

# Reimagining Affordable Primary Care: A Micro-Clinic Innovation Model for The U.S. Healthcare System

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## ABSTRACT

The United States spends more on healthcare when compared to any other country, but when it comes to affordability and timely access to primary care, it remains a big question in millions of residents. The high-cost settings for basic medical needs contribute to financial hardship and lack of efficient use of resources in spite of widespread insurance coverage. The study clearly investigates the ground level need for low-cost primary care in the US and also evaluates the option of flat-fee micro-clinics as a cost-effective alternative. This research uses mixed methods in analyzing cross-country benchmarking of the World Bank health system indicators by conceptualizing the model of a micro-clinic delivery framework. When compared, the results show that the United States is a clear outlier in per capita health expenditure and healthcare spending as a share of GDP, but it still exhibits measurable levels of financial hardship and poverty attributable to healthcare costs. On the other hand, countries with decentralized community-based primary care systems achieve higher growth in terms of providing primary care with lower costs and broader access. The findings clearly show us that U.S. affordability challenges are not driven by the amount of out-of-pocket spending, but by the pricing of the care for low medical services. From the findings, the paper proposes a very practical and scalable micro-clinic model which offers a flat fee, walk-in primary care, and which is not at all dependent on insurance reimbursement. The study finally concludes that micro-clinics is a clear pathway to improve primary care affordability by reducing reliance on high-cost care settings and enhancing access without increasing national health care expenditure.

**KEYWORDS:** *Affordable healthcare; Primary care access; Micro-clinics; Healthcare affordability; Health system efficiency; Out-of-pocket expenditure; Decentralized care models; Primary care innovation*

## 1. Introduction

The healthcare in the United States is not affordable when compared to other countries in the global sector. Especially, the need for primary care is too expensive, and in order to have health insurance, you get primary care that is bundled with other benefits. This, in turn, causes expensive health insurance that comes with many other benefits that are not needed by many people during their entire lifetime. The United States is the only wealthy industrialized nation

without universal health coverage, a crucial component to ensuring quality health care for all without financial burden that causes delay or avoidance of necessary medical care (Crowley et al., 2020). There is a high cost even for minor medical needs such as treating small injuries, common infections, or routine wellness checks on a daily basis, whereas other countries have primary care in a very easy and convenient manner that does not require health insurance or sometimes only requires a limited health insurance plan. Many people in the United States

have different income levels, and a lot of international students come here and pay for health insurance as part of their tuition fee, which is too expensive. So, the people who fall under the low-income category cannot afford health insurance that has more benefits which are not needed for them, and they are always looking for healthcare that is affordable and easily available in their locality with minimum monthly premiums. Not all people can afford higher premiums with all the benefits, and there is a clear need for affordable primary care access with minimal insurance requirements or even without insurance if needed.

Sometimes people get illnesses, and they do not have appointments available as part of their health insurance with either in-network or out-of-network providers. There is an urgent care option available, but sometimes the options are limited. People try to overuse the emergency room for non-emergency issues, and this is quite common. Most people do not understand the difference here, which leads to long waiting times and access barriers, causing a major problem in the health insurance system. When you see all the health indicators on a global arena, the importance and uniqueness highlight the severity of affordable healthcare issues in the United States. Even though a well-functioning primary care system is widely acknowledged as critical to population health, the number of primary care physicians (PCPs) practicing in the United States has steadily declined, and PCPs are in short supply (Hoffer, 2024). We have the World Bank's World Development Indicators that clearly reveal numbers showing that the United States is always among the highest in the world for per capita health expenditure, healthcare spending as a percentage of GDP, and the out-of-pocket burdens placed on patients (Crowley et al., 2020). Much of U. S. health care has been corporatized, with a shift to for-profit health care, increased privatization, and growth of investor-owned corporate health care (Geyman, 2022). There is a lot of investment spent on healthcare in the United States, but despite this, the results in getting access, preventive care coverage, primary care access, and the availability of services do not match the spending levels. Whereas other countries in the global sector have great access to primary care, where people can just go to a primary clinic, wait less than five minutes to see a doctor without health insurance, get treated, and receive a handwritten prescription with the drugs to be taken.

Efforts have been made to identify the need for affordable primary care access in the United States, but there is limited research on how exactly care can be provided or how care can be delivered for common treatment without health insurance or with minimal insurance that has a very low premium. The global comparisons among different countries clearly prove that affordability is achievable by having less spending with community primary care access. There are inefficiencies in the U.S. healthcare system that leave the majority of people underserved, particularly people in rural regions, those with low-income levels, and communities with limited provider availability (Mongelli et al., 2020). Sometimes people cannot get appointments, urgent care options are limited, and the emergency room becomes overused. There were limited solutions provided to increase primary care access on a community level with lower premiums and lower spending. Prior research clearly indicates that the fundamental issue is not only cost but also the structural design of the present infrastructure, which is not optimized for affordability or for rapid and community-level care. There are many barriers that result in delays in treatment, higher long-term costs, and avoidable emergency department utilization, and there are many gaps that affect people seeking immediate medical care with low-cost options. The research also shows that indicators such as physicians per 1,000 population, nurse and midwife density, and completeness of vital event registration suggest gaps in basic healthcare.

The challenge here is to get primary care access without insurance for people who need treatment for smaller injuries, common infections, routine wellness checks, or common drugs. Most of the drugs must be available in the drug facility centers, which can and should be accessible to people by getting a prescription handwritten or online after treatment from the doctor in that primary care center. This model of spending significantly lower expenditure per capita in most countries demonstrates higher efficiency and community-centric primary care delivery models that show high spending does not always deliver higher impact and does not inherently translate to better access that improves health performance. As there is a need, this paper proposes the introduction of community-based micro-clinics, which is a reliable solution for improving affordable care access in the United States. Micro-clinics are small walk-in primary care clinics designed with minimal infrastructure and equipment to

deliver basic health services at a minimal cost, typically ranging from \$10 to \$30 per visit without insurance coverage. This idea is inspired by many international healthcare models adopted by different countries, which have shown proven success as low-cost community healthcare systems in the global sector.

