



# Building on our Strength:

Achieving Equity in Health Outcomes  
for Children and Families in Wisconsin





Close to one-fourth of Wisconsin children identify themselves as African American, Asian, Native American, multi-racial or Hispanic/Latino. These children represent the future parents, teachers, health professionals and policy makers of our state. But despite the advances in civil rights that have been made over the last 50 years, race remains a determining factor in health outcomes. According to the Kaiser Family Foundation, lasting health disparities between racial and ethnic groups are based mainly on factors outside the control of the individual children and families affected. They are largely rooted in social and community environmental factors (social determinants) and a health care system that at times is unresponsive or unavailable. These disparities are the result of political, economic and social policies. Fortunately, policy can be changed. This WisKids Count brief reviews the current racial and ethnic gaps in child health, discusses some of the major causes of these disparities, and proposes a number of policy solutions for a healthier future.

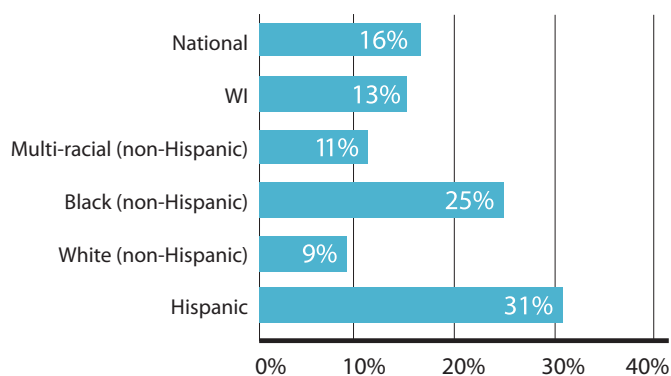
## The Current State of Things

All children get sick or injured on occasion. Children of color, however, suffer the same injuries and illnesses more frequently and with greater severity. The chart below shows the percentage of children 17 and under in Wisconsin who are in less than very good health. It illustrates that the percentage is much lower in Wisconsin than the national average, but the rate for Hispanic children in Wisconsin is more than five times the percentage for non-Hispanic white children. In addition, non-Hispanic black children are almost twice as likely as non-Hispanic whites to be in less than optimal health.

It is important to appreciate that it is the combination of adverse life experiences and barriers to quality health care that result in dramatic racial disparities in health outcomes in Wisconsin. The following indicators are a sample of the wide-ranging effects of the challenges faced by the state's children and families of color.

**Infant mortality** is a critical indicator of the overall health of a community. In Wisconsin, the burden of infant mortality is carried disproportionately by African Americans.<sup>1</sup> While the overall infant mortality rate in Wisconsin was 7.0 deaths per 1,000 live births in 2008, the black infant mortality rate in 2008 was 13.8, 2.3 times as high as the rate for whites. The rate for Hispanic infants is the same as the state average. Although the decline in the total infant mortality rate in Wisconsin over the last decade is encouraging, the disparity between non-Hispanic whites and blacks in Wisconsin continues to be alarming. Data indicates that the leading causes of infant mortality for African American babies are related to preterm birth and low birth weights while the leading cause for white infants is birth defects.<sup>2</sup>

