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Reimagining Community Health Systems for Equity and Resilient Population Health Care

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Abstract

Introduction: Community and public health systems face persistent fragmentation, inequitable access, and limited capacity to respond to evolving population health needs. These challenges are intensified by epidemiological transitions, social inequalities, and uneven access to preventive and primary healthcare. This study aimed to develop a systems-based conceptual framework to strengthen population health, health equity, and health system resilience.

Methods: A conceptual synthesis was conducted through an integrative review of peer-reviewed empirical and conceptual literature addressing community health systems, primary healthcare, population health, health equity, and resilience. International databases were searched without geographic restriction. Following screening, 84 studies were included and thematically synthesised to identify interconnected mechanisms and develop an integrated conceptual framework.

Results: Four interconnected domains emerged: population health surveillance, primary healthcare integration, social determinants and equity-oriented interventions, and adaptive health system resilience. Fragmentation and weak intersectoral coordination were identified as major barriers.

Conclusions: A systems-based approach can strengthen community health systems, advance equity, improve population health, and enhance resilience. The proposed framework provides a foundation for policy development and future empirical validation.

KEYWORDS

Community health services; health equity; health systems; population health; primary health care

INTRODUCTION

Community and public health systems are fundamental to population health, disease prevention, and equitable access to essential health services. Yet many health systems remain fragmented across programmes, institutions, and service structures, limiting their capacity to address complex and evolving population health needs. Such fragmentation can produce duplication, discontinuity of care, inefficient resource allocation, and unequal access to preventive and primary healthcare, particularly among socioeconomically and geographically disadvantaged populations (Atun et al., 2010; Kruk et al., 2018). These challenges are compounded by epidemiological transitions, demographic change, emerging health threats, and widening social inequalities, underscoring the need to move beyond disease-specific approaches toward integrated, population-oriented models of care.

Primary healthcare provides a critical foundation for addressing these challenges by connecting individuals and communities with preventive, promotive, curative, rehabilitative, and palliative services across the continuum of care. Strong primary healthcare systems are associated with improved population health, greater accessibility, and more equitable service distribution (Macinko et al., 2003; Starfield et al., 2005). However, contemporary primary healthcare extends beyond clinical service delivery to encompass meaningful community participation, cross-sectoral collaboration, and responsiveness to the social and environmental contexts in which people live (World Health Organization, 2018; World Health Organization, 2021). Community health systems are therefore increasingly recognised as essential platforms for linking formal healthcare structures with local knowledge, community resources, and population health priorities.

Despite these advances, substantial inequities in health outcomes and service access persist. Health is shaped by the conditions in which people are born, grow, live, work, and age, including income, education, housing, food security, employment, gender, and social protection (Marmot et al., 2008; World Health Organization, 2025). These determinants interact with health-system barriers to produce unequal exposure to risks and unequal opportunities to benefit from care. Improving population health therefore requires more than expanding service coverage; it demands equity-oriented interventions that address structural disadvantage and allocate resources proportionate to population needs (Kruk et al., 2018; World Health Organization, 2025). Community health systems are particularly important because they operate at the interface between health services and the social environments that shape health and well-being.

Health systems must also respond to uncertainty, disruption, and rapidly changing population needs. Pandemics, climate-related events, demographic transitions, emerging diseases, economic instability, and workforce pressures have exposed systemic vulnerabilities and highlighted the importance of adaptive capacity. Health-system resilience encompasses the ability to prepare for, absorb, adapt to, and respond to shocks while maintaining essential functions and advancing health outcomes. Resilience, however, should extend beyond crisis recovery to include continuous learning, adaptation, and transformation while preserving equity and continuity of essential services.

Systems thinking provides a valuable conceptual basis for understanding these interdependencies. Population health outcomes emerge from interactions among individuals,

families, communities, healthcare organisations, public institutions, and wider social and political environments rather than isolated interventions (Peters, 2014). Community health systems can thus be understood as interconnected networks in which primary healthcare, public health surveillance, community participation, social determinants, and governance interact dynamically. Integrated care is consequently not merely an organisational arrangement but a mechanism for connecting services, professionals, communities, and sectors around shared population health goals (Valentijn et al., 2013; Atun et al., 2010).

