

Chapter 1

Introduction to Social Determinants of Health among African-American Men

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Learning Objectives

- Acquire an overview of the health inequities affecting African-American men.
- Appreciate the significance of socially determined health inequities faced by African-American men.
- Understand the concept of “social determinants of health status” with reference to African-American men.
- Understand the concept of “social determinants of health behavior” with reference to African-American men.
- Understand the concept of “social determinants of health care” with reference to African-American men.
- Gain an awareness of potential strategies for addressing socially determined health inequities faced by African-American men.

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This chapter is an introduction to the **social determinants of health** among **African-American men**, and lays the foundation for the book.¹ It starts by presenting an overview of the serious **health inequities** affecting African-American men, and then describes why this volume is needed. Next, it considers the social determinants of health among African-American men in relation to health status, health behavior, and health care, subdividing this concept into three interrelated components—the **social determinants of health status**, the **social determinants of health behavior**, and the **social determinants of health care**. Finally, suggestions are offered for addressing these **socially determined health inequities** affecting African-American men. These consist of recommendations for research and programs that address the social determinants of health among African-American men, social policies that tackle social and environmental issues affecting African-American men's health, and health policies that promote **health equity** among this and other vulnerable populations.

The Health Status of African-American Men

African-American men have the lowest life expectancy and highest mortality rate among all other racial, ethnic, and gender groups in the United States. The life expectancy of black men is 70 years as compared with 76 years for white men, 76 years for black women, and 81 years for white women (National Center for Health Statistics, 2007). African-American men's mortality rate is 1.3 times greater than white men, 1.7 times greater than American Indian/Alaska Native men, 1.8 times greater than Hispanic men, and 2.4 times greater than Asian or Pacific Islander men (Henry J. Kaiser Family Foundation, 2007). To cite some examples:

- With regard to cardiovascular disease, African-American men's mortality risk for stroke is 60 percent greater than white men (Office of Minority Health, 2008a). Additionally, among 30- to 39-year-olds, the likelihood of African-American men developing kidney failure as a result of hypertension is approximately 14 times greater than their white counterparts (USRDS, 2005). Moreover, the mortality rate for heart disease among African-American men is 30 percent greater than their white counterparts (Office of Minority Health, 2008b).
- With respect to cancer, black men in the United States suffer significantly greater rates of prostate cancer than their male counterparts worldwide (Zerhouni, 2002). In addition, African-American men's chances of developing lung cancer are 37 percent greater than white men (American Lung Association, 2007). Also, oral (mouth) cancer occurs far more frequently among African-American men than other population groups

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in the United States (NIDCR, 2008). The disparities in the survival rates for oral cancer are striking, with only 36 percent of African-American men surviving five years or more as compared with 61 percent of their white counterparts (National Institute of Dental and Craniofacial Research, 2010).

- Among African-American men, the death rate for diabetes is 51.7 per 100,000 as compared to 25.6 per 100,000 among white men (Office of Minority Health, 2008b).
- African-American men are more than seven times more likely to develop AIDS, and more than nine times as likely to die from AIDS as their white counterparts (Office of Minority Health, 2008b).
- Among young African-American men, the mortality rate for homicides is 84.6 per 100,000 of the population compared with 5 per 100,000 of the population for their white counterparts (Henry J. Kaiser Family Foundation, 2006). To put it another way, the mortality rate for homicides among young black men aged 15 to 19 is 46 times greater than young white men (National Urban League, 2007). Homicide-related mortality rates are not as high among older African-American men, but the rates among the 25-to-44 age group are still overwhelming (61 per 100,000 of the population) as compared with 5.1 per 100,000 among their white counterparts (Henry J. Kaiser Family Foundation, 2006).

Why This Book Is Needed: Social Determinants of Health and African-American Men

As has just been demonstrated, the health inequities affecting African-American men are staggering when compared to other racial, ethnic, and gender groups in the United States. Although there have been considerable efforts in recent years to tackle **health disparities** (Mullins, Blatt, Gbarayor, Yang, & Baquet, 2005), serious inequities persist, especially with regard to African-American men, who continue to face worse health outcomes than other racial, ethnic, and gender groups in the United States. At the same time, it is becoming increasingly clear that social determinants or social factors (e.g., low socioeconomic status, poor neighborhood conditions, discrimination, reduced access to quality education, reduced access to employment, incarceration, reduced access to quality health care) have a major impact on the health inequities affecting this population (Xanthos, Treadwell, & Braithwaite-Holden, 2010).

