Medical and Health Studies

Medical and Health Sciences
Volume 1, Issue 1, Mei 2026
E-ISSN : xxx-xxxx
ellpub

Digital Primary Care, Chronic Disease Management, and Health System Resilience: A Comparative Public Health Analysis of Telemedicine Integration in Canada and South Korea

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Citation: Aziz (2026). Digital Primary Care, Chronic Disease Management, and Health System Resilience: A Comparative Public Health Analysis of Telemedicine Integration in Canada and South Korea (Book Antiqua 14pt Bold). *Medical and Health Studies*, *10*(4), xx–xx. https://doi.org/0000-0000

Published: 12/05/2026

ABSTRACT

Digital health has become a major institutional and clinical strategy for improving healthcare access, chronic disease management, and health system resilience. This study examines how telemedicine integration influences primary care accessibility, patient engagement, treatment continuity, and chronic disease outcomes through a comparative public health analysis of Canada and South Korea. The article argues that telemedicine effectiveness depends not merely on technology availability but on healthcare governance, reimbursement policy, digital infrastructure, clinical workflow integration, data interoperability, patient trust, and equity-sensitive implementation. Using comparative health systems analysis, epidemiological interpretation, digital health policy review, and evidence-based synthesis, the study evaluates two advanced but institutionally distinct health systems. Canada represents a publicly financed, provincially administered system with strong primary care orientation but persistent geographic access barriers, while South Korea represents a technologically advanced, insurance-based system with high digital infrastructure capacity and historically cautious telemedicine regulation. The findings indicate that digital primary care can improve continuity for chronic disease management when integrated with clinical governance, remote monitoring, patient education, and equitable access strategies. However, digital interventions may widen disparities when older adults, rural communities, low-income groups, and digitally excluded patients face barriers to use. This article contributes to medical and health sciences scholarship by integrating epidemiology, health systems

governance, behavioral medicine, digital health implementation, and chronic disease management into a comparative framework.

Keywords: telemedicine; digital health; primary care; chronic disease management; health systems; Canada; South Korea; health equity; patient engagement; public health resilience

INTRODUCTION

Health systems worldwide are confronting a dual challenge: the rising burden of chronic non-communicable diseases and the institutional need to deliver accessible, continuous, and financially sustainable care. Cardiovascular diseases, diabetes, chronic respiratory diseases, cancer, and mental health conditions account for substantial morbidity, mortality, disability, and healthcare expenditure globally (WHO, 2024). At the same time, population aging, workforce shortages, geographic inequities, pandemic disruptions, and increasing patient expectations have intensified pressure on primary care systems (OECD, 2023; World Bank, 2023). These developments have accelerated interest in digital health and telemedicine as tools for extending care beyond conventional facility-based encounters.

Digital health refers to the systematic use of information and communication technologies, data systems, mobile devices, teleconsultation platforms, remote monitoring, artificial intelligence, and electronic health records to improve health services and population outcomes (WHO, 2021). The World Health Organization's global strategy on digital health emphasizes that digital technologies should strengthen health systems rather than operate as isolated technological projects (WHO, 2021). The World Bank similarly argues that health systems must move from narrow "e-health" projects toward "digital-in-health" transformation, where data and technology are embedded across financing, service delivery, governance, and public health functions (World Bank, 2023). OECD evidence also indicates that digital readiness depends on data availability, interoperability, institutional trust, and the capacity to use information for clinical care, health system management, and research (OECD, 2023).

Telemedicine became especially prominent during the COVID-19 pandemic, when many countries used remote consultations to maintain care continuity while reducing infection exposure. However, the post-pandemic question is no longer whether telemedicine can substitute temporarily for in-person care, but how it can be institutionally integrated into routine healthcare delivery without compromising quality, safety, equity, continuity, or clinical accountability. This question is particularly relevant for chronic disease management, where patients require repeated monitoring, medication adjustment, lifestyle counseling, self-management support, and timely escalation when clinical deterioration occurs.

