving force behind the research that we do. I have tried to address my points relating to infrastructure and how best to provide that, use it and how to obtain those people and train them for the next generation of the workforce. Do you want me to go into the specific details?

**CHAIR**—We could flesh that out through questions. Of course, during the questions if you feel you would like to give some additional information we would welcome that as well. We are also mindful that you are appearing by yourself today.

**Prof. Risbridger**—Yes. It is fairly nerve racking.

**CHAIR**—You will find we are all human.

**Prof. Risbridger**—As I am.

**CHAIR**—There are a number of different views on the efficacy of prostate screening and the benefits to the wider community. You may have heard some of the earlier evidence today where I asked a question as follows. Of 40 men treated for prostate cancer, one of those will truly benefit from the treatment and the remaining 39 will have various dysfunctions as a result of the treatment that was unnecessary. In your view, is this an accurate assessment of how we are dealing with prostate disease now and the diagnosis of it?

**Prof. Risbridger**—I hear your statements. Where I come from as a biomedical researcher is not just what the utility is of the prostate cancer screening; we all know, as you heard earlier, that

it is not good enough at the moment for people to feel that you can have a prostate cancer screening program. Therefore, at my end of the business, as a biomedical researcher, the task I have to undertake is to find a way to make that test better or to come up with a better diagnosis or better treatments. Those are all the sorts of things that we grapple with. A single researcher cannot do all of them but they usually tackle one particular end of it. It might be to develop a new diagnostic tool from their particular gene or market that they are interested in, or it might be someone like me who wants to find a way in which you can treat men who have prostate cancer that is advanced and incurable. It is not a question of what is right or wrong; it is a question of what you, as a medical researcher, can do to make the situation better because you know you have to do something.

**CHAIR**—There is a direct link between the clinicians and the researchers?

**Prof. Risbridger**—Yes. The clinical need drives the research that you do, as I do as a biomedical researcher, and then the outputs that you generate as a biomedical researcher are considered by the clinicians. It is a very old paradigm but it is called a virtual cycle where each inform one another.

**CHAIR**—You mentioned in your report what I call prostate banks, but you call them the right terminology—collection nodes. How important is that to ongoing research and is there a unified approach to this from all organisations that are interested in research in prostate cancer?

**Prof. Risbridger**—This is one of the key things that I would like to discuss. The reason that biobanks and specimens taken from men are so important to a biomedical researcher in prostate cancer is that you do not have mouse models to work with. Mice do not get prostate cancer. You can make them do that if you genetically manipulate them, but it is not something that occurs spontaneously. Mice are not men. Unlike other diseases, that makes it quite difficult for you to work with mice.

You have to have some reasonable alternative, and what most of us do is work with human prostate cell lines that have been banked and used over the years or, more recently, we use fresh specimens. Someone like me would be isolating cells from these fresh specimens as well as looking at them. The issue with the biobanks is that you collect from men over a period of five years. They do not become useful until you have had them for five years because they have what is called follow-up. You need to know what happened to the men from whom you took the initial sample. So we have to generate this repository. At a national level this has been done very successfully by the Prostate Cancer Biobank. Judith Clements in Queensland runs that and I and two other major groups contribute to that. You have to have that in order to do the research. That has been extraordinarily successful. I point to its success and would like you to know that success because it is now at a critical point where these enabling grants or capacity building grants, as they now call them, are up for renewal and we have to decide how to move that forward.

**CHAIR**—Where is that grant coming from?

**Prof. Risbridger**—Out of the National Health and Medical Research Council. That is a really good success story, but you have other state based ventures where people have been collecting state based specimens. It is inevitable that there will be multiple activities around the country,

but the challenge is not to allow them to compete with one another, but to coordinate their activities. My point would be that you always have multiple activities, but how do you ensure that what we do in Victoria is not better than New South Wales, Queensland or whatever, but that what are we doing is best and can be coordinated best—because in the end it is all Australian men and men with prostate cancer?

**CHAIR**—It is about collaboration.

**Prof. Risbridger**—You need to keep collaboration, not the competition.

**CHAIR**—In Victoria there is the Victorian Prostate Cancer Research Consortium. Do they maintain their own biobanks?

**Prof. Risbridger**—No. I will be here tomorrow when you talk to the Victorian Prostate Cancer Research Consortium. They are a research based organisation and their funding is around research related activities, which they will probably explain to you. In Victoria, the biobanking is done by the Victorian Cancer Agency and it is biobanking for all cancers. You can see how there is now a need for prostate cancer researchers to coordinate their role in the national consortium versus their obligation to contribute to what is happening in their own state. I do not think that a researcher should be faced with an either/or option. They should be given the option of bringing it all together.

**CHAIR**—Recommendation 1 in your submission is that prostate cancer tissue banks remain coordinated at a national level. I get the sense that there is not as much coordination as there could be. There may be at a state level for exclusive prostate cancer biobanks that you have talked about in Adelaide, Melbourne and Sydney, but not with prostate cancer samples in Victoria and perhaps in other states.

**Prof. Risbridger**—It comes down to a lack of funding and not so much lack of desire. The funding is not there to support the establishment of these wider virtual networks that allow you to integrate all of the activities, whether it is through the national prostate cancer bioresource that I already belong to or these various state based initiatives. New South Wales has one, too.

**CHAIR**—If you were minister for the day, how would you better deliver research funding so that there is a more coordinated approach?

**Prof. Risbridger**—You need to get the infrastructure through the national prostate cancer biobank in a virtual network with the other activities that are going on. They could be state based or some of them might even be private banks. You need to provide the virtual network for that, and there is no obvious mechanism for that at the moment.

**CHAIR**—Is there a national prostate cancer representative body that encompasses all the other bodies that are interested in prostate cancer?

**Prof. Risbridger**—There is the Prostate Cancer Foundation of Australia. It was initially involved in establishing the biobank, as Andrology Australia was, but none of them has the funding that is required to do this at a national level. You cannot do it on \$50,000 here or there. You need to have the funding to be able to do that. The successful mechanism that you have in

place at the moment is the one through the NHMRC, which is called a capacity building grant. It has proven to be successful over the last five years, but as I said it is at a fairly critical stage where it simply does not know what is going to happen.

**CHAIR**—It does not know whether there is going to be ongoing funding for that?

**Prof. Risbridger**—Yes. There could probably be an argument, ‘You need to find additional partners and you need to be self-funding.’ It is very hard to make something like that completely self-funding. The only way to do that would be to ask the researchers who are using it to pay. As you know, the researchers who are using it are usually funded off grants, and the NHMRC cannot fully fund their grants. Again, it is a vicious cycle again where at the end you have got something that is successful. My recommendation was: if it is successful and proven to be successful then why not continue to build and maintain that?

**Senator LUNDY**—I would like to continue with the questions about the Victorian Prostate Cancer Research Consortium, the funding for that and obviously the coordination issue that you have been referring to. Could you outline the source of funding for that consortium and extrapolate on the point you make about ongoing funding being desirable?

**Prof. Risbridger**—Yes. Again, there is a certain level of uncertainty. The funding for the Victorian Prostate Cancer Research Consortium came from the Victorian state government. Initially, the idea was that it would be similar to the Victorian Breast Cancer Research Consortium, which has been extremely successful in delivering outcomes for breast cancer research. The intent was to do that. It has taken almost two years to get that signed off, and the funding for that is just about to hit my laboratories this year, after more than two or three years negotiation. That funding, at the moment, is only for one year and not for the three years, so tomorrow, I would imagine, you will get the same story from the Victorian Prostate Cancer Research Consortium; you will see the level of frustration. It is not coordinated, either. It is not a coordinated strategic approach to prostate cancer research.

**Senator LUNDY**—How does that compare to breast cancer research? You made the point that the idea behind it was to set up something parallel.

**Prof. Risbridger**—Similar, but not identical. That was the original intent, and things changed or they are always fluid along the way. I do not know where it is going to go to now. As to how it compares with other things, other funding streams that fund my programs and many of our programs are usually for three years if not five years. You can see that it is a very different scenario and, as I just told you, when you are dealing with a collection of patient tissues that you have kept for five years and you have a five-year program to work on, the outcomes that you deliver will be quite different than where funding takes two years to arrive and is only for one year.

**Senator LUNDY**—What engagement, if any, have you had with counterpart organisations from other states or other universities? What movement is out there to achieve the sort of national coordination that you are referring to?

**Prof. Risbridger**—Most of us have worked through what is called the Australian Prostate Cancer Research Consortium, which had a research and education arm. That was a

multidisciplinary group of biomedical, clinical, researchers, oncologists and education programs that has now transitioned and not held together. Over time it has become more focused on patient education and consumer interaction with PCFA as well. Again, it never had the money to fund research programs. However, it did have a major role in setting up the prostate cancer bioresource. There is not a national funding body other than the National Health and Medical Research Council. It is the prime one for funding prostate cancer research. There are other organisations such as Cancer Australia, which works through National Health and Medical Research Council, and the Cancer Councils of Victoria and New South Wales, which work through the National Health and Medical Research Council. That is probably how they coordinate their research funding.

**Senator LUNDY**—From your perspective, are they the appropriate people for that coordination? Is it more about levels of funding and continuity?

**Prof. Risbridger**—I have made a couple of copies here. I do not know whether you would like to read them.

**CHAIR**—We would be happy to receive them if you would like to table them.

**Prof. Risbridger**—Yes. What they show you is the level of direct funding per tumour stream. If you look at breast cancer, the number of grants funded versus the incidence, it is on a par—one-to-one. But if you look at prostate cancer—the red bar with the blue line—you can see that it is halfway down, which means that the incidence and the amount of funding is half, but when you go to leukaemia it is actually double. The levels of funding relative to the incidence are quite different. You can argue various reasons as to why that should be appropriate or inappropriate, but that is the fact. There are other documents that I can table showing you how prostate cancer research is underfunded relative to breast cancer and therefore it is under-researched relative to breast cancer.

**Senator LUNDY**—Those documents would be very important for the committee to have.

**Prof. Risbridger**—We got those from the National Health and Medical Research Council.

**Senator LUNDY**—Will you be able to supply those to the committee?

**Prof. Risbridger**—I can give you those.

**Senator LUNDY**—We will get them from you. I wanted to explore that proportionality in relation to research and spend relative to incidence and other forms of cancer. How does that inform your wish list? What is your perfect scenario if the government were able to respond in public policy terms?

**Prof. Risbridger**—If the figures show you that prostate cancer research is less researched than breast cancer and underfunded relative to breast cancer, for example, then the question is: do we have enough researchers working on prostate cancer? I would say to you, no, you have not, because as I said right at the very outset there is clearly a need for biomedical research, exemplified by the whole issue of prostate cancer screening and treatment. If you accept that you do need to do prostate cancer research, you need to train the next workforce.

**Senator LUNDY**—Hence your recommendation 4.

**Prof. Risbridger**—Yes. The training of the next workforce is essential if Australia wishes to maintain its momentum in the field. There are two things here. Firstly, it relates to how we assess our researchers and, secondly, how we get the clinicians in. How we get the clinicians in is, as I have said, critical because you must have that interaction. I sit on one of the National Health and Medical Research Council's training panels. The figures again show that for biomedical research the numbers of applicants are going up constantly and so are the biomedical research positions, but clinical fellowships are staying static. That says that we do not have enough applicants and we do not have enough money. It is the chicken and egg argument. This is absolutely critical. It is again about money, especially if you deal with a clinician who has his or her MBBS, is now a surgeon and, before they go into the urology program, you want to pay them \$20,000 to \$25,000 to do a PhD. You might get them for \$70,000, but even then that is a small amount of money compared with what they can earn and for the training they have done. It is inordinately difficult to get these people. However, if you do not get them at that stage, by the time they become consultants it is going to be very difficult to get them back into the training and to have the ability to do the research. As Professor McLachlan said, if you do not get them early then it is very difficult.

The second issue is about how we assess our researchers. As I have said, the goal of the research must be: how can your research benefit patients? Most of our funding agencies have a system of ranking researchers as individuals. The way that we do that is by looking at one of their key outputs, which is the publications. You can publish in what we call a high-impact journal, which is a general biomedical journal that has a numerical value of something like 20, or you can publish in a specialist journal, which might have a numerical impact of two or three. Funding agencies like you to have lots of the 20s and not many of the 3s. That ranking is based on how our peers view, read and cite us. Twenty means that many of our peers cite us from all different disciplines, but if it is three then it is within that discipline.

The consumer and the patient are not involved in this ranking. It is not what the consumer or the patient thinks of it. Often in these journals where they are publishing in what we call low impact they have a very immediate and defined benefit to the patient. I would take an example of a publication we had recently on evaluating the information on the internet on prostate cancer screening and how best to deliver that to patients. Obviously patients want to know the best place to go on the internet, what the best information is, what credentialed information is and so on, but it has a very low impact. When the researchers go to be evaluated, this one does not really matter very much.

**Senator LUNDY**—Hence recommendation 3, which says your research funding schemes should also include metrics that recognise and reward involvement of basic researchers in broader activities, public education, infrastructure, development, clinical engagement and policy development, and the website is one example.

**Prof. Risbridger**—It is not just about whether you publish in a high-impact journal that all of your peers are going to read, it is about whether the patients are going to read it or whether it is going to have any benefit. The previous government was trying to assess research quality. We grapple all the time with what is good-quality research, and community engagement and the

benefits to the men with prostate cancer have to be somehow factored into that. Have I explained that clearly enough?

**Senator LUNDY**—You did. What strikes me about it is that the change there is pretty fundamental to the way research grants are allocated. It is a big thing to make that change. Presented in the context that you have presented it in, it appears to make really good sense, particularly if public policy is aiming, in the first instance, to make a real difference where it matters, and that is with patients and the services they are receiving.

**Prof. Risbridger**—As a biomedical researcher it is something that you always grapple with. There is always a tension between the fact that you must publish in these high-impact journals because that is how you get your grants; for somebody like me, I have the ability to work with people in public health and the clinicians, and I am able to do some of these other things as well. I feel that sometimes not enough weight is given to that activity, but I consider it to be an important thing for people like me and my successors to do in our everyday activities as a researcher. Delivering these publications is one. The other is interacting with the general public in various forums, such as Rotary Club talks and so on, which are important. It is called community engagement. The university asks you to do it, but not necessarily everybody else does that. We do not have a good reward system for that, which makes it a disincentive.

**Senator LUNDY**—It means that the professional pressure lies in the other areas and not specifically in that area.

**Prof. Risbridger**—It comes back to my point and the thing that we ask all the time: how does your biomedical research deliver the best benefit to your patients? Yes, you can do the various high-quality research, and you must do that and you must publish in high impact journals, but you must do the other as well, or you should be encouraged to do the other as well, because then it will generate the loop or the connections between the biomedical researcher, the clinicians, the public health researchers and the patients.

**Senator CASH**—I would like to ask a follow-up on that. It is in relation to a recommendation that our next witness has put to the committee. It is a recommendation for a national information pack to be distributed to each man diagnosed with prostate cancer. Do you have any comment on that and, if you agree with the dissemination of such information, what would you see the pack containing?

**Prof. Risbridger**—It is probably better that they answer that. There would be multiple things that would go in there. I could answer that question in terms of prostate cancer research and from my experience of giving presentations to Men's Forum, Rotary, Probus or Freemasons. They clearly need to understand their problem and have that information pack with all the sorts of information that Professor McLachlan was talking about earlier. They also would ask someone like me, 'So, what are you doing? What research is coming down the track? What are the possibilities? Will a cure for prostate cancer be seen in my lifetime?' Sometimes they find it very interesting to know what is going on. More importantly, the point that I make to them—going back to the biobank—is that it is important that patients understand you are asking them to consent to give their material to you so that you as a researcher can do X, Y and Z on their material and what you are trying to do is test a new drug, do pre-clinical testing or whatever that

may benefit them. Again, it is completing that loop between the science, investigation and the patient.

To give written material on the latest prostate cancer research is probably a hard ask because things change so much, but let us come back again to web based activities. That is a very good way to respond to what is actually happening in the research communities. Again, you saw that Andrology Australia was able to respond by putting up a position statement on the two major publications on prostate cancer screening. There is another good compound called abiraterone that is in clinical trials for men with advanced prostate cancer. That is something that you could put up on the web. It is probably best given on the web, rather than on pieces of paper, which can always be updated fairly quickly. That is a longwinded response.

**Senator CASH**—No, that is all very interesting. A comment in your opening submission was that one of the driving forces in relation to what you do is that you work with patients with prostate cancer. I would like to take one step back and get your comments on how we take that step, in working with patients with prostate cancer, to get men to go to the doctor to have those tests? Do you have any comments on that?

**Prof. Risbridger**—My comments would be similar to Professor McLachlan's, and that is that it is all about patient awareness and awareness of men. That is why organisations such as Andrology Australia are so important, as well as PCFA and the Cancer Councils. They are able to raise awareness. As you heard earlier, it probably needs to be at a very early age. Nevertheless, for something like prostate cancer, it is terribly important to get to the older age groups and to target those men at that time. We are doing that through those education forums, but it always comes down to funding. Andrology Australia is another body whose funding is at a critical phase. It is a recurring theme for you, but it all comes back to support.

**Senator CASH**—My understanding is that there is a number of organisations within the field looking at prostate cancer and obviously, as you have stated, funding is an issue. Is overlap or duplication of effort a problem in this field and can funding be better targeted?

**Prof. Risbridger**—I think it is inevitable that there will be different activities going on around Australia funded by different organisations doing slightly different things. Again, there is the point I was making about infrastructure support. You need to make sure they are not tripping over one another and that they are not duplicating resources. The way to do that is through a coordinated effort. Somebody somewhere has to take on that role and it has to not just coordinate educational activities but also research activities, infrastructure, people training and so on. It has to be the whole gamut.

**Senator CASH**—Do you have any ideas on how such a coordinating body would work and who would be involved in it?

**Prof. Risbridger**—We do not have any at the moment and so that is the problem. As you can see, whilst there are a number of organisations that might be able to take the lead, such as Andrology Australia or the Australian Prostate Cancer Consortium, it is again whether they are able to do that if they have only one year's or three years funding. You really need a more coordinated effort with more solid financial foundations.

**CHAIR**—I had a question in regard to this document that you tabled outlining funding through mortality. I looked in your submission and I could not find it. I looked briefly in some other submissions as well. What is the mortality rate for prostate cancer? There are apparently 18,000 cases diagnosed every year.

**Prof. Risbridger**—Currently in Australia one in seven men is diagnosed with prostate cancer in their lifetime. About 10,000 are newly diagnosed, and about 2,000 per annum die. Those are the rough figures. I could give those to you.

**CHAIR**—It has just been given to me. It is 2,946.

**Prof. Risbridger**—It is around that figure.

**CHAIR**—How does that compare with, say, breast cancer mortality? Do you have any idea?

**Prof. Risbridger**—The argument here is the mortality may well be similar, but what the breast cancer people would argue is that it is usually women that die younger and therefore the life years lost is much greater than it is for men who are diagnosed with prostate cancer later in life and who would usually die later in life. I do not necessarily hold with that argument. The fact is that these men still die and the numbers are still similar.

**CHAIR**—I now have this great book and I realise that the percentage is about 0.4 per cent.

**Prof. Risbridger**—That is from the Australian Institute of Health and Welfare.

**CHAIR**—I am trying to assess whether we are comparing like with like when people come out and say that so much money is spent on breast cancer and yet more people are diagnosed with prostate cancer. Breast cancer always requires treatment. Is that a reasonable observation? It is not just, 'Let's watch, wait and see what happens'?

**Prof. Risbridger**—I am not an expert in breast cancer so I cannot tell you that. The point is that breast cancer would need treatment and it usually occurs in younger women. The issue for prostate cancer is that we do not know which men to treat with prostate cancer, because we do not have markers that are prognostic. That means they will predict that, if you have prostate cancer, it will go on to kill you. There is a mantra that many men have prostate cancer and die with prostate cancer, but not of prostate cancer. Have you heard that?

**CHAIR**—Yes, I have. That reinforces the concept that we are going to be much more effective at treating this disease and preventing deaths through greater research.

**Prof. Risbridger**—Absolutely. You have heard the issue about prostate cancer screening. You can have a PSA test and your PSA levels may be up, but that marker will not tell you whether you are going to die of prostate cancer. It is not going to tell you whether your prostate cancer is active or latent/sleeping. The patient always has to make the decision as to how they are going to treat it.

The other issue then comes back to patient awareness and the interaction among the biomedical researchers, clinicians and patients. Increasingly, patients are being involved in their

decision making, but how do they inform themselves to be able to contribute to the decision making with their clinicians? I get funding from the US Army and Department of Defense, and the approach that has been taken in the US is not simply patient awareness and involvement in educational material. When you submit your grants to the US Army they have an expert peer review, but they also have patient advocates on those panels. When you get a grant from them you get a peer reviewed scientific report and you get a consumer report as well. That is a fantastic way for the consumers to see what is coming through in terms of prostate cancer research. Again, because I am funded by the US Army—and have been for a number of years—the consumers convene an international meeting where we are all asked to provide our latest research findings and updates on the grants that we have, and the patients listen to it. It is a brilliant way of involving them in the research.

**CHAIR**—Unfortunately we are out of time. Thank you very much for your submission and appearance today. It has been very interesting and enlightening. I trust that it was not as nerve racking as you thought it might be.

**Prof. Risbridger**—Thank you.

[11.30 am]

**SIDDONS, Dr Heather, Clinical Psychologist, Department of Urology, Royal Melbourne Hospital**

**WOOTTEN, Dr Addie, Clinical Psychologist, Department of Urology, Royal Melbourne Hospital**

**CHAIR**—Thank you for joining us today to give some evidence. The committee has received your submission No 23. Would you like to make any amendments or alterations to the submission that we have received?

**Dr Wootten**—There are two clarifications. I have noticed that I have used abbreviations and perhaps not defined what they are. One is QoL, which I refer to as quality of life, and then later on in the document, on page 4, I have used the abbreviation PCLN. I should have indicated that that meant prostate cancer liaison nurse.

**CHAIR**—Thank you for that. I invite you to make a brief opening statement before we go to questions.

**Dr Wootten**—I am coming to you today from the perspective of a public hospital, but also with an interest in the private practice patients as well. I thought I would open and then Dr Siddons can add more as we go along.