**Research Question:**

How can decentralized, flat-fee micro-clinics improve affordability, accessibility, and care efficiency for everyday medical needs in the United States?

**Significance:** This paper has a clear objective as it explores the financial logic, public health considerations, and the potential of micro-clinics in the United States. It analyzes global expenditure data, compares primary care infrastructure indicators, and identifies current affordability constraints, making this study a data-driven argument for micro clinic adoption. This paper clearly outlines how micro-clinics operate, the kind of people they can serve, and the impact they can have on low-cost health plans and health equity. It clearly addresses one of the most urgent challenges in American healthcare today.

Micro-clinics are a practical solution to streamline minor medical treatments, which in turn reduces a great burden on emergency rooms and increases care toward preventive services. This requires minimal staff, minimal infrastructure, minimal medical equipment, and integration with pharmacy networks, which makes them uniquely suited to address existing gaps while keeping the economic burden of care delivery low. This usually works when a patient needs basic treatment for common problems without insurance. The patient can walk in, get treatment in less than five minutes, receive a proper prescription—handwritten or computer-generated—with the doctor’s information and care details, and then obtain the required drugs from the integrated pharmacy. People want primary care providers with whom they can have ongoing relationships. They want to know when they need help. They want to have access to someone with knowledge of their health problems and their individual characteristics (Josiah Macy, Jr. Foundation, 2010). This paper outlines why such a system is necessary, how these micro-clinics address existing inefficiencies, what structural changes they introduce, and how they align with global primary care models. It then presents the implementation strategy, operational workflow, and evaluation metrics that guide

the rest of the paper.

The paper clearly presents micro clinics as the viable and evidence-based solution by examining the affordability crisis of primary care in the United States. After this, the Related Work section showcases the prior work and research on healthcare affordability, primary care access and community-based models in the USA and other countries globally. The Methodology section involves design which includes analysis of different countries using the World Bank Health System Indicators, and a clear framework which is used to develop a micro-clinic model. The Results section presents the key findings, that shows US as an outlier in the comparison in parameters such as healthcare cost intensity and, financial burden, The findings also clearly identify the structural patterns that support decentralized primary care delivery. The Discussion happens on the findings that show why the model of micro-clinics is a proven solution which addresses the inefficiencies in the US healthcare system. Finally, the Conclusion summarizes all the key insights, determines the practical implications, gives a lot of scope for future research and implementation.

**2. Related Work**

Affordable health care has been the main topic of discussion over the past few decades and there are different perspectives involved in it. A lot of research explains this topic in different ways. But one of the common things in all the work is the improvement in affordability and access to primary care, and this is a continuous challenge in the United States. The majority of the research highlights different aspects revolving around structural, financial, and operational barriers for providing equal health to everyone. Huyang et al. clearly identifies in their research that the lower cost care may not come at the expense of better quality. Their work clearly identifies that the total cost of care that is provided is a function of both the fees and the quantity of services. The analysis clearly shows that both the prices and quantities of services will affect affordability and that it significantly reduces the prices when compared with quantities and may have different effects on the provider’s profits.

Geyman (2022) It clearly says that there is a need for primary care, which has to be the foundation in the U.S. healthcare, and this has been a very important thing for years. There were many efforts that were taken to make

that happen through medical education and practice, but however, all through these years, nothing was achieved. The work clearly identifies there is a severe lack of a strong primary care infrastructure throughout the United States, and it clearly compares how other countries have built easy and budget-friendly infrastructure and prioritize primary healthcare in their healthcare industry. The research shows that there is an economic situation in which the current rate of rise for medical costs is unsustainable, and with the higher population, the healthcare needs and expectations are also rising, and there are very few primary care physicians and primary care clinics available to meet the needs of the people. This literature also clearly shows why US is compared as very poor among other countries by spending too much on health care than any other country in the world but is lagging in terms of mortality amenable to health care. McGough et al. (2017) Clearly documents how the Affordable Care Act has expanded the insurance coverage and intensified the pressure on primary care systems by clearly identifying and exposing the shortages in the staff, the delays in the appointments, and no proper scheduling models in meeting the same daycare expectations. Their work is also focused on the limitations of existing improvement strategies that are needed for expanding the clinic hours, setting up clinic infrastructure, having some advanced scheduling access options, providing embedded urgent care, and virtual care. This proves that there is a need for alternative options such as micro-clinics that will be able to deliver low-cost care without any traditional primary care infrastructures which are overwhelming.

One other research focuses on affordability challenges, particularly among the populations which are vulnerable. Park and Fung (2025) clearly showcases that majority of the people having the Medicaid beneficiaries with a low income face a lot of problems in spite of having the insurance coverage they have a lot of significant affordability burdens and higher rates of medical debt lot of delay in the care with added financial stress so their analysis clearly points out the patterns that reveals the affordability of health care problems still persist for people even though they are having health coverage and the out-of-pocket maximums are lower this clearly indicates there are obstacles in the care and benefit design so all these problems clearly shows the importance of low-cost walk-in micro clinic models which reduces all the barriers by offering flat fee services outside of the insurance based structures. Other literature

that explores the concept of Autonomous Mobile Clinics (AMCs), as described by Liu et al. (2022), It illustrates how some of the mobile platforms are equipped with infrastructure and with tools which can provide remote connectivity from anywhere, anytime, and can have healthcare access at low cost and can be provided with limited facilities which are good to the underserved in geographically isolated communities. Healthcare work in micro-clinics differs from AMCs in operational design with both having different approaches but follow the same underlying principle of decentralization and community proximity which clearly demonstrates the feasibility of alternatives in care delivery and to reduce all the physical and financial barriers to care.

