

# Health Reform: An Opportunity to Address Health Disparities among Women

A woman's access to quality health care in the U.S. is a function of where she lives, her race and ethnicity, her family income, and her citizenship status, among other things. Millions of women experience comparatively worse health outcomes because they do not have equal access to the nation's health resources.

These health disparities are due, in large part, to differences in rates of health insurance coverage. Women of color, poor women, and women who live in rural areas, for instance, are all at greater risk of being uninsured and in turn, they suffer from higher rates of illness and unmet health needs. But some health disparities—particularly those between whites and racial or ethnic minorities—persist even when people are insured. These health disparities are a consequence of lower-quality care and problems with the way health care is delivered.

Health reform presents a unique opportunity to address the health disparities that have long troubled the U.S. health care system. Women's advocates can work to ensure that health reform proposals include measures that will make the health system more equitable, so that health disparities among women are eliminated.

## What Are Health Disparities?

Health disparities are differences in health outcomes that result from unequal distribution of or access to the resources that promote good health. Health disparities are not the result of biological risk or any other natural cause—they are the consequence of harmful public policies and unequal access to health care for certain populations.<sup>1</sup>

## Which Populations Experience Health Disparities?

Populations that experience health disparities include (but are not limited to) women of color, women who are poor, disabled women, those who live in rural areas, immigrant women, and women who identify as lesbian, gay, bisexual, or transgender (LGBT). Examples of the health disparities that exist for a few of these groups are highlighted below.

### **Women of Color**

Over the last decade, the issue of racial and ethnic health disparities, in particular, has received growing attention. In the United States, people of color are more likely to lack health insurance, receive lower-quality care, and suffer from worse health outcomes. Compared to whites, they often have poorer access to care, are more likely to receive lower-quality health care, and experience higher rates of injury, illness, and premature death.

The National Women's Law Center's 2007 edition of *Making the Grade on Women's Health: A National and State-by-State Report Card* demonstrates that the nation as a whole and many individual states are falling further behind in their quest to reach national goals for women's health. The report's findings related to racial and ethnic health disparities are particularly dismal. Consider these statistics:

- In the **United States**, nearly 86 percent of white women receive first trimester prenatal care (i.e. within the first 12 weeks), compared to just 71 percent of American Indian/Alaskan Native women.

- In **Ohio**, the average life expectancy for white women is 79 years, compared to 74 years for black women.
- In **California**, only 73 percent of Asian/Pacific Islander women received a Pap test (i.e. screening to detect cervical cancer) in the past three years, compared to 82 percent of white women.
- In **Louisiana**, the death rate for coronary heart disease is 135.5 per 100,000 for white women, compared to 191.7 per 100,000 for black women.

For more information about health disparities among women of different racial and ethnic populations, visit the interactive website for the *Making the Grade* report, at <http://hrc.nwlc.org>.

### ***Women Living in Rural Areas***

Women living in rural areas of the United States face unique barriers to accessing health care. They are more likely to be uninsured or underinsured (i.e. with health coverage that leaves them vulnerable to financial risk and/or unmet health needs).<sup>2</sup> Research demonstrates that rural residents are more likely than their urban counterparts to be self-employed or to work for small or low-revenue employers that do not offer job-based health insurance. They are also more likely to purchase coverage directly from insurers through the individual insurance market, where women face many obstacles to obtaining comprehensive and affordable coverage.<sup>3,4</sup>

Regardless of their insurance status, rural women have more trouble finding a health provider near their home. Rural residents are four times more likely to live in a medically underserved area, since health care facilities in rural parts of the country have more trouble attracting and retaining doctors, nurses, and other health providers.<sup>5</sup> Providers practicing certain specialties, such as those in the obstetrics/gynecology field, are particularly lacking in rural areas; this often presents a major barrier for rural women who need reproductive health services.

Long travel distances and limited transportation options create additional obstacles to rural women's access to health care. If a woman needs a health service that is only offered by a very limited number of providers in the area, such as reproductive or mental health care, transportation is especially problematic. For instance, a woman and her family may need to travel for hours—sometimes by multiple modes of transportation—in order to reach a pharmacy that stocks contraceptives, an abortion provider, or a mental health provider that can treat depression. Rural women and men have higher rates of chronic disease, including cancer and cardiovascular disease.<sup>6</sup> To maintain good health, it is essential that chronic diseases are well-managed, but the provider shortage and transportation issues described above make effective disease management more difficult for rural residents.

