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Assessing Patient-Centered Care in Indonesia: Patient's Perceptions and Key Factors in Private vs Public Hospitals

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Abstract

Patient Centered Care (PCC) improves health literacy, adherence, and satisfaction, yet its implementation across Indonesian hospitals remains unclear. This study compared patients' perceptions of PCC and identified determinants in public and private hospitals in Jakarta and surrounding areas. A multi-center cross-sectional survey was conducted in September 2024 with 500 inpatients (250 public, 250 private) selected using multi-stage random sampling from three public and two private hospitals. Private hospitals outperformed public hospitals on all structural and process indicators, yielding higher Patient Centered Healthcare Performance (PCHCP) scores (90.8% vs. 78.4%). The largest gaps were observed in access to services (OR 3.4) and respect for patient preferences (OR 3.1). In public hospitals, poor PCC was associated with lower education (AOR 2.8), suburban residence (AOR 2.1), limited involvement in decision-making (AOR 2.7), and restricted access (AOR 5.1). In private hospitals, dissatisfaction was driven by inadequate care plan information (AOR 4.1) and limited privacy (AOR 3.2). While private facilities demonstrated stronger PCC, deficiencies in communication and shared decision-making were evident in both sectors. Targeted interventions transparency of information, structured medication counseling, improved access, and enhanced privacy are essential to strengthen PCHCP, particularly in public hospitals, and should be embedded within national hospital quality regulations.

Introduction

Patient-Centered Care is a care concept that began in the early 1950s and then grew rapidly in healthcare service research in the late 1990s (Catalyst, 2017). Patient-Centered Care is a collaborative care approach between the patient's family and healthcare providers, focusing on patient-centered actions and service empowerment (Levitan & Schoenbaum, 2021). This model offers significant benefits, including effective access to healthcare, improved health literacy, better adherence to treatment plans, increased survival rates and patient satisfaction, and reduced psychological distress during treatment.

If the primary quality of healthcare is prioritised, it will reduce the negative impact of workforce shortages and task duration on patient safety and care quality. Additionally, it will positively influence the work environment, leading to better patient outcomes (Jarrar *et al*., 2021; Jarrar *et al*., 2019). Conversely, if the quality of healthcare services is not optimized, it will result in lower service quality, such as missed appointments and decreased adherence to treatment (National Academies & Science, 2018). The approach that should be prioritised focuses on patients, healthcare workers, and healthcare organisations in providing care, as this encourages patients to actively participate in maintaining and improving their treatment. The patient's perception of the healthcare services they receive is the primary goal of healthcare organisations (Bokhour *et al*., 2018).

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In the healthcare sector, delivering patient-centered care is vital for enhancing results and ensuring favorable experiences for individuals. Coordinating care contributes critically to attaining patientcentricity by enabling smooth and efficient interaction and partnership among healthcare professionals, patients, and their families (Satoto *et al*., 2025). There are eight parameters to measure patient-centered care, which include: patients' choices, information and education, access to care, physical comfort, emotional support, involvement of family and friends, continuity and transition, and care coordination (Vancampfort *et al*., 2017).

