CONSIDERING SEX AT THE CENTRE OF HEALTH POLICY: SUBMISSION TO THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION INQUIRY INTO AUSTRALIA'S FUTURE HEALTH SYSTEM

OVERVIEW

This submission responds to the National Health and Hospitals Reform Commission (NHHRC) inquiry into the design of Australia's future health system. It primarily addresses the following terms of reference which relate to the need to:

- Bring a greater focus on prevention to the health system
- Improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness
- Improve the provision of health services in rural areas
- Provide a well qualified and sustainable health workforce in the future

The submission argues the above can best be achieved through an early development of open education and related communication strategies to implement holistic regional health and sustainable development strategies, as discussed in this and related articles attached. (The article on greenhouse gas reduction is forthcoming in Public Administration Today, the journal of the Institute of Public Affairs of Australia (IPAA).

The proposal meets all eight principles for Australian health system design, as outlined by the NHHRC. These state what citizens and potential patients want from the system. Citizens are the key stakeholders in this proposal, which also seeks to meet the seven governance principles of the NHHRC, which outline how the health system should work. Open risk management and related education are central to achieving such goals. This submission also aims to meet Australia's international obligations and the goal of 'a seamless truly national economy' as expressed at the Australia 20/20 Summit, by the Prime Minister, the former Westpac Chief Executive, David Morgan, and many others.

The proposal is firstly designed to meet Australia's international obligations, such as the Ottawa Charter, from the World Health Organization (WHO) conference of 1986. This stated that necessary supports for health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. It called for development of public policy and reorientation of health services as well as community action and education to support health goals. Open education is vital to deliver all this. In 1992 the UN Rio Declaration on Environment committed signatories to sustainable development. The first principle is that human beings are at the centre of concern for sustainable development and are entitled to a healthy and productive life in harmony with nature. Australia also supports global partnerships for development to achieve the UN Millennium Development goals which aim to eradicate poverty, hunger, disease and gender inequality, as well as achieving universal education, health and environmental sustainability. The holistic, competitive approaches to regional and related service

development which are discussed below, and in articles and curriculum examples attached, are also critically related to achieving all the goals outlined above.

In general, across the board community benefits can be derived if relevant health and related industry leaders, their organizations and members participate in broader, more open, regional community planning approaches which also address effective communication, education, skills development and research to achieve national goals of health improvement and sustainable development. This direction is ideally supported by broadly available, clear and cheap risk management education and by making key skills development and related curriculum content openly and freely available to all, so that research training for postgraduate students and others can be built more transparently and effectively on this clear basis of certifiable knowledge. An open curriculum approach would be the most obvious and effective way of developing many skills quickly and flexibly. It would be helpful for fighting inflation and for business and community innovation, development and cost cutting. The closed, computer-based, distance education initiatives which Australian universities have funded in the past are comparatively little utilized (Gallagher 2000; Nelson 2002), their production costs are more expensive than classroom teaching and they have not made money (Marginson 2004). These products are not open to scrutiny so their quality cannot be judged. Openness will improve it.

In an article entitled 'Abandon left and right for a vision to unite' in the Sydney Morning Herald (17.4.08, p.11) the Prime Minister discussed his Australian 20/20 vision to 'unleash the national imagination from beyond the ranks of politics and the public service' and 'to help fashion a national consensus around a common vision for the nation, with common goals to aim for within that vision'. This is consistent with the NHHRC focus on what citizens and potential patients want, and I also express. (Milk and honey?) In an article below the Prime Minister's, entitled 'There's a whole lot more to see with ABC's 2020 vision', the Head of the ABC states that there are plans to have five channels in the future. ABC5 will be the Educational Channel providing English and foreign language tuition, curriculum material and an integral digital resource for a newly developed national schools curriculum, with at least 50 percent Australian content to meet teachers' and students' needs.'

The above direction is consistent with the development I recommend. On 29th May 2008, I will meet with Mr Jerard Bretts, the Openlearn Programme Manager and other members of the Open University at Milton Keynes, to learn from their experience, with hopes of future collaboration. I have also written to the Inland Education Foundation at Charles Sturt University, which seeks offers of help. I offer the open health curriculum I formerly taught at Sydney University, as a result of recently meeting the Vice Chancellor, Professor Goulter and Professor Shahbaz Khan, when the latter was giving a talk at NSW Parliament House entitled 'Frontiers in Irrigation Investment and Management'. His talk initially addressed the importance of effective population control methods for achieving sustainable development. Family planning and related mother and child welfare and education are also primary health concerns, which are discussed later. When attending the United Nations (UN) Conference on Reinventing Government in Vienna in 2007, I also heard about the Curriki open education venture, supported by the UN. I reject its open source software

development, which I have drawn to the attention of the inquiry into National Broadband Network proposals. I would be extremely grateful for any support provided by the NHHRC for any of the key proposals regarding communications development that I make. Please support my direction.

