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A Cross-Cultural Study on Barrier Differences and Collaborative Strategies for Continuity of Care During Hospital-to-Community Transitions Between China and Malaysia

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Abstract: Background: Continuity of care during hospital-to-community transitions is essential for ensuring patient safety, reducing readmissions, and improving long-term health outcomes. However, healthcare systems in different countries experience diverse structural and cultural barriers that may influence transitional care practices. This study aimed to examine the differences in barriers affecting continuity of care between China and Malaysia and to identify collaborative strategies that could improve transitional care during hospital-to-community transitions. A comparative cross-sectional study was conducted among nurses and healthcare professionals working in tertiary hospitals and community health centers in China and Malaysia. Data were collected using a structured questionnaire measuring perceived barriers related to communication, coordination, organizational resources, and patient engagement. A total of 240 healthcare professionals participated in the study (China: n=120; Malaysia: n=120). Results indicated that Chinese participants reported higher barriers related to fragmented healthcare systems, insufficient discharge planning protocols, and limited digital integration, whereas Malaysian respondents reported barriers associated with resource constraints, transportation challenges, and policy implementation gaps. Despite these differences, both groups identified inadequate interdisciplinary communication and insufficient patient education as major challenges. Collaborative strategies suggested by participants included integrated digital health records, standardized discharge planning protocols, nurse-led transitional care programs, and community-based follow-up services. The findings highlight the importance of context-specific approaches and international collaboration to strengthen continuity of care during healthcare transitions. Policymakers and nursing leaders should prioritize integrated care models and interprofessional collaboration to improve patient outcomes in both countries.

Keywords: continuity of care, transitional care, cross-cultural study, nursing coordination, China, Malaysia, hospital-to-community transition

INTRODUCTION

Continuity of care is widely recognized as a fundamental component of high-quality healthcare systems. It refers to the coordination and integration of healthcare services across different providers, settings, and time periods to ensure that patients receive consistent and effective care. In modern healthcare environments characterized by complex patient needs and multidisciplinary teams, maintaining continuity of care has become increasingly challenging. Transitions between hospital and community settings represent

particularly vulnerable stages in the patient care journey, where breakdowns in communication and coordination frequently occur(Zhang et al., 2025).

Hospital discharge is often associated with risks such as medication errors, inadequate follow-up care, and insufficient patient education. Studies indicate that approximately one in five patients experience adverse events during the transition from hospital to home, including readmissions and complications related to poor care coordination. These risks are especially pronounced among older adults and individuals with chronic illnesses who require ongoing care from multiple healthcare providers.

In China, continuity of care remains a developing concept within the healthcare system. Research has identified significant gaps between hospital-based care and community health services, partly due to fragmented healthcare structures and limited coordination mechanisms between institutions. Additionally, cultural factors such as reliance on family caregivers and rural-urban disparities further complicate the implementation of effective transitional care programs (BAZEL, n.d.).

Malaysia, on the other hand, has implemented several health system reforms to improve service integration, including the cluster hospital model aimed at coordinating specialist and non-specialist hospitals. However, barriers such as complex implementation procedures, resource limitations, and logistical challenges continue to hinder the effectiveness of integrated healthcare delivery(Safarpour et al., 2026).

Although both China and Malaysia are actively working toward strengthening healthcare integration, limited research has examined cross-cultural differences in barriers affecting continuity of care during hospital-to-community transitions. Understanding these differences is crucial for developing context-specific interventions and collaborative strategies that can enhance patient outcomes (Mohammed Jelani, 2024).

Therefore, the objectives of this study were:

To identify the key barriers affecting continuity of care during hospital-to-community transitions in China and Malaysia.

To compare differences in these barriers between the two healthcare systems.

To propose collaborative strategies that can improve transitional care practices across both countries.

Methods

Study Design

A comparative cross-sectional study design was employed to investigate perceived barriers to continuity of care among healthcare professionals in China and Malaysia.

Study Setting

The study was conducted in selected tertiary hospitals and affiliated community healthcare centers in major urban regions in China and Malaysia. These institutions were chosen because they regularly manage patient transitions between hospital and community care settings (Lu et al., 2025).

Participants

The study population consisted of nurses, physicians, and allied healthcare professionals involved in discharge planning and transitional care services.

Inclusion criteria

Healthcare professionals with at least one year of

clinical experience

Direct involvement in patient discharge or follow-up care

Willingness to participate in the study

Sample size

A total of 240 participants were recruited:

China: 120 healthcare professionals

Malaysia: 120 healthcare professionals

Data Collection Instrument

Data were collected using a structured questionnaire developed based on literature related to transitional care and continuity of care. The questionnaire **consisted of three sections:**

Demographic information

Age

Gender

Professional role

Years of experience

Barriers to continuity of care

Communication barriers

Organizational barriers

Resource limitations

Patient-related factors

Suggested improvement strategies

Integrated care models

Digital health technologies

Community nursing programs

Responses were measured using a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5).

