OnMed®
Healthcare Anywhere.

Why Cost, Outcomes, and Workforce Stability All Converge Here, and Why Every Other Solution Depends on Getting This One Right

ONMED | THE ACCESS GAP | RESEARCH REPORT 2026



EXECUTIVE OVERVIEW

Across every sector of American healthcare from health system boardrooms and employer benefits offices, to university campuses, biopharma pipelines, and the kitchen tables of families drowning in medical debt—the same structural crisis keeps surfacing. A physician shortage, a cost crisis, deepening system fragmentation: each is real, and each absorbs enormous investment. But none of that investment delivers its full value until people can actually walk through the door.

This paper is about people. It is about what happens to a child who can't get care, a town that loses its hospital, a family destroyed by a bill that access would have prevented, a generation that never caught up. It builds—sector by sector, story by story—to a single conclusion: the front door to healthcare is the front door to everything. And it has been closed for too long.

ABOUT ONMED

OnMed is transforming how the world accesses healthcare. With its patented OnMed CareStation®, an 8×10 foot "Clinic-in-a-Box", OnMed delivers comprehensive, immediate care wherever people live, work, and learn.

The OnMed CareStation® is a tech-enabled, AI-powered, and human-delivered platform that blends the comprehensiveness of traditional in-person care with the rapid scalability of telemedicine. Each CareStation serves as a local access point within a scalable, connected grid that delivers everyday healthcare at scale.



SECTION 01 THE FRONT DOOR THESIS

You Can Renovate Everything Inside. But Without the Front Door, None of It Reaches the People Who Need It.

Think about a house. You can gut the kitchen. You can retile the bathrooms. You can repaint every room, install smart lighting, upgrade every appliance. You can put the most sophisticated, innovative, forward-thinking interior in the world inside those walls.

If there's no front door—if people cannot get in—every dollar spent inside delivers a fraction of its intended value. The investment still matters. The kitchen still works. But it only works for the people who can get to it.

This is American healthcare in 2026.

We have built extraordinary things behind the door. The finest medical training in the world. Nobel-winning research. Breakthrough therapies. AI-powered diagnostics. Gene therapies that were science fiction a decade ago. Surgical techniques so precise they border on miraculous. We have spent, collectively, more than any nation in history—more than $4.8 trillion annually—on the machinery of health.[1]

And for 120 million Americans—one in three—the door doesn't open.[2]

The other problems are real.
The front door is the one that makes them worse.

The physician shortage is real. Rising costs are real. Coverage complexity is real. Workforce burnout is real. But every one of these problems is compounded—sometimes catastrophically—by the access gap. When people can't get in, conditions escalate into the most expensive settings. Physician time gets consumed by non-emergent volume it was never meant to carry. Preventable costs become unavoidable ones. The access gap doesn't just create its own problems. It makes every other problem in healthcare harder, costlier, and less solvable. That is why access is not one variable among many. It is the variable every other solution depends on.

This report does not argue for any single policy fix. It does not take a partisan position on insurance or government spending. It makes a simpler, harder-to-dispute claim: every major failure mode in the American healthcare system—seen from the perspective of employers, payors, health systems, universities, schools, biopharma companies, and patients themselves—converges at the same structural breakdown.

The front door is missing.

And until we fix it, everything we build inside keeps failing the people it was built to serve.

