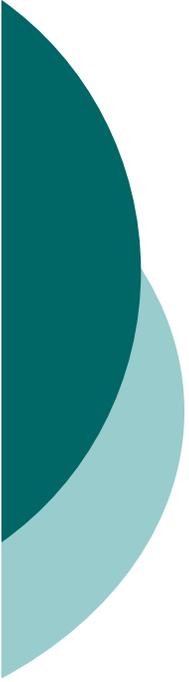




National Policy Agenda The Men's Health Example

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in Primary Health Care, UWS,
Men's Health Ambassador,
Visiting Professor of Public Health, Birzeit, Palestine



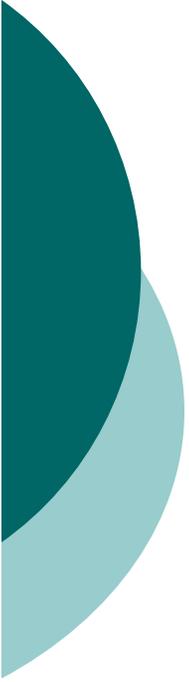
“Chronic” and “Acute”

- The distinction between chronic and acute conditions is sometimes useful: acute being those conditions generally caused by infection and chronic those with a less clearly specific aetiology, more imbedded in the contexts of people’s lives rather than in a single identifiable factor like a virus or some bacteria.
- However, sometimes the distinction is not so useful – some “acute” conditions like acute respiratory infections can only be understood and dealt with in the light of the chronic conditions of people’s lives, like poverty, disenfranchisement and the like.



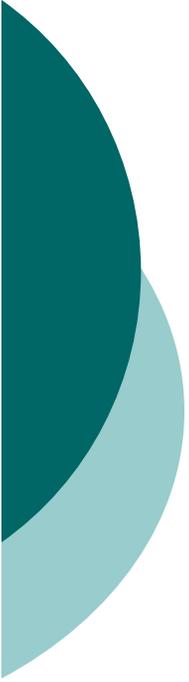
Acute and chronic in Palestine

- An example from Palestine: one does not have to be a genius to work out that people presenting with acute respiratory infections or gastroenteritis in Gaza may be classified as having “acute” conditions, but also that to deal with the condition effectively one has at least to acknowledge the “chronic” pathogenic state in which they live: a large concentration camp with limited food, movement, water supply.



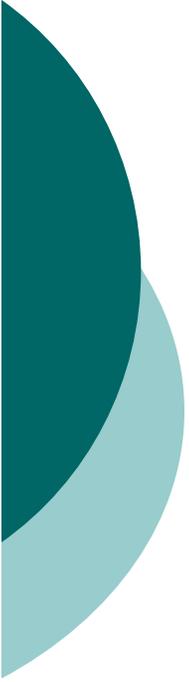
Chronic contexts

- It is clear that the contexts of people's lives (whether Palestine, NSW or the NT) have a great influence on their health and result in poor health for many, whether we call these diseases "acute" or "chronic".
- I think it also appropriate at this point to raise the issue of Aboriginal definitions of health – there is some evidence that the Aboriginal definition of health as encompassing the total physical, psychological well being of individuals and communities influenced the World Health Organisation's 1940's definition
- We should learn with and from Aboriginal people



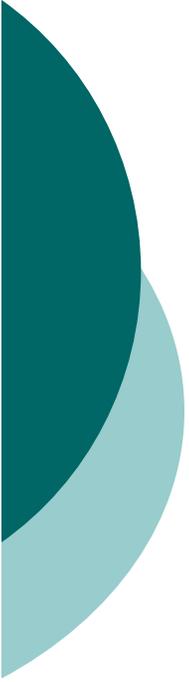
Honouring

- It is customary to acknowledge elders and traditional owners at the beginning of presentations. I do so now, acknowledging the traditional owners of the land we are now on, both living and dead, and my own elders, Uncle Wes Marne in Sydney and Mick Adams of NACCHO
- In particular, I want to honour the recently tragically dead Mr Ward who died in his own country, burned alive in the back of a security van. The horror of this death is enormous and it dramatically illustrates that if we are to close any gaps we must look beyond “life style” and address the chronic conditions of exclusion and racism which are at the root of many diseases in our country.