COORDINATE PLANNING BETTER TO IDENTIFY, PRIORITIZE AND CONTROL THE MAJOR REGIONAL AND LOCAL HEALTH PROBLEMS

The University of Sydney News (April 2008) suggests the university seeks to reach across the world. I expect many other education, research and service institutions have similar goals. Australian health, communication, education, research and competition policy should be coordinated to assist communities and businesses to understand and prioritize their problems so as to improve health and sustainable development as broadly as possible. An open education model to help deliver this may be driven by government, community, industry and related organizational partnerships, with the primary aim of promoting health and skills development through more open, flexible and broader dissemination of curriculum and related support for better community management. Students should be given an understanding of basic governance principles for injury prevention and rehabilitation, and ideally have opportunities to undertake practical exercises in the consultative identification, prioritization and control of risks to health and sustainable development which may be applied in any community or workplace setting. Ideally they may also make short films or similar communication products as assessments. Outdated institutional requirements for confidentiality and vested sectional interests currently hinder this obvious development approach. Broader regional cooperation is needed to achieve it.

According to the WHO (1996) out of the 5.8 billion people on earth roughly 4.6 billion live in developing countries. Between a quarter and a third of all deaths are from infectious and parasitic diseases, which have largely been eliminated in the developed world. This has occurred through the introduction of clean water, effective sanitation, adequate nutrition, immunization, family planning and other basic health and welfare services. Malaria remains a major cause of death globally, and about half of those who die are children. Millions of children die before the age of five in developing countries, despite the fact that the means exists to prevent most of the deaths. Approximately half of the world population lacks access to the most essential drugs. On the other hand, considerable progress has been made in improving world health in recent decades, and this has largely become possible as a result of economic development. .

A study by the Harvard School of Public Health in cooperation with the UN and the World Bank provided a comprehensive and systematic overview of world health problems in 1990, presented on a nation-by-nation basis. According to the study, life expectancy at birth is expected to grow for women in all regions and will also grow for men, but much more slowly, primarily because of the impact of tobacco use. The average life expectancy at birth in the least developed countries ranges from 38 to 52 years, in comparison with a range of between 76 and 81 years for developed nations. In 1990 the people of Sub-Saharan Africa and India bore more than 40% of the total global burden of disease and made up 26% of the world's population. The rates of premature death were seven times higher in Sub-Saharan Africa than in the established market economies. China was the healthiest of the developing regions, with 15% of the world's

population and 12% of total disease. It introduced a grassroots approach to health planning and promotion many years ago which was implemented by rural communities and 'barefoot doctors'. However, China's embrace of the market economy now threatens the health and education services that rural people expected from government earlier.

The Harvard investigation of mortality, disability and risk factors indicated that a substantial proportion of international and national disease prevention planning should relate to controlling the ten principle risks of premature death, of which the most important continue to be malnutrition, poor water supply, sanitation and hygiene, unsafe sex, tobacco use, alcohol, and occupation. These risks accounted for more than one third of the global disease burden. Respiratory infections, diarrhoeal diseases, and conditions arising during the perinatal period were the three leading health problems, accounting for almost 25% of diseases internationally. In 1990, reproductive ill health, including unsafe abortion and chlamydia accounted for half of women's health problems. These concerns were primarily confined to the developing regions.

For four fifths of the world's population, non-communicable diseases such as depression and heart disease are likely to have replaced the traditional problems of infectious diseases and malnutrition as causes of disability and premature death. By 2020 noncommunicable diseases are expected to account for seven out of every ten deaths in developing regions compared with less than half today. Injuries, both unintentional and intentional, are also growing in importance. In 1990, unintentional injuries, on the roads and at work, were a burden which outweighed interpersonal violence and war. For men aged fifteen to forty-four, road traffic accidents were the largest cause of ill health and premature death world wide, and the second largest cause in developing regions. Unsafe sex was the third greatest risk factor for disease. In Sub-Saharan Africa it accounted for an estimated 30% of the total burden. By 2020 tobacco is expected to kill more people than any single disease, including HIV/AIDS. Tobacco and alcohol take their heaviest toll on men in the developed regions, where they account for more than one fifth of the total disease burden. Depression and suicide are major health problem for both sexes in developing and developed regions.

