Overlooked and Underserved: Improving the Health of Men of Color

One of my goals as director of the National Center for Primary Care at the Morehouse School of Medicine is to continue the effort that I put forth as surgeon general to eliminate health disparities in the United States. These disparities in health care and health outcomes exist across race, gender, and income level. Among the most overlooked populations who experience the poorest health outcomes and face the biggest barriers to care are men of color.

This issue of the Journal begins the critical process of uncovering the disparities experienced by men of color and suggests some of the solutions to the problems of improving both health and health care. The articles provide a base for national, state, and local discussions about the importance of focusing on men of color as a specific population. It is imperative that we in public health recognize and address the needs and issues of this long-overlooked population.

The need to address the health of men of color is in large part due to the sociopolitical environment. While we have made considerable advances over the past several decades, men of color continue to struggle against oppression and discrimination that result in lesser opportunities

with regard to employment, housing, education, and health. In terms of health, this means greater barriers to care, poorer quality care, and even poorer health outcomes compared with the general population. On the positive side, we have entered an era of research and advancement that has begun to explore how the sociopolitical environment affects health, and there are national, state/local, and community efforts focused on health disparities and inequities. We need to create an environment that fosters health and well-being, not just for men of color, but for all Americans.

ACCESS TO HEALTH CARE

There are 5 areas that I would like to highlight as we address the issue of men's health. The first is access to care for men of color. We must work to ensure that men of color and indeed all Americans have access to culturally competent, affordable, and accessible health care services. What does this mean? At the most basic level, it means that men of color must have health insurance coverage. Of all racial and gender categories, men of color are the least likely to be insured. Among men, greater percentages of Hispanics (46%) and African Americans (28%) than Whites (17%) are uninsured.[1] These high rates of uninsurance may in part be attributable to the higher rates of unemployment among men of color; lack of coverage offered to part-time employees, small-business employees, and lower-skilled workers; and policies that disadvantage non–native born individuals and childless individuals. We should consider a multipronged approach to covering the uninsured. For men of color, it is important to examine ways to expand insurance to working individuals, families with low or moderate incomes, and those unable to find work. We must also develop new insurance products for those who cannot afford private coverage and who are currently ineligible for publicly funded coverage. This approach will require cooperation from both the public and private sectors.

We need to address the nonfinancial barriers to care as well. We need to tackle issues of racism and sexism within our health systems and among our health providers. Health care providers may unintentionally act on the basis of negative societal stereotypes of men of color. Providers need to be conscious of these biases and the potentially negative impact they can have on treatment and the delivery of services. For men of color, having health care providers who look like them, who can relate to their experiences, and who are sensitive to issues of masculinity will improve the likelihood that they will be comfortable in seeking out and using needed services.

HEALTH CARE WORKFORCE

We must also increase the representation of men of color at all levels of the health care delivery system. It is well documented that physicians of color are more likely than their White counterparts to practice in underserved areas and serve minority populations; however, Hispanics, African Americans, and Native Americans represent only 6% of practicing physicians, whereas they account for approximately 25% of the US population.[2] We must strengthen our educational pipeline programs and reexamine the academic process at our academic health institutions in our search for ways to be inclusive. We should promote strategies that endorse diverse student bodies and offer support as minority individuals make their way into the workforce. Morehouse School of Medicine and Meharry Medical College, as examples of institutions that embrace diversity, have created educational environments in which Black men see themselves as leaders and as agents of change; these institutions have proud records of producing health care providers of color who are disproportionately more likely to care for the underserved.

In addition, there must be efforts to build a linguistically and culturally competent workforce. Being able to communicate effectively with a health care provider is paramount to receiving satisfactory and appropriate treatment. We should encourage all health systems to adopt the National Standards for Culturally and Linguistically Appropriate Services in Health Care. These standards were designed "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers."[3(p1)]

MENTAL HEALTH AND SUBSTANCE ABUSE

I had the privilege of releasing first-ever surgeon general's reports on mental health and oral health. These are 2 issues that often fall by the wayside, yet they have a great impact on the daily lives of men and women. Mental health is an essential and inseparable part of health, yet the stigma associated with mental disorders often inhibits individuals from seeking care.[4] This may be especially true for men of color, who come from communities where acknowledging mental or emotional distress is associated with being weak or "not acting like a man." We need to educate men of color about mental health to reduce stigma and make it acceptable to seek out needed services. We also need to advocate the allocation of additional resources—both the number of care providers and coverage for mental health services is inadequate.

