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RESEARCH ARTICLE

DIFFERENCES IN PERSON-CENTRED CARE BETWEEN PUBLIC AND PRIVATE HOSPITALS IN MONGOLIA

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ABSTRACT

Healthcare management plays a critical role in improving clinical outcomes. Globally, there has been an increasing focus on person-centred care as a means to enhance healthcare management. In Mongolia, although person-centered care is reflected in health sector policy documents and accreditation standards, the associated health outcome indicators remain insufficiently comprehensive. Therefore, this study was designed to assess person-centred care in hospitals and to compare the differences between public and private hospitals.

The study involved physicians, healthcare workers, and patients from three public hospitals and three private hospitals. A cross-sectional study design was employed, using the Person-Centred Climate Questionnaire to assess perceptions of person-centred care. Key factors were identified through principal component analysis. Differences between public and private hospitals were analyzed using a one-way ANOVA test. The reliability and validity of the questionnaire were assessed using Cronbach's alpha, and sample adequacy was evaluated using the Kaiser-Meyer-Olkin (KMO) test.

Patients in both public and private hospitals rated person-centred care based on two factors: the climate of safety and the climate of everydayness. Physicians and healthcare workers in public hospitals also assessed person-centred care using these two factors, whereas those in private hospitals identified only one factor. The climate of hospitality—a key dimension of person-centred care—was not measured in any of the surveyed hospitals. Patients in public hospitals rated person-centred care more highly than those in private hospitals. However, physicians and healthcare workers gave higher ratings to private hospitals compared to public hospitals.

KEYWORDS

person-centred care, healthcare management

INTRODUCTION

Person-centred care is grounded in the values of respect for individuals, the right to self-expression, mutual respect, and understanding—principles shaped and influenced by cultural context [1]. David Edvardsson et al. (2008) defined person-centred care as focusing on caring, personalizing the environment, shared decision-making, interpreting symptoms and behaviors from the person's perspective, and prioritizing communication over care [2]. It considers the whole precondition and the patient's health condition and empowers the individual to play an active role in the healthcare process [3]. It serves as the foundation for delivering safe, high-quality healthcare, contributing to improved outcomes and experiences for patients, caregivers, and families [4].

A theoretical framework of person-centred care refers to the concept of humane care with a moral component, and this practice is described as a relationship based on effective interpersonal processes aimed at achieving therapeutic goals. The following principles are recognized as the foundation of a person-centred approach: treating people as individuals, respecting their rights as a person, building mutual trust and understanding and developing positive relationships [5]. This philosophical position reflects models for developing person-centred care that place the humanity of individuals at the core of care. While person-centred care is increasingly central to healthcare, theoretical development has often focused on related concepts and theories, particularly relationship-centred care, compassionate care, and dignified care. However, none of these theories fully endorses a holistic view of person-centred care as a unified theory of how all individuals—healthcare professionals, patients, families, and communities—experience healthcare [5].

There are several models of person-centred care, all of which are described as 'placing the person at the center of care [6]:

- The authentic consciousness model (McCormack 2003) [6]
- The tidal model (Barker 2000) [6]
- Skilled companionship (Tichen 2001) [6]
- The senses framework (Nolan et al. 2004) [6]
- Dementia reconsidered (Kitwood 1997) [6]
- VIPS (Brooker 2007) [6]
- The Burford model (Johns 1994) [6]

The Person-Centred Practice Framework was developed to support the implementation of person-centred practices and to provide clinicians with a shared language to identify the components of person-centredness, along with the barriers and enablers that influence its development in the workplace [5]. This framework, developed by Tanya McCance and her colleagues over more than a decade, originated in the nursing field but has since been adopted more broadly across healthcare systems. The Person-Centred Practice Framework comprises four core domains, with a fifth domain currently being developed as an additional component.

1. Prerequisites. It focuses on the attributes and qualities of healthcare staff.
2. Practice environment. This reflects the complexity inherent in the healthcare delivery context.
3. Person-centred processes. It emphasizes participatory methods that foster meaningful connections between people.
4. A healthful culture. The result of developing effective person-centred practices is a healthy culture that promotes human flourishing.
5. Macro context. This framework provides a macro-level context that reflects the strategic and political factors influencing the development of person-centred cultures.

