

PERSPECTIVE

I Hope You Are Doing Well — Will AI Widen or Close Health Care’s Disparity Gap?

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Abstract

Artificial intelligence (AI) promises equal access to medical knowledge, yet history suggests low-resource hospitals and underserved patients are often the last to benefit from new technologies. As an administrator at an independent safety-net hospital in Brooklyn, New York, the author has seen this pattern with the adoption of electronic health records, diagnostic technologies, and telemedicine — and AI risks repeating it, particularly as insurers deploy these tools for claim denials while underresourced providers struggle to afford comparable systems. Algorithmic inequality could become health care’s newest disparity factor. However, if we act deliberately, AI can strengthen rather than fragment care. This requires promoting equitable access policies modeled on Health Information Technology for Economic and Clinical Health Act investments, engaging in national AI governance discussions through organizations such as the Coalition for Health AI, and implementing rigorous equity metrics before deploying them. The integration of AI into medicine should be shaped by those who understand its human stakes and are focused on patients’ best interests. Thoughtful engagement by all will ensure that medicine continues to progress with all its human elements.

Introduction

When I open an email that begins with “I hope you are doing well” in 12-point Times New Roman and has abundant bolding and hyphenation, I know I have been ChatGPTed. This recognition distracts me from the intended pleasant-ries and instead surfaces a familiar and growing unease; the progressive march of artificial intelligence (AI) has entered into the daily life of my community hospital. Then I really do wonder if any provider will soon be “doing well.”

The rapid integration of AI into health care presents a troubling paradox. The same tools that promise to democratize medical knowledge may instead deepen the divide between well-resourced health systems and safety-net hospitals. How we govern AI adoption in the coming years will determine whether it becomes medicine’s great equalizer or its newest social determinant of health.

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Health Care AI's Potential and Risks

The patients at our independent safety-net community hospital in downtown Brooklyn, New York, have multiple comorbidities and face both social and economic challenges. We suspect the integration of advanced AI tools will follow the well-known pattern we have seen with electronic health records (EHRs), new diagnostic technologies, and telemedicine: Our patients are often the last to benefit. During the Covid-19 pandemic, non-English speaking patients, Black patients, and those with zip code-linked incomes below US\$50,000 were significantly less likely to complete telehealth visits.¹ Safety-net hospitals often adopt technologies with fewer features, higher costs, and limited support. When EHRs became the standard of care, small hospitals lagged large hospitals by over 34 percentage points in comprehensive adoption.² Safety-net hospitals faced the steepest challenges, constrained by limited capital, technical support, and Internet infrastructure.^{3,4} Even with billions invested in federal incentives, researchers identified an emerging “advanced use” divide, where safety-net hospitals adopted basic EHRs but lagged in advanced functions.⁵ As the proliferation of AI continues, this cycle is likely to repeat.

AI can improve health care. It can offer powerful clinical diagnostic services via decision support tools, intelligent transcription, and real-time access to AI assistants that present helpful and potentially missed diagnoses and suggestions that are on par with those of skilled providers and continually improving.⁶⁻¹³

The potential of AI to strengthen the health care safety net is enormous. When implemented thoughtfully, it could democratize medical expertise, extend clinical reach, and provide consistent evidence-based care where disparities currently exist. It could serve as a dependable second opinion in hospitals unable to afford specialists during nonpeak hours, provide radiologic reviews, or help nurses with sign-outs. However, overreliance on these systems may render the quality of care contingent on the capabilities of the tools themselves. In a National Association of Insurance Commissioners survey from 2025, 71% of insurance companies admitted they use AI for utilization management.¹⁴ A United States Senate report documented how insurers deployed AI to deny claims, “substituting judgment about medical necessity with a calculation about financial gain.”¹⁵

Clinical Care and Workforce Implications

If insurance companies adopt progressively more sophisticated AI tools and use them to deny claims, providers may be unable to afford versions that can effectively counteract this. In an AI arms race, algorithmic inequality could become the next frontier of health care disparity, deepening the divide in an unfair contest between modest community hospitals and for-profit systems and insurers. We may soon measure disparity not only by income or race but by the version number of the model an organization can afford. Practicing medicine could become unrecognizable.

