

# WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES



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Welcome to the first issue of the *Wisconsin Chronicles of Black Health Disparities!*

This publication is an outgrowth of the *State of Black Health in Wisconsin* report that the Black Health Coalition of Wisconsin publishes. Through the research involved in the report, it became evident that greater attention could be focused on racial disparities related news and research. This medium allows us to share with you important information on a more regular basis. We hope to publish this newsletter on a semi-annual basis.

With this being the first issue, we look forward to receiving your feedback and suggestions for future issues. We hope to

## Publishers' Welcome!

one day get to the point where a publication such as this is not needed, but as you read through this information you will see that this hope is a long way off.

In the meantime we hope that this information will serve to motivate our community to become more aggressive advocates for equitable healthcare. Policy makers will not just research the disparities but more importantly invest the needed political and financial support to eliminate them. Healthcare providers will provide services to patients based upon their healthcare needs versus their race/ethnicity, education level or financial status.

We started a "Walk for Quality

Health" three years ago to support the publication of the "State of Black Health Report" and this newsletter. This year the "Walk" is Saturday, June 3, 2006. Please go to our website, [www.bhcw.org](http://www.bhcw.org) to obtain registration information or to make a donation. Thank you!

Patricia McManus, PhD., RN, Publisher

Executive Director of the Black Health Coalition of Wisconsin, Inc.

***"Of all the forms of injustice, injustice in health care is the most shocking and inhumane.***

-Dr. Martin Luther King, Jr.

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## HHS releases it's 2005 National Healthcare Disparities Report

The Office of Minority Health branch of the U.S. Department of Health & Human Services (HHS) held it's second National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health in January of this year. The Summit brought together key leaders from a cross sector of government, health and academia to advance issues regarding minority health with the goal of closing the gap that is well documented in Unequal Treatment by the National Institute of Health.

The 3rd annual *2005 National HealthCare Quality Report* and its companion document, *2005 National Healthcare Disparities Report* was released at the Summit. These annual reports, produced by HHS' Agency for Healthcare Research and Quality (AHRQ), measure quality and disparities in effectiveness, patient safety, timeliness, and patient centeredness in health care.

As a mandate by Congress in the Healthcare Research and Quality Act of 1999, AHRQ's

priority populations are: minority groups, low income groups, women, children, elderly and individuals with special health care needs.

The governments acknowledgement of racial health disparities dates back to twenty years ago when DHHS published the *Report of the Secretary's Task Force on Black Minority Health*. Quite similar to the current disparities report, this report document many disparities in health.



### 2005 National Disparities Report (continued)

That report was suppose to lead to interventions to improve the health and health care of minorities due to the priority groups having unique health care needs or issues that require special attention.

Yet, as one reads through the pages of the 2005 report it is clear that we have not come very far over these twenty years.

Although the 2005 National Healthcare Disparities Report identifies areas of racial disparities in quality and access to care that are seeing narrowing gaps, there yet remains far too many areas in which the disparities continue to exist for Blacks. The gaps in both of these area are growing wider for Hispanics.

The Disparities Report focuses on four key areas:

- Disparities still exist.
- Some disparities are diminishing.
- Opportunities for improvement remain.
- Information about disparities is improving.

The disparities are inclusive of race, ethnicity, and socioeconomic status are seen through all levels of health care.

Here are some examples of disparities that have been researched and included in the report:

- Minorities and the poor receive lower quality care.
- The largest disparities in quality of health care for Black vs. White included new AIDS cases, children with hospital admission for asthma and problems with timeliness of care (left emergency room without being seen, not getting care for illness or injury as soon as wanted).
- The largest disparities in quality of health care for Hispanic vs. non-Hispanic White included new AIDS cases, illness/injury care as soon as wanted and children with patient-provider communication problems.
- The largest disparities in quality of health care for poor vs. high income include children with patient-provider

communication problems, illness/injury care as soon as wanted and children with dental visits.