Widely recognized as the gold standard in healthcare delivery [7], person-centred care has become a guiding principle for health systems globally [8]. The concept has also evolved beyond a narrow focus on patients, encompassing a broader approach that includes relationships, communication, and systemic responsiveness. For example, in 2001, the Institute of Medicine included ‘patient-centred care’ as one of the six goals of twenty-first century healthcare system in ‘Crossing the

quality chasm' [25]. The World Health Organization has developed 'Global strategy on integrated people-centered health services 2016-2026' [9] and in order to improve healthcare services the Tokyo Declaration on Patient Safety was adopted in 2018, and it was decided to make September 17 of each year 'World Patient Safety Day'. Such as all of this indicates a global focus on person-centred care.

In Mongolia, the long-term development policy 'Vision-2050' [10] set the goal of providing quality, comprehensive healthcare services that meet the population's needs. In addition, the 'Action Plan for 2022-2025 to Improve the Quality and Safety of Healthcare Services' [11] emphasizes person-centred care by including the development of such services. Furthermore, the criteria for accrediting healthcare providers [12] require the inclusion of a person-centred service evaluation group. Collectively, these documents demonstrate that Mongolia's health sector is focusing on delivering person-centered care.

Person-centred care in hospitals has demonstrated positive impacts on the healthcare sector, including increased patient satisfaction, reduced emergency room wait times, fewer medication errors, and lower mortality rates [8]. The quality of healthcare can be measured using outcome indicators, and person-centred care as the foundation for delivering high-quality health care. But the incidence of diseases in Mongolia increased 1.68 times, from 2,262.7 cases per 1,000 population in 2014 to 3,808.8 in 2023 [13]. The average incidence over the past 10 years has been 2,930.3 per 100,000 population. In 2014, the national death count was 16,495, of which 21.6 percent occurred in hospitals. In 2023, hospital deaths accounted for 4,127 out of 17,533 total deaths, indicating that this proportion has not decreased. However, the percentage of hospital deaths that underwent pathological autopsy has declined over the past 10 years, from 68.1 percent to 43.8 percent (1,807 cases). However, the discrepancy in primary diagnoses identified through this analysis increased from 5.7 percent in 2014 to 11 percent [14], suggesting that current health outcome indicators remain insufficient. Compared to some East Asian countries, Mongolia's under-five and perinatal mortality rates per 1,000 live births are among the highest.

The low level of satisfaction among physicians and healthcare workers contributes to poor patient satisfaction [15]. Furthermore, the current quality and availability of healthcare services do not meet citizens' expectations, resulting in low satisfaction with the quality of care [16].

Researchers have noted that well-managed hospitals achieve better clinical outcomes and that effective management plays a crucial role in ensuring patient well-being [17]. Therefore, we conducted this study based on the belief that assessing the current state of person-centred care in Mongolian tertiary public and private hospitals is essential, and that the findings will play an important role in supporting future improvements in hospital management.

METHODS

HYPOTHESIS

People-centred care in both public and private hospitals is determined by three factors: safety, daily routine, and hospitality. However, there are notable differences in how these factors are implemented in public and private hospitals.

SAMPLING OF STUDY

This study utilized a cross-sectional study, examining three public hospitals and three private hospitals that offer tertiary healthcare services. The study covered 314 patients, 289 physicians and health workers from public hospitals, and 202 patients, 237 physicians and health workers from private hospitals.

Mongolian Health Law defines 14 types of organizations that provide healthcare services [26]. This research focused on a specialized hospital that offers nationwide referral healthcare services. Currently, nine state-owned specialized hospitals operate under the Ministry of Health. From these hospitals, three comparable hospitals that provided similar care were selected; after obtaining permission from their managers to participate in the study, data were collected.

As of 2023, there are 239 private hospitals operating across the country, with 69.2 percent (165 hospitals) located in Ulaanbaatar [13]. Within Ulaanbaatar, there are 32 private hospitals with 50 or more beds, and 8 hospitals with more than 89 beds. Of these eight hospitals, five were invited to participate in the study, and three agreed to take part. The sample consisted of all physicians and healthcare workers employed at the three public hospitals and three private hospitals that agreed to participate in the study, with a confidence interval of 95%. Respondents were selected randomly.