### Children in less than very good health

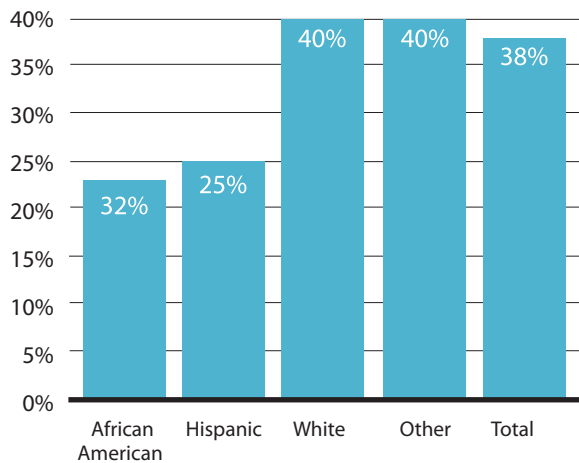


Source: 2007 National Survey of Children's Health





**Percentage of Wisconsin students who were physically active on five of the seven days before the survey, 2007**



Source: CDC, National Center on Chronic Disease Prevention

**Low Birth Weight** – Infants born at low birth weight—less than 5 lbs 8oz (2500 grams)—are at higher risk for health problems than other children. In Wisconsin, the rate of children born at low birth weight has increased from 6.4 percent in 1997 to 7.0 in 2007. The rate for blacks was 2.2 times the rate for non-Hispanic whites. By school

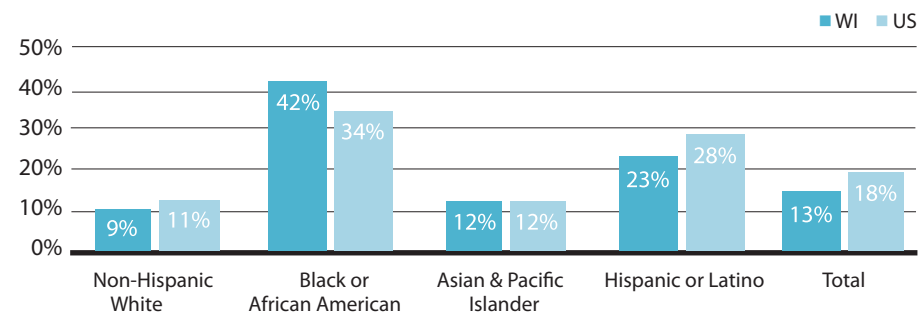
age, children born at low birth weight are more likely to have mild learning disabilities, attention deficits, developmental disabilities, and breathing problems. A prime contributor to low birth weight babies is smoking during pregnancy. Smoking nearly doubles a woman’s risk of having a low birth weight baby. Babies whose mothers smoked during pregnancy are up to three times as likely to die from sudden infant death syndrome (SIDS) as are babies of nonsmokers.<sup>3</sup> Children of mothers who smoke are more likely to have colic and asthma. Exposure to secondhand smoke increases the frequency at which children will contract colds and respiratory and ear infections.

**Suicide and Homicide** – A recent study by the Wisconsin Medical College found that suicide and homicide are a significant burden for children and youth in Wisconsin.<sup>4</sup> The number of deaths from suicide and homicide far exceeds the deaths from cancer and other diseases. Suicide is a serious issue for Wisconsin. Native American children, in particular, are significantly more likely to take their own life than white children.<sup>5</sup> Young men and boys are at far greater risk than young females of violent deaths. Boys are five times as likely as girls and young women to die from suicide and more than three times as likely to be a victim of homicide. Violent deaths are significantly linked to guns. Nearly half of all suicides involved the use of a gun, usually owned by someone else. Alcohol has also been shown to be an important factor in both suicides and homicides.

**Teen births** – When teens become mothers, both their future and their child’s are compromised. Babies born to adolescent parents generally lack the resources of babies born to older parents, and the teenage parents themselves are less likely to continue their education and gain sufficient employment. In Wisconsin, African American and Hispanic teenagers are three times more likely to give birth