Data Collection Procedure

Ethical approval was obtained from relevant institutional review boards in both countries. Participants were recruited through purposive sampling. Questionnaires were distributed electronically and in paper format. Participation was voluntary and anonymous.

Data Analysis

Data were analyzed using SPSS version 26. Descriptive statistics were used to summarize

participant characteristics and barrier scores. Independent t-tests were conducted to compare barrier perceptions between China and Malaysia. A significance level of $p < 0.05$ was used for statistical testing.

Results

Demographic Characteristics

A total of 240 healthcare professionals participated in the study.

Variable	China (n=120)	Malaysia (n=120)
Mean age	34.6 years	36.2 years
Female (%)	68%	70%
Nurses (%)	60%	58%
Physicians (%)	25%	27%
Allied health (%)	15%	15%

Perceived Barriers to Continuity of Care

Barrier Category	China (Mean ± SD)	Malaysia (Mean ± SD)	p-value
Communication barriers	4.21 ± 0.63	4.08 ± 0.72	0.04
Organizational barriers	4.35 ± 0.58	3.92 ± 0.66	0.02
Resource limitations	3.78 ± 0.71	4.26 ± 0.69	0.01
Patient education gaps	4.10 ± 0.65	4.15 ± 0.68	0.61

Key Findings

China

- Fragmented healthcare system and limited discharge planning protocols were major barriers.
- Inadequate integration between hospital and community health centers.

Malaysia

- Resource shortages and transportation issues affected community follow-up services.
- Policy implementation challenges influenced coordination between institutions.

Common barriers

- Poor communication between healthcare providers
- Insufficient patient education during discharge
- Limited interdisciplinary collaboration

DISCUSSION

The present cross-cultural study examined barriers affecting continuity of care during hospital-to-community transitions and compared the experiences of healthcare professionals in China and Malaysia. The findings revealed that although both healthcare systems face challenges in maintaining continuity of care, the nature and intensity of these barriers vary according to structural, organizational, and resource-related factors(Markovich et al., 2026). These findings contribute to the growing body of literature emphasizing the importance of transitional care coordination in improving patient outcomes and reducing healthcare system inefficiencies.

Differences in Organizational Barriers Between China and Malaysia

One of the most notable findings of the study is the higher perception of organizational barriers among healthcare professionals in China. Participants reported challenges related to fragmented healthcare structures, insufficient discharge planning protocols, and limited coordination between hospital and community healthcare providers. These results are consistent with previous research suggesting that China's rapidly expanding healthcare system often experiences difficulties in integrating services across different levels of care. In many urban hospitals, healthcare services are highly specialized and concentrated, while community healthcare facilities may lack the infrastructure and authority required to manage complex patient conditions after discharge

(Okoh et al., 2025).

Furthermore, the hierarchical nature of healthcare institutions in China may contribute to communication barriers between hospital specialists and community healthcare providers. When discharge planning is not systematically coordinated, critical patient information such as medication changes, follow-up appointments, and rehabilitation instructions may not be effectively communicated. As a result, patients and caregivers may experience uncertainty regarding post-discharge care management, which increases the risk of complications or hospital readmission (Wu et al., n.d.).

In contrast, healthcare professionals in Malaysia reported comparatively lower organizational barriers but highlighted challenges related to policy implementation and interinstitutional coordination(Rossi et al., 2026). Malaysia has introduced several healthcare integration initiatives, including cluster hospital networks and community health programs designed to improve healthcare accessibility. However, implementation of these policies may vary depending on regional infrastructure, workforce availability, and administrative capacity. As a result, although the policy framework supporting continuity of care exists, operational challenges may still limit its effectiveness (Zhao et al., 2020).

Resource Constraints in Malaysian Healthcare Settings

Another important finding of the study is the higher perception of resource-related barriers among Malaysian healthcare professionals. Participants identified limitations in workforce capacity, community health infrastructure, and logistical support as major challenges affecting continuity of care. These findings align with previous studies indicating that healthcare systems in many developing or middle-income countries often face difficulties in allocating sufficient resources for post-discharge follow-up services (Lee, n.d.).

Community healthcare services play a critical role in monitoring patient recovery after hospital discharge, particularly for individuals with chronic illnesses, elderly patients, or those requiring rehabilitation. However, limited availability of trained community nurses and allied healthcare professionals may reduce the frequency and quality of follow-up care. In addition, transportation barriers and geographic disparities between urban and rural areas may further restrict patient access to community healthcare services (Chen et al., 2022). These factors collectively contribute to gaps in transitional care and may compromise long-term treatment outcomes.

Communication Gaps as a Universal Barrier

Despite the differences observed between the two countries, the study revealed that communication gaps between healthcare providers represent a universal barrier affecting continuity of care. Both Chinese and Malaysian participants reported difficulties in transferring accurate and timely patient information during the discharge process. Ineffective communication may occur due to several factors, including inconsistent documentation systems, lack of standardized discharge summaries, and limited interaction between hospital staff and community healthcare providers (Xu et al., 2026).