There are severe border country comparisons that clearly demonstrates that the U.S. affordability crisis in healthcare is not inevitable, but it has a lot of consequences in structural inefficiencies. Vujicic (2014) clearly showcases that the United States experiences the highest number of financial constraints in the health sector for providing medical and dental care among many other countries despite of spending more than any other nation in the world on the healthcare per capita. His analysis clearly pinpoints to high prices and all the administrative waste and the inefficiencies which are the main cause of affordability and clearly shows that the conditions that the micro-clinics provide based on their simplicity and cost-effectiveness are specifically positioned to counteract all the analysis that his work shows clearly aligns with global evidence that community-based models are always effective and they outperform high-cost centralized systems in providing basic care. The role that administrative overhead has, is exposed by Woolhandler et al. (2003) in his research By identifying that United States Health Care Administration consumes nearly double the amount of spending that is observed in Canada with billions of dollars that is lost every year for the redundant insurance processes, which has a lot of complexities in the billing and fragmented workflows. But administrative simplification is not only the primary thing that micro-clinics offer, but the streamlined operational structure that they have with very less minimal billing and having no staff requirements without any many workflows directly addresses the administrative things in this research. It's a direct connection to strengthen the economic rationale for the implementation of micro-clinics, which will be a part of a broader affordability

strategy.

## 2.1 Synthesis and Gap Identification

The research provides a detailed diagnosis of affordability failures, shortages in primary care, and the systematic inefficiencies in the US health care system. But one thing that is not resolved in the existing body of literature is the absence of a clearly defined primary care delivery model, which addresses affordability without relying on traditional insurance or a hospital-centric infrastructure. Although prior studies dealt with proposing policy reforms, expanding insurance coverage, administrative simplification, extending the clinic hours, expanding the workforce, and getting in the technology, all these approaches largely function in the existing health care structures, which deal with insurance and high expenditures. This at the endpoint retains high costs, high dependency on centralized facilities, a very less reimbursement mechanism, which are all the obstacles to deliver low-cost primary care access. This clearly makes the way for micro-clinics as an operational response to all the unresolved challenges and making that possible to achieve a low care delivery mechanism by translating all the insights of the prior research. This module is not heavily focused on the policies or the incremental reforms but it operationalize affordability through simple service, flat fee pricing, less staff, and very minimal infrastructure. This directly eliminates primary care from insurance complexity and high-cost environments. This module directly address the structural inefficiencies, household burdens, and any of the barriers that the existing literature has. This study clearly builds on the proper findings, but the goal is to not propose another adjustment in the policy, but to implement and innovate a new model of micro-clinics as an implementable and community-level solution that aligns with global evidence and low-cost primary care.

## 3. Methodology

This study follows a mixed method of analytical framework that integrates the factors like cross-country health system comparison, economic indicator analysis, and conceptual modeling. This helps to clearly evaluate the feasibility of micro-clinics as the most reliable and a low-cost option for primary care in the United States. The entire methodology section is structured around three main components: (1) the section of global health system indicators that helps to diagnose the affordability challenges, (2) a comparative

assessment which helps to identify structural patterns across different healthcare systems, (3) the development of a new micro clinic operational setup, clearly showcased by empirical evidence.

### 3.1 Analytical Strategy and Research Approach

The main objective of this research is to understand whether this model of introducing micro-clinics can address the affordability gaps in US primary care. To do this, the study clearly employs the comparison of health systems which are widely used in the global health sector. This methodology examines the contrasts in spending, household burden, and the financial protection across different countries to identify all the inefficiencies in the structural design. At first instance, the research approach is primarily quantitative in its assessment of all parameters, and complementing this, the research uses a qualitative conceptual modeling approach to construct the micro clinic framework. This methodology was chosen because of the research question: "Can micro-clinics improve affordability and access in the US healthcare system?" This requires both a diagnostic component and a qualitative component, which appropriately addresses both needs.

The United States was analyzed along with five other countries, Canada, the United Kingdom, the Netherlands, Singapore, and India. These countries are selected as a spectrum of health care financing and delivery models. These were chosen specifically because of the proven methodological value of illustrating different strategies for cost control, providing primary care at very low cost, easy primary care access, and having all the conceptual reference points for the development of micro-clinics. Their systems are naturally adapted for many years for providing primary care as a part of these clinics. This was successful in their health systems and continuously serving many people without any major problems and are setting up a definition for Low-Cost primary care.

### 3.2 Data Sources and Data Collection Methods

Data for quantitative analysis was obtained from the World Bank World Development Indicators (WDI): Health Systems dataset, a globally recognized source for cross-country health expenditure, financing, and financial protection measures. The dataset (2014-2024) was accessed through the World Bank Databank (2024 release)

and imported into Google Colab for computational processing and visualization.

This entire study does not involve any primary data collection. It solely focuses on the secondary data collection using open access, internationally validated indicators. This clearly aligns with the established methodologies to compare health systems that rely on large-scale global datasets, which help us to identify structural patterns and benchmark health systems.

### 3.3 Indicator Selection, Evidence Foundations and Computational Methods:

The foundation of the analysis mainly consists of six globally recognized affordability and financial protection indicators from the World Bank's World Development Indicators (WDI). These indicators clearly showcase the economic burden of healthcare at both system and household levels:

- Per-capita health expenditure (US\$) – a measure of system cost intensity.
- Health expenditure as a percentage of GDP – reflecting macroeconomic weight.
- Out-of-pocket (OOP) expenditure share – reflecting direct household spending.
- Financial hardship due to OOP spending – reflecting affordability stress.
- Population impoverished due to OOP spending – capturing downward economic mobility.
- Population pushed into poverty by healthcare payments – capturing catastrophic vulnerability.

All these indicators (System Level, Household Level, Financial burden, poverty Impact) were selected because they clearly reflect the measurement of the economic pressures that the micro-clinics are designed to relieve, high care prices, and being reliant on the high-cost settings, as well as insufficient financial protection during day-to-day life for primary care encounters.