Patient-centered care is a crucial aspect for service providers to deliver high-quality services (Wahyuni *et al*., 2025). Hospitals play an important role in healthcare services because all types of services provided have an impact on public health. The healthcare service pathway is provided by the government through both private and public healthcare systems (Basu *et al*., 2012). In Indonesia previous study by Risca *et al*. (2023) with the title "The Correlation between the Implementation of Patient-Centered Care and the Fulfilment of Patient Rights at Regional General Hospital of Bireuen Regency", using the Cross-Sectional Research method, found that, to improve the quality of healthcare services and fulfil patient rights, directed and structured Patient-Centered Care services are still needed. This is because undirected patient-centered services force healthcare workers to urge patients and their families to actively participate in the treatment process. Patient empowerment aims to provide patients with information, assistance, and self-assurance, enabling them to engage and collaborate actively in health-related decisions (Tjiptabudi & Antonio, 2025). Furthermore, a previous study conducted in another region of Indonesia, namely in Banda Aceh, by Rachma & Kamil (2019), indicated that Patient-Centered Care had been implemented at 88.6%, covering various dimensions such as respect for patient values and preferences (75.4%), care coordination (78.9%), communication and education (85.1%), physical comfort (87.7%), and emotional support (88.6%). However, the continuity and transition dimension was only implemented at 67.5%, highlighting the need to improve coordination and communication among healthcare providers in discharge planning to ensure the continuity of care, medication administration, and family involvement in patient care after hospital discharge. Research in several high-income countries states that patient-centered care strengthens collaboration between patients and healthcare providers, as well as increases patient adherence to treatment plans (Roumie *et al*., 2011). Patient complaints about the services provided are a comparison between the patient's perception of the services received and their expectations of the services provided (Pratiwi *et al*., 2023). Therefore, the objective of this study is to analyse patients' perspectives on patient-centered care and the associated factors among patients admitted to public and private hospitals in Jakarta City and its suburbs. Understanding patient-centered care from the patients' perspectives is crucial for improving healthcare services and gaining a deeper understanding of patients' needs.

Method

This study was conducted in Jakarta City and its suburbs in September 2024. According to statistics, there are 42 private hospitals and 196 public hospitals in Jakarta and its surrounding areas (Yankes, n.d.). From this total, the study was conducted in 2 private hospitals and 3 public hospitals. This study included all adult patients admitted to surgical and medical wards, as well as those who were waiting for treatment in the hospital. However, patients in critical condition and outpatients were excluded from the study. The sample size was calculated using EPI INFO version 7.2.0.1, which employed independent variables. The factors included prescription information exchange, provider closeness, and ease of access to service. Using the premise that the confidence interval (CI) was 95% and the power was 80%, with an unexposed to exposed ratio of 1:1, the percent outcome in the exposed group (P1) was 60.1%, and the percent outcome in the unexposed group (P2) was 38.9%. As a result, the sample size estimated using the independent variable patients' intimacy with care providers was determined to be the largest, with 10% of non-respondents included. Using a

TABLE 1. Sampling Procedure for Patients' Perception of Patient-Centered Care Among Patients Admitted in Jakarta City and Suburban Public and Private Hospitals, 2024

Type of Hospital	Hospital	Total Respondents	Female	Male
Public Hospital	A	83	37	46
	B	83	37	46
	C	84	37	47
Private Hospital	D	120	67	53
	E	130	70	60

1:1 ratio, the final projected sample size was 500 individuals (250 public and 250 private).

A multi-stage sampling approach was employed in this study. The research was conducted in five hospitals, consisting of two private hospitals and three public hospitals. These hospitals were selected through a simple random sampling method using a lottery system. The sample size was evenly distributed between private and public hospitals. The sample size for each hospital was proportionally determined based on the average number of inpatients in the preceding month. Accordingly, 75 respondents were drawn from Hospital A, 90 from Hospital B, and 85 from Hospital C. Hospital D, which had the largest patient population, contributed 150 respondents, while Hospital E accounted for 100 respondents.

A similar proportional allocation was applied to the selected wards (surgical and medical) based on the previous month's average patient admissions. For both public and private hospitals, the first patient was selected randomly, followed by every fourth and second patient from each ward until the required sample size was reached (see Table 1). Patients who were not present during data collection were excluded, and the next patient in line was included to maintain the sample size.

Data were collected using a standardized interviewer-administered questionnaire supervised by three diploma nurses and one BSc nurse. The instrument covered sociodemographics, organizational and provider-related factors, and eight patient-centered care dimensions developed by the Picker Institute and Harvard University: respect for preferences, physical comfort, coordination, continuity, emotional support, accessibility, information and education, and family involvement. The tool had a five-point Likert scale with 34 items (McCormack, 2004). The 34 elements were calculated and classified as "good" or "poor". The provider-related questionnaire consists of six items with yes/no answers. Nine items on a five-point Likert scale were used to assess organizational factors, which were then calculated and dichotomized. The data were categorized as "good" or "poor" patient-centered care. Here is the sampling procedure table for patients' perception of Patient-Centered Care in public and private hospitals in Jakarta. The total sample was randomly selected from three public hospitals and two private hospitals to assess patients' perceptions of Patient-Centered Care.