Canada and South Korea provide analytically valuable comparative cases. Canada has a publicly financed universal healthcare system administered largely by provinces and territories. Its geography creates persistent access barriers for rural, remote, and northern populations, while primary care shortages and long waiting times remain significant institutional challenges (OECD, 2023). Telemedicine therefore offers potential to improve access and continuity, especially for chronic disease patients requiring frequent

monitoring. South Korea has a national health insurance system, high broadband penetration, advanced digital infrastructure, and strong hospital capacity, yet telemedicine policy has historically been cautious due to regulatory concerns, professional resistance, patient safety debates, and institutional protection of conventional care models (Kim et al., 2021; OECD, 2023). Comparing these systems allows analysis of how governance, infrastructure, reimbursement, clinical culture, and digital readiness shape telemedicine outcomes.

The academic and healthcare problem is both theoretical and practical. Telemedicine is frequently discussed as an innovation that increases access, but access is not equivalent to effective care. A video consultation may reduce travel time yet fail to improve outcomes if clinical data are unavailable, remote monitoring is absent, patient self-management is weak, or follow-up pathways are fragmented. Conversely, digital primary care may improve chronic disease outcomes when linked to evidence-based protocols, electronic records, multidisciplinary teams, medication management, and behavioral support. Therefore, telemedicine should be conceptualized as a health system intervention rather than a communication technology.

Existing medical and public health literature provides important but incomplete insights. Greenhalgh et al. (2020) argue that remote care must be evaluated within clinical context, relational continuity, and safety governance. Bashshur et al. (2020) emphasize that telemedicine can support chronic disease care when integrated into broader service delivery models. Omboni et al. (2020) demonstrate that telemedicine and remote monitoring can improve hypertension management through better blood pressure surveillance and feedback. Eberly et al. (2020) show that telemedicine uptake may reproduce inequities when digital access differs by age, race, income, and language. Other medical scholars argue that digital health interventions improve patient engagement only when they are acceptable, usable, and aligned with behavioral change mechanisms (Michie et al., 2011; WHO, 2024).

Health systems scholarship adds institutional complexity. Kruse et al. (2021) identify reimbursement, privacy, workflow integration, clinician acceptance, and digital literacy as recurrent barriers to telemedicine adoption. Shaw et al. (2018) argue that digital health implementation requires attention to infrastructure, organizational readiness, policy alignment, and professional practice. The OECD (2023) emphasizes that digital health readiness depends not only on technical platforms but on governance frameworks capable of linking data across health settings. While previous studies emphasize the clinical effectiveness of telemedicine for selected conditions, current health sciences literature fails to adequately explain how institutional governance mediates the relationship between telemedicine adoption and chronic disease outcomes across different healthcare systems.

Several gaps remain. First, the theoretical gap lies in the tendency to treat telemedicine as a technological intervention rather than a governance-mediated care transformation. Second, the empirical healthcare gap concerns limited comparative evidence explaining why telemedicine produces stronger results in some systems than others. Third, the comparative clinical gap concerns insufficient analysis of chronic

disease management across systems with different financing, primary care structures, and regulatory histories. Fourth, the institutional governance gap concerns the limited integration of reimbursement policy, data interoperability, privacy regulation, and workforce capacity into clinical interpretation. Fifth, the public health implementation gap concerns the persistent risk that digital health may widen inequities if vulnerable populations lack devices, connectivity, digital literacy, or culturally appropriate support.

The novelty of this article lies in its interdisciplinary integration of epidemiology, primary care medicine, behavioral health, health systems governance, and digital health implementation science. Unlike descriptive telemedicine studies, this article conceptualizes digital primary care as a multilevel intervention linking institutional policy, clinical workflow, patient behavior, and population health outcomes. It compares Canada and South Korea to identify how different health system architectures shape telemedicine accessibility, chronic disease management, and equity.

The analytical framework follows the causal pathway: healthcare governance → digital service accessibility → patient engagement and behavioral adaptation → treatment continuity → clinical and population health outcomes. Telemedicine improves outcomes when governance enables reimbursement, privacy protection, interoperability, clinical accountability, and equitable access. Patient engagement mediates effectiveness because chronic disease management depends on adherence, self-monitoring, lifestyle behavior, and communication with clinicians. Institutional capacity moderates outcomes because weak data systems or fragmented care pathways reduce clinical utility.

This study aims to analyze comparatively how telemedicine integration in Canada and South Korea influences primary care accessibility, chronic disease management, patient engagement, healthcare equity, and health system resilience.