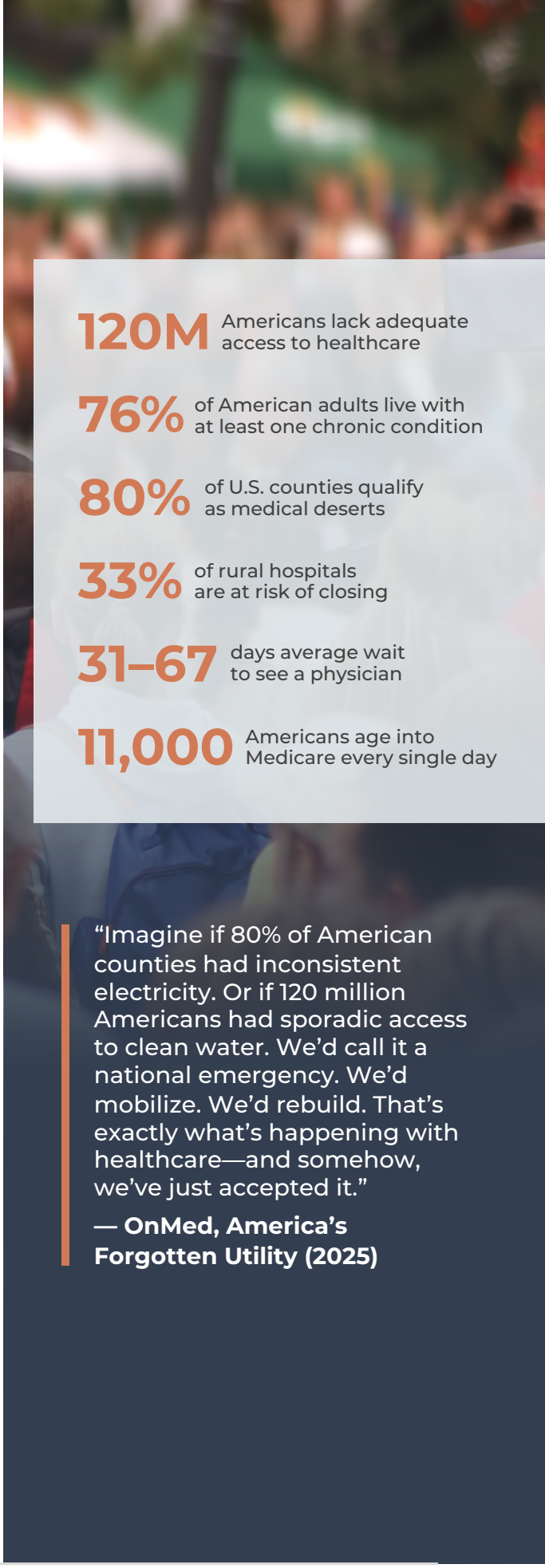
SECTION 02 THE SCALE OF THE CRISIS

120 million people. Nowhere to go.

The access crisis in American healthcare is not a fringe phenomenon. It is not confined to poor rural counties or uninsured populations. It is structural, pervasive, and accelerating, and it touches virtually every sector of the economy and every corner of the country.

The physician pipeline compounds the crisis. Fewer than 29,000 new doctors enter the workforce annually. Half of all currently practicing physicians are approaching retirement age. Nurse practitioner and PA pipelines are already stretched. Beyond the workforce shortage, the physical infrastructure is eroding: 44 million Americans live in a designated primary care shortage zone, and 28 million live more than 30 minutes from the nearest hospital. The gap between the care we need and the care we can deliver is not closing—it is widening. And the AAMC has calculated that if underserved populations had the same healthcare access as the rest of America, the U.S. would need 202,800 more physicians than it has today just to meet existing demand.[7] That number does not describe a future problem. It describes the scale of inequity that exists right now.

Meanwhile, the traditional solutions have hit their limits. Brick-and-mortar clinics cost $2–5 million to build and cannot serve the communities that most need them. Traditional telehealth—adoption still below 8%—cannot capture vitals, perform examinations, or deliver the diagnostic confidence that most clinical decisions require.[8] And 42 million Americans lack reliable broadband access, leaving them excluded from even that incomplete solution.[9]



120M Americans lack adequate access to healthcare

76% of American adults live with at least one chronic condition

80% of U.S. counties qualify as medical deserts

33% of rural hospitals are at risk of closing

31–67 days average wait to see a physician

11,000 Americans age into Medicare every single day

> "Imagine if 80% of American counties had inconsistent electricity. Or if 120 million Americans had sporadic access to clean water. We'd call it a national emergency. We'd mobilize. We'd rebuild. That's exactly what's happening with healthcare—and somehow, we've just accepted it."
>
> **— OnMed, America's Forgotten Utility (2025)**

SECTION 03 THE COST CASCADE

Access Failure Doesn't Save Money. It Defers It—With Interest.

There is a persistent myth embedded in American healthcare economics: that limiting access reduces cost. That when people don't go to the doctor, the system spends less. The data says otherwise—decisively and expensively.

When people cannot access care early, conditions escalate. A $25 antibiotic becomes a $5,000 hospitalization. A managed blood pressure check becomes a $150,000 stroke workup. A $200 chronic disease management appointment becomes a $40,000 readmission. The cost of untreated illness doesn't disappear—it compounds, defers to higher-acuity settings, and redistributes across the entire system in the form of emergency department overuse, preventable hospitalizations, lost productivity, and ultimately, medical debt.