While addressing issues of mental health, it is also necessary to address issues of alcohol and drug abuse. Seven to 10 million Americans have co-occurring mental health and substance abuse disorders.[5] Substance abuse treatment is a critical element of treatment for individuals with mental disorders and vice versa. Despite the high prevalence of comorbidity, the mental health and substance dependence treatment systems are separate. Research supports treatment that addresses comorbid conditions simultaneously. We need to reform systems and treatment approaches so that mental disorders and substance abuse are treated together.

ORAL HEALTH

Good oral health is essential to general health. Yet the surgeon general's report shows that African Americans, Latinos, and Native Americans are less likely than Whites to have visited a dentist in the past year.[6] Among males with teeth, Mexican Americans (47%) and non-Hispanic Blacks (54%) are much less likely to have visited the dentist in the past year than are non-Hispanic

Whites (68%).[7] African Americans, Latinos, and Native Americans are also more likely to have untreated dental caries. Strikingly, African American males have the highest incidence of oral and pharyngeal cancers.[6] These indicators of poor oral health partly reflect the poor access to dental services experienced by these groups. According to the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, only 57% of men have dental insurance and, even with dental insurance, they may experience difficulty accessing care.[8] We need to improve access to dental services to alleviate the unnecessary pain and discomfort of oral disease.

HIV/AIDS

It would be remiss to talk about the health of men of color without addressing the issue of HIV/AIDS. HIV/AIDS is one of the driving issues of sexual health that led me to produce *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior.*[9] HIV/AIDS is a disease that is ravaging our communities of color. In 2000, HIV/AIDS was the third leading cause of death for African American men between the ages of 25 and 34 years and the fourth leading cause of death for Latino men in the same age group.[10] Reasons for increased risk of HIV/AIDS among men of color include higher poverty rates, lack of insurance coverage, stigma surrounding homosexuality, and drug use. We must break the silence about HIV/AIDS among men of color and advocate increased prevention and treatment, including palliative care. We have identified the basic elements of prevention: education, behavioral change, voluntary testing, and counseling. We must dedicate resources toward preventive efforts and actively reach out to men of color. We must also create the political will to tackle this disease in our communities of color.

Clearly, there is much work to be done toward improving the health of men of color. Eliminating disparities by race, gender, and class will require commitment in our response, collaboration among the various sectors of our society, and sustainable resources dedicated to finding and implementing solutions. Addressing men's health will require efforts at the national, state, local, and community levels. The National Center for Primary Care is dedicated to working with communities to develop strategies to eliminate these disparities and to improve the health of men of color. ■

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References

1. Brown ER, Ojeda VD, Wyn R, Levan R. *Racial and Ethnic Disparities in Access to Health Insurance and Health Care.* Los Angeles, Calif: UCLA Center for Health Policy Research and The Henry J. Kaiser Family Foundation; 2000.

2. Gonzalez P, Stoll B. *The Color of Medicine: Strategies for Increasing Diversity in the US Physician Workforce.* Boston, Mass: Community Catalyst; 2002. Also available at: http://www.kaisernetwork.org/health_cast/uploaded_files/ The_Color_of_Medicine.pdf (PDF file). Accessed March 15, 2003.

3. *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Rockville, Md: US Dept of Health and Human Services, Office of Minority Health; 2001.

4. US Dept of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, Md: National Institutes of Mental Health, 1999.

5. *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.* Rockville, Md: US Dept of Health and Human Services, Substance Abuse and Mental Health Service Administration; 2002.

6. *Oral Health in America: A Report of the Surgeon General.* Rockville, Md: National Institute of Dental and Craniofacial Research; 2000.

7. National Health and Nutrition Examination Survey III: National Center for Health Statistics, Center for Disease Control and Prevention, 1988-1994.

8. Centers for Disease Control and Prevention. 1997 Behavioral Risk Factors Surveillance System. Available at http://drc.nidcr.nih.gov/report/dqs_tables/dqs_16_1_1.htm. Accessed April 4, 2003.

9. The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior. June 2001. Available at: http://www.surgeongeneral.gov/library/sexualhealth. Accessed March 15, 2003.

10. Anderson RN. Deaths: leading causes for 2000. *Natl Vital Stat Rep.* 2002;50(16):1–85.