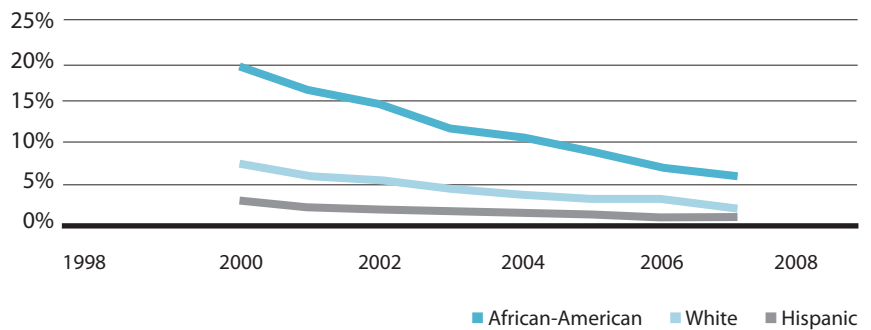
**Children living in poverty, 2008**



Source: US Census Bureau, American Community Survey



**Percent of Wisconsin Children under age 6 with a positive blood lead test**



Source: Wisconsin Department of Health Services

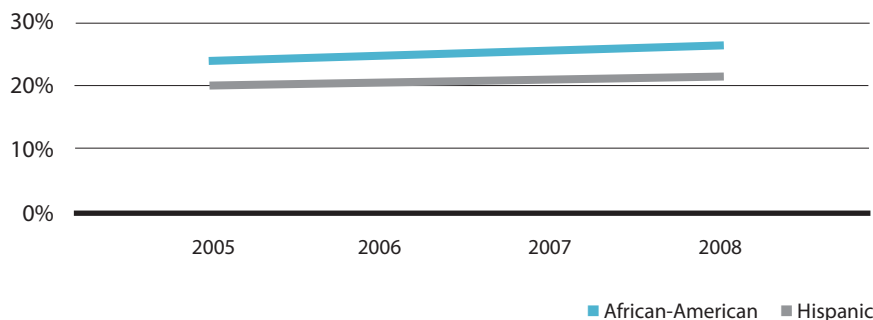
than the state average for all teens, and Native American girls are more than twice as likely to become teen mothers. More than one-fifth of all African American babies born in 2006 had mothers under the age of 20, while just over one in 20 white babies born that year had teen mothers.

**Overweight & lack of physical activity** – The percentage of Wisconsin children who are overweight or obese has increased dramatically in recent decades, causing a corresponding increase in preventable health problems, including the appearance in the last 20 years of Type 2 diabetes, which was previously so rare in children and adolescents that it is referred to as “adult-onset” diabetes. Overweight children are also at risk of high blood pressure, heart and gall bladder disease, cardiovascular prob-

lems, orthopedic abnormalities, gout, arthritis and skin problems. Being overweight can negatively affect children’s social and psychological development, and it has been linked to the premature onset of puberty. In Wisconsin, Hispanic students are more likely to be overweight or obese than their African American or white peers. Physical activity is a key indicator of child well-being because it decreases the likelihood of obesity and the health problems resulting from it. The Centers for Disease Control recommends that all adolescents engage in three or more sessions per week of activities that last 20 minutes or more at a time and that require moderate to vigorous levels of exertion. Young children should engage in 30 to 60 minutes of moderate, developmentally appropriate physical activity daily.



### Percent of students who had ever been told by a doctor or nurse that they had asthma



Source: CDC, National Center for Chronic Disease Prevention

### What Causes Disparities?

Poverty and race lie at the root of community level conditions that create health disparities. These factors affect where people live, their access to good nutrition, stable neighborhoods, safe housing, family supporting jobs, transportation, good schools, parks and recreation areas and preventive health care. These significant barriers to good health have been built over time and continue to affect health care outcomes.

#### Where children live

Residential segregation perpetuates these unequal outcomes and contributes significantly to the community and social determinants of racial and ethnic health disparities.<sup>6</sup> Children of color in Wisconsin are many times more likely to grow up in neighborhoods that compromise their health. The following factors deserve more discussion.

- **Poverty** - Poverty denies children safe and healthy housing, compromises their chances for success in school, limits access to nutritious meals, and severely increases parental stress. Children of color in Wisconsin are many times more likely than white children to be living in families with earnings below the federal poverty level (\$21,200 for a family of four). In 2007, African American children in Wisconsin were five times more likely to be living below poverty than white children (see Fig. 2). Living in poverty affects the health and well-being of children in a myriad of ways.