Computational methods used in Google Colab include:

- Data filtering and transformation
- Cross-country comparison
- Descriptive statistical analysis
- Visualization through bar charts and comparative graphs

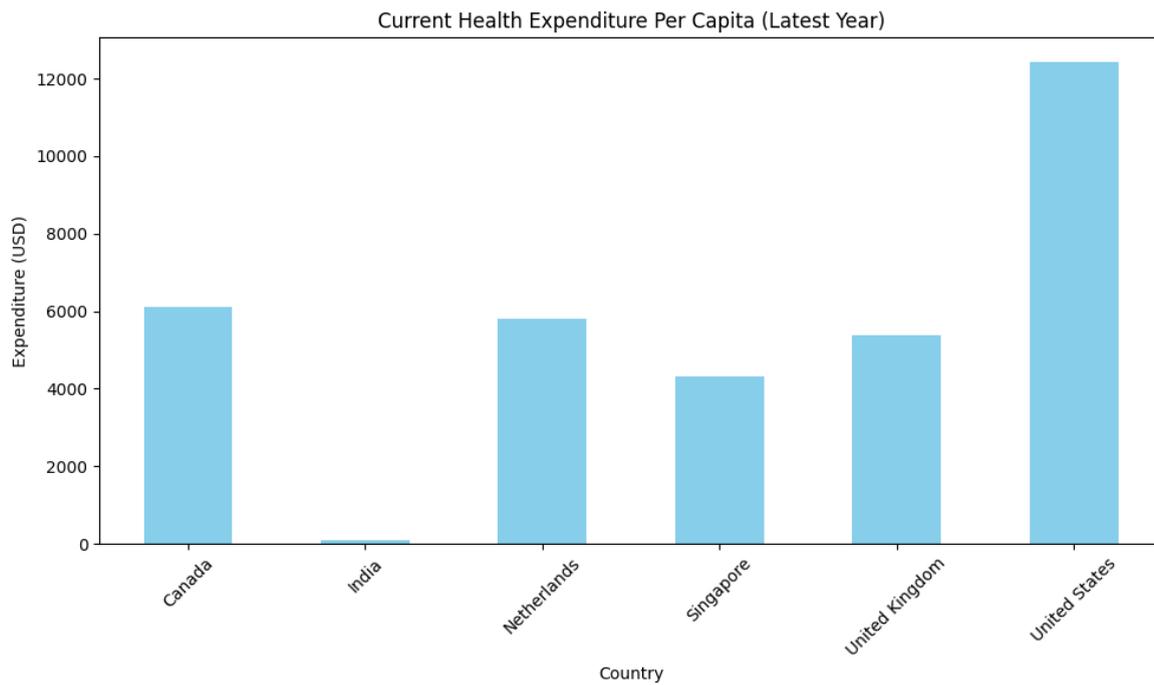
These computational methods are exploratory rather than experimental, which are appropriate for policy analysis and innovation modeling and the goal is to identify structural gaps and propose interventions.

### 3.4 Comparative Assessment and Interpretation

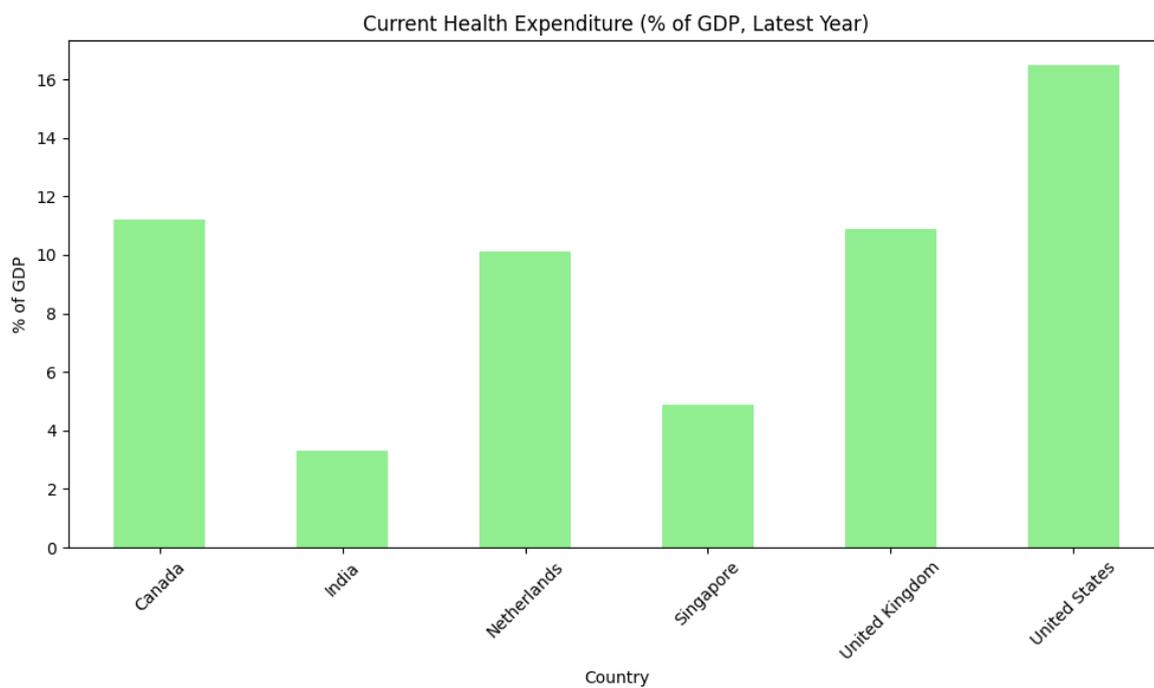
The analysis was both descriptive and comparative, and it clearly evaluates how each country performs on different parameters with the help of these indicators. This whole idea was to compare United States with other countries having proven low-cost primary care systems in their health sector. And comparing the indicators with them along with the United States. There is no intention to build a proactive or a casual model, but the primary goal is to clearly define structural pattern that explains why some of the health systems deliver low-cost primary care, but in contrast, others continue to struggle.