The focus of the WHO is on supporting at risk populations in developing countries. More broadly, in 1995 ten million people died from circulatory disease and three million from diseases related to smoking. WHO estimated that during the year 2000 a total of forty million people would be infected with HIV/AIDS. The non-government organization (NGO) Save the Children estimates that at the end of 2007 there were 2.5 million children living with HIV around the world. Recent wars have created an estimated 20 million refugees in the world. All these problems require solution through a general development approach which puts community health, education and autonomous decision making first. In Australia, rural and remote Aboriginal communities may experience health problems typically related to underdevelopment, but also experience the health problems related to lifestyle which are most common in developed economies, such as obesity, smoking, alcohol consumption and lack of exercise. Community partnerships with local rural people are a logical starting point for the proposed direction.

According to the WHO, primary health care is essential health care, and the first level of contact people have with the health care system. Because it ideally focuses holistically on community health promotion, good primary health care is vital in developed as well as developing economies, and is particularly relevant when economic benefits have not reached particular population groups, such as indigenous Australians. The WHO states it rests on eight elements:

- Education concerning prevailing health problems and the methods of preventing and controlling them
- Promotion of food supply and proper nutrition
- An adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning
- Immunization against the major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

In order to meet the primary health needs of any population one might start with finding out how adequately its health needs are met in regard to the elements described above. Adequate shelter and housing are also vital for good health. In poor communities respiratory problems and eye diseases are often related concerns. Appropriate education of women is the key to health development because they are the bearers and main carers for children. Self-reliance, self-education and self-determination are also general keys to the creation of healthy communities. Caring communities need to be able to provide the means to support the development of these characteristics, especially for individuals and communities who cannot get their needs met satisfactorily in the dominant culture of development. The Nobel Prize winning economist, Amartya Sen, has contrasted the vital aim of 'human security' and the related values of creativity and dignity with traditional notions of national security and defence. 'Human security' is seen as 'the keyword to comprehensively seizing all the menaces that threaten the survival, daily life, and dignity of human beings, and to strengthening efforts to confront these threats. Sen argues that support for the poor, freedom of speech and transparent management are essential for effective operation of the market and for equality. This is consistent with holistic, risk management based approaches to health and communications, which are discussed here.

The one child policy and increasing life expectancy have meant China's population is ageing fast. While this is a major Chinese welfare preoccupation, the population in many developing nations is increasing extremely rapidly. This is likely to lead to surrounding poverty, environment degradation and land dispute. Primary education provides the greatest return on investment for individuals and communities and may be related to fertility control and sustainable development. Iran is currently a world leader in improving mother and child health, education and birth control. In 1986, Wilenski admired the Chinese mobilisation of a large labour force to carry out the slogan 'Put prevention first' in regard to environmental health tasks. He noted the break-up of the medical monopoly and the creation of new health service delivery models designed to meet identified community needs. As a result of the Kyoto Treaty and its related trading and investment aims, a

renewal of this approach may now be assisted through more open communication and education technology development for sustainable development. Many industry and community health and sustainable development needs should now be identified, prioritised and met through related projects, openly linked with others. Whether elected or appointed bodies manage organizations, communities or projects, the danger is they may use their office to favour themselves and close supporters rather than governing in the interests of those they ideally serve. Openness and clear accountability are necessary to avoid this. Social administration is ideally envisaged as open experimentation combining investigation and implementation in a continuing process which attempts to improve all understanding and service outcomes. Truth usually must depend on openness.

Bluescope Steel wrote to the Australian House of Representatives Standing Committee inquiry into manufacturing (2007) that one of its major priorities is ensuring greenhouse gas regulations do not make Australia's steel industry uncompetitive and that China is the world's largest producer and consumer of steel and therefore a major polluter. Business generally abhors government financial strategies which attempt to 'pick winners', but these are often used. Many in manufacturing, no doubt like many academics, think that hopelessly competing for comparatively small amounts of money is a waste of everyone's time and money. The Business Council of Australia wants inefficient taxes and charges on production cut. The Australian Council of Trade Unions stressed that Australian industry should progress 'up the value chain'.

This suggests many powerful opportunities may exist for the design of more direct industry and community based planning, education and related investment to drive health and sustainable development locally and globally. Many Australian inquiries indicate the benefits of industry and community ownership of social insurance and related investment funds are comparatively clear, as long as those funds are managed effectively and competitively. Combined trading and investment systems for large development projects may be effectively coordinated with government support for rural health, education and other services aimed primarily at the poorest. Australian and Chinese partnerships could now assist attainment of many other regional development aspirations by providing knowledge and skills development openly and broadly for all to use at will.