- **Local Resource** - Research shows that the availability of nutritious foods in local markets is closely tied to dietary habits and health outcomes. Nationally, majority minority neighborhoods are less likely to have major grocery stores with fresh inexpensive fruits and vegetables than

majority white neighborhoods. In fact, white Americans are five times more likely than black Americans to live in a neighborhood with a supermarket.<sup>7</sup> Lack of a nutritious diet can lead to iron deficiency (anemia), which is associated with developmental delays and behavioral disturbances in children.<sup>8</sup> Breast milk, beans, spinach, meat and fortified cereal, as well as foods that assist with iron absorption, such as

fresh fruit and vegetables, all contribute to a diet rich in iron and vitamins necessary for health development. Nationally, the highest prevalence of anemia was among black children (21.0 percent), while the lowest prevalence was among white children (11.1 percent).

- **Housing** - Inadequate and unsafe housing can literally make kids sick. Exposure to lead can cause significantly reduced IQ and attention span, hyperactivity, impaired growth, reading and learning disabilities, hearing loss, insomnia, and a range of other health, intellectual and behavioral problems. Children with blood lead levels as low as 5 micrograms per deciliter score significantly lower on standardized reading tests. Even at these low, but still dangerous levels, lead poisoning may not present identifiable



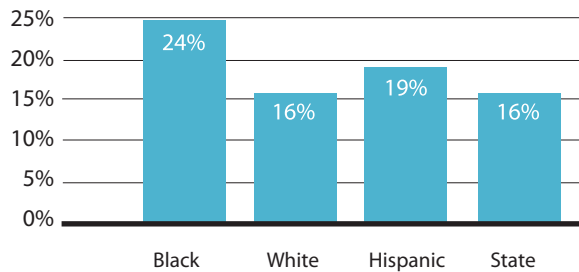


symptoms, and a blood test is the only way to know if a child is poisoned. Most lead-poisoned children are exposed to lead in their own home. Children from low-income families are at greater risk of lead poisoning from older housing stock, often the only choice for families on a tight budget. Children from families receiving Medical Assistance are three times more likely to be poisoned than those from higher-income families.<sup>9</sup> Children of color in Wisconsin are poisoned at greater rates than white children; African-American children are six times as likely as non-Hispanic White children, and Hispanic children twice as likely, to be poisoned. Fortunately, both the prevalence and incidence of childhood lead poisoning is declining (see Fig. 3), primarily through the removal of older housing from the market, as well as through some public health education efforts. However, even with this decline, 1,400 children were first identified as lead poisoned in 2006. Among the Midwestern states, Wisconsin ranks second highest, with 2.6 percent of children tested having high levels of lead in their bloodstream. The Department of Health Services estimates conservatively that the cost of lead poisoning for each year's group of children is \$14 million in special education, medical care, juvenile justice, and lost future earnings.<sup>10</sup>

Housing plays a key role in children's experience of asthma as well. Approximately 9 percent of all Wisconsin children currently have asthma. Children living below poverty are more likely to contract asthma, the leading cause of childhood disability.<sup>11</sup> Twelve percent of children from low-income families have asthma, versus 7 percent of children living above the poverty line. Numerous studies have shown that asthma attacks are triggered by exposure to allergens such as dust mites, cockroaches, cats, ragweed, mold and secondhand smoke. Other common triggers are colds and flu, exercise, cold air, and changes in the weather. In addition to precipitating asthma attacks, exposure to allergens may play a role in inducing the onset of asthma itself.<sup>12</sup> According to the Wisconsin Department of Health Services, "The burden of asthma is not equally shared in the population. African Americans have the highest prevalence of asthma (19 percent in 2002-2005),<sup>13</sup> are hospitalized at five times the rate of whites (36.6 versus 7.1 hospitalizations per 10,000 population in 2005), and have a 3.5 times higher rate of asthma mortality than whites (41.2 versus 12.0 deaths per million population in 2000-2005).<sup>14</sup> Native Americans also have higher asthma hospitalization rates than whites (11.7 versus 7.1 hospitalizations per 10,000 of the population in 2005)." Childhood asthma is one of the most frequently cited reasons for missing school, and is a leading cause of preventable hospitalizations of children. Quality primary health care can manage the effects of asthma.<sup>15</sup>