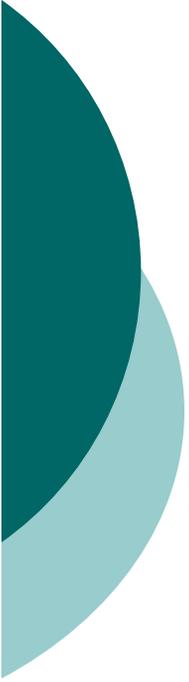
Medical Model of Health

- Although it is somewhat simplistic, there is truth in the notion that our health systems all over the world are heavily imbalanced, focusing on the treatment of conditions which present themselves to our systems of care. Often these conditions are acute and the “solutions” are seen to consist of medical interventions, either pharmaceutical or surgical. The money and prestige in our society have, for a long time, gone to fund expensive medical technology and they still do.



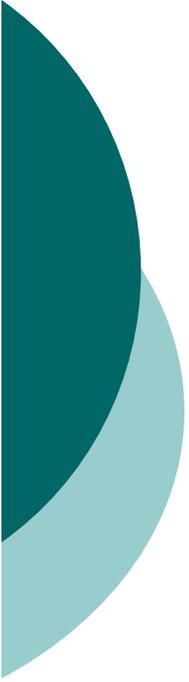
Professional active, patient and community passive

- The medical model has the health professional in an active role: working *for* and sometimes *on* the patient (sometimes necessary as in surgery) and the patient and community in a passive role
- Especially with chronic conditions we need a model which sees the professional as *partner* with the patient and the community in a much more active role
- Dramatic medicine (like surgery) does not give a good model for the whole of the health system



Limitations of the Medical Model

- Most critics say that the model of health care which we call the medical model is largely out-dated by our understandings both of human beings' health and by the process of healing and of maintaining well-being in individuals and communities.
- It nevertheless shapes much health funding



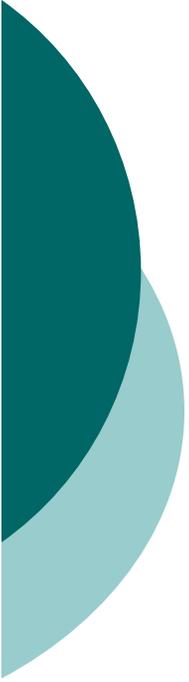
An Engineering Model?

- The medical model can be seen as an engineering model.
- This way of thinking of health and health work is firmly embedded in western thinking and practice, with the doctor or nurse as the engineer and the patient as the broken down vehicle to be fixed up.
- At its worst the medical model reduces human health and illness to the biological, to the **pathological - what is wrong - on the physical or mental level.**



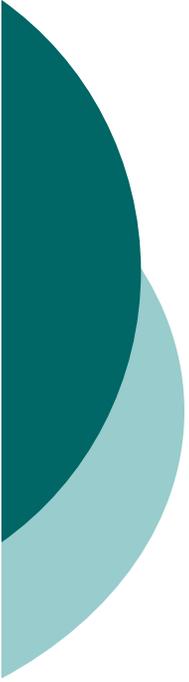
Limitations of the engineering model

- Is an ill human being simply a broken-down body/machine to be fixed? Clearly not.
- When a child falls in the playground she or he is not just a bruised and bleeding leg.
- When an elderly person is admitted to hospital in Sydney with malnutrition, her condition is not just a biological one



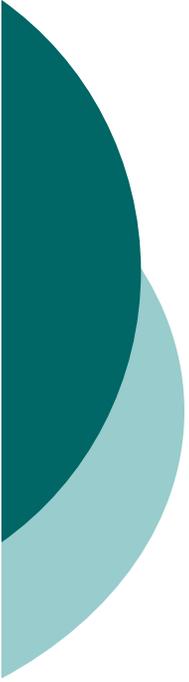
Microscope AND “Macroscope”

- By this is meant the need to see the biological e.g. through the microscope
- but in its real setting: the social, economic, cultural, emotional context of the person (“macroscope”).
- In this way health care would not pretend to have simple technical answers for complex human problems
- (Macdonald 1994, 2000)



