EDITORIALS

The *Right* US Men's Health Report: High Time to Adjust Priorities and Attack Disparities

The October 2011 release of the European Commission (EC) report on the state of men's health in the European Union (EU)[1,2] focused attention on men's health around the world. It also inspired calls for a report on the state of men's health in the United States, among other regions. These calls contrast with the silences and omissions of a national and global public health discourse that has left men's health largely unaddressed and has done little to illuminate the dynamics behind patterns of early illness and premature death.

It is critical to acknowledge that meaningful answers to the broad question of where men stand concerning health will emerge from the particulars of what is cultivating or compromising their health. US men continue to fare worse than their female counterparts; this we know. We also know enough thus far to look to the persistent health disparities within the US male population to understand the aggregate effect of poorer health outcomes among men. A true picture of US men's health status will require focused investigation into these disparities and the structural realities that cause and sustain them. A US report would allow exploration of the social determinants of men's health and would give the nation a chance to squarely confront enduring disparities.

NOT JUST ANY HEALTH REPORT WILL DO

As demands mount, it is important to begin enumerating the characteristics of an effective US report.

Such a report must identify and disseminate new reality-based perspectives that are embedded in the data and our existing knowledge about the health disparities among US men. The EC publication largely ignores the diversity[3] of racial, ethnic, cultural, linguistic, sexual, and socioeconomic class groups in EU nations and omits important topics such as men's bio-sexual and reproductive health, sexualities, condom use, and suicide.[4] The exclusions are glaring, given what we know of health disparities in the United States and their intricate influences. Here, as in Europe, health disparities preclude a one-size-fits-all approach to men's health planning and practice.

However, beyond observing and substantiating health disparities, a US report must pay careful attention to the structural and systemic forces, such as incarceration, poverty, the erosion of public education, labor market collapse, and food insecurity, that jeopardize the health of some men more than that of others.[5] It should pay attention to geographic access barriers, permitting us to reckon with such facts as an 11% variation in ischemic heart disease death rates among men within large metropolitan areas.[6]

Policy recommendations must be an integral part of the US report. The nation's poor and working-poor men largely lack provision for primary and preventive care.[7,8] Without recommendations, which the EC report foregoes, advocacy potential and the call to action diminishes. A US report might seize the opportunity to inaugurate and ground a men's health policy discussion.

An effective US men's health report will strive for a comprehensive scope, ensuring meaningful consideration of the frequently overlooked areas of oral, mental, and behavioral health. For instance, suicide rates among men confirm that mental health is not a side issue but a central one. Differential rates—with American Indian, Alaskan Native, and elderly White men at greater risk—call for deeper investigation to improve our understanding of risk.[9]

Finally, we need a document that frames the issue of men's health in the United States in all its complexity. It will provide a strong baseline and set parameters, serving as both a tool for raising awareness and a blueprint for taking action against disparity. It will consider what is known to matter, the substance of social norms: what US boys do and do not learn early in their school lives, the ways they are disciplined in educational and correctional settings, their formative encounters with society's central institutions, how young men are acculturated to (dis)regard their bodies and psyches, and what is treated, mistreated, and untreated across the male life span. This awareness will be inscribed and fully articulated in a report that examines men and where jeopardy enters their lives.

IMPETUS FOR REAL CHANGE

Ideally, the project of a US men's health report should be

strongly connected to a funding and policy collaborative made up of government, private philanthropy, clinicians, men themselves, and health services delivery specialists, including community health workers. The collaborative would be ready to tailor and support major pilot initiatives based on the report. It also would be committed to pursue the broad policy change suggested by the report and lessons from the pilot initiatives. Furthermore, there would be a strongly motivated cross-country coalition to translate insight from the report and the pilots into grassroots knowledge, neighborhood-level action, and broad-based support in US communities.

IMPLICATIONS FOR POLICY

Underpinning the call for an effective US men's health report is recognition that social ills become health urgencies, and a conviction that health ills should be deemed social priorities.

