

# System Racism and CHBRP's Health Policy Analysis

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California Health Benefits Review Program (CHBRP)  
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The California Health Benefits Review Program's (CHBRP) authorizing statute directs the Program to analyze “the impact on the health of the community, including diseases and conditions where disparities in outcomes associated with the social determinants of health as well as gender, race, sexual orientation, or gender identity are established in peer-reviewed scientific and medical literature.”<sup>1</sup> CHBRP analyzes health disparities and social determinants of health (SDOH)<sup>2</sup> when evidence demonstrates that these factors influence health outcomes, providers, or access to health care tests, treatments, and services identified in the bill. Because many disparities in health outcomes have their roots in systemic racism, it is important to explore the impact that systemic racism has on health policies, practices, structures, and systems, as well as the information available to CHBRP for conducting its analyses.

## Background

Racism is the relegation of people of color<sup>3</sup> to inferior status based on unfounded beliefs and biases (Braveman, 2022). Racism can be conscious or unconscious as well as explicit or implicit. Racism occurs at multiple levels – from individual and interpersonal interactions to the systems and structures upon which society is built.

Systemic racism is pervasive in all aspects of society and contributes to racial disparities in health (Feagin, 2013; Bailey et al., 2021). In the United States and in California specifically, there is a history of racism in policies related to housing, employment, education, healthcare, and more (CA Reparations Task Force, 2022). A major body of literature indicates the myriad of ways in which historical policies and practices have established structural racism that exists today (Solomon et al., 2019; Mauer, 2017). Although many explicit racial biases have been stripped from policies and programs, the legacy and impact of racism remain embedded in systems and structures (Feagin, 2013). Therefore, understanding and acknowledging the impacts of systemic racism on health is an important component of policy analysis.<sup>4</sup>

<sup>1</sup> See [CHBRP's authorizing statute](#).

<sup>2</sup> “Social drivers of health” is increasingly used as a substitute for “social determinants of health”, as “driver” allows for the possibility for change whereas “determinant” implies no room for change.

<sup>3</sup> For the purposes of this issue brief, CHBRP will use the term “people of color” to refer to African Americans, American Indians/Alaska Natives, Asian Americans, Latinos/Hispanics, and Native Hawaiians/other Pacific Islanders (Braveman, 2022). There are numerous terms that can be used to collectively refer to these populations, and there is not strong consensus on the most appropriate one. Other terms include “historically marginalized racial and ethnic groups” and Black, Indigenous, and People of Color (BIPOC) communities.

<sup>4</sup> CHBRP acknowledges that racism is not the only form of systemic discrimination that impacts health. Sexism, ableism, homophobia, transphobia, xenophobia, colorism, and ageism are examples of discrimination based on personal identities, stigma, and power structures; and all have significant health impacts. There are also intersections between these identities that result in people with multiple marginalized identities experiencing compounded discrimination.

# Systemic Racism and Health Policy Analysis

CHBRP has identified five key ways in which systemic racism directly affects policy analysis of health insurance-related legislation in California.

1. **Health Insurance Coverage.** Racism impacts the income and financial assets of Californians, creating inequities in the ability to pay for health insurance. The fact that the health insurance system is largely employer-based contributes to health disparities for people of color. People who do not have a stable, full-time job with benefits often do not have stable access to health insurance, and due to systemic racism in education and employment, people of color are more likely to experience this instability (Sohn, 2017). While health insurance is also available to purchase through the individual market (such as through Covered California), not all Californians are eligible for premium subsidies or cost-sharing assistance, either due to income or documentation status. Similarly, while Medi-Cal is available to low-income Californians regardless of documentation status, disparities in access and quality of care remain. The overall differences in required cost sharing, premiums, covered benefits, and providers accepting the forms of insurance impact whether Californians are enrolled in health insurance, which form of health insurance, and whether they are able to access and utilize health care services.