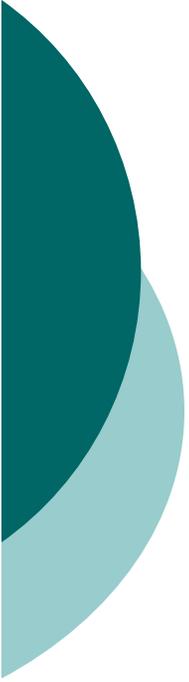
Medical Model's Limitation in health education

- Often health education in the medical model means the doctor or the nurse telling the patient what he or she should do to get well: don't do this or do that. Modern understanding of human health and how human beings behave has developed to show that such simplistic notions of health education are out of date.
- Health promotion now talks of helping people to make healthy choices. Perhaps we should have *life-context* health education rather than *lifestyle* education.
- The mere handing out of information regardless of the context of the lives of those people who receive this message is not education in the true sense it is more like propaganda.



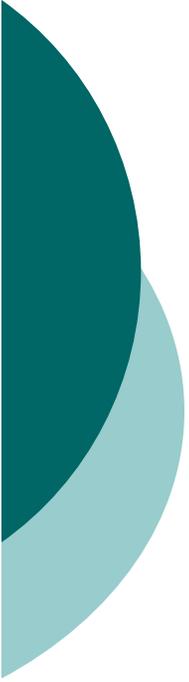
Primary Health Care: expanding the Medical Model

- One of the first global attempts to expand the medical model was the WHO initiative called “Primary Health Care” (PHC)
- PHC saw the importance of individual clinical care – everyone should have the right to Affordable, Accessible and Appropriate care (3 A’s)
- But Comprehensive PHC embraced the role of other sectors like housing, education etc in building health
- PHC saw an active role for the community and the individual
- And denounced injustice, inequalities in health



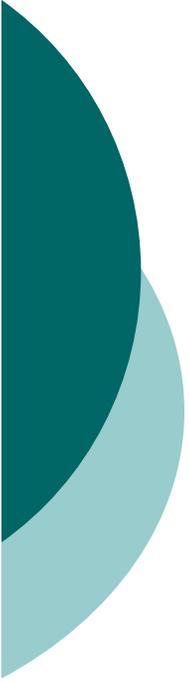
Health Promotion

- Alma Ata laid the foundation for the Ottawa Charter on Health Promotion in 1986 (WHO, 1986) which spelled out the need to promote healthy environments and healthy social policies. This led to the notion of 'settings': the idea that health should be addressed in the context, the environment in which people live out their lives, whether their homes, their communities, schools or workplaces.
- The role of communities and their involvement was acknowledged
- Interestingly, one of the "objectives of Health Promotion was "the re-orientation of the health services". – 1986 till now... has it happened? Even been talked about?



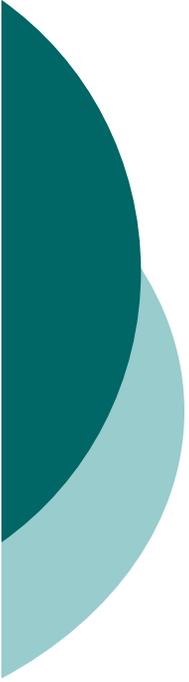
Weak Primary Health Care

- Alma Ata proposed a strong (Comprehensive) PHC: good access to essential care for all PLUS the “3 Pillars” of PHC: Equity, intersectoral work and PARTICIPATION 1978
- USAID (1979) followed by World Bank said it wouldn't work and proposed a weak version –Selective PHC, endorsed, sadly by Unicef



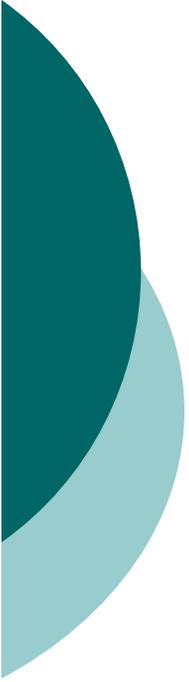
“Strong” and “Weak” Public Health

- Example of ORT (Oral rehydration therapy):
- Comprehensive PHC advocated strong Public Health e.g. tackle diarrheal disease with community involvement: good water supplies, waste disposal, political change etc
- USAID/Unicef said too difficult: let's have Oral Rehydration: individual family responsibility dealing with SYMPTOMS