RESEARCH QUESTIONNAIRE

The Person-Centred Climate Questionnaire (PCQ) was developed in 2008 by David Edvardsson et al. The patient version (PCQ-S) includes three subscales: a climate of safety, a climate of everydayness, and a climate of hospitality, comprising 17 questions [6]. The staff version of the Person-Centred Climate Questionnaire consists of three subscales: a climate of safety, a climate of everydayness, and a climate of community, with 14 questions [18, 7]. This questionnaire is rated on a 6-point Likert scale.

In the patient version of the questionnaire, the 'climate of safety' subscale includes items related to the knowledge and education of physicians and health workers, their friendliness, the reliability of care, the safety of the hospital environment, and the opportunity for patients to communicate with healthcare providers. The 'climate of everydayness' reflects how comfortable the hospital stay feels—similar to being at home—as well as the ability to engage in simple conversations and maintain a positive atmosphere. The 'hospitality' subscale assesses the dedication of staff toward patients, the opportunity for patients to make their own choices, and the perceived advantages the hospital offers over others.

TABLE 1. QUESTIONS OF THE PERSON-CENTRED CLIMATE QUESTIONNAIRE, CATEGORIZED BY EACH FACTOR

Factors	Patient Version	Staff Version
A climate of safety	1,2,3,4,5,6,7,8,9,10	1,2,3,4,5
A climate of everydayness	11,12,13,14	6,7,8,9,10
A climate of hospitality/community	15,16,17	11,12,13,14

Source: [6, 18]

The 'climate of safety' in the staff version of the questionnaire is measured by the reliability and security of the care environment, the clarity with which patients can express themselves, the availability of personal space in the workplace, and the overall friendly and warm atmosphere. The 'climate of everydayness' reflects how peaceful and homelike the work environment feels. It includes the ability to see the positive aspects of the workplace, maintain focus, and work in an orderly setting. The 'climate of community' is assessed by the amount of time patients have to meet and speak with visitors, as well as the opportunities they have to communicate with physicians, healthcare workers, or other staff members.

ETHICAL APPROVAL

The University of Finance and Economics requested permission to conduct the study from three public hospitals (letter No. 4/420, 2021) and from three private hospitals (letters No. 4/645, 4/646, and 4/647, 2021). With the approval of the hospital administrators and the medical ethics committee, a questionnaire survey was conducted among patients and staff of the respective hospitals. The survey did not request the names of patients or staff, and their identities could not be determined.

VALIDITY AND RELIABILITY

The Person-Centred Climate Questionnaire was originally developed in Swedish and has not been translated into Mongolian, so it was translated from the English version with the author's permission. The translation was done using the forward-backward method (English-Mongolian and Mongolian-English) and reviewed by two different professional translators. The Mongolian-translated version of the questionnaire was also completed and tested by physicians, nurses, and health workers. During the test, brief conversations were held with participants to assess the clarity of the questionnaire and whether the basic content of the questions—rooted in cultural differences—was understood. The reliability of the questionnaire was tested by calculating Cronbach's a coefficient.

STATISTICAL ANALYSIS

IBM SPSS (version 25.0) was used to analyze the survey data. The means and standard deviations of each subscale of the questionnaire were calculated, along with the observed values at a 95% confidence interval. The Kaiser-Meyer-Olkin (KMO) test was used to assess sampling adequacy. The internal consistency of the Person-centred Climate Questionnaire was evaluated using Cronbach's alpha coefficient, and the factor structure was examined through Principal Component Analysis (PCA). All statistical analyses were considered significant at $p < 0.05$.

