

The Third World Health Status of Black American Males

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In contrast to their white counterparts, black men in the United States live sicker and die younger. This longstanding phenomenon is sharply reflected in the poor international health status of black males. The NMA president discusses major health issues facing black males and posits a multidimensional strategy for addressing racial disparities in men's health, with a national focus on health promotion and disease prevention, improving healthcare quality and access, and eliminating structural inequities.

Key words: African Americans ■ men's health ■ racial disparities ■ international health

In 1990, an article in the *New England Journal of Medicine* reported that “black men in Harlem were less likely to reach the age of 65 than men in Bangladesh.”¹ A recent comparison of current federal health data with the 2005 Human Development Index published by the United Nations shows that the poor international health status of black men in the United States persists in the new millennium. Today, the average American can expect to live five years longer than a Palestinian—unless that American is a black male, in which case he can expect to die three years sooner.^{2,3}

The life expectancy at birth for black males in the U.S. (68.8)³ is lower than that for males in Iran (69.0),² Colombia (69.3)² and Sri Lanka (71.5)²—populations identified by the United Nations as having “medium human development.” In fact, the average life expectancy for black males is much closer to that of Viet Nam, El Salvador and Iraq than it is to the life expectancy of white males in the United States (Table 1).^{2,4} What accounts for this strikingly poor international health status for black males in the United States? And, most importantly, what should we do about it?

A Reflection of Racial Disparities in Health

The peculiar paradox of a “third world” health status for a group living in the richest and most medically advanced country in the world is deeply unsettling. Grasping this phenomenon requires a core understanding of the enduring racial differences in men's health in the United States. Black males have the shortest life span of all racial or ethnic groups in the nation^{3,5}—a fact that has remained unchanged for at least the past 100 years.⁵ In fact, black men have the highest overall mortality rate across all geographic regions in the United States³ and across all age groups from birth to age 84, with the widest racial gaps in mortality occurring in the prime adult years, ages 25–54.⁵

Racial disparities in men's health exist across virtually all major chronic diseases. For example, in

© 2006. From the National Medical Association, Washington, DC. Send correspondence and reprint requests for *J Natl Med Assoc.* 2006;98:488–491 to: Dr. Sandra L. Gadson, President, National Medical Association, 1012 Tenth St. NW, Washington, DC 20001; phone: (219) 885-3300; fax: (219) 885-3306; e-mail: president@nmanet.org

comparison to their white male counterparts, black men have a 40% higher incidence of type-2 diabetes,⁶ and they are 20% more likely to die from heart disease.⁷ Black males ages 22–44 are 20 times more likely to develop kidney failure due to high blood pressure than are white males in the same age group.⁸ Black men also have the highest overall cancer incidence and mortality in the country and the highest rates of hypertension in the world.⁹

Racial disparities in men's health are hardly limited to chronic diseases. For example, black men have the highest HIV incidence and AIDS mortality rates, the highest STD incidence and the highest homicide rates in the United States.⁵ Black veterans are more likely to suffer combat-related posttraumatic stress syndrome.¹⁰

In addition, black men are severely overrepresented in the nation's prisons, and black male inmates have worse health, including higher rates of circulatory disease, HIV and dental health problems than do white inmates.¹¹ The black male incarceration rate (3,457 per 100,000) is eight times higher than that of whites, with black men comprising roughly half (47%) of the nation's 2.1 million inmates but only 6% of the general population.¹¹ Black males and females are also overrepresented among other medically at-risk populations, including foster care residents¹² and the homeless.¹³

Root Causation

A tremendous and growing volume of research identifies a range of key factors that contribute to racial disparities in health, including behavioral,^{14–17} cultural,^{18,19} socioeconomic,^{20–23} and psychological factors,^{24,25} racism;^{26–29} and healthcare access and quality.³⁰ Focusing on individual behavior has been our most common approach for addressing racial disparities in men's health. For example, public health initiatives aimed at reducing chronic disease disparities, typically focus on improving diet and exercise behaviors or increasing doctor visits among black men. These interventions often contain cultural components that address such factors as ethnic dietary traditions (e.g., soul food) and male cultural attitudes about acknowledging illness symptoms and putting off doctor visits.