- The disparity level between black vs. white was getting worse in four measurable areas; 12 areas for Hispanics vs. non-Hispanic White and 5 for poor vs. high income.
- In 1992, 1993 & 2002 Black women had higher rates than White women of those diagnosed with advanced stage breast cancer.
- Blacks and Hispanics are more likely to have or die from diabetes.
- Minorities were more like to develop End Stage Renal Disease and less likely to be treated.
- The prevalence and death rate of hypertension and heart disease was higher among Blacks.
- The recommended hospital care for heart attack was lower among Blacks and Hispanics compared to Whites.
- In 2003, the rate of new AIDS cases among non-Hispanic blacks was more than 10 times higher than the rate among non-Hispanic Whites. The rate among Hispanics was over 3 times as high as the rate among non-Hispanic Whites.
- Blacks were less like to complete substance abuse treatment compared with non-Hispanic Whites.
- Between 1999 & 2003, the proportion of adults age 65 and over who ever had pneumococcal vaccine was lower among Blacks compared with Whites; Hispanics compared with non-Hispanic Whites; poor compared with high income elder and elderly with less than a high school education compared to elderly with any college education.
- Blacks were more likely to live in nursing homes with limited resources.
- Racial minorities had higher rates of some safety events.

- Blacks were more likely to leave ER's before being seen compared to whites.
- Between 1999 & 2003, the proportion of person with insurance was lower among Blacks compared with Whites; among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with a high school education or less compared with persons with some college.
- High income Blacks and Blacks with a high school education or any college education were less likely than respective Whites to have health insurance.
- In 2001-2002, rates of emergency department visits were significantly higher among Blacks compared with Whites.
- The proportion of person who received mental health treatment/counseling was lower among Blacks compared to Whites and among Hispanics compared with non-Hispanic Whites.

To better understand these disparities, here is some demographical information from the U.S. Bureau of the Census:

#### 2000 Population:

- 36 million Blacks or African Americans (12.9% of total population)
- Over 35 million Hispanics or Latinos (12.5% of total population)
- 211.5 million Whites (77.1% of total population)

#### 2002 poverty prevalence:

- 24% of Blacks, 22% of Hispanics, 10% of Asians and 10% of Whites were poor.

To view the disparity report in it's entirety, please go to:

<http://www.ahrq.gov/qual/nhdr05/nhdr05.pdf>

## Black Wisconsin Women at Greater Risk for Osteoporosis

According to an article featured in the Wisconsin Medical Journal, Black women in Wisconsin have a greater risk for low bone mass prevalence and osteoporosis.

Osteoporosis is a disorder in which the bones become increasingly porous, brittle, and subject to fracture due to the loss of calcium and other minerals. This sometimes results in pain, decreased height and skeletal deformities. This condition is mostly experienced by the elderly, especially postmenopausal women.

The osteoporosis article was based on research completed by Srividya Kidambi,

MD; Susan Partington, PhD; and Neil Binkley, MD. For their study, one hundred fifty African American women greater than age 45 completed questionnaires that asked for their responses to known osteoporosis risk factors. The participants also were given medical exams involving ultrasounds.

The study concluded that African American women are at greater risks for developing osteoporosis in part because they do not perceive it to be a health risk. Additionally, the prevalence of sickle-cell anemia and systemic lupus erythematosus are noted as

putting this population at greater risk.

The findings of the study also stated that the risks levels are higher for African American women because preventive strategies are not focused on them, rather on White women instead.

This disparity can be corrected with better awareness of osteoporosis risk factors targeted specifically at African American women as well as improved diagnosis and treatment.

**Source:** [Low Bone Mass Prevalence and Osteoporosis Risk Factor Assessment in African American Women](#), Wisconsin Medical Journal 2005—Vol. 104, No. 8

## Heart Attack Care Withheld from Women and Minorities

Cardiovascular diseases are among the leading causes of death, this includes heart attacks and strokes. Based on recent findings from doctors at Duke University Medical Center, White men receive greater care and protection from these conditions while women, minorities and the elderly receive less care and/or care that is poor in quality.

Duke staff presented their study findings at the 55th annual scientific session of the American College of Cardiology in March of this year. Their report asserts that whether a heart attack patient is white and male is what determines quick and appropriate treatment as opposed to the patients' medical condition.