Strong Public Health and community involvement

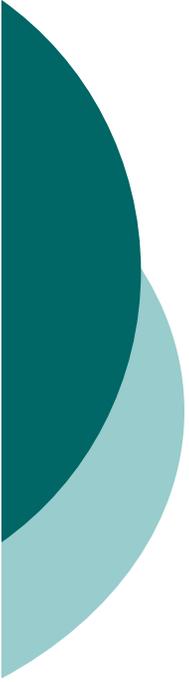
- Essential to strong Public Health, what is sometimes called the “New Public Health” (Fran Baum) is the active involvement of the community
- Conservative medicine and conservative politics prefer top-down approaches with a passive community. Why?



Strong and Weak Health Promotion?

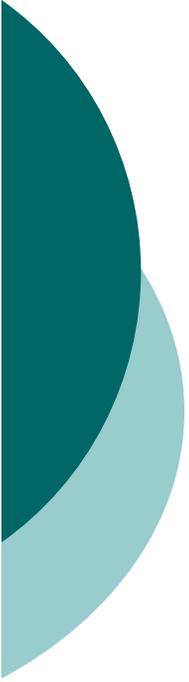
Although Health Promotion was conceived as involving communities actively it quickly became (in many places) “weak” and often consists of professionals telling people what to do

- Moreover, from the beginning Health Promotion was seen as separate from medicine and not an essential part of a whole, so medicine can ignore it if it likes
- It does NOT involve re-orientation of health systems



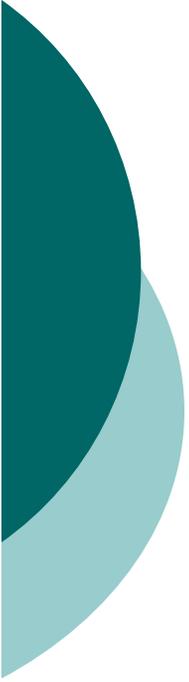
From clinical intervention to behavioural modification

- So, although it is somewhat of a caricature, one can surely say that the dominant model of thought behind health services is one of medical intervention.
- Of course, prevention has always been recognised as being important, sometimes more in rhetoric than in reality. When the medical world does venture into the social world it is often with exhortations to do with behavioural modification and “life-style”. Obesity, abuse of alcohol, smoking cessation etc.



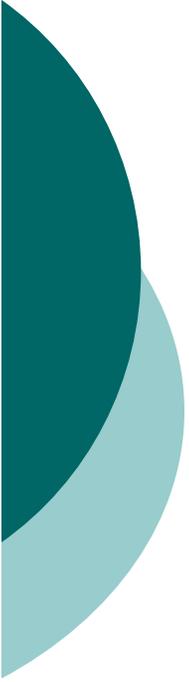
Too easy

- The problem with this emphasis on lifestyle is that it is too easy. Deliberately or otherwise, when the health profession encourages lifestyle changes it often does so making abstraction from the context, the social and economic milieu of those whose health it is claiming to improve.



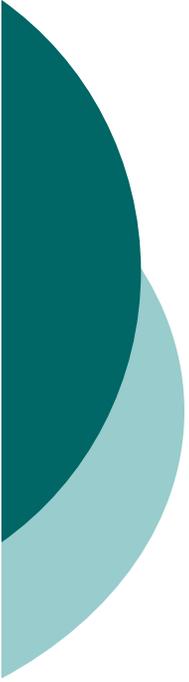
Preventative Health Task Force

- The Strategy puts forward a number of recommendations aiming to make Australia the healthiest nation by 2020. Specifically, the Strategy aims to:
 - halt and reverse the rise in overweight and obesity
 - reduce the prevalence of daily smoking to 10% or less
 - reduce the proportion of Australians who drink at short-term risky/high-risk levels to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels to 7%
- contribute to the 'Close the Gap' target for Indigenous people, reducing the life expectancy gap between Indigenous and non-Indigenous people. These targets have been aligned with similar targets set by the Council of Australian Governments (COAG) for the National Partnership Agreement on Preventive Health and the National Healthcare Agreement.
- WE MUST ASK: LIFE CONTEXT OR LIFE STYLE?