• **Exposure to violence** – Research clearly demonstrates that chronic neglect, stress and trauma early in life can damage the developing brain by literally changing the brain's chemistry, interfering with the child's ability to integrate sensory, emotional and cognitive information. Children who live in constant fear or experienced trauma live in a state of chronic stress. The result is that these children's brains become organized for survival in a persistently threatening and violent world. They tend to be on high alert, overly quick to interpret others' actions as threatening and quick to respond aggressively in their own defense.<sup>16</sup> This organization of children's brains obviously has serious implications for their ability to make decisions long after their physical experience of abuse or neglect has ended. The MacArthur Foundation reports that that "people repeatedly exposed to aversive events they cannot predict or control may learn to become helpless." In addition, studies found that higher current depression and hopelessness and lower purpose in life were associated with higher frequency of exposure to or victimization by violence.<sup>17</sup>

### Tooth decay or cavities, age 1–17



Source: National Survey of Children's Health, 2007



### Access to quality health care

Unlike adults who more often see health care specialists for their care, the bulk of children's health care is provided by primary care professionals. A shortage of primary care professional, including pediatricians, dentists and mental health providers, has an impact on the quality of care available for children in the shortage areas. In Wisconsin, 101 areas of the state are designated as Primary Care Health Professional Shortage Areas (HPSAs).<sup>18</sup> Children and families of color are many times more likely to live in areas

that are underserved. This has serious implications for everyone. For example, inadequate health care during infancy can result in poor health later in life. Factors such as poor prenatal care and low birth weight can cause a child to suffer from preventable health concerns as he or she matures. A child whose mother receives little or no prenatal care is far more likely to experience chronic health problems than children whose mothers did receive prenatal care.<sup>19</sup> The greatest disparity in prenatal care exists between whites and Laotian or Hmong mothers. Almost nine in ten white mothers in Wisconsin receive first trimester care, while only about six in ten Laotian or Hmong mothers receive similar care

• **Unmet Dental Needs** – Good oral health is essential to a healthy child. Untreated oral diseases may lead to problems in eating, speaking and sleeping. Poor oral health among children has been tied to poor performance in school and trouble with social relationships. Children with chronic mouth pain may have difficulty concentrating, poor self-image, and problems completing schoolwork.<sup>20</sup> According to the American Academy of Pediatric Dentistry, all children should visit the dentist every six months. In a study of state 3rd graders, the Wisconsin Department of Health and Family Services found that family income makes a significant difference in children's oral health. More than 44 percent of children from low-income families were reported to have untreated tooth decay, compared to 17 percent of students in higher-income schools.<sup>21</sup> Hispanic third-graders were more likely to have untreated tooth decay than either white or African American students. There are currently 52 dental shortage areas in the state. In 2007, only 1,242 (29%) of the 4,297 dentists licensed in Wisconsin were certified Medicaid providers.

The National Health Care Disparities Report (NHDR) found, in 2006, evidence of significant disparity between the quality of health care services received by white patients and patients of color even when they are insured at the same levels and are experiencing the same types of health problems.<sup>22</sup>

### Health insurance

While health insurance alone is not a guarantee of health care services, it is an essential first step in gaining access to affordable care. Families without quality health insurance are financially vulnerable. One of the leading causes of bankruptcy is lack of access to good, affordable health insurance. This goes beyond the issue of cost. Parents with



untreated health problems have trouble maintaining steady employment because they miss work so often. Although Wisconsin has made great strides in this area through the BadgerCare Plus program, a few gaps remain in access to insurance, most notably for childless adults and adults in immigrant families. There is also room for improvement in the enrollment process and in reducing the cycling of eligible families onto and off BadgerCare Plus.