What this means is when women/minorities go to medical facilities with symptoms related to a heart attack, instead of them being quickly seen and treated they often have to wait long periods of time before they are seen, are not given proper treatments and/or not transferred to larger more equipped facilities.

Every minute counts when a person is experiencing a heart attack, so delays such as these causes these populations to suffer unnecessarily and in some cases their lives are put in jeopardy. This is especially true when patients are given treatments through drugs as opposed to surgical interventions.

The study also noted that younger, white men with symptoms of less serious heart attacks were still more likely to be transferred to larger hospitals. The care and treatment at larger hospitals is crucial because they have the staff and technology necessary for the performance of angioplasty and bypass surgery. Women were 16% less likely to be transferred, African Americans were 31% less likely to be transferred and Hispanics were 7% less likely to be transferred.

**Source:** Jeffrey Berger, M.D., M.S., cardiology fellow, Duke University Medical Center, Durham, N.C.; Nieca Goldberg, M.D., chief, women's cardiac care, Lenox Hill Hospital, New York City; March 12, 2006, presentation, 55th annual scientific sessions, American College of Cardiology, Atlanta

## Black Youth More Likely to Drown

Young Black males are usually not at the top of any list, unless it is a negative one. This too being the case when looking at the populations that are most likely to drown. Based on an article in the April 2006 issue of the American Journal of Public Health, young Black males make up almost half of all recorded drowning deaths. These incidents happen in motel and hotel pools in comparison to private pools, wherein more whites tend to drown.

This information was based on research conducted by the U.S. National Institute of Child Health & Human Development. For this particular study, the Institute examined the federal database of 678 drowning deaths in the United States between 1995—1998. All of the drowning victims in the study were between the ages of 5 - 24 years. Data wise, 75% of the victims were male, 47% Black, 33% were White and 12% were Latino. Yet Blacks and Latinos each only make-up about 13% of the U.S. populations according to the U.S. Census Bureau.

The study also noted the regardless of race, poverty was a leading characteristic of the drowning victims. More focused is needed on teaching Blacks how to swim to change this disparity.

**Source:** American Journal of Public Health, April 2006



## Asthma Disparity Gap Remains

The February 2006 issue of the Journal of Allergy and Clinical Immunology gives troubling news in reference to asthma and the minority community. Based on the article, Blacks Americans are five times more likely to die of asthma and four times more likely to be hospitalized for the condition in comparison to other American populations.

Some doctors theorize that a lack of insurance for many Blacks contributes to this disparity. Others say genetics may be a leading cause.

**Source:** Feb. 13, 2006 Press Release from the American Academy of Allergy and Immunology

## Asthma Medications May Be too Risky for Blacks

Serevent, a commonly prescribed asthma medication, was the focus of a large study that discovered it may contribute to more respiratory and asthma-related deaths for Blacks. GlaxoSmithkline is the manufacturer of the drug. In 2003, they made their warning labels for the prescription stronger as a result of these risks, yet they are not counting the deaths a strong enough evidence to pull the drug or restrict it in any way. This was also done for the drug Advair, which is a combination drug of Serevent and Flovent. These drugs work in combination as Serevent opens restricted airways and Flovent eases inflammation.

A recent article in Forbes magazine also warned that about 4,000 people a year may die as a result of their usage of Advair or Serevent. One of the doctors in the article stated that four of every five asthma-related deaths each can be attributed to Advair and Serevent. Currently the pharmaceutical giant is conducting a 460-patient trial with Black patients that compares Advair usage versus Flovent and a 540-patient study that looks at genetic risk factors.

The researchers hesitated to say that ethnicity was the problem, instead they contribute the disparity to people who have less access to medical care and/or their asthma was not controlled well. Serevent should never be used on its own, according to a new warning by the FDA.

**Sources:** Chest, January 2006 Forbes, April 24, 2006

## Asthma Meds Disparity

A leading factor in the asthma morbidity and mortality rate can be attributed to minority children not receiving needed medications according to the January 2006 issue of Medical Care.