To ensure data quality, three diploma nurses and one BSc nurse were trained on study objectives and data collection procedures. The questionnaire was pretested on 5% (25) of patients to assess reliability and appropriateness, with revisions made as needed. During data collection, supervisors provided continuous oversight, and completed questionnaires were reviewed daily for accuracy and completeness before entry into the database.

The data were checked for completeness and consistency before being cleaned, coded, and entered into Epidata 4.6, then exported to SPSS version 25 for analysis. Multi-collinearity was assessed using the variance inflation factor (VIF), with all variables demonstrating a VIF of <5. The Hosmer-Lemeshow goodness-of-fit test was applied (P>0.05). Descriptive statistical analysis, including frequency distribution and percentages, was conducted for both dependent and independent variables. To adjust for potential confounders, explanatory

variables with a p-value ≤0.25 in the binary logistic regression model were included in the multivariable logistic regression model. Independent predictors of the dependent variable were identified using a 95% confidence interval and p-values <0.05.

Result and Discussion

This study involved 500 hospitalised patients, achieving a 100% response rate in both public and private hospitals. In public hospitals, male patients accounted for 139 individuals (55.6%), while female patients totalled 111 individuals (44.4%). In private hospitals, male patients comprised 113 individuals (45.2%), while female patients made up 137 individuals (54.8%). Based on the age variable, the majority of patients in public hospitals fell within the age groups of 17–30 years (39.6%) and 61 years and above (37.6%). In contrast, private hospitals were predominantly occupied by patients aged 31–60 years (76.4%).

Regarding income, the majority of patients in public hospitals earned below IDR 5,000,000 (52.4%), whereas in private hospitals, most patients earned between IDR 10,000,000 and over IDR 20,000,000. Based on residence, a greater proportion of public hospital patients came from suburban areas (65.2%) compared to urban areas (34.8%). On the other hand, private hospitals primarily served patients from urban areas (78.8%). In terms of educational background, most public hospital patients had completed high school (50%), while the majority of private hospital patients held higher education degrees (Bachelor's and Master's) (70.4%). Finally, regarding the duration of hospitalisation, the majority of public hospital patients were admitted for 1–8 days (84.4%), while in private hospitals, most patients were also hospitalised for 1–8 days (70.4%). However, private hospitals had a higher proportion of patients hospitalised for 27 days or more (13.2%) compared to public hospitals.

Patients in private hospitals (38%) reported feeling a greater sense of closeness with their healthcare providers compared to those in public hospitals (33.2%). The provision of accurate information regarding disease progression and available treatment options has been identified as a critical determinant in improving patient satisfaction with healthcare providers, as well as enhancing their perception of the quality of care delivered (Tjiptabudi & Antonio, 2025). Consequently, fostering effective two-way communication between patients and healthcare professionals may significantly strengthen the therapeutic relationship and contribute to greater overall patient satisfaction.

A significant proportion of patients lacked awareness of their diagnosis, with 79.2% in public hospitals and 76.8% in private hospitals being unaware of their condition. Only 37.6% of public hospital patients and 42% of private hospital patients received information regarding their treatment options. For comparison, a survey conducted at Dr. George Mukhari Academic Hospital in Pretoria reported that 78% of inpatients understood their diagnosis and treatment plans, which was positively associated with adherence and readiness for follow-up consultations (Mabuza *et al*., 2015). This indicates that when awareness is systematically established, its effects are directly reflected in health behaviors.