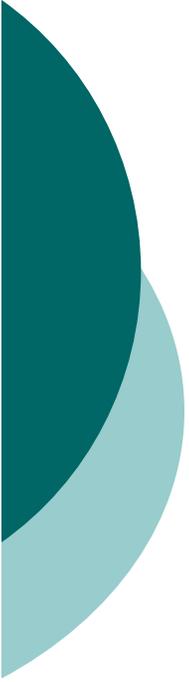
Glasgow

- A run down housing estate: Acute Respiratory Infections (ARI): antibiotics and exhortations to keep children warm
- “Brown bread and jogging”? “Get lost”
- The people improved the houses, the ARI disappeared



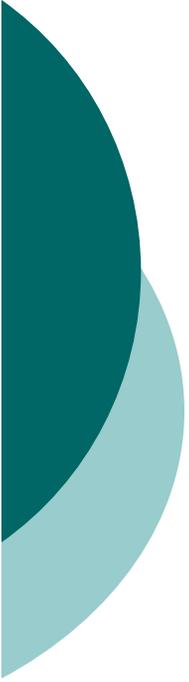
NSW: PND and Suicide

- PND – do we wait till mothers knock at the door of the surgery?
- (The LINCIS program)
- Suicide: again, do we wait till people knock at our doors with suicidal intent?
- (The Shed in Mt Druitt)
- (Incidentally both = PHC!)
- Without community involvement???



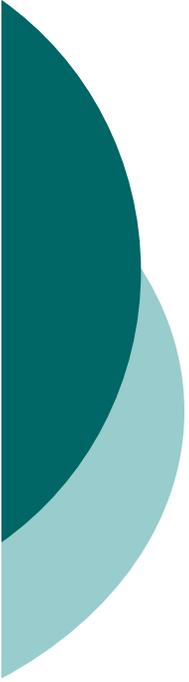
Salutogenesis

- Health systems can no longer be contained within a model in which the main focus is the health professional acting upon a decontextualized needy or un-well passive individual.
- Just as inadequate in terms of the role of *context* is the notion of health as being principally a matter of individual responsibility: the person 'taking charge' of the factors affecting their health.
- We need a way of thinking – and acting – about health which sees the wellbeing of a person as a process in which that person interacts dynamically with their total environment: their physical, emotional and social contexts



Resilience plus

- *Salutogenesis* potentially encompasses the idea of resilience but would include also being nourished by the positive in the environment. The word allows for the process of engagement with those things in the environment **which foster health, which nourish wellness.**



The social determinants of health

- The research into the *social determinants of health* gives us very powerful evidence that health is inextricably linked to context, to environment.

Common sense tells us that health is at least closely linked to our surroundings – our physical, social and spiritual context – and that it (health) has to do with the *interaction of human beings with this environment*. The studies on the social determinants of health give substance to this common sense view by providing us with empirical evidence of this impact.

This framework takes us way beyond individual pathologies and behavioural change

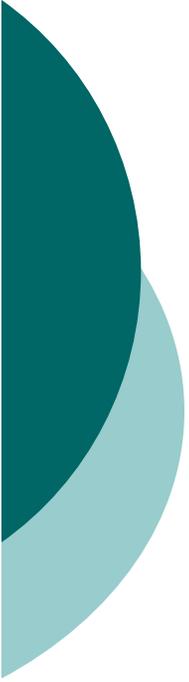


WHO (Europe): The Solid Facts

- The determinants chosen for inclusion in this document by WHO are:

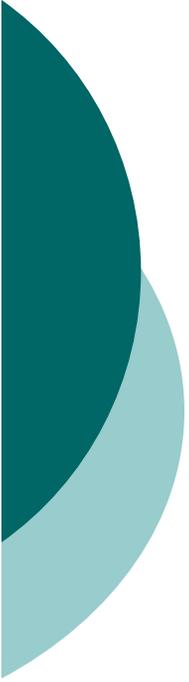
- 1 The social gradient
- 2 Stress
- 3 Early life
- 4 Social exclusion
- 5 Work
- 6 Unemployment
- 7 Social support
- 8 Addiction
- 9 Food
- 10 Transport