This finding comes from a study by researchers at the Massachusetts General Hospital Institute on Health Policy. The research looked back to the early 1980s when asthma inhalers with steroid medications were initially introduced in the United State, during this period these medications were not prescribed to minority patients and children.

The researchers speculated that this was the case because minorities did not have access to specialist who could then prescribe the medications and they could not afford them. Children were less likely to receive the medications because the manufacturers may not yet proven that they were safe enough to be used by children.

The findings pointed to improvements by the mid-1990 for minorities, with the exception of Hispanics.

**Source:** Dec. 23, 2005 Press Release from Massachusetts General Hospital

## Minorities & Poor People Suffer More from

Researchers from the University of Wisconsin, Madison are placing the responsibility of pollution disparities on local, state and federal governments. This is based on their recent study that show poor or minority kids being impacted the most from environmental toxins. These findings were published in the March/April 2006 issue of Child Development. The toxins harm the brain development and other areas of health development of the children.

The study specifically looked at the higher incidents of exposure that Black children have to lead, much of this based on them being more poor and living in dwellings that do not meet lead safety specifications. The poisoning from the lead create cognitive problems for the children that can lead to lower IQ scores and learning disabilities.

**Source:** March 22, 2006 Press Release from The Society for Research in Child Development



## National Urban League Releases 2006 Report on the State of Black America

The National Urban League released its annual State of Black America 2006 in March of this year. Once again, the civil rights organization uses the publication as a medium to shine the light on national inequities. These inequities include; homeownership, employment, business, the state of Black children, health, poverty, and the incarceration system

The section of the report that deals with health is titled, "Race, Poverty, and Health Disparities." As one reads the essay, you are reminded of the irony of the state of black America considering the United States is considered the industrialized powerhouse. The democratic country is touted as being the best in all regards and superior to all others. Yet, the World Health Organization ranks the United States 37th out of 191 countries when assessing health systems. The author of the essay attributes this despairingly rank to the health inequities that Black suffer. While many other countries have a national health care system that guarantees coverage for all, millions in the United States remain without health insurance coverage. The essay stated that 45.8 million Americans did not have health coverage in 2004.

The National Urban League makes the following recommendation in the report:

"Healthcare inequality must be tackled by state and federal efforts to develop a universally accessible, comprehensive, and equitable healthcare system. Access to healthcare can be expanded by: 1) Creating a "Medicare for all" national single-payer plan; and 2) covering all children under a comprehensive health insurance plan."

The report acknowledges that the achievement of these outcomes will be difficult considering the long legacy of health inequities that this country has allowed, purposefully so in many cases. Thus the need for real partnership between "government, healthcare providers and institutions, health systems, and other important stakeholders—such as the business community, labor, faith groups, and others."

**Source:** The State of Black America 2006: Opportunity Compact, National Urban League March 2006

## Minorities will Suffer the most if HIV/AIDS Act is not renewed

The National Minority Health Month Foundation (NMHMF) is pressuring the U.S. Congress to support the reauthorization and modernization of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE) in 2006.

CARE is the HIV/AIDS funding stream that provides financial support to community programs. These funds then provide services and resources to those that need them the most because they have few other options, if any.

Despite HIV/AIDS no longer being consistently highlighted in the media, it is still very much a disabling and deadly disease. This is especially true in the Black community. According to the CDC, minorities accounted for almost three-fourths of the new cases of AIDS in 2004. With the vast majority (48%) of these cases being Blacks and Latinos making up 21%. Even more disturbing is when you look at the number of African American women who are being impacted by the disease. During this same time period, Black women made up 67% of all of the newly diagnosed female AIDS cases.

The need for adequate HIV/AIDS funding and resources to minority communities is further highlighted in the latest fact sheet by the Kaiser Family Foundation. The opening line states, "African Americans have been disproportionately affected by HIV/AIDS since the epidemic's beginning, and that disparity has deepened over time."

The NMHMF campaign, which began in January, encourages HIV-positive patients and community leaders to urge Congress to not just reauthorize CARE, but to also make the resources available in a more equitable way. This would involve the inclusion of smaller and rural communities that oftentimes are excluded from such grants because of their relatively smaller population sizes.