However, individual behavior alone does not fully explain the significant racial differences in morbidity and mortality among U.S. males. As noted, there are many significant factors that contribute to racial disparities in health. One of the most powerful and well-documented factors is socioeconomic status (SES)—a factor that has long been correlated to human health. Low-SES groups tend to have less economic capacity to buy nutritious foods; are more likely to live in communities where there is limited

availability of wholesome foods^{31–33} and ubiquitous access to unhealthy foods³⁴; and are more likely to be exposed to environmental toxins,^{35,36} cigarette and alcohol advertisements,^{37–41} and violent crime.^{42,43} In the United States, blacks are significantly more likely to have a lower SES.^{44–46} For example, in 2002, the black poverty rate was more than 2.5 times higher,⁴⁶ unemployment was nearly twice as high,⁴⁷ and black median household earnings were <70 cents for every dollar earned by whites.⁴⁴

Notably, although controlling for SES has been shown to substantially reduce racial differences in health, these differences are not altogether eliminated by taking SES into account,²² suggesting that there are other important factors that cause racial health disparities. For example, researchers have observed that the way in which blacks mentally process their individual and collective experiences of racism can powerfully influence their self-perceptions and health behaviors.^{24,48} Racism is an abnormal phenomenon that stimulates unnatural human behaviors that can prove self-destructive.^{48,49} Black distrust in the medical establishment—whether based on past or present racial mistreatment—can influence whether or not a black individual seeks medical attention or complies with medical advice.⁵⁰

Indeed, perhaps the most troubling root cause of higher morbidity for black men (and women) is the phenomenon of pervasive racial inequality in healthcare. At least eight major studies and independent reviews, most notably the Institute of Medicine's 2002 report "Unequal Treatment," have verified that there are serious and persistent differences in the quality of healthcare delivered to blacks versus whites. The IOM report found that even when you control for such factors as insurance, education, severity of illness and compliance with medical advice, black men and women receive a significantly lower quality of care than do their white counterparts.³⁰

Racial disparities in healthcare exist in treat-

Table 1. Selected male life expectancies at birth

United States (white)	74.6
Sri Lanka	71.5
Ecuador	71.4
Malaysia	70.9
Occupied Palestinian territories	70.9
Iran	69.0
Colombia	69.3
United States (black)	68.8
Viet Nam	68.6
El Salvador	67.8
Iraq*	67.5
Nicaragua	67.3

U.S. data from NCHS, 2005; International data from HDR, 2005;
* Iraq data from CIA, 2005

ments for heart disease, cancer, stroke, diabetes, end-stage renal disease, asthma, pneumonia and AIDS. Disparities even arise from such routine clinical procedures as history-taking, physical examination and pain management. The IOM report found that these entrenched racial patterns of “unequal treatment” result in significantly higher death rates for black men and women.³⁰

A Multidimensional National Response

Our nation's capacity to eradicate racial disparities in men's health—and thereby abolish the “third-world” health status of black men—depends significantly on our ability to acknowledge all of the root causes of health inequality and to put into place effective policies and interventions to address them. Rising to this challenge requires a vigorous, sustained and multidimensional national commitment. Several important lessons emerge from the evidence base to inform this commitment.

First, disease prevention and health promotion must be the mainstay of our intervention. Seven of the top 10 leading causes of death for black men in the United States are treatable and preventable diseases. However, we must shift the paradigm from a behavior-only prevention model to one that addresses black male behavior in a broader and more meaningful structural context. How people act and live are in no small part shaped—though not necessarily dictated—by the larger cultural, environmental and socioeconomic circumstances in which they exist.

Health disparity policies and interventions for black male populations must establish a realistic balance between promoting behavior change and significantly altering the structural and environmental factors that interact with behavior. Thus, in addition to the micro-level prioritizing of basic health promotion and disease prevention, there must also be a macro-level focus on improving the SES of black men.

Second, we must close the racial gap in healthcare. It is unacceptable that despite our extraordinary advances in medicine, our health system continues to grapple with the fundamental task of how to deliver equitable, high-quality healthcare to all of our nation's citizens regardless of race or ethnicity. In 2004, the Sullivan Commission, a multiracial body of national leaders in healthcare, business and law, chaired by former health secretary Louis Sullivan, put forth a viable and promising a dual approach for addressing racial inequality: 1) increasing diversity and 2) improving cultural competence in the healthcare workforce.⁵¹

Indeed, our nation must move forward with greater speed in producing an ample supply of minority health professionals at all levels of the healthcare system, including clinical care, research, public health

and academia. We must also ensure that the general healthcare workforce—and the academic pipeline leading to the workforce—provide comprehensive opportunities for training in cultural competence.

Third, we must address the access problem wherein minorities are disproportionately overrepresented among the nation's 45.8 million people who have no medical insurance.⁴⁵ Racial and ethnic minority groups comprise one-third of the nation's population but over half of the uninsured,^{45,52} one out of five blacks compared to one out of 10 whites utilize Medicaid for medical coverage.⁵² The uninsured are more likely to postpone or forgo care, which increases their chances of illness, disability and premature death.⁵² Consequently, the uninsured are less likely to receive needed services for life-threatening health problems, including heart disease, diabetes, hypertension and cancer.

The ongoing health crisis of black men in the United States is a multidimensional problem that requires a multilevel remedy. Raising the overall health status of our black male population to that of a western nation requires addressing the dynamic root causes of health inequality while upholding the highest standards of disease prevention and healthcare access and quality.

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