

Focusing on Race and Racism is Critical to Advancing Health Justice

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This Commentary was submitted as a Letter to the Editor in response to Yancy, C. W., S. H. Golden, and V. J. Dzau. 2025. A call for broadening the lens on health disparities. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. Available at: <https://doi.org/10.31478/202509a>.

The *NAM Perspectives* Commentary, “A Call for Broadening the Lens on Health Disparities,” is critical of what it posits has been a narrow focus of health disparities research “on outcomes according to race and ethnicity,” pointing to the “unintended consequence” of “advancing the public misperception that health disparities are *only* a concern for people of color” (Yancy et al., 2025, p. 1). It concludes that health disparities research should be more inclusive of multiple social characteristics along which health disparities are observed, for example, by socioeconomic status and geography. Some aspects of the Commentary are problematic:

1. Health disparities (or inequities) are considered unfair and preventable, based on “characteristics historically linked to discrimination or exclusion” (US Department of Health and Human Services, 2010, as cited in Braveman, 2025, p. 997), and are generated by systems that privilege or disadvantage some groups compared to others. Accordingly, although some health outcomes are worse

among men compared to women (e.g., life expectancy) or among White people compared to people of color (e.g., suicide), whether or not these differences are deemed health disparities is arguable because patriarchy and racism confer other benefits to men and White people, respectively (e.g., socioeconomic and political power). While public health should be concerned that “mortality rates have been increasing for middle-aged White men” (Yancy et al., 2025, p. 2), it is debatable whether this is a health disparities issue.

2. The claim that the public perceives health disparities to be “*only* a concern for people of color” (Yancy et al., 2025, p. 1) is dubious. Evidence suggests the general population recognizes income and geographic disparities more than racial disparities. In the 2023 National Survey of Health Attitudes, 66.9 percent believed it was more difficult for those with lower versus higher incomes to access health care; a lower percentage, 43.0 percent, believed it was more difficult for Black/African

Americans compared to other races (Chandra et al., 2024). When asked to rate factors that affect health and well-being, 64.1 percent reported income and 54.0 percent reported where a person lives as having a “strong” or “very strong” effect, whereas only 37.7 percent reported the same for race. These findings echo those from a 2021 survey which concluded that people were “more likely to see social and economic inequities than racial inequities” (Robert Wood Johnson Foundation, 2021, n.p.).

3. The position that health disparities research has narrowly focused on race lacks empirical support. Although when first institutionalized in the mid-1980s the term “health disparities” referred to racial disparities, its usage has widened significantly, describing health differentials experienced among any “groups of people who have systematically experienced greater obstacles to health” (US Department of Health and Human Services, 2010, as cited in Braveman, 2025, p. 997). To examine the scope of research funded under the health disparities umbrella, new research grants (R01, R21, and R03) awarded by the National Institute on Minority Health & Health Disparities in the previous fiscal year (October 2023 to September 2024) were examined. Of 76 grants identified using NIH Reporter (National Institutes of Health, 2025), 41 (53.9 percent) were classified as having a primary focus on race (e.g., participant inclusion criteria, documenting/investigating associations with racial health disparities). The remainder focused on socio-economic factors (e.g., low-income, Medicaid recipients), geographic characteristics (e.g., disadvantaged neighborhoods, rural areas), sexual and gender minorities, and other related topics, such as health policies, food insecurity, incarceration, and specific health outcomes (some with and others without mention of race), demonstrating how the field includes a breadth of topics spanning multiple dimensions.

While keeping a broad lens on health disparities, there is a critical need for focused research on race. From an intersectionality perspective, because systems that produce health disparities are intertwined, dismantling other forms of health disparities requires a focus on race. Rather than advocating for an *additive* broadening, an *intersectional expansion* that integrates consideration of race and racism across arenas is warranted. For instance, predominantly Black/African American and American Indian/Native American rural counties are among the least healthy, yet rural health research has mostly focused on White people (Richman, 2019). Racial health disparities are observable along other characteristics, for example, within income and education strata, by disability status, and among gender and sexual orientation groups. Health disparities in these domains are to some degree influenced by racial disparities and cannot be eliminated without a focus on race.

Additionally, it is critical to focus on racial disparities in a health justice framework. While health equity highlights intervening on social determinants of health and channeling health-promoting resources to groups facing systematic challenges to optimal health, health justice is more explicitly rooted in transforming systems and structures that (re)produce inequity, engaging communities in pursuit of epistemic justice; it is also concerned with addressing the consequences of historical injustices, for example, through affirmative action, reparations, and other restorative and redistributive policies and practices. A deliberate shift toward health justice is needed for interventions and solutions-oriented science. From a health justice perspective, a focus on racial disparities is paramount.

Indeed, health disparities are a shared societal problem negatively impacting the whole population (e.g., via cost of health care and dragging the economy). However, such messages should complement those recognizing that socially

disadvantaged groups are most adversely impacted. Universalist statements should be used cautiously because they often de-center race and may inadvertently undermine efforts to address racism. The principle of *targeted universalism* suggests that carelessly “broadening the lens” may result in losing sight of the qualitatively unique contexts giving rise to racial disparities (Othering and Belonging Institute, 2025). “Common good” rhetoric may be strategic, but risks devolving into colorblind jargon that minimizes the foundational role of racism in shaping virtually all aspects of US society, including health disparities more widely.

The science on racism and health has evolved, with increasing attention to systemic, structural, and institutional racism—factors below the proverbial tip of the iceberg; there is a need to focus on these levels to foster the next generation of research. And while health and medical sciences have firmly acknowledged that racism is a public health issue and fundamental cause of racial inequities in health, foremost, racism is an enduring ethical and moral problem. Given efforts to erase race, defund the study of racism, and dismantle initiatives aimed at enhancing racial diversity, equity, and inclusion, it is critical—possibly now more than ever—to redouble efforts to put race and racism at the forefront in health disparities discourse to advance health justice.

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