METHODOLOGY

This study employs a comparative health systems research design integrating epidemiological interpretation, digital health policy analysis, chronic disease management theory, and evidence-based healthcare evaluation to examine how telemedicine integration influences primary care access and chronic disease outcomes in Canada and South Korea. These countries were selected because they represent advanced but institutionally distinct health systems: Canada combines universal public financing with provincial governance and significant geographic access challenges, whereas South Korea combines national health insurance, high digital infrastructure capacity, dense hospital networks, and historically cautious regulation of remote care. The unit of analysis consists of telemedicine-enabled primary care and chronic disease management systems, with analytical variables including service accessibility, reimbursement policy, digital infrastructure, clinical workflow integration, electronic health record interoperability, patient engagement, continuity of care, medication adherence, remote monitoring capacity, provider acceptance, privacy governance, health equity, and chronic disease outcome pathways. The theoretical-methodological alignment draws on health systems theory, chronic care models, behavioral medicine, and implementation science to explain how institutional conditions shape the clinical effectiveness of digital health

interventions.

The empirical foundation consists of peer-reviewed medical and public health literature, WHO digital health guidance, OECD health system indicators, World Bank digital-in-health reports, national health policy documents, telemedicine implementation studies, and chronic disease management evidence. No patient-level data, interviews, or identifiable clinical records were used; therefore, the study does not fabricate clinical observations or individual patient experiences. Comparative analysis was conducted through structured synthesis of institutional evidence, clinical outcome literature, and public health implementation research. Triangulation was achieved by comparing international health reports with peer-reviewed studies and national policy evidence, while validation was strengthened by prioritizing convergent findings across multiple evidence streams. Ethical considerations include attention to privacy, data protection, digital exclusion, clinical safety, and equity in access to care. The study is limited by heterogeneity in telemedicine definitions, variation in national data systems, and uneven availability of post-pandemic outcome measures, but it provides analytically transferable insights into digital primary care governance and chronic disease management.

Findings and Discussion

1. Healthcare Governance and Institutional Conditions for Telemedicine Integration

The comparative evidence demonstrates that telemedicine effectiveness depends strongly on healthcare governance. Canada and South Korea both possess advanced healthcare infrastructure, but their institutional conditions for telemedicine integration differ substantially. Canada's universal health system provides a strong normative basis for equitable access, yet its decentralized provincial governance produces variation in telemedicine reimbursement, platform adoption, data integration, and service availability. South Korea has strong national insurance capacity and advanced digital infrastructure, but telemedicine adoption has historically been constrained by regulatory caution, concerns about patient safety, and opposition from parts of the medical profession.

In Canada, telemedicine expanded rapidly during the COVID-19 pandemic, supported by temporary billing codes, remote consultation reimbursement, and urgent need to maintain care continuity. The institutional advantage was that public financing could incorporate virtual visits relatively quickly once billing mechanisms were established. However, decentralization created uneven implementation across provinces and territories. Rural and remote communities benefited from reduced travel burden, but digital access depended on broadband availability, local provider capacity, and integration with existing primary care relationships.

In South Korea, digital infrastructure is highly advanced, and population-level internet access is strong. Nevertheless, telemedicine policy historically developed more cautiously because the healthcare system is institutionally shaped by dense in-person service availability, hospital competition, and strong professional regulation. During emergency conditions, remote care became more visible, but long-term integration required regulatory negotiation. This illustrates that technological readiness does not automatically produce institutional adoption.

The comparison demonstrates that telemedicine integration requires alignment between financing, regulation, clinical accountability, infrastructure, and professional legitimacy. Canada's strength lies in universal coverage and geographic need, but weaknesses include fragmented data systems and provincial variation. South Korea's strength lies in digital readiness and insurance infrastructure, but weaknesses include policy caution and institutional resistance.

These findings are consistent with WHO guidance emphasizing that digital health must be embedded within health system governance rather than implemented as isolated technology (WHO, 2021). They also align with OECD findings that digital health readiness depends on interoperability, governance, and data use capacity (OECD, 2023). This study extends prior scholarship by showing that governance mediates clinical effectiveness: telemedicine improves care only when institutional structures make it accessible, reimbursable, safe, and clinically integrated.

Clinically, the implication is that virtual care should not operate parallel to primary care but as part of coordinated chronic disease management. Public health policy should focus on payment stability, quality standards, privacy regulation, interoperability, and equity safeguards.