$168B
wasted annually on non-emergent and avoidable ED use[10]

$320B+
lost annually to preventable complications from unmanaged chronic conditions[11]

220B
in medical debt currently held by American households[12]

The emergency department is the most expensive access point in the healthcare system—and it has become the de facto front door for tens of millions of Americans. Studies consistently show that 60–70% of ED visits are for non-emergent conditions: ear infections, UTIs, sinus infections, prescription refills, blood pressure checks.[13] These visits generate little or no reimbursement, consume disproportionate clinical resources, and do nothing to address the underlying access gap that sent the patient there in the first place.

Federal law requires hospitals to evaluate and treat anyone who arrives at the emergency department regardless of their ability to pay—and that mandate, however essential, means health systems absorb the cost of tens of millions of non-emergent visits every year. U.S. hospitals have absorbed nearly $745 billion in total uncompensated care costs since 2000, with the burden falling hardest on safety-net and rural institutions already operating on razor-thin margins.[14]

The Cost Deferral Equation

Every dollar not spent on accessible primary care generates approximately $4–7 in downstream costs through emergency intervention, hospitalization, specialist escalation, and chronic disease management. Access isn't an expense. It's the most cost-effective investment in the healthcare system—and the one we're currently refusing to make.

SECTION 04 THE EMPLOYER VERTICAL

A $575 Billion Problem Hidden in Plain Sight.

Employers are the largest single purchaser of healthcare in the United States, covering over 160 million Americans through workplace benefits. And the cost of that coverage has become one of the fastest-growing line items on the corporate balance sheet—with no sign of slowing down.

Employer healthcare spending has increased more than 50% over the last decade.[1] Average family premiums in employer-sponsored plans now exceed $23,000 per year—up from under $15,000 a decade ago. Claims costs have risen in lockstep, driven by the same access failure that defines every other sector of the crisis: employees who can't get timely primary care end up in urgent care, emergency departments, and specialist offices—the most expensive settings in the system—for conditions that early access would have caught, managed, or prevented entirely.

The Integrated Benefits Institute estimates that poor employee health costs U.S. businesses $575 billion annually in lost productivity alone—through absenteeism, presenteeism, and disability.[15] But for most CFOs, that figure is secondary to the one that shows up directly in the budget: the premium renewal that arrives every fall, 8–12% higher than last year, for a benefit that employees are using less because they can't afford the deductible.

50%+

increase in employer healthcare spending over the last decade—one of the fastest-growing corporate cost centers[21]

$23K+

average annual family premium in employer-sponsored health plans—up from under $15K a decade ago[21]

$575B

annual U.S. business loss from poor employee health in productivity alone—absenteeism, presenteeism, disability[15]

The Hidden Cost Centers Driving Claims Higher

The premium increase is the symptom. The claims pattern is the cause. And the claims pattern is almost entirely driven by access failure: employees who cannot get a primary care appointment in a reasonable timeframe end up in urgent care, emergency departments, and specialist offices—generating claims that are 3–12 times more expensive than the primary care visit that should have come first. Chronic conditions that go undetected or unmanaged until they reach acute thresholds. Mental health needs that go untreated until they generate disability claims. Preventive screenings that don't happen until something goes wrong.

Most employer healthcare analytics focus on what happened in claims. The more powerful question is what didn't happen—and why. The Monday morning where 12% of a shift doesn't show because they couldn't get a doctor's appointment last week. The high performer managing undiagnosed hypertension who works at 60% capacity for months before a cardiac event pulls them out entirely.

The employee with untreated anxiety who calls in sick, stays less engaged, and leaves within 18 months—taking $25,000 in replacement costs with them. None of these show up in a benefits report until it's too late. All of them are access failures. And all of them are driving the renewal number higher every year.

Gen Z and the Expectation Gap

Gen Z now represents the fastest-growing segment of the U.S. workforce, and they are reshaping what employees expect from workplace health benefits. Raised in a digital-first world, Gen Z expects speed, convenience, and transparency across every experience—including healthcare. They order food in minutes, stream anything instantly, and book services on demand. They bring those same expectations to care.

And they are making career decisions based on whether those expectations are met. Research shows that healthcare access quality is increasingly a factor in whether Gen Z employees join, engage with, and remain at an organization. Traditional benefits structures, a PPO card, an EAP number, a list of in-network providers—are not meeting the moment.[17]

The employers who solve access—who bring care on-site, remove friction, make wellness genuinely easy—will have a structural advantage in attracting and retaining the generation that will define the next two decades of the American workforce.