Consider a plausible near-term scenario where a patient arrives to an emergency department with a “diagnosis” provided by their iPhone’s AI assistant. Earlier, the phone moderated a discussion with the patient, reviewing their symptoms, historical information, and vital signs from their smart watch or ring augmented by a home lab drawing service. The patient comes seeking not a diagnosis, but an AI-recommended intervention: a computed tomography scan to assess the extent of an AI-diagnosed case of pancreatitis or an operating room booking for an appendectomy. Providers just need to greet the patient, make them feel at ease, and approve the requested services.

Providers may increasingly find their roles narrowed as AI systems become more capable. As these models improve, studies may demonstrate their noninferiority — and eventually superiority — in certain aspects of clinical decision-making. Patients may overcome their current hesitancy and accept these cheaper, less intrusive, and seemingly effective diagnosticians, especially as uninsured and underinsured patients begin to receive real clinical guidance from AI beyond the limits of an Internet search. Insurers, supported by emerging evidence, may increasingly promote lower-cost AI-mediated pathways of care.

These developments raise important questions about the future structure of the clinical workforce, physician training, the role of human judgment in medical decision-making, and even the potential of hands-on help from AI model-trained surgical robotics. In time, clinicians may find themselves mostly providing empathy and context for care while AI systems increasingly contribute to diagnostic reasoning and therapeutic recommendations. The possibility that clinicians could be displaced, even partially, by technologies originally designed to assist them remains an unsettling prospect.

Strategies to Advance Equity in Health Care AI

The true measure of AI's success in medicine will be whether it raises the standard of care for everyone and does not widen the existing gap. We can take three steps now to steer AI toward equity.

First, we must advocate for equitable access by supporting policies and laws that mandate AI tool availability across payer types. We should require that any AI diagnostic tool approved by insurers for commercially insured patients be equally available to Medicaid beneficiaries. Legislation requiring tiered pricing for AI vendors serving Medicaid-dominant hospitals, 90/10 federal matching funds for AI implementation at critical access facilities, and reinvestment requirements directing a portion of health care AI profits toward infrastructure support for underresourced providers could all ensure an even playing field. We must advocate for an investment in AI equity that aligns with the Health Information Technology for Economic and Clinical Health (HITECH) Act. The original US\$27 billion HITECH Act raised hospital EHR adoption rates from 3.2% to 14.2% annually and established 62 regional extension centers. A comparable AI extension center program could ensure safety-net hospitals are not left behind.

Second, clinicians must engage in national discourse through professional societies, public comment periods on Food and Drug Administration AI guidance, and health system AI governance committees. Participation in organizations such as the Coalition for Health AI helps ensure that those who care for underserved populations have seats at the table.

Third, we must recognize that implementation matters as much as policy. Health systems should adopt AI deliberately, with equity metrics built into evaluation frameworks from the outset. Before deployment, institutions should require vendors to disclose training data demographics and demonstrate comparable performance across different demographics, such as race or ethnicity, language, and insurance status, with auditable reports. Algorithms that cannot explain their recommendations should not be trusted with patient care, particularly in safety-net settings where biased AI disproportionately harms those with the fewest resources.

The integration of AI into medicine should be guided by those who understand its human stakes, not by profit-driven

incentives that accept workforce displacement, the erosion of clinical judgment, and unequal access as collateral damage. If clinicians and health care leaders committed to equity shape this transformation, AI could narrow disparity gaps while preserving the central role providers have held since Hippocrates.

When I open my next ChatGPTed email, I'd like to simply answer that I am feeling hopeful. Hopeful that we will together shape a future that we all want. I hope, but my uneasiness lingers.

Disclosures

Author disclosures are available at ai.nejm.org.

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