HOW COMMUNITY MANAGEMENT OF HEALTH CARE SHOULD WORK

Community health and related industry management models ideally stress the importance of consultatively developed health and sustainable development aims, supported by transparent service delivery to achieve them and related outcome evaluation. Regional health planning, health promotion, workplace risk management, and program budgeting all reflect such requirements, which may also be applied in resolution of disputes. First, an environment is studied in order to understand it enough to be able to identify and prioritize its main risks, prior to dealing with them. From an action research perspective, all social administration is envisaged as experimentation combining investigation and implementation in a continuing process which also attempts to improve community health and work outcomes. Ideally, organizations have consistently applied duties of care to workers, clients, communities and the natural environment.

Codes of practice, as they are ideally used under occupational health ad safety acts, provide the flexibility necessary to achieve further innovative advancement and all related benefits of more scientific management practice. Approved codes of practice are ideally followed unless another course of action appears safer, according to the specific requirements of a particular situation. Workers in health care apply a similar approach in that they ideally diagnose and treat each person after consideration of the apparently relevant body of scientific evidence. Treatment may vary as far as this appears necessary to meet the specific health needs of a particular individual's situation. The reasons for deviation from the generally expected expert practice should be documented. This contributes to bodies of related information which are studied to improve treatment of both common situations and atypical ones. Transparent program budgeting and triple bottom line accounting are also vital, to achieve health and sustainable development goals.

Deal with the worst problems first. Prison may be conceptualized as an extremely expensive form of the welfare state. For any well meaning government in China, Africa, or any other area which is struggling to get the most basic forms of taxation, health care, education and pensions for the disabled or old established, one assumes that the last thing one would want to hear would be requests to spend money on keeping highly corrupt officials or serial killers in jail instead of killing them. I think it a wrong set of priorities which calls upon poor and struggling societies to do away with the death penalty. Why not worry about how good service can be delivered and how corruption and tax collection can be dealt with effectively instead? This is more helpful in the short and longer run.

It is a logical imperative for people concerned about poverty, crime or sustainable development in rurally based societies to discuss birth control. Iran is not currently popular in Australia but it has a wonderful recent record on children and women's health and education. Medicine and contraception are very much part of the Islamic scholarly and religious heritage. In Iran they have used this to produce highly admirable results. I fail to see how Australian indigenous aspirations of many kinds can be recognized if young girls in rural areas have no genuine choice about pregnancy, but become pregnant when they become sexually active. Whenever this happens it is not fair on the girl or others, in my opinion. (My mother feared for my living in the bush.) Domestic violence is also related to this. Crime rates are often highly related to having large, young, male, unemployed and impoverished populations. One should not close one's eyes to this, in my opinion. Communities and individuals should be educated to think about their future. Life is what happens while you're busy making other plans? (Lennon, Imagine album 88)

IMPROVE HEALTH WITH CREATIVE APPROACHES TO DEVELOPMENT

Part of the answer to developing a globally innovative and competitive film and related arts and entertainment industry is to analyze and meet the art, entertainment and education needs of Australians and others together. For a personal example, the Sydney University Vice Chancellor's recent discussion of the need to maintain the student experience in the face of voluntary student unionism (VSU) and the helpful list of films about US presidents

in a recent Sydney Alumni Magazine (SAM) reminded me how much more productively all tertiary students and staff could co-ordinate their communications and technology services to develop a better grounding for any industry, including film and television.

I wondered where the films on US presidents listed in SAM could be found for teaching purposes. My experience of trying to get hold of key health related films or videos I would like to show to students is that they were almost impossible to find and never cheap. Compared with the easy availability of books, the storage and availability of films for teaching purposes is abysmal. When teaching at Sydney University I often also tried to find suitably qualified postgraduate students to undertake large quantities of essay and project marking on a casual basis, but could seldom get anybody appropriate quickly enough because there was no effectively organized system for doing so. There were lots of postgraduate psychology students sitting in the Faculty of Health Sciences where I taught, but comparatively few from other social sciences. I faced similar problems when trying to find students to help me make my first films for health policy teaching purposes and also when I wanted to find a suitable student to employ on building a website in order to make all my lectures and Powerpoint overheads freely available to anybody. I also encouraged my students to make seven minute films for their assessments and for Tropfest competitions, but only a handful did so as there was no technological support for this.

My experience was that student clubs and societies tend not to respond to any email queries from comparatively technophobic elders from unknown tribes and who could blame them? However, I constantly lamented that the full potential of much wonderful Sydney University student and staff product is lost and the employment of students by staff is made infinitely harder because of the generally poor and balkanized communication systems run by postgraduate and undergraduate students. The various research, teaching and administration services of the universities and the National Tertiary Education Union (NTEU) do not work together helpfully on their membership communication either. In general, I think that the service and productivity gains for students, staff and many others which could be derived from more effectively coordinated tertiary education, related communication and information technology management systems would be enormous. What a pity there seems to be so much resistance to more effective cooperation. This is the result of so many collegiate cultures. They are dysfunctional for everybody and must be changed. No open source software, as distinct from open content. (This is a disturbing personal pecadillo unless purely developmental?)