You are well aware that there are a large number of treatment options available for prostate cancer patients and, from a psychological point of view, this can be a very daunting task. Patients are often asked to make their treatment decision themselves, so without specific guidance from their treating urologist or doctor. Often patients and their families can feel a sense of paralysis around which decision to make. You just heard from the previous witness about not having clear evidence about which treatment option to choose, which can be a really daunting task. The decision-making process can be clouded by confusion and, unfortunately, later on down the track, often patients can come back with a large degree of decisional regret. There is a really big psychological impact in terms of that decision-making process.

The major morbidities associated with treatment included failed cancer control, incontinence of the bladder or the bowel, sexual dysfunction and psychological trauma. These morbidities seem to have a very big impact in terms of patient quality of life later on down the track and also how they cope with these difficulties psychologically. There has been quite a lot of research in Australia looking at patient quality of life in the prostate cancer context, but it has predominantly been overseas in the United States and the United Kingdom. This research has found that these morbidities following treatment impact negatively on quality of life. Patients often report that issues such as incontinence or sexual dysfunction actually have a detrimental impact on their life in a number of different areas.

Different studies have reported different rates of anxiety and depression in the prostate cancer population. This is because we use different measures to capture those rates. There seems to be

clear consensus that anxiety and depression are predominantly higher in the prostate cancer arena and, interestingly, there is very good evidence to suggest that the partners of men with prostate cancer actually report higher levels of distress than the patients themselves. It seems to be a disease that impacts not only the patient but also their broader context.

The psychological impacts of prostate cancer appear to be particularly associated with the negative impacts of the treatment options, but from a more psychological point of view it appears to really target a man's sense of masculinity. There seems to be a core impact in terms of how they feel about themselves, their self-concept and their relationships with other people. It seems to have a destabilising effect across many areas of their life. In our clinical work we see the negative impact in terms of their relationship with their spouse or their partner.

In terms of patient reported needs, there have been a number of studies asking patients about what they actually want or need in terms of their treatment and their care. One large study in New South Wales found that over 50 per cent of men expressed some psychological support need. So, there was a need there that we were not meeting. Just under 50 per cent of men expressed some need in terms of sexuality, or support in terms of coping with that change in sexuality after treatment. That domain covered issues around coping with sexual dysfunction as well as accessing and obtaining medical support or intervention.

One clear issue that we hear time and time again from patients, particularly in the public health care system, is that the cost of the medication that doctors recommend for them to use in terms of rehabilitation after prostate cancer treatment is just far too expensive for them to afford. Their ability to cope is hampered by the fact that they cannot access the treatment that could be helping them.

Another issue that we routinely hear in our clinical work is that the patients reported need for a very practical issue in terms of disposal of their continence pads. The majority of men, particularly after surgery, will have to wear incontinence pads for some time. If you think about it, we know that women's toilets are well facilitated with disposal bins but men's are not. It is a very simple issue, but it is a very key issue in terms of how men adjust and cope with having to use pads.

In terms of anecdotal evidence from our contact with patients, the patients and their partners want to be better informed about the treatment side effects and their treatment options. They do want to be informed about research. They often ask us what research we are doing and we try to engage them as much as we can in terms of feeding back what research has been happening around Australia and the world. Patients and partners want more consistent information about associated risk. There seems to be a huge impact in terms of how they cope when deciding on a treatment option. Some sources will say a certain percentage of people will experience this symptom, whereas another source of information might actually contradict that and give a different rate of incidence. There seems to be this mismatch between what patients need to hear and what we are able to provide to them. Patients and partners, when seeking psychological support, have repeatedly told us that they wish they had accessed this support earlier on. Offering support in a more timely manner would be very useful.

I have made a number of recommendations in the document and I will not go through those now. I think the key issue for us is that we need to provide more psychological and emotional

support to men who have prostate cancer. Unfortunately, there is commonly a thought that this cancer is something that you live with and you do not die from, so therefore it does not have a big impact. In working with patients every day we see that it does take a big psychological toll on both the patient and their partner.

**CHAIR**—Thank you. Dr Siddons, did you have anything to add?

**Dr Siddons**—No. Dr Wootten has covered it very well.

**CHAIR**—I have a question that I will address to you, Dr Wootten, although Dr Siddons may have a view on this as well. Do you find in your private practice that men feel uncomfortable about going in and discussing issues such as prostate cancer, incontinence and so on with a female doctor?

**Dr Wootten**—I ask patients that myself. When I first started I felt that there would be a barrier in terms of speaking to a young female about these types of issues, but I do not find any difficulty at all. The barrier is actually coming in and making an appointment, but once they are seated and feeling comfortable they find that speaking with a female can be very easy and open. If you allow a space for people to talk then they will talk. The barrier is more about making an appointment and getting to that appointment.

**CHAIR**—I have a question that relates to your practice. Do you have long-term patients or are these people who say, ‘I need to see a doctor’, they call up and you are the portal? Is it easier for those who have a longstanding relationship with you to raise these issues, or do you think it is easier for someone to just walk in and say, ‘You don’t know me; this is my story’?

**Dr Wootten**—It is easier once they get to know me and build up a relationship of some sort. I will ask the questions of men. If I know that they have had prostate cancer I will certainly make it a point to ask about sexual functioning and how they are coping with that. Right from the start, from the very first session, we will start that conversation.

**CHAIR**—My questions were premised around men who suspected they had a problem and the initial diagnosis.

**Dr Wootten**—Prior to prostate cancer diagnosis?

**CHAIR**—Prior to any surgery or any treatment options.

**Dr Wootten**—It is rare for anyone to come and talk about those types of issues. Occasionally we will be referred a man who may have an elevated PSA and be wondering whether or not to have a biopsy or whether or not to investigate further. At that point the discussion would primarily be with their treating physician rather than a psychologist.

**CHAIR**—I know Senator Cash is itching to ask you some questions, but how does a man know that he has an elevated PSA if he has not done a test through his GP?

**Dr Wootten**—He would not know. After an elevated PSA that could be a point when they would access support from a psychologist, but it would be very rare. Do you mean perhaps in terms of the man having a family history of prostate cancer or a symptom?

**CHAIR**—No. I am interested in exploring men's psychological approach to not only seeking help from a doctor, then discussing things that are male related with a female doctor and whether there is an impediment to that. I will just explain this. We have heard evidence that medicine is becoming increasingly a female oriented profession and that there are more part-time female doctors out there. That is a thing that is growing. I am just wondering whether this is an issue that we are going to have to deal with perhaps through men just saying, 'All professionals are professionals irrespective of gender'?

**Dr Wootten**—I am not a medical doctor so I do not see people talking generally about things. I will be referred a patient for a specific reason. It is a bit of a myth that men prefer to talk to men. A lot of the anecdotal feedback that we get from our patients and from the doctors that we work with is that they actually feel more comfortable talking to women about certain issues, particularly things around masculinity. You can imagine that sometimes talking to a man about problems in getting an erection can be quite intimidating because there is a comparison there man to man. Whereas with a women sometimes that stigma can be reduced and there can be more comfort in speaking to a woman about problems that they might be experiencing.

**CHAIR**—Thank you.

**Dr Siddons**—With regard to men and their comfort in seeing a female psychologist, what I have found in my experience is that if I show them at the very start just through my questioning and the way that I relate to them that I am not embarrassed talking about these issues it tends to put them at ease as well. We will just treat them in a way that we would treat a female patient and ask specific/direct questions. It shows them that we are not embarrassed and therefore they feel more comfortable in talking about the issues as well. That has been my experience.

**Senator CASH**—Picking up from that point, you said that you make the patient feel comfortable.

**Dr Wootten**—I try.

**Senator CASH**—I can see from both of you that you could quite easily have those conversations with men just from the way that you present here today. One of the issues that was discussed before you arrived this morning was that gap; that a man might go to a doctor for one issue that is not the real issue, but there is that disconnect and those questions do not get asked. What do we need to do to facilitate that next step with our doctors where they will ask those questions without necessarily being prompted by the patient? They are questions that you have openly stated you are quite happy to ask.

**Dr Wootten**—It is around education. There has been a move in the newer graduates that are coming through that there is a much bigger focus on engaging patients, how to pick up subtle cues and know when to ask certain questions as part of their training. We need to push that a bit more and help general practitioners, in general, and specialist doctors to know how to ask

questions or know how to pick up on those subtle cues. The other side is the time issue. Our consultations are an hour at the minimum.

**Senator CASH**—They are not 15 minutes.

**Dr Wootten**—They are not 15 minutes. GPs are often very pushed for time and they just cannot ask the question. I have had a number of doctors say to me, ‘I would have loved to ask that question, but I thought that I would have opened up a can of worms and I would never get them out of the surgery.’ There is a real issue in terms of the time that doctors can spend speaking to their patients.

**Senator CASH**—There is something that I have been thinking about after listening to you. Is it worth having a set of very basic questions that each GP should ask a patient and, if I do not have time in that particular consultation I can at least say: ‘You’ve flagged an area of interest. Can you please make another consultation to see me?’

**Dr Wootten**—Yes. That is a really good idea. You would have to cover a whole lot of issues, but particularly for prostate cancer or prostate awareness it is going to be things around erectile dysfunction and mental health. There should certainly be a mental health scan for everyone, particularly for men, because men are less likely to report their own psychological distress.

**Dr Siddons**—If a standard set of questions were asked routinely, I think it would help to normalise the whole issue and perhaps over time men might feel more free to raise it themselves because it is actually okay to talk about it.

**Senator CASH**—I know we are short of time, but I would like to take you to page 5. You would have heard me raise this issue with the previous witness—the national information pack. You are obviously doing work on this. Can you to expand on that for us?

**Dr Wootten**—A year ago a nurse colleague and I at the Royal Melbourne Hospital decided that we were seeing too many patients coming into our clinics not knowing what their treatment options are. We work in a urology department, so we offer surgery and that is all we offer. Unfortunately, men were coming into the clinic and not being aware that they could have a whole plethora of other treatment options, including radiotherapy and cryoablation—a whole range of different things.

Dr Siddons and I also found in our work running support groups for men with prostate cancer that there was consistent feedback from men saying that they did not have enough support around the time of diagnosis, they did not know about the different support agencies, they did not know that there were different treatment options, they did not know that there were treatment options for sexual dysfunction or where to get pads—a whole range of different things that they just felt they were not being provided information about.

The information pack we put together, which the Prostate Cancer Foundation will probably speak to you about this afternoon, has a whole lot of information. The information is available. The Cancer Councils around Australia provide great information. It may not be as up to date as we would hope, but it is available. However, it is just not getting out to patients.

We have compiled a pack. I should have brought one in to show you. It is basically full of booklets. It has a DVD in it. It has a range of different products and actually has a pair of underpants in it. At the moment we are piloting it across Australia with 250 packs that have gone out, and we are collating the data at the moment. Basically, we are wondering whether we need to be providing this at the point of diagnosis when men and their partners can take it away, sit down and share it with each other.

You might be familiar with the National Breast Cancer Foundation's My Journey Kit. It is a breast cancer pack that gets distributed to everyone. They also give people a bra. We thought that was a good model to try to follow, and the feedback so far has been resoundingly positive. There seems to be a real need for information.

**CHAIR**—Everything always comes down to funding. What types of costs are you looking at? Have you done any analysis of that?

**Dr Wootten**—We have not looked at the cost as yet. Perhaps the Prostate Cancer Foundation might be able to speak to that in a bit more detail. Yes, it will come down to the funding and whether we can secure funding to be able to distribute it. Hopefully, at least 18,000 packs will be distributed each year, so there is the potential there for it to cost a fair amount.

**Senator CASH**—You would obviously see it as something that has a benefit that would outweigh any cost involved?

**Dr Wootten**—A huge benefit. Accessing information that is credible and evidence based is very difficult for patients. Accessing information on the internet is great, but many patients will stray off into territory that is not evidence based and is not actually good information for them to be looking at. If we can direct them to where to look and provide them with a good Australian information base, that is the ground that they can start on. It also talks a lot about the follow-on issues around how to prepare or cope with sexual dysfunction, incontinence and what different support agencies are available for them.

**Senator CASH**—Do you work in conjunction with anything like beyondblue?

**Dr Wootten**—We do. At the moment we are hoping that beyondblue will be involved with the pack. There will be some products from beyondblue. They are working on a booklet and a handout in terms of anxiety and depression with respect to prostate cancer.

**CHAIR**—You referred to Australian-made information.

**Dr Wootten**—Yes.

**CHAIR**—Is there a comparable international model that you are working off or are we at the forefront of doing this?

**Dr Wootten**—No. There does not seem to be an information kit for men. A lot of people will go on to American based websites. There are groups like Us TOO, which is a big support agency, basically, similar to the Prostate Cancer Foundation but American based.

**Senator CASH**—Does that have the potential to compromise care here if I am offered a product on the American based system that I am not offered here and I head off in the wrong direction thinking that all my problems are solved and the bad news is that they are not?

**Dr Wootten**—Yes. That is the real problem, because there are different treatment approaches across countries. It is really important for patients to know what is accessible in their own country.

**CHAIR**—That raises an interesting question from a psychological perspective as much as a physical treatment perspective. You said there are different approaches available. It would be awful for someone to say, ‘Why can I get this in America when it is not being done in Australia?’ or vice-versa. Have you had to deal with that?

**Dr Wootten**—Yes. Not very often, but every now and again I will speak to a patient who has decided to travel overseas for a newfangled treatment option.

**CHAIR**—Do you mean alternative therapies?

**Dr Wootten**—No, not alternative. One example that jumps into my mind is a radiotherapy approach that we do not offer here as yet. Apparently there is good evidence that it works very well, but it has not arrived here. I am definitely not an expert in treatment options, but I have had that conversation with a patient about whether or not to take that option. It would be very rare. I think our hospitals would pride themselves in saying that we offer the best and most up-to-date treatment options.

**CHAIR**—I say this for the benefit of people listening, and it might be something that we will explore a bit later on in the afternoon. Senator Lundy, do you have any questions or are you happy for Senator Cash to continue?

**Senator LUNDY**—Please keep going.

**Senator CASH**—You can jump in at any stage. I would like to change the focus slightly, again to page 2 of your submission, to the development of the database. Are you able to expand further on that for us?

**Dr Wootten**—I can try. Professor Costello was not able to attend today and this is his idea. We do not capture much information. We have a data registry at the Cancer Council of Victoria, and I assume that they are across Australia, where certain details of patient diagnosis, morbidities or mortalities are captured. We do not actually store long-term outcome data. We do not look at PSA changes and biopsy results and then follow patients throughout their recovery period. This idea comes out of a need, in an epidemiological approach, to match the patterns of care and the outcomes of that care so we really know what happens to our patients and how to give the right information to patients about what the outcomes actually are. At the moment it happens, but I do not think that it is a very coordinated approach. There is no centralised body that captures that information. I am sure you will hear that again and again.

**Senator CASH**—We heard that this morning. From your perspective, in terms of raising awareness amongst men of prostate cancer and getting them to take that next step of going to

visit their doctor, are there any innovative and effective projects that you believe have been successful in actually doing that that we should be referring to?

**Dr Wootten**—There has not been a lot of public campaigning around this issue. The Prostate Cancer Foundation has run a couple of quite well received programs. The Be a Man campaign was one that they reportedly found quite successful. The difficulty is finding a way to assess those campaigns and following through with capturing some data about whether there are changes in terms of attitudes or in terms of presentation to doctors. I am not aware of any research that has looked at the quantitative impact or the data that shows that those campaigns have been successful. I do not know of any other examples that are good.

**Dr Siddons**—I do not, either. Awareness raising seems to be helped by celebrities.

**Senator CASH**—Yes, that works.

**Dr Siddons**—That is what seems to happen. If someone who is very well known is diagnosed with prostate cancer and has the courage to talk about it, then we will hear, certainly in our work, that men will be talking about that and how great it is that they came out and told everyone.

**CHAIR**—I would like to pick up on that point about celebrities. I go back to the women's movement and specifically breast cancer. Lots of women are prepared to identify themselves as having suffered from breast cancer; they are survivors and they are proud of it. They have marches and all that sort of stuff. Is there hesitancy amongst men? You do not have to be famous, but if you have been through prostate cancer and received treatment for it, how many people are happy to be identified and be a champion of that cause? I can see a real psychological impediment, because the first thing you think of is whether they can still have sex. That is the first thing that other men think of when one of their mates tells them that they have had prostate cancer.

**Dr Siddons**—That is one of the challenges. Men do find it more difficult to talk about it, because as Dr Wootten said in her opening statement for many of them it strikes their core sense of masculine identity and who they are. It is a difficult thing for them to talk about in a public way. Having said that, though, what we find, even on a very small scale, when men get together with other men is that it is a huge relief for them to be able to talk about it. They find it very beneficial. We will often find that men who are diagnosed with prostate cancer will tell all of their friends who have not had a PSA test to go and have the test.

**CHAIR**—That supports some of the other evidence that we have that small group sessions or things like Men's Sheds that we heard from last night, and Dads in Distress—whatever they are dealing with in those small group sessions—are very effective for men in discussing issues that they otherwise would not discuss or would not like to talk about even with just a single individual.

**Dr Wootten**—There are men that are willing to put their hands up and champion the cause. The Prostate Cancer Foundation has a large number of volunteers it accesses and uses for their community events. If you can provide a forum for men or a little bit of encouragement they are willing to take part and to speak out. It is perhaps a difference in terms of gender in that women

are often more proactive with starting that ball rolling, and men sometimes need a little bit of encouragement to talk about these types of personal things.

**CHAIR**—The discussion of sexuality, function and all of these things makes men squirm. You can sense it. Being a man, I have some experience of that. That is a huge barrier to overcome in the public arena.

**Dr Wootten**—It is. We need to find a balance between talking about the facts of prostate cancer—it is an important disease to take note of; it is not an old man’s disease and it is a disease that can potentially be life threatening—and weighed against that, hopefully, the open discussion of coping with sexual dysfunction. There are many men who return to good sexual function. We need to be able to educate people in a very realistic way to show them that, yes, there are potential difficulties surrounding prostate cancer, but there are also ways they can move through that, and there is help available in terms of recovering from that.

**CHAIR**—I have a couple of related questions. How important is it for the partner of a man to be engaged in the diagnosis of these issues or referring their partner to see a doctor, particularly after the fact about how they are going to cope psychologically?

**Dr Wootten**—It is very important.

**CHAIR**—Should the marketing be directed to the partners of men?

**Dr Wootten**—Not necessarily. One thing that we have to think about is how to empower men to take responsibility for themselves and to look after themselves in all ranges of men’s health, particularly issues around relationship breakdown and those types of things. Men have to find a way to access support. Women can be vital in terms of encouraging their partners to attend a doctor’s appointment, to get a check-up, to follow through on some test results or to access psychological support. It probably should not be a focus on either/or; it needs to be on both. We need really to encourage families, perhaps, to talk about the issues around prostate cancer. We know that it does affect the whole family, and it affects men from 40 to 90. It is not an old man’s disease. We need to provide some realistic evidence and information to people.

**CHAIR**—This question might be outside of your scope of expertise. You talked about prostate cancer between the ages of 40 and, say, 60, but do you think that we need to spend/invest more time and perhaps resources on very young males, 15, 16 or 17, highlighting that there are specific health issues that men will face through their lives and that they should be aware of this? Would that be an effective approach in your opinion?

**Dr Wootten**—Any education is good education. Particularly talking about broad issues around men’s health for younger men is a very good idea. I do not think that prostate cancer needs to be drilled home to them in adolescence. Perhaps when they get to their thirties, forties or fifties that is the time we need to educate and start people talking about issues around prostate cancer. Any education or any encouragement for men to talk about and take responsibility for their health is really important.

**CHAIR**—It is more of an encouragement, that they should get a check-up every year and the doctor will know about these issues that you should be talking about?

**Dr Wootten**—What to talk about and to feel comfortable in asking those questions.

**Dr Siddons**—Ways of behaving/coping develop from childhood and adolescence and then become engrained. If we can try to introduce the idea that it is really okay to talk about problems, to ask for help at a young age, then hopefully that pattern can be established throughout adulthood.

**Senator CASH**—The comparison perhaps is breast cancer. That is the example that keeps coming up in terms of similar women's issues. Do we need to not elevate as such but put in the level of effort with prostate cancer that we have over a long period put into breast cancer. Around the table breast cancer is talked about? Is that something you would like to see going forward?

**Dr Wootten**—Definitely. There are huge differences. The inclusion of the breast cancer liaison nurses has been amazing for breast cancer patients and their families. They would not have the good outcomes they have without the care that those nurses provide. Similarly, prostate cancer patients really do need ongoing care. They need a contact person they can come back to and say, 'I'm not coping with this. How do I get help for this?' We really need to invest much more effort, money and time in supporting men with prostate cancer. Similarly, we need to raise awareness. Breast cancer is huge out there. It is everywhere. We see it on bottles of water and everything. Unfortunately, prostate cancer has a stigma around it, and it is our job as health professionals but also as government to provide a way for people to start talking about this issue in a way that reduces that stigma.

**CHAIR**—Thank you very much for your submission and for coming in and providing evidence today. It is very much appreciated.

[12.06 pm]

**CELI, Dr Elizabeth, Private capacity**

**CHAIR**—Thank you for joining us today, for making your submission, which is No. 68, and for your book, which has been tabled.

**Dr Celi**—It may be something we will be able to refer to today.

**CHAIR**—Do you have any amendments or alterations to your contribution?

**Dr Celi**—No amendments to the submission.

**CHAIR**—Would you like to make a brief opening statement?

**Dr Celi**—I appear in a privacy capacity as a psychologist, professional speaker and author, and with my psychology work specialising more so in men's mental health and the psychological aspects, both clinically and non-clinically, in terms of manhood and masculinity.

I will give you a brief background on myself to let you know how I am positioned in all of that. I am a privately practising psychologist, both in the city of Melbourne and in the regional area of the Mornington Peninsula, which is also where I reside. I have done that for the last six years after working at a private psychiatric clinic for six years for people hospitalised with chronic depression, anxiety and psychosis. During that time I also completed my PhD, which is looking quite holistically, as is the theme with most of my work, at genetic and personality vulnerabilities in people experiencing major depression. It was during that time when I worked at the clinic.