Distribution of racial/ethnic groups vary between commercial health insurance and Medi-Cal, as well as within each market, and legislation written to exempt one market or the other may unequally affect different racial/ethnic groups, causing more change in benefit coverage and related health outcomes for some racial/ethnic groups than for others. People of color represent a larger portion of Medi-Cal enrollees in managed care plans (around 80%) and a smaller portion of commercial enrollees (55%).<sup>5</sup> However, although these racial/ethnic groups are overrepresented in the Medi-Cal population relative to their share of California's population, there are more people of color among commercial enrollees (around 8 million) than there are among Medi-Cal beneficiaries enrolled in DMHC-regulated plans (around 5 million). Therefore, within CHBRP's analyses, it is important to discuss whether health insurance-related legislation unequally affect groups of Californians based on insurance status.

2. **Prevalence and Severity of Health Conditions.** Some differences in prevalence and severity of health conditions between groups are the result of systemic racism. This is not due to any inherent differences between groups but rather differences in the access to resources and conditions that promote health for people of color. As a result, legislation related to varying conditions may have differential impacts on different racial and ethnic groups and the mandate will not impact all Californians' health in the same way.

For example, Latino people living in the US are more than twice as likely as Non-Hispanic White people living in the US to develop type 2 diabetes (CDC, 2022). This disparity is due in part to lower income and decreased access to education and health care for Latinos in the US as compared with Non-Hispanic White people, which is an outcome of systemic racism, not any inherent medical differences between groups (Aguayo-Mazzucato et al., 2018). Therefore, legislation related to diabetes that are analyzed by CHBRP may have different impacts for Latino Californians compared to other groups.

3. **Health Care Treatment and Workforce.** Racism can impact the treatment that individuals receive when they seek care, at both an interpersonal level and a systemic level. The composition and actions of the healthcare workforce contributes to differences in quality of care received by people based on race. The healthcare workforce is disproportionately white, and medical education often lacks adequate training for providing care for people of color (Mora et al., 2022; Pfeffinger et al., 2020; Louie and Wilkes, 2018). Therefore, when a new health benefit mandate is enacted in California, its effectiveness is limited by the ability of the workforce to adequately provide it to all Californians who seek the corresponding test, treatment, or service. Due to systemic racism, there may be disparities based on race in how providers interact with the patient and how well the provider carries out the test, treatment, or service once they are with the patient.
4. **Social Determinants of Health.** Systemic racism contributes to racial disparities in SDOH, such as housing, employment, environment, education, nutrition, community safety, socioeconomic status, and more (Braveman et

<sup>5</sup> See CHBRP's [Analysis Methodology](#) document, *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts*.

al., 2022). These social conditions impact the extent to which individuals are able to experience the benefits of a covered test, treatment, or service. Examples include limited resources to recover from a procedure due to unsafe or unstable housing, inability to dedicate time to seeking treatment or follow-up due to employment or transportation conditions, or likelihood of relapse of a substance use disorder based on the conditions of the community to which a patient returns. These factors directly influence how different communities experience the impacts of a health benefit mandate. In some bill analyses, CHBRP notes how SDOH are relevant to the test or treatment at hand. For example, CHBRP's abbreviated analysis of AB 391 (2017) "Medi-Cal: Asthma Preventive Services" found that housing type and health literacy impacted the burden of poorly controlled asthma in the Medi-Cal population; therefore, preventative services may disproportionately alleviate the burden of asthma for racial and ethnic groups that have historically experienced disparities in these SDOH.<sup>6</sup> For some bills, CHBRP's analyses may suggest a potential impact of the policy on SDOH. CHBRP's analysis of AB 1316 (2017) "Childhood Lead Poisoning: Prevention" found that changes to screenings may ameliorate disparities in educational attainment and socioeconomic status due to lead exposure; children, including Black children who are disproportionately impacted by lead poisoning, would experience improved treatment and abatement due to increased screening.<sup>7</sup>

5. **Research and Data.** Academic, research, and government institutions that fund and conduct medical, public health, and health services research are also susceptible to the impacts of systemic racism, which affects these institutions' contributions to the field. Many of these institutions have histories of discriminatory policies and practices, both at specific institutions and systemically. There is poor representation of people of color both in the design of research and in study participants (Frogner, 2022; Hoppe et al., 2019; Chen et al., 2022; Mervis, 2022; Salazar et al., 2021; Else and Perkel, 2022; Harvey, 2020; Ejogu et al, 2011). This affects the data that are available, the topics that have been funded and studied to create the evidence base, and the urgency with which different topics are addressed (Hardeman and Karbeah, 2020). CHBRP is therefore limited by the evidence that is available to assess the financial, public health, and medical impacts of proposed health insurance-related legislation.

