EDITORIALS

Poverty, Race, and the Invisible Men

Improving access to primary health care by the poor, the underserved, and those living at the economic and social margins of this nation's social construct has been work that the W.K. Kellogg Foundation has pursued rigorously and with deep commitment. We have worked to lead and serve as we supported health clinics, as well as to define, refine, and implement pathways to improve health for many. But like most, we have neglected a significant part of the population most in need of health care. We were blind to the fact that when we visited clinics and worked with communities to address their health needs, there were few men in the waiting rooms of the clinics where primary health and prevention services were being provided. Virtually no health efforts were directed toward men. Poor men had become invisible and their health needs neglected.

WHY A FOCUS ON MEN'S HEALTH

Ultimately, we confronted the brutal reality: Poor men and men of color live with a tremendous amount of pain, are demeaned and devalued in a system that rewards wealth and values some people over others, and die early. When social determinants of health—such as poverty, poor education and educational opportunities, underemployment and unemployment, confrontations with law enforcement, the sequelae of incarceration, and social and racial discrimination—are factored into the health status of men, the scope and depth of the health crisis is even more evident and poignant. Poor men are less likely to have health insurance, less likely to seek needed health services, and less likely to receive adequate care when they do.

Even among the poor, some men are less than equal. The generally abysmal health status of men of African descent best demonstrates the great peril that poor men have to face. Life expectancy for African American men is 7.1 years shorter than that for all men.[1] Forty percent of African American men die prematurely from cardiovascular disease, compared with 21% of White men.[2] And death rates for HIV/AIDS are nearly 5 times higher for African American men than for White men.[3] African American men also have the highest incidence rates of oral cancer.[4] Sadly, the health status of African American men may serve as the proverbial canary in the coal mine for other poor men in this nation and in our global village, and it is a clarion call to health care providers and policymakers charged with defending the nation's health.

This society has no system in place to support the health and health-seeking behaviors of men who work at the lowest wage levels or of those who are unable to work as a result of poor education, absence of jobs, mismatch in skills, or other reasons. Those in the faith-based community and in community-based organizations tell us that men are so concerned about their daily survival, caring for their families, and having a good job, that they do not make their health a priority. Recent articles in major US newspapers have shown how poor men jeopardize their health as they seek to support their families and themselves.[5–9] Working conditions are frequently hazardous, and policies designed to protect these employees are often grossly inadequate. Most often, low-paid and low-skilled workers are not offered health insurance coverage through work. Low-income men who are childless are excluded from publicly funded insurance programs. The only exceptions are for those who qualify for insurance because of disability or who find coverage through very limited state or local programs for the indigent.

Sadly, the penal system is the only place where men have the right to health care, under the US Constitution's protection from "cruel and unusual punishment." There are currently more than 1.4 million inmates in federal and state prisons, and more than 600000 inmates are to be released during the year.[10] A recent report funded by the US Department of Justice highlights the great need for health care by this population.[11] The report demonstrates the high rates of communicable disease, chronic disease, and mental illness of inmates (93% of whom are male and 44% of whom are people of color). The report acknowledges that these men are a largely underserved population. It recommends federal support for the

provision of services for these "captive" men, in part to reduce the threat to the public's health upon their release. Clearly there is a need to treat inmates, but what are we doing for these men before they enter the penal system, and if we are not doing anything, what is the cost to them and to society?

While access to care is theoretically available through prisons, there are no clear data that suggest that the care provided results in improved health status. Studies have clearly indicated that mental health and oral health access in prisons is extremely curtailed despite the high need.[11,12] In addition, the health care that is provided is expensive. Wisconsin alone spent $37.2 million to provide health care to approximately 14 900 inmates in fiscal year 1999–2000.[13] A rough comparison reveals that federal and state health care expenditures per inmate approximate or exceed expenditures for a Medicaid enrollee. The average cost for health care in prison was $3242 in 1999, while the average cost for health care for a Medicaid enrollee was $3822 in 1998.[14,15] However, if we exclude the elderly, blind, and disabled, the average cost for an adult Medicaid enrollee was $1892. We must ask whether the federal and state money being spent on inmate health care could be better spent, both within and outside prison walls.