Visualizations produced from the dataset (Figures 1–6) enabled interpretation of each indicator:

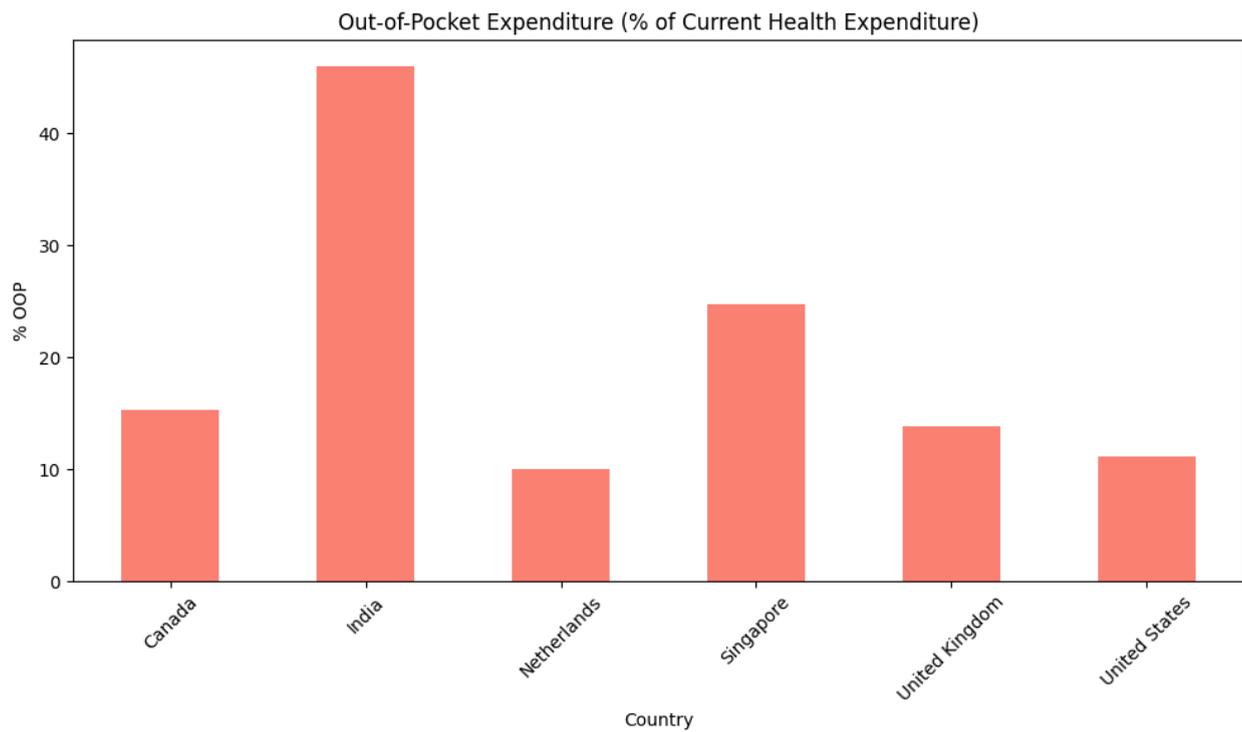
- Per-capita spending revealed U.S. cost escalation.
- GDP share highlighted macroeconomic inefficiency.
- OOP share and hardship metrics exposed household vulnerability.
- Impoverishment and poverty metrics revealed systemic exposure to catastrophic cost shocks.



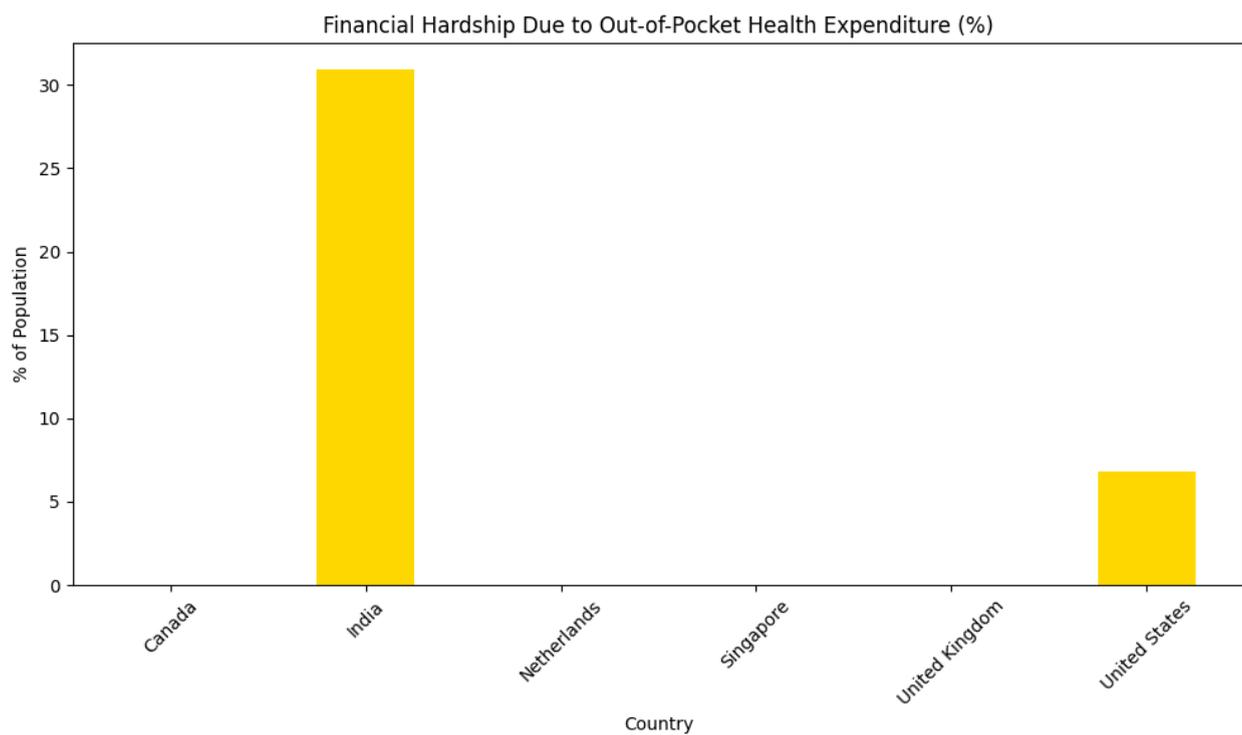
**Figure 1.** Cross-country comparison of current health expenditure per capita (US\$), highlighting the United States as a cost outlier among peer and reference countries.