In our study, we selected two groups of public and private hospitals to evaluate person-centred care. Hospitals are divided into two groups – public and private – based on their form of ownership. Patients and healthcare workers from both groups were included, allowing us to assess person-centred care from two perspectives. To determine whether patients and staff evaluate person-centred care differently based on the type of hospital, we conducted a one-way ANOVA test. In addition, demographic characteristics of patients such as age, gender, are of residence, frequency of hospitalization, days spent, and education were considered for both groups. It was also necessary to analyze whether the demographic characteristics of healthcare workers differed in terms of age, gender, education level, job position, department, and years of healthcare institution. Therefore, since one-way analysis of variance is used to determine whether group means differ across demographic variables, we employed the One-Way ANOVA with Post-hoc Tukey test for this analysis.

RESULTS

The average age of patients in public hospitals was 48.5 years, with 56.4% being female. In private hospitals, the average age was 38.7 years, and 53.0% were female.

Regarding education, 36.9% of public hospital patients completed secondary education, while 48.5% of private hospital patients held a bachelor's degree. Among public hospital patients, 69.1% were residents of Ulaanbaatar (UB), and 62.1% were hospitalized for the first time. In private hospitals, 77.7% of patients were UB residents, and 66.3% were first-time inpatients (Table 2).

TABLE 2. DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Variables	Total participants (n, %)		Mean ± SD	
	Public hospital	Private hospital	Public hospital	Private hospital
Gender				
male	137 (43.6%)	89 (44.0%)	-	-
female	177 (56.4%)	107 (53.0%)	-	-
Age (year)			48.5±16.0	38.7±11.8
Education level				
secondary school	116 (36.9%)	19 (9.4%)	-	-
middle school	52 (16.6%)	45 (22.3%)	-	-
bachelors	107 (34.1%)	98 (48.5%)	-	-
masters	30 (9.6%)	26 (12.9%)	-	-
PhD	3 (1.0%)	3 (1.5%)	-	-
Are of residency				
Ulaanbaatar city	217 (69.1%)	157 (77.7%)	-	-
rural	96 (30.6%)	40 (19.8%)	-	-
Frequency of hospitalization				
first time	195 (62.1%)	134 (66.3%)	-	-
2 or more	107 (34.1%)	52 (25.7%)	-	-
Days spent			4.9±3.6	5.1±2.5

The average age of physicians and health workers in public hospitals was 33 years, with 77.9% being female. In private hospitals, the average age was 33.8 years, with 75.5% female.

Regarding education, 64.4% of physicians and health workers in public hospitals held a bachelor's degree, while 62.0% in private hospitals had the same level of education.

The average years of experience among physicians and health workers in public hospitals was 9.1 years, with 6.9 years of professional experience. In private hospitals, the average was 8.9 years, with 6.0 years in the profession (Table 3).

TABLE 3. DEMOGRAPHIC AND PROFESSIONAL CHARACTERISTICS OF THE PHYSICIANS AND HEALTH WORKERS

Variables	Total participants (n, %)		Mean ± SD	
	Public hospital	Private hospital	Public hospital	Private hospital
Gender				
male	62 (21.5%)	51 (21.5%)	-	-
female	225 (77.9%)	179 (75,5%)	-	-
Age (year)			33.0±9.4	33.8±9.5
Education level				
professional diploma	39 (13.5%)	42 (17.7%)	-	-
bachelors	186 (64.4%)	147 (62.0%)	-	-
masters	42 (14.5%)	29 (12.2%)	-	-
PhD	1 (0.3%)	2 (0.8%)	-	-
Total work experiences (year)			9.1±9.5	8.9±8.6
Current work experience (year)			6.9±8.2	6.0±7.1

In the person-centred care assessment of patients in the inpatient wards of public hospitals, two factors were identified through Principal Component Analysis (Tables 4 and 6).

TABLE 4. FACTOR LOADING MATRIX FOR EACH ITEM OF THE PCQ-PATIENT VERSION (PUBLIC HOSPITALS)

№	Items	Factor 1. A climate of safety	Factor 2. A climate of everydayness	Factor 1. A climate of hospitality
P4	A place where I feel welcome	0.830		-
P5	A place where it is easy to talk to the staff	0.829		-
	A place where I rely on receiving the best care	0.812		-
P7	A place where the staff come quickly when I need help	0.688		-
P3	A place where I feel in safe hands	0.651		-
P1	A place where the staff is knowledgeable	0.645		-
P10	A place where the staff have time for the residents	0.628		-
P8	A place where the staff use language, I can understand	0.568		-
P6	A place where the staff take notice of what I say	0.546		-