The integration of community health, primary healthcare, equity-oriented action, and system resilience is particularly important because these dimensions are often addressed through separate policy and service frameworks. Such fragmentation limits the capacity to achieve sustainable population health improvements. A coherent systems-based approach is therefore needed to conceptualise surveillance, primary healthcare integration, social determinants, equity-oriented interventions, and adaptive resilience as mutually reinforcing components of comprehensive community health systems (Sacks et al., 2019; Kruk et al., 2018).

This study therefore aimed to develop a systems-based conceptual framework for strengthening community health systems, advancing population health equity, and enhancing health-system resilience. Through an integrative synthesis of empirical and conceptual literature, the study identified interconnected domains and mechanisms through which population health surveillance, primary healthcare integration, social determinants and equity-oriented interventions, and adaptive resilience contribute to stronger and more responsive community health systems. The resulting framework provides a conceptual foundation for informing health policy, strengthening community and primary healthcare, reducing health inequities, and guiding future research on resilient population health systems.

MATERIALS AND METHODS

2.1 Study Design

This study employed a conceptual synthesis design informed by an integrative literature review to examine the interrelationships among community health systems, population health, primary healthcare, health equity, and health-system resilience. An integrative approach was selected because it enables the synthesis of diverse empirical and conceptual evidence, supporting a comprehensive understanding of complex and multidimensional health-system phenomena. This approach was particularly appropriate for examining community health systems, which operate across interconnected individual, community, organisational, institutional, and policy levels and require integration of evidence from multiple disciplinary and conceptual perspectives (Atun et al., 2010; Peters, 2014).

The synthesis was guided by a systems-based perspective, conceptualising population health outcomes as emerging from dynamic interactions among individuals, communities, healthcare services, institutions, and broader social and structural environments. Accordingly, the analysis examined not only individual interventions but also the relationships and mechanisms linking community health services, primary healthcare, social determinants of health, equity-oriented action, and health-system resilience (Peters, 2014; Sacks et al., 2019). The overall process comprised problem identification,

literature searching, study selection, data extraction, thematic synthesis, and conceptual framework development.

2.2 Literature Search Strategy

A comprehensive literature search was conducted across major international scientific databases covering health, public health, healthcare systems, and interdisciplinary research. No geographic restrictions were applied to capture evidence from diverse health-system and sociocultural contexts. Search terms and Boolean operators were structured around the core domains of community health systems, population health, primary healthcare, health equity, social determinants of health, integrated care, healthcare accessibility, health-system resilience, and public health.

The search strategy focused on literature examining relationships among community-based health services, primary healthcare integration, population health surveillance, social and structural determinants, equity-oriented interventions, and health-system capacity to adapt to changing conditions. The conceptual scope was informed by established scholarship on primary healthcare, integrated care, systems thinking, and health equity (Macinko et al., 2003; Starfield et al., 2005; Valentijn et al., 2013; World Health Organization, 2021).

2.3 Eligibility Criteria

Eligible publications were peer-reviewed empirical or conceptual studies published in English that addressed at least one core domain: community health services or systems, population health, primary healthcare, health equity, healthcare accessibility, social determinants of health, integrated care, public health systems, or health-system resilience. Studies were excluded if they focused exclusively on specialised clinical conditions without relevance to population or community health systems, lacked substantive or conceptual relevance to the study objectives, or provided insufficient methodological or conceptual information. Non-scholarly publications, editorials, opinion pieces, conference abstracts, and studies lacking adequate methodological or conceptual substance were also excluded.

2.4 Study Selection and Screening

Study selection was conducted sequentially through title and abstract screening, followed by full-text assessment of potentially eligible publications or studies for which eligibility could not be established from the abstract. Screening considered both substantive relevance and conceptual contribution to a systems-based understanding of community health systems.

Following screening and eligibility assessment, 84 studies were included in the final synthesis, with each published study serving as the unit of analysis. Selection aimed to ensure sufficient conceptual diversity while maintaining alignment with the study objectives, particularly the relationships among population health surveillance, primary healthcare integration, social determinants, health equity, and health-system resilience.

2.5 Data Extraction and Thematic Synthesis

Data were extracted using a structured synthesis matrix covering publication characteristics, study objectives, population or context, key concepts, community health-system characteristics, primary healthcare functions, population health outcomes, social and structural determinants, equity dimensions, health-system characteristics, resilience mechanisms, and principal findings.

Extracted evidence was organised into thematic categories representing distinct yet interconnected dimensions of community and population health systems. Particular attention was given to mechanisms operating across individual, family, community, organisational, health-system, and structural or policy levels. This multilevel approach was informed by systems thinking, which conceptualises health outcomes as emerging from interactions among interconnected components rather than isolated causal factors (Peters, 2014).