### ***Women in the LGBT Community***

Women in the lesbian, gay, bisexual, and transgender (LGBT) community experience health disparities. Research indicates that LGBT people are more likely to be uninsured and to lack a regular health provider than the general population.<sup>7</sup> Lack of formal recognition of same-sex relationships poses a major barrier to insurance coverage, as a majority of employers do not sponsor health benefits for their workers' same-sex partners as they do for married spouses. Even when they are available, domestic partner health benefits do not receive the same favorable tax treatment as other employer-provided coverage for workers' family members.<sup>8</sup>

The LGBT population is also more likely to face barriers in access to care and preventive services.<sup>9</sup> With an insufficient number of health care providers who can sufficiently treat this population—either due to outright discrimination, ignorance, or misinformation—it is often more difficult for women in the LGBT community to get comprehensive care, and they may actually be less willing to seek care if they cannot find a provider who can adequately meet their needs.<sup>10</sup> One large-scale study of health risks for older women, for instance, found that lesbian and bisexual women are significantly less likely to receive regular cancer screenings such as mammography and the Pap test.<sup>11</sup> Women of color who identify as LGBT face multiple levels of discrimination related to both racism and homophobia.<sup>12</sup> To increase rates of preventive screening and counseling among the LGBT population, the health provider workforce should be trained to provide culturally-competent care. Such training will help providers be more informed, accepting, and supportive of this population.

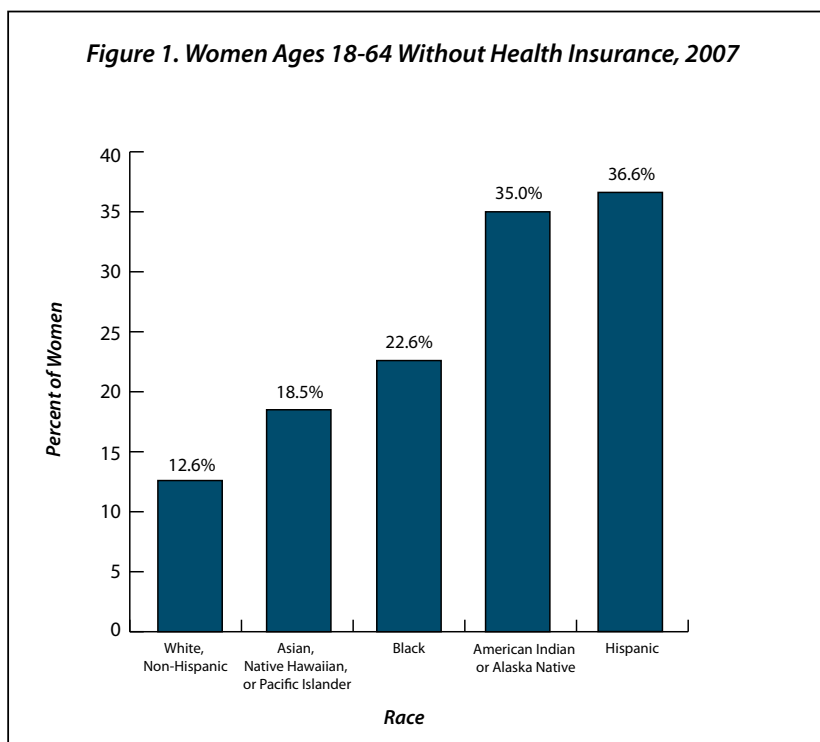
**Why Do Health Disparities Exist?**

Unequal health outcomes are caused by inequities in the structure of the health system itself, including differences in access to health coverage and in the quality of health care that some populations receive. Health disparities are also influenced by a range of social and environmental determinants of health, which are typically outside the purview of health reform plans—these include access to adequate and safe housing, nutritious food, education, and transportation.

**Differences in Access to Health Coverage**

Women with health insurance are more likely to seek timely preventive care, to effectively manage their chronic conditions, and to have a usual source of health care.<sup>13</sup> The relationship between coverage and positive health outcomes is well-documented. Yet women of color are considerably more likely to be uninsured than their white counterparts, as demonstrated in Figure 1. Hispanic women, for example, were roughly three times as likely as white women to be uninsured in 2007 (36.6 percent vs. 12.6 percent, respectively).