> **THE EMPLOYER ACCESS ROI**
>
> Employers who invest in on-site or near-site access infrastructure reduce the claims that drive premium increases: fewer avoidable ER visits, earlier chronic condition detection, improved medication adherence, reduced mental health disability claims, and lower absenteeism. The return is not theoretical—it shows up in the renewal. Access infrastructure is not a wellness perk. It is a claims management strategy with a direct line to the cost that keeps rising every year.



SECTION 05 THE PROVIDER VERTICAL

When the System Turns Against Its Own Builders.

Providers built the healthcare system. They trained for decades to staff it. They sacrificed more than most professions ask of anyone. And the access crisis is now consuming them.

Emergency departments—designed for true emergencies—have become the nation's primary care safety net. When a patient can't get an appointment for six weeks, can't afford an urgent care copay, or lives in a county without a single primary care physician, the ED is the only door that doesn't close. Federal law requires hospitals to evaluate and treat anyone who arrives at the emergency department regardless of their ability to pay and that mandate, however essential, means health systems absorb the cost of tens of millions of non-emergent visits every year. The math is brutal: 60–70% of ED visits are for non-emergent conditions,[13] consuming clinical bandwidth, generating uncompensated care costs, and creating the conditions for the burnout epidemic that now defines the medical profession.

63%
of physicians report burnout—the highest levels ever recorded

$500K–1M
average cost to replace a physician

$745B
in total uncompensated care costs absorbed by U.S. hospitals since 2000

Left-without-being-seen rates—the patients who arrive at an ED, wait, and leave without care—signal a system at capacity. Research shows that LWBS patients are disproportionately younger, female, and non-White, presenting with lower-acuity complaints that were entirely treatable. The majority of non-urgent ED visits are actually made by insured adults—patients with primary care providers who came because they had an acute need and no convenient alternative.[20]

Every patient who walks out without being seen doesn't just cost the system one visit. They represent a lifetime of care that shifts to a competitor or to no one—and the erosion of a relationship that should have been built.

> "This isn't a breakdown in care. It's a breakdown in access—and it demands a new blueprint."
>
> **— OnMed, Returning Emergency Departments to Emergency Medicine (2026)**

Beyond the ED, the access crisis creates a structural patient leakage problem for health systems that compounds annually. A patient who seeks care outside your network doesn't just cost you one specialist visit—they cost you every downstream encounter that care generates: imaging, labs, follow-up, interventional procedures, hospitalization. The lifetime value of a captured patient is enormous. The lifetime cost of a lost one compounds in a competitor's favor.

SECTION 06 THE PAYOR VERTICAL

Premiums Rising. Coverage Shrinking. Value Disappearing.

The American insurance market is caught in a paradox of its own making: the product it sells—health coverage is becoming simultaneously more expensive and less useful, because the thing that makes coverage valuable—access to care—is eroding beneath it.

Average family premiums in employer-sponsored health plans have increased over 47% in the past decade, now exceeding $23,000 per year.[21] Employee cost-sharing has risen alongside premiums, with average deductibles for individual coverage now exceeding $1,500 and family deductibles routinely surpassing $4,000–$5,000. The result is a population that technically has insurance—and practically cannot afford to use it.

23K+

Average annual family premium in employer-sponsored health plans[21]

$168B

Wasted annually on non-emergent and avoidable ED visits. Care that should have happened in a primary care setting[10]

41%

Of insured adults report delaying or skipping care due to cost[22]

The irony is sharp: payors are spending enormous amounts on the most expensive settings—emergency departments, urgent care chains, unnecessary specialist escalation—precisely because the least expensive settings are inaccessible. A non-emergent ED visit costs payors 10–12 times what the same care would cost in a primary care setting. $168 billion in avoidable ED costs flow through the system every year—not because patients want to be there, but because the front door to primary care is closed. When the only door that opens is the most expensive one, everyone pays for it.[10]

The Medicaid Unwinding and the Coming Surge

Between April 2023 and mid-2025, more than 25 million people were disenrolled from Medicaid during the post-pandemic coverage unwinding. Nearly 70% lost coverage for procedural reasons—not because they became ineligible, but because they couldn't navigate the renewal paperwork.[23] These individuals did not stop needing care. They stopped having coverage for it. The downstream costs are flowing toward emergency departments, public health systems, and the uncompensated care budgets of every safety-net hospital in the country.