The majority of patients were not involved in decision-making regarding their care, with a higher percentage in private hospitals (80.4%) compared to public hospitals (73.2%). Based on research (Arboh *et al*., 2022) discusses the importance of involving patients in decision-making regarding their care, known as patient-centered care. The results obtained show that patient-centered care should be prioritised in healthcare to improve the quality of care and patient health outcomes. Research Arboh *et al*. (2022) also explains that several aspects of patient-centered care, such as physical comfort, patient preferences, and information and education, influence doctors in providing quality healthcare.

The lack of education about medications was a common issue in both hospital types, as 71.2% of public hospital patients and 75.6% of private hospital patients did not receive sufficient information. Additionally, healthcare providers in public hospitals demonstrated a better understanding of patients' diseases (43.6%) compared to those in private hospitals (33.6%). In terms of Reception Presence, private hospitals had a better reception service,

with 74.8% of patients rating the reception presence as "good" compared to 53.2% in public hospitals. This indicates that private hospitals have a more organised reception service. Regarding Ease of Access to Services, 71.6% of patients in private hospitals perceived having good access to services, which is higher than the 42.4% in public hospitals. Private hospitals tend to have a more efficient service system or fewer barriers to accessing care.

Concerning the Presence of Disturbing Sounds, 72% of patients in private hospitals reported a good condition, whereas only 40.4% of patients in public hospitals shared the same perception. Public hospitals appear to be noisier and have more sound disturbances than private hospitals. In terms of Hospital Attractiveness, 71.2% of patients in private hospitals found their hospital appealing, compared to only 39.6% in public hospitals. Private hospitals generally offer better facilities or a more aesthetically pleasing environment than public hospitals. Regarding Privacy During Care, 72.4% of patients in private hospitals felt they had good privacy during their treatment, compared to 46% in public hospitals. This suggests that private hospitals place greater emphasis on patient privacy during care.

In terms of Information on Patient Safety, 77.2% of patients in private hospitals received safety-related information, significantly higher than the 49.2% in public hospitals. This indicates that private hospitals are more effective in providing safety-related information. Regarding information on the Plan of Care, only 34.8% of patients in public hospitals received adequate information, whereas 84% of patients in private hospitals received clear details. This highlights a significant difference in communication between private and public hospitals.

Concerning Information on Diet, 57.2% of patients in private hospitals received sufficient dietary information, compared to 36.4% in public hospitals. This suggests that private hospitals pay more attention to patients' nutritional needs. Finally, in terms of Medication Availability, 76.8% of patients in private hospitals reported good medication availability, whereas only 44.4% of patients in public hospitals had the same experience. This indicates that private hospitals have a more stable supply of medication compared to public hospitals. Table 2 underscores that, relative to public hospitals, private hospitals outperform across all structural and process-related indicators. This gap aligns with systematic evidence from 157 international studies identifying easy access, clear communication, and a comfortable physical environment as primary determinants of patient satisfaction (Ferreira *et al*., 2023). Overall, the deficiencies in access, noise control, privacy, and patient education observed in public hospitals highlight the need for targeted interventions to narrow this quality disparity.

Private hospitals (76.4%) outperform public hospitals (40.4%) in respecting patients' needs and preferences. Only 50% of patients in private hospitals feel they receive adequate information and education, slightly higher than in public hospitals (46.8%). Private hospitals (66%) provide better physical comfort compared to public hospitals (50.4%). Access to healthcare services is more efficient in private hospitals (93.6%) than in public hospitals (56.4%), indicating greater operational efficiency in private facilities. Patients in private hospitals (80.4%) receive more emotional support than those in public hospitals (75.2%). Regarding continuity and transition of care, there is no significant difference, with private hospitals (79.2%) and public hospitals (78.8%) showing nearly identical rates. Private hospitals (97.6%) demonstrate significantly better care coordination compared to public hospitals (86%). Additionally, private hospitals (84.4%) slightly surpass public hospitals (81.2%) in involving family or friends in patient care.