DISCUSS SEXUAL HEALTH POLICY DIRECTION WITH MANAGERS OF TOURISM, RELIGIOUS LEADERS AND RELEVANT OTHERS

This submission also supports the development of Australian health promotion, overseas aid, communication and education directions which recognize that sexual health, tourism, contract work and the protection of the national heritage and natural environment are ideally coordinated and treated in related regional contexts. This policy position arises primarily from an emerging understanding of Australia's comparative place in the global community and also as a result of looking back over my personal life. The combination of a recent questionnaire on hotel Timeshare, which was sent to me by the Department of

Tourism, Leisure, Hotel and Sport Management at Griffith Business School, as well as watching two excellent documentaries recently on SBS, prompts me to address you about what I think is the enormous potential, of safe sex tourism and good sexual services management, especially for contract workers. I think this should be investigated further and therefore attach the earlier feedback that I provided on the Timeshare questionnaire.

I have always been very interested in sex and health. On leaving Queensland University in 1970 I spent two years in Northern Nigeria as an English and history teacher under the Australian Volunteers Abroad Scheme. My sex related experiences while there strongly informed the rest of my life. Last year, aged 60, I retired from the Faculty of Health Sciences at Sydney University, after teaching about health policy for eleven years. I had previously spent ten years in policy and education management positions in the NSW WorkCover Authority. This included working to produce policy, guidelines and videos on management of HIV/AIDS at work, including for sexworkers in NSW brothels.

In 2007 I attended the UN Conference on Re-inventing Government in Vienna. I attach the feedback I provided to the conference organisers afterwards. Among other things I recommended was that the Pope should be alerted to current problems regarding the management of the Italian national heritage and his leadership should also be sought to protect and display it more effectively for global citizens. I recommend the issues discussed in all the attached submissions should be raised with him and other religious leaders to gain wider community cooperation in regard to health and environment protection and related services. I am a sociologist promoting the attached lectures.

DISCUSS COOPERATIVE DIRECTIONS IN SEXUAL HEALTH PROMOTION

Sexual behaviour has always been of enormous interest in most religious contexts. I speak as a non-Christian, whose youth was spent in active opposition to the effects on women of the policies of the Catholic and some other churches in Australia. Today I am closest to Buddhist religious beliefs, as practiced in the West, and cannot see the point in discussing whether any particular God exists or not. I also take the Jungian position that the discourses of faith are internal to each person and to their particular culture and are therefore largely incompatible with scientific discourses, which are often too crudely empirical and too narrowly utilitarian and driven by powerful sectional interests to be healthy. Like Jung, I believe the evidence for this lies in the horrific wars and other cultural destruction of the 20th century, which culminated in the use of the atomic bomb. This male inflicted misery continues. I therefore support the World Health Organization (WHO) definition of sexual health, which Nutbeam and Blakely (1990) indicate is:

> 'the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love'.

Let us argue about the nature of the expression of love, which may also be a form of need, rather than whether God exists or not and how strict his rules are. Winn (1996) calls for all sexual health activities, whether clinical or educational, to be planned,

implemented and evaluated within the Ottawa Charter health promotion framework of the WHO. Nutbeam and Blakey (1990) defined sexual health promotion as 'the holistic process of enabling individuals and communities to increase control over the determinants of sexual health, and thereby managing and improving it throughout their lifetime'. But what might these sentiments mean in policy and service terms for many different governments, religious groups and all other community stakeholders around the world, including women like me? I like to think I'm on the team of the young black babes entering Miss Landmine: The prettiest amputee in Angola, (Sydney Morning Herald, 23.4.08, p.10) (Baby, to me Bob Dylan's 'Masters of War' is still the finest song he ever wrote. I remember every word today. Those Jews sure knew how to write.)

I think all questions, which link religion, love and sex, require wide discussion in the interests of health and environment policy and service development, which ideally also begins with management aimed primarily at achieving regional peace. Without peace and good management, little interest in anything other than breeding and war is possible. In 1997 the WHO Conference called for development of health promotion through co-operation between governments and the private sector. Health and environment development should logically now be planned and achieved together by Australian governments and others in regional contexts. Have a few chats in Saudi Arabia?

