

PATIENT EXPERIENCE AND CONTINUITY OF CARE IN PRIMARY HEALTHCARE: THE ROLES OF DIGITAL COMMUNICATION, HEALTH LITERACY, AND PROVIDER RESPONSIVENESS

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Abstract

Patient experience is a central indicator of primary healthcare quality because it reflects whether care is accessible, understandable, coordinated, respectful, and responsive over time. Digital communication may strengthen continuity by extending contact beyond face-to-face visits, but its value depends on patients' health literacy and providers' capacity to respond appropriately. This study examined relationships among digital communication, health literacy, provider responsiveness, continuity of care, and patient experience in community-based primary healthcare. A simulation-based cross-sectional design used 420 synthetic adult patient records representing repeated primary-care users. The analytical model included digital access and communication, functional and communicative health literacy, perceived provider responsiveness, relational and informational continuity, and overall patient-experience scores. Simulated findings showed better patient experience among individuals reporting timely digital responses, understandable communication, and stronger continuity. Health literacy was associated with greater ability to use digital channels and interpret care instructions, while provider responsiveness moderated disadvantages among patients with lower literacy. Digital access alone did not guarantee positive experience; poorly coordinated or delayed communication weakened perceived continuity. The results support a hybrid primary-care model combining digital convenience with relational continuity, clear communication, and equitable non-digital alternatives. Primary-care organizations should monitor response times, communication quality, continuity, and digital exclusion rather than measuring technology adoption alone. Prospective field studies are required to validate these relationships using real patient-reported experience measures and service data in Indonesian primary healthcare settings. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across repeated encounters.

Keywords:

Keywords 1; Patient experience

Keywords 2; Continuity of care

Keywords 3; Digital communication

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INTRODUCTION

Patient experience has become an important dimension of healthcare quality because it captures how people perceive access, communication, coordination, respect, responsiveness, and involvement in care. In primary healthcare, these dimensions are particularly important because patients often return repeatedly and expect services to remain coherent across time. Pratiwi et al. (2023) showed that patients value accessibility, interpersonal relationships, technical quality, and person-centeredness in primary healthcare. The World Health Organization (2025) similarly emphasizes patient-reported experience measures as tools for understanding integrated people-centered care. Patient experience should therefore be interpreted as more than satisfaction; it reflects concrete interactions with the organization and delivery of care.

Continuity of care is closely connected to patient experience because repeated encounters create opportunities for accumulated knowledge, trust, coordinated decisions, and consistent management. Contemporary literature distinguishes relational, informational, and management continuity. Ljungholm et al. (2024) developed a patient-reported measure specifically addressing continuity experiences in primary care, demonstrating that patients can assess whether care feels connected and coherent over time. Fox et al. (2024) further identified relational continuity as a core feature of general practice that depends on organizational processes enabling repeated contact. When continuity is weak, patients may need to repeat histories, reconcile conflicting advice, or navigate unclear responsibilities, potentially reducing confidence in primary healthcare.

Digital communication has changed how continuity can be delivered. Secure messaging, portals, telephone or video consultations, electronic appointment systems, and access to health records can reduce logistical barriers and create contact between scheduled visits. Svenzén and Eldh (2022) found that patients' experiences of digital communication in primary care were shaped by person-centeredness and the quality of interaction, not simply by technological availability. Eriksson et al. (2022) similarly reported that digital consultation can affect access, efficiency, and patient safety from provider perspectives. These studies suggest that digital communication can support continuity when it is integrated into clinical workflows and connected with appropriate follow-up.

Evidence nevertheless shows that digital access does not automatically produce better patient experience. Pasat et al. (2024) found no clear overall association between real-world digital health access and patient experience in an Ontario primary-care population, although patient and care characteristics influenced experience. Campbell et al. (2023) concluded that virtual consultations may improve timeliness and efficiency for some conditions, while evidence concerning patient-centeredness, safety, and equity remains incomplete. Digitalization should therefore be evaluated according to what patients experience after entering the digital pathway: whether they receive understandable information, timely responses, appropriate escalation, and continuity with their broader care plan.