- **Health care for adults without children** – There is growing evidence that the health of women prior to having children has a profound impact on the health of both mother and baby. Young adults often work in positions that do not offer health insurance. A 2008 report by the University of Wisconsin School of Medicine and Public Health recommends that a key element in reducing adverse birth outcomes for African American mothers and babies is to improve the health and safety of women over their entire lifespan. In particular, the authors stress the importance of addressing the health needs of women prior to their pregnancies as a critical component to healthy births.<sup>23</sup> Wisconsin received a waiver to begin covering adults without dependent children through the BadgerCare Plus Core Plan. Enrollment in the program has already far exceeded projections, forcing the state to cap enrollment much sooner than expected. As of mid-November 2009, about 51,000 adults were enrolled in the program, with 7,000 more on a waiting list. The state hopes to create a cost neutral program that will allow those on the waiting list to access coverage at a price they can afford. Currently, the vast majority of those on the Core Plan either have no reported income or have income below the federal poverty line.

- **Immigrant Families** – Federal changes to the Medicaid program allow certain children that have documented immigrant status in the United States to receive health care. In contrast to prior federal law, the new law no longer bars “lawfully residing” children and pregnant women from being eligible for Medicaid or CHIP coverage until they have lawfully resided in the U.S. for five years. The Department of Health Services began to implement that change in October 2009, but work still needs to be done to ensure that eligible children are enrolled. Federal law still does not allow adults in immigrant families to be covered within the five year window. Advocacy groups nationally are calling for this gap in coverage to be addressed by the national health care reform bill.

## Progress & Solutions

Children’s health outcomes are in great measure determined by where they live, learn and play, and where their parents work. Poor outcomes are the result of multiple barriers to health for many in our communities. Solutions must address the whole range of challenges families face, both within the health care system and outside of it.

Although we have yet to see evidence of significant progress in closing Wisconsin’s disparities in health outcomes, there has been a notable increase in efforts to identify the problem and possible solutions. For example, the Department of Health Services has made elimination of disparities in birth outcomes a high priority and developed “A Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes.” The department has also assembled a broad range of expertise on a large committee that is taking a comprehensive look at how to implement the framework for action.



Another very important development is the work of the University of Wisconsin Population Health Institute, which has made the elimination of racial and ethnic disparities a priority. The Institute has been conducting a thorough review of efforts across the country, in order to identify best practices for reducing racial disparities.

One area where the state has made a substantial advance in combating racial and ethnic disparities in children's health is in moving toward the goal of ensuring that all children have health insurance. The enactment and implementation of BadgerCare Plus has tremendously improved insurance access for children, parents and pregnant women. Nevertheless, there is still more work to be done, particularly with respect to coverage of immigrants and the families of workers in small businesses.

The following changes are needed to improve access to insurance:

- **Fill gaps in BadgerCare Plus coverage of children and parents** – There are still a few holes in BadgerCare Plus. For example, current law excludes families with income above 150 percent of poverty from participating in BadgerCare Plus if they have access to employer-sponsored insurance that pays at least 80 percent of premiums costs, even if high deductibles and co-pays make the coverage too expensive for a low-income family. Families below 200 percent of the poverty level should be allowed to participate in BadgerCare Plus if cost sharing requirements make their employer's insurance unaffordable.
- **Adequately fund coverage for adults without children** – The implementation of the BadgerCare Plus Core Plan for adults without dependent children was a huge step forward in beginning to fill the largest hole in the state's health care safety net. It's clear that young women who have good health care before they get pregnant have healthier babies. However, additional state and federal funding is needed to meet the demand for that coverage.
- **Improve coverage for immigrants** – The state and community groups need to do outreach to achieve broader awareness that lawfully present immigrant children and pregnant women are eligible for BadgerCare Plus. In addition, some immigrant families would benefit from adoption of national or state health care reforms that use the Massachusetts model, which creates insurance "exchanges" as a way to help individuals and small businesses buy affordable coverage.