Although the social determinants of health are increasingly recognized as a critical issue in the public health debate, this topic has been largely neglected in much of the public health literature relating to African-American men. Indeed, the literature on African-American men's health has often been informed by a

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“health behavior framework” as opposed to a “social determinants of health framework.” Research and programs relating to African-American men’s health often concentrate on individual **health behavior** (e.g., unhealthy diet, lack of exercise, failure to participate in health screenings) (Gadson, 2006). What is missing from this framework is a recognition of African-American men’s often difficult life circumstances. African-American men typically face more life adversity (e.g., reduced access to quality education, reduced access to employment, disproportionate rates of incarceration) than less vulnerable population groups (see Gehlert et al., 2008). In addition, African-American men are among the most **underserved populations** in the United States with regard to access to quality health and mental health services, which similarly contributes to their poor health outcomes (see Smedley, Stith, & Nelson, 2003). Although health behavior determines health to a certain degree, it is important to acknowledge that negative social and environmental factors play a critical role in negatively impacting the health of vulnerable minorities such as African-American men. As such, ascribing the health inequities affecting African-American men to health behavior only is not an adequate explanation (Gadson, 2006). Indeed, the health behavior framework can be problematic in that it can lead to “blaming the victims” for their unhealthy behavior, without taking into account the social and environmental factors that cause poor health (see Raphael et al., 2003). Exploring the social determinants of health allows us to reconceptualize the debate around African-American men’s health by drawing attention to the critical impact of social and environmental factors on health.

In this volume, we seek to fill this gap by moving beyond a simple examination of health disparities among this population; we highlight the **social determinants of health inequities** affecting African-American men, and offer solutions to address these socially determined inequities. Further, the concept of social determinants of health is subdivided into three interrelated components—“social determinants of health status,” “social determinants of health behavior,” “social determinants of health care”—to allow for a comprehensive understanding of this issue among African-American men. In this vein, the book introduces students, faculty, researchers, policy makers, and professionals to the following major areas:

- The social determinants of health status among African-American men
- The social determinants of health behavior among African-American men
- The social determinants of health care among African-American men
- Addressing the social determinants of health inequities affecting African-American men

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These themes are reflected in the subsequent chapters in this volume and are discussed next.

Social Determinants of Health Status

African-American men are exposed to a multitude of social and environmental conditions that have the potential to affect their health status, including both physical and mental health (Xanthos, 2008, 2009). For the purpose of this chapter, the focus is on three key social determinants of health that are particularly relevant to African-American men: **low socioeconomic status**, **racial discrimination**, and **incarceration**. These should not be seen as discrete factors; there is significant interplay between them, as is apparent in the following discussion. No list can be exhaustive, so these three social determinants encompass a broad array of some of the most significant stressors and negative life events affecting African-American men's health.

Low Socioeconomic Status

African-American men are disproportionately impacted by low socioeconomic status (SES). First, African Americans are three times more likely to live below the poverty line (approximately 25 percent of African Americans) than their white counterparts (National Urban League, 2007). Indeed, African-American men are paid less than 75 percent of what their white counterparts are paid; 9.5 percent of African-American men are unemployed as compared with 4 percent of white males. Additionally, African-American men are more likely to be in lower-income jobs as compared with their white counterparts (National Urban League, 2007). Due to lower incomes when compared with other racial/ethnic groups, African-American men are often forced to reside in disadvantaged communities, with poor neighborhood conditions (e.g., crime, substandard housing, crowding, noise pollution) (Adler & Snibbe, 2003) and environmental hazards (Bullard, 1990).

Concurrently, the relationship between low SES and poor health is well documented (Baum, Garofalo, & Yali, 1999; Marmot & Shipley, 1996). It has been suggested that the conditions associated with low SES lead to stress, and that in turn, stress leads to poor health outcomes (Baum et al., 1999). As such it is clear that reduced access to socioeconomic opportunities among African-American men is an important social determinant of health.