In terms of overall Patient-Centered Healthcare Performance (PCHCP), private hospitals (90.8%) are rated higher than public hospitals (78.4%). The table indicates that private hospitals consistently outperform their public counterparts across nearly all dimensions of PatientCentered Healthcare Performance (PCHCP). The widest gaps emerge in service accessibility and respect for patients' needs and preferences, suggesting that the infrastructure and service culture of private facilities are more adept at reducing bureaucratic barriers and tailoring care to individual expectations—findings consistent

with recent research that identifies easy access and individualized care as primary determinants of patient satisfaction. Process dimensions such as care coordination also score markedly higher in private hospitals, underscoring the role of robust interprofessional organization in enhancing the patient experience (Al-Jabri *et al*., 2021). Conversely, two dimensions—continuity and transition of care, and involvement of family or friends—are relatively comparable across sectors, indicating that discharge pathways and family participation are generally accommodated in both settings. Interestingly, the information and education dimension is slightly superior in public hospitals, implying that, although face-to-face communication with physicians is stronger in private institutions, structured educational approaches in public wards remain effective. Overall, the aggregate "good" PCHCP score reaches 90.8 percent in private hospitals and 78.4 percent in public hospitals, highlighting the need for public facilities to prioritize improvements in access, service personalization, and strengthened team coordination.

The majority of patients in public hospitals are aged 17–30 years and 61 years and above. A total of 79.2% are unaware of their health condition, 73.2% are not involved in medical decisions, and 71.2% lack information about their medication. Only 33.2% feel close to their doctor, 46% feel their privacy is protected, and 42.4% consider service access to be good. Care coordination is rated fairly well by 86%, with a Patient-Centered Healthcare Performance (PCHCP) score of 78.4%. Patients with lower education levels tend to rate the service poorly. These findings underscore that quality improvement in public hospitals must prioritize information transparency, patient involvement in decisionmaking, structured medication counseling, streamlined access pathways, and enhanced privacy protection so that PCHCP scores can approach the standards achieved by private hospitals. The majority of patients in private hospitals are aged 31–

TABLE 2. Eight-Dimensional Measuring of Patient-Centered Care at Public and Private Hospitals of Jakarta City and Suburbs, 2024

Dimensions	Categories	Private	Frequency	Public	Frequency
Respect patients' needs and preferences	Good	191	76.4	101	40.4
	Poor	59	23.6	149	59.6
Information and education	Good	125	50	133	53.2
	Poor	125	50	117	46.8
Physical comfort	Good	165	66	126	50.4
	Poor	85	34	124	49.6
Access to care	Good	234	93.6	141	56.4
	Poor	16	6.4	109	43.6
Emotional support	Good	201	80.4	188	75.2
	Poor	49	19.6	62	24.8
Continuity and transition of care	Good	198	79.2	197	78.8
	Poor	52	20.8	53	21.2
Coordination of care	Good	244	97.6	215	86
	Poor	6	2.4	35	14
Family or friend involvement	Good	211	84.4	203	81.2
	Poor	39	15.6	47	18.8
Overall PCHCP	Good	227	90.8	196	78.4
	Poor	23	9.2	54	21.6

60 years and experience relatively short lengths of stay of only 1–8 days, reflecting a working-age population that seeks rapid recovery.

Although care coordination is rated as excellent (97.6 %) and the PatientCentered Healthcare Performance (PCHCP) score is high (90.8 %), a paradox remains: 76.8 % of patients do not understand their diagnosis, 80.4 % are not involved in medical decisionmaking, and only 38 % report feeling close to their physician. Multivariate analysis confirms that satisfaction is higher among patients with greater income and educational attainment (AOR = 2.1) and among urban residents (AOR = 1.8), whereas noninvolvement in decisionmaking (AOR = 3.4), inadequate information about care plans (AOR = 4.1) and medications (AOR = 2.5), difficulty accessing services (AOR = 5.2), and limited privacy (AOR = 3.2) significantly increase the likelihood of negative evaluations. These findings suggest that, despite the efficiency of clinical coordination in private hospitals, qualityimprovement efforts should prioritize information transparency, structured shared decision-making programmes, standardized medication counselling, streamlined access pathways, and enhanced privacy safeguards to ensure an equitable patient experience across all socioeconomic strata.

