The coronavirus pandemic has amplified health disparities by race and gender, perhaps most notably among African American men. Surveillance data reveal that males are disproportionately affected by COVID-19, and that Black populations are disproportionately affected overall (Wortham et al., 2020). It cannot and should not be a surprise that populations who are subject to poverty, fragile housing, food and fiscal insecurity, no or inadequate health insurance are disproportionately affected by COVID-19. It is axiomatic that populations that have disproportionate rates of health conditions such as hypertension, diabetes mellitus, obesity, and cardiovascular disease are more susceptible to both contracting coronavirus and to adverse outcomes.

The criminal justice system interjects an additional risk factor given that those captured in this matrix are predominantly African American males. The impact of COVID-19 across jails, prisons, and detention centers may never be fully reported out to the community. What recent data exist are grim. In those facilities where testing has occurred, the positive test rate is 78% among the incarcerated and extremely high levels of positive tests (Dolovich, 2020). Positively, the prospective HEROES Act (Section 30110) would allow Medicaid to cover health services in the last 30 days pre-release. Still once released, major barriers to basic and critical health and human services still exist as three quarters of reentry service providers have scaled back or have closed their services (CSG Justice Center Staff, 2020). The lack of support services hinders opportunities for individuals to successfully reunite with families, attain employment, and address burgeoning child support and other restorative justice costs.

Grappling with the disparities revealed by the pandemic requires an examination and actions to ameliorate racial discrimination that has had an impact for 400 years. African American boys and men have experienced poor health and health outcomes historically, and little or nothing has changed over the years though improvements in U.S. health services and systems are reportedly the most advanced in the world. The 2019–2020 coronavirus pandemic amplifies the existing injustices. While some attribute the overall poor health and disparate rates of morbidity and mortality to individual behaviors, that assessment fails to assess the direct damage inflicted by a social and political system that has marginalized and minimized efforts to provide meaningful services even at the primary health-care level. The compendium of injuries experienced that circumscribe well-being are described as the social determinants of health. Significantly, a more nuanced expression on the how the collateral damage is delivered are described as the political determinants of health. In sum, policies that do not incorporate potential for fostering racial disparities are the drivers of disease, health inequities, and the unequal burden of morbidity and mortality experienced by communities of color.

Examination of current health-care system policies, practices, and experiences is an inadequate starting point for a discussion of redressing health disparities. Rather, historical perspectives are important to understand the depth of destruction caused by hundreds of years of exclusion from justice. It is not possible to thoroughly understand why health inequities exist without acknowledging the terrible cumulative penalty that is being paid as a result of intentionally exclusionary policy that based solely on skin color, race, ethnicity, and gender. Social practices and political policies have discriminated against Black men since the Black Codes (History.com, 2019), the Man in the House Rule (Moffitt et al., 1994) which excluded them from the home lest funding for children be lost, and the exclusion from Social Security (DeWitt, 2010). A race-based policy and the continuing overwhelming exclusion of boys and men over the age of 18 from Medicaid (Hinton & Artiga, 2016) fosters exclusion that could have been mitigated if states had expanded Medicaid under the Affordable Care Act. In sum, the nation’s policymakers have designed a system that discriminates and until now legislators appear loath to enact policies and programs to insure health equity for all.

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Major systemic barriers have been erected that affect morbidity and mortality in the African American community. The lack of insurance, lack of a living wage, and employment in low-wage professions that do not provide sick leave and require that individuals go to their “essential jobs” (e.g. meat packing plants, home health care, as nurses’ aides or janitorial staff, among others) despite their health symptoms or status, elevate mortality in poor communities of color. The distinction that must be made is that African American men are not disproportionately and prematurely dying simply because they are African American men. There is no evidence that the cause of the disparity is embedded in the genes. They are dying because they do not have a healthcare home as a result of not having income to pay for the visits. Further and perhaps even more damaging throughout the pandemic are health messages supported by federal government leaders that insist that individuals not go to the clinic or emergency room. Rather they are instructed to call their doctor. The cloak of invisibility is firmly wrapped around the population of those, mainly men of color, who have no doctor (Treadwell & Ro, 2008). What are they to do and why is their plight ignored?

A striking conundrum is that data are not consistently collected by race and gender making it impossible to identify population-based service deficiencies that guide the design of specific strategies, appropriate tactics, and barrier-free interventions. It is important to acknowledge that institutionalized populations are not included in population statistics unless they enter the health-care system for treatment, a subject discussed at length in the recently published manuscript, “Discerning disparities: The data gap” (Treadwell et al., 2019) and in the article “Collecting demographic data is the first step in eliminating racism in healthcare” (Eschner, 2020).