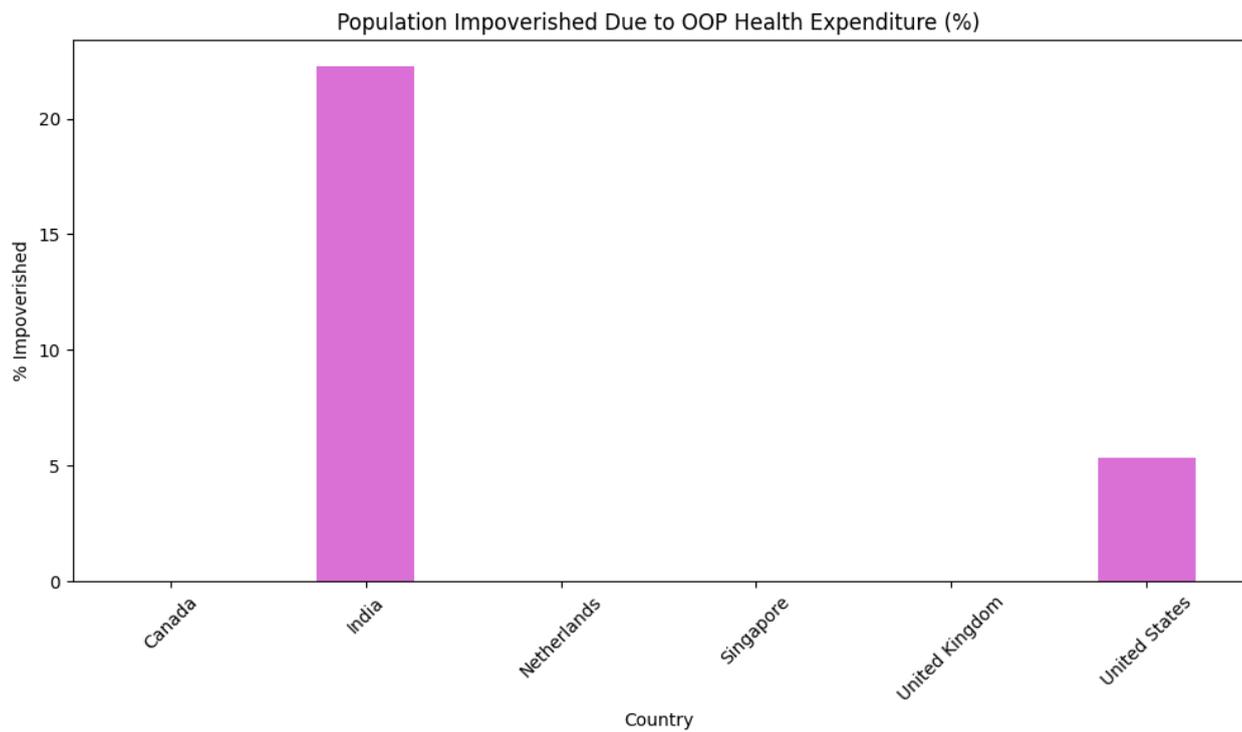
**Figure 2.** Health expenditure as a percentage of GDP across selected countries, illustrating the disproportionate economic burden of healthcare in the United States.



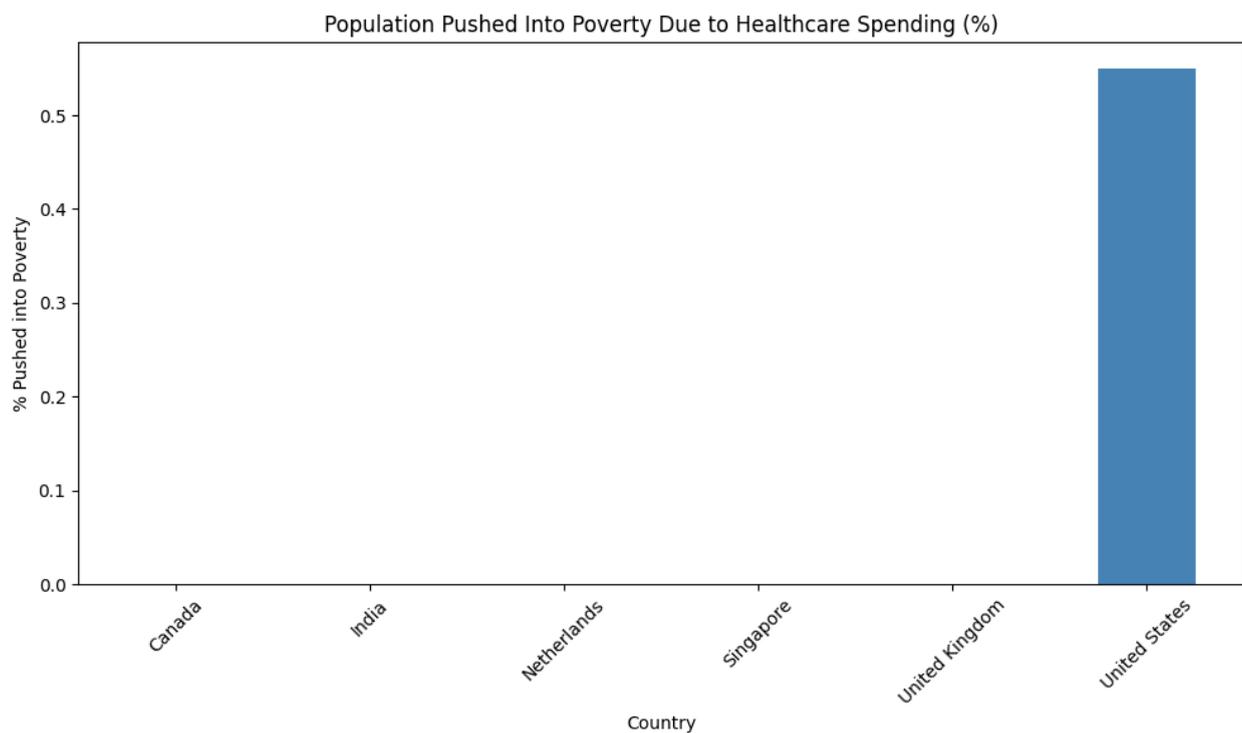
**Figure 3.** Out-of-pocket expenditure as a percentage of total health spending, showing variation in household cost-sharing across healthcare systems.