To call for a US men's health report that meets the criteria presented here is also to make a set of normative claims about the roles of government, philanthropy, private enterprise, and the third sector. In subscribing to a family health model that recognizes the interdependence of women's health, children's health, and men's health, the importance of engagement by each of the partner entities becomes clear. Securing support and establishing accord among the potential partners is a grand plan; however, without full participation and a well-coordinated agenda, a transformative US men's health initiative is unlikely.

WHERE ARE THE WOMEN?

It is also time for the voices of women to resound in organized support of men's health. A feminist women's perspective on what the men around them need—their sons, fathers, brothers, partners—could aid in understanding what it is to try and meet basic needs in the face of systemic challenges. What does a feminist mother have to say about the needs of her African American son? A feminist wife about her middle-aged husband who has heart disease and just lost his job? The nation needs what feminists know: that unexamined notions of male privilege and exclusionary legislation obscure but do not erase the real vulnerability of male family members who do not or cannot access preventive and primary care. They know that a vision and provision for the health of men in their households is not a contradiction, but a critical complement, to their own.

COMMUNITY HEALTH INCLUDES MEN'S HEALTH

A broader community health agenda that includes men is required to promote a healthy society. It involves recommitting to the lofty principle of health as a civil right and pursuing a standard no less than health provision for all. It means seeking out the vulnerable and barely visible, many of whom are men, to improve their prospects and our collective chances. A US men's health report is an opportunity to articulate aspirational principles and pave the way for policy that addresses men's health disparities. The United States, still the superpower for global forward movement, can serve as a beacon for other nations, demonstrating how more male-inclusive health policy can reduce disparities and improve well-being for all. ■

Henrie M. Treadwell, PhD
April M. W. Young, PhD

About the Authors

Henrie M. Treadwell is with Community Voices & Men's Health and the Department of Community Health and Preventive Medicine, Morehouse School of Medicine, Atlanta, GA. April M. W. Young is with New Equity Partners Inc, Miami, FL.

Correspondence should be sent to Henrie M. Treadwell, PhD, Department of Community Health and Preventive Medicine, Morehouse School of Medicine, NCPC 216, Atlanta, GA 30310 (e-mail: htreadwell@msm.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This editorial was accepted May 6, 2012.

doi:10.2105/AJPH.2012.300895

Contributors

H. M. Treadwell and A. M. W. Young jointly developed the editorial.

Acknowledgments

The corresponding author acknowledges the support of the W. K. Kellogg Foundation.

References

1. The state of men's health in Europe: extended report. Available at: http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf. Accessed October 26, 2011.

2. The state of men's health in Europe: report. Available at: http://ec.europa.eu/health/population_groups/docs/men_health_report_en.pdf. Accessed October 26, 2011.

3. Eurostat data on population by citizenship, number of foreigners. Available at: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tps00157&plugin=1. Accessed October 26, 2011.

4. European Men's Health Forum. EMHF responds to the EU men's health report. Available at: http://www.emhf.org/index.cfm/item_id/782/CFID=15833142&CFTOKEN=14308333&jsessionid=e4309e6050ba$25$1Bq$. Accessed October 26, 2011.

5. Treadwell HM, Nottingham JH. Standing in the gap. *Am J Public Health.* 2008;98(9 suppl):S170.

6. Ingram DD, Franco S. 2006 NCHS urban-rural classification scheme for counties. Available at: http://wonder.cdc.gov/wonder/help/cmf/urbanization-methodology.html. Accessed October 27, 2011.

7. Young AMW, Meryn S, Treadwell HM. Poverty and men's health. *J Men's Health.* 2008;5(3):184–188.

8. Treadwell HM, Ro H. Poverty, race, and the invisible men. *Am J Public Health.* 2003;93(5):705–707.

9. National Institute of Mental Health. Suicide in the US: statistics and prevention. Available at: http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml. Accessed October 27, 2011.