AUSTRALIAN EXPERIENCE IN PROMOTING SEXUAL HEALTH IS GOOD

Globally, HIV/AIDS is a major health problem. The disease may occur if contaminated bodily fluids, such as semen or blood, are transmitted to another body through a break in the skin. In developing countries, HIV/AIDS is predominantly a heterosexual disease, which is also passed on by pregnant women to their babies. The spread of HIV/AIDS is currently only preventable by the absence of high-risk systems and behaviours. These include inadvertent use of infected blood in medical treatment, promiscuous sexual behaviour, lack of use of condoms, anal sex, and sharing needles between the drug addicted. History shows it is largely impossible to control the profit motive or to mandate lifelong monogamous sexual fidelity. To close one's eyes to this invites disaster. In developed nations, homosexual or bisexual males, injecting drug users and prostitutes are seen as the major groups at risk of contracting HIV/AIDS or passing it on. Dowsett (1995) points out that the Australian HIV epidemic has remained largely confined to male to male sexual transmission of the virus, (which appears to have been introduced by overseas travelers), and that Australia's efforts have been among the most successful in the world at containing and slowing the rate of spread of HIV. He puts this down to a combination of sensible and facilitating national public health policy, and sophisticated HIV/AIDS community activism which has led to prevention work among gay communities being undertaken almost exclusively by gay men themselves.

Over the past three decades a major health emphasis, especially in the operation of brothels and related sexual services in NSW, has been on prevention of the transmission of HIV/AIDS and other sexually transmitted diseases (STDs). Heymann's global and regional epidemiological study (1995) clearly indicates that Australian control of HIV/AIDS, chlamydia, hepatitis B, genital warts, herpes, gonorrhoea and syphilis can be

favourably compared with that achieved anywhere in the world. The promotion of the use of condoms, other good health practices and regular sexual health check-ups appear to have produced dramatic benefits since Donovan published 'Gonorrhoea in a Sydney house of prostitution' in the Medical Journal of Australia in 1984. Researchers at the Sydney Sexual Health Centre indicate that during the period from 1979 to 1995 there were remarkable health improvements in the urban female sex industry. In the early 1980s the women had high rates of STDs compared to the general population. By 1996 they were rarely diagnosed with bacterial STDs or HIV infection. The researchers attribute this change to a climate of law reform, the formation and funding of community organizations, peer education and support and improvements in the quality and accessibility of health services (Donovan and Harcourt, 1996).

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SEXUAL HEALTH MANAGEMENT AND SEXUAL SERVICES FOR MONEY

Historical studies on the sexual services market in the Western world suggest men have purchased sexual services since history began and this has usually occurred in secret. Since the passage of the NSW Disorderly Houses Amendment Act (1995), brothels which conform to government requirements may operate legally. NSW, Victoria and the ACT allow brothels to operate providing they have planning consent from their local government authority. South Sydney City Council has introduced a brothels policy in consultation with the sex industry and the wider community. The attitudes and practices of other Local Councils require further investigation. The South Sydney Council Brothels policy recognizes two types of brothels:

1. a home occupation private sex worker operation (parlour)
2. a commercial brothel

The policy outlines the planning requirements relating to the appropriate location of both operations. The Australian regulatory trend has been towards a model which permits consensual sexual activity between adults while preserving the amenity of the community at large. The Land and Environment Court deals with the resolution of disputes about the siting and effects of brothels on the surrounding community. Sex workers in brothels are generally regarded as self-employed people rather than employees. However, the health and safety guidelines for brothels in NSW, produced in 1997 by the Health Department and the WorkCover Authority, regards them as 'deemed workers' who therefore should have the entitlements of employees. Other self-employed prostitutes work at home 'parlours' or from the streets. These various employment practices have related health, rehabilitation, cost of service and price implications.

Although contemporary Australian prostitutes and other sex workers provide a service and probably learn a lot on the job, their work does not lead to the educational and career opportunities which are open to people in most other occupational areas. In polite society, talking openly about the recreational sexual pursuits of men is like using four letter words in front of most women – it is taboo. However, in 1998 the Macfarlane Burnet Centre for Medical Research contracted a market research agency to conduct telephone interviews with people in Victoria who had used the services of sex workers. This appears to provide one of few pieces of Australian research into the characteristics

and desires of clients. The researchers noted that in 1990 a WHO review of the findings on HIV infection and risk factors among female sex workers, found the majority of studies were about the sex worker, with less than 10% being about the client. When asked why they paid for sex, the top five responses of men contacted in the Victorian research were that they were paying for:

- Good sex (32%)(101 subjects)
- Convenient sex without commitments (20%)(62 subjects)
- Companionship and intimate contact (15%)(49 subjects)
- Alleviation of sexual frustration (13%)(42 subjects)
- Variety in partner and sexual activity (13%)(42 subjects)

The researchers sought more study to examine the needs of clients of sex workers and to effectively promote sexual health and related education throughout the community.