## Conclusion

Systemic racism has profound impacts on health; it leads to disparities in SDOH as well as unequal treatment within and access to health systems for people of color. Systemic racism also influences the evidence available to conduct health policy analysis, potentially limiting conclusions CHBRP is able to draw from available research.

While it is true that health insurance benefits mandates and repeals cannot remedy systemic racism, it is important to understand how and why tests, treatments, and services may have different impacts across racial and ethnic groups. Because CHBRP is statutorily tasked with determining the potential impacts of a bill with regards to health disparities and SDOH, it is essential to take systemic racism into account in its rigorous, evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

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<sup>6</sup> See CHBRP's 2017 [analysis](#) of Assembly Bill 391.

<sup>7</sup> See CHBRP's 2017 [analysis](#) of Assembly Bill 1316.

## Appendix A. Definitions

CHBRP reviewed and considered multiple sources of definitions of the following terms. The definitions selected are from well-respected sources and are most appropriate in the context of CHBRP's work in analyzing health insurance benefit mandates and related legislation.

**Health Disparities:** “A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (HP2030).

**Racism:** “The relegation of people of color to inferior status and treatment based on unfounded beliefs about innate inferiority, as well as unjust treatment and oppression of people of color, whether intended or not. Racism is not always conscious, intentional, or explicit—often it is systemic and structural” (Braveman et al., 2022).

- **Individual Racism/Interpersonal Racism:** Refers to the ways in which people, intentionally or not, treat racial and ethnic groups differently, thereby perpetuating systemic and structural racism and producing inequitable access to resources and opportunities (Williams et al., 2019).
- **Systemic Racism:** “Emphasizes the involvement of whole systems, and often all systems—for example, political, legal, economic, health care, school, and criminal justice systems—including the structures that uphold the systems” (Braveman et al., 2022).
- **Structural Racism:** “Emphasizes the role of the structures (laws, policies, institutional practices, and entrenched norms) that are the systems’ scaffolding” (Braveman et al., 2022).

**Social Determinants of Health (SDOH):** “The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and are the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems” (WHO, 2023). SDOH affect everyone and can have a positive or negative impact on health.