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2. Chronic Disease Management, Patient Engagement, and Behavioral Adaptation

Chronic disease care depends on repeated monitoring, medication adherence, behavioral modification, timely clinical review, and patient self-management. Telemedicine can strengthen these processes by reducing travel barriers, enabling frequent follow-up, supporting remote monitoring, and improving communication between patients and providers. However, its effectiveness depends on patient engagement and behavioral adaptation.

In Canada, telemedicine has particular relevance for patients living in rural, remote, and northern communities where primary care access may require long travel distances. For patients with diabetes, hypertension, chronic obstructive pulmonary disease, and heart failure, remote consultations can improve follow-up continuity and reduce missed appointments. However, patients without stable internet, private space, digital literacy, or an ongoing primary care provider may experience limited benefit.

In South Korea, telemedicine can leverage high digital infrastructure and strong population familiarity with mobile technology. Digital monitoring for blood pressure, glucose, and lifestyle behaviors may support chronic disease management if integrated with clinical protocols. However, strong reliance on hospital-based care may complicate primary care-centered digital management unless institutional reforms strengthen continuity and prevention.

The clinical evidence suggests that telemedicine is most effective when combined with structured disease management rather than used as an episodic consultation substitute. For hypertension, remote blood pressure monitoring with clinician feedback can improve blood pressure control compared with usual care in some contexts (Omboni et al., 2020). For diabetes, digital self-management tools may improve glycemic monitoring and patient engagement when supported by education and clinician response pathways (WHO, 2024). For heart failure, remote

monitoring may reduce decompensation risk when alerts lead to timely clinical action (Bashshur et al., 2020).

Behavioral medicine is central because chronic disease outcomes depend on daily patient actions. Telemedicine can reduce friction in care, but it cannot automatically produce adherence. Patient motivation, health literacy, trust, social support, and perceived usefulness influence whether digital tools are used consistently. This aligns with behavioral change theory, which emphasizes capability, opportunity, and motivation as determinants of health behavior (Michie et al., 2011).

The comparative evidence indicates that Canada's telemedicine challenge is equitable access and continuity across geography, while South Korea's challenge is institutional integration into chronic care pathways. Both systems require digital health models that include patient education, remote monitoring, clinician feedback, medication management, and escalation protocols.

Public health implications include the need to evaluate telemedicine using outcome indicators beyond visit counts. Metrics should include blood pressure control, HbA1c change, medication adherence, avoidable hospitalizations, patient-reported access, continuity, and equity.

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3. Comparative Matrix of Healthcare Governance, Clinical Intervention, and Health Outcomes

Table 1. Comparative Matrix of Healthcare Governance, Clinical Intervention, and Health Outcomes

Variable	Case 1: Canada	Case 2: South Korea	Empirical Evidence	Analytical Interpretation
Healthcare governance model	Publicly financed, provincially administered universal system	National health insurance with strong digital infrastructure and dense service networks	OECD health system indicators; national policy evidence	Governance structure shapes telemedicine financing and implementation
Primary telemedicine rationale	Geographic access, continuity, rural and remote care	Digital innovation, efficiency, emergency response, chronic monitoring potential	WHO and OECD digital health reports	Health system needs differ despite shared digital potential
Reimbursement and regulation	Expanded during pandemic with provincial variation	Historically cautious, gradually expanded under emergency and policy debate	Policy and implementation studies	Payment stability determines sustainability

Chronic disease mechanism	Improves follow-up access and reduces travel burden	Supports monitoring and data-driven management if integrated into care pathways	Telemedicine chronic disease literature	Clinical benefit depends on workflow integration
Equity risk	Rural broadband gaps, older adults, low-income and Indigenous communities	Older adults, low-income groups, privacy concerns, provider acceptance	Digital divide and public health evidence	Digital access must be treated as health equity infrastructure
Data interoperability	Variable across provinces and providers	Strong digital capacity but integration depends on governance rules	OECD digital readiness evidence	Data linkage is essential for safe chronic care
Clinical outcome pathway	Better continuity may improve adherence and prevent complications	Remote monitoring may improve control if linked to clinician response	Evidence from hypertension, diabetes, and heart failure studies	Telemedicine effectiveness is mediated by patient engagement
Public health implication	Strengthen equitable virtual primary care and broadband access	Institutionalize safe telemedicine within chronic care governance	WHO and World Bank digital-in-health strategy	Digital health must be embedded in health system strengthening

The table demonstrates that telemedicine is shaped by institutional variation rather than technology alone. Canada's telemedicine model is driven by access gaps and geographic inequity. South Korea's model is shaped by digital capacity and regulatory caution. In Canada, digital primary care may be most valuable for improving access and continuity in underserved regions. In South Korea, digital health may be most valuable when integrated into structured chronic disease monitoring and preventive care.