**Figure 4.** Proportion of the population is experiencing financial hardship due to out-of-pocket healthcare spending.



**Figure 5.** Population impoverished as a result of out-of-pocket healthcare expenditure across selected countries.



**Figure 6.** Proportion of the population pushed into poverty due to healthcare-related out-of-pocket spending.

Affordability & financial protection indicators (Top-ranked countries) — US highlighted

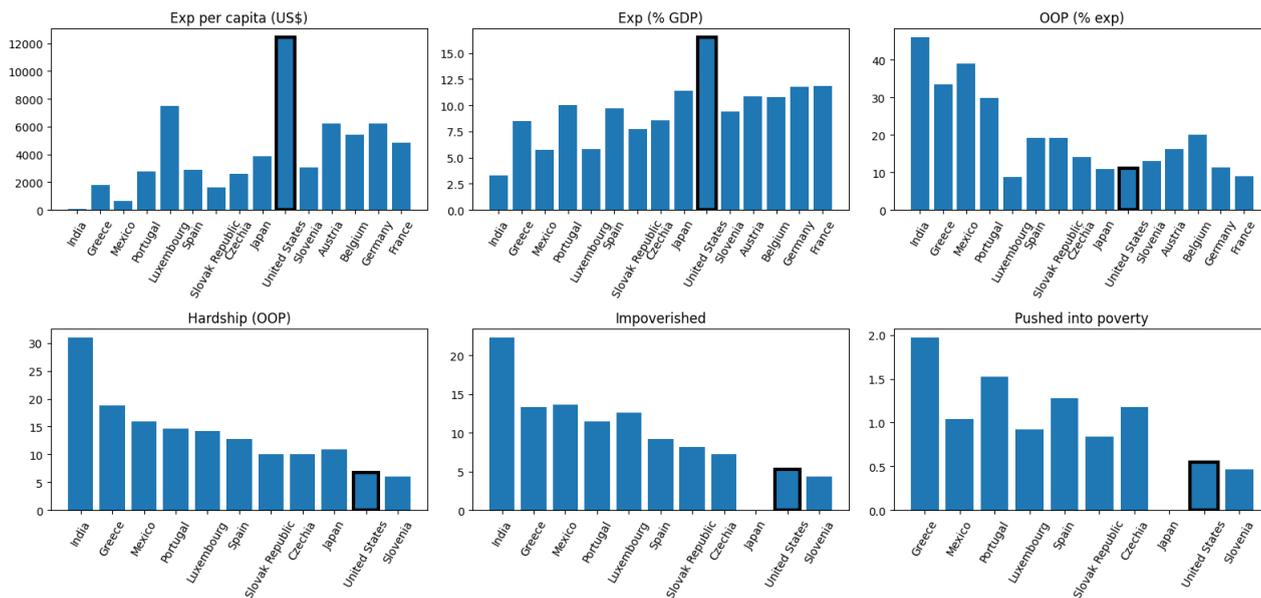


Figure 7. Affordability and Financial Metrics of Leading Countries: Spotlight on the United States.

Now with these insights, it is clearly identified that the modeling of micro-clinics clearly clarifies where the cost burden starts and which population is affected and how the breaking down access points could reduce the dependency for expensive care.

### 3.5 Micro-Clinic Conceptual Modeling Approach

The main concept involved here is to construct a micro-clinic operational model, which is grounded in empirical evidence and follows all the global health design principles. This conceptual framework synthesizes:

- Lessons from low-cost, high-efficiency systems (e.g., India’s community clinics),
- The cost-intensity profile revealed in U.S. expenditure metrics,
- The household vulnerability patterns seen in financial hardship indicators, and
- The structural gaps are highlighted by cross-country comparison.

The model mainly defines the micro-clinic as a local hospital which offers a flat fee for some of the basic treatments that are a part of a primary care and which is designed to deliver some of the essential services which include very minor injuries, some of the basic health care screenings and

clearly avoid things which are outside of health insurance. This entire framework follows basic staffing requirements, quality service, fixed flat fee pricing, integration of a small pharmacy and availability in locations closer to communities.

This entire strategy and framework is not at all a theoretical construction. It is clearly based on the evidence that this model is maintained and developed with proven efficiency

in the global healthcare systems, which directly encounters problems such as affordability, accessibility, and financial exposure.

The workflow of the micro-clinics can be described just like a story of a person having a minor cut in the process of cooking and rushing to a hospital without needing health insurance. The patient gets treated by the doctor in less than five minutes or with a minimal wait time with a valid hand written or an encrypted email prescription of drugs needed which can be picked up in the pharmacy that is integrated to the micro clinic or any other local pharmacy which is tied up to the micro clinic and the prescription follows all the global health standards which are needed with a clear authority or stamp with the doctor information and drugs that are needed for the patient. The payment is done based on the type of treatment instantly in the micro clinic immediately after the treatment and the

drugs which are prescribed by the doctor should be available in the pharmacy and as the drugs are prescribed by the doctor, the pharmacist should be able to sell them to the patient. The patient can pick up the drugs in any associated pharmacy by paying at the counter based on patient's financial status by following cheaper options. The pharmacies will have an option to sell the required number of drugs needed for the patient instead of selling the whole box that came from the manufacturer. This logic eliminates a huge complication of having an office visit via health insurance and getting the drugs based on the pharmacy that is tied to the Health Insurance Plan.