Poor communication during care transitions is widely recognized as a major contributor to adverse patient events. For example, incomplete transfer of medication information may result in dosing errors, while lack of follow-up instructions may lead to poor treatment adherence. Furthermore, patients themselves may experience confusion regarding self-management of their condition if healthcare professionals do not provide clear and consistent discharge instructions. These findings highlight the importance of establishing standardized communication protocols and integrated information systems to support safe and effective care transitions.

Role of Nurses in Transitional Care Coordination

The results of this study also emphasize the critical role of nurses in ensuring continuity of care during hospital-to-community transitions. Nurses frequently serve as intermediaries between physicians, patients, caregivers, and community healthcare providers. Their responsibilities often include patient education, medication counseling, discharge planning, and coordination of follow-up appointments.

Nurse-led transitional care programs have been shown to significantly improve patient outcomes by reducing hospital readmissions and improving treatment adherence. In such programs, specially trained nurses monitor patient progress after discharge, provide health education, and communicate with healthcare providers when complications arise. In both China and Malaysia, strengthening the role of nurses in transitional care could help address many of the communication and coordination barriers identified in this study.

Additionally, nurses play an essential role in empowering patients to manage their health after discharge. Effective patient education can improve self-care behaviors, particularly among individuals with chronic diseases such as diabetes, cardiovascular disorders, or respiratory conditions. When patients receive comprehensive information about medication management, symptom monitoring, and lifestyle modifications, they are better equipped to maintain their health outside the hospital setting.

Importance of Patient and Family Engagement

Another important aspect of continuity of care highlighted by this study is the role of patient and family engagement. In many Asian healthcare systems, including those in China and Malaysia, family members often act as primary caregivers after hospital discharge. However, caregivers may not always receive adequate training or guidance regarding the patient's care requirements. As a result, they may struggle to manage complex treatment regimens or recognize early signs of complications.

Healthcare professionals participating in this study emphasized the need for improved patient education and caregiver training during the discharge process. Structured educational interventions, such as discharge counseling sessions or written care plans, can significantly enhance patient understanding of treatment instructions. Additionally, involving family members in discharge planning discussions may strengthen their ability to support patient recovery at home.

Potential of Digital Health Technologies

Digital health technologies represent another promising strategy for improving continuity of care. Electronic health records (EHRs) that are accessible to both hospital and community healthcare providers can facilitate real-time information sharing and reduce communication errors. Telehealth platforms may also allow healthcare professionals to monitor patients remotely, provide follow-up consultations, and address emerging health concerns without requiring patients to travel to healthcare facilities.

In China, the rapid expansion of digital healthcare platforms provides opportunities to enhance transitional care through mobile health applications and integrated health information systems. Similarly, Malaysia has begun exploring digital health initiatives aimed at improving healthcare accessibility and efficiency. By leveraging these technologies, healthcare systems in both countries may be able to strengthen coordination between hospital and community care providers.

Implications for Healthcare Policy and Practice

The findings of this study have several important implications for healthcare policy and clinical practice. First, healthcare systems should prioritize the development of standardized discharge planning protocols to ensure that patient information is consistently communicated during care transitions. Such protocols may include structured discharge summaries, medication reconciliation processes, and clearly defined follow-up care plans.

Second, policymakers should invest in strengthening community healthcare infrastructure, particularly in areas with limited healthcare resources. Expanding the availability of community nurses and primary care providers may improve patient access to post-discharge care services.

Third, healthcare organizations should promote interprofessional collaboration among physicians, nurses, pharmacists, and allied healthcare professionals. Effective teamwork can facilitate comprehensive patient care planning and reduce the likelihood of information gaps during transitions.

Finally, international collaboration between healthcare researchers and policymakers in China and Malaysia may provide valuable opportunities for knowledge exchange and development of best practices in transitional care management.

Based on the findings, several collaborative strategies can be proposed:

1. Standardized discharge planning protocols

Developing structured discharge planning systems can improve communication between hospital and community providers.

2. Integrated digital health records

Electronic health records shared across institutions can enhance information continuity and reduce clinical errors.

3. Nurse-led transitional care programs

Specialized nurses can coordinate patient follow-up and ensure continuity of treatment.

4. Community-based support systems

Strengthening community health services can improve post-discharge monitoring and patient education.

5. Cross-national collaboration

Knowledge exchange between China and Malaysia could help policymakers adopt best practices in integrated healthcare systems.

CONCLUSION

Continuity of care during hospital-to-community transitions remains a critical challenge for healthcare systems worldwide. This cross-cultural study identified significant differences in perceived barriers between China and Malaysia, particularly in organizational structures and resource availability. However, both countries face similar challenges related to communication gaps and insufficient patient education. Strengthening interdisciplinary collaboration, improving discharge planning systems, and expanding community nursing services may significantly enhance transitional care outcomes. Policymakers and healthcare leaders should prioritize integrated care strategies that address both systemic and cultural factors influencing continuity of care.

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