(Many, myself included, see the need to add gender and the Global Commission has expanded way beyond Europe)



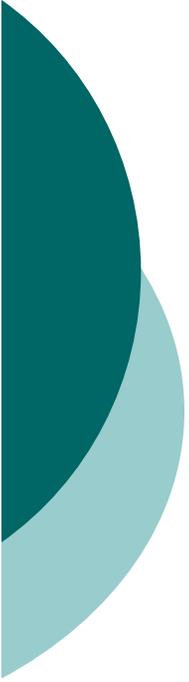
Social determinants **interact**

- E.g. PND: social gradient, transport, social exclusion all contribute to the “risk”
- E.g. suicide prevention: own study shows that unemployment, separation from support (e.g. from children), social exclusion – all contribute.



Social determinants of HEALTH

- Importantly, the social determinants allow us to break the pathologising perspective – they are determinants of **health** and not just disease
- They help us focus on the salutogenic, what is nourishing of wellbeing – social support, early childhood, meaningful employment etc
- So **Social Epidemiology**, the study of social determinants, must look at the roots of health and not just study disease



Now! – Pathology focus, behavioural change and Men's Health Policy

- International Men's Health Conferences focus on the prostate – not on support for men who experience difficulties after operations, but on technical interventions

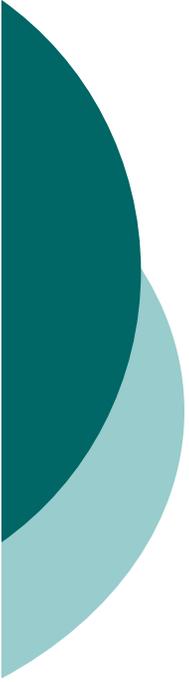
When they speak of the social dimensions, it is not of social determinants but of men behaving badly

In policy and funding, much emphasis is put on the physical or social pathologies of men



“Masculinity is the problem”

- “Masculinity”, a term generally attributed to Professor Connell, helped us see that there are many “masculinities” and the stereotyping of genders can be unhelpful
- It is a sociological construct, not evidence-based
- Unfortunately, “masculinity”, especially in Australia, has reinforced a deficit idea of men: “Men don’t go to the doctor”, “men don’t get in touch with their feelings”
“Men are violent”



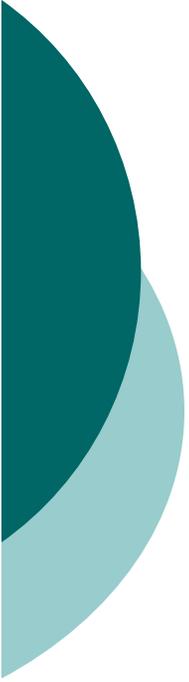
One example of a policy: Doctors Reform Society

- 8.3.1 The DRS recognises that there are particular issues for men which affect their health. These issues can arise from the process of socialisation to compete and dominate in social and political spheres which can foster violence. As a result of this, many men experience a number of psychological difficulties, a reluctance to acknowledge and address their own health issues and diffidence in approaching health services. (see also [15. Violence and Aggression](#))

8.3.2 The DRS recognises that despite the fact that the majority of health research has been conducted on men and that there are biases towards men in health care teaching (due to the dominance of men in teaching and research positions), men still have poorer health in a number of areas and a lower life expectancy than women.

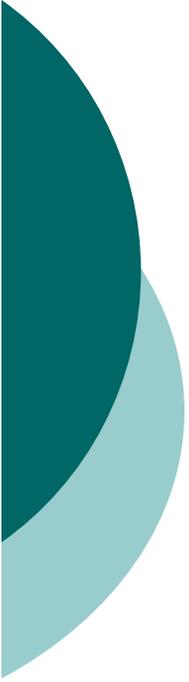
8.3.3 The DRS believes that increased attention to lifestyle changes (such as exercise, reduction of alcohol consumption, and strategies to reduce violence) are more important in improving the health of men than technological improvements in health care.