Ongoing changes to Medicaid eligibility are projected to result in millions more losing coverage in the years ahead. For payors, for health systems, and for communities, this is not a policy abstraction. It is a patient surge arriving without a destination.

The Payor's Access Imperative

Payors who invest in access infrastructure—CareStation deployments at employers, in communities, at schools—reduce avoidable ER utilization, lower claims costs, improve medication adherence, enable earlier chronic condition intervention, and build member relationships that reduce churn. Access is not a member benefit. It is a claims management strategy.

SECTION 07 THE UNIVERSITY & CAMPUS VERTICAL

The Crisis No One Puts in the Brochure.

Across the country, university campuses are facing a quiet but escalating crisis. It doesn't show up in rankings. It doesn't make it into guidebooks. It rarely gets addressed in an admissions packet. But it is shaping the daily experience of millions of students in ways that affect their academic performance, their long-term health, and in the most serious cases, their lives.

The crisis is access—the growing gap between how much care students need and how much they can actually get. Respiratory illness, infections, skin conditions, STIs, chronic condition management, urgent care needs that arise at 10pm on a Tuesday—these are the physical health realities of campus life, and the existing infrastructure was not built to handle them at the volume and on the schedule that students actually need.

Students arrive on campus managing chronic conditions that were handled at home—by a parent who scheduled the appointments, filled the prescriptions, and knew the family doctor by name. That infrastructure disappears the moment they move into a dorm. Add congregate living, irregular sleep, inconsistent nutrition, and the physical stress of academic pressure, and you have a population with substantial ongoing medical needs—and shrinking access to care.

1:3,000–4K

counselor-to-student ratio at many major universities the same capacity problem exists on the physical health side[25]

<4 in 10

college students report actively flourishing, with health cited as a primary driver of that gap[24]

35%+

of college students experience moderate-to-severe depressive symptoms, compounding physical health outcomes[24]

Campus health models were largely designed for a different era: centralized facilities, business-hour availability, and a presumption that students could schedule appointments and navigate a system that sometimes feels more like a bureaucratic hurdle than a front door to care. That model is straining under the weight of current demand—not just on the mental health side, but across every dimension of student health.

Today's students—part of Gen Z—have grown up with on-demand everything. The students most likely to delay care are not indifferent to their well-being. They are unwilling to navigate a system that was not designed for them. That gap between expectation and experience is where early physical health problems quietly become serious ones.

> "Fewer than four in ten college students report actively flourishing—and health is a primary reason why. That is not a mental health statistic alone. It is a whole-person health statistic that starts with whether students can get care at all."
>
> **— OnMed, Returning Emergency Departments to Emergency Medicine (2026)**

Mental health compounds the physical health picture in ways that cannot be ignored—and OnMed's platform is expanding to address behavioral health directly. But the physical health access gap alone is severe enough to demand urgent attention: the student with an untreated ear infection who misses three days of class, the chronic asthma patient who can't get a refill without a week's wait, the athlete managing an injury without access to evaluation. These are not edge cases. They are the daily reality of campus health at institutions across the country.

South Carolina State University, Auburn University, Tuskegee University, the University of West Alabama—these institutions have recognized what the data makes undeniable: the campus health crisis is a retention crisis, an academic performance crisis, and an equity crisis, all rooted in the same physical access failure.[26]

SECTION 08 K–12 SCHOOLS & GENERATIONAL POVERTY

The Cycle That Starts in the Classroom.

There is a quiet truth living inside nearly every school system in America—one we feel every day but rarely say out loud. We are asking children to learn while their bodies, minds, and families are struggling to stay well.

We talk about test scores, graduation rates, teacher burnout, and workforce readiness as if they are separate challenges. As if another curriculum, another assessment, or another mandate will finally fix what's broken. But underneath all of it is the same root issue: access to healthcare—or the lack of it.

If a child isn't well, they can't focus. If they can't focus, they fall behind. If they fall behind, they disengage. And once that spiral begins, it doesn't stop at graduation. It follows students into adulthood, shaping income, health, stability, and opportunity for the rest of their lives. Healthcare access isn't adjacent to education. It is foundational to it.

26–28%

of U.S. students were chronically absent in 2022–2023—71% higher than pre-pandemic levels[27]

67%

of students cite illness as the primary reason for missing school—the #1 cause[28]

13.8M

school days missed annually due to asthma alone—the leading chronic disease cause of absenteeism[29]

Chronic absenteeism—missing 10% or more of the school year—is one of the strongest predictors of academic failure and dropout. Health is a major driver. A fever that lingers because care isn't easy to reach. A sore throat that turns into three missed days. An asthma flare that could have been managed earlier. A toothache that becomes unbearable. Individually, these feel small. Collectively, they change trajectories.