P9	A place which is neat and clean	0.534		-
P17	A place where I can get "that little bit extra"		0.782	-
P13	A place where it is possible to get unpleasant thought out of your head		0.768	-
P12	A place where which feels homely even though I am in an institution		0.761	-
P14	A place where people talk about ordinary things, not just illness		0.735	-
P11	A place where there is something nice to look at		0.730	-
P16	A place where I can make choices, for example what to wear		0.677	-
P15	A place where the staff make extra efforts on my behalf		0.650	-
Cronbach's Alpha		0.932		
KMO test		0.924		

Patients defined person-centred care as a climate of safety, a climate of everydayness, and a climate of safety is 0.534-0.830 and a climate of everydayness is 0.650-0.782. Table 5 shows the results of the principal component analysis of the assessment of the person-centered care in public hospitals' physicians and health workers.

TABLE 5. FACTOR LOADING MATRIX FOR EACH ITEM PCQ-STAFF VERSION (PUBLIC HOSPITALS)

№	Items	Factor 1. A climate of safety	Factor 2. A climate of everydayness	Factor 1. A climate of community
S1	A place where I feel welcome	0.784		-
S2	A place where I feel acknowledged as a person	0.782		-
S5	A place where the staff use a language that the patients can understand	0.762		-
S3	A place where I feel I can be myself	0.761		-
S4	A place where the patients are in safe hands	0.648		-
S12	A place where it is easy for the patients to receive visitors		0.817	-
S14	A place where the patients have someone to talk to if they so wish		0.779	-
S13	A place where it is easy for the patients to talk to the staff		0.771	-
S8	A place where it is quiet and peaceful		0.769	-
S11	A place where it is easy for the patients to keep in contact with their loved ones		0.738	-
S9	A place where it is possible to get unpleasant thoughts out of your head		0.673	-
S7	A place where there is something nice to look at		0.641	-
S10	A place which is neat and clean		0.618	-
S6	A place which feels homely even though it is in an institution		0.597	-

Cronbach's Alpha	0.937
KMO тест	0.932

Physicians and health workers defined the person-centred care in public hospitals using two factors: a climate of safety (0.648-0.784) and a climate of everydayness (0.597-0.817).

TABLE 6. FACTOR LOADING MATRIX FOR EACH ITEM OF THE PCQ-PATIENT AND STAFF VERSION (PRIVATE HOSPITALS)

	Patients	Physicians and health workers
A climate of safety	0.670-0.853	0.493-0.877
A climate of everydayness	0.608-0.835	
A climate of hospitality/ community	-	
Cronbach's Alpha	0.968	0.954
KMO test	0.958	0.945

Patients in private hospitals defined person-centred care in terms of a climate of safety and everydayness, while physicians and health workers defined person-centred care as a single factor (Table 6).

Table 7 shows the average scores for each of the factors determining person-centred care for patients in public and private hospitals, as well as for physicians and health workers working in these hospitals.

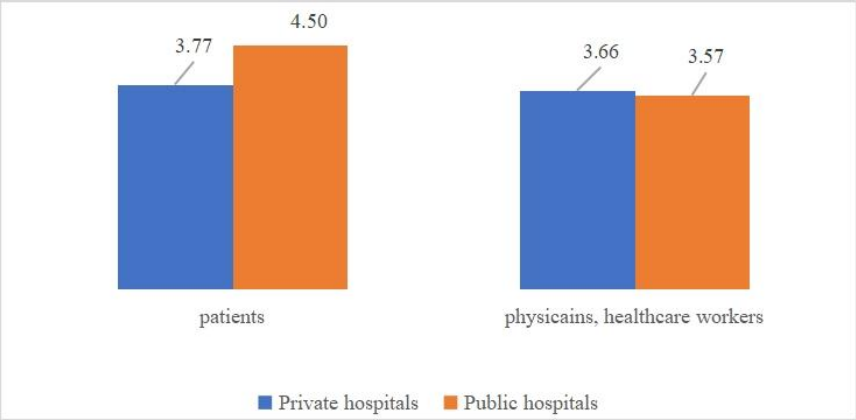
TABLE 7. MEAN VALUES FOR EACH FACTOR (PUBLIC AND PRIVATE HOSPITALS)