This discussion situates the principal findings within the theoretical framework of PatientCentered Care (PCC). Applying Donabedian's structure–process–outcome model, private hospitals exhibit superior structural elements—organized reception areas, rapid access, quieter wards, and preserved privacy—which, in turn, facilitate key communicative processes (provision of careplan information, shared decisionmaking, and structured medication counseling) and ultimately yield higher PatientCentered Healthcare Performance (PCHCP) scores. These dimensions align with the eight Picker principles—access, information and education, patient preferences, physical comfort, emotional support, coordination, continuity and transition, and family involvement—and can also be interpreted through gaps in the SERVQUAL domains of Tangibles, Responsiveness, Assurance, and Empathy.

This study highlights that patients in public hospitals predominantly come from lower to middle economic groups and generally have lower educational levels compared to those in private hospitals. The length of hospitalisation in private hospitals varies more significantly, with a notable proportion of patients staying for more than 27 days. This suggests differences in the complexity of diseases or patients' ability to afford long-term treatment. The level of closeness between patients and medical personnel is higher in private hospitals compared to public hospitals, which may reflect differences in patient load and the interpersonal approach of healthcare providers. In both private and public hospitals, patients exhibit a relatively low understanding of their disease diagnosis, indicating ongoing challenges in communication between healthcare professionals and patients.

Patient involvement in medical decision-making is lower in private hospitals than in public hospitals, possibly due to a higher level of trust in doctors' decisions among private hospital patients. Interestingly, healthcare professionals in public hospitals demonstrate a better understanding of patients' diseases compared to those in private hospitals. This could be attributed to greater experience in handling more complex cases or differences in training. Access to healthcare services is more efficient in private hospitals, indicating that public hospitals still face challenges related to bureaucracy and service capacity. Overall, private hospitals excel in implementing patient-centered care compared to public hospitals. Aspects such as physical comfort, access to healthcare services, emotional support, and care coordination are superior in private hospitals, highlighting a gap in service quality.

Although private hospitals generally perform better, certain aspects, such as continuity of care and family involvement in patient care, do not show significant differences from public hospitals. The study's strengths include the use of primary data and a multi-centre cross-sectional design. However, social desirability bias may have influenced the results, as patients self-rated their care experiences and may have feared potential consequences for future treatment. To minimise bias, interviewers

were selected from various hospitals, and interviews were conducted privately.

Conclusion

This study reveals marked differences between public and private hospitals in socio-demographic characteristics, service provision, and institutional factors. Patients in private hospitals had higher education and income, and these facilities performed better in accessibility, comfort, privacy, care coordination, and patient involvement in decision-making. However, both hospital types showed weaknesses in patient education regarding diagnoses and treatments. While private hospitals are more advanced in applying patient-centered care, improvements in communication and patient engagement remain necessary. Public hospitals should enhance accessibility, adopt patient-centered communication, and upgrade facilities to improve comfort. At the policy level, the Ministry of Health should establish national standards for patient-centered care and provide training for healthcare professionals to ensure consistent implementation across hospital sectors.

Author Contributorship

Johanes Ronaldy Polla : Conceptualization, Methodology, Data Curation, Formal Analysis, Writing – Original Draft Preparation, Writing – Review & Editing.

Harjanto Prabowo : Supervision, Project Administration, Conceptualization, Validation, Writing – Review & Editing.

Sutoto : Resources, Methodology Support, Validation, Writing – Review & Editing, Data Analysis Support.

Sri Bramantoro Abdinagoro : Data Analysis Support, Visualization, Supervision, Writing – Original Draft Preparation.

Conclusion

The authors: **Johanes Ronaldy Polla, Harjanto Prabowo, Sutoto, Sri Bramantoro Abdinagoro** we demonstrate our commitment to data openness and transparency. To facilitate further research, we have made the data used in their study publicly available.

The data used by the author can be opened via the link below:

https://doi.org/10.5281/zenodo.16868176

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