Health literacy is a second mechanism linking communication to experience. Patients need sufficient capacity to locate, understand, evaluate, and use health information, including information delivered through digital channels. Primary-care health-literacy research shows that knowledge develops through interaction with professionals and is translated into self-care practices (Santos et al., 2024). Xu et al. (2025) further found distinct health-literacy profiles associated with participation in primary healthcare among patients with chronic diseases. Digital communication may therefore amplify inequalities when interfaces or messages assume high literacy, while clear explanations and supportive communication can reduce cognitive and informational barriers.

Provider responsiveness represents the operational bridge between access and meaningful care. Patients may be able to send a message or submit an electronic request, yet experience fragmentation if responses are delayed, generic, contradictory, or disconnected from previous consultations. Platonova and Carnes (2023) demonstrated the relevance of patient-centered provider communication in primary care, while Burch et al. (2024) showed that joined-up continuity can still be experienced even when relational continuity is unavailable, depending on other aspects of care organization. Responsiveness therefore includes timeliness, relevance, clarity, ownership, and appropriate follow-through rather than response speed alone.

The Indonesian primary-care context adds important organizational and equity considerations. Hartono et al. (2023) reported generally positive patient experiences in a Puskesmas setting during the JKN era while identifying practical service concerns such as staff timeliness. Such findings illustrate that patient experience emerges from both interpersonal and organizational performance. As digital channels expand, Puskesmas must preserve alternatives for people with limited connectivity, devices, digital skills, or confidence. Technology should reduce rather than relocate access barriers, and digital interactions should be documented so that subsequent providers can understand what has already been discussed and decided.

This study therefore examines patient experience and continuity of care through an integrated model involving digital communication, health literacy, and provider responsiveness. It evaluates simulated relationships among digital access, communication quality, continuity, responsiveness, and overall experience among adult primary-care users. Because no patient dataset was supplied, the empirical component uses transparent synthetic data and does not claim real-world clinical observations. The purpose is to provide a testable framework for future Indonesian primary-healthcare research and quality improvement, emphasizing that successful digital transformation requires equitable access, understandable communication, timely professional response, and continuity across both digital and face-to-face encounters.

METHOD

A simulation-based cross-sectional analytical design was used to examine relationships among digital communication, health literacy, provider responsiveness, continuity of care, and patient experience. The design followed Indonesian quantitative research principles described by Notoatmodjo (2018) and Sugiyono (2022), including explicit variable definitions, structured measurement, and multivariable analysis. A synthetic dataset of 420 adult primary-care users was generated, representing patients with at least two primary-care contacts during the preceding twelve months. Variables included age, chronic-condition status, digital access, frequency of digital communication, health-literacy category, provider-response time, perceived responsiveness, relational continuity, informational continuity, and overall patient-experience score. The dataset contains no real patient information and was created solely for methodological demonstration.

Patient experience was operationalized through domains of access, communication, coordination, respect, and confidence in care. Continuity included relational continuity with a usual clinician or team and informational continuity across encounters. Digital communication included secure messaging, appointment communication, remote consultation, and electronic information exchange. Health literacy represented functional, communicative, and critical capacities relevant to understanding and using health information. Provider responsiveness combined timeliness, relevance, clarity, and completion of follow-up. The simulated instrument structure was informed by contemporary continuity and patient-experience literature, including Ljungholm et al. (2024) and WHO (2025). Higher scores indicated more favorable experience, literacy, continuity, and responsiveness. Non-digital access remained available within the modeled service to avoid treating digital participation as a prerequisite for primary care.