	Patients (SD)		Physicians and health workers (SD)	
	Public hospital	Private hospital	Public hospital	Private hospital
A climate of safety	4.60 (0.82)	3.95 (0.99)	3.31 (1.43)	3.66 (1.16)
A climate of everydayness	4.33 (1.14)	3.63 (1.23)	4.01 (1.11)	
A climate of hospitality/ community	-	-	-	

The difference between the mean values of public and private hospitals for assessing the climate of everydayness is 0.7, and the difference for the climate of safety is 0.65.

Figure 1 compares the mean values of the person-centred care assessments by patients, physicians and health workers in public and private hospitals.

FIGURE 1. MEAN VALUE OF THE PERSON-CENTRED CARE ASSESSMENT



Patients in public hospitals rated the hospital's person-centred care higher than those in private hospitals (0.73). However, physicians and health workers in public hospitals rated person-centred care lower than their counterparts in private hospitals (0.09).

TABLE 8. RESULT OF ONE-WAY ANOVA TEST, PATIENTS

№	Variables	Person-centred care (Sig.)	P value
1	Type of hospital	0.000*	< 0.05
2	Age	0.000*	< 0.05
3	Gender	0.502	> 0.05
4	Residential address	0.152	> 0.05
5	Hospital stay recurrence	1.000	> 0.05
6	Days in hospital	0.382	> 0.05
7	Education level	0.455	> 0.05

Patients indicated that there were differences in the level of person-centred care provided by public and private hospitals, which was statistically significant. Patients also assessed person-centred care differently depending on age group.

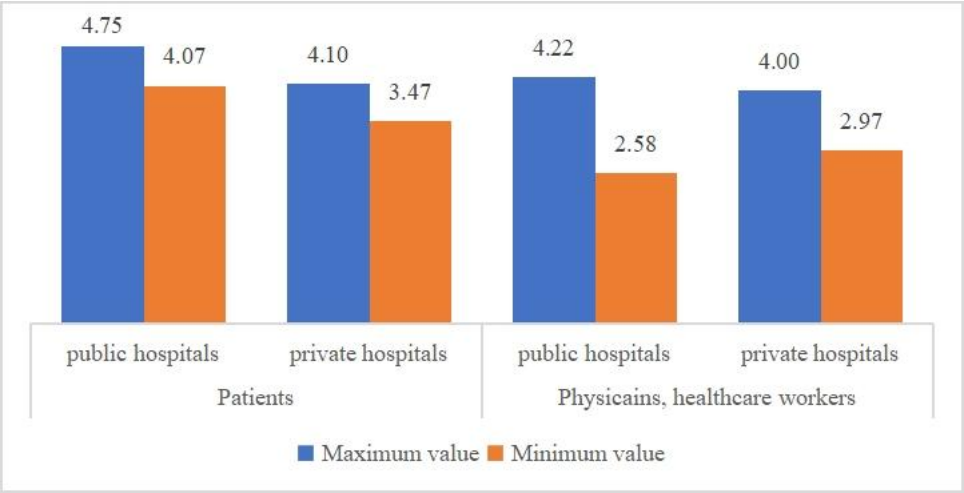
TABLE 9. RESULT OF ONE-WAY ANOVA TEST, STAFF

№	Variables	Person-centred care (Sig.)	P value
1	Type of hospital	0.040*	< 0.05
2	Group of age	0.152	> 0.05
3	Gender	0.982	> 0.05
4	Occupation, position	0.000*	< 0.05
5	Years of work in the now position, by group	0.669	> 0.05
6	Department	0.041*	< 0.05
7	Education level	0.007*	< 0.05

Physicians and health workers believe that person-centred care varies depending on the type of hospital (p=0.040 < 0.05). Physicians and health workers evaluate person-centred care differently depending on their position, department, and education level.

Figure 2 compares the maximum and minimum values of person-centred care assessments by patients in public and private hospitals, as well as by physicians and health workers working in these hospitals.