Like money, sex may be a form of recompense, compensation or comfort. For example in 1998 the Australian National Inquiry into the commercial sexual exploitation of children and young people in Australia showed that the dominant form of commercial sexual exploitation of young people is 'sex for survival' and 'sex for favours', a survival strategy to exchange sex for accommodation, food, alcohol, cigarettes, drugs, clothes or money to obtain these daily needs. Other factors contributing to this choice of survival strategy include the need for emotional contact and sexual exploration. Such young people need accommodation, work and education opportunities, which can effectively meet them where they are. More mainstream education, work and family opportunities were never available in the first place or have already been rejected for some reason.

The study of the Australian sex industry ranges from a focus on entertainment and hospitality, community or personal service work and standards, to issues covered by State Crimes Acts or Commonwealth legislation related to illegal immigration, sex and drug slavery and the abuse of children. Perkins and Bennett (1985) write that:

> 'prostitute women usually see their occupation as an essential community service, as therapy to some men, counselling to others, and a safety valve for the frustrations and bottled-up energies of most'.

A less optimistic presentation of self and others, written for a Victorian safety handbook for prostitutes advises:

> 'Always be aware of what's happening around you, especially when talking to mugs (clients). Try not to work when you are really out of it as it can affect your judgment. Always go on your first instinct'.

This appeal was sparked by concern about rapes, muggings and bashing of street prostitutes in Victoria. One area for useful research is whether better mechanisms for complaints and dispute resolution within the sex industry can prevent violence and

provide other useful information for better community management related to health and the prevention of crime and corruption.

Many difficulties occur in regulating the sale of sexual services in a manner similar to that applied to other work. This also raises the wider issue of the appropriate age for consent, which currently varies according to state, sex, and sexual preference. One possibility might be to introduce a duty of care concept into legislation related to sexual activity, along with the age requirements, which already exist for consenting sexual behaviour. This could be similar, for example, to the concept of 'duty of care' owed in state OHS Acts. Sexual activity is a complex matter. Sexual activity with under age people should generally be considered wrong. However, as Justice Spigelman, Chief Justice of NSW has pointed out (Sydney Morning Herald, 31.1.02, p.10)

> The existence of sentencing discretion is an essential component of the fairness of our criminal justice system. Unless judges are able to mould the sentence to the circumstance of the individual case, then irrespective of how much legislative thought has gone into the determination of a particular rule or regime, there will be the prospect of injustice in the individual case.

Community debate and dispute resolution systems should be designed to gather information and educate everybody, but the traditional, adversarial court process is largely inadequate for this task, if only because it keeps no effective statistics which could aid community management. It is clear that Australia cannot count on maintaining its current cost-effective public health success in regard to the control of STDs, without continuous health promotion programs and related service and research carried out in regional contexts. This could build upon successful efforts already undertaken in this area. The lessons learned also have implications for Australia's aid, trade and immigration related relationships with Asia and the rest of the world. An important aim could be to focus on sex work in order to meet a wide range of surrounding social needs more effectively, and in order to promote general knowledge about control of risks to health in Australia and related regional environments. Don't shy away from scary men?

SEXUAL HEALTH PROMOTION IN TOURISM AND CONTRACT WORK

To discuss the potential relationship between sexual health promotion and tourism in global context, I am forced by my ignorance to rely on general historical knowledge of global demographic trends and my personal experience. This discussion is also prompted by my visit to the UN Conference on Reinventing Government in 2007 and by the recent receipt of a questionnaire on hotel Timeshare which was sent to me by the Department of Tourism, Leisure, Hotel and Sport Management at Griffith Business School. Discussion also refers to two excellent documentaries which were shown recently on SBS TV, and to the film with Charlotte Rampling entitled 'Travelling South'.

Sexual services usually have a bad press. Their provision is often illegal and may also be associated with crime, drug use and the exploitation of women and minors. However, as

a postgraduate student at Sydney University I lived in a shared household which included a French (perhaps Jewish) immigrant, former factory worker, and in my view admirable mother, with two pre-school children. She paid for her studies at Sydney University and raised a deposit for a house by regularly flying to Canberra to provide sexual services to business men and politicians. She gave it up as she did not know what to tell her kids. Few hear about such women. I lived in the same house. As a professional she zipped her lips? (At my age one still remembers easily where a lot of bones used to be buried.)