Differences in access to health coverage contribute to the persistent health disparities between racial and ethnic groups. Unequal access to health coverage is also an important factor in the health disparities that exist for people living in rural areas of the United States and for those living at or near the federal poverty level.



Source: National Women’s Law Center analysis of Current Population Survey’s (CPS) March 2007 Annual Social and Economic Supplement, using the U.S. Census Bureau ‘CPS Table Creator,’ [http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html), on August 15, 2008.

### Connecting the Dots between Health and Wealth.

In general, populations that suffer from the worst health status are also those that have the highest poverty rates. Those who have the fewest resources in the United States also report worse health outcomes, regardless of whether the measure is mortality, the prevalence of acute or chronic diseases, or untreated mental health problems.<sup>14</sup> Unsurprisingly, women in populations that experience health disparities—including women of color and those living in rural areas—are also more likely to have lower incomes.<sup>15</sup> Lower-income women are, in turn, disproportionately represented among uninsured women, who are more likely to delay or go without necessary medical care than their insured counterparts. Considering the connections between poverty, poor health, and insurance status, it is critical that health reform plans prioritize access to high-quality and **affordable** health coverage so that poverty-related health disparities are eliminated.

### Differences in Health Care Quality

Health insurance is the single most significant factor in determining an individual's access to health care. Even for people who have health coverage, however, health care delivery may be inequitable, contributing to disparate health outcomes. In a landmark 2003 report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, a panel of scientists and doctors assembled by the Institute of Medicine (IOM) concluded that “minority patients are less likely than whites to receive the same quality of health care, even when they have similar insurance or the ability to pay for care.”<sup>16</sup> Quality health care (which is discussed in

more detail elsewhere in the *Reform Matters Toolkit*) is often described as the **right care**, at the **right time**, for the **right reason**.

Indeed, there is a growing body of evidence that people of color receive lower-quality care, on average, than white people. The most recent National Healthcare Disparities Report (an annual assessment conducted by the U.S. Agency for Healthcare Research and Quality) details the range in health disparities resulting from differences in health care quality—these differences in health outcomes exist even for those who are insured. For instance:<sup>17</sup>

- In 2004, the rate of lower extremity amputations in diabetic adults was over three times higher for blacks than whites (104.0 per 1,000 compared with 27.6 per 1,000);
- In 2005 the proportion of Medicare patients with pneumonia who received recommended hospital care was lower for blacks (69.5 percent), Asians (68.7 percent), and Hispanics (66.2 percent) than for whites (74.6 percent);
- In 2004, blacks and Asians were more likely than whites to report they had poor communication with their health providers (11.3 percent for blacks and 14.3 percent for Asians compared with 9 percent for whites).

According to the IOM's *Unequal Treatment* report, inequitable health care delivery is primarily due to two sets of factors, 1) health care systems' operating environments (e.g. cultural or linguistic barriers, provider incentives to contain costs such as spending a minimal amount of time with a patient) and 2) provider uncertainty, bias, or stereotyping when treating patients of racial or ethnic minority groups.

### Strategies to Eliminate Health Disparities

As federal and state policymakers develop proposals to address myriad gaps in the current U.S. health system, they must take advantage of the important opportunity to incorporate health reform provisions that could eliminate the nation's persistent health disparities. These efforts, which are described in greater detail below, include measures to: expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health. More information about these and other reform provisions for equitable health care can be found in a 2008 report prepared by the Opportunity Agenda and Families USA, titled *Identifying and Evaluating Equity Provisions in State Health Care Reform*.

- **Expand Affordable Health Coverage.** A health system that provides high-quality, affordable health coverage for all will go a long way to eliminate the inequitable distribution of health care resources. If people of color, rural residents, and low-income people have equitable access to health insurance, they will be able to seek timely care—including preventive care—before a health problem becomes complicated and costly. Moreover, in a system where everyone has high-quality health coverage, hospitals and other health care providers have equal incentives to serve wealthy and poor communities alike.<sup>18</sup>

#### The Importance of Public Coverage Programs.

People of color are disproportionately represented in Medicaid, the health insurance program for low-income people that is jointly funded by the federal and state governments. Racial and ethnic minorities comprise about one-third of the total U.S. population but more than half of all Medicaid recipients.<sup>19</sup> Consequently, policy changes to the Medicaid program have disproportionate impacts on communities of color. Program expansions and enhancements can serve as an effective tool to improve health access and to target health disparities; at the same time, cuts and restrictions to the Medicaid program are especially harmful.