- **Maintain strong BadgerCare Plus outreach and continue to improve enrollment processes** – A number of steps are needed to achieve this goal, including continuing the efforts to alleviate enrollment problems in Milwaukee that have denied residents equal access to BadgerCare Plus, and filling vacant DHS outreach positions. The state should also consider enacting 12-months continuous eligibility for children, and increasing use of the state unemployment insurance database to expedite verification of income.

As Wisconsin closes in on the goal of health insurance for all children, it is time to begin making the broad changes necessary to improve the quality of care for all state residents, with an emphasis on systemic changes that could eliminate or at least reduce racial and ethnic disparities in health care outcomes. Accomplishing that objective will require action on several fronts, including these key areas:

- **Eliminate child poverty** – Because poverty and poor health are so intertwined, and people of color in Wisconsin are so much more likely to be poor, strategies to reduce poverty should play a significant role in Wisconsin's effort to combat racial and ethnic disparities in health. This means, among other things, taking aggres-



sive action to promote access to safe, affordable housing, high-quality early care and education, and post-secondary education and job training programs for parents.

- **Eliminate disparities in birth outcomes** – Health care providers and policymakers should implement the recommendations of the state’s “Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes.”
- **Learn from what has worked elsewhere** – Policymakers should study the results of the UW Population Health Institute’s comprehensive review of best practices for combating disparities in order to identify the most promising prospects for implementation in our state.
  - **Promote the medical home model** – The state and the private sector need to work together to change how they deliver and pay for health care to ensure that all Wisconsin children have a medical home, which the American Academy of Pediatrics defines as “primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”
  - **Improve access to dental care** – Wisconsin should fund more services at public health clinics, increase reimbursement rates for dentists, and expand the supply of dentists who serve low-income and underserved parts of the state. The Marshfield Clinic

has engaged in an aggressive campaign to provide dental services in the upper half of the state. To date, Marshfield Clinic is responsible for opening five more dental clinics. The clinic is also interested in exploring the possibility of establishing a second dental school in the state, which would focus on attracting students who wish to remain in rural and underserved areas.

- **National health care reform** – Any discussion of health disparities must include the possibility of improvements or setbacks as a result of sweeping health care reforms being debated in Congress. Elements of health care reform that could help close gaps in health outcomes include: increasing eligibility for adults in Medicaid; increasing reimbursement rates to ensure that access to Medicaid or CHIP coverage also means access to care; creating health exchanges that provide access to subsidized insurance for people up to 400 percent of the federal poverty level; promoting the medical home model; and placing greater emphasis on preventive care for chronic health conditions. However, the federal legislation could also have negative consequences for low-income and minority families in Wisconsin if the state is allowed or even encouraged to move people above 133 percent or 150 percent of the poverty level off BadgerCare and into a health exchange, where the plans will have considerably higher premiums, co-pays and deductibles.



## Conclusion

Wisconsin has long been a national leader in assuring that most families have access to health care coverage. But significant problems remain. One of the state's most vexing health care shortcomings has been the severe racial disparities in child health outcomes. Although state-specific data on cost is not available, a study by the Joint Center for Political and Economic Studies finds that between 2003 and 2006 alone, the combined cost of health inequities in the US was \$1.24 trillion dollars. By accurately identifying the root causes of these disparities, we can aggressively work toward eliminating these social determinants of poor health. This is the more effective form of prevention.