NMHMF launched a website dedicated to this effort in February 2006, [www.ryanwhitecareact.org](http://www.ryanwhitecareact.org).

**Source:** January & February 2006 Press Releases, The National Minority Health Month Foundation  
HIV/AIDS Policy Fact Sheet—African Americans and HIV/AIDS, The Kaiser Family Foundation  
February 2006

## Breast Cancer Mortality Rate Higher for Black Women

White women have greater survival rates from breast cancer than black women according to information published in the March 20, 2006 issue of the Journal of Clinical Oncology. One study states that Black women die at a rate of 19 percent more so than the comparison population.

Another study by researchers at the Mount Sinai School of Medicine examined the medical records of over 600 women who had surgery for early-stage breast cancer between 1999 and 2000 in six New York City-area hospitals. This study found that the minority cancer patients were only 50 percent likely as white women to receive adjuvant treatment. This was despite the minority women having similar rates of referrals to oncologists.

**Source:** March 20, 2006 Press Release of the American Society of Clinical Oncology



## Status Report on Wisconsin Infant Mortality

The Wisconsin Department of Health and Family Services (WDHFS) released an Infant Health Fact Sheet, *Wisconsin Health Facts: Racial and Ethnic Disparities in Infant Mortality*, in January of 2006 that further expresses the need for improved health outcomes for minority pregnant women and infants in the state.

The report identifies the elimination of health disparities as a key goal of the *Healthiest Wisconsin 2010* initiative. The continued stark disparities in infant mortality shows that the State is far from reaching its goal. This reality also give one an view of how the overall health of Blacks in Wisconsin, as the state of infant health is a good indicator of health outcomes in other areas. If the most vulnerable in Wisconsin are not afforded adequate health, than others are not as well.

Black infants in Wisconsin are 3 - 4 times more likely to die within their first year of life in comparison to White infants. This is not a new phenomena in Wisconsin, this said reality has existed for twenty years. The issue has been studied at the leading medical schools and on all levels of government, yet no real and consistent change has occurred. Community based interventions have been proven effective in addressing the issue, yet the needed resources are not at adequate levels to truly make a difference.

The state of white infant health in Wisconsin has seen improvements, but the disparities continues for all minority populations. As the WDHFS report states, these tragic losses affect the individuals, families and the community as a whole.

Key text from the report reads as follows:

***“The African American infant mortality rate was 19.2 (in 2004). The disparity ratio of African American to white infant mortality rates was 4.3, meaning an Infant born to an African American woman was 4.3 times more likely to die before reaching its first birthday than an infant born to a white woman. If African American infant mortality were reduced to the white infant mortality level, 96 of the 125 deaths would have been prevented.”***

When infant health in Wisconsin was compared to other States, the African American rate was the worst of 40 reporting states between 2000–2002 according to the WDHFS’ report. This was in comparison to being the 3rd worst out of 34 reporting states between 1979 - 1981.

This disparity is further evidenced in the 2003 Big Cities Health Inventory that ranked Milwaukee 3rd worst out of 16 cities.

Here are a few data tables from the WDHFS’ report:

**Table 1. Number of Infant Deaths and Births by Race/Ethnicity, Wisconsin, 2004**

	African American	American Indian	Hispanic	Laotian/Hmong	White	Other/Missing	All Race/Ethnicity
Infant Deaths	125	6	30	9	245	5	420
Births	6,497	1,034	5,915	1,045	54,217	1,423	70,131

**Table 2. Infant Mortality Rates and Number of Infant Deaths for Selected Infant Characteristics by Race/Ethnicity, 2002-2004**

	All Race/Ethnicity	African American	White	Black/White Disparity Ratio
<b>Birth weight</b>				
Very low (less than 1500g)	273.5 (722)	329.2 (210)	251.1 (419)	1.3
Low (1500g-2499g)	16.5 (191)	30.2 (40)	14.9 (122)	1.4
Normal (2500g and above)	2.1 (417)	5.3 (88)	1.8 (276)	2.9
<b>Gestational Age</b>				
Preterm	39.4 (897)	76.3 (249)	32.0 (533)	2.4
Full term	2.4 (443)	5.6 (89)	2.0 (294)	2.8
<b>Postpartum Stage</b>				
Neonatal (<28 days)	4.4 (913)	11.4 (220)	3.5 (569)	3.3
Post neonatal (28-365 days)	2.1 (432)	6.2 (119)	1.6 (262)	3.8