Thematic analysis was conducted iteratively to identify recurring concepts, relationships, mechanisms, and patterns across the literature. The synthesis progressed from descriptive themes to cross-theme comparison and higher-order analytical concepts, focusing on how community health systems connect population health surveillance, primary healthcare integration, equity-oriented interventions, and adaptive capacity. Interpretation was further informed by integrated-care and primary-healthcare perspectives emphasising coordination across services, levels of care, professional groups, and community contexts (Valentijn et al., 2013; World Health Organization, 2018).

2.6 Conceptual Framework Development

The conceptual framework was developed through iterative thematic integration and conceptual interpretation. Identified themes were examined for their relationships, interdependencies, and potential mechanisms influencing population health and equity. Rather than treating the domains as independent components, the framework conceptualises them as mutually reinforcing elements within a dynamic community health system.

Four interconnected domains were integrated: (1) population health surveillance; (2) primary healthcare integration; (3) social determinants of health and equity-oriented interventions; and (4) adaptive health-system resilience. Population health surveillance was conceptualised as a mechanism for identifying population needs, monitoring health inequalities, and informing timely action. Primary healthcare integration was positioned as the principal service-delivery mechanism connecting preventive, promotive, and essential healthcare functions with community needs. Social determinants and equity-oriented interventions represented mechanisms for addressing unequal exposure to risks and unequal access to resources. Adaptive resilience reflected the capacity to absorb disruption, learn, adapt, maintain essential functions, and respond to changing population health needs.

The framework was refined through iterative comparison of themes, assessment of conceptual coherence, and alignment with established systems-based and integrated-care perspectives (Atun et al., 2010; Peters, 2014; Valentijn et al., 2013). The resulting model illustrates how these four domains interact dynamically to strengthen population health, reduce health inequities, and enhance the capacity of community health systems to adapt to emerging and evolving challenges.

2.7 Ethical Considerations

This study synthesised previously published literature and involved no direct recruitment, interaction, or data collection involving human participants. Therefore, informed consent was not required, and formal ethical approval was not applicable. The synthesis nevertheless adhered to principles of academic integrity, transparent reporting, accurate interpretation of published evidence, and appropriate citation of all sources informing the analysis and conceptual framework.

RESULTS

The integrative synthesis of 84 publications identified four interconnected domains: population health surveillance, primary healthcare integration, social determinants and equity-oriented interventions, and adaptive health-system resilience. These domains functioned as mutually reinforcing mechanisms linking information, service integration, community participation, equity, and adaptive capacity. Their interaction informed the development of the **Systems-Based Community Health Framework for Equity and Resilient Population Health Care**, which conceptualises community health systems as dynamic structures capable of improving population health, reducing inequities, and strengthening resilience through continuous feedback, coordinated action, and adaptation.

3.1 Population Health Surveillance

Population health surveillance emerged as a foundational system function for identifying health needs, monitoring disease patterns, detecting emerging threats, and guiding timely responses. Beyond technical data collection, surveillance connects population-level information with decision-making, resource allocation, service planning, and community action. Its effectiveness increases when community and primary healthcare data are integrated with broader public health and health-system information, enabling earlier recognition of changing needs and adaptive responses (Peters, 2014). Surveillance also advances health equity by using disaggregated and community-level data to identify geographic, socioeconomic, and demographic disparities, thereby supporting proportionate responses to unequal vulnerability and barriers to care (Kruk et al., 2018; World Health Organization, 2025).

3.2 Primary Healthcare Integration

Primary healthcare integration emerged as a central mechanism for translating population health information into accessible, continuous, and equitable care. The synthesis showed that integration is most effective when preventive, promotive, curative, and community-based services are connected through coordinated structures and referral pathways, improving accessibility, continuity, and population health outcomes (Macinko et al., 2003; Starfield et al., 2005). Effective integration extends beyond clinical coordination to include healthcare professionals, community health workers, families, public health programmes, local organisations, and other sectors. Such collaboration reduces fragmentation, strengthens continuity, and facilitates timely care while addressing geographic, socioeconomic, and service-related barriers, particularly among underserved populations (Atun et al., 2010; Valentijn et al., 2013; Kruk et al., 2018; World Health Organization, 2018).