During that time a lot of the basic strategies and education for chronic patients had not quite reached them, to have them end up in hospital, so I then went into private practice, started training in organisations and professional speaking to raise some of that awareness, primarily in mental health awareness and mental health first aid, to reduce some the fear and particularly some of the stigma surrounding mental health programs.

During that time, I also qualified as a personal fitness trainer and for about 4½ years brought my health psychology principles into the gym training context. It was from there that some of my men's health work started to develop and I noticed some of the men's mental health issues, particularly how they used exercise as a means of stress management and perhaps sometimes turning exercise into an unsafe outlet for that. As much as it has positive benefits, if you have clinical issues motivating it, it can become unsafe.

During that time, and in parallel with my clinical work, I noticed certain patterns, which resulted in the publication of the book in 2007 that has been tabled, and the promotion of that last year. The book's construction and the flow within the table of contents is reflective of the statement that I put in the submission of men's health being wrapped up in men's identity. I have written that quite non-technically. It is there as an education tool for men primarily to help

increase their emotional and mental health literacy and assertive communication with some of the issues that I have spoken about in the submission.

I interviewed six men aged between 43 and 67 years of age to provide words from men for men in acknowledging how men learn and providing them with as non-judgemental and as supportive approach as possible to increase their learning in the privacy of their own home, which is a huge area for men. Privacy and anonymity works really well for men initially in receiving non-judgemental information that is vital for them to take the next steps.

An important factor that I also include in the book is the breakdown of men's psychology in terms of Regular Joe, Mr Invincible and the True Man. Whilst they are quite conversational facets of men's psychology, I did that deliberately in order to help society, in particular with the social awareness and education campaign, to ensure that we are not demeaning men as a whole in terms of some of the social psychology things that I have noticed, but a certain aspect, which is the part that does not get them to the doctor or the part that will not let them do certain things. That is the Mr Invincible, the false ego and façade, which is also part of the blokey mode. We cannot knock it because it is an important part of masculinity, but he overrides Regular Joe or, as I put it across in my presentations, there is a great power play between Mr Invincible and Regular Joe and he tends to grapple him to the ground. There is a lot there in the construction of the book that I am happy to go through with any questions if it is appropriate. My capacity today is speaking about some positive health promotion strategies for men's mental health and how we can assist that moving over to the medical side, which is not my area of expertise, but primarily psychological health.

**CHAIR**—I have a number of questions, as do my colleagues. I have to say that your submission and some of your work, which I have read before, is provocative in a way. It challenges a great many beliefs, which I think would be intimidating particularly to some of the champions of women's rights. There is a risk, quite frankly, in that sort of discussion that there is a battle between men and women. How do you respond to those sorts of accusations?

**Dr Celi**—Unfortunately, it is a risk and, yes, I get plenty of accusations like that. An important message to get across is that this is not an us-versus-them approach. In terms of female psychology, the instant personalisation or perhaps reactivity to that, based on some anxieties or fears perhaps of the past, naturally bring out some of that response. My approach to that is very much that it is not about demeaning women and it is not about saying it is any less important, but it cannot be at the cost of men's health. It cannot be at the cost of men's dignity, and unfortunately it seems to have worked in that capacity. I very much look at balancing that out and educating women along the way. It is not a blame game, and it is not about making them the baddies at all. It is simply highlighting some of the inherent social bias that seems to have developed for many reasons.

**CHAIR**—Is it reasonable for me to characterise it in saying that men's health and men's egos are inter-related? If these sorts of things are undermining men's sense of masculinity or their sense of personal wellness, that relates around ego, does it not?

**Dr Celi**—Yes. Men's ego is an important part. We all have ego, so it is the fact that ego might be used against men as a negative in writing off their whole nature. Again, if I use the breakdown of Regular Joe and Mr Invincible, you have got that ego of the Mr Invincible—yes,

we need to acknowledge that—but it is not all of him. It is just ensuring that it is not used against men. It is one component and it is balancing it out.

Similarly, with some of the discussion this morning of men's sexuality and how important that is to their identity, whilst it can be an open door and a portal to their reaching other medical avenues, it is important that we do not make it the only one, because there are so many other facets. In the first half of the table of contents you will see that I break down those various identities so that men start to become aware that it is not just your ego, not just your sexuality; there are other roles you also play that make you a valuable and important person. As we educate men and women in that we start to balance out some of the social paradigm that I have spoken about in the submission.

**CHAIR**—We did have some evidence yesterday, and I am not sure if you heard it. The evidence was that men's role has been diminished and there was a need to reinstate the benefits of fatherhood and an office of man and the family. You have made a similar recommendation in your report. Could you expand upon what you think are the pressures that men find themselves under in the sense of their identity outside of purely masculinity, the conflicting messages, and how an office on the status of men—for want of a better word—would help redress that?

**Dr Celi**—One of the important things that we need to acknowledge is the huge gender role identity redevelopment that has been happening in the last few decades. Gender roles used to be very clearly defined. There were clear boundaries, which then assisted men in their contribution to the family, for example, as a provider and as a working man. With the feminist movement, with all of its benefits, it changed some of those roles, so there is overlap in some of those roles, which has left men at a bit of a loss and uncertain as to what to do, particularly men 40-plus, which is the age group I tend to work with most. Being able to acknowledge that is important.

Another component to realise is within the legal system. Unfortunately, from a lot of my clinical experience, men seem to be at a disadvantage in terms of how they either express themselves within the legal system or how they are supported within the legal system if there is marital breakdown and access to their children, how that may work against them, and from how I have helped many of my clients through that time. What was your other question?

**CHAIR**—It was in relation to an office of men.

**Dr Celi**—In putting down that suggestion in the submission it is about really legitimising and officially acknowledging in a centralised manner the importance of men. We have an Office of Women's Health. There were women's health advisers appointed, all for good reasons, when the National Women's Health Policy was first developed, but we are now 20 years down the track and the position that women were in back then seems to be the position that men are in at the moment. That is particularly so in terms of intimate partner violence or abuse, which is an unspoken or a silent phenomenon at the moment.

It is about socially on quite a broad level indicating that we are creating a supportive environment for men to come out and speak about the issues they are feeling inside or that their Regular Joe is experiencing inside. I have no doubt in my mind, from my clinical work and speaking work, that the Regular Joe in men wants to come out and speak. They want to go to the doctor, but they also know when they do they are likely to either be slammed, insulted or

demeaned somehow, and in the most subtle of ways sometimes; they are not necessarily supported all the time or challenged supportively. Creating an office for the status of men and masculinity or fathers, as it may turn out, would be an acknowledgement for men to observe that from a distance and start generating some comfort in being able to come out with some of the issues.

I have a very firm belief—again from a lot of my clinical work in the last few years—that men want the help and are more than happy to accept that help and learn. They absorb the information amazingly and learn it brilliantly with the skills training that I, as a psychologist, and other psychologists may deliver. They are more than happy to do that, but we create a supportive environment and a therapeutic alliance to do that. On a community and national level we need to think about doing that because of the broader issues of men's health, which I am sure you have heard a lot about.

**CHAIR**—We have heard lots of ideas on how to get men to engage in dealing with the health issues, but all the effective ones that we seem to hear about are targeted to help men's health without men really knowing it. For example, Dads in Distress is a group where men can get together and talk about an issue that they have in common, which is basically about parenting and loss of access to their children. Men's Sheds movements are getting men engaged in activity where, as a consequence of that, they actually talk to each other and it provides some psychological help, whereas if we advertise it as a men's health evening then men are not that interested in coming along to it. Have you had any experience in providing community sessions to engage men in issues such as this, and is there a psychological approach that perhaps is not being undertaken that should be undertaken?

**Dr Celi**—What I have also tabled is a copy of the two research papers that I referred to in the submission and a hard copy of the flyer for the forum that I initiated and directed the organisation of in November last year. This would be an example of a positive health promotion strategy that I applied, which I would be happy to walk you through. If there is an extra copy could I grab one? I am not sure about the accuracy of your comment earlier in terms of programs where men do not know it is targeting their health. Men are still coming together for a purpose. An important factor that we need to consider in men's identity is the value of mentoring and role modelling amongst men. That is how they learn and that is how they support each other. There is a double bind in that they want that and they appreciate that, but they may not necessarily ask for it. When things are organised in that respect they will tend to accumulate in there and get all the benefits that go with it.

The forum that I am referring to is through a Rotary grant. I am a Rotary member. The strategy that I approached with that was very much about revaluing manhood, as opposed to directing anything towards sickness or health. We have to be very careful; men's health is not always about sickness. Men's health is also about manhood and masculinity.

If you look on the national women's health side, it is the same thing, only the inherent appreciation of femininity is there and did not need to be talked about. It was just there in the process, whereas we need to articulate that for men. You will notice on the flyer that there is no mention of health, other than Men's Health Forum, but I put there 'with a difference', and I will mention why. There is no mention of mental health. The only mention of any mental health is depression under my dot points of topics, and more so the important part there is local

psychologists. I waited to do this forum until I had established a presence in the community to acknowledge the community psychology of living in a regional area.

The other components there are those questions that highlight the various roles of men that show them: 'You have a value in society. People need you.' Men being able to be reminded of that in a non-threatening, non-judgemental manner makes them think: 'I do have more of a role to play here. I did not realise that.' And if they did, 'Someone is actually approaching it.' Obviously having a profile figure like Max Walker helped with that one in attending to the older generation of men and putting down under his points, which Max naturally and easily talks about, in terms of the vulnerability of men; it is okay to be vulnerable.

One of the key messages through my book is having the courage to be vulnerable and the strength to defend it. The strength to defend it is the part where the Regular Joe knows that he is not likely to get too much support in his personal context or even with the blokes that might give a bit of a dig, but are quietly going, 'Good on you.' That was one component to tend to the older generation.

The second speaker on there tended to the middle generation, and particularly his topic of covering rites of passage, which is a huge issue for developing boys and adolescents into manhood. It is very important to recognise for young boys and young men the value of older men and the quiet mentoring that happens, the passive observation that inevitably happens from young boys and young men to older men. Putting that as a dot point initiated a lot of discussion at the forum that night, both in Andrew's presentation and afterwards, when the three of us were swarmed by the men in the audience to ask questions and introduce themselves.

Myself being there as a female created a bit of a difference, but also local psychologist and psychologists, to be able to attend some of the clinical side without making a big deal about it. That was very much spoken in men's language, the way men would understand it, such as the book being geared in that manner. All of those factors and dot points, and giving them thinking points, also helped women. It helped men feel comfortable to call and register. I was the person they registered with, so I had some great conversations in terms of, 'I'm really looking forward to this.' It actually helped men get together as a group. Some of them normally might have gotten together that night, but decided they would go to the forum instead, or the women that called bringing together their male friends, taking them out for dinner beforehand and then bringing them there.

The social psychology and social awareness is happening on multiple levels. I believe with all of those factors, particularly the non-judgemental and 'you're not just sick', but more than health in terms of physical health, was important. I had men coming up to me afterwards introducing themselves. They had come with their sons. It was a great outcome of having men of all generations there openly telling me that they had experienced depression or that they had gone to counselling and subsequent emails letting me know what they got out of it. There were two waiting for me by the time I got home that night saying, 'Thank you for raising my awareness on these issues.'

They are not necessarily going to tell you straightaway, but provide the environment and they will gravitate there. It may not be the first time, but the second time as they see this is for real and they are going to get some support and positive support as well as educational information.

**CHAIR**—How long did this forum run for?

**Dr Celi**—Two and a half hours.

**CHAIR**—How many people attended?

**Dr Celi**—Three hundred and four in total. It was booked out. The day before I had to unfortunately put people on a reserve list.

**Senator LUNDY**—We have heard a lot in this inquiry about how reticent men are in talking about their specific health issues, but the story you are telling is that if you provide the right environment, like this forum, then it is certainly there. The key is providing the right kind of forum and getting men to come along, even in a group. This is counter to what we have heard to date, that men just do not talk about this stuff in front of anybody else, so it becomes this personal one-on-one and whether you are comfortable in that situation. Is this how it has always been? You have been looking at this for a long time and public speaking about it. Can you tell us more about the general reaction you get and that sense of enthusiastic participation from men, their sons and their fathers in hearing this kind of stuff and that it is okay?

**Dr Celi**—Even using the word ‘reticence’ already provides a judgement and blame towards men. The minute men hear that they will just go: ‘Fine. See you later. Fair enough.’ If I were called reticent I would probably do the same.

**Senator LUNDY**—We have heard a lot of that through the course of this inquiry.

**Dr Celi**—There is a misunderstanding and perhaps a lack of awareness of what is happening inside. Obviously, because it is intangible, even men cannot articulate it. Being able to acknowledge that there is a lot happening in their own motivations, in terms of Mr Invincible, Regular Joe and the aim for the true man, which is their own true self, their own inner leader which happens over time and in those chapters is referred to through mentoring and basically letting men be men to live their life and develop. They appreciate that and it is a relief. The response I have tended to get from men in particular when I have done certain presentations has been, firstly, surprise, secondly, relief and some comments have been, ‘I really learnt a lot from that.’ It was in their language. It was in their learning mode. It was not all verbal. There was a lot of humour around it. There was the quote: ‘I never thought I would hear a woman actually speaking that way about men.’

That really highlights a lot of what I see in terms of how quickly women can demean men, unfortunately, whether they notice it or not. It can be quite frivolous comments. ‘You think you’re a man’ or, ‘You know what men are like’ or ‘Men just don’t listen.’ Men take this on board and they notice it. I have also had women approach me saying, ‘I didn’t realise that and thank you for alerting me to that.’ I truly do believe in creating a supportive environment for men. They will not trust you straightaway. They will not give you that trust straightaway, which is fair enough. They need to really see over time that they mean it, that it is genuine, and then they will slowly step out. Regular Joe will give it a go and dip the toe in the water to see what the response is, because they are so used to the negative response. If we can re-create that on a societal level and a national level, I believe it will be extremely powerful and men will respond

because they are used to the opposite at the moment, particularly in terms of abuse and how you would see this.

**Senator LUNDY**—Let us develop that theme a little further. The federal government is in the process of hosting consultations for developing a men's health policy and this committee was established looking specifically at the range of issues associated with men's health. To me, that is a political affirmation of the need for concern about men's health. Is that kind of political affirmation of men's status, in the context of their health, going to help?

**Dr Celi**—Yes and no.

**Senator LUNDY**—Tell me what you think.

**Dr Celi**—Yes. It is a great start and acknowledgement. I have some concerns as to the comprehensiveness and the objectivity of the process so far in terms of doing that. If I may refer to an example in the actual National Men's Health Policy information paper put out by the Department of Health and Ageing, already within that there is a section that is looking to dispel masculinity, questioning where the evidence is and how we can explicitly show masculinity. I find that quite intriguing. If we were looking at women's health we would not ask the question about femininity and whether that is involved with their health. It is inherent in being a female; you are naturally going to have some sort of femininity and a balance of feminine and masculine. And yet the question comes up, not in a strength based 'let us acknowledge it, recognise it and work with it by being informed by it', but 'let us try to dispel it all for the evidence'. I find that intriguing in a document toward the development of the national men's health policy. There are mixed messages.

I made a comment toward the concept of gender equity in that it was a bit of a flawed concept. There are going to be natural differences between men and women and to try to go for equal distribution or equal and fair is again trying to equalise something that should not be equalised, because we all have natural differences, strengths and weaknesses, and that is how we complement each other in our skills. For example, women have the contextual information based, nurturing, 'emotional'—I put that in quotation marks because men also have that; they bring that context. Men get to the point. They will look at it, but they do not get bogged down by it perhaps like women will. Vice-versa, men might get to the point without looking at the context, and so we complement each other in that process. If we are going to insult masculinity and those strengths that they bring, we are not doing ourselves any favours. As I have reviewed that information paper there is some of that inherent underneath. A part of me recognises there may be women writing that—I do not know that for sure—perhaps out of lack of awareness or understanding. They are two things that spring to mind in terms of the yes and no answer.

**Senator LUNDY**—I am curious to explore this. The issue of the pejorative of language pervades the world of, as you say, men and women alike. Both genders experience that on a daily basis. What you are saying is that what is changing for men is introducing the language of this and identifying what constitutes pejorative language and demeaning treatment of men inadvertently, bringing that back into the public arena and having a discussion about it.

**Dr Celi**—I think so. We need to counterbalance a lot of the damage that has been done. We do need to bring it into the public domain a little bit more and be very mindful of the language that

is used, but most importantly be genuine about it. An important component that is undermined in men is their level of intuition that they do not even realise that they can connect with. If you are saying one thing, but underneath there is another meaning and it is not quite genuine they will detect it, but it will create an inner conflict that they are not quite sure what to respond to. If we are not careful in building their trust quite genuinely, they may or may not come to the party.

I would be very mindful in any coordinated efforts, particularly because I am thinking of a very broad national kind of marketing-type campaign that revalues manhood and revalues masculinity. By that you will no doubt get rollout benefits into men's health and all the other behavioural manifestations that you will find. They will naturally want to value that because they will see that they mean something to their partners. They mean more to their kids. They need to be there for their kids. A lot of my clients will be very much motivated by that.

You can look at the WorkSafe ads, for example. They are for WorkSafe, but they inadvertently, or perhaps in the background marketing campaign, really value that men are valued. They would be sorely missed. There are multiple layers that you can work with on that.

**CHAIR**—Are the WorkSafe ads that you are referring to specifically Victorian?

**Senator CASH**—I have seen Western Australian WorkSafe ads.

**Dr Celi**—I apologise.

**Senator LUNDY**—Different state bodies have presented ads in different ways. The state based occupational health and safety entities, in most states, have produced something.

**Dr Celi**—Perhaps if I could provide you with another example on the other side of the table, there is the Victorian Family Violence campaign, the ENOUGH campaign. I am not sure how much it has gone out to others, but I know it is Victorian. If you step into the shoes of a man who has been abused by his partner, verbally or physically—and as I mentioned in the submission it can often happen more emotionally, which is difficult to detect, difficult to defend and just leaves men confused—with the ENOUGH campaign, which does great work for family violence, if he is sitting at a bus stop he is going to see a huge poster on the side of that bus stop that has got visual images of women or children in distress. He is going to be wondering, 'But she does that to me. She slaps me. She throws the hot water on me. She tells me off for doing things I didn't mean. She takes my keys off me. She takes my credit card off me' or whatever it might be. He is going through all of those psychological issues that go with abuse or demeaning. Then he looks down that poster and he sees Women's Domestic Violence Crisis Line. Then he sees Kids Help Line and that is it. 'Where do I go?' is a key question.

If you go to the website, which for men is a source of privacy and anonymity to get information, they will see the same thing. Where to get help, Women's Domestic Violence Crisis Line, Kids Help Line, Men Wanting to Attend to their Violent Behaviour and Anger Management. That is what is on there right now and there is not even a number for them to contact. When you click into the real stories it is all women giving their stories. As a male victim he is being revictimised on a campaign that is attending to family violence. Some language has been changed to not say women and children as it has been in the past, but it is not acknowledging men either. You are changing the language, but you are still visually, and in other

means, creating this invisible wall such that he does not know where to go for help, which then unfortunately perpetuates the cycle. To assume that men, in that context, only need anger management is a very quick brushstroke consequence that has come out of domestic violence in helping women—absolutely necessary—but where women were 20 to 30 years ago with that topic men are at now and they are not likely to speak up. The Mr Invincible certainly will not and the Regular Joe is too scared to. Their True Man has kind of learnt perhaps, ‘I should just be quiet or find other means’, but they are likely to keep it under wraps, unfortunately, unless they come and see a psychologist by some means because their quality of life has become so difficult to handle and they have had some insight to go and get some help.

Not all men have anger management issues. They have frustration tolerance skill sets that they need to develop, as any of us do. They have stress management needs, as any of us do. Unfortunately, when they show natural masculine anger/aggression, which is not always negative, they are either called chauvinistic, aggressive or it is used against them, which then again puts them back in a position of, ‘I’d better not speak up.’ With many clients that I will be asked to assess or review, and at times have been asked to write reports for their court situations or access to the children, it has been about dispelling the automatic assumption that they need anger management. In actual fact, it is about speaking with their Department of Human Services manager saying, ‘You might want to have a look at the partner, because by what he is telling me, she may need anger management training.’ That is quite objectively said. That is not to insult women at all. It is purely and simply to indicate that there are also women that have affect regulation difficulties and need to learn productive coping skills as well. Even if it as simple as a slap—I say ‘simple’ loosely—scratching, biting and throwing objects, these all constitute abuse. You have to be mindful that is where men are starting from.

Australian Bureau of Statistics numbers are showing you that with physical assaults and physical threats 77 per cent of men report these are in the home, compared with 64 per cent of women reporting it is in the home, and yet it is not out there. Whenever you see the reporting of information it is about the impact on women. That is fine, but let us not do so at the expense of men not even getting a mention. I think that needs to be more proactively managed.

**Senator LUNDY**—I wanted to take you back to the observations that you made about your role as a physical trainer and men using physical exercise as an outlet in an unsafe way if they were experiencing psychological problems. Any more insight into that would be useful, but also what role sport and intense physical activity can play in underpinning the psychological health of men?

**Dr Celi**—My gym work as a personal trainer for a couple of years was in a general community gym and for the other 2½ years was operating a franchise at more of a corporate gym, which is where I saw a lot of the stress management happening, and a lot of the unofficial informal health banter that would happen on the gym floor with the men that I interacted with. As you would know, exercise is fantastic in helping mental health. It has a lot of positive health benefits to it. When depression, anxiety or stress are a part of the picture the natural physical movement that men do, appreciate and is part of their masculinity will result in upping the plates on the barbell, overworking certain muscles and imbalanced workouts. They will pulverised their joints so that they can get as much of the stress out as possible and manage, perhaps, some of the internal aggression that they are experiencing because they either have not learnt other means to express the normal frustration and stress they may be experiencing for all of the

identity roles that I break down in the book. But also if they do have the ability to express it, when they do they are not supported or they are chastised for it. That is one avenue that they will look to because it is amenable. It is easy. No-one tells you off for going to the gym. In fact, you are encouraged, whether it is gym or exercise in general. That is one area to look at in terms of excessive exercise in that respect.