Within the conclusion of the report, WDHFS announced their commitment to improving maternal and child health. They plan to release a five-year strategic plan this spring that will detail the goals to eliminate these disparities. Targeted services will include:

- Expansion of tobacco cessation treatment to pregnant and post-partum women
- Expansion of home visiting
- Expansion of access to alcohol and substance abuse treatment for pregnant women
- Improvements in prenatal care coordination services
- Improvements in consumer health literacy about safe sleep environments
- Improvements in health professional’s knowledge and use of evidence-based, culturally competent treatment approaches

**Sources:** Wisconsin Health Facts: Racial and Ethnic Disparities in Infant Mortality - Wisconsin Department of Health and Family Services, January 2006

Big Cities Health Inventory - National Association of County and City Health Officials, 2003



## Health Disparities Glossary

**Health Disparities:** The National Institute of Health defines health disparities as the differences in incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. This means that there are groups of people within the U.S. that are less likely to be healthy and live a long life than other groups of people. Population groups that are less likely to experience good health and longer life include the poor, those with less than a high school education, African Americans, Native Americans, Asian Americans and Hispanics.

**Health Care Disparities:** The differences in access, process, and structure of healthcare among specific population groups. Health care disparities can lead to health disparities in some cases.

**Cultural Competence:** An ability to understand and relate to others in a trustworthy manner, with respect for individual and cultural differences. Cultural competence is critical in healthcare. Examples of this include:

- Differences in language usage can hinder or even prevent communication between a patient and a physician.
- Cultural/educational background of the provider may conflict with deeply held patient beliefs about managing illness, disease, and treatment.

Culturally competent healthcare providers acknowledge and respect differences and take steps to ensure that they do not compromise the health care their patients receive.

**Health:** The state of being of sound mind and body, free from pain or disease. The health of individuals and populations can be affected by genetics, social and physical environment, and access to health care.

**Incidence:** How often new cases of a health problem occur in a population. Often confused with frequency, it is not the same. Frequency reports the total number of cases and incidence reports new cases only. Incidence can also be used to compare the health of populations.

**Socio-Economic Status:** A measure of a person's available advantages in comparison to others in society. The factors that make up socioeconomic status include income, wealth, education, and employment. In addition, some are investigating the link between perceived social status and health. Better health is associated with having more income, more years of education, and a more prestigious job as well as living in neighborhoods where a higher percentage of residents have higher incomes and more education.

**Environmental Factors:** Qualities or contaminants of living and working surroundings that contribute to health and health care disparities such as poor air quality, crime, contaminated water, and exposure to toxic chemicals. If environments are different for different groups of individuals, sometimes their health will be different too. Environmental factors in combination with individual, social and health system factors lead to health and health-care disparities.

**Health System Factors:** Characteristics of the insurers, public health, Medicare, Medicaid and the Veterans Administration that contribute to health and health care disparities. This may include lack of organization and staffing, and a misallocation of resources.

**Individual Factors:** Characteristics of an individual that contribute to health and health care disparities. Examples of individual factors include culture, socio economic position, biological and clinical characteristics, behaviors and living conditions.

**Policy Factors:** Legislation that leads to health and health care disparities, primarily through resource allocation.

**Provider Factors:** The knowledge, attitudes, practice patterns, communication style and cultural competence of the health care provider that contribute to health and health care disparities. This includes all actions, conscious or unconscious, on the part of the health care provide that can influence their interaction with their patients. In addition, provider factors such as referral patterns also play a role in the healthcare patients may receive.

**Social Factors:** Characteristics of human society that contribute to health and health care disparities. These include racial segregation, social cohesion, income, and education.