In particular, inadequate provider reimbursement is a persistent problem in the Medicaid program, which typically reimburses providers at a considerably lower rate than both private insurance companies and Medicare. This inequity contributes to health disparities. Providers will not agree to participate in Medicaid if reimbursement rates are too low, which makes it more difficult for Medicaid enrollees to find health providers when they need care. States have the authority to increase these rates, which has the potential to reduce health disparities.<sup>20</sup>

- **Improve the Health Infrastructure.** Communities that are predominantly minority, as well as those that are located in rural areas, have fewer health care resources such as hospitals, primary care providers, outpatient clinics, and nursing home facilities.<sup>21</sup> States must continue to direct resources and incentives to improve provider availability in these underserved areas, and they must support new initiatives for correcting the imbalance of health resources. These initiatives include graduate medical education programs that focus on medically underserved areas, as well as loan forgiveness or



scholarship programs that require service in such areas. Safety-net hospitals and other providers (i.e. those that serve a high proportion of uninsured, publicly-insured, and other underserved communities) serve as critical links to health services for many communities of color, and reform plans can ensure that these institutions receive adequate financial support from the government so that they are not financially vulnerable.

- **Increase Provider Diversity.** Increasing the number of minority health care providers has proven effective in improving the quality of care delivered to racial and ethnic minorities.<sup>22</sup> Health care providers of color, for instance, are more likely to work in minority or underserved communities, therefore increasing the availability of health resources in those communities. Minority populations are also more likely to report satisfaction with care delivered by racially diverse providers.<sup>23</sup> Yet these types of providers are under-represented in the health care workforce. In 2004, for example, over 80 percent of registered nurses in the United States were white.
- **Promote Cultural Competency.** It is equally important that federal and state reform initiatives promote cultural competency among health care providers. For example, in a recent study that found unequal health outcomes for black and white diabetes patients treated by the same doctor, authors concluded that such disparities do not result from overt racism, but rather a “systemic failure to tailor treatments to patients’ cultural norms.”<sup>24</sup> They recommended basic cultural competency for diabetes management—that is, that health providers learn more about treating minority communities and tailor strategies for educating minority patients about managing a chronic disease.

By improving provider-patient communication and supporting the delivery of care that accommodates patients’ cultural factors, training in culturally-competent medicine can eliminate racial and ethnic health disparities. Ensuring that patients with Limited English Proficiency (LEP)—including those in the immigrant community—have access to accurately translated health-related materials that they can comprehend (sometimes referred to as linguistic competence) is another important component of delivering culturally-competent care.

- **Collect the Right Data to Document and Address Health Disparities.** Without accurate and complete data on health consumer demographics—including language status, race/ethnicity, sexual orientation, and income—and the different health outcomes that these consumers experience, it will be impossible to fully address health disparities. For public and private health systems to have the ability to monitor racial and ethnic, language status, and income-based health care disparities, federal and state governments must support the collection and regular analysis of disparity data, measured both in terms of health care access and quality.<sup>25</sup>
- **Promote the “Medical Home” Model.** A “medical home” (sometimes called a “health care home”) generally refers to a centralized location for health care, with one personal health care provider who coordinates an individual’s care. This personal provider is responsible for all of a patient’s health care needs, including appropriately arranging care with other health professionals. Public and private health insurers have implemented medical home initiatives as strategies to improve health care quality and safety, and research demonstrates that when minorities have a medical home, their access to preventive care improves substantially (e.g. about two-thirds of all adults

who have a medical home receive preventive care reminders). Similar (and significant) proportions of white, black, and Hispanic Americans with medical homes report getting the care they need when they need it, indicating that these initiatives have the potential to reduce or even eliminate racial and ethnic disparities in access to care.<sup>26</sup>