Analytically, the table reveals that telemedicine has multiple causal pathways. It may improve outcomes by reducing distance barriers, increasing contact frequency, supporting self-monitoring, improving data availability, or reducing system congestion. However, these pathways require different institutional supports. Reducing travel barriers requires broadband and reimbursement. Improving chronic disease control requires remote monitoring and clinician response protocols. Reducing inequity requires digital inclusion and culturally appropriate care.

This interpretation extends previous telemedicine literature by connecting clinical mechanisms with health system governance. Studies that evaluate telemedicine as a single intervention may miss why outcomes differ across populations and countries. The same digital consultation platform can produce different results depending on payment, data systems, provider incentives, and patient support.

Clinical implications include the need for risk stratification. Low-risk follow-up visits, medication reviews, and stable chronic disease monitoring may be appropriate for telemedicine, while new symptoms, complex diagnostic uncertainty, or physical examination needs may require in-person care. Public health implications include the need for hybrid models that preserve access while avoiding unsafe substitution.

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4. Health Equity, Digital Exclusion, and Social Determinants of Telemedicine Use

The comparative evidence indicates that digital health can either reduce or widen health inequities. Telemedicine reduces barriers for some patients, but creates new barriers for others. Digital exclusion may occur through lack of internet access, limited devices, low digital literacy, language barriers, disability, cognitive impairment, privacy constraints, and distrust of digital systems.

In Canada, equity concerns are pronounced for rural and remote communities, Indigenous populations, older adults, low-income households, and patients without regular primary care. Telemedicine may reduce travel burden but cannot compensate for inadequate broadband, limited local clinical capacity, or structural barriers rooted in colonial and geographic inequities. Therefore, virtual care must be accompanied by infrastructure investment and community-centered service design.

In South Korea, high connectivity reduces some access barriers, but digital exclusion remains relevant for older adults, socially isolated individuals, and patients requiring complex care. Privacy concerns and trust in remote diagnosis may also influence use. Furthermore, if telemedicine is implemented mainly through market-oriented platforms, inequities may emerge between patients who can navigate digital services and those requiring assisted access.

This finding aligns with Eberly et al. (2020), who showed that telemedicine uptake can reflect social inequities. It also aligns with Marmot's social determinants framework, which emphasizes that health outcomes are shaped by social conditions rather than medical services alone (Marmot, 2005). Digital health must therefore be examined as part of social infrastructure.

The theoretical implication is that access should be conceptualized multidimensionally. Geographic access, financial access, digital access, cultural access, and clinical access are distinct but interacting dimensions. A patient may have insurance coverage but lack digital literacy; another may have a smartphone but no private space for consultation.

Public health policy should therefore include digital navigators, community telehealth hubs, multilingual

platforms, accessibility standards, device support, broadband investment, and culturally safe care. Clinical systems should avoid assuming that telemedicine is universally preferred or appropriate. Equity-sensitive triage is essential.

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5. Health System Resilience, Quality Governance, and Post-Pandemic Digital Transformation

Health system resilience refers to the capacity to absorb shocks, maintain essential services, adapt institutional processes, and transform in response to changing population needs. Telemedicine contributed to resilience during the pandemic by allowing continuity of care when in-person visits were disrupted. The post-pandemic challenge is to convert emergency adoption into sustainable, quality-governed digital primary care.

Canada's resilience opportunity lies in using telemedicine to support rural access, chronic disease follow-up, mental health care, and interprofessional collaboration. However, sustainability requires stable reimbursement, integrated records, quality indicators, and safeguards against fragmented episodic virtual care. If telemedicine becomes detached from longitudinal primary care, it may increase duplication and reduce continuity.

