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Ethn Dis. 2015;25(3):237-239.

Key Words: Life Expectancy, Life Course

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Although women in general, and women of color in particular, continue to be disadvantaged on multiple social dimensions,^{1,2} women have markedly better health than men on multiple indicators of health status.^{3,4} For example, life expectancy at birth for American women in 2010 was 4.8 years longer than for their male peers.⁴ This pattern was evident across race and ethnicity where the gender difference was 5.3 years among Hispanics; among non-Hispanics, the gender difference was 4.7 years for Whites and 6.3 years for Blacks (or African Americans). Instructively, these gender differences are larger than the 4.1 year racial difference in life expectancy in 2010, between non-Hispanic Blacks and Whites that garners considerably more research and policy attention.⁴ These gender differences exist for all of the leading causes of death in the United States, with the exception of Alzheimer's disease,⁴ and are evident at every level of socioeconomic status (SES).³ Moreover, the pattern of gender differences in morbidity and mortality exists for both African Americans and Whites.⁴ Thus, although even the highest SES group of American women, in almost every state, falls short of a level of good health that is attainable now,⁵ the health of women can serve as an achievable target for the health of men in American society.

Given that both minority men and women are challenged by patho-

genic exposures linked to their race and SES, the presence of a gender gap suggests that minority men likely face additional health challenges linked to their structural location and the cultural meaning and constraints of masculinity. Considerable evidence suggests that the primary drivers of these gender differences in health are linked to a broad range of social factors that ensure reduced access to societal resources and power.³ These social determinants include poor quality education, high rates of unemployment and underemployment, poor working conditions and high job insecurity, racial discrimination (institutional and interpersonal), and poor quality housing and neighborhood conditions that increase the risk of incarceration, criminal victimization, and limited exposure to role models and social networks that facilitate socioeconomic success.

We need a clearer understanding of how multiple risk factors in the social environment relate to each other and combine to create particular profiles of risk. The editors of this special issue have brought together an outstanding multidisciplinary group of academic experts who provide a nuanced portrait of the ways in which the health of men from multiple minority populations is shaped by exposures over the life course in the larger social contexts in which they are embedded.

An enhanced understanding of the determinants of the shortfalls in

the health of men also delineates areas of intervention for a concerted and comprehensive agenda to improve their health. Scientific evidence continues to mount that clearly indicates that racial disparities in health among adults begin very early in life and that an effective approach to improving health and reducing disparities must include a robust strategy of interventions in early childhood.⁶ Growing evidence indicates that such investments payoff. For example, the Abecedarian project in North Carolina randomized poor, predominantly Black infants to a comprehensive birth-to-age-5 intervention that provided good nutrition, health care, social and cognitive stimulation and supervised play.⁷ By their mid-30s, the intervention group had lower levels of multiple risk factors, such as blood pressure, metabolic syndrome and weight, than the control group. Importantly, the observed effects were stronger for men than for women. Similarly, a recent Baltimore study documented that in those neighborhood areas where Black and White men with similar incomes lived under the same social environmental conditions, there were no racial disparities in common chronic conditions, such as hypertension and diabetes, among the men.⁸ These data suggest that interventions that improve living and working conditions can lead to improved health.

History has taught us that with the right social policies, marked improvements in health and the narrowing of racial inequalities in health are possible. For example, between 1950 and 2006, Blacks had larger gains in life expectancy than Whites, with greater

increases for Black women than Black men.⁹ African American women, for example, had life expectancy at birth that was 3.6 years shorter than that of White males in 1950, and although they still lag behind White women, they have had longer life expectancy than White males since 1970.⁹ These gains have been directly tied to social policies. The Civil Rights movement and anti-poverty policies of the 1960s led to increases in income for Blacks relative to Whites and a narrow-

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ing of the Black-White income gap. These economic gains were greater for Black women than for Black men.¹⁰ Strikingly, between the mid-1960s and the mid-1970s, several studies have found that Blacks experienced greater improvements in health than Whites, with the increases greater for Black women than for their male peers.¹⁰⁻¹³ However, throughout the 1980s, the Black-White income gap widened from the 1978 level while the health of Blacks worsened for multiple indicators of health.¹⁴ For example, the life expectancy for Blacks declined from the 1984 level

for five years in a row while the life expectancy of Whites increased slightly during this same period.

We still have much to learn to fully understand and better implement comprehensive, multi-level solutions to improve the health of minority men. The articles in this issue of *Ethnicity & Disease* provide a roadmap for some of the needed research and interventions that can enable the field to take a great step forward. At the same time, we do not need to delay action while waiting for more research. We currently know enough to act.^{15,16} Our greatest need is to make a resolute commitment to utilize all the knowledge that we have to create a healthier future for all, and to prioritize the allocation of resources to match the depth of the challenges currently faced by minority males.

ACKNOWLEDGMENTS

Preparation of this paper was supported by National Cancer Institute grant P50 CA 148596. We thank Maria Simoneau and Zhaozhong Zhu for assistance in preparing the manuscript.

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