3.3 Social Determinants of Health and Equity-Oriented Interventions

Social determinants—including income, education, housing, food security, employment, gender, geography, and social protection—fundamentally shape population health, exposure to risk, and access to healthcare (Marmot et al., 2008; World Health Organization, 2025). The synthesis showed that health inequities often arise from the interaction of social disadvantage and health-system barriers, making service expansion alone insufficient. Equity-oriented interventions must address structural conditions that produce unequal risks and access to resources (Kruk et al., 2018; World Health Organization, 2025). Meaningful community participation further strengthens equity by identifying local needs, building trust, and supporting culturally responsive interventions (Sacks et al., 2019).

3.4 Adaptive Health-System Resilience

Adaptive health-system resilience emerged as a dynamic capacity to anticipate, absorb, respond to, learn from, and adapt to changing epidemiological, demographic, social, environmental, and economic conditions. Resilience is strengthened by flexible services, effective information flows, strong primary healthcare, community engagement, and cross-sectoral coordination. Continuous feedback and organisational learning enable systems to adjust strategies in response to emerging needs and threats (Peters, 2014). Population surveillance and community participation therefore contribute directly to adaptive capacity. Importantly, resilience must also protect equity, ensuring that vulnerable populations maintain fair access to essential services during disruption and that crises do not deepen existing health disparities (Kruk et al., 2018; World Health Organization, 2021).

3.5 Interconnections Among the Four Domains

The synthesis identified four cross-cutting mechanisms—information, integration, equity, and adaptation—that connect the four domains to population health outcomes. Surveillance informs decision-making, resource allocation, and service planning; integration links primary healthcare with public health, communities, and other sectors; equity ensures responses reflect differential needs and structural disadvantage; and adaptation enables systems to learn and respond to changing conditions. These mechanisms operate reciprocally, forming a dynamic network rather than isolated processes. Effective surveillance supports responsive care, integrated services strengthen prevention and engagement, equity-oriented action reduces structural barriers, and adaptive resilience enables continuous adjustment to emerging needs and threats (Peters, 2014; Valentijn et al., 2013).

3.5 Interconnections Among the Four Domains

The synthesis identified four interconnected mechanisms—information, integration, equity, and adaptation—linking the four domains to population health outcomes. Surveillance supports informed decision-making and service planning; integration connects primary healthcare with public health, communities, and other sectors; equity ensures responses address differential needs and structural disadvantage; and adaptation enables continuous learning and responsiveness. Operating reciprocally, these mechanisms form a dynamic system in which effective surveillance strengthens care, integrated services enhance prevention and engagement, equity-oriented action reduces structural barriers, and adaptive resilience enables timely responses to emerging population health needs (Peters, 2014; Valentijn et al., 2013).

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DISCUSSION

This study developed a systems-based conceptual framework integrating population health surveillance, primary healthcare integration, social determinants, equity-oriented interventions, and adaptive health-system resilience as interconnected community health-system domains. Its central contribution lies in positioning equity not as a secondary outcome but as a foundational principle shaping system design, implementation, and evaluation. The findings demonstrate that sustainable population health improvement cannot rely on isolated interventions or service expansion alone. Rather, it requires health systems to integrate information, services, communities, and sectors while continuously adapting to evolving population needs and contextual challenges.

The first major implication concerns population health surveillance as a foundation for system responsiveness. Beyond conventional disease detection and epidemiological monitoring, surveillance should generate actionable intelligence on health inequities, social vulnerability, service utilisation, and emerging community needs. From a systems perspective, such information functions as feedback, enabling health systems to detect changing conditions and adapt interventions accordingly (Peters, 2014). This perspective aligns with high-quality health systems, where timely information, accountability, and responsiveness are essential to achieving meaningful and equitable population health outcomes (Kruk et al., 2018).

The equity dimension of surveillance is particularly important because aggregate indicators may conceal disparities across socioeconomic, geographic, and demographic groups. The proposed framework therefore positions surveillance as an equity-enabling mechanism that identifies who is reached, who remains underserved, and where health-system barriers are concentrated. Such an approach aligns with the social determinants of health perspective, recognising that inequities arise from unequal distributions of resources, opportunities, and living conditions. Disaggregated and context-sensitive surveillance is thus essential for making hidden disparities visible and guiding proportionate, equity-oriented responses (Marmot et al., 2008; World Health Organization, 2025).