Finally, it is important to note that the relationship between SES and race is complex. For example, socioeconomic status is an important factor in explaining racial inequities in health, but by itself it is not an adequate explanation because racial disparities in health persist among populations with similar socioeconomic backgrounds (Williams, 1999). In addition, racial

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discrimination can have a harmful impact on health due to its negative influence on socioeconomic status (Williams, 1999). The following subsection seeks to shed some light on this issue.

Racial Discrimination

Racial discrimination is a significant aspect of life for African-American men; they must deal with everyday racism (e.g., proactive police surveillance, workplace tensions) as well as institutional racism (e.g., employment discrimination). In the interests of brevity, we highlight three important discrimination-related issues faced by African-American men and boys: reduced access to quality education, reduced access to employment, and disproportionate rates of incarceration.

First, African-American male students face significant educational inequities when compared to their white counterparts (Schott Foundation, 2006). Black boys are generally more likely to attend the poorest and most segregated public schools as compared with other racial, ethnic, and gender groups in the United States (Schott Foundation, 2006). In addition, underfunding of schools in African-American communities is a serious problem; in 2007, funds allocated per black student represented just 82 percent of funds allocated per white student (National Urban League, 2007). Moreover, it has been argued that school policies and practices play a role in the disproportionate levels of expulsion, suspension, and special education placement among African-American boys (Monroe, 2005; Salend, Duhaney, & Montgomery, 2002). As such there is a resulting achievement gap between black males and other racial, ethnic, and gender groups, which is well documented (Roderick, 2003; Schott Foundation, 2006; U.S. Department of Education, 1995).

Second, as noted earlier, there are significant employment inequities among African-American men and their white counterparts (9.5 percent of African-American men are unemployed as compared with 4 percent of white males) (National Urban League, 2007). Pager's study (2003) demonstrated staggering employment inequities among African-American men and white men. Among African-American men without criminal records, only 14 percent received callbacks for jobs as compared with 34 percent of white men without criminal records. Furthermore, the study found that white men with criminal records (17 percent) are more likely to receive callbacks for jobs than African-American men without criminal records (14 percent).

Third, inequities in incarceration are another important discrimination-related issue faced by African-American men and boys. (For a detailed discussion on incarceration, see the following section.)

Concurrently, there is now significant literature suggesting that racial discrimination leads to negative health outcomes (see, for example, Geronimus,

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Hicken, Keene, & Bound, 2006; Krieger & Sidney, 1996; Taylor et al., 2007). To be sure, Geronimus et al. (2006) note that racism-related stress may cause disproportionate physiological deterioration and in turn greater morbidity and mortality among African Americans. This suggests that racial discrimination is a significant social determinant of health among African-American men.

Incarceration

Incarceration is a stark reality for many African-American men. First, discrimination and reduced access to socioeconomic opportunities such as education and employment can leave African-American men with few positive life options and a vulnerability to involvement in situations that could potentially lead to incarceration. To be sure, the term “school-to-prison pipeline” has been used to describe the increasingly recognized link between the exclusionary discipline practices in schools and incarceration (Fenning & Rose, 2007).

The disproportionate incarceration rate among African-American men is also due to racial biases in police and prosecutor discretion and sentencing guidelines. African-American men face significant inequities in arrest, conviction, and incarceration rates when compared with other racial and ethnic groups (Williams, 2006). Black men are six times more likely to be held in custody as compared with their white counterparts. In addition, the incarceration rate for black men is 4,618 per 100,000 as compared with their white and Hispanic counterparts (773 per 100,000 and 1,747 per 100,000, respectively) (Sabol & Couture, 2008).

At the same time, there is evidence suggesting a connection between incarceration and health status (Graham, Treadwell, & Braithwaite, 2008; Massoglia, 2008). As noted earlier, it has been suggested that stress can lead to poor health outcomes (Baum et al., 1999). Thus, if we consider that prisons are highly stressful places, it follows that they are likely to have a negative impact on health (Massoglia, 2008). Additionally, the stressors associated with reentering society after incarceration (e.g., unemployment, inadequate access to housing and health services) may have a negative impact on the health of African-American men (Massoglia, 2008). In short, incarceration and its related stressors are other significant social determinants of health among this population.