## References

- Aguayo-Mazzucato C, Diaque P, Hernandez S, Rosas S, Kostic A, Caballero AE. Understanding the growing epidemic of type 2 diabetes in the Hispanic population living in the United States. *Diabetes Metab Res Rev*. 2019 Feb;35(2):e3097. doi: 10.1002/dmrr.3097. Epub 2018 Dec 4. PMID: 30445663; PMCID: PMC6953173.
- Bailey ZD, Feldman JM, Bassett MT. How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. *New England Journal of Medicine*. 2021; 384(8): 768-773.
- Braveman PA, Arkin E, Proctor D, Kauh T, Holm N. Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling. *Health Affairs*. 2022;41(2): 171-178.
- California Task Force to Study and Develop Reparation Proposals for African Americans (CA Reparations Task Force). *Interim Report*. Sacramento, CA: CA Reparations Task Force; 2022.
- Centers for Disease Control and Prevention (CDC). Hispanic or Latino People and Type 2 Diabetes. CDC; 2022. <https://www.cdc.gov/diabetes/library/features/hispanic-diabetes.html>.
- Chen CY, Kahanamoku SS, Tripathi A, Alegado RA, Morris VR, Andrade K, Hosbey J. Systemic racial disparities in funding rates at the National Science Foundation. (2022)eLife.11:e83071. doi: <https://doi.org/10.7554/eLife.83071>.
- Ejiogu N, Norbeck JH, Mason MA, Cromwell BC, Zonderman AB, Evans MK. Recruitment and retention strategies for minority or poor clinical research participants: lessons from the Healthy Aging in Neighborhoods of Diversity across the Life Span study. *Gerontologist*. 2011 Jun;51 Suppl 1(Suppl 1):S33-45. doi: 10.1093/geront/gnr027. PMID: 21565817; PMCID: PMC3092978.
- Else H, Perkel JM. The giant plan to track diversity in research journals. *Nature*. February 21, 2022. <https://www.nature.com/articles/d41586-022-00426-7>
- Feagin, Joe. *Systemic racism: A theory of oppression*. Routledge, 2013.
- Frogner BK. How the health services research workforce supply in the United States is evolving. *Health Serv Res*. 2022 Apr;57(2):364-373. doi: 10.1111/1475-6773.13934. Epub 2022 Jan 17. PMID: 34982473; PMCID: PMC8928029.
- Harvey JA. Black Lives Matter: Racism in Research Needs to be Acknowledged in U.S. Preventive Services Task Force Guidelines, *Journal of Breast Imaging*, Volume 2, Issue 5, September/October 2020, Pages 422–423, <https://doi.org/10.1093/jbi/wbaa063>
- Healthy People 2030 (HP2030). Health Equity in Healthy People 2030. Department of Health and Human Services; 2023. <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>
- Hoppe T, Litovitz A, Willis K, Meseroll RA, Perkins MJ, Hutchins BI, Davis AF, Lauer MS, Valantine HA, Anderson JM, Santangelo GM. Topic choice contributes to the lower rate of NIH awards to African-American/black scientists. *Science Advances*. 2019;5. <https://www.science.org/doi/10.1126/sciadv.aaw7238>.
- Louie P, Wilkes R. Representations of race and skin tone in medical textbook imagery. *Social Science & Medicine*. Feb 2018;202:38-42.
- Mauer M. Incarceration Rates in an International Perspective. *The Sentencing Project*. 2017. <https://www.sentencingproject.org/policy-brief/incarceration-rates-in-an-international-perspective/>.
- Mervis J. NSF grant decisions reflect systemic racism, study argues. *ScienceInsider*. 2022. <https://www.science.org/content/article/nsf-grant-decisions-reflect-systemic-racism-study-argues>

- Mora H, Obayemi A, Holcomb K, Hinson M. The National Deficit of Black and Hispanic Physicians in the US and Projected Estimates of Time to Correction. *JAMA Network Open*. 2022;5(6). <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792848>.
- Pfeffinger A, Fernández A, Tapia M, Rios-Fetchko F, Coffman J. Recovery with Limited Progress: Impact of California Proposition 209 on Racial/Ethnic Diversity of California Medical School Matriculants, 1990 to 2019. *Health Workforce Center at UCSF*. December 2020. [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Recovery%20with%20Limited%20Progress\\_Impact%20of%20California%20Proposition%20209%20on%20Racial%20and%20Ethnic%20Diversity%20of%20California%20Medical%20School%20Matriculants%2C%201990%20to%202019.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Recovery%20with%20Limited%20Progress_Impact%20of%20California%20Proposition%20209%20on%20Racial%20and%20Ethnic%20Diversity%20of%20California%20Medical%20School%20Matriculants%2C%201990%20to%202019.pdf).
- Salazar JW, Claytor JD, Habib AR, Guduguntla V, Redberg RF. Gender, Race, Ethnicity, and Sexual Orientation of Editors at Leading Medical and Scientific Journals: A Cross-sectional Survey. *JAMA Intern Med*. 2021;181(9):1248–1251. doi:10.1001/jamainternmed.2021.2363
- Sohn H. Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course. *Popul Res Policy Rev*. 2017 Apr;36(2):181-201. doi: 10.1007/s11113-016-9416-y. Epub 2016 Oct 15. PMID: 28366968; PMCID: PMC5370590.
- Solomon D, Maxwell C, Castro A. Systematic Inequality and Economic Opportunity. *Center for American Progress*. 2019. <https://www.americanprogress.org/article/systematic-inequality-economic-opportunity/>
- Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. *Annual Review of Public Health*. 2019;40(1):105-125. <https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-040218-043750>.
- World Health Organization (WHO). Social determinants of health. WHO; 2023. [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

# About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource [Academic Rigor on a Legislature's Timeline](#).

To read any of the 200+ bill analyses CHBRP has completed, see the [Completed Analysis](#) page on [CHBRP's website](#). In addition to analysis of introduced legislation, CHBRP produces [other publications](#) including several annually updated resources, as well as issue briefs and explainers.

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