The second major implication concerns primary healthcare integration as the operational foundation of community health systems. Primary healthcare translates population health priorities into accessible preventive, promotive, and essential services and is associated with improved outcomes and more equitable access (Macinko et al., 2003; Starfield et al., 2005). However, the proposed framework extends this role beyond an isolated sector, emphasising integration with public health surveillance, community-based services, referral systems, social programmes, and other sectors influencing population health. Such integration can reduce fragmentation, strengthen continuity, and enhance system responsiveness to diverse community needs.

This interpretation aligns with integrated-care frameworks that view integration as multidimensional, encompassing clinical, professional, organisational, and systemic connections (Valentijn et al., 2013). The proposed framework further emphasises its contribution to population health equity by reducing fragmentation and strengthening responses to complex, overlapping needs. Integrated primary healthcare thus translates population health information into coordinated action. Equally, health inequities cannot be addressed through healthcare interventions alone. Poverty, education, housing, food security, employment, gender, and geographic disadvantage shape health risks and access, requiring community health systems to engage with broader social and structural conditions (Marmot et al., 2008; World Health Organization, 2025).

The proposed framework contributes to this perspective by positioning equity-oriented interventions as an active system domain rather than as an external policy consideration. This means that community health systems should systematically identify structural barriers and incorporate equity considerations into planning, resource allocation, service delivery, and evaluation. Such an approach is particularly relevant for populations that experience multiple forms of disadvantage, where the cumulative interaction between social vulnerability and health-system barriers may produce disproportionately poor outcomes. High-quality health systems must therefore be judged not only by overall performance but also by their ability to reach populations that face the greatest barriers to care (Kruk et al., 2018).

Community participation represents an important pathway through which equity-oriented systems can become more responsive. Communities possess contextual knowledge about local health priorities, cultural practices, barriers to access, and informal resources that may not be captured through conventional health-system data. Meaningful community engagement can therefore strengthen the relevance, acceptability, and sustainability of health interventions. The inclusion of community roles within health-system frameworks has been increasingly recognised as essential for achieving universal health coverage and ensuring that health systems remain connected to the realities of the populations they serve (Sacks et al., 2019).

The fourth major implication concerns health-system resilience. The findings suggest that resilience should be understood as more than the capacity to withstand acute shocks. Community health systems operate within continuously changing environments characterised by epidemiological transitions, demographic change, climate-related risks, economic pressures, workforce constraints, and emerging health threats. Resilience therefore requires the ability to anticipate, absorb, adapt, learn, and transform while maintaining essential health functions.

The proposed framework connects resilience directly with equity and population health rather than treating resilience as a separate emergency-management concept. A health system may remain operational during a crisis while simultaneously producing unequal consequences if vulnerable populations experience greater barriers to access or reduced availability of essential services. Resilience should therefore include the capacity to protect equitable access and prevent the widening of pre-existing disparities. This interpretation is consistent with the broader emphasis on high-quality and people-centred health systems, in which system performance must be understood in relation to population needs and equity (Kruk et al., 2018; World Health Organization, 2021).

An important contribution of the framework is its emphasis on the interdependence between resilience and primary healthcare. Strong primary healthcare can provide a stable foundation for resilience because it maintains essential services, supports prevention, strengthens community relationships, and facilitates early identification of emerging threats. Conversely, resilient systems can strengthen primary healthcare by enabling services to adapt to changing conditions and maintain continuity during periods of disruption. This reciprocal relationship suggests that resilience should be built into routine health-system functions rather than activated only during emergencies.

The framework also highlights the importance of systems thinking for understanding community health. Population health outcomes are not produced through linear relationships between isolated interventions and outcomes. Rather, they emerge from dynamic interactions among multiple components, including healthcare services, social conditions, community structures, governance, and information systems (Peters, 2014). The four domains identified in this study therefore operate through feedback loops rather than sequential pathways. Surveillance informs planning; integrated primary healthcare generates information and strengthens access; equity-oriented interventions address structural barriers; and resilience enables the system to adapt based on new information and changing conditions.

This systems perspective also helps explain why fragmentation remains a persistent barrier to population health improvement. When programmes operate independently, information may not flow effectively across organisational boundaries, referral pathways may be weak, and resources may not be allocated according to population needs. Fragmentation can therefore create reinforcing cycles in which underserved populations remain poorly identified, poorly reached, and insufficiently represented in health-system decision-making. Integration, by contrast, can create positive feedback loops that connect information, services, and community participation, thereby strengthening system responsiveness (Atun et al., 2010; Valentijn et al., 2013).