The Caregiver Connection

One of the most overlooked drivers of absenteeism has nothing to do with the child's health at all. It's the health of their caregiver. Research shows that caregiver illness and lack of healthcare access significantly increase student absenteeism, particularly in underserved and rural communities.[30] When a parent can't get care, can't miss work, or can't reliably manage transportation, children stay home even when they are well.

The Generational Loop

The connection between healthcare access and generational poverty is not metaphorical—it is documented, quantified, and devastating in its consistency. Children from low-income families face disproportionately high barriers to healthcare access, which leads to higher rates of untreated illness, higher absenteeism, lower academic attainment, and ultimately lower lifetime earnings. Lower earnings mean less ability to afford healthcare as adults. And the cycle continues into the next generation.

Breaking the cycle requires breaking the access barrier—not with willpower or policy aspiration, but with infrastructure that makes care available at the point of life, wherever that life is being lived. In the school. In the community center. In the workplace. In the places where people already are.

SECTION 09 BIOPHARMA & CLINICAL TRIALS

When the Best Medicine Can't Reach the Patient.

The U.S. drug development model has a structural problem—and it has nothing to do with the science. It has everything to do with the same access gap that runs through every other sector of American healthcare.

Fewer than 150 institutions drive the majority of clinical trial activity in the United States.[31] These are academic medical centers—world-class institutions concentrated in major metropolitan areas, serving a patient population that represents a fraction of the Americans who live with the conditions being studied. The result is a trial ecosystem that systematically excludes the 120 million Americans who lack adequate access to those centers: rural populations, communities of color, low-income patients, elderly individuals, and anyone living outside a major metro area with an academic hospital.

~1/3

of the U.S. population is effectively invisible to clinical trial data—the same populations who carry the highest chronic disease burden and need the drugs most[31]

$1.89B

spent annually on clinical trial patient recruitment—before a single drug reaches patients who need it[31]

30%+

average trial dropout rate—driven in large part by patients who cannot sustain access to AMC-based trial sites[31]

The industry spends $1.89 billion annually on patient recruitment and still can't find enough participants. Trials are delayed by an average of 6–9 months due to enrollment challenges, at a cost of $37,000–$40,000 per day in delayed revenue for a Phase III asset.[31] Dropout rates—driven in large part by access barriers to trial sites—average 30% and threaten data integrity and approval timelines.

The drugs that emerge from this system are tested on populations that don't represent the patients who will use them. Efficacy and safety data is skewed toward the populations who could most easily access trial sites—not toward the populations most likely to need the drug, most likely to respond differently, or most likely to experience adverse events. The science is exceptional. The access infrastructure is not.

> "The patients most likely to need a new drug are the least likely to be in the trial that proved it works. One third of the U.S. population—the same communities carrying the highest burden of chronic disease, the highest rates of health disparity, and the greatest unmet medical need—is generating none of the data that determines what gets approved, how it gets dosed, and who it's labeled for. That is not a diversity problem. It is a science problem."
>
> **— OnMed, The True Cost of the Clinical Trial Access Gap (2026)**

Post-approval, drugs that could be prescribed to broad populations remain underutilized because the primary care access points that would generate those prescriptions don't exist in the communities that need them. Real-world evidence from diverse, community-embedded populations would improve label expansions, pharmacovigilance, and payor negotiations. The access gap isn't just a public health problem for biopharma. It is a revenue problem.



SECTION 10 THE CHRONIC CONDITION CRISIS

Escalating. Undetected. And Entirely Preventable.

76% of American adults live with at least one chronic condition. Four in ten have two or more.[32] Chronic disease drives 90% of the $4.1 trillion in U.S. healthcare spending annually.[32] Heart disease, cancer, diabetes, COPD, obesity—these conditions are the dominant drivers of mortality, disability, healthcare cost, and quality of life decline in the United States. And they have one thing in common: most of them are either preventable, detectable early, or manageable—if care is accessible.

The cruel arithmetic of the access crisis is most visible in chronic disease. Hypertension, Type 2 diabetes, COPD, and early-stage cardiovascular disease often go undetected for years—not because patients are indifferent, but because they lack an accessible, low-friction point of entry into the care system. By the time these conditions present in an emergency department, they are often acutely decompensated, expensive to treat, and generating the kind of high-cost encounters that drive up system costs without improving outcomes.