In terms of the positive health benefits of sport overall, you have the same things that Senator Bernardi mentioned before. They are around other men or they are around other people that are there for a common purpose. They are naturally supporting each other. They work as a team. They help each other out. There are informal chats that go on. Often there are easier chats going on side by side or without eye contact that are very profound conversations that help men go off and think about stuff. One thing I have noticed is that we cannot push them or force them by saying, 'Talk to me. Tell me what you're thinking.' That is it; you've got a block. You have developed a whole, 'I could have told you if you didn't ask me, but I've got a mental blank now' kind of factor.

That observational learning and the 'no pressure' type of learning, particularly no blame, no judgement, naturally comes out of a sporting environment. The competitive nature helps the men's natural competitive nature as well, whether it is on the sports field, in the boardroom or in any other type of business or work environment. It is all of those positive health promotion benefits that come from that.

**Senator LUNDY**—Does that make sport or physical activity environments particularly conducive for health promotion messages? Having seen the health promotion sponsorship operate really effectively in the past, do you have an insight into how men respond to health promotion messages and attempts to change attitudes and behaviour in those environments?

**Dr Celi**—It is one avenue that you can utilise because it is an interest and motivation for men, for all the reasons I just mentioned before. I would see it as one of many. If you look at the forum I just described, it had nothing to do with sport other than Max Walker. It was about pure male health stuff and they still responded. Yes, there is a place for it.

**Senator LUNDY**—The sporting figure was still used in Max Walker. Is that built on the fact of his being a celebrity and an association with sport? Was there more of an identification thing?

**Dr Celi**—More of an identification; it is an interest of men. You have to look at what the interests of men are. Any time I do my keynote presentations or training I am very much looking at it from the perspective of men and what they will be interested in? It is not going to be what I am interested in. I will not try to convince them to learn that way either. Step into their shoes and have a look at what interests them. It is not always sport. That is one avenue. Their kids are huge. They connect with that and they will walk heaven and earth to be able to maintain health for that. Their work environment and being able to show them success indicators there and how it connects in that avenue as well is an important factor to consider. We have to be very careful not to pigeonhole men too much, but expand their interests, because they do have those interests. It is providing the environment for them to connect with it in that manner. I am not sure that is answering your question.

**Senator LUNDY**—It was not a very good question, but thank you for trying to answer it.

**Senator CASH**—One of the comments you made was in relation to websites providing information but also anonymity for men in doing so. Is there merit in investing more funding in developing websites specifically for men, which would have to be Australian government websites, where you have appropriate information so that men can go to these websites and access basic information?

**Dr Celi**—I would see merit in an educational context where they can obtain that information privately and anonymously. Yes, most definitely, assuring that it is quality information.

**Senator CASH**—Absolutely.

**Dr Celi**—It could give them avenues for where to next. That would have good merit. I would not limit it there. The sort of education they need is also about taking action beyond that. An analogy I will use for you is people using self-help books. They are great to teach you something, but a book cannot challenge you. A psychology can. A doctor can. There are still things that they need to liaise with people about. Informing them and destigmatising those services is very important so that men learn that it is not about going to the head shrink, the head doctor or something that means they are weak or vulnerable. It is highlighting the strengths of these various health professionals that you can approach. That could include GPs, psychologist, psychiatrists, naturopaths, physios—you name it—so they have a broad range and the mental health professionals are simply one of them.

I often become a project manager for my clients because of the holistic nature in how I work and how psychologists generally would work, in ensuring, ‘This is something for the GP and these are some of the questions you might need to consider asking, even if they do not ask you’, which hopefully they would. Or, ‘These are the things that you need to look out for. Have you thought about this?’ You are constantly looking at the situation for that person and project managing the holistic health team around them. You are pretty much normalising it for them so they can see, ‘I’m not going to be called weak or vulnerable as a result of this.’

The calls to action would be important on the website that give them very clear cut steps, and ensuring success in each of those steps, in the sense of education of, ‘Ask these questions and you will get more out of your half an hour. You do not need to be there for an hour. If you want to maximise your time this is how you can do it.’ The anonymity is important in the initial information seeking stage.

**Senator CASH**—One of the issues that were raised in Canberra was in relation to the definition of men’s health. To date we have perhaps not used the appropriate definition and that it should not be limited to the absence of disease. You have consistently referred to a holistic approach to men’s health, and I see that is outlined in your introduction to your submission. What would you put forward as an appropriate definition of men’s health?

**Dr Celi**—There would need to be something inclusive of men’s identity in the various roles that they play, no clinical references, valuing manhood, valuing masculinity, recognising it and letting it inform you. They are important components to include in the definition of men’s health. I put quite clearly in the introduction that men’s health is wrapped up in men’s identity. Go through the table of contents and that will give you some key words in terms of men’s health. Masculine mentoring is very important for young boys and young men. I am of a firm belief,

whenever I see either a male as a client or his wife or partner as a client, in wanting to change her behaviour, I am sending back an adult that ultimately benefits the child or the family, because they are getting a less stressed adult and someone who is more in tune with themselves. In an efficient and effective manner, by managing the adult and the partnership, the kids benefit. Their role modelling and mentoring learning processes are naturally tended to in that process. It is a huge component for young boys in what they need. Does that answer some of your questions?

**Senator CASH**—It does. In relation to the forum that you conducted last year, I note that it states, ‘The forum had Elizabeth answer the Australian public’s questions on the facts behind why he just won’t go to a doctor’, which really has become a major part of this inquiry. I was thrilled to see it there. What are the basics behind why men do not go to the doctor? Could you make practical recommendations as to how that can be overcome?

**Dr Celi**—When you look at going to the doctor, it is not a hard logistical process. It is really not difficult to do. Men are logistical. They are rational, reasonable and step-by-step. There is no practical reason why they cannot do it, so we are undermining that there is more to it, and this is where Regular Joe, Mr Invincible and the True Man come into it in non-technically, conversationally and quite light-hearted education that there is a part of you that will stop you. There is a part of you that will not want to do this. Helping men understand their psychology in that helps them go, ‘There’s my Mr Invincible talking. What does my Regular Joe need?’ I can email my list to you. There is a breakdown of questions that you can ask or give a male that I prepared for an editorial that I write for the *Rotarian Life* of yes, no, yes, no, Mr Invincible, Regular Joe and True Man-type statements, which can be a very fun-loving light-hearted manner in which to help men learn it and consider, ‘Yes, I do that’, and have a laugh at themselves in a very productive learning kind of way. But then I have every faith in men’s ability to follow through on things once they realise it is of benefit, and I leave that to them. I will not interfere in their learning process. You do not impose on it. You have to watch the forcefulness when you are saying, ‘Go to the doctor. Go to the doctor.’ That is where the Men’s Health Forum with a difference component comes in.

On the Mornington Peninsula many families got used to the Men’s Health Forums. They are very much along the lines of what Andrology Australia mentioned this morning—physical health and prostate health. I was very mindful of not medicalising men’s health. I made a clear point that we are not talking medical here and we are not talking sickness. We are talking about you as a person.

That would be another component that I would incorporate, similar to the questions, as a practical means of addressing that. It gets them thinking of their role and it then empowers them to take action. You do not have to force them. They will do it. I have every faith in that. I have seen them do it, particularly those that have emailed me—and I can only speak on that experience—letting me know, ‘I spoke to someone at work after the forum and they suggested I should go to counselling. What do you think?’ ‘Yes.’ They will think about it.

The other thing to consider, which I spoke about in one of my TV stints last year, is being very mindful not to expect men to do things the way women do it. Women will chat and network for support. Men are not necessarily going to network for support primarily. They will network for success indicators, whatever that is and how they define success for themselves, where their

Regular Joe is at so to speak. We need to be very mindful that we do not expect them to do it the way women do it. Just because he is not talking does not mean that he is not learning.

**Senator CASH**—In that respect, what is your opinion in terms of how we can make health services more responsive to men? I would say that they are exceptionally responsive to the way women operate.

**Dr Celi**—Absolutely. Expecting fewer verbals would be one thing, because that can create a lot of frustration and then a lot of the judgemental statements come out. How can you make them more men health responsive? Provide men's related information unobtrusively. Do not feminise an environment too much, which we naturally do. Put things out that will make it amenable for men, say, men's health-type magazines or golf/sports oriented magazines that make them feel at home in that environment that passively demonstrate that, 'We are here for men' and the environment tells you that. That is already one obstacle overcome and another defence will come down before they walk into the health professional's office. Again, you are creating an environment that says, 'We're here for you as men' through typical day-to-day men's interests. You can often ask them. 'What would you like? What would help you?' We need health professionals who are aware of this. Ask them specific questions. Get to the point.

**Senator CASH**—Do you mean the health professional?

**Dr Celi**—The health professional asking the men.

**Senator CASH**—I do not think that you were here earlier for the doctors from the Urology Centre.

**Dr Celi**—I was here for part of it.

**Senator CASH**—They said that there would be value in almost having a set of questions that a health professional should ask that were all overarching, but it gets over that, 'I'm waiting for you to ask me the questions.'

**Dr Celi**—Absolutely, because they will not. It is not that they just will not because they know it and they will not; they might not realise the importance of something. That goes across-the-board. Men and women do not know the importance of certain information. It is the health professional's responsibility to know that and to ask the key questions.

You can take sexual functioning as an example. As a psychologist, at some stage once I have built good rapport with my male clients I will need to ask those questions, but to make sure that I have got good trust with them and normalise the functioning. I let them know that it is not a mechanistic function, despite the many ads that you see or the many judgements and timing issues that come about in those particular ads. This is normal and there are emotional stress and fatigue factors that can affect sexual functioning. There will be specific questions that you will need to ask and ensure you ask them pointedly and get to the point. Women go contextual and give a lot of information. Sometimes guys say, 'Just get to the point.'

An example I have used is often male associates that I have worked with. I will send them an email of three paragraphs, because I do the female contextual thing and think they need the

information. I will get an email back with three sentences. I have a good chuckle at myself. They have covered everything that I need, but I go, 'Yes, that's cool.'

I have adjusted how I send emails as a simple factor to my male associates, because it is more like if they want to know then they will ask and they know they can because I will not slam them for it, if I could use that jargon. So get to the point. They will answer your questions typically, but create the environment around them to let them know that if they do answer it will be accepted and normalised. That is very important.

**CHAIR**—We have taken up more time than we allowed, but I do not want that to dissuade the conversation, because it has really been quite fascinating. We do have a few minutes before lunch. I have a question. You made reference to someone that came to one of your forums or perhaps this forum, then went to their workmates and will call you and say, 'My workmate said I should seek some counselling.' You just said, 'That's a no-brainer; der!' Let us just say a man has been taken to this point where he realises he needs some help. What is the next port of call? Who do they ring? Do they look in the Yellow Pages? If they say, 'I don't need Crisis Line or Lifeline. I just do not feel I'm doing well', where do they look?

**Dr Celi**—As I was mentioning to Senator Cash before about the website information, the calls to action would have that kind of information to let them know simple psycho education. You can go to your GP if you want Medicare rebates, but for a psychologist you can go straight to a psychologist. Let them know it is private. It is confidential. They will do a review of your situation.

You are giving them the specific steps of GP and psychologist. If you want a psychiatrist then you need to go via a GP. It is basic practical information, which in that forum I covered as part of my presentation. I did not wait for them to ask in the question time. I just said, 'Often a question I get asked is what is the difference between these? What do I do next?' Let them know.

**CHAIR**—That is a very reasonable question, even for educated people. With a psychiatrist and a psychologist there is a blurring of distinctions, and one is where you have to be a bit crazy almost. That is the psychology around it.

**Dr Celi**—Absolutely. Again, on the men's health side of things it is also dispelling some of the myths. As to privacy and confidentiality, it is about really letting people know that is important, because for men that is important to know. As I have learned with my male clients, I am an objective party to their life. I have no association with anyone else in their life. They can pretty much leave their problems in the room, whilst I have them walking out with extra skills. They know it is a distinct part of their life. A component of men's psychology is the ability to compartmentalise things and to be able to keep things separate. In orienting health services in that manner it can help them feel more comfortable to step over that bridge. I have often educated men in that manner when it comes to psychology because of the stigma associated with it. It is about letting them know that. With my male clients, if they want their partner to come in to come up to speed, they are more than welcome to do that, but it is when they say so or when they are comfortable with it. It is educating them on what I have mentioned already, but letting them know it is a supportive environment. 'You will be valued. You will not be judged. It is a non-blaming, non-judging environment'—all of the things that are some of the blocks that Mr Invincible to put up to stop their Regular Joe coming to the party.

**CHAIR**—Thank you very much for your attendance today. It has been a real insight. We appreciate your submission. The committee will now stand adjourned until 1.45 pm.

**Proceedings suspended from 12.59 pm to 1.43 pm**

**RICHARDSON, Professor Gary, Chairman, Foundation 49**

**CHAIR**—I thank you very much for coming along and talking with us today. The committee has received your submission No. 10. Do you wish to make any amendments or alterations to your submission?

**Prof. Richardson**—No.

**CHAIR**—Would you like to make an opening statement?

**Prof. Richardson**—Yes. Basically, I just wanted to talk to the submission. Foundation 49 is a not-for-profit organisation that is supported by Cabrini Health, which is a Catholic private hospital institution. It was set up with the aim to reduce the number of men dying of preventable illnesses. We have gone about that by trying to raise health awareness, develop health education programs, and encouraging men to have regular health check-ups.

There are three points in the submission where I would like to highlight certain areas. The first was probably the most important, the educational needs analysis, which was a national educational needs analysis where we surveyed a large number of institutions that were involved in some form of men's health education. It went from government institutions down to individuals. The findings were that there were significant gender inequalities with regard to health education across Australia, that the approach to health education across Australia was fragmented and often only done at a local level, and that the vast majority of resources were either dedicated to prostate cancer, erectile dysfunction or to relationships and parenting.

There were major deficits with regard to most chronic disease, particularly heart disease, specifically directed at men and specifically generic cancers that affect both men and women but in language directed towards men. There was also little in terms of male-friendly literature that we thought was available. We felt that a strategic education program was needed for individuals, the community and for health professionals, because we felt health professionals were also at a loss with regard to men's health.

The second issue that we looked at was the issue of men's attitudes to health. For a long period there has been the idea that men behave badly and it is their own fault that they get health problems. We have not found that since Foundation 49 has been in existence, and we have found that men are actually quite interested in their health. Often there are barriers placed to them, particularly with regard to the concept of male-friendly environments. The concept of going to the general practitioner and sitting in a waiting room looking at signs that tell you to have mammograms and pap smears is something that men are not comfortable with. The concept of waiting for hours with many children around them in waiting rooms and the concept of how the general practitioners engage them has not been done in a male-friendly fashion. A number of papers from Australia have been written about this.

We therefore did an internet based survey that we sent out to the people that subscribed to our men's health magazine, which is about 500, and asked them to pass it on. We got over 2,000 men over a wide spectrum of ages. We found that about half the men had health checks in the last 12

months, although about a third of those had gone because they had health problems rather than going for a routine health check. We then asked them a number of questions about whether they thought the check was worth while and had they got something out of it. On the whole the people who went found it a positive experience.

As part of the questionnaire, it also asked: if you did not go then why did you not go? The two main reasons for not going were either men did not have time to go or their health practice was not open at times they could get to it, or they did not have the knowledge to understand that there was a concept of preventative health strategies and the need to go for regular health checks. About 20 per cent of them also did not have a regular GP or felt they had a GP that they could trust.

As to what came out of this overall, the survey went to four times more than we actually sent it out to. There was interest from men in looking after their health, but not all of them are being engaged in a correct fashion. We found that 82 per cent of them said they would actually have a regular health check if it were done at their workplace.

The third and final thing that the report talks about is the concept of work health assessments. We have a health program that is basically internet based with a short examination. We have done pilots with Foster's Brewing Group and also with the Victorian Police. We went in and looked at a few hundred men in each organisation and we found that all of the slots were pretty much taken up within the first few days for the entire month of the pilots on both occasions. There was a lot of interest in the men to actually go ahead and have the health checks. These were supposedly a group of men who were completely healthy, and we went in thinking that we were basically looking for risk of disease rather than actual disease. We found that about 35 per cent had high blood pressure, 15 per cent had high cholesterol, 10 per cent to 15 per cent had high blood sugars, about 50 per cent were overweight and about another 20 per cent were obese. Twenty per cent smoked, which is about the current standard in the population for men, and about 40 per cent to 45 per cent had medium to high levels of psychological distress or depression markers.

There was all of this illness in what was meant to be a healthy workplace. We found the same thing, with high levels of stress in the Victorian Police, that we did at Fosters. Within that, we could do a fairly simple evaluation that gave us a lot of information. They were then referred on to their GPs to have further work done. We could get a lot of people assessed, but also we were able to engage the men. We gave them a lot of health information about other issues with regard to their health as well as the problems that we found in them, and we referred them on routinely to their general practitioners. We did not treat them. It was just a screening to move on. We found that you can engage men.

If you look at the issues of how you would develop an effective health policy for Australia and what you would do, obviously the health policy is being done by the federal government at the moment, and also there is a state initiative in Victoria. I am not sure about the other states. A whole lot of issues need to be dealt with regarding that. The first one is that you would need to create an office for men's health that can interact with the other departments, because issues with regard to poverty, education, culture and also housing, for example, impact on men's health. Being able to identify at risk groups is very important and obviously all of these departments

collect a lot of information which needs to be fed into a men's health office that could probably be housed within the Department of Health.

Secondly, you should have comprehensive education programs and the education programs should start at school. It is ridiculous that kids still go to school and spend their time learning Latin and things like that when there is very little that is given on health on a general basis from day one to the end of school. If you could do that at school and then go on to tertiary institutions it would ingrain in the next generations the concept of looking after their health better, being able to prevent health problems and understanding their health issues.

You also need education beyond that. It then becomes an issue of how you engage men with regard to the education. Men are harder to engage in certain environments and certainly the current medical system does not work well for men in terms of prevention. The women's health preventative movement started 30 or 40 years ago, and they have got to the point where they have a reasonable service, but it does not work for men. As to the concept of saying to the whole of Australia, 'Go and see your GP tomorrow,' there are not enough GPs. How do we develop a structure such that we can look after these men, check them, educate them and use the GPs as we need to? I think the GPs are the cornerstone of enacting medical treatment and looking after problems, but you need a much broader structure if you are going to have a health prevention policy.

Getting back to the education, you also need to educate the medical profession better. The medical profession is not well educated, as we found, with regard to preventative strategies for health. That is a broad statement and it is not true for all practitioners, but it is true for some. We have found that a lot of men who have gone for general health checks have had areas missed, such as a mental health assessment and so on, which are obviously extremely important. You need better education for the doctors as well as the population.

The key thing that I would like to leave you with is the concept of engaging the men. Whatever policies you develop, whatever strategies you want, if you cannot get them to do it or come to the point where they learn about it and then want to do it then it is not going to work. You can certainly do schools. You can certainly do workplace. The challenges are the Indigenous population and the other disadvantaged groups, the homeless and people who are socially isolated that do not have a job, the unemployed, and so on. You need a multistrategy approach as to how you are going to engage all of these groups to get them to the point of understanding what problems they can have with their health and what they should do about it.

**CHAIR**—Thank you.

**Senator LUNDY**—I note that in your recommendations you make the point quite strongly that the workplace is an effective place to deliver information to men about their health. I spent many years working in the building industry as an organiser and my area of specialty was occupational health and safety, so I completely agree with you. Where do you think that is falling over and what more could be done to engage with both employers and unions to deliver health messages as opposed to the sort of more industrial occupational health and safety approach that you and I are familiar with? What else can we do in that workplace environment in engaging those different stakeholder groups?

**Prof. Richardson**—This is a great lead in, because we have just engaged the construction industry with our Decades of Life program. The major issue for us was getting both the employers and the unions to come together and agree that it was something worth doing. There was a lot of paranoia, particularly from the unions, about the concept of men being put off work if they were found to have health problems and issues like this.

Occupationally, what is currently out there is pretty thin on the ground and very haphazard. An industry like the construction industry highlights the many difficulties in the concept that many of these people work on sites that are unsafe for normal human beings to go on and things like that, so how do you engage that group with regard to having a health check? You need to have employer support, so there has to be an incentive for the employer. We have used the concept of many of the studies that have come out showing a healthier workforce and more productivity.

**Senator LUNDY**—The evidence has been there for a long time.

**Prof. Richardson**—They do not necessarily listen to that. The concept may need to be some government support or some sort of support on a global basis with regard to encouraging the employer to do it. It has to filter down through the organisation that you approach champions within the organisation to do it. You need workers that relate to the workers to pass it on.

**Senator LUNDY**—That is my experience. It is the peer-to-peer-type programs that were most effective when it came to the health related issues as opposed to the safety related issues, where you are quite right; it has quite an industrial connotation and a traditional way of approaching it that is quite adversarial. On the health issues, things like drug and alcohol overuse and abuse, mental health related issues and identifying those problems, and the fundamental physical issues, I have seen some great examples where unions and employers have united behind programs in particular cities or in particular states. How can you help this committee get more evidence of the sort of example that you are referring to and are involved in? Have you any suggestions for us?

**Prof. Richardson**—In relation to evidence as to whether it is worth while in terms of outcome measures, you need some time to develop those. With the pilots that we have done our aim is to go back to Fosters to see whether that intervention that we did 12 months ago actually made a difference and whether they, firstly, sought medical attention for problems; and, secondly, changed health related behaviours that were unsafe. That is the first thing that you can do. The second thing is continuing to do research. You collect data as you go. From our point of view, we collect a lot of data when we put these people through. The construction industry holds a lot of challenges for us. The health check that we do is meant to drag the men in, so once they are there you can talk to them about other issues—smoking, alcohol and drug abuse. As part of the program there are identifiers for drug and alcohol problems.

The program is basically web based. Once your date of birth has gone in, the questionnaire relates to your age. We found that most health checks related to men in their fifties. If you talk to guys in their twenties, they have no interest in talking about prostate examinations, colon cancer and whether they are going to die of heart disease, but you want to know whether they have drug or alcohol issues, whether they smoke and whether they have unhealthy lifestyle issues that will give them heart disease later on. Do they have risk factors for heart disease? Are they going to kill themselves? Suicide is a high cause of death in that age group? It tends to stratify for the age.