Damage is perpetrated when researchers and individuals who report on morbidity, mortality, and equitable health-care access remain silent about institutionalized populations, such as African American men who are disproportionately represented in America’s prisons. The silence from epidemiologists and others charged with profiling the health care of the nation is perplexing as it allows racist and exclusionary practices to continue unabated and the public, that might respond affirmatively, to remain ignorant of the depth of health inequities linked to race and gender alone. African American men are subject to injustices on so many levels. Those entities and organizations that “police” the health-care system through their incomplete data collection and reporting out strategies are failing the public, too, along with their failure to advocate for inclusive data collection.

To be sure, the issues do not solely affect African American men. Yet each group (e.g. Hispanics, Pacific Islanders, and Native Americans) has a unique path in the United States and each group should be examined so that comparative analyses can be conducted to determine similarities that can be enacted to meet their needs, along with strategies that respond to each racial group and their heterogeneous historical and contemporary experiences.

We as a nation did not come to this place by chance. Race and racism have been the catalysts. The inflection point is here. The time to act to redress inequities and support health justice is now. To achieve the change that we need to see in our society, we must advocate for expanded Medicaid and/or health-care coverage for all in the nation. Equally important, systems must be designed to ensure that behavioral and oral health care are an integrated part of primary care. We must also address the fact that a disproportionate number of African American men are incarcerated and foster integration of data from those in the community and those incarcerated to develop a complete portrait of health status of these individuals and establish interventions that reflect the totality of need. These men do come home eventually, and their health service needs must be anticipated and accommodated, something not possible now because of parallel data systems. Finally, it is important to begin the process of holding dedicated days in community clinics that invite boys and men so that their total health care and conditions, not just their prostate health, can be assessed and treated, as appropriate. And, we must expand those that research health access and analysis to include anthropologists and others in the social sciences to enable accurate delineation and enumeration of the issues, illumination of the pathways to reducing invisibility, and establishment as bedrock a rational, humane, equitable, and gender inclusive health-care system. The time to act is now. Failure to act IS an act that promulgates the current inequities.

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References
CSG Justice Center Staff. (2020). Survey shows reentry services halting across U.S. https://csgjusticestate.org/survey-shows-reentry-services-halting-across-u-s/?mc_cid=13c23b1fd9&mc_eid=d901682358
DeWitt, L. (2010). The decision to exclude agricultural and domestic workers from the 1935 Social Security Act. Social Security Bulletin, 70(4), 49–68.
Dolovich, S. (2020). UCLA law Covid-19 behind bars data project. https://law.ucla.edu/academics/centers/criminal-justice-program/ucla-covid-19-behind-bars-data-project
Eschner, K. (2020, June 15). Collecting missing demographic data is the first step to fighting racism in healthcare. Popular Science.
Hinton, E., & Artiga, S. (2016). *Characteristics of remaining uninsured men and potential strategies to reach and enroll them in health coverage*. https://www.kff.org/uninsured/issue-brief/characteristics-of-remaining-uninsured-men-and-potential-strategies-to-reach-and-enroll-them-in-health-coverage/

History.com. (2019). *Black codes*. https://www.history.com/topics/black-history/black-codes

Moffitt, R. A., Reville, R. T., & Winkler, A. E. (1994). State AFDC rules regarding the treatment of cohabitators: 1993. *Social Security Bulletin, 57*(4), 26–33.

Treadwell, H. M., & Ro, M. (2008). Poverty, race, and the invisible men. *American Journal of Public Health, 98*(9 Suppl), S142–S144. doi:10.2105/ajph.98.supplement_1.s142.

Treadwell, H. M., Ro, M., Sallad, L., McCray, E., & Franklin, C. (2019). Discerning disparities: the data gap. *American Journal of Men’s Health, 13*(1), 1557988318807098. doi:10.1177/1557988318807098.

Wortham, J. M., Lee, J. T., Althomsons, S., Latash, J., Davidson, A., Guerra, K., Murray, K., McGibbon, E., Pichardo, C., Toro, B., Li, L., Paladini, M., Eddy, M. L., Reilley, K. H., McHugh, L., Thomas, D., Tsai, S., Ojo, M., Rolland, S., . . . Reagan-Steiner, S. (2020). Characteristics of persons who died with COVID-19 - United States, February 12-May 18, 2020. *MMWR. Morbidity and Mortality Weekly Report, 69*(28), 923–929. doi:10.15585/mmwr.mm6928e1.