80%

of CareStation users have no primary care provider—for many, this is the first time they have experienced care they can count on[33]

37%

return voluntarily—no reminders, no mandates, no prescriptions forcing the visit. In a system where urgent care follow-up is below 8%, trust built that return rate[33]

The window for intervention in chronic disease is wide—and systematically missed. Blood pressure that's been silently elevated for three years. A respiratory pattern suggesting early-stage COPD. Pre-diabetic glucose levels that could be reversed with early lifestyle intervention. These are not complex diagnoses requiring subspecialty expertise. They are conditions that a comprehensive primary care encounter—with vitals, screenings, and appropriate diagnostic tools—can identify and begin managing in a single visit.

The access gap doesn't just fail patients when they're sick. It fails them before they know they're sick. And that failure is where the most preventable costs in American healthcare accumulate.

The Detection Opportunity

When comprehensive, diagnostic-capable care is placed where people already are — at their employer, in their school, in their community — conditions are detected at the earliest, most manageable, least expensive stage. Every undetected hypertension patient found in a workplace CareStation is a potential stroke prevented. Every pre-diabetic identified before progression is a lifetime of insulin costs avoided. The value is not theoretical. It is measurable, per patient, per encounter.

SECTION 11 MEDICAL DEBT

The Bill That Arrives After the Access Fails.

Medical debt is the final insult of the access crisis. It is what happens when a person waits too long—because they couldn't get care sooner—and then receives care in the most expensive setting, at a point when their condition can no longer be ignored. The debt is not the cause of the crisis. It is the receipt.

Americans now carry more than $220 billion in medical debt—the leading cause of personal bankruptcy in the United States.[1][2] One in four Americans has skipped recommended medical care due to cost concerns.[3][4] In a bitter feedback loop, the debt itself becomes a barrier to future care: patients who have been financially devastated by a healthcare encounter are less likely to seek care in the future, less likely to fill prescriptions, and more likely to delay follow-up—creating the conditions for the next escalation.

$220B

medical debt held by American households—#1 cause of personal bankruptcy[1][2]

100M

Americans—nearly 41% of adults—carry some medical debt[1][2]

1 in 4

Americans have skipped recommended medical care due to cost concerns[3][4]

The demographics of medical debt track precisely with the demographics of access failure. Rural communities. Communities of color. Low-income households. People with chronic conditions. These are the same populations drowning in debt that was generated, in large part, by the cost multiplication that happens when access-deferred illness reaches emergency acuity.

Medical debt is not a financial literacy problem. It is not a personal responsibility failure. It is the predictable downstream consequence of a system that does not provide adequate access to affordable early care—and then charges catastrophic prices when the deferred illness can no longer wait.

SECTION 12 HEALTH DESERTS

When Geography Becomes a Death Sentence.

A healthcare desert is commonly defined as a rural area with insufficient providers. The reality is far more severe—and far more widespread. A medical desert is any area where population healthcare needs are partially or entirely unmet due to inadequate access or poor-quality care.

These gaps stem from shortages of clinicians, limited facilities, long wait times, high costs, or sociocultural barriers. And they exist everywhere—in rural Appalachia and in urban Miami, in farming communities and in the ZIP codes of cities with world-class hospitals that simply cannot be accessed without money, insurance, transportation, and time.

80%
Of U.S. counties qualify as medical deserts[3]

33%
Of rural hospitals are at risk of closing[35]

202,800
Additional physicians the U.S. would need today if underserved populations had the same access as everyone else—a measure of existing inequity (AAMC)[7]

The burden of health deserts falls most heavily on the most vulnerable. Diabetes rates are 30% higher among Native American and Latino populations compared to White Americans.[3] Six conditions account for 86% of excess mortality among Black Americans—most of them preventable with earlier detection and equitable access to care.[3]

Hospital closures accelerate the desert dynamic in rural communities. When the nearest hospital is 45 minutes away—and the nearest specialist is two states away—the practical reality is that people don't get care. Not because they don't want it. Not because they don't value their health. But because the infrastructure to deliver it doesn't exist where they live.