Social Determinants of Health Behavior

As noted previously, research and programs relating to African-American men’s health often focus on health behavior (Gadson, 2006). This may be due to the fact that men in general have significantly less healthy lifestyles than women. Males of all ages are more likely than females to increase their

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risk of morbidity, injury, and mortality by their high-risk behaviors, including the use/overuse of tobacco, alcohol, and other drugs, as well as high-risk sexual activity and violence (Courtenay, 2000). However, as pointed out earlier, explaining unhealthy behaviors simply as a matter of individual choice is problematic because it does not consider why vulnerable populations adopt these behaviors in the first place; it also leads us to blame disadvantaged populations for engaging in unhealthy coping mechanisms (Raphael et al., 2003).

As discussed in the previous section, African-American men are exposed to a whole host of social and environmental conditions that can have a negative impact on their health status. We consider that these difficult social and environmental conditions can similarly have a negative impact on *health behavior*, which can negatively impact health status. Indeed, the social environment can simultaneously *encourage the practice of unhealthy behavior* and *discourage the practice of healthy behavior* (Williams & Collins, 2001). For example, unhealthy products such as alcohol are often disproportionately marketed in the black community. LaVeist and Wallace (2000) found that liquor stores are more likely to be located in majority black census tracts than less black census tracts, and that this disparity could not be explained by census tract SES. LaVeist and Wallace's study also demonstrates significant correlations between liquor store locations and the risk of health-related problems in low-income neighborhoods.

Additionally, as indicated earlier, unfavorable social and economic conditions such as those faced by many African-American men can create psychosocial stress. This, in turn, can have a negative effect on health behavior (Xanthos, 2009). As indicated by a national survey (APA Online, 2006), Americans use unhealthy behaviors (e.g., comfort eating, smoking) as coping mechanisms for stress.

Moreover, as noted in the previous section, due to disproportionately low incomes when compared with other Americans, African-American men are often forced to reside in unfavorable neighborhood locations. High crime levels and a lack of recreational facilities in these locations can impede physical activity due to fear of being a victim of crime, and the lack of suitable places to exercise (Williams & Collins, 2001). Unfavorable neighborhood locations are also associated with reduced access to healthy foods. Many businesses (e.g., supermarkets) avoid segregated areas, which frequently results in fewer, poorer quality, and more expensive goods (e.g., food) than those available in less segregated locations. This can lead to poorer nutrition (Williams & Collins, 2001).

In short, African-American men are exposed to a whole host of social and environmental conditions (e.g., low socioeconomic status, racial discrimination, incarceration [discussed in the previous section]) that can have a negative impact on health behavior (as well as health status).

Social Determinants of Health Care

In addition to the aforementioned social determinants of health, health care has also recently started to be considered as a social determinant of health. Indeed, the barriers to accessing quality care among specific population groups plays a key role in the poor health of these populations (McGibbon, Etowa, & McPherson, 2008).

With respect to men generally, gender stereotypes can affect the quality of men's health care. For example, physicians may make the assumption that men are uninterested in psychosocial help for health problems (Bird & Rieker, 1999). African-American men, in particular, face reduced access to quality health care; health care providers who are unfamiliar with diverse populations may unconsciously be influenced by negative stereotypes of men of color (Satcher, 2003). In 2003, the groundbreaking Institute of Medicine report *Unequal Treatment* (Smedley et al., 2003) found that across a range of disease areas and clinical services, African Americans (and Hispanics) generally receive a lower of quality of health care as compared with their white counterparts. These disparities could not be explained by clinical factors (e.g., stage of disease presentation, severity of disease) or socioeconomic factors (e.g., health insurance status); furthermore, they are associated with higher mortality among these population groups. With specific reference to African-American men, Felix-Aaron et al. (2005) found that African-American men received lower quality end-stage renal disease care as compared with white men. Additionally, in a study exploring prostate cancer screening behaviors among black men, Woods, Montgomery, Belliard, Ramirez-Johnson, and Wilson (2004) found that 62.8 percent of African-American men believed that they received poor treatment because they were African-American, and 58.6 percent considered that their race/ethnicity had an effect on the quality of care provided to them. In addition, African Americans are affected by significant mental health care inequities (Braithwaite-Holden & Xanthos, 2009). To cite one example, research indicates that African Americans are more likely to be prescribed older antidepressant medications (with more serious side-effects) than whites (Melfi, Croghan, Hanna, & Robinson, 2000). (Please refer to Chapter 11 for more details on mental health care inequities affecting African-American men.)