- **Address the Environmental and Social Determinants of Health.** Disparate health outcomes are not solely a product of inequities in the health system. Unequal access to other resources in a woman's social and physical environment may also have a negative impact on her health. Poor housing conditions, a dearth of safe public spaces for outdoor activities, and a scarcity of grocery stores selling fresh fruits and vegetables, for example, can all contribute to poorer health outcomes among people living in minority communities. Some of the solutions to these problems are admittedly beyond the scope of even a very comprehensive health reform plan. But, health reform plans may incorporate community-level interventions that address multiple determinants of health—social, environmental, and health-related factors—as a starting point for incorporating these important issues into health reform. Community interventions supported through grant programs of the Center for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH 2010) and the Department of Health and Human Services' Office of Minority Health have effectively reduced racial and ethnic disparities in targeted subpopulations. These interventions—which include efforts to organize communities, provide mass and one-on-one health education, conduct screenings for risk factors, and reduce environment risk factors through local program and policy change—can improve overall quality of life for minority groups.<sup>27</sup>

### Lessons from the States:

#### Statewide Councils on Health Disparities.

As an initial step to implementing reforms that would address unequal health outcomes among their residents, many states have created special entities expressly for the purpose of tackling health disparities. At least 35 states have taken such steps, including:<sup>28</sup>

- **Massachusetts:** As part of its broad 2006 health reform package, the state established the Health Disparities Council, charged with developing recommendations on several minority health issues including workforce diversity, disparate disease rates among communities of color, and social determinants of health.<sup>29</sup>
- **Pennsylvania:** The Office of Health Equity, established in April 2006 within the state's Department of Health, collaborates with state agencies, academic institutions and community groups to improve the health status of groups experiencing health disparities. The office does not limit its work to health disparities among racial and ethnic minorities, but also focuses on disparities in geographic areas and among socioeconomic groups.<sup>30</sup>
- **Washington:** In 2006, the state legislature created the Governor's Interagency Coordinating Council on Health Disparities. This council is charged with creating an action plan to address the contributing factors of health that can have broad impacts on improving health status, health literacy, physical activity, and nutrition.<sup>31</sup>



## What Can Women's Advocates Do to Ensure That Health Reform Addresses Health Disparities?

***Women's advocates should inquire how health reform plans will affect populations that experience health disparities.***

Advocates must determine whether and how health reform proposals may differentially affect women of color, low-income populations, and other underserved groups that experience health disparities. Health reform plans that expand health insurance coverage but do nothing to improve provider availability, for example, may hold little benefit for women who live in rural areas with severe health provider shortages. Plans that enhance and sustain the Medicaid program, on the other hand, will have a positive impact on the health of communities of color and low-income populations, since these groups are particularly dependent on Medicaid for their care.

***Women's advocates can promote health reform measures that explicitly address health disparities.***

Health reform presents a unique and important opportunity to incorporate initiatives that could eliminate the nation's persistent health disparities. These include efforts to expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health.

***Women's advocates can partner with groups that represent or serve groups that experience health disparities.***

Many organizations are working at both the national and state level to address health issues that specifically affect those women most likely to experience health disparities, including women of color, rural women, women living in poverty, and women in the LGBT community. By joining forces with these groups, advocates for health reform can ensure that their work incorporates the interests of women who experience health disparities, and ultimately promote health reform plans that correct inequities in the health care system.



### For further reading, see:

U.S. Agency for Healthcare Research and Quality, *National Healthcare Disparities Report (2007)*, <http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf>

Brian Smedley, et al., The Commonwealth Fund, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (Apr. 2008), [http://www.commonwealthfund.org/usr\\_doc/Smedley\\_identifyingequityprovisions\\_1124.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Smedley_identifyingequityprovisions_1124.pdf?section=4039)

"Unnatural Causes: Is Inequality Making Us Sick": This seven-part documentary series on health inequalities, which aired on PBS, is available (with supporting materials) at [www.unnaturalcauses.org](http://www.unnaturalcauses.org)

The Rural Women's Health Project, <http://www.rwhp.org/>

The National Coalition for LGBT Health, <http://www.lgbthealth.net/>



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- 4 See the “The Individual Insurance Market: A Hostile Environment for Women” section of the *Reform Matters Toolkit* for a more detailed discussion of the problems women encounter in the individual insurance market.
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- 8 See the “Domestic Partner Health Benefits and Tax Policy” section of the *Reform Matters Toolkit* for further discussion.
- 9 Los Angeles Gay and Lesbian Center, *Advancing Gay and Lesbian Health: A Report from the Gay and Lesbian Health Roundtable* (Jan. 2000), cited in *Healthy People 2010*, *supra* note 7.
- 10 *Making the Grade*, *supra* note 7.
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2008