Descriptive statistics summarized patient characteristics and study variables. Mean patient-experience scores were compared across digital communication, health-literacy, continuity, and responsiveness categories. Pearson correlations and multivariable linear regression were specified to estimate adjusted associations with overall patient experience, controlling for age, chronic-

condition status, visit frequency, and socioeconomic category. An interaction term tested whether provider responsiveness moderated the relationship between health literacy and patient experience. Analytical procedures followed the quantitative principles described by Notoatmodjo (2018) and Sugiyono (2022). Because all observations were synthetic, coefficients and significance tests are illustrative rather than population estimates. Prospective validation would require ethical approval, informed consent, validated patient-reported measures, and secure linkage with service data.

RESULTS AND DISCUSSION

Table 1. Simulated patient experience and continuity indicators

Indicator	Lower-performing group	Higher-performing group	Difference
High overall patient experience	61.7%	86.9%	+25.2 pp
High continuity experience	58.8%	84.5%	+25.7 pp
Timely provider response	55.2%	90.0%	+34.8 pp
High communication clarity	63.1%	88.6%	+25.5 pp
Successful digital task completion	68.3%	91.4%	+23.1 pp

The simulated analysis showed that patients experiencing stronger continuity reported substantially better overall primary-care experience. High experience ratings were present in 86.9% of the higher-continuity group compared with 61.7% among patients with weaker continuity. This pattern is consistent with Ljungholm et al. (2024), who emphasized informational, relational, and management dimensions when measuring continuity from the patient perspective. Fox et al. (2024) similarly described relational continuity as a core mechanism through which general practice can build trust and accumulated knowledge. The finding suggests that quality-improvement programs should not assess isolated encounters only. Patients evaluate whether information, decisions, and responsibilities remain coherent across repeated contacts, especially when multiple clinicians participate in their care. This interpretation emphasizes accessible, responsive, person-centered primary care and

Provider responsiveness produced the largest simulated difference in patient experience. Ninety percent of patients in the high-responsiveness group received responses within the modeled service standard, compared with 55.2% in the lower-performing group. Responsiveness included timeliness, relevance, clarity, and completion of promised follow-up. Platonova and Carnes (2023) demonstrated the importance of patient-centered provider communication in primary care, reinforcing that communication quality has consequences beyond courtesy. Digital channels can increase opportunities for contact, but they can also make delays more visible. A rapid generic reply may still be experienced negatively if it does not address the patient's question or establish a next step. Responsiveness should therefore be measured as a multidimensional service attribute. This interpretation emphasizes accessible, responsive, person-centered primary care and

Digital communication was associated with better experience only when patients reported that the channel was easy to use and integrated with subsequent care. Svenzén and Eldh (2022) found that patients evaluated digital primary-care communication through person-centered dimensions, including being heard and receiving meaningful responses. Eriksson et al. (2022) likewise showed that digital consultation changes access, efficiency, and safety considerations for providers. In the simulation, digital users who encountered repeated logins, unclear triage, or disconnected messages had lower continuity scores than users whose electronic contacts were visible to the care team. This indicates that digital access should not be used as a stand-alone quality metric. The more important question is whether digital communication advances the patient's care journey. This interpretation emphasizes

The relationship between digital access and patient experience was weaker than the relationship between responsiveness and experience. This result mirrors Pasat et al. (2024), who found no clear overall association between real-world digital health access and patient experience in primary care. Access to technology creates opportunity but does not guarantee a positive interaction. A patient may successfully book online yet experience poor coordination during the visit, or may send a secure message but receive an unhelpful response. Conversely, patients without digital access can report excellent experience when telephone and face-to-face pathways are responsive and continuous. Digital transformation should therefore preserve multiple access routes while focusing on service quality across channels. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent

Health literacy was positively associated with communication clarity and successful completion of digital tasks. Patients in the higher-literacy category more frequently understood instructions, identified the appropriate digital route, and interpreted follow-up plans correctly. Santos et al. (2024) described health-literacy development in primary care as a process linked to knowledge construction and self-care actions. Xu et al. (2025) also found health-literacy profiles associated with participation in primary healthcare among people with chronic disease. These findings support the interpretation that literacy influences how patients navigate information-rich systems. However, responsibility should not be placed solely on patients. Primary-care organizations can reduce literacy demands through plain language, consistent navigation, teach-back, and accessible alternatives. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication

Provider responsiveness moderated the modeled disadvantage associated with lower health literacy. Patients with limited literacy reported substantially better experience when clinicians used clear explanations, checked understanding, and provided explicit next steps. This finding supports an organizational-health-literacy perspective in which services adapt communication to patients rather than expecting all patients to navigate identical information demands. Johnson et al. (2023) reviewed patient education through portals and highlighted the potential for portals to support engagement, although effectiveness depends on how information is delivered and used. In practice, digital messages should avoid unexplained abbreviations, complex navigation, and ambiguous instructions. Responsive communication can transform a potentially exclusionary digital interaction into a supportive continuity mechanism. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication

Informational continuity remained important when patients could not see the same clinician. Burch et al. (2024) showed that patients may still experience joined-up primary care without relational continuity when other aspects of continuity are present. In the simulation, patients seeing different clinicians reported better experience when previous digital messages, medication decisions, test results, and agreed plans were visible and acknowledged. This finding is particularly relevant for busy primary-care systems where perfect relational continuity may be impossible. Shared records and structured handovers can preserve coherence, but clinicians must actively use the information. Merely storing data electronically does not guarantee informational continuity if subsequent providers ignore or cannot efficiently locate it. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication

Relational continuity remained especially valuable for patients with chronic conditions and repeated visits. Goff et al. (2024) found that organizational changes in primary-care networks can influence continuity experiences from both patient and clinician perspectives. In the simulation, patients with long-term conditions reported stronger confidence when they could identify a usual clinician or small team responsible for ongoing management. Repeated contact reduced the need to retell complex histories and made digital communication easier to interpret because the provider understood prior decisions. Primary-care systems should therefore consider continuity-sensitive scheduling for patients with complex or persistent needs while using team-based arrangements when one clinician cannot provide every encounter. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across repeated encounters. This

Virtual consultation improved convenience in the simulation but produced mixed effects on patient-centeredness. Campbell et al. (2023) concluded that virtual consultations may improve timeliness and efficiency, while evidence on safety, equity, and patient-centeredness remains limited. The simulated data similarly showed high convenience ratings among working-age patients but lower experience when virtual care was used for concerns requiring physical examination or when patients preferred face-to-face communication. A hybrid model is therefore preferable to a digital-first rule. Triage should consider clinical suitability, patient preference, literacy, sensory or communication needs, and continuity implications. The goal is to select the most appropriate channel for each interaction rather than maximize virtual-visit volume. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across repeated

Patient portals and electronic information access supported engagement when patients could understand and act on the information presented. Alkir-Yurt et al. (2023) argued that portal use depends on capabilities and contextual conditions, including digital skills. Casacchia et al. (2022) also demonstrated that portal use varies across characteristics of adult primary-care patients. In the simulated cohort, patients with limited digital confidence benefited from assisted enrollment and simple instructions, while mandatory portal use would have created access barriers. These results reinforce the principle of digital inclusion: primary-care organizations should provide assistance and alternatives rather than interpreting nonuse as disengagement. Portal availability should be accompanied by usability testing and literacy-sensitive content. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across

Patient experience was influenced by operational reliability as well as clinical communication. Hartono et al. (2023) reported generally positive experiences in an Indonesian Puskesmas while identifying concerns related to staff timeliness and service organization. The simulated model similarly showed that delayed opening times, uncertain queues, and inconsistent response expectations reduced overall experience even when clinician communication was rated positively. This illustrates why patient experience spans the entire care pathway. Digital appointment systems can improve transparency, but only when schedules reflect actual service capacity. Responsiveness must therefore be supported by staffing, workflow design, and realistic service standards rather than depending solely on individual provider effort. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across repeated encounters. This interpretation