### 3.6 Methodological Positioning

By combining the comparison with the conceptual system design, this study moves beyond the traditional method of cost analysis towards the innovation that is driven by the research of health systems. The approach uses data not just to describe the problems but also to inform the architecture of a novel solution. That is, a nationwide micro clinic network which can deliver affordable, accessible care without the reliance on health insurance.

### 3.7 Limitations

This study relies on the WDI indicators, which may change in the coming years, or the completeness might be different. The results that are obtained identify different patterns but may not establish causal mechanisms. There are a lot of cross-country differences in cultural and structural variations that limit the direct comparison from system to system, but most of the analysis still provides a clear and meaningful directional insight. This micro clinic model is theoretically designed, but it also requires implementation, research, and some pilot studies and pilot projects. But apart from these limitations, the methodology provides a proven and rigorous evidence-informed foundation that is clearly suitable for innovation of this proposal and policy-informed research.

## 4. Results

Using the latest data from the World Bank Health Systems Indicators, this research clearly compared the healthcare affordability and the financial protection in the United States to that of other countries. The results clearly indicate that the United States is a clear outlier in terms of low-cost healthcare and household financial exposure, particularly

for primary care.

The United States has the highest per capita health expenditure among all the countries which are analyzed, exceeding \$12,000 annually, as shown in Fig. 1. which is a surprising fact when compared to other high-income countries such as Canada, the United Kingdom, the Netherlands, and Singapore. There exists a huge difference when measured as a share of GDP where the U.S. allocates the large amount of its economy to healthcare as shown in Fig. 2. The findings indicate that the United States is spending higher amount of money, which is more than the required amount.

The out-of-pocket (OOP) expenses when calculated for total health spending varies widely across different countries. As shown India demonstrates the highest OOP share, but whereas the United States is in the moderate range as shown in Fig. 3. However, this metric alone does not capture affordability. When you look at the financial hardship, impoverishment, and poverty, the United States shows a clear vulnerability as shown in Fig. 4 and Fig. 5 when measured in terms of household expenses in spite of having a widespread insurance coverage. One of the points to be noted is the United States is one of the few countries with very high income and high healthcare expenditure that continues to push some of the population into financial hardship, and in some cases, below the poverty line as shown in Fig. 6.

The results clearly demonstrate that people in the U.S. cannot afford unnecessary healthcare. This is because of high sticker price for doctor visits and minor illnesses. And it's just not the percentage they have to pay out of the pocket. Everything clearly indicates that we need different ways to deliver primary care. To synthesize these findings, a consolidated comparison of affordability and financial protection indicators across leading healthcare systems is presented, highlighting the United States' relative position across multiple parameters of cost and household burden as shown in Fig. 7.

## 5. Discussion

The findings show a significant contradiction in the U.S. healthcare system, which is the highest pending, coexists with continuous affordability and as well as the challenges in access to primary care. It is clearly evident that the United States spends more per person and more of its GDP

on healthcare than any other nation. This huge investment does not guarantee financial protection or efficient access for day-to-day medical needs. This persistent affordability challenge, particularly in the United States, reflects the structural inefficiencies identified in the comparative analysis as shown in Fig. 1 and Fig. 2.

A critical takeaway from the study is that the moderate out-of-pocket costs do not define affordability when the basic service fees is extremely high. In the US, even the people who are fully insured face financial stress when the care is delivered with high-cost settings in ER departments, or when hospital-affiliated clinics charge high amount for the services. This clearly explains why financial hardship and poverty are always non-zero in a high-income country and a country with many insured populations, which is a rare outcome when compared with other countries.

### 5.1 Why India Appears Higher in Some Indicators (and Why the U.S. Is Still the Focus)

India appears higher in some of the indicators, such as the out-of-pocket and the hardship metrics, because the system relies heavily on direct payments from people who have lower average income. But India has extremely low cost of care and its healthcare delivery is largely a decentralized and community-based system, which enables fast access to primary care at minimal cost. But on the other side of the coin, the United States exhibits affordability failures and it's just not because of the people paying larger costs but it's because of the price of the care, it is extraordinarily high. So, that is the reason why India is clearly compared as a structural reference for low-cost access models and not as an outcome benchmark. The U.S. always remains the central focus because it has high national wealth, extensive insurance coverage and continuous affordability breakdowns.

These results serve as the basis for the proposal of micro-clinic innovation. Micro-clinics address some of the specific weaknesses and drawbacks which are revealed by the data for over-reliance on high-cost care settings, lack of predictable pricing, and no access points for low-cost routine care. With a flat fee and walk-in primary care services which are established within the communities, people can divert away from the expensive facilities which in turn reduces the household financial exposure and this in turn improves health care access without much need in increasing the national health care spending.

### One-sentence validation:

The data confirms that the U.S. healthcare system is expensive in different ways and financially destabilizing for primary care needs and hence decentralized micro-clinic models offer a clear pathway to improve affordability without increasing national health spending.

## 6. Conclusion

The study demonstrates why the United States continues to experience affordability crisis in primary care, characterized by extreme cost intensity and the spending of the households, despite of having the insurance coverage. Cross-country analysis determines why countries with decentralized, community based primary care systems perform better in terms of low-cost primary care and offer greater accessibility without sacrificing essential services.

Addressing the research question—how decentralized, flat-fee micro-clinics can improve affordability, accessibility, and care efficiency for everyday medical needs in the United States—the findings indicate micro-clinics offer a very practical and scalable solution. Micro-clinics solve the problem of affordability by providing basic preventive care with a flat fee which directly reduce cost barriers while improving access at the community level. The benefit of not adding this to healthcare spending allows it to be shifted to a setting where cost, access, and efficiency are balanced equally.

The evidence presented in this study support micro-clinics as a pathway towards affordability, accessibility for primary care in the United States. Future research should focus on pilot implementations, regulatory integration, and the strategic use of digital and AI-enabled tools to enhance scalability and reach. As healthcare systems cannot afford any rising costs and access inequities, micro-clinics provide a simple blueprint for structural reform, which is grounded in empirical evidence.

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