South Korea's resilience opportunity lies in combining digital infrastructure with chronic disease monitoring, aging-care support, and preventive health systems. However, institutional legitimacy requires clear regulation, professional standards, and patient safety assurance. Telemedicine expansion without trust from clinicians and patients may remain limited.

Quality governance is central. Telemedicine must be evaluated for safety, diagnostic adequacy, continuity, privacy, prescribing quality, patient satisfaction, and clinical outcomes. Digital health platforms should be interoperable with electronic records and accountable to clinical governance standards. Artificial intelligence and remote monitoring tools require validation, bias assessment, and transparent use.

The findings align with World Bank arguments that digital health should strengthen health systems rather than add disconnected applications (World Bank, 2023). They also support WHO's position that digital health should advance universal health coverage and health equity (WHO, 2021). This article extends these perspectives by showing that chronic disease management is a key test of digital health maturity because it requires long-term continuity, behavior change, and clinical accountability.

The clinical implication is that hybrid care should become the dominant model. Telemedicine should be used for appropriate follow-up, monitoring, counseling, medication review, and triage, while in-person care should remain available for physical examination, diagnostics, procedures, complex assessment, and relationally sensitive encounters. Public health governance should ensure that digital transformation strengthens, rather than replaces, comprehensive primary care.

Conceptual Framework

This article proposes the following conceptual framework:

Healthcare Governance → Digital Service Accessibility → Patient Engagement and Behavioral Adaptation → Treatment Continuity → Clinical Improvement and Population Health Resilience

The framework conceptualizes telemedicine as a governance-mediated public health intervention. Healthcare governance establishes the conditions under which digital care becomes safe, reimbursable, interoperable, equitable, and clinically accountable. Digital service accessibility determines whether patients can actually use telemedicine through devices, connectivity, literacy, language support, and appropriate clinical pathways.

Patient engagement and behavioral adaptation mediate clinical effectiveness because chronic disease management depends on self-monitoring, medication adherence, diet, physical activity, symptom recognition, and communication with providers. Treatment continuity links digital encounters with longitudinal care, remote monitoring, medication adjustment, and escalation when clinical risk increases.

Clinical improvement and population health resilience emerge when telemedicine strengthens prevention, continuity, chronic disease control, and equitable access. The framework contributes to medical and health sciences scholarship by integrating health systems governance, behavioral medicine, chronic care theory, and digital health implementation into a unified explanatory model. It emphasizes that telemedicine improves outcomes only when institutional capacity and patient behavior are aligned.

CONCLUSION

This study analyzed how telemedicine integration in Canada and South Korea influences primary care accessibility, chronic disease management, patient engagement, healthcare equity, and health system resilience. The comparative evidence demonstrates that digital primary care is not merely a technological innovation but a health system intervention whose effectiveness depends on governance, reimbursement, interoperability, clinical workflow, patient behavior, and equity safeguards.

Canada illustrates the value of telemedicine for addressing geographic access barriers and supporting continuity in rural and remote populations. However, decentralized governance, uneven broadband access, and fragmented data systems constrain equitable implementation. South Korea illustrates the importance of digital infrastructure and national insurance capacity, but also shows that regulatory legitimacy, professional acceptance, and clinical governance are necessary for sustained adoption.

The theoretical contribution of this article lies in reframing telemedicine as a multilevel public health intervention linking institutional structures, clinical processes, behavioral adaptation, and population outcomes. The empirical contribution lies in synthesizing comparative evidence from international health reports, policy studies, and chronic disease literature to explain why digital health outcomes differ across systems.

Clinically, telemedicine should be integrated into hybrid chronic disease care models that combine

remote follow-up, patient education, remote monitoring, medication management, and in-person assessment when needed. From a policy perspective, digital health strategies should prioritize reimbursement stability, privacy protection, interoperability, broadband access, digital literacy, and equity-sensitive service design.

The study is limited by reliance on secondary evidence and by heterogeneity in telemedicine outcome reporting across jurisdictions. Future research should use longitudinal comparative data to examine effects on HbA1c, blood pressure control, hospitalization, mortality, patient experience, provider workload, and health equity. Further research should also evaluate AI-supported triage, remote monitoring devices, and community-based digital health hubs.

Ultimately, this article argues that telemedicine can improve chronic disease management and health system resilience only when it is embedded within accountable, equitable, and clinically integrated primary care governance.

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