FIGURE 2. COMPARISON OF MAXIMUM AND MINIMUM VALUE



Patients in public hospitals rated person-centred care higher than those in private hospitals. The difference in the highest score was 0.65 (public: 4.75, private: 4.10), and the difference in the lowest score was 0.6 (public: 4.07, private: 3.47).

TABLE 10. COMPARISON OF MAXIMUM AND MINIMUM VALUES OF PERSON-CENTRED CARE RATINGS

	Patients		Physicians and health workers	
	Public hospital	Private hospital	Public hospital	Private hospital
Maximum score value	P2. A place where I rely on receiving the best care (4.75)	P9. A place which is neat and clean (4.10)	S5. A place where the staff use a language that the patients can understand (4.22)	S1. A place where I feel welcome (4.00)
Minimum score value	P12. A place where which feels homely even though I am in an institution (4.07)	P14. A place where people talk about ordinary things, not just illness (3.47)	S12. A place where it is easy for the patients to receive visitors (2.58)	S12. A place where it is easy for the patients to receive visitors (2.97)

Patients in public hospitals rated the hospital's 'reliable and best' healthcare the highest (4.75), while patients in private hospitals rated it as 'neat and clean' (4.10). Patients admitted to private hospitals rated the 'opportunity to talk about simple things, not diseases' in a hospital setting as the lowest (3.47), whereas patients in public hospitals rated the 'hospital environment' as the lowest (4.07).

Physicians and health workers working in public hospitals rated 'speaking words and phrases that are understandable to their patients' the highest (4.22), while physicians and health workers in private hospitals rated 'friendliness' the highest (4.00).

Patients, and physicians, health workers in both public and private hospitals rated 'free spaces for patients to meet their visitors' the lowest, with scores of 2.58 and 2.97, respectively.

DISCUSSION

According to international surveys, patients typically define person-centred care in hospitals based on three subscales: a climate of safety, a climate of everydayness, and a climate of hospitality [7, 8]. Similarly, health workers define person-centred care using three subscales: a climate of safety, a climate of everydayness, and a climate of community [7, 19]. However, a study conducted by Korean and Swedish researchers found that health workers identified person-centred care using four subscales, with an additional dimension called the "climate of comprehensibility" [20, 21].

In this survey, person-centred care in public hospitals was defined by both patients and physicians/health workers using two subscales: a climate of safety and a climate of everydayness. The third subscale—a climate of hospitality (for patients) or a climate of community (for physicians and health workers)—was not measured.

Hospitality refers to the manner in which hosts receive, welcome, and interact with guests [22]. In healthcare settings, a hospitality-centered philosophy aims to enhance patient satisfaction and emotional well-being through genuine acceptance, fulfillment of needs, and effective problem-solving during interactions between patients and providers [23]. Hospitals are expected to offer patients a warm welcome and farewell, as well as a comfortable environment that fosters care, communication, and support.

The results of this study suggest that in the current Mongolian context, patients tend to prioritize the treatment of their illnesses while overlooking the importance of service quality and hospitality. On the other hand, healthcare in hospital

settings is still characterized by provider-centricity. In other words, patients tend to follow and implement the instructions of physicians and healthcare workers without question. Recently, researchers have suggested that shifting from a provider-centric approach to a person-centred care is more appropriate and mutually beneficial for both patients and providers. Our study did not measure the hospitality climate in either public and private hospitals, which suggests that the Mongolian healthcare sector continues to deliver predominantly provider-centred care. This phenomenon can be better understood in the context of Mongolia's healthcare system. Until 1990, Mongolia had a centrally planned economy, and its healthcare sector followed the Semashko model, which was widely used in such economies.

The Semashko model, developed by Soviet People's commissar for healthcare Nikolai Semashko, is based on the principle that the state is responsible for ensuring the health of all citizens by providing free and high-quality healthcare services. This model reflects the centralized planning approach of the state [24]. Therefore, the results of our study suggest that although Mongolia has transitioned to a market economy, its healthcare sector has not yet undergone a full transition.

