

Oral Testimony | Meeting the Health Needs of Maryland's Boys and Men

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Affiliations (for identification purposes):

- Policy Committee Member, American Public Health Association Men's Health Caucus
- Chairman, Men's Health and Well-Being, Million Men Vote, Inc.
- Deputy Surgeon General and Chairman, Healthcare Disparities Subcommittee, Alpha Phi Alpha Fraternity, Inc.

Chair, Vice Chair, and members of the Committee—thank you for the opportunity to testify.

My name is Dr. Okey K. Enyia. I'm here today in support of establishing a Maryland Commission for Boys' and Men's Health (HB0341).

Let me begin with a straightforward policy reality:

Men don't experience health in silos, but our systems are often designed that way.

Across the life course, boys and men are less consistently connected to preventive and primary care—entering the system late, often through emergency settings rather than ongoing care. That pattern reflects design choices that increase long-term costs and reduce effectiveness.

The consequences are measurable.

Nationally, Black men have a life expectancy of 72.8 years, compared to 77.5 years for White men—a gap driven in part by chronic disease and cancer. As I document in my book, Black men are about 70 percent more likely to be diagnosed with prostate cancer and more than twice as likely to die from it, despite the disease being highly treatable when detected early. That is not a failure of individuals; it is a failure of early detection, follow-up, and coordination.

System capacity gaps reinforce these outcomes.

Black men make up less than 3 percent of physicians, and Black principal investigators are 40 percent less likely to receive NIH research funding, limiting culturally responsive care, slowing innovation, and weakening prevention efforts.

The same pattern appears in mental health.

Only 26.4 percent of Black adults with mental illness receive treatment, and men die by

suicide at nearly four times the rate of women—clear signals of systems that respond too late and at higher cost.

These outcomes matter not only for health, but for workforce participation, family stability, and state spending. Nationally, racial and ethnic health disparities cost an estimated \$421 billion each year, with education-linked health inequities adding another \$940 billion. At its core, this is about economic stewardship—our health is our wealth.

Heather McGhee, in her book *The Sum of Us*, makes clear that equity is not a zero-sum proposition—when systems work better for those carrying the greatest structural burden, everyone benefits.

I want to be clear about the solution.

This is not about creating a separate system or shifting resources from one group to another. The goal is shared: healthier Marylanders, lower long-term costs, and a stronger workforce. Achieving that goal requires practical targeting—fixing where the system is weakest so it works better for everyone.

I often say that if you are not at the table, then you are on the menu. But when you help build the table, you get to decide who gets served. A Maryland Commission for Boys' and Men's Health ensures boys and men are not an afterthought in policy design, but partners in building solutions that strengthen the entire state.

Maryland already understands the value of permanent policy infrastructure through the Commission for Women.

Boys and men deserve the same level of coordination, accountability, and focus.

A Maryland Commission for Boys' and Men's Health would not deliver services. It would align data, reduce duplication, and ensure that existing investments are used more efficiently.

My ask is simple: advance legislation to establish this Commission.

Thank you. I'm happy to serve as a technical resource.