- How salutogenic is this?



A pathologising focus

- 5 men a day kill themselves in Australia and 1 woman
- 5 **males** – if it were 5 **whales** there would be a national empathetic movement. But there isn't
- “At least they (men) are doing something right” – comment from prominent Australian expert in social capital
- What is obscene in this is not just the lack of compassion but that there was not a national outrage at the remark
- We have a culture which tolerates this putting down of men



This government

- *8 June 2008*

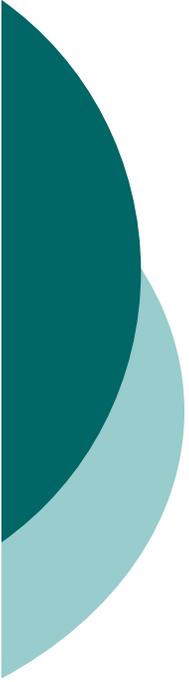
The Rudd Government will develop Australia's first ever National Men's Health Policy - in recognition of the fact that men often have poorer health than women, are likely to die earlier, and are at greater risk of suicide.

- <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr094.htm?OpenDocument&yr=2008&mth=6>



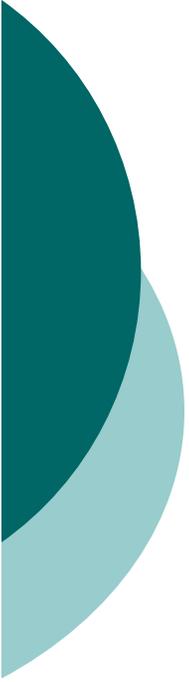
Same (Australian Government)

- *Men's health is too often overlooked. This comes at a cost. We know that:*
- *Men are expected to live 4.8 years less than women*
- *Men are three times more likely to commit suicide*
- *Men experience 70 per cent of the burden of disease related to injury*
- *Men are over-represented in deaths related to HIV/AIDS.*
- *The health of Indigenous men is also significantly worse than for any other group in Australia, with an average life expectancy of only 59 years - some 20 years less than non-Indigenous Australian males.*



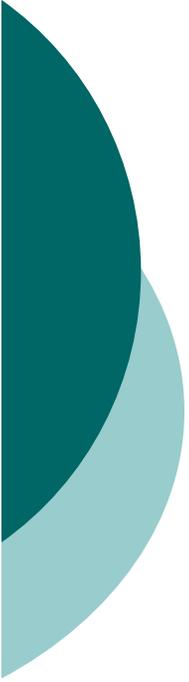
The National Men's Health Policy

- The discussion document speaks of the social determinants of men's health. For once we have the chance to build a rational and evidence based policy about men's health- looking at the effect of work, unemployment, lack of access to services etc would all be taken into consideration



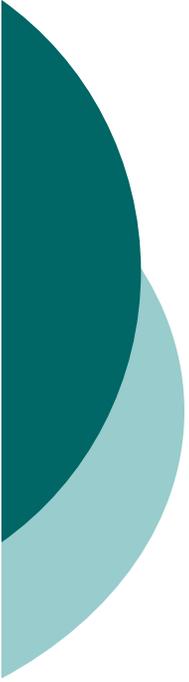
Gender as a Social determinant of men's health = men's power over women?

- It has been said that gender as a social determinant of health means gender equity, understood as men's power over women
- Unemployment, retirement, men dealing with incontinence and impotency after prostate interventions, men commuting four hours a day to boring insecure jobs, often hazardous to their health, to support their families, coming too late and too tired to go to the doctors - these are all gendered social determinants of health.
- If we say gender as a social determinant is only the unequal share of power in society, men are violent, that's what counts
- If we accept this totalising view we all lose out
- Of course violence has to be dealt with, of course gender equity in many situations means an imbalance of power in gender relationships
- But only this?



“Male friendly health services”

- The discussion document speaks of this – a sea change in language
- Instead of the pathologising men: “Men don’t”, we can now as health services – doctors and community health services: “What are you doing to make your services more male –friendly?”



Conclusion

- Building on evidence based research on the social determinants of men's health, rather than assumptions and sociological theory, we can build a rational and compassionate national men's health policy
- We should
- Thank you