The proposed framework makes three principal conceptual contributions. First, it integrates **population health surveillance** with **primary healthcare integration**, thereby linking information generation with service delivery and system responsiveness. Second, it positions **social determinants and equity-oriented interventions** as an intrinsic component of community health-system functioning rather than as external contextual factors. Third, it conceptualises **resilience as an adaptive and equity-oriented capacity**, linking preparedness and system adaptation with the protection of population health and equitable access. Together, these contributions move beyond fragmented approaches that address surveillance, healthcare delivery, social determinants, or resilience as separate domains.

The framework has important implications for policy, governance, and practice. Community health systems should be governed as interconnected structures requiring coordination across health and non-health sectors, supported by surveillance, community participation, social protection, and shared resource planning (World Health Organization, 2018). Performance evaluation should extend beyond coverage and efficiency to include continuity, integration, equity, responsiveness, and adaptive capacity. This perspective is particularly relevant in resource-constrained settings, where strengthening community-based primary healthcare, local surveillance, participation, and cross-sectoral collaboration can improve responsiveness, build local capacity, reduce fragmentation, and strengthen resilient connections between communities, primary care, and higher levels of health systems.

Nevertheless, the proposed framework should be interpreted as a conceptual contribution rather than a validated causal model. The framework was developed through synthesis of published empirical and conceptual literature and therefore requires empirical testing across diverse health-system and sociocultural contexts. Future research should examine whether the four domains operate as hypothesised, identify measurable indicators for each domain, and investigate the pathways through which their interaction influences population health outcomes and equity. Comparative research across countries and health-system contexts may also clarify how different governance structures, resource environments, and community capacities influence the implementation and effectiveness of the framework.

Overall, the findings suggest that the future of community health systems depends on moving beyond fragmented, programme-specific approaches toward integrated systems that can continuously learn, adapt, and respond to population needs. The proposed **Systems-Based Community Health Framework for Equity and Resilient Population Health Care** provides a conceptual foundation for this transition by connecting surveillance, primary healthcare, equity-oriented action, and resilience within a unified systems perspective. Its central proposition is that stronger population health and greater equity emerge when communities, services, information systems, and institutions are connected through adaptive and mutually reinforcing relationships.

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CONCLUSIONS

This study demonstrates that strengthening community health systems requires a shift from fragmented and programme-specific approaches toward integrated, equity-oriented, and adaptive systems capable of responding to complex and changing population health needs. The integrative synthesis identified four interconnected domains that are central to this transformation: population health surveillance; primary healthcare integration; social determinants of health and equity-oriented interventions; and adaptive health-system resilience. These domains should not be understood as independent components but as mutually reinforcing elements that collectively shape population health, health equity, and system capacity.

The proposed **Systems-Based Community Health Framework for Equity and Resilient Population Health Care** provides a conceptual foundation for understanding how information, integration, equity, and adaptation interact within community health systems. Its central contribution is to connect population health surveillance with primary healthcare delivery, structural determinants, community participation, and adaptive resilience within a unified systems perspective. The framework positions health equity as both a guiding principle and a core outcome, while resilience is conceptualised as the capacity to continuously learn, adapt, and maintain essential functions without widening existing health disparities.

In practice, policymakers and health-system leaders should strengthen primary healthcare, population health surveillance, community participation, cross-sectoral collaboration, and equity-oriented resource allocation. Particular attention should be directed toward populations experiencing structural disadvantage and barriers to essential services. Future empirical research should validate and refine the proposed framework across diverse cultural, socioeconomic, and health-system contexts and develop measurable indicators for its four core domains.

Ultimately, resilient population health systems cannot be achieved through isolated interventions. They require sustained connections among communities, primary healthcare services, public health institutions, information systems, and broader social sectors. Reimagining community health systems through a systems-based, equity-oriented, and adaptive perspective may provide a pathway toward more responsive, inclusive, and resilient population health care.

DECLERATION OF GENERATIVE ARTIFICIAL INTELLIGENCE (AI) USE

During the preparation of this manuscript, the authors used generative artificial intelligence (AI) tools, including ChatGPT, solely for language editing, grammar checking, clarity enhancement, and refinement of academic expression. AI tools were not used to generate or fabricate research data, conduct data analysis, interpret research findings, or determine the scientific conclusions of the study. The authors retain full responsibility for the content, accuracy, originality, integrity, and final version of the manuscript. All AI-assisted content was critically reviewed, verified, and revised by the authors, who take full responsibility for the submitted work.

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