Inequities in health care also emanate from residential factors; residence in segregated medically underserved neighborhoods particularly affects African-American men's access to quality health services. Residential segregation negatively impacts access to health care among African-American men in a number of ways, including a shortage of hospitals in African-American communities (Randall, 2006), a lack of quality physicians in poor African-American neighborhoods (Bach, Pham, Schrag, Tate, & Hargraves, 2004), as well as a lack of quality hospitals in African-American communities (Gaston, 2009). For example,

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research conducted by Hayanga et al. (2009) indicates that in highly segregated areas, surgical services are less readily available than in less segregated areas, and that there is a greater use of emergency services in highly segregated communities; these disparities cannot be explained by socioeconomic or health factors.

Finally, lack of access to health insurance has traditionally been a major factor in the health care inequities affecting African-American men. Indeed, in 2005, African-American men were 75 percent less likely to have health insurance when compared with their white counterparts (Office of Minority Health, 2010). Undoubtedly the health care reform legislation passed on March 23, 2010, will be an important tool in tackling these insurance-related health care inequities.

The above examples demonstrate that health care is a crucial social determinant of health among African-American men.

The Need to Apply the Social Determinants of Health Model to the Health of African-American Men

Funding bodies, researchers, program developers, and policy makers must recognize the social determinants of health inequities affecting African-American men, including the social determinants of health status, the social determinants of health behavior, and the social determinants of health care. In addition, public health research, programs, and policies for African-American men must establish a reasonable balance between focusing on health behavior and tackling the social and environmental factors that influence health behavior (Gadson, 2006). The following recommendations are not meant to be exhaustive, but rather illustrative of key issues that funding bodies, researchers, program developers, and policy makers should be concerned about when considering the health of African-American men.

Research and Programs

Funding bodies must show a greater willingness to fund research and programs that address the social determinants of health among African-American men, including the social determinants of health status, health behavior, and health care. It is imperative that researchers and program developers acknowledge the necessity of moving beyond a simple health behavior model to explore the social determinants of health behavior among this population. In short, there is a need for more research that demonstrates that health outcomes among African-American men are related to social and economic conditions, as well as interventions that address these conditions. Additionally, more diversity may be needed among health policy researchers and program developers in order to achieve a broader research and intervention agenda (Treadwell & Ro, 2003).

Social Policy

Given the impact of the social environment on the health of African-American men, policy makers must promote social policies that address these social and environmental issues. Social policies should include:

- **Labor:** It is necessary to strengthen systems to remove barriers to equal opportunity and adopt compensatory programs as and when necessary in employment (e.g., strengthening anti-discrimination legislation in the area of employment in relation to hiring and promotion) (Danziger, Reed, & Brown, 2004).
- **Education:** There is a need to strengthen systems to remove educational inequities and adopt compensatory programs as and when necessary (Danziger et al., 2004). This should include reforming the system of allocating funds to schools to address the disparities in fund allocation, and promoting race equity within schools (e.g., educational advocacy initiatives for African-American male students, increasing the numbers of African-American male teachers [Courtland, 1991], increasing the accountability of school educators with regard to exclusionary discipline practices in schools).
- **Poverty and the urban environment:** It is important for policy makers to strengthen systems that act as a safety net for low-income workers and individuals who are confronted with financial hardship (e.g., increasing the minimum wage, extending unemployment benefits). In addition, it is necessary to invest in revitalizing poor neighborhoods (e.g., developing walkable communities, mixed-income housing developments, crime-prevention programs) (Xanthos, 2009).
- **Criminal justice:** It is imperative to establish systems to tackle racial biases in the criminal justice system, including biases in police and prosecutor discretion and sentencing guidelines. In addition, it is necessary to address the various social barriers that ex-offenders face after they are released from prison (e.g., providing incentives to employers to encourage the hiring of ex-offenders) (Xanthos, 2009).