> "Underserved is underserved—no matter your ZIP code or your net worth. Sitting eight hours in an ER because your child has an ear infection. Missing a day's wages just to see a doctor. Driving two hours for urgent care. Living in a major city where getting an appointment is a months-long wait."
>
> **— OnMed, America's Forgotten Utility (2025)**

SECTION 13 THE FRONT DOOR SOLUTION

The CareStation Is the Front Door.

Every argument in this paper converges at a single question: what does the front door look like?

It cannot be a brick-and-mortar clinic. Those cost $2–5 million to build, take years to open, and serve only the geography immediately around them. They cannot scale to meet the demand of a 120-million-person access crisis.

It cannot be traditional telehealth. With adoption below 6%, no ability to capture vitals or perform examinations, and 42 million Americans without reliable broadband, telehealth can expand communication—but it cannot deliver the clinical confidence most care decisions require.

The front door has to be different. It has to be deployable anywhere—at the employer, the school, the senior center, the hospital waiting room, the rural community with no clinic for 60 miles. It has to be diagnostically capable—not a symptom screener, but a real clinical environment with the tools to evaluate, diagnose, and treat. It has to be human-delivered—because healthcare requires trust, and trust requires human connection. And it has to scale—to the 120 million people who need it, in the communities where they actually live.



The OnMed CareStation®: A Clinic-in-a-Box

The OnMed CareStation® is an 8×10 foot, permanently-installable, tech-enabled, AI-powered, human-delivered clinical environment that can be deployed anywhere with an electrical outlet—in 45 days. It combines medical-grade diagnostic instruments (digital stethoscope, HD camera, thermal imaging, pulse oximetry, blood pressure monitoring), a 55-inch life-size display connecting patients to licensed clinicians in real time, and AI-enabled clinical decision support. It requires no construction, no permanent staffing, and no broadband-only connectivity—it operates on dual broadband and satellite to serve even the most underconnected communities.

The results are not theoretical. The CareStation has a 4.96 out of 5 patient satisfaction score. 86% of patients are fully diagnosed and treated without escalation. 80% have no primary care provider—for many, this is the first time they have experienced care they can count on. And 37% return voluntarily—no reminder, no mandate, nothing forcing their hand. That number is built entirely on trust.[33]

That 37% voluntary return rate—consistent across rural, suburban, and urban settings, across demographic groups, across clinical contexts—is not the return rate of a stopgap. It is what happens when people feel genuinely cared for. In a healthcare system where urgent care follow-up is below 8%, where retail clinic chains have shuttered nationwide after failing to earn continuity, the CareStation's 37% is not just a metric. It is proof of something the system has struggled to build for decades: trust.

SECTION 14 CONCLUSION

The Access Imperative. There Is No Other Lever.

We have spent decades and trillions trying to fix American healthcare from the inside—and much of that work has real value. Better technology. Better clinical protocols. Better insurance products. Better billing systems. Better outcomes metrics. Better training. These things matter. The kitchen is extraordinary.

But the argument of this paper is not that the inside doesn't matter. It is this: every major problem in American healthcare—rising costs, soaring premiums, escalating chronic disease, crushing medical debt, workforce burnout, generational poverty, failed drug trials, crumbling university health systems, empty rural hospitals—is made measurably, demonstrably worse by the same structural failure. People cannot get in. The conditions they carry escalate. The care they eventually receive costs more. The physicians who provide it burn out faster. The system that built all of that extraordinary infrastructure inside delivers it to a fraction of the people it was built to serve.

OnMed is building that infrastructure. One CareStation at a time, in employers and schools and rural communities and hospital waiting rooms and campus health centers and correctional facilities and senior centers and airports. In every ZIP code that has been told, for decades, that care is coming—just not yet, just not here, just not for you.

The front door doesn't fix the physician shortage on its own. It doesn't restructure insurance markets or reprice drugs. But it changes what every other solution can accomplish, because it determines who those solutions can actually reach. A physician who isn't buried under non-emergent volume can practice at the top of their license. A payor no longer drowning in avoidable ED costs has room to invest in preventive infrastructure. A biopharma company with access to 120 million previously unreachable patients can run better science. Every solution in healthcare gets more effective when the access gap closes. And many of them remain severely limited until it does.

> "Access is not a feature of healthcare. It is the variable every other solution depends on. When people can reliably enter care through a consistent, trusted access point, everything downstream works better—the physician shortage hurts less, the chronic disease burden shrinks, the costs come down. Without that first step, every promise in healthcare is made to people who can't get through the door."
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> **— OnMed, The Platform Where Healthcare, Intelligence, and Humanity Converge (2026)**



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