We had good engagement with it. We found lots of problems. People were not deliberately lying. They were not saying, 'I don't have any problems.' Particularly with the mental health and the drug and alcohol, we found a significant amount of alcohol problems obviously in Fosters. I think you can do it. I think that the men are actually interested in seeking help. They are not doing it because the boss told them to; they are doing it because they need to.

You need a program like that. Our program takes 15 minutes. They are only engaged for 15 minutes and then they can be engaged in other things. They can go back to their GP and they can be given health information. One of the key challenges is the issue of people who do not speak English or are not very literate and so on. We have not had that sort of experience yet, but we are going to be working with that in the construction industry.

**Senator LUNDY**—In your experience, what level of knowledge exists with employers about the benefits to productivity by a little investment in health and safety in the workplace?

**Prof. Richardson**—Not much. It is probably also not high on their agenda. I do not know that there are a lot of employers that we have dealt with that are the greatest corporate citizens. It is a lot of bottom line as to, 'How much is this going to cost?'—that sort of thing.

**Senator LUNDY**—There is a lot of quality information out there, though, about that relationship.

**Prof. Richardson**—I agree.

**Senator LUNDY**—That is a good pointer for this committee.

**Prof. Richardson**—The other thing that we found is that the men, in general, do not have that knowledge either. They do not have the concept that if they stay healthy, they will work longer, be more productive and be better fathers, brothers and so on. They do not have that concept a lot.

**Senator LUNDY**—Thank you.

**Senator CASH**—On that point, I am aware of an international mining company in my home state, in one of the remote towns, that runs the town and invested huge sums in the workforce. It has changed the face of the town and it is a brilliant example of what can be done when an employer does buy in and promote healthy living. They realised that, if they did not do it, because of the nature of the town, people would do nothing. I totally agree with that.

I would like to take you to your definition of men's health. I was very interested to read your comments. It is something that has been raised with us, that there is no clear definition of men's health, but the point has also been made to us that if there is going to be a definition can it not be 'free from disease', and that is it. Can I get you to expand on what you would say or recommend to us that the definition of what men's health should be, and how the definition goes forward to affect policy making in the area of men's health?

**Prof. Richardson**—The major thing about the definition is the concept of being holistic. It is not a word I like much, but there is not a word much like it.

**Senator CASH**—Yes.

**Prof. Richardson**—If you look at specific problems with the concept of the biomedical, the physical health being your health, and then you leave out mental health. Mental health is a huge issue, as I am sure you have heard from other people. There is then the concept of what we call the third one, which is hard to define, being the emotional health. How do you fit in to your society and your family? Are you happy or not so much depressed, but how do you feel about where you are in life? Why is someone disadvantaged? Why are all of these things occurring?

I have wrestled with this in many meetings with many other individuals who have spoken today or are going to speak. The WHO's definition is pretty good. They are the World Health Organisation, so from that point of view I am not arrogant enough to say that I do not agree with it. I think in saying that complete physical, mental and social wellbeing is a good definition you are never going to get everyone on side with it, but I like the second part, that it is not just the absence of disease or infirmity. People do tend to focus a lot on a specific disease. I noted from the timetable today that is fairly heavily prostate driven, so from that point of view prostate cancer is one of the key drivers for men's health. It is certainly part of the burden of disease in Australia, but it is not the largest part, so from that point of view things get quite skewed if you focus on a specific disease. I quite like that definition, to be honest.

**Senator CASH**—In terms of its impact on policy, I am assuming a narrow definition would possibly limit the development of policy in relation to men's health, but the broader definition would allow a lot more scope. For example, it would bring in depression or mental health.

**Prof. Richardson**—The concept of the policy has to be as broad as possible. I am sure that you have probably seen the Irish men's health policy.

**Senator LUNDY**—No.

**Senator CASH**—We did talk about it in Canberra.

**Prof. Richardson**—They have a men's health policy document, which is basically devised on a social determinacy concept, whereas a man's health is not related just to his genes and what he is exposed to but what his financial capabilities are and so on. From that point of view you need to be as encompassing as possible. The one great thing the government does is that it collects lots of information. You guys have so much information. That is why I think whatever policy is developed there needs to be an office or something where it can draw information collected by the departments, the Department of Health or whoever holds it.

**Senator CASH**—There needs to be a national database where the states feed the information in?

**Prof. Richardson**—Exactly. You heard from Dr Holden first today, so you would have heard the longitudinal men's health study about 4,000 times because that is her baby. I would fully support that concept. We do not know what is going to help men's health the most. We know what diseases occur. We know what the burden of illness is. When you institute a campaign to reduce obesity, how do we know that it is going to work, and how do we know down the track whether there is not two other social determinants or something else that we do not know about?

As to the concept of having research outcome measures in all of these things that are done, whatever policy you have has to be very strong in those areas. A policy may be developed, but it may not be achievable or it may be that it has missed one of the main points. That is why I would like it to be as broad as possible.

**Senator CASH**—From your perspective, what are the gaps in knowledge and information in relation to men's health that we need to overcome before we can take that next step and put in place policy that will be effective?

**Prof. Richardson**—Through our surveys and health checks we always do a satisfaction survey. We found that, on the whole, men's knowledge about their health was fairly poor. Everyone knows you should not smoke, but people still do. It is the concept of how you stay healthy and that definition. How, when you are 20, do you plan to be healthy when you are 50? No-one gets taught that in Australia. I do not know if anyone in the world gets taught that. It may be, for example: how do I stop getting arthritis or lung disease? If you want glaringly obvious omissions in terms of education and resources, they are two, but they are both in the top 10.

**Senator CASH**—Are you saying that we need to take that right back to teenage years or even before that, so that when we are 40 we do not end up going in and being diagnosed; there has been a gap of 20 or 30 years?

**Prof. Richardson**—Yes. We have a perfect chance to do it at school. Health could become a curriculum item at school like geography.

**Senator CASH**—It used to be. Certainly, when I was at school it was, but it seems to have been phased out.

**Prof. Richardson**—I thought you were younger than that.

**Senator CASH**—I will not comment on that.

**Prof. Richardson**—You need a generational change. The people that are already 40 or 50 can be educated to a certain degree, you can help them with their diseases, help them get screened better, and hopefully help them with their mental and emotional health, but they have 30 years ingrained in terms of their health already. You really want to go back and say, 'Curriculum policy is that everyone is going to get education at school, university and whatever else they do, and what we are also going to do is medical education not just for doctors or nurses but every health individual.' Part of it is prevention. A large part is prevention. In the medical curriculum prevention is really small.

**Senator CASH**—They are looking at cure, as opposed to prevention?

**Prof. Richardson**—Yes. Health in Australia is entirely reactive to problems, rather than sitting there and going, 'What is up?' The 2020 prevention strategy is another fantastic initiative, but its initiative for the next five years is only on obesity, diabetes and blood pressure. You sit there and ask, 'What about mental health and cancer?' I understand you cannot do everything.

**Senator CASH**—The point being that we might be able to do a little more.

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**Prof. Richardson**—Yes. A cornerstone of what you do has to be education, and then you have to put in place the concept of measuring the outcome of that. How does that improve the population over time? You can look at how many people get sick and what the mortality is, which are easy to measure, but there are issues of attitudinal changes and the concept of violence, behaviour related to alcohol, car accidents and things like that, which are all as important but different and harder to measure.

**Senator CASH**—I note that one of your statements is:

Foundation 49's vision is 'to reduce the number of men dying from preventable conditions by raising health awareness and encouraging regular check-ups'.

How do you do that? That goes to the crux of what we are doing here with this inquiry. Also, in your opinion, have there been any innovative and effective campaigns that have achieved that we should be referring back to as a good starting point?

**Prof. Richardson**—When we decided our mission statement we had to fiddle around for about a year to work out what we were going to do. It is difficult to try to do everything. One of the things that we felt we could measure was the concept of preventable death. Could we look at innovations that might change that? Mortality is easily measurable. That was the first thing—that we had an outcome measure that we could potentially justify later on.

The second thing was that we did not want to be just another public awareness organisation, because we found in some of the awareness campaigns that we did men actually took the message, went to their general practitioners, but found that the experience they had with them was less than what they thought. This might be a perfectly healthy man in his thirties that goes to have a health check and his blood pressure done—two things. 'Out you go. You're good.' He might never be asked how life is at home or never asked four or five questions about mental health and so on. This guy could be near suicidal, in divorce or just lost his job. We got that feedback constantly.

What we decided to do was to develop the concept of a health check. So we have a front end and a back end. We drive men in, but we have something that catches them that they can do. We developed this health check. We had an advisory board through the hospital that I work in, a number of GPs and people from the Royal College of General Practitioners. We then tried to get the general practitioners to use it and we had really poor uptake. GPs, as a whole, are a hard group to get to do new things. They have a lot of things that they have to do. We went to three divisions, paid the divisions to do it, and they were meant to have 10 doctors that did 10 patients each over three months. It was not very many. It is about a 20-minute health check. We paid them double what you would get for a consultation. The three divisions did 12 patients overall. We were meant to get 300. We just could not get them to engage. We tried to get one practice to do it. We found it very difficult to get GPs to do it.

**Senator CASH**—Why was that?

**CHAIR**—You have parliamentary privilege.

**Prof. Richardson**—To some degree they are a disenfranchised group. I am making shocking broad statements here, but they all feel they have many regulatory things that they have to do, much paperwork and a lot of programs that they have to fill forms in for to get someone to get something or other. When you go in with a new thing and say, ‘We want to do this. We think it is really neat. Do you want to do it?’

**Senator LUNDY**—It is like curriculum overload.

**Prof. Richardson**—It is exactly the same. They sit there and go, ‘No. We can’t do it.’ Even though they will go, ‘It looks good’ and things like this, but at the end of the day they are sitting there going, ‘Do I want to do this?’ and they do not do it. We are not the only people that have found that. The people who did the diabetes programs and the asthma programs have found it hard to get them in. The only reason those programs are done is they get money from the government for doing any of those programs. I do not want to sound bad about it, but that is the way it is.

**CHAIR**—It is not just about the overload of bureaucracy with GPs. They are extraordinarily busy seeing patients as well.

**Prof. Richardson**—Absolutely. There are not enough GPs. Also—as I have parliamentary privilege—I do not think they have been innovative enough in looking at how their workload was going to increase. Medicine has become much more complicated in the last 20 years. There is the concept of bringing in people like practice nurses. If you cannot get more doctors, what do you do? You get people who can do 70 per cent of what you can do to do that initial triaging part of it. They actually opposed practice nurses up until a few years ago, and so from that point of view I think they shot themselves in the foot a bit, because the amount of work out there is enormous. You will never get enough GPs. The workforce issues are huge. The rural issues are horrendous. There is also a primary care document being made, which I had a look at.

**CHAIR**—How effective would it be to have a practising nurse there that could take a blood sample, conduct some simple tests in a standardised arrangement to screen or check up on general health issues and then if there was an issue that you could then make an appointment with your GP? Is that process undertaken at all on any widespread scale?

**Prof. Richardson**—Not as far as I know. That is how our program works. We use nurses in the workplace. We do not use doctors. The nurse does the examination. The computer works out the risks and the diseases and it makes a report that then goes to the GP. It could quite effectively be put into any general practice with five or six nurses there and have loads of people go through it. In the general population hopefully the amount of disease is not as much as at Fosters and the police, but the reality is that anyone who is found to have a problem could immediately make an appointment to see a GP.

**CHAIR**—Did you say it was a 10-minute consultation?

**Prof. Richardson**—It is about 15 minutes on the computer. The only problem with it is that you have to be able to use a computer. If there is someone there they can help you through it, and obviously if they cannot speak English then you would need to have someone change the language or have someone who was an interpreter to do it with them.

**CHAIR**—In the 15 minutes is there a serious of questions as well as the functional test?

**Prof. Richardson**—No. The functional test takes about two minutes.

**CHAIR**—What do you do? Do you take blood and blood pressure?

**Prof. Richardson**—We found that we could not get men to come back after they had a test, so we had to do it all at once. It is basically height, weight, waist circumference, blood pressure, finger prick for blood glucose and cholesterol.

**CHAIR**—Are there any other tests that men should be undergoing on an annual basis, say, to assess their overall health?

**Prof. Richardson**—Yes. There are specific ones for specific ages, such as colorectal cancer screening. That is the most common cancer in Australia. The issue of prostate cancer screening, which I am not going to talk about because it is contentious and there are many other people talking about it. There is the concept of screening for iron levels at some point in your life. Ten per cent of the population of Australia are carriers for haemochromatosis. That is a simple blood test that you have once in your life. There are other things that can be done, but from our point of view, we wanted a simple screening procedure that then gave them information about more testing should they wish to pursue it. For anyone over 50 you would recommend that they have colon cancer screening.

**CHAIR**—I am just trying to educate myself as to whether there is an effective method that encompasses what you are doing, which is obviously very good work in particular workplaces, but that would be even broader for the general population. There could be a marketing pitch along the line of, ‘If you go in here and you spend 10 minutes it is effectively your annual check-up. There is no out-of-pocket cost or whatever and the government will fund it.’ As a preventive or early diagnosis tool that would be much more cost effective in the long run than treating the results of illness.

**Prof. Richardson**—Far less. Our program not only identifies disease; it identifies your risk. It will assess you for a risk of colon cancer through your family history and through a number of other questions. If your risk was within a certain level you would be recommended to have colon cancer screening. You do not have that screening there in that 10 or 15 minutes.

It is the same with the other common cancers. We do the four main ones—prostate, melanoma, lung and colorectal cancer. It gives you a risk assessment of what your risk is that you may get it. If you are 40 and you come in, it would say to you, ‘Not only is your blood pressure high, but you have a risk of developing colon cancer and your mental health scale is seven out of 10, which means that you are at risk of serious mental problems, so we need to address these two things.’ If you are going to do a population based thing, I do not think you can do more than that. You cannot do the whole lot. You need a two-tiered scale. It is an effective triage. What it does is send people in through that system and some would go to the next level and some would say, ‘No, you’re healthy, but you need to come back next year and do the same thing.’

**Senator CASH**—Is it similar to the men’s Pit Stop program?

**Prof. Richardson**—It is similar to that.

**Senator CASH**—My understanding is that has been very successful.

**Prof. Richardson**—From the rural perspective it has been really good.

**Senator CASH**—Have you tried to work in conjunction with them?

**Prof. Richardson**—The problem at the moment is that we just do not have the resources to fund it, and they are pretty resource poor. Their questionnaire is a lot less comprehensive than ours. Their health assessments are a little less comprehensive, but what they do is they have the concept that once they engage the men, the men will start talking about their health and they have health information for them. It is a good program.

**CHAIR**—In your submission it says that a staggering number of men do not have a regular GP.

**Prof. Richardson**—Yes.

**CHAIR**—Who do you refer the results off to if they do not have a regular GP?

**Prof. Richardson**—We use one of the internet based services to identify a GP from where they live and as long as they are amenable to that, we will then send the results to them. Obviously there are privacy issues. If they do not want to do anything then they do not have to, but we would suggest two or three GPs for them to see and if they identify that they will go to one then we would then send the information to them.

**CHAIR**—Would you give the results of the testing to the individual then and there?

**Prof. Richardson**—Yes. We give them a copy and we would also email it to the GP.

**CHAIR**—Is that only when they have given permission for choice?

**Prof. Richardson**—Exactly.

**CHAIR**—Do you ever ascertain how many follow up with their GP?

**Prof. Richardson**—We are going back to do the Fosters follow-up 12 months later. In talking with the College of General Practitioners, the concept of finding out how many people go on to their GPs after something has been identified at a screening thing is very hard to do. They have tried postcard programs where you take a package to the GP and the GP posts the program back. They said the maximum replies they ever get is about 10 per cent, even if 90 per cent go. We felt that the only way we could really do it was to go back, and because of the privacy issues, we struggled with the concept of actually contacting each one after we screened them, but they agreed to be rescreened a year later, so we are going to ask them then.

**CHAIR**—Okay.

**Prof. Richardson**—The reality would be that, if you had the money and the set-up, as soon as everything went in it electronically went to the general practitioner, or the general practitioner had access through the website into that person's information. You could do all of those things, but you would need about seven levels of passwords and things, which costs an enormous amount of money.

**CHAIR**—I would like to go back to your earlier statements about education, particularly school based education. I applaud you in that because I think that it is absolutely important that you can change the country and the world if you can change the children's attitude to various things. We have had some success in it. My kids, for example, will not go out in the sun without a hat. Smoking is no longer the fashion item it once was 20 or 30 years ago. It has been effective in some areas. Do you think that there are some impediments because of societal attitudes about making judgements on children? I am being deliberately provocative. When dealing with obesity in kids there is a large group of people out there saying that we should not be condemning of children because they have got weight issues, or we should not be drawing to their attention that they have weight issues for fear that we are going to impede their psychological development and so on. In reality I have a view, that you may or you may not share, that we are creating a bigger problem down the track. Do you have a response to that, maybe not specifically, but to the general approach and are we limiting ourselves?

**Prof. Richardson**—The problem will relate to this generation of children because of their parents. If you educate this generation of children then it will not occur with the next generation of children because the parents will be educated, if that makes sense.

**CHAIR**—It does.

**Prof. Richardson**—Today society unfortunately hides a lot behind the concept that everyone should be able to do whatever they like and not be persecuted for anything—that is another parliamentary privilege type thing here—so people do not take enough responsibility for what they do. That concept of responsibility for your health has to be engrained into any system of education. They will certainly be heard in bringing that in, but the reality is that it is a bit like mental illness and how they have approached that. The concept of mental illness—and beyondblue have done a great job with that—is that it is common. People are not mad; and you should try to help them rather than poke fun at them. From that point of view they have destigmatised mental illness to some degree—I do not think completely, but to some degree.

It is a matter of making sure that those sorts of destigmatising things are put in. If there are fat kids at school it is ensured they do not get bullied and that there is a bullying system. There are good bullying systems in a lot of schools. That has to be part of it as well. You could hide behind that, but I would not think it is a good defence, to be honest.

**CHAIR**—I tend to agree with you. Ideally, when would this sort of education and information start with children?

**Prof. Richardson**—I would start it straightaway.

**CHAIR**—Not now. I mean what age?

**Prof. Richardson**—That is what I mean, it could be in grade 1 with healthy eating or how your heart works.

**CHAIR**—There is a great book I should refer you to called *Fit For Life*.

**Senator LUNDY**—They do some of that in some schools.

**Prof. Richardson**—They do. I agree.

**Senator LUNDY**—It is not like it is not happening out there.

**Senator CASH**—In playgroups or playschools now you only get served fruit, but it needs to be far more structured, as you said, with the educational system. It needs to ideally be part of the curriculum.

**Prof. Richardson**—The great corollary of that is that if the kids do it then they may go home and tell their parents to do it. It is a bit like the sun campaign. It has been so effective with the children that if you go outside now without a rash shirt on at the beach, then the kids tell you to put it on.

**CHAIR**—Just for the record, I mentioned a book called *Fit for Life* which deals with this.

**Prof. Richardson**—So you have read it.

**CHAIR**—No, it is a new book. I mentioned it because I wrote it. That is why I raised it, because it is going to be on *Hansard* and I did not want see it as plugging my own book without doing that. We launched it in Canberra a few weeks ago. It is a booklet designed just to do this, to help children understand some issues and go through them with their parents. It is a fictional story. It truly is important, so that is why I am so intrigued as to your evidence for having that view, whereas I just had two children who I wanted to see better a bit later on. I will send you a copy.

**Prof. Richardson**—Thank you.

**CHAIR**—Do you think that there should be a structured program then that starts at reception, effectively, and goes through until year 12, or completion of school, dealing progressively with issues that children are going to face?

**Prof. Richardson**—Through to completion of school.

**CHAIR**—But then you are going to need to have a stream with one for girls and one for boys.

**Prof. Richardson**—Absolutely. You could not just do it for men.

**CHAIR**—You could have a generic one, but there has got to be two particular streams because there are going to be different issues.

**Prof. Richardson**—Yes, but there is no reason that women cannot learn about men's health and men about women's health.

**Senator CASH**—Yes.

**CHAIR**—Except that there is a cringe factor for boys and girls.

**Prof. Richardson**—It would depend on when you introduce it. One of my daughters goes to a school where they have done that over the last year. The teachers said that there was embarrassment initially, but they then became interested and curious about it, and finally felt comfortable about it. It is probably much better that you end up like that, rather than always wondering about some female health problem. A lot of those things are just destigmatising them. I do not think there is a problem with learning about health problems of the opposite sex, to some degree.

**CHAIR**—Just to pick up on that, men just do not worry about women's health problems, but find them intriguing. There are a lot of men and boys who do not understand their own health problems.

**Prof. Richardson**—I agree.

**CHAIR**—That is what we are really trying to get to the nub of here, how best we can educate them about the issues that they are going to face and how we can deal with them.

**Prof. Richardson**—Just getting back to one of my main harping points, it is the engagement concept. Engaging the kids tends to engage the family. Families are a pretty strong unit still in Australia, so if you can engage a whole family then it streams into community groups and you get more champions that want to do things and have more people that become involved and interested. It becomes a much more mainstream concept that you want to do things with regards to health.

**CHAIR**—Thank you for the comprehensive submission on behalf of the foundation. Today has been really insightful and enjoyable and I thank you for sharing your time with us.

**Prof. Richardson**—Thank you for inviting me.

[2.32 pm]

**FAIRBAIRN, Mrs Jo, National Community Partnerships and Health Promotion Manager, Prostate Cancer Foundation of Australia**

**GILES, Mr Andrew, Chief Executive Officer, Prostate Cancer Foundation of Australia**

**McHUGH, Mr Bill, Consumer Consultant, Prostate Cancer Foundation of Australia**

**CHAIR**—I welcome the representatives from the Prostate Cancer Foundation. Thank you for coming along and talking with us today and thank you for your interest. I have noticed that you have been in the audience for the bulk of the day. The committee has received your submission, which is numbered 72. Do you have any intentions of making alterations or amendments to the submission as it has been received?

