

A Call for Broadening the Lens on Health Disparities

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For decades, efforts to study and address health disparities in the United States have focused to a large extent on outcomes according to race and ethnicity,¹ with an emphasis on comparatively poorer outcomes for people of color. This long-standing approach has revealed substantial burdens that impact quality of life for minoritized racial and ethnic groups and developed the foundation for important research and policy efforts to advance the health of all communities, regardless of racial or ethnic background.

Yet, this steady focus has created an unintended consequence: advancing the public misperception that health disparities are *only* a concern for people of color. The reality is far different and quite sobering. Health disparities exist in a wide variety of forms, affecting many more Americans than previously considered—perhaps *50 percent of the US population or more*.² This includes approximately 82 million people who reside in rural areas and 37 million who live in poverty (FHFA, 2024; US Census Bureau, 2025). Therefore, it is crucial to expand the lens on health disparities—not only in terms of what is studied and how policies are targeted, but also in terms of how disparities are discussed and how public understanding and support for actions meant to address them are shaped.

A useful example is the higher-than-average prevalence of diabetes in Appalachia, New Mexico, and Mississippi. The racial and ethnic compositions of these regions are quite different, yet each experiences a higher-than-average diabetes burden (ADA, n.d.). Rurality and poverty are the commonalities here—factors that make it more difficult to access health care, eat healthy food, and engage in healthy lifestyles. These challenges are amplified when considering the hardwired characteristics of the physical environment and social structures, such as air and water quality, housing, employment, education, and, perhaps most importantly, economics. This aggregate of risk factors both increases the likelihood of diabetes and complicates diabetes care—while increasing vulnerability to almost all other chronic conditions, especially cardiac disease.

Given the common characterization of health disparities as an issue affecting primarily people of color, it may come as a surprise that White Americans living in rural areas experience the highest risk for certain health disparities in the country. This includes disproportionately higher rates of drug overdose deaths and chronic lower respiratory disease than other groups, including Black, Hispanic/Latino, Asian American, and

1 The authors acknowledge that the field of health disparities research has also robustly examined outcomes according to other characteristics, including income, education, and gender. However, the field is inextricably linked—both historically and in terms of public perception—to efforts to correct the long-standing history of inequitable treatment of people of color within US health and the social systems contributing to these disparities (IOM, 2003).

2 The authors determined this number by adding the following populations: racial and ethnic minoritized people (140 million); people living in rural areas (82 million); people with disabilities (70 million); and people living in poverty (37 million) (Jensen et al., 2021; FHFA, 2024; CDC, 2024; US Census Bureau, 2025). Allowing for both overlap and imprecision, a reasonable estimate of those experiencing health disparities is approximately 150 to 175 million, or nearly half of the US population.

American Indian/Alaska Native people living in the same areas (Spencer et al., 2022; Probst et al., 2020). Rural White Americans also report more days of poor mental health—including stress, depression, and emotional problems—than both nonrural Whites and all Black Americans (Efird et al., 2023). In general, mortality rates have been increasing for middle-aged White men, particularly in rural areas, due in large part to suicide and substance use—part of a trend that has been referred to as “deaths of despair” (Scutchfield and Keck, 2017).

Many other groups experience serious, avoidable gaps in health care access and health outcomes, including people with disabilities, people with limited education, immigrants, LGBTQ+ individuals, and many older adults, especially the growing population of older women living alone. Yet, these groups are less often centered in public discussions about health disparities. As a result, many have drawn the erroneous conclusion that addressing health disparities means prioritizing the concerns of certain groups while overlooking others. It is important to reframe the conversation and emphasize that lessons learned from the study of minority health have yielded universal insights and created a template for supporting all groups at risk of health disparities.

The unfortunate truth is that approximately half of the US population belongs to at least one group disproportionately affected by chronic illness, reduced life expectancy, or limited access to care. There can be no aspiration of greatness for this nation when the health and prosperity of well over 150 million citizens is compromised or lagging.

Furthermore, the other half of the country's population should still be concerned. *Everyone* in the United States feels the burden of health disparities, if not as a direct impact on their personal health, then through the economic consequences of ill health in society. The cost? *Hundreds of billions per year* (LaVeist, 2023). Health disparities place substantial strain on the health care system and drain the nation's economy. Nearly incalculable unrecovered and unbudgeted dollars are lost each year to avoidable hospital visits, untreated con-

ditions, and especially reduced productivity due to both absenteeism and presenteeism (i.e., being at work but working ineffectively). These costs affect the lives of everyone in America by driving higher insurance premiums, increasing taxes, and diverting public resources away from priorities such as education, infrastructure, and national security. In other words, each person pays for a system that fails to effectively serve all.

Crucially, health disparities are not an unavoidable facet of society. They are not innate, inevitable, or immutable. In truth, many health disparities are indeed preventable, and, with purposeful investments, health and health care disparities can be significantly reduced by deploying tested models derived from decades of studies in minoritized racial and ethnic populations and other groups. A broader understanding, first of avoidable differences across a broad spectrum of groups, and then of the heterogeneous causes of these differences, can inform the development of tailored and effective interventions. Moreover, there is a skilled public health and scientific workforce trained in the measurement and management of disparities standing at the ready.

Solutions are already available. Some communities have implemented local programs that bring preventive care closer to where people live and work. Others have improved health outcomes by integrating social services like housing support and nutrition counseling into care delivery. Emerging technologies like telehealth have shown potential to connect more patients with the care they need (although improving digital and broadband access in rural areas is necessary to fully realize this promise). And, increasingly, AI and data science, such as geospatial community mapping, can spotlight previously unrecognized disparities and offer more efficient and earlier deployment of interventions.

In policy discussions today, there is rightly a strong emphasis on responsible and efficient use of taxpayer-supported federal resources. In this context, addressing health disparities may represent the best use case for federal investment.

Preventing disease costs far less than treating it. Allocating resources today can reduce expenditures tomorrow. Closing the gaps in outcomes can strengthen communities, boost workforce participation and the economy, and lower costs for everyone—and everyone means *everyone*.

If the American ethos is the pursuit of best life, then surely enabling as many citizens as possible to live longer, healthier lives free of avoidable diseases is an essential goal. Health disparities are not someone else's problem (Cooper, 2021). Everyone has skin in the game. It is time to reframe and reinvest in the elimination of health disparities as a shared national priority.

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