One of the major challenges we face in addressing the health status of poor men and men of color is a lack of data. Existing research, while important, focuses on issues related to reproductive organs, illnesses resulting from sexual practices or contagious disease (e.g., HIV/AIDS),

violence, substance abuse, behavioral health, and other conditions that characterize these men, by inference, as not having the same illnesses and concerns that women and well-to-do men face. Does this lack of research reflect society's "isms" that perpetuate disparities in health and well-being? Or does it reflect limited interest by a cadre of health policy researchers who may need more diversity in their ranks to broaden the research agenda and fill in the gaps? How else to explain this epidemic of poor health among men of color and poor men and lack of proven intervention and prevention strategies?

In the numerous documents on access to care and quality of care that we examined, little mention was made of poor men. Seminal reports such as those produced by the Institute of Medicine have yet to examine the availability and quality of prison care. Nor is there adequate documentation on the accessibility or quality of preventive and primary health care for the diverse population of poor men. We were not able to identify benchmarks for access to or quality of care that apply universally to all men, women, and children.

Despite our efforts, we did not find the intellectual underpinnings that would guide our actions or affirm our strategies. Ultimately, we were left to decide that our responsibility was to act now, even though the practice and policy pathways were not apparent.

A MEN'S HEALTH INITIATIVE

As part of Kellogg's Community Voices initiative (http://www.communityvoices.org), we began the process of teaching ourselves about the issues. We developed 3 publications, designed for a variety of audiences, that highlight the disparity in health outcomes and the barriers to care experienced by men, particularly men of color.[16–17] (Additional information available from the authors upon request.) Included in each publication are policy strategies and recommendations for improving the health of men.

The Kellogg Foundation's trustees authorized $3 million for a men's health initiative. The use of these funds in specific markets (Atlanta, Ga; Baltimore, Md; Boston, Mass; Clarksdale, Miss; Denver, Colo; Miami, Fla) will provide focused care for men and education for health care providers, as well as inform policy on shaping health services and providing health care coverage for poor men. An equally important goal of this initiative is to engage men in shaping the delivery of care for themselves. Social and educational programs will be included as integral components of comprehensive primary care. Strategies will include extensive use of community outreach, use of focus groups, case management, and identification of service gaps. Proposed coalitions including men, health and human services providers, family members, and concerned community members will work across state lines to build a policy program that informs decisionmakers and promotes inclusion of poor men as beneficiaries of publicly supported coverage programs (e.g., Medicaid and the Children's Health Insurance Program).

While many in the policy arena tell us that the time may not be right for a discussion of coverage for poor men, we know that it is not acceptable for any human beings to be left out, included incrementally only when convenient. Regardless of whether the nation's budget is running a surplus or a deficit, our nation's leaders have never declared it the right time for providing coverage to poor adults, specifically poor men. Yet the financial, physical, and emotional devastation that is experienced by poor men who have no health care is too harsh a price for all of us to pay.[18,19] Emphasizing treatment rather than prevention creates a system that is impossible to sustain and perpetuates disparity. We know how to improve the public health of our nation. We simply have yet to do what is best for

our nation's families, and particularly its sons.

SUSTAINING CHANGE IN A TIME OF COMPETING PRIORITIES

The opportunity we have with this issue of the Journal is to begin to change the paradigm that treats poor men and men of color as undeserving of routine primary health care. The articles in this issue begin the process of revealing men's needs, the services that exist, and the changes in services, systems, and policies that are required to improve the situation. We wish we could tell you more about what men want, their priorities, and their aspirations with regard to health and well-being. We wish that more voices could have been raised in this issue. We wanted to gain more understanding about men's social contexts and be provided clues as to how to support them. And we wanted to discuss how good primary health care providers take into account all contextual variables (educational level, employment, housing, enfranchisement) when they treat the body so that they might also heal the spirit.

We are at the beginning. We are so very proud to be able to help guide comprehensive efforts to include men in the realm of health and health care services so that they and their families can live with more dignity, respect, and freedom. We hope that these efforts will also serve as a platform for health and human rights, reminding us that inclusiveness in the health care setting and good health cannot exist in a world where priorities are based on wealth, social status, race, or creed. We hope that all who read this issue of the Journal will join us in our mission: "Leave no poor father, brother, uncle, nephew, or son behind, as they too have a right to the tree of life."

We trust that we at the Kellogg Foundation have done no harm as we have stepped forward to claim this public health issue and to initiate this review of what we know, what we do not know, what we must do—and why we cannot wait. ■

Henrie M. Treadwell, PhD
Marguerite Ro, DrPh

About the Author

Requests for reprints should be sent to Henrie M. Treadwell, PhD, W.K. Kellogg foundation, One Michigan Ave E, Battle Creek, MI 49017 (e-mail: hmt@wkkf.org).

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