Health Policy

As argued earlier, health care is another social determinant of health. The following are examples of health policies that policy makers need to develop to address inequities in health care affecting African-American men.

- **Training to promote gender-specific health services:** There is a need to promote gender-specific health care within health services (Banks,

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2004). For example, health service providers should receive training in gender-specific health care in order that more appropriate services for men can be provided. This would include directing health care providers away from stereotypes that disadvantage men (e.g., “men are better at coping with pain”) (Banks, 2004). In addition, training should include communication, relationship building, patient education, and sensitivity to patient privacy and embarrassment (Dubé, Fuller, Rosen, Fagan, & O'Donnell, 2005). Moreover, health providers' offices should be tailored to improve men's access (e.g., services available outside working hours, availability of men's magazines in waiting rooms) (Banks, 2004).

- Training to promote race equity in health services: It is necessary to promote the provision of racially equitable health services to African-American men and other vulnerable minority populations. As argued by Xanthos (Chapter 11), health care providers should receive training to address the unconscious racial attitudes and stereotypes that negatively impact health care interactions and health care decisions. This would include developing an awareness of any biases relating to African-American men in order to improve service delivery (Cardarelli & Chiapa, 2007). This would also involve directing health care providers away from stereotypes that have a negative impact on health services (e.g., “African Americans are not likely to adhere to medical advice”) (Van Ryn & Burke, 2000).
- Diverse health care workforce: It is imperative that the representation of African-American men be increased at all levels of the health care delivery system. Having health care providers who can relate to the experiences of African-American men will increase their comfort level in utilizing health services (Satcher, 2003). The authors support the recommendations of the Institute of Medicine (Smedley, Stith-Butler, & Bristow, 2004) with regard to this issue. (These recommendations are dealt with in more detail in Chapter 11.)
- Health services in underserved areas: It is crucial to improve the quality of health services in underserved African-American communities. This might include increasing federal funding for hospitals in medically underserved areas; increased funds would go towards financing high-quality medical equipment and the salaries of highly performing physicians/other medical personnel. Other initiatives might include increasing the availability of incentives to physicians to relocate to underserved areas (e.g., increase Medicaid and Medicare reimbursement rates for providers practicing in underserved communities).

Summary

In this chapter, we have argued that there are serious health inequities affecting African-American men and that these inequities are often socially determined; in other words they can often be attributed to the multitude of social and environmental factors which impact the lives of African-American men. Indeed, one would be hard pressed to find a population group that better illustrates the social determinants of health. In this chapter, we have illustrated the social determinants of health among African-American men with reference to three interrelated areas—the social determinants of health status, the social determinants of health behavior, and the social determinants of health care. Additionally we have made a number of recommendations for tackling socially determined health inequities affecting African-American men. These recommendations relate to research and programs, social policies, and health policies. Ultimately, funding bodies, researchers, program developers, and policy makers must adopt a broader framework for understanding and tackling health inequities (Gadson, 2006); they must address the underlying social determinants of health among African-American men.

Key Terms

African-American men	social determinants of health behavior
health behavior	social determinants of health care
health disparities	social determinants of health inequities
health equity	social determinants of health status
health inequities	socially determined health inequities
incarceration	underserved populations
low socioeconomic status	
racial discrimination	
social determinants of health	

Discussion Questions

1. Were you surprised to learn the extent of health status inequities affecting African-American men? Why/Why not?
2. Low socioeconomic status, racial discrimination, and incarceration were presented in this chapter as key determinants of African-American men's health. Do you agree with this assessment? Why/Why not?

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3. How important are “social determinants of health status” versus “social determinants of health behavior” versus “social determinants of health care” as determinants of health among African-American men? In other words, are these three components equally important in terms of their potential to affect African-American men’s health outcomes? Why/Why not?
4. Discuss the advantages and potential barriers to implementing the strategies suggested for addressing socially determined health inequities faced by African-American men. Can you think of any additional strategies?

Notes

1. This chapter draws largely from Xanthos, C., Treadwell, H., & Braithwaite-Holden, K. (2010). Social determinants of health among African-American men. *Journal of Men’s Health*, 7(1): 11–19. Copyright Elsevier (2010).

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