**Mr Giles**—No. We will leave it as it stands.

**CHAIR**—I invite one or all of you to make a brief opening statement.

**Mr Giles**—Thank you for taking our submission and for your interest in men's health. It comes at a great time for the PCFA as an organisation. We started off as a very small consumer based organisation about 10 years ago. Something seemed to be happening across the country, particularly around prostate cancer, but generally in terms of men's health. Roger Climpson, who was a newsreader in Sydney, was diagnosed with prostate cancer. He was somewhat surprised to know that he had a prostate, and even more surprised when he realised it could kill him. No-one told him. He was surprised that there was no support and very little awareness. He was a member of Lane Cove Rotary. He walked up the stairs of the Lane Cove club one Tuesday night and said, 'Guys, we have to do something about this,' so Rotarians, being Rotarians, went and set up the Prostate Cancer Research Foundation of Australia.

At the same time, around the country men who also had prostate cancer were getting together for the first time to talk about their issues as a group. In Brisbane, Adelaide, Sydney and Melbourne these men were forming the very first support groups and they loosely formed an association of prostate cancer support groups around the country. In 2000, out of not exactly good management but perhaps through luck, the two organisations bumped into each other. In 2000 the support group organisation and the research organisation amalgamated and we became the Prostate Cancer Foundation of Australia.

Things have really gotten a run-on in the past four or five years. Our profile has certainly grown. Men have become increasingly keen to talk about prostate cancer and to talk about men's health. We have been very lucky to get some impressive community support, with some very generous corporate support, and of course we have been heavily involved in the event called Movember, where we encourage people to grow moustaches. That has been fantastic for us, because in some respects it changed the entire dynamics of prostate cancer from what it has usually been seen as a older man's disease to being something that all men should be aware of, including young, middle-aged and of course older men.

Now, 12 years on, we have become the peak body for prostate cancer in the country. We are the only national organisation in Australia that deals solely with prostate cancer. We have three main aims. The first one is to fund and direct prostate cancer research in this country. The second one is to provide support and advocacy for the men with prostate cancer and their families, and of course the third is to raise awareness of prostate cancer. However, what has been happening in the past couple of years—and a lot of this is actually a credit to my colleague Mrs Fairbairn—is that we have been trying to look at prostate cancer less as a tumour specific concept but as a whole-man issue. Our call to action for the Prostate Cancer Foundation is to go to your doctor and have a conversation about prostate cancer. As we know, and as Professor Richardson was just saying, men do not go to the doctor that often. Our strategy has been that when men go to the doctor to talk about prostate cancer that they should also have the conversation about heart disease, diabetes, cholesterol and depression. Increasingly, we have been running men's health forums around the country for the past couple of years, and prostate cancer is just one of the issues that we have faced.

We are a small organisation. We receive limited government funding, although we have recently received some generously recently for our Ambassador program. We try to make the biggest impact by working collaboratively with the other peak groups in the country, so we do a lot of work with beyondblue, the national depression initiative. We do a lot of work with Andrology Australia and Foundation 49. For example, their Decades of Life that Professor Richardson was talking about is a fantastic way for men to become aware of their health all the way through their lives. Last year, for Movember, rather than getting our Be A Man brochure about prostate cancer, we combined with Foundation 49 and everyone who did Movember got a zip card, one of those things that pulls out, that had decades of life from 20 all the way through to over 70. Also, we were the official charity for the Grand Prix in Melbourne last year. We were able to secure some funding to have Foundation 49 nurses there in our tent, so the 430 guys that came by did the Foundation 49 test. I am a great believer of working collaboratively with people who are the peak bodies around the country.

Going on from that with what has been happening recently, we decided to put a small amount of money into trying to facilitate conversations with the other peak bodies. We have always done it one-to-one. I will have a conversation with Professor Richardson or Mrs Fairbairn will talk to beyondblue, but we never seem to sit around the table. We spent some money to bring together some of our partners in what has been loosely called the Men's Health Alliance, and all those peak bodies now sit around that table and we meet every six to eight weeks to talk about ways that we can have greater collaboration and interactions.

At the moment our greatest challenges are that we need to find a more integrated way of dealing with research. We have become a major funder of research in this country, on the back of our corporate support and on the back of Movember. We have got about \$11 million of research out there at the moment. We could only work out where that money was supposed to go by some money that we received in 2005 from BHP Billiton. They gave us some money to do an audit of all the prostate cancer researchers in the country because we wanted to know who was doing the research and, more importantly, was it good research or just the hobby of some person working on the side. What we found was that we have some great researchers here in Australia, some of whom are doing really great work, but there are other people where perhaps it is just a hobby and not the best use, certainly of our donors' money, to be funding.

What we did identify were about seven centres of excellence around the country, so part of our research strategy has been to try to get those seven centres to talk to each other in a more collaborative way, which has been reinforced recently by the federal government's funding of two designated prostate cancer research centres, one in Queensland and one here in Melbourne. It looks like those centres, in some respects, are going to combine and become one centre with two campuses. That, to us, is a great way of really making sure that our money and the donors' money is well spent.

Our second big challenge of raising awareness about prostate cancer is the very complicated issue. At the moment there is no data to suggest that we should be screening all men for prostate cancer over a certain age, so that is causing us a lot of confusion and a lot of noise out there, because GPs are ringing us and saying, 'What should I do?' We really need to get together and work out what that message should be so that GPs are empowered to give men the right response. We heard earlier that GPs are very busy people and the prostate cancer conversation that we encourage men to have with their doctors is a long conversation.

The third thing that we are keen to deal with is the fact that last year almost 3,000 men died of prostate cancer. Putting the whole debate about PSA testing and even research to one side, what did we, as the Prostate Cancer Foundation of Australia, do for those men, their families and carers? Did we do enough to alleviate their pain or did we just stand by and help them die with dignity? I think that when you look at the thrust of even our research program, a lot of it is focused on that early detection, as opposed to what we can do at the translational end of research. That is something that is very big for us.

They are my opening remarks. I think that this committee has come at a good time when you have a great opportunity to do a lot in the men's health business; this is something that we have been waiting for over the past couple of years so we are, of course, delighted to be here.

**CHAIR**—Just as a point of clarification, we are not going to Queensland, but where in Queensland are the centres located that you referred to?

**Mr Giles**—The second prostate cancer research centre that has been funded by the federal government is at Princess Alexandra Hospital.

**Mr McHugh**—QUT is the main manager of it.

**Mr Giles**—Professor Judith Clements and Professor Colleen Nelson are the key people.

**CHAIR**—I have a couple of questions before I hand over to my colleagues. Mr Giles, you may not have heard some of the evidence, but Mrs Fairbairn heard most of it today. Some of it was, frankly, critical of a focus on prostate cancer. We heard from psychologists that once a man is diagnosed with prostate cancer they are given a choice of seven different treatments that they scarcely understand and quite often their advisers do not fully understand, either. How do you respond to those statements?

**Mr Giles**—That is an example of how complicated prostate cancer is. One of those seven treatment options is, in some respects, to do nothing. It is to watch and wait, or active surveillance. You tell a man he has got cancer and he will say, 'Cut it out', but we are saying to

him, 'No. It's a low-grade tumour. We're going to watch it because it could take 13 years for that tumour to leap out into your bones, so at some stage we are going to step in and help you.' That is one of the major problems we have. It is an incredibly complex issue.

In terms of men going to have treatment for prostate cancer, their main port of call is urologists. Urologists, as a trade, are surgeons. So if you go to see a urologist they are more than likely going to recommend that you do have surgery. That is not to say that they are doing that for any other reason other than they think that is the best treatment option for you. Again, I look at breast cancer and they have moved a long way from just having surgery as the only treatment. I think that we need to ensure that men have access to a whole variety of treatment options.

In terms of oncology and those sorts of things, we do not have that many medical oncologists or radiation oncologists working in prostate cancer, so over time we would like to encourage more people to move into that field. I know that in places like Port Pirie, where we have a very active support group, their only option in terms of prostate cancer diagnosis is to be treated by the urologist who comes through on a 12-week rotation, so it is not even offered that they would see an oncologist. Things like brachytherapy are not available in some states of Australia, so it is an incredibly confusing thing.

**CHAIR**—We heard today that there are treatments that are available overseas but are not available in Australia. They are not regarded as whacky alternative treatments. One that was mentioned was radiation treatment. Would that be correct?

**Mr McHugh**—Proton.

**Mr Giles**—Proton therapy.

**Mr McHugh**—It is a massive capital investment for that item of equipment and its selling spiel is that you have no side effects. The side effects are absolutely minimal. The other side to that coin is that it has only an 85 per cent success rate by its historic views.

**Senator CASH**—What is the cost that you mentioned?

**Mr McHugh**—If you want to go over for that treatment you have to have \$100,000 in your pocket and you have got to be prepared to go to the United States at least three times. In the second stint you will remain in the states for something like six weeks where you have to establish yourself as a family unit somewhere. The Loma Linda situation that I went to look at is set up like a resort because they have got to entertain the people who are there and they become a community. People are coming and going throughout that treatment process, so they welcome people in and they farewell people out. It is a resort attitude to make it successful.

**CHAIR**—You seem to know a fair bit about this. Is it an effective, or the most effective, treatment for prostate cancer, albeit expensive and inconvenient at times?

**Mr McHugh**—I would say no. For the right situation, surgery is as good as that. I had external beam and that is right for me, as well. It really does depend upon the situation that presents within the patient at that time and the patient's ability to take on that form of treatment emotionally and financially.

**Mrs Fairbairn**—I know a man on active surveillance. He is in his 12<sup>th</sup> year. He measures every aspect of his own health with his urologist and he is going along very well. That is another choice.

**CHAIR**—That is active surveillance.

**Mr Giles**—Just on the proton therapy, the thing in its favour is that it actually treats a whole range of cancers. It has already been used for cancer of the brain and the lung and it is now moving into prostate. There has been some talk about bringing a proton machine to Australia. The benefit of that is that it would do a whole range of cancers, not just prostate cancer.

**CHAIR**—I would like to establish that we are not behind the times and that we are not blinkered in our approach to how we are dealing with this. We are examining world's best practice and we are trying to move with it.

**Mr McHugh**—Yes. What you are saying is right.

**Mr Giles**—The biggest development in prostate cancer treatment recently has been the development of robotic surgery. We were one of the first countries to have an uptake in robotic surgery. We are one of the first countries in the world to actually get robots, outside of America. They are over in Adelaide, in Melbourne and now in Sydney and Brisbane, so we are at the forefront.

**CHAIR**—Mr Giles, you will correct me if I am wrong, but a significant number of the robots that are available have been bought by private individuals or private foundations. Is that right?

**Mr Giles**—There are currently no robots in public hospitals in the country.

**Mr McHugh**—I do not think that is correct. They are in Royal Brisbane Hospital right now and there is one in Adelaide.

**CHAIR**—The Royal Adelaide one was provided by a private donor.

**Mr McHugh**—But it is available to public patients.

**CHAIR**—Is the cost of the robot \$5 million?

**Mr Giles**—The initial purchase is \$3.5 million and there is \$1 million in upkeep fees a year.

**CHAIR**—What are the public health grounds for not having more of them, apart from cost?

**Mr Giles**—Again, there is a huge debate going on at the moment among the urological society around that issue. Is it better to have a surgeon who cuts you open, does it with his hands and fingers and gets to feel everything, or using a robot that may reduce the size of your scar but does not have the same feeling or touch as a good urologist? Again, there are some randomised trials that are going on around the world at the moment that are trying to help us work out what is the best. The thing about robots was that you lose less blood and that you are in hospital for a shorter period, but for men with prostate cancer, who cares how long you are in hospital. It is,

‘How soon will I get back to being continent and potent?’ They are time issues. People were measuring robots on one thing that did not really affect the men, because it is all about quality of life.

**CHAIR**—You mentioned that you had men’s health forums. How many men turn up to these forums?

**Mrs Fairbairn**—I would like to speak about the men’s health forums. First of all, it is wonderful being here today because most of our community partners have put submissions in and we have been working closely with a lot of these major men’s health organisations for nearly four years now.

The National Men’s Health Promotion forums have been run in every state except the Northern Territory at this stage. We attract about 250 to 350 men and women. In Newcastle, there was standing room only and it was just amazing. We are attracting large numbers of men and women. We do all the measurements. We regularly get 60 per cent men and 40 per cent women, because we encourage men to bring their wives or partners. That seems to be a great successful element of the day. We include top cardiologists and diabetes specialists. We look at the whole man. As Mr Giles said before, we really believe that if we are going into western Queensland to a small remote town, to go with one part of the man, the prostate, is not really acceptable any more. We do not think it is. There are so many other issues affecting men. We will always have a big room full of men with lots of different requirements or trying to prevent different illnesses.

We have found that the general public love to go to something where there are medical specialists and professors presenting. I was motivated to develop this project by Don Baumber, who told me that he wanted to attend a urology conference one year—he is an independently wealthy man—but because he was not a urologist, he was not able to do so. We have been developing the most professional men’s health forums that we could based on a conference model. We bring in experts from all the areas sharing a health promotion and a prevention of chronic illness perspective, and that has been a very successful model for us. I would add that none of it has been funded by government; it has been funded by corporate sponsorship that we have attracted because of our belief in this model.

**CHAIR**—What attracts men to coming to this? Is it because they have an existing illness and they think they might?

**Mrs Fairbairn**—Not necessarily. You said you have heard a lot yesterday at other meetings about men not being interested in their health and not going to the doctor. I would like to repeat the research from Andrology Australia this morning about the MATeS study, which actually showed that most men do go to the doctor and most men are interested in their health. You may remember our health promotion meeting that we had with the senior executive of our team. We decided we wanted to move on past the myths that we confront everywhere we go in Australia, where men would say to me, ‘Men aren’t interested in their health. Women go to the doctor more.’ As an organisation, we have stopped perpetuating that kind of negative role modelling, if you like. We try very hard not to compare men to women in any way at all because it does not seem to achieve a lot of outcomes. The only comparison we make is that more Australian men are diagnosed with prostate cancer than women are diagnosed with breast cancer, which is

something the community does not know. That is basically the only comparison I would ever say publicly if I was managing one of these. I have brought for your consideration the programs from our men's health promotion forums. I can give them to you.

**CHAIR**—We will table that. Thank you. I have two more questions before I hand over to my colleagues. You just said that most men do go to their doctor. It would only be a slim majority, if there was a majority of men. Was it 40 per cent in the last 12 months that had seen their doctor?

**Mrs Fairbairn**—The MATeS study was done more than 12 months ago. I do not know what the statistics are now.

**CHAIR**—It was 40 per cent of men surveyed had seen a doctor in the last 12 months in that MATeS study.

**Mrs Fairbairn**—I do not have that statistic.

**CHAIR**—Other evidence is that it is more like 52 per cent of men. The most significant one was from Foundation 49, which said it was 72 or 82 per cent of men would go to the doctor if it was in their workplace.

**Mr Giles**—We know from the MATeS study that when they do go to the doctor—you are right, it may only be 40 per cent in the past 12 months—they go for shorter periods of time and they go for a single purpose. They only go because something is weeping, bleeding or falling off. We are encouraging GPs to grab these men and have that broader conversation about their men's health.

**CHAIR**—There are lots of comparisons drawn between breast cancer and prostate cancer. You may have heard my question earlier. Is there a perception out there or is it a reality that breast cancer always needs to be treated, whereas prostate cancer clearly does not always need to be treated or the right treatment is to wait, watch and do nothing immediately, so in that regard one is seen as a much more urgent, pressing issue than another?

**Mr McHugh**—I think it is because the women are so articulate and so concerned about their health that they have advocated for the position that they have got. It is not just because of the disease, it is because of the way that women deal with their health. As far as men go, unless something is wrong with us, we do not need to go to the doctor. That is our logic. One of the major other situations is that going to your GP can be very inconvenient. You have got to take time off work if it is in the suburb. When I was going to my doctor it was a suburban guy, and when he sold the practice it was just when city clinics were starting to come up and it was far more convenient to be able to go to a medical appointment vacancy at 3.25 around the corner from where you worked rather than having to try to get the first one in the morning, go to the doctor there, and then go into work.

**Mrs Fairbairn**—By definition, both breast cancer and prostate cancer are hormonal cancers. Oestrogen feeds breast cancer and testosterone feeds prostate cancer. However, the breast is an external gland so it is able to be treated and found, but the prostate is an internal gland and probably a bit more along the ovarian cancer line where it is inside the body and there are often no symptoms whatsoever with prostate cancer, so it is totally undiagnosed unless a PSA test or a

DRE test is done and then a follow-up biopsy. It is a difficult cancer because it is internal and even with advanced prostate cancer there may be no symptoms at all that the man is showing.

**Senator LUNDY**—I wanted to follow up and get clear in my mind when we talk about screening for breast cancer. It is not a test; it is a screen. As you say, it can be done externally. Comparing prostate screening does not work, because the testing for prostate is a test and it requires a much higher level of intervention. How does that relate to the public calls for prostate ‘screening’ in the current debate?

**Mrs Fairbairn**—We probably do not want to comment on that.

**Mr Giles**—We tend to view screening as a way of defining government led initiatives. The government would implement a screening policy where they would encourage every man to go and get tested for prostate cancer.

**Senator LUNDY**—When you are talking about prostate screening, are you talking about a test?

**Mrs Fairbairn**—No. We do not use the word ‘screening’. We think of it as population screening, like breast screening or cervical screening. It is a population project, whereas the test that is currently done is a pathology test. We think the terminology of ‘test’ is correct in that setting.

**Senator LUNDY**—You do not use ‘screening for prostate cancer’ in your advocacy?

**Mrs Fairbairn**—We do not use that term. We would like others to not use it either, because it is very confusing in the market place.

**Senator LUNDY**—I am glad I asked the question because it is used and it was confusing me as to what was being sought by the different organisations.

**Mr McHugh**—I would say the correct descriptor is ‘monitoring your prostate health’.

**Senator LUNDY**—‘Monitoring your prostate health’, of which tests are a part of it?

**Mr McHugh**—That is correct.

**Mrs Fairbairn**—I would also clarify that the two tests, the PSA test and DRE test, do not find prostate cancer. They are not definitive of prostate cancer, they are an indicator of some abnormality in the prostate and the next step is a biopsy. I think that is a misunderstanding as well in the discussion.

**Senator LUNDY**—This is very helpful. Thank you. It is only at the point of biopsy that it is a test for cancer?

**Mrs Fairbairn**—Absolutely. That is in the hands of the pathologist who is examining the prostate tissue.

**Mr McHugh**—That is your first definitive piece of information that you have prostate cancer or not.

**CHAIR**—Does the biopsy require hospitalisation?

**Mr McHugh**—Yes. Over in the United States they would do it in a doctor's surgery. You would go in and he would do it there. There is a whole procedure. You need to clean out your bowel, you go into theatre or whatever, so there is a recovery period of time. The answer is yes. You use hospital facilities in the way that we do it in Australia.

**Mr Giles**—They will take between eight and 14 samples. They put 14 needles into the prostate, pull them out and then set all 14 of them to see whether there is cancer in them. If you have cancer in two then you get a particular Gleeson score; if you have cancer in 14 then you get a different Gleeson score.

**Senator LUNDY**—What was the term?

**Mr McHugh**—Monitoring your prostate health.

**Senator LUNDY**—For the record, can you describe what your organisation specifically asks the government to do with respect to monitoring your prostate health?

**Mr Giles**—At the moment, we are not asking the government for anything. Our call of action is to men to take control of their health. We would recommend that every man from 50 onwards would go to his GP and have a conversation about prostate cancer. If they are concerned about prostate cancer, they should have the blood test, the PSA, and they should also have a physical digital erectile examination to feel whether there is any growth on the prostate. At the moment that is our call for action. Both of those tests are funded by the government for every man over 50; if you need to have more than one a year because you are in active surveillance, then the GP writes a letter and the government funds it. There is no data to recommend universal screening for men for prostate cancer.

**Mrs Fairbairn**—I would like to add one more bit of information. Benign prostatic hyperplasia is an enlarged prostate. That is a much more common medical condition in men as they age and it is what gets our grandpas up three or four times at night, so they may need to speak to their GP about it. We also try to clarify that that is a much more common condition so that everyone does not think that any symptom that they have will be prostate cancer.

**Mr McHugh**—I would like to tell my little story about how I monitor myself. The change from my suburban practice into the city was my intention. Before I actually did it I was really quite unwell on a Saturday and I still got in the car, drove to town, and I struck the medico who was on roster at that stage. She basically said, 'You have come to me without any records at all. I want you to do these tests', and that is exactly how I was picked up.

From that stage on I was then diagnosed with prostate cancer. I had a choice. There was not a lot of choice in Queensland 10 years ago. Surgery or radiation was my choice. With radiation I was able to retain a level of work involvement and so I chose radiation because I needed to travel up to Longreach to remain on assignment. I would skip a treatment or two, travel up on

the Sunday, work Monday, come back Tuesday and go to treatment. I have had no trouble whatsoever and no major side effects. My readings have been relatively low. Just as I am now approaching the 10-year goalpost of a cure, my readings are going strange. I am now posed with the possibilities that maybe the prostate, which was not absolutely destroyed, is now becoming alive again or maybe the cancer which was possibly not entirely removed is coming along. I am going into another regime of monitoring without treatment and that sort of thing.

**Senator LUNDY**—Under the supervision of your GP?

**Mr McHugh**—No. I think I know more than my GP. He is quite uninformed. Every time I go to a conference I take him back these pads and all these sorts of things with diagrams.

**Senator LUNDY**—Your advice to people, in terms of monitoring their prostate health, would be to inform themselves, but also to involve their GP in that process? How do you express it?

**Mr McHugh**—Irrespective of our age, we have the right to know what the health of our prostate is. At this stage I have become so involved in the support group activity that I just go direct to a research guy who is a urologist and I go straight to a radiation oncologist, because that is how I had my treatment. I will just go and talk to both of those and they will say what they think. It is not really a consultation, but that is because of the connection that I have.

**Mr Giles**—We run a helpline, a 1800 number that goes nationally, and people ring up all the time. A lot of men and women will ring up and want to talk about prostate cancer. They will always say, ‘Where do I go for these tests? Do I go to my local hospital? There is a breast care clinic, so where do I go?’ We would say, ‘Go to your GP.’ If they say, ‘My GP told me not to worry about prostate cancer and would not even have the conversation’, then we would say, ‘Go and find another GP.’ If you want to have it tested then you should be tested, because you actually sound like you are fully informed and you have decided that prostate cancer is a big issue for you.