**Source:** Center for Health Equity Research and Promotion, Department of Veterans Affairs pulled from website ([www.cherp.research.med.va.gov](http://www.cherp.research.med.va.gov)) on 3/11/06

**Scientific Racism:** The creation and employment of a body of legitimately scientific, or patently pseudoscientific, data as rationales for the preservation of poverty, inequality of opportunity for upward mobility, and related regressive social arrangement. Usually creating a myth of two distinct races of mankind - one consisting of a small, healthy, wealthy, educable elite, while the second race is a far larger population of poor or non-wealthy, vulnerable, and allegedly uneducable by virtue of hereditarily inferior brains - scientific racism has often also institutionalized and lent scientific respectability to racist dogma and practices that were all far, far older than science itself.

**Slave Health Deficit:** The dramatic and deleterious Black/White differentials in health status and outcome presumed to be the consequence of slavery and subordinate racial status.

**Source:** Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare - Institute of Medicine of the National Academies, 2003



## WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES

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WE ARE ON THE WEB @  
WWW.BHCW.ORG

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“The health of African Americans has suffered greatly because of social disparities that rendered us, and therefore our treatment, less than equal in quality and access. There are major disparities in healthcare and health outcomes.”

- David M Satcher, M.D.

### Health Disparities Resources

City of Milwaukee Health  
Department  
841 N. Broadway, 3rd Floor  
Milwaukee, WI 53202  
Phone: 414-286-####  
Website: [www.milwaukee.gov/health](http://www.milwaukee.gov/health)

Wisconsin Department of  
Health and Family Services  
Division of Public Health  
1 Wilson Street, Room 250  
Madison, WI 53702  
Website: [www.dhfs.state.wi.us](http://www.dhfs.state.wi.us)

Minority Health Program  
Division of Public Health  
Department of Health and  
Family Services  
P.O Box 2659  
Madison, WI 53701  
Phone: 608-266-1512  
Contact: Denise C. Carty  
Website: [www.dhfs.state.wi.us](http://www.dhfs.state.wi.us)

[Unequal Treatment: Confronting  
Racial and Ethnic Disparities in  
Healthcare](#), Institute of Medi-  
cine of the National Academies,  
2003

[The Covenant with Black  
America](#), The Smiley Group,  
Inc., 2006

U.S. Department of Health &  
Family Services  
Office of Minority Health  
Phone: 1-800-444-6472  
Website: [www.omhrc.gov](http://www.omhrc.gov)

U.S. Department of Health &  
Human Services  
Center for Disease Control and  
Prevention  
Phone: 1-800-232-4636  
Website: [www.cdc.gov](http://www.cdc.gov)  
Email: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)

Center for Disease Control and  
Prevention  
Office of Minority Health  
Website: [www.cdc.gov/omh/](http://www.cdc.gov/omh/)

U.S. Department of Health and  
Human Services  
National Institutes of Health  
9000 Rockville Pike  
Bethesda, Maryland 20892  
Phone: 301-496-4000  
Email: [NIHinfo@od.nih.gov](mailto:NIHinfo@od.nih.gov)  
Website: [www.nih.gov/](http://www.nih.gov/)

U.S. Department of Health &  
Human Services  
Agency for Healthcare Research  
and Quality  
540 Gaither Road, Suite 2000  
Rockville, MD 20850  
Website: [www.ahrq.gov](http://www.ahrq.gov)

Black AIDS Institute  
1833 W. Eight Street  
Los Angeles, CA 90057  
Phone: 213-353-3610  
Website: [www.BlackAIDS.org](http://www.BlackAIDS.org)

National Minority Health Month  
Foundation  
1200 New Hampshire Ave, NW  
Suite 575  
Washington, DC 20036  
Phone: 202-223-7560  
Fax: 202-223-7567  
Website: [www.nmhmf.org](http://www.nmhmf.org)

National Black Leadership  
Commission on AIDS, Inc.  
105 East 22nd Street Ste, 711  
New York, NY 10010  
Phone: 211-614-0023  
Website: [www.nblca.org](http://www.nblca.org)

The Henry J. Kaiser Family  
Foundation  
2400 Sand Hill Road  
Menlo Park, CA 94025  
Phone: 650-854-9400  
Fax: 650-854-4800  
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