According to a study by Chinese researchers, health workers rated person-centred care higher than patients [7]. The difference in mean values for the climate of safety was 1.30, for the climate of everydayness was 0.30, and for the climate of hospitality/community was 2.72. However, in this study, physicians and health workers rated person-centred care lower than patients. The difference in mean values for the climate of safety was 1.29, and for the climate of everydayness was 0.32.

Our study found that person-centred care was rated more highly by patients than by staff, which contrasts with the findings of Chinese researchers. However, the focus of the two studies differs. The Chinese study was conducted in a nursing home setting, while our research was carried out in hospitals providing clinical care. Furthermore, differences in socio-economic status, health systems, health outcome indicators, and demographic characteristics between the two countries may also contribute to the variation in findings. These factors should be examined and explained in more detail in future studies.
In this study, physicians and health workers rated person-centred care lower than their patients, which contrasts with findings from studies in other countries. However, the difference between the mean values for the climate of safety and the climate of everydayness was at a similar level.

Public hospital patients rated person-centred care higher than patients in private hospitals, suggesting greater confidence in the reliability and safety of public healthcare. In our study, private hospital physicians and healthcare workers identified person-centred care as one factor, which may be related to the fact that worker member performs multiple functions. The public and private hospitals included in the survey offer a similar range of healthcare services but differ in terms of the number of beds, patients, and staff. The number of medical professionals, such as doctors and nurses, is adjusted based on patient volume and demand. However, it cannot be overlooked that physicians and nurses also perform support functions beyond the provision of direct medical care.

The greatest strength of public hospitals lies in their ability to provide reliable, safe, and quality healthcare to patients—an aspect also recognized by healthcare providers themselves. For patients of private hospitals, the highest value is placed on the hospital's cleanliness, orderliness, and environment, while staff members appreciate the warm and comfortable working conditions. The aspects of person-centred care that received the highest ratings are expected to continue performing at this level.

Patients and physicians, healthcare workers should take action to improve person-centred care by focusing on the aspects that received the lowest ratings. For instance, physicians, healthcare workers in both public and private hospitals highlighted the need to enhance the hospital environment and the climate of hospitality. It is also recommended to improve the climate of everydayness by helping patients feel more at home and engaging in simple, non-medical conversations.

CONCLUSION

The Person-Centred Climate Questionnaire is designed to be defined by three sub-scales: a climate of safety, a climate of everydayness and a climate of hospitality/community. We hypothesized in our study that it would be measured by the above three factors, but the Principal Component Analysis found that it was measured by two factors. Both the service provider and the service recipient reported that there was no climate of hospitality person-centred care in the hospital environment.

The second hypothesis, that person-centred care differs depending on the type of hospital, was confirmed by a One-way ANOVA analysis. People-centred care is valued differently by patients depending on their age group, and by physicians and health workers depending on their education, position, and department.

Person-centred care in public hospitals was defined by participants using two factors. Similarly, patients in private hospitals identified two factors, while physicians and health workers in private hospitals identified only one. These findings suggest that the climate of hospitality and community is not functioning effectively, indicating a need for greater attention from healthcare providers. Furthermore, it is essential to focus on the lowest-scoring areas and implement measures to improve them.

Future researchers in this field should consider using qualitative research methods, such as interviews, to explore individuals' perceptions and cultural patterns, and to better understand the underlying causes. As this is the first known study evaluating person-centred care in hospitals has not been conducted previously in Mongolia, making it the first to contribute to the improvement of hospital management. Therefore, further research is needed to re-confirm the validity and reliability of the Person-Centred Climate Questionnaire. It is also recommended to include samples from various types of healthcare providers or to conduct an expanded study that incorporates provincial and local hospitals.

LIMITATIONS

This study included only major tertiary public and private hospitals operating in UB. A limitation of the study is that it did not include or compare aimag (provincial or regional hospital) or secondary-level hospitals, which are more geographically dispersed and serve populations with lower density. The sample was selected from tertiary hospitals that provide similar types of care and services, allowing for comparability. However, while obtaining informed consent is ethically appropriate, selecting hospitals based on their willingness to participate may have introduced selection bias. Another limitation is the exclusive use of quantitative research methods.

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