Obviously, if you have a family history of prostate cancer you are at greater risk. If your father, grandfather or uncle had prostate cancer the risk can actually go up by seven times. What we increasingly finding is that a lot of men have no idea what their fathers died of. We ask them, ‘What did your father die of?’ They will respond, ‘I don’t know. He was pretty sick at the end.’ If you have got a family history then you need to go and get checked earlier, but they do not know how their fathers died.

**Mrs Fairbairn**—Family history is a really important part of any men’s health policy and we need to encourage some formal way for family history to be recorded. I do not know how it should be recorded, possibly through the family solicitor or through the family GP, but it is a very important marker for health in future generations.

**Mr Giles**—One of the great things that the BCNA, the Breast Cancer Network of Australia, developed was the My Journey book which you can write all your things in. They very kindly gave that to Ovarian Cancer Australia. They did a thing called Resilience, which is a little book for women with ovarian cancer and they have very kindly given that to us. We are now working on a similar diary thing that you can write all your PSA levels and those sorts of things. In Mr McHugh’s case, he needs to know what his treatment options were 10 years ago. Most men are

not as organised as Mr McHugh and it is in a drawer, it is in a shoebox, they ate it or whatever. That is our way in trying to deal with the fact that men do not collect their own data.

**Senator LUNDY**—To finish off, the point that you are making about where government can help you in your organisation's advocacy, one of the areas might be to support a policy that strengthens the public messages on familial history, about reinforcing the advice that you are giving to people and to really develop, for example, this message of monitoring your prostate health, so reinforcing and proliferating that rather than allowing the messages to get confused. Sorry, I am just trying to interpret what you are saying to us.

**Mrs Fairbairn**—It is also the value of support groups.

**Mr Giles**—In 2005 we launched our Be A Man campaign, which was to talk to your doctor about prostate cancer. In 2007 we launched a grey campaign with Angry Anderson telling men to go out there and talk to their doctor. In September, which is international prostate cancer awareness month, we are going to launch a new TV campaign. It will be a great success and raise awareness, but people are still looking for the government to step in and endorse some of these things. It is in the same way that the government does things for breast cancer and ovarian cancer; again, there is nothing for men's health at the moment.

**Senator LUNDY**—This is what this inquiry is all about.

**Mr Giles**—In terms of helping PCFA, for us to work with the government on a campaign that educates men and GPs would be fantastic. The first port of call, as we said, is GPs, but once you have been diagnosed with prostate cancer, although you obviously see your urologist on a regular eight or six week cycle, it is the nurses who are the most important thing.

We have been funding some scholarships through La Trobe University for the past five years. One of our recommendations is the great initiative that the government is doing with the breast care nurses around the country. It is great that they are doing that for breast cancer, but it would be good if they could broaden that out so that they cover all tumour streams. You could have these nurses who are cancer nurses who can deal with the full spectrum of issues for people with cancer.

**Senator LUNDY**—Have you had the opportunity through the consultations that are occurring with the government's development of a men's health policy to present all of these views to the government as yet?

**Mrs Fairbairn**—We have attended every consultation forum in every state, even in rural areas. If it has not been with staff or with Mr McHugh and support group people, then we have an Ambassador program and we have had ambassadors there as well, which has been fantastic. I have been to five of them.

**Senator LUNDY**—Well done.

**Mrs Fairbairn**—They actually asked if I was a groupie.

**Mr Giles**—We are finding that is a great way for men to actually turn up and talk. People would have said, ‘No-one’s going to turn up.’ Even the minister was surprised at how many men wanted to turn up. Our team is ready to talk about prostate cancer, but our team does not need to say anything because it is the men themselves that get up and say, ‘Prostate cancer is our biggest issue.’

**Mrs Fairbairn**—That is why we have attended all of them, so that we can hear from the men that we do not know and what they are saying in the community. It has been very valuable.

**Mr Giles**—We see a lot of men who are in metropolitan Australia, but not a lot of men in rural and regional Australia. We do not see a lot of men who are culturally and linguistically diverse. As our small organisation moves forward one of the things that we are talking to the Department of Health and Ageing about is some sustainability for the PCFA as an organisation. People kept saying to us, ‘How much government funding do you get?’ We say, ‘We’ve been very lucky because we get great community and corporate support’, but down the track we are hoping that will change and we are doing it on a project basis at the moment.

**Mrs Fairbairn**—As an organisation, we are not funded by any government, state or territory, but we do have a couple of projects that are funded?

**Senator LUNDY**—Would you like to be?

**Mrs Fairbairn**—I believe we need to be. I would like to say, in case Professor Richardson did not tell you, that Foundation 49 is not funded by any government either. We are major players in this marketplace and we are all working very collaboratively with other organisations. The National Men’s Health Alliance that the Prostate Cancer Foundation of Australia has initiated is, in fact, the coming together of well-funded organisations and small not-funded organisations with a common ground. We believe that we can reduce inefficiencies. For example, as Mr Giles would agree, the Andrology Australia material is evidence based and fantastic. We use that everywhere we go and we work with Foundation 49 as well. We are looking at what each of us is good at, and where we can do things together. Attracting joint funding, or the National Men’s Health Alliance attracting some secretariat funding could be very valuable.

I would also just like to say that if you look up the World Health Organisation website, the definition that they give is excellent. If you look up men’s health on the World Health Organisation website it does not exist, but women’s health certainly does. We need to see that as a huge opportunity and not a criticism, because men have been involved in women’s health for all of those years as well.

**Senator CASH**—I would like to take you back to the centralised data collection system and get you to expand on where we are at in relation to the collection of data at the moment. Why do you say we need the centralised data collection system and the benefits that would flow from that, and are there any examples of well functioning centralised data collection programs that we could look to by way of an example?

**Mr Giles**—Were you referring to the bioresource?

**Mrs Fairbairn**—Is this the tissue bank?

**Senator LUNDY**—Yes—data, in general, in relation to prostate cancer.

**Mr Giles**—The very first thing that we funded as an organisation was the bioresource. Obviously what was happening was that a lot of people were having their prostates removed, but every urologist was doing it in a different way. It was taking the prostate, looking after it in a different way with different solutions, so you could not pull them all together for research. We thought that was quite silly. We funded a standardisation of the whole system, so now every time a prostate is removed from a man following a radical prostatectomy it is maintained in a similar solution. If you are a researcher you can access world quality samples from across Australia.

It has been quite good in trying to get us some traction about what are the outcomes for men who have radical prostatectomies and what grade their prostate cancer was at. The best example of a uniform system is actually over in Western Australia, where one pathology group does every prostate cancer sample in the state. That is the way that Western Australia works. The database that they are collecting, which PCFA is funding, is giving us world class data. In a couple of years we will be able to look back and say, ‘This person’s prostate was removed. In some respects perhaps they did not need to have it out for another three or four years’, and when we look at their PSA test for the previous couple of years, we could have identified what was going to be an aggressive cancer. There are some good ones around the world, like the Mayo Clinic in America, because it does so many prostates. It is the same with Florida Hospital, where Vip Patel is. He does thousands of robotic surgeries; he has his own database.

**Mr McHugh**—The advice or the urging which Professor Risbridger was making this morning is very much in their field as to where those samples go.

**Mrs Fairbairn**—It is the sharing, rather than the competition.

**Mr McHugh**—Whilst we would fund some of the organisations involved in that, that is not really our call.

**Senator CASH**—Would you agree that we need the more centralised data?

**Mr McHugh**—Yes.

**Mr Giles**—Absolutely.

**Senator CASH**—Is that a recommendation that you would like to see going forward?

**Mr Giles**—Yes, indeed. It goes back to that core message of getting all the researchers to be more integrated. Again, they are so busy with their heads down their test tubes doing what they have to do that they do not get a lot of chance to interact with each other. If we look at those seven centres that we think are world class in Australia, we are considering perhaps offering fellowships where a researcher from one can travel to the other one for six months and they can all interact on an ongoing way to try to share ideas, because they just do not seem to have that opportunity.

We have a Young Investigator Grant Program. It is \$125,000 a year for four years. They are the biggest grants that you can get. That is about getting younger researchers into the prostate

cancer field on novel ideas, and then making them stay so that we can build capacity in the same way that breast cancer did 15 years ago, when particularly the National Breast Cancer Foundation started to put money into research which is now paying huge dividends because they have built capacity.

**Mr McHugh**—That is exactly what Professor Risbridger was saying this morning. We need to bring in this second wave of researchers. Our funding goes a lot in that direction, to bring them into prostate, as well as attracting very competent researchers into the field of prostate who are not yet there.

**Mrs Fairbairn**—It can also be linked to education. Sadly, our universities are declining in science graduates. If you want to take it back a step further, if we have less students applying to do science, research could be in a very bad way 15 years down the track.

**Senator CASH**—I would like to ask you about your national information pack and what that is? What is the purpose of it, how is it funded, and are there any benefits that have flowed from it? Should it be expanded and continued?

**Mr Giles**—Yes, yes and yes. There is some data that shows that the vast majority of men, following their treatment for prostate cancer, in looking back, say that they were uninformed. They were not really aware of what the side effects were going to be. They were not really aware of what the emotional roller coaster was going to be, and that is compounded for their carers who did not seem to know either.

We have developed this idea of a prostate cancer pack, which you get at the time of diagnosis. At the time you get your biopsy and you have got to make those seven decisions, you get a pack that covers all the information. There is some great information out there. Our committee is putting it together to say this is the credible information. It includes our DVD, but it also includes Foundation 49 and Andrology Australia. It is a way of empowering men to go and make the right decisions. PCFA is funding it. We are trialling it through 18 hospitals at the moment across the country, just as a pilot for four months to get some feedback from both the medical professionals but also the men and the carers who are using it. The feedback is incredibly positive, that it was great to get the information at the one time and in the one place.

**Mr McHugh**—The physical thing is that the kit is in a very neat and small case that you can carry in your hand. It has your records of where you need to be, what you want to do, and so it is very much modelled along the lines of the breast cancer document.

**Senator CASH**—In terms of funding, how expensive is producing something like this?

**Mr Giles**—We underestimated what the cost was going to be. Even just for the pilot pack itself and then the evaluation it has been much more expensive. We allocated a budget of \$20,000 for the pilot.

**Senator CASH**—How many packages?

**Mr Giles**—It was for 270 packs to 18 hospitals, but that also included the set-up and the evaluation processes. There are 19,000 men diagnosed with prostate cancer every year, so that is

a huge logistical thing. How do we get them out to all these people? We are evaluating what is the best way to do it. Again, ovarian cancer has their Resilience pack, which is fantastic. That was funded by the William Buckland Foundation here in Victoria. That is the sort of thing, which is fantastic, but they only send out 500 a year. Down the track it would be a fantastic thing to get the government's support to roll that out and also work out what is the distribution and how do we get it out to urologist, GPs or the oncologists so that it is all there.

**Senator CASH**—What is your time frame in terms of the data for the evaluation? How far away will that be?

**Mr Giles**—They are presenting it to the national board on 7 May.

**Senator CASH**—That is not far away at all.

**Mr Giles**—No, not far away at all. We were trying to get some funding from a private donor to get the first \$20,000. It fell through so the board said, 'Use consolidated funds and we will do it.' I will happily send you all of that once it is available.

**Senator CASH**—We would appreciate that. One of the things that you have referred to twice now is what I refer to as the holistic conversation between the person going to the doctor and the doctor. I go in for an issue and all I discuss is the issue, when really what we should have had is a far wider conversation. How do we close that gap, engage those parties, and in particular the doctor, to ask the right questions so that we do not misdiagnose something that we should have diagnosed?

**Mr Giles**—I am very lucky. I live in one suburb and I only work a suburb away, so I get to take my children to the doctors if they are occasionally sick. When I took my little girl to the doctors at the end of last year for something that she had done, my GP at the end of the conversation said to me, 'Before you go I am going to do your blood pressure because you do not look well.' That, to me, is an example of a great GP. There was a discussion today about the workload for GPs. A lot of that could be taken up. People do not want to waste GP's time. Even when they get in the room the guys go, 'The waiting room is full of people. I already waited 20 minutes. I do not want them to wait.' So they go, 'Look, I'm really sorry, this is hurting.' If the GP could say, 'Let's have that conversation', or, 'While you're here, see the practice nurse who could go through this issue with you in more detail because prostate cancer is quite a complicated thing.' The government does have schemes where they tell women to go in and have pap smears and mammograms, so perhaps there could be some government intervention. We did discuss this as something to do for Movember last year. We wanted to get all the guys in Movember with their moustaches on to go in and have a health check.

**Mrs Fairbairn**—There were 94,000 of them.

**Mr Giles**—You could just imagine the Australian General Practice Network when we told them. They just turned around and went, 'You can't flood us with all these young men coming to the GP.' Also, you will not get young men to the doctors if they are not sick. There needs to be some follow up.

**Senator LUNDY**—Maybe you could say, 'Go on your birthday.'

**Mr Giles**—Yes. The Foundation 49 online test is a good way, because you can do it on online and then if it does come up with any issues you can just take it to the doctor. There is the Pit Stop that you mentioned. We have been involved in those in Adelaide at the Clipsal 500 and they are fantastic because all the guys go in. Really the conversation there is pretty brief about prostate cancer, because we are not going to take blood; we are not going to do a physical test. We are just going to talk.

**Senator CASH**—You have got them in and at least you are doing the general overall—

**Mrs Fairbairn**—Pit Stop has been part of the forums in Perth as well.

**Senator LUNDY**—What is your assessment of why Pit Stop is so successful? Is it the novelty value of the approach they take that gets people in?

**Mrs Fairbairn**—I can speak about the Western Australian ones. There is a wonderful man running Pit Stop in Western Australia and I believe that they have money from the agriculture department to run it in rural Western Australia. Sometimes programs that are fantastic are even more fantastic with the right person, or otherwise they can be just average. The model in Western Australia is absolutely a winner on every level and the man in charge of it is outstanding. That is my observation, having worked with them in trials.

**Senator LUNDY**—They are good models, but reinforced by having an effective person at it.

**Mrs Fairbairn**—It has strong leadership and credibility.

**CHAIR**—I regret to say that we are out of time. Senator Cash does have one more question.

**Mrs Fairbairn**—Could I table something?

**CHAIR**—Yes.

**Senator CASH**—I have been asking a number of the witnesses whether they are aware of any effective and innovative campaigns that worked to raise awareness. I would like to ask you why Movember is so successful. Everybody knows about it, and I would hope that your data would show that it has done something to raise awareness. Why has it been so successful?

**Mrs Fairbairn**—It is young men. They are entrepreneurs. It was a family idea and it has worked. It has worked with young men, and nothing else has worked with young men before. It is a clever notion and it is easy, and it gets the girls in as well. It embraces young men, their girlfriends and partners and it has been well marketed by the internet. It is only an internet idea. You cannot find much on their website until about September; then it is all on, and it has been very clever.

**Mr Giles**—It is male only.

**Mr McHugh**—It is blokey.

**Mr Giles**—You have got to grow a moustache. It is an easy thing for them to do, as Mrs Fairbairn said. Shaving your head is also easy, but the side effects go on for a little while, whereas the moustache has a little bit of individuality about it, and it is the workplace environment where it has its greatest impact, because people challenge each other to do it.

**Mrs Fairbairn**—We funded the first Movember. We got right behind it and Mr Giles paid for everything. We took the risk, but it was a great risk.

**Mr Giles**—There are three charities now. The guys who are doing it like them. The young men actually view prostate cancer as being a very important issue for their dads and their granddads. Everyone seems to know someone with prostate cancer and, of course, depression is a huge issue. It is a huge issue for men with prostate cancer, but a huge issue for men in general. They like the cause and it is a fun way to raise money.

**Mrs Fairbairn**—The boys were at the Ute Muster in Deniliquin. It is a big rural event where lots of young men were coming to them about depression. These young Movember men learnt first-hand about depression in rural Australia, and that is why they wanted beyondblue to be part of it.

**Senator CASH**—I would like to put one question on notice. How important is it for the collaboration between the other peak bodies that you have referred to, because you have consistently referred to depression, and I would really like to know more about why you say there needs to be that collaboration?

**Mr Giles**—Certainly.

**CHAIR**—Can you answer it in two minutes or less?

**Mr Giles**—The data we have shows that the vast majority of men who have prostate cancer are at risk from increased depression. We also know that the carers of these men, and the majority of these carers are women who are married to these men, also have a high level of depression because they do not view themselves as carers; they view themselves as wives and their husband is currently sick. There is no mechanism. Some of these men who are rurally isolated do not have access to support services. That is why the support group movement that Bill McHugh chairs is fantastic, because we have 90 support groups around the country.

My meetings this morning with the Cancer Council of Victoria were about the new telephone and online support groups, but depression just keeps coming up as an issue. Therefore, it is not our strength, so we go to beyondblue. We say, ‘What are you doing?’ They are government funded, so we are asking them to do it and we will help get it out.

**Mrs Fairbairn**—There is a great opportunity to do men’s health without factions. Collaborative partnerships. Men’s health could exist without factions. We do not want 17 prostate cancer foundations popping up around Australia. That is just an example, but that is what can happen.

**Mr McHugh**—There is a tsunami of men from baby boomers coming into our age range. They are right on the edge, so the volume is going to go up tremendously.

**CHAIR**—Thank you for your evidence and contribution today.

[3.23 pm]

**RILEY, Ms Karen, Deputy Chief Executive Officer, Bendigo Community Health Service**

**STRANGE, Mr Peter, Nurse Practitioner, Men's Health, Bendigo Community Health Service**

**CHAIR**—I now call the next witnesses, from the Bendigo Community Health Service. We know that you have had a long day and a drive so we thought that rather than keeping you waiting for 10 minutes or so just because of the program we would welcome you to this men's health committee hearing. I note your submission has been received and is numbered 63. Do you have any amendments or alterations to the submission that we have received?

**Ms Riley**—No.

**CHAIR**—I invite you to make a brief opening statement.

**Ms Riley**—Firstly, we would like to thank you for the opportunity to come and have this conversation. I am sure that this is a really special occasion for Mr Strange because he has been quite a pioneer when it comes to rural men's health, particularly in the area that we live in.

I would like to make a few points in terms of introducing our conversation this afternoon. The first thing is to say that this has been a model of rural men's health that has evolved over a period of time. We believe that we have learned many things during that period of time and the opportunity to share our experiences is a really valuable one. The model is based on early intervention and prevention. It really is trying to engage men in a positive way early on and to work with men in a male friendly environment. I am sure there has been a lot of conversation with regard to the difficulty in terms of engaging men, and particularly rural men. One of the strengths of this model is the capacity to do so in a way that has produced some very successful outcomes.

The model has three components. One is around men's health promotion, and we can talk to that if you wish. The second part is around almost a settings approach, so engaging with men in the setting that they work, play or live, which Mr Strange can talk to more broadly. The third one is one that we are particularly proud of and that was establishing a men's health and wellbeing clinic within our general practice at one of our sites at Bendigo Community Health.

The model has been supported by very strong leadership, both in terms of Mr Strange who is someone that is very passionate around men's health, but also because we were fortunate enough to pick up a demonstration project around the nurse practitioner role. That enabled us to support Mr Strange to become a men's health nurse practitioner and he was the first men's health nurse practitioner to be endorsed within Australia, so we are very proud of that. We would like to talk about that role because it is a particularly interesting one, and for us it has opened up a whole range of doors, but it has provided us with some challenges as well.

We have learnt a lot in terms of the development of the model and our experiences along the way. We are at what we would see as a crossroads. We think that there is an opportunity for us to replicate the model more broadly, particularly in rural areas of Australia, but to perhaps use a train-the-trainer model around sharing our experience, giving the information and doing some capacity building in order that other people can benefit from the model that we have produced. Hopefully, it is something that can produce a successful outcome in communities that are not dissimilar to ours.

**CHAIR**—Thank you. I would like to touch on the role and responsibilities of the nurse practitioner. It is something that arose earlier and clearly you have just suggested that it is an area that you think there can be some development in. Specifically, in asking you to describe the duties of a nurse practitioner—Mr Strange might be better placed to do this—regarding the roles and the responsibilities, but also what specific training is required to achieve that level of endorsement?

**Mr Strange**—The nurse practitioner is required to have a masters in nurse practitioner from South Australian university and it is regarded that a nurse needs to be experienced and needs to be specialising in a particular area. It might be a nurse practitioner in accident and emergency, men's health or women's health. The nurse practitioner is able to go outside the usual legal constraints of a nurse by being able to prescribe medication, in my case being able to refer through to specialists, and order diagnostic tests, such as blood tests. I am set by guidelines that are prewritten and accepted, and obviously I had to have an interview with an expert panel to become a nurse practitioner, so then I am able to operate within those guidelines. We took the challenge and we developed this process because there was no-one else doing men's health. That is why we took that challenge on and did a research project over two years and I became a nurse practitioner.

**CHAIR**—How many other nurse practitioners are there now in men's health in Australia?

**Mr Strange**—None.

**CHAIR**—Are you it?

**Mr Strange**—Yes.

**Senator CASH**—Congratulations!

**CHAIR**—You are the expert.

**Mr Strange**—We are trying to encourage others.

**CHAIR**—I congratulate you on that. As a product of your study and your masters you have developed a program, effectively, for the training of nurse practitioners in men's health?

**Mr Strange**—We have developed the program, or if you like the model of practice, that is based on the needs in a regional area as we have seen it. The bread and butter of what I do in a clinic is the annual check-up, which I can quickly whiz through.

**CHAIR**—I would appreciate if you could do that.

**Mr Strange**—We have developed that in consultation with evaluation from the men. We believe we have developed a male-friendly clinic, which is really important. I will just talk about that briefly. I see there are a lot of organisations that do not have male-friendly clinics or services. We run the clinic of an evening so that if men are working they can come, which is really important. Probably the most important thing that we provide now is a 45-minute consultation to do an annual check-up, not a 10-minute consultation, which is impossible to do. We give a copy of those results and information on what the result means to each man that comes through, and we even have a reminder system for the guys to come back and have an annual check-up. That is the bread and butter. We also do other areas of men's health as well if they specifically come in for a particular cause. It is aimed at early intervention and prevention; that is pretty much how it works.