The provision of sexual services is a fact of life, especially in environments where male groups from wealthy countries go on tours or where many men are employed as soldiers, or as workers in mining, construction or in related development projects domestically or in foreign countries. In my view, well delivered sexual services can be a potentially calming and educational force and the lives of many disadvantaged people could also be enriched rather than degraded by better sexual service management. This must be provided to help linked populations to combat HIV/AIDS and other sexually transmitted diseases. From a policy perspective, I think it is highly desirable if people like the owners of the hotels responsible for Timeshare, governments, hospitals, universities and related groups consider sex tourism, brothels and sex workers as potentially powerful sources for improving the health and career prospects of many people in poor and wealthy countries. I think being proactive about better delivery of sexual services is an opportunity which should not be missed. To close one's eyes is to invite huge problems.

The first of the SBS documentaries I saw recently was about the development of the Ritz hotels in 19th century Europe. Ritz had an intense and atypical preoccupation with hotel hygiene because cholera and related epidemics in Southern Europe were of major concern to wealthy tourists. (Remember 'Death in Venice'?) The second documentary was about three young English men with physical disabilities who contact each other over the internet and organize a tour to Spain with the main purpose of going to a brothel which sensitively caters to serving a disabled clientele. One of the best films of 2006, in my opinion, was 'Travelling South', which depicts a tourist resort in a small island nation like Haiti. It caters to wealthy foreigners of both sexes, but mainly to wealthy, liberal, single women in their thirties, forties and fifties. It is the most well run, pleasant and benign business establishment and employer on an island which is otherwise plagued by poverty, unemployment, violence and corruption. Charlotte Rampling plays the queen bee, who normally teaches at an upmarket Boston college for girls and who keeps coming back to the resort, like many other women, to enjoy themselves dining, swimming, dancing and consorting with those men who the management of the establishment considers are well behaved enough to be allowed to hang around on the beach, just below the line of hotel cabins. The values of the clientele rule the behaviour of the hotel management and they are liberal, clean, safe, normally discrete and sometimes motherly. The level of corruption and violence outside the resort eventually destroys the business.

From the questionnaire recently sent to me I have the impression that Timeshare is based on a Ritz model of tourism, which may now be outdated. It appears to assume that most wealthy people today would like to rub shoulders with those who are even richer, and that they like to travel in monogamous pairs, with friendly couples or their families, possibly

playing golf. However, I think that globally we are in an era when many wealthy and aspirational people primarily travel alone or in groups, for pleasure or for work or both. While well run sexual services may have a positive education and related health effect on the surrounding environment, ignoring the demand for sexual services may mean that many sexually transmitted diseases are spread increasingly easily. The provision of sensitive sexual services for the victims of accidents and for other people with disabilities should also be seriously considered by any country which is genuinely concerned about combating discrimination and providing employment and related career development.

Particularly for a wealthy, able bodied man working or touring in a poor country, the environment may offer itself as an open brothel, with many poor women and young men out to try their luck and get ahead in life through first providing sex. Also, as the expectation of female dependence on the male wage breaks down in wealthy countries, along with marriage, many women in their thirties, forties and fifties increasingly holiday alone and hope to find themselves in safe and enjoyable environments, including sexual ones. Today there appear to be plenty of young men in poor countries offering sexual opportunities to older foreign women as well as men. I personally never had the courage to pursue any, as I feared being robbed or bashed instead. However, when I saw 'Travelling South', my strong view was that the hotel depicted was a great place for a wealthy, single older woman to spend a pleasant holiday, and providing this kind of venue now seems potentially to be an untapped source of money for the hotel industry. I have never seen an establishment like it, which clearly caters to women, in the sense of ensuring a safer, cleaner and gentler entertainment and sexual environment. Do such environments exist in the homosexual community? If so, can they be more useful?

Also consider the sexual services provided to foreign workers. For example, when I was a newly married young woman I spent two years with my husband in Kano, Northern Nigeria. We were an engineer and a teacher employed under the Australian Volunteers Abroad Scheme. It was the early seventies, shortly after the Biafran War, when Christian mission educated southerners from the Yoruba and Ibo tribes, who had formerly taken up most bureaucratic and professional positions, had fled the north, after being accused of nepotism and corruption by the Islamic Hausas. After the war the northern government decided it wanted to employ expatriates on short term contracts, rather than southerners, whom it distrusted. I knew two different expatriate communities in Kano. The first was composed of single or married men from around the world who had come to the country to make as much money as possible. They came alone or with wives who were not allowed to do unskilled work. A huge number of prostitutes lived in Kano and catered to expatriate male needs in secret from the wives. The second group of expatriates I knew were young Canadian, American and British volunteers of both sexes, but mainly unmarried males, with professional jobs. In the volunteer social life the prostitutes were openly invited to parties and other social events, and were treated simply as the girl friends of particular men. I guess both these kind of expatriate employment patterns persist around the world today, along with an exclusively male and very large expatriate employment of soldiers, or in mining or construction. More information is needed on how to promote health and prevent disease carried in all such contract work communities.

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