We can finish the job of covering ALL Wisconsin children and families by focusing on closing the few remaining gaps in our insurance system. From there we can concentrate our efforts on finding strategies for translating health insurance coverage into actual access to quality health care services. By making smart policy choices and investments, and replicating practices that have been successful elsewhere, Wisconsin can in the not-too-distant future become a model among the states, a place where quality health care for all residents is a given, regardless of their economic standing, race or ethnicity. ■



<sup>1</sup> Aronson, Richard Allan, MD, MPH, *Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin*, The Wisconsin Partnership Program, University of Wisconsin School of Medicine and Public Health, February 8, 2008

<sup>2</sup> Ibid, pg 9

<sup>3</sup> *Quick Reference Fact Sheets*, March of Dimes, <http://marchofdimes.org>

<sup>4</sup> Thomas Shiffler, MD; Stephen W. Hargarten, MD, MPH; Richard L. Withers, JD, *The Burden of Suicide and Homicide of Wisconsin's Children and Youth*, Wisconsin Medical Journal, *Preventing injuries in Wisconsin*, volume: 104, no. 1,

<sup>5</sup> Wisconsin Department of Health Services, [http://wish.dhfs.state.wi.us/cgi-bin/hi\\_iq\\_func](http://wish.dhfs.state.wi.us/cgi-bin/hi_iq_func)

<sup>6</sup> Unequal Health Outcomes in the United States, Racial and Ethnic Disparities in Health Care Treatment and Access, The Role of Social and environmental Determinants of health and the Responsibility of the State, January 2008,

<sup>7</sup> Ibid, pg 19

<sup>8</sup> Polhamus B, Dalenius K, Borland E, Smith B, Grummer-Strawn. *Pediatric Nutrition Surveillance 2006 Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007.

[http://www.cdc.gov/pednss/pdfs/PedNSS\\_2006.pdf](http://www.cdc.gov/pednss/pdfs/PedNSS_2006.pdf)

<sup>9</sup> Data are from non published reports by the Wisconsin Childhood Lead Poisoning Program

<sup>10</sup> Lead Report to the Legislature

<sup>11</sup> *Burden of Asthma in Wisconsin*, 2004, Wisconsin Department of Health and Family Services

[http://dhs.wisconsin.gov/eh/asthma/pdf/boawi\\_2007.pdf](http://dhs.wisconsin.gov/eh/asthma/pdf/boawi_2007.pdf)

<sup>12</sup> *Childhood Asthma*, Center for Children's Health and the Environment, Mt. Sinai School of Medicine, <http://www.childenvironment.org/factsheets/asthma.htm>

<sup>13</sup> *Burden of Asthma in Wisconsin*, 2007 Wisconsin Department of Health and Family Services

<sup>14</sup> Ibid, pg. 1

<sup>15</sup> *Better Management of Asthma Through Improved Monitoring and Communication*, The Commonwealth Fund, [www.cmwf.org](http://www.cmwf.org)

<sup>16</sup> Brain Watch Paper, Wisconsin Council on Children and Families

<sup>17</sup> MacArthur Network on SES and Health,

[www.macses.ucsf.edu/Research/Psychosocial/notebook/violence.html](http://www.macses.ucsf.edu/Research/Psychosocial/notebook/violence.html)

<sup>18</sup> Note: Areas of the state are likely to be underserved when the ratio of primary care physicians to population is over 1:3,500

<sup>19</sup> *The Right Start for America's Newborns: City and State Trends*, The Annie E. Casey Foundation, 2005, [www.aecf.org](http://www.aecf.org)

<sup>20</sup> ChildTrends Data Bank, [www.childtrendsdatabank.org](http://www.childtrendsdatabank.org)

<sup>21</sup> Overview of Children's Oral Health in Wisconsin; Youth Oral health Data Collection Report, Wisconsin Department of Health and Family Services, 2001-2002.

<sup>22</sup> Unequal Health Outcomes in the United States, Racial and Ethnic Disparities in Health Care Treatment and Access, The Role of Social and environmental Determinants of health and the Responsibility of the State, January 2008, pg 14

<sup>23</sup> Aronson, Richard Allan, MD, MPH, *Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin*, The Wisconsin Partnership Program, University of Wisconsin School of Medicine and Public Health, February 8, 2008

<sup>24</sup> "The Economic Burden of Health Inequalities in the United States", Joint Center for Political and economic Studies, September 2009



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