If a man came in for an annual check-up, let us say a 40, 45 or 50-year-old man, then obviously it is related to age and we would go through his past medical history to give us a bit of information. We would ask him about what medications he was already on. We would then start with the family history, which is really important as the previous speaker commented on, particularly with regards to prostate cancer, bowel cancer, cardiovascular health and diabetes, but there are others as well. We ask those questions as we are going through. We do fundamentals of asking about smoking, exercise and weight, and we record all of those important issues.

We would then go and look at some of the cardiovascular risk factors, which include cholesterol. If they have not had it done and they require that, then we order a fasting blood test for cholesterol. It is the same for diabetes. If they are at risk particularly of type 2 diabetes, then we order a fasting blood glucose and we follow through with that. We then look into immunisation to see if they are up to date, particularly with tetanus and pneumococcal vaccinations.

We then get a little bit more personal. We start to talk about depression and mental health, and I would like to say, sexual health. We ask each man that comes through, where it is appropriate, do they have any problems having an erection. There are a few more things that we go through, but the two major areas which are not asked particularly by GPs—and I think GPs are wonderful—are mental health and sexual health, and therefore none of that ever gets discussed.

We would also look at prostate cancer and we talk about whether they require a PSA blood test for prostate cancer and I can also offer digital erectile examination, which I believe should be completed together in most cases. We talk about bowel cancer and the testing that is possible for those age-related faecal occult blood tests. I have probably forgotten a few, including alcohol and drugs.

To get through all those questions is difficult and you need 45 minutes, so it cannot possible be done in 10 minutes. The guys love it because they have the time to discuss their mental health and their sexual health. We bring up those topics, and that is a really effective way to engage with a guy. We are then finding that a high percentage of these men are coming back, so they are engaging in their health and coming back for an annual check-up, which I think is the most rewarding evaluation—that they are coming back year after year. We have been going for three or four years and we are seeing changes over that time.

The biggest barrier is not being given the time and not being asked the questions. They are the two changes which are very important. I think nurses can offer that service and time, and mobilise. We can offer that time and service out into the community and out into the workplace to work in partnership with doctors.

**CHAIR**—Do you work out of a doctor's surgery or do you have your own place of practice?

**Mr Strange**—I have a clinic of an evening which is in a typical doctor's surgery. We also go out to workplaces and the community. There are a couple of really good examples that I would like to give. Yesterday we were out at a place with a population of 100. It has a bush nursing centre that has no doctor. They are farmers who are 50 minutes out of Bendigo and they will not come in and have an annual check-up or come in again for the results. We go out to them and I offer that annual check-up out there. We often give, if appropriate, the results over the phone and we make it easy for them. We simply send an invitation to come in. We have two full days of bookings and we see each individual gentleman for 45 minutes.

We also go out to workplaces, which is an explosion and it is fantastic. We are working with men in their own environment. They are comfortable in that environment. We can do limited screening and full extensive screening, particularly into men's health, in that environment.

We even go out to saleyards. We are very adaptable, so we let the guys sell their sheep first because they will not do anything until that has happened, but then once they have done that we will give them a half-hour preliminary screen out there. They will come in and we give them appointments pretty much on the spot. We go out to meatworks and industrial places. We have run a program in one of our big industries in which I saw 140 men and ran the full program that I do in the medical centre involving the 45-minute session. We took the blood tests out there, delivered those, came back and gave the results to the firm, which requires quite a bit of time, but it was extremely popular and well detailed preventative type health. That was as a trial, but obviously we are running short of manpower.

**CHAIR**—What sort of cost is attached for the individual? Do they have to pay? Are there any out-of-pocket costs to see you?

**Mr Strange**—No.

**CHAIR**—Why not?

**Mr Strange**—If we engage with industry, they will support a per head payment for that.

**Ms Riley**—The employer will pay for that.

**Mr Strange**—That is not always the case. We do not charge when we go out to saleyards and we do not charge for my care, which is pretty much a dead loss for the Bendigo Community Health Service.

**CHAIR**—Is there any other remuneration through Medicare?

**Ms Riley**—No, there is not.

**CHAIR**—There is no recognition of the role of a community practitioner.

**Ms Riley**—I will just take up your point there because I think it is a really important one, the nurse practitioner role is an incredibly valuable one. At this point in time nurse practitioners do not attract a Medicare provider number, so there is no way that Mr Strange or our organisation can attract a rebate through Medicare. Our board and our executive have identified for a number of years that men's health was absolutely a priority, particularly in our area, so we have funded that partially through our core state funding of health promotion, but it only goes so far. We have been very reluctant to charge any sort of fee because, as Mr Strange rightly points out, quite often that is another barrier to men accessing the service. They could just as easily go to a general practitioner where it is bulk billed, but they will not go because it is essentially within a time frame that is not easy for them to adhere to. If we were to charge anything for Mr Strange's services, it would act as a barrier.

**CHAIR**—I can understand that. You made a comment about how you send reminders out to men. Yesterday, the comment was made by one of my Senate colleagues who is not here today that his vet sends a reminder out every year when his dog needs its distemper shots and parvovirus shots, but it seems that we are not reminding human patients, or men, specifically. He said his wife actually gets a reminder from her GP.

**Mr Strange**—That is right.

**CHAIR**—This is something that is a rarity.

**Mr Strange**—Yes. It is very simple. We immediately put that into our program. I am a guy, exactly the same as everyone else. My dentist sends me out a reminder; my doctor does not. The only way that I get my check-up—and he is a great doctor—is for me to remind him. I go and ask for the tests because I know what they are, but I have to remind him that I want this annual check-up. We talk out in the community about that, but that is really important.

The point is that the GP is never going to have enough time to do that part of the work, so it has pretty much been forgotten. The partnership which could be formed between a practice nurse and a doctor is great. Being a nurse practitioner is wonderful. You have got autonomy and you can travel as well, which is ideal, but we have got to also accept that perhaps not every community is going to be able to have a nurse practitioner in men's health as well as other things.

It is about the partnership where there is enough time and interest for people to go out and engage men. To engage men is what we do in the first place. We go out to workplaces and we go out to community. We run a health promotion week in September, which we have been doing for seven years now. We get 1,000 men out in Bendigo every year; it has a population of 100,000. Last year we got 2,000 out because we had Centacare put on another event. We did that early and we had almost too much success early, and we did not have a men's health clinic. We found them saying, 'What is the point of getting interested in my health because when I go there I may only get five, 10 or 15 minutes?' They were really upset about that. That is not blaming GPs; it is just that they are dealing with the acute illnesses as they are coming in, with two or three week's wait, so it is a hard thing to achieve.

To solve the problem, if we are engaging with men in good health and asking them for preventative health, then we have got to have somewhere to be able to service that is male friendly as well, and to be able to handle that. I do believe our model acknowledges that and works with that.

**CHAIR**—That is the other term that you use and it was used throughout your submission. It is about a male friendly environment. Clearly, you have identified some of the issues there in that it is accessible in an environment where men are going to be. It seems that they will not travel particularly far for a preventative maintenance check-up. Is having a male practitioner a part of being a male friendly environment?

**Mr Strange**—I am not sure. I have read a lot of theories about that and I get asked that question all the time. If it is presented in the right way then in most areas it would be okay if there was a female practitioner there. I have seen a couple of very good female health promoters that were interested in men's health that have done very well and they, without blushing or anything, can talk about all of those issues.

I see a lot of men that have mental health issues, particularly relationship issues or maybe depression, and it can get very difficult for men to bring that topic up. Also, with sexual health issues with regards to erectile dysfunction and those sorts of things, a man-to-man relationship is good. There are advantages, but I do not think that it is absolutely vital that we have to have male nurses or male doctors to do that.

**CHAIR**—Could it possibly be an impediment to some men discussing these issues in that they do not want to discuss it with another man?

**Mr Strange**—No. I find it is very relaxed when talking to men about all of these issues and there is almost a sigh of relief when we bring it up. A little anecdote which I would really like to say because it was sort of astounding to us is that when I was training to be a nurse practitioner all of the patients would come through. I had my P-plates on and all of the patients would come through and they would see me, and then they would see a GP who was supporting the initial system. Once a month we would go and have a case conference about the people that I was seeing, to see that I was doing everything right. We went over all the month's patients together to see that I was doing things correctly. We never used to have a question on erectile dysfunction in the early stages because we thought that was a bit embarrassing actually, but one month we had five or six men that the GP found to have that problem. They saw me first. I did not find that problem, or they did not bring up that issue. I was absolutely distraught with that. I said, 'What am I doing wrong?' He said, 'I've decided to start asking.'

**Senator CASH**—It is a sense of permission.

**Mr Strange**—These men were actually coming in wanting us to ask them about mental health, sexual health and some of those problems. They would go through a 45-minute consultation and if you did not ask them that question then they would walk out the door with us having not heard what they wanted to say. We need to invite them. You need to present that time. The 45 minutes is important. How can you bring up those issues if you do not get to know your patient first? You need to have time and then kindly ask them about it, and then they will be very open about it. I have no problems with them talking about any of those issues at all.

**CHAIR**—Do you find that you are replacing the role of a GP in their lives or do you see what you are doing as complementary to the work of general practice in ensuring there is appropriate accommodations made for these annual check-ups which GPs, who are under pressure from the time constraints, may not be able to provide?

**Mr Strange**—It is very much complementary and it is filling the void. We are recognising that we are establishing a service where there is a hole at the moment. There is no blame on the GPs. If they are not getting all of that done, we are able to do that and most, if not all, of the information that I gather—so if I find that a PSA is up or something is wrong—I offer to refer back to their GP. If they have not got a GP I will find them a GP. That is part of the service that, if we cannot provide one, then we follow that through. It is part of a nurse practitioner's or a nurse's role to be able to do that. I do give out some medications but we stop at a particular level. Obviously they need support in that way as well.

**CHAIR**—What is your strike rate when you say to men, 'You haven't had a cholesterol screening?' The other one was immunisation where you said that they had to fast in order to receive them. When you say, 'You've got to fast and come back and see me tomorrow or next week or next month', what is your success rate in getting them back again?

**Mr Strange**—Almost all of them. There are very few that do not. I would say probably five per cent might not come back. It is because we have spent so much time with them. We usually order that test. They go away the next day, have the test, and then they come back when it is suitable. Some of them take two or three days. Some of them take two or three weeks.

**CHAIR**—Do you do the test yourself? Is it just blood for cholesterol and things?

**Mr Strange**—Yes. We do different tests. Obviously it is more than I have mentioned here.

**CHAIR**—Do you take the blood and then send it off?

**Mr Strange**—No. I give them a pathology slip and it is done the next day at a pathologist in Bendigo. It is based on the fact that a lot of them are fasting. We could do it, but it is of an evening as well, so it is best to have a specimen done and processed straightaway.

**CHAIR**—What about bowel cancer screening? There has been a program where bowel cancer test kits were sent out to men over the age of 50. Do you have those kits available as well?

**Mr Strange**—Absolutely. We do it very commonly. As you said, that program is targeting people turning 50 and 65. I might be corrected. It might be 50 and 60. It is for all the men in between that. It is recommended by Cancer Victoria that men, and women for that matter, after the age of 50 have a faecal occult blood test bowel screen every two years and it is statistically proven to pick up enough that is important. I offer all the men that program. They go away and collect those specimens and present back for the results.

**Senator CASH**—In relation to the conversation between the nurse practitioner or a doctor and the patient, translated back to a doctor I have got 15 minutes to see the person. They have come in for a certain ailment. How do we go about engaging the doctor and the patient to

actually have that additional conversation that you are clearly able to have with your patients and ask those additional questions that might lead us on to other issues?

**Mr Strange**—One way a doctor can do it, and some doctors do, is by doing the annual check-up over various stages. They could do a little bit of it at the consultation and then they do a little bit more as they go on. If they record that on a computer then they can tick it off as they go along. It is not vital every year, but as long as you get some of those tests done, providing that patient is coming in on a reasonably regular basis, which is the problem.

**Senator CASH**—How do you overcome that problem? I note that you said that you have a lot of your clinics at night, but many doctors' surgeries are open from 8 am to 6 pm, so a lot of men cannot get there. How do you overcome that having to come back factor when it may not be convenient?

**Mr Strange**—Do you mean having to come back after they have seen them once?

**Senator CASH**—Yes, if you are advocating on an ongoing basis doing tests over a period of time.

**Mr Strange**—You need to engage other people's help. You need to engage nurses and practice nurses that are experienced in that sort of area or can gain experience in that area. They can do a lot of that and then, in consultation with the GP, can follow through.

**Senator CASH**—A lot of the non-diagnostic tests such as the taking of the blood.

**Mr Strange**—Yes. The preliminary tests can be done, fundamentally, with the support of the doctor. This is where the nurse practitioner actually eventuated because they recognised that the nurse could actually do this, but they are not legally allowed to do that. That is a really good case to take. If you look at type 2 diabetes, which is an explosion in the modern world—America and Australia—my guidelines state that I ask a male what risk factors he has for type 2 diabetes. Over 55, over 45 and overweight, over 45 and high blood pressure, Aboriginal and Torres Strait Islander and over 35 are all risk factors. I also ask them the chest pain question that is put in there. If he has one of those risk factors and he has not recently had a fasting blood glucose, then that is what he should have. A nurse can do that and should be able to order that test at that point of time. As a nurse practitioner I can do that. With the doctor sitting in the next room it can almost be signed and can be done in agreement based on that setting. That can be done. When the results come back, if they are normal then that is okay. If they are abnormal then obviously we refer on and we engage in that. I believe that is where the partnership can grow and is really important.

The problem is the questions are not being asked and they are not being engaged. They are coming in with a sore knee and they are going out with their knee fixed, but we still do not know whether they are going to have a heart attack the next day.

**Ms Riley**—I would like to respond to that in the context of how you might be able to make it easier for GPs to have the type of consultation that Mr Strange describes. Maybe it sits in the comparison to women's health where there is an incentive program for GPs to make sure that pap screening and so forth are done. If there was an item number that funded a consultation and

incentivised the practice of going through this type of consultation that Mr Strange describes, then GPs would find it easier to undertake that. The way we currently fund GPs is on a single discipline model, whereas we believe increasingly that a better way to fund these sorts of practices is to fund the team to do the consultation or the care in that sense. Mr Strange often talks about the partnership, and it is a critical partnership between the GP and the nurse practitioner or the GP and a practice nurse, but for the most part the system we have in place in terms of funding is really only funding the GP.

**Senator CASH**—So for my consultation I am billed number 60 or whatever the Medicare item might be?

**Ms Riley**—That is right.

**Senator CASH**—That was my consultation. Are you saying that I should be billed number 61, for example, which means that the doctor can then say, ‘Peter, step outside. You are now going to have your blood pressure taken by the nurse practitioner’?

**Ms Riley**—Yes.

**Senator CASH**—This will obviously cost more, but I have now had more services made available to me.

**Ms Riley**—Yes.

**Mr Strange**—That person is able to provide outreach services. We are saying that even if I had a men’s health clinic going, even if it is male friendly, the guys will still not necessarily turn up for preventative health care. I have to go out and, if you like, sell myself and sell the clinic. I have to go out into the workplace and the community to engage with the men where they feel comfortable and then they will come and utilise the clinic. It is required that a health promotion worker, a men’s health worker, a nurse, a practice nurse or someone like that, needs to go out and create that, and then we need to have that service. That is a successful model.

Here is an example of what can happen when I go to a workplace and I run a health check within the program. We did an evaluation at an industry in Bendigo and half of the guys turned up for this free evaluation. The employer gave them 40 minutes off work. It was a lot of machinery and they organised for someone else to go over and take their machines, but only half of them turned up for this free evaluation. We were allowed to go out on to the floor and talk to the guys that did not turn up. We said, ‘Why didn’t you turn up?’ There were confidentiality problems. They were worried what was going to happen in that little room with Peter Strange. So now before we go out to a workplace I go out and I talk to all the guys first. It is a half hour talk, have a little bit of fun with them, say what we are going to do, tell them the importance of preventative health and then say, ‘Put your hands up if you want to come and have a screening program’, and that has changed that dramatically. It is about allaying the fears.

**Senator CASH**—Or normalising?

**Mr Strange**—Yes, normalising it and it is a male-friendly way of doing it. Once they have been introduced to you, met you and you have been out there even for a preliminary screen,

which is not as extensive, then they can come in to a clinic or come in to a doctor. The doctors also need to be educated. If we get that far and they get a five minute consultation, looking at their watch, then all that good work is flattened.

**Senator CASH**—In listening to you and certainly reading your submission, your health services, the ones that you particularly provide, would seem to be responsive to men. How do we translate that into the wider community as a federal government? How do we ensure that health services do become more responsive to men?

**Mr Strange**—Obviously I am supportive of nurses being involved in this partnership. I wrote an article in the *Australian Nursing Journal* a little while ago, which is basically spelling out my model of practice and I got contacts from all over Australia. They loved it. There were many people who were interested in doing men's health as nurses all over Australia, in a fascinating variety of areas—from prison, the outback to urological wards. They were interested in being involved in that. The question was, 'What is your job description and how did you get funded? How can I get my organisation funded?' There are very few practical men's health workers or nurses, whatever you want to call them, throughout Australia. The organisation has not got a pot of money to be able to fund them and then the person that was interested in it cannot get their organisation to fund them. I have been very lucky that the organisation put it in their strategic plans seven years ago that they wanted to do something with men's health because of the statistics, and I am one of the very few people that have got that support. At the end of the conversation we find them saying, 'I'm no further. I can't convince my organisation. There's no money.'

It is funding the positions and then I would like for those people to be educated to a certain extent to be male friendly in health promotion and the clinic. I think they could work with the divisions, general practice and GPs, and develop a program where we have to firstly engage the men out in the community, whatever we can do, then provide that service and then, in conjunction with that, as it gets more complex with the health issues, then certainly the GP handles that. That would be very effective in a preventative health practice in early intervention.

**Ms Riley**—I would like to respond to that as well. Again, I am making the comparison to women's health. One of the things that really mobilised this country's response to women's health and the quality outcomes that it has achieved was a women's health policy. A men's health policy, in that sense, really does give credence and it gives a framework within which people can work. Again, if you think about the women's health policy—and this is going back some time now—it was a dual strategy so it was around direct service delivery, and certainly the model that Mr Strange describes is around direct service, but the other was about capacity building and actually influencing and increasing the capacity of mainstream providers to provide male sensitive practice. In the instance with women's health it was all around women sensitive practice. I would suggest that the same could be framed around men's health, albeit the engagement strategies are very different and they need to be led by people like Mr Strange who have developed this skill and expertise.

He is right. We do, as an organisation, get requests from all over Australia for Mr Strange to participate on working groups and to publish. We would like to be able to support that, and we do, because it is critically important, particularly from where we sit in terms of rural practice and rural men's health promotion. It is quite different to those in terms of urban. A lot can be learned

in terms of the women's health policy, and a men's health policy goes a very long way to being the enabler of this.

**Senator CASH**—You have both mentioned early intervention and prevention. One of the issues that has been raised today is taking all of this back to the school curriculum. What are your comments on that in terms of early intervention?

**Mr Strange**—I believe that is a great way of going. I have stepped back from that because we have run out of time. It was very interesting with regards to father and son days in schools. It was inundated. I was asked to go out and my manager said, 'We just can't do that because we can't spread you that thin.' So we really stayed out of it. Within the Bendigo Community Health Service we do have people that go out to the school with school focused youth services and we have also trialled connecting up with a university at that level and tried to engage young men with regards to men's health. We have found that particularly difficult. The 18-to-22 age group is a difficult area to penetrate and at this stage I can honestly say that we have not been successful.

We do get young men come along to the men's health clinic, and the numbers are increasing, with sexually transmitted infections, testicular cancer and concerns like that. The percentage is certainly not as high as the other age groups. I find that we do need to keep on passing those messages on. Even though they do not often react face to face if I was doing a talk with them or be quite as open as the older men, I find that they do take up the service. I think it is a different style. Perhaps I am too old for that.

**Senator CASH**—I would like to place one question on notice.

**CHAIR**—You can ask it now.

**Senator CASH**—How do you believe the health and wellbeing needs of men in rural and remote communities could be better met?

**Mr Strange**—It is exactly what we are doing, which is increasing funding and increasing positions that are directed towards those sorts of areas. We certainly need to dictate a plan that is effective. We need something like we have got, that is a model effective for this particular area, and there needs to be an encouragement to educate people in that sort of area. So educate clinicians, run those programs and evaluate those programs, which will go a long way to improving that.

The model that I have got can be tweaked and changed to different environments. As I talk to different people around Australia I find that they would do it a slightly different way and they will improve that. So pilot programs such as this and positions that are funded we would develop and we can discuss, change and alter. It needs to be evaluated. We have done a small amount of evaluation. We would like to do more but, once again, we are running out of time in keeping up with the service. We have got to be very careful that we do not just supply the clinical service and not evaluate it and push it on.

A big part of my job now is actually trying to develop more men's health workers to see that nurse practitioner partnerships between doctors, nurses and health promoters in a big area. That is a huge job, but I think if we have taken that on and we have a funding program or some pilot

programs then that will certainly develop. We do know how to engage with men now and they will certainly be engaged. As a matter of fact, once they do get engaged they are often better than women at taking care of their health, but that initial engagement is really important and the ongoing service that needs to be delivered.

**Ms Riley**—I have one comment about that. Mr Strange is right. The strength of our model is around the engagement and it is the timeliness that is very important within the context of rural men. We do believe that the model, in itself, is one that is just sitting there and could be replicated.

As I said, Mr Strange receives invitations to go Australia wide, and we support him as best we can to do that, but it would be great to develop a manual. We often talk about it, to do more rigorous evaluation. We have a research partnership with one of the local universities where we are looking to do this, but from a rural men's health perspective we think that capacity building and developing a framework that overarches the model that we have developed, that brings in those partners as in the GPs, the practice nurses and the GP networks, and then the existing infrastructure within small rural communities just needs to be mobilised.

**CHAIR**—Thank you for coming in today. We really appreciate your time. It has been terrific. That concludes today's proceedings. I thank all the witnesses for their informative presentations. I also thank Hansard for their indulgence today, and the members of the secretariat. We will now adjourn until tomorrow.

**Committee adjourned at 4.05 pm**