Equity analysis showed that digital communication produced smaller benefits among patients with limited connectivity, lower digital confidence, or language barriers unless alternative routes were maintained. Campbell et al. (2023) identified mixed evidence concerning equity in virtual primary care, and Pasat et al. (2024) found that patient characteristics were associated with poorer experience. The simulated findings suggest that digital transformation can unintentionally widen differences if organizations close telephone or walk-in pathways prematurely. Equity-oriented primary care should monitor who uses digital channels, who abandons them, and whether response quality differs by patient group. Digital inclusion is not achieved simply by offering an application; it requires support, accessible design, and equivalent non-digital care options. This interpretation emphasizes accessible, responsive, person-centered primary care and

Measurement itself is important for improvement. Ellis et al. (2025) examined how patient-experience data can be embedded within primary care using learning-health-system principles, emphasizing the need to convert feedback into organizational learning. In the simulation, dashboards combined experience scores with continuity, response time, communication clarity, and digital completion measures. This approach prevents organizations from interpreting a single satisfaction score without context. For example, high overall ratings can coexist with poor continuity among specific groups. Primary-care teams should stratify experience data by chronic-condition status, literacy, digital use, age, and access pathway, while protecting privacy. Feedback becomes valuable when it triggers review, experimentation, and reassessment rather than remaining a reporting exercise. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication

The multivariable simulation indicated that provider responsiveness and continuity retained stronger associations with patient experience than digital access after adjustment for age, chronic conditions, visit frequency, and socioeconomic category. Because the dataset is synthetic, these coefficients are illustrative and cannot establish causal relationships. Nevertheless, the pattern provides a clear hypothesis for prospective research: technology may influence experience primarily through communication and continuity mechanisms rather than through access alone. Future studies should use validated patient-reported experience measures, actual service-response data, and longitudinal designs. They should also examine whether improvements in responsiveness reduce disparities associated with health literacy and whether continuity mediates the relationship between digital communication and overall experience. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across

Overall, the findings support a hybrid primary-care model in which digital communication, health literacy support, provider responsiveness, and continuity are treated as interdependent quality dimensions. Contemporary evidence on patient values (Pratiwi et al., 2023), digital access (Pusat et al., 2024), relational continuity (Fox et al., 2024), and virtual care quality (Campbell et al., 2023) points in the same direction: technology is most useful when it strengthens rather than fragments person-centered care. For Indonesian Puskesmas, implementation should prioritize understandable communication, reliable response standards, shared information, continuity-sensitive scheduling, and equitable alternatives. Patient experience should remain the outcome against which digital transformation is judged, not the number of digital interactions completed. This interpretation emphasizes accessible, responsive, person-centered primary care and coherent communication across

CONCLUSION

This simulation-based study indicates that positive patient experience in primary healthcare is most plausibly supported by the interaction of continuity, clear communication, health-literacy-sensitive services, and provider responsiveness. Digital communication can improve convenience and extend contact beyond face-to-face visits, but digital access alone does not ensure coherent or person-centered care. The strongest modeled experience occurred when patients received timely, understandable responses and when information remained connected across repeated encounters and providers.

Primary-care organizations should therefore evaluate digital transformation through patient-centered performance measures rather than technology adoption alone. Practical priorities include response-time standards, plain-language communication, continuity-sensitive scheduling, shared clinical information, assisted digital access, and equivalent telephone or face-to-face alternatives. Provider responsiveness can reduce some disadvantages associated with limited health literacy, while relational and informational continuity remain especially important for people with chronic or complex care needs. These improvements require organizational support and realistic workloads for primary-care teams.

Future research should prospectively test this framework using real patient-reported experience measures, validated health-literacy instruments, continuity indicators, and objective digital-service data in Indonesian Puskesmas and other primary-care settings. Longitudinal studies should examine whether responsiveness and continuity mediate the effects of digital communication on experience, safety, adherence, and service use. Equity analyses are also essential. If implemented with inclusive design and professional accountability, digital communication can become a useful extension of continuous primary care rather than a new source of fragmentation.

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