

SOCIAL RESPONSIBILITY: ANALYSIS OF THE QUALITY OF MEDICAL CARE PROVIDED IN KYRGYZSTAN (PATIENT ASSESSMENT)

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Abstract The study was conducted to determine the level of social responsibility of the medical staff of the Osh City Clinical Hospital of Kyrgyzstan. For this purpose, a survey of 251 respondents was conducted among residents of the Osh region on the provision of qualified medical care. The results showed that the level of social responsibility of the hospital was assessed predominantly at an average level by 55-60% of respondents. Patients highly evaluated the effectiveness of treatment (63% high evaluations), whereas the performance of nursing staff was rated highly by only 26% of respondents, indicating an asymmetry in professional responsibility. In addition, 52% of respondents assessed the accessibility of healthcare services as high, while institutional and financial barriers remained significant. The findings demonstrate that social responsibility in healthcare is shaped by the uneven distribution of professional, institutional, and organisational resources, which is reflected in differentiated assessments of medical staff performance, service accessibility, and financial coverage.

Keywords

healthcare reform,
public health,
treatment effectiveness,
professional ethics,
accessibility of medical
services

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1 Introduction

The quality of medical care is increasingly recognised not only as a clinical outcome but also as an indicator of social responsibility within healthcare systems. In this study, social responsibility in healthcare is understood as a system of interrelated obligations and practices shared collectively by the state, healthcare institutions, health insurance funds, and medical professionals, aimed at ensuring accessible, safe, ethical, and high-quality medical care. In Kyrgyzstan, this concept is a key component of national healthcare policy and practice. Social responsibility is based on respect for the individual, humanistic values, and the pursuit of social well-being.

The principle of social responsibility of healthcare workers is stipulated in the Law of the Kyrgyz Republic No. 14 “On the Protection of Health of Citizens in the Kyrgyz Republic” (2024), Article 19, the Code of Ethics for State Civil Servants and Municipal Employees of the Kyrgyz Republic (2022), and various international legal acts. It should be interpreted as a social contract with humanity and a medical professional's duty to each patient. However, in practice, implementing social responsibility in healthcare is influenced by systemic, institutional, and resource-related constraints.

Leaders of Kyrgyzstan's health care system have worked diligently to regulate the level of medical care in the country. However, despite ongoing investments in the material and technical infrastructure of healthcare institutions and financial support for medical workers, significant disparities in the quality and accessibility of medical services persist (Chalova et al., 2024; Khamchiev et al., 2024). Therefore, Kyrgyzstan is developing an extensive reform of the health care system, the aim of which is to improve the health of the country's inhabitants by ensuring accessibility, improving medical care, and optimising the use of resources. Funding problems, lack of qualified personnel and epidemiological threats such as COVID-19 have served to intensify the need for greater social responsibility.

The issue of social responsibility was considered by contemporary researchers, including Beauvais et al. (2021), Musaeva et al. (2021) and Layman et al. (2023). According to Shrivastava et al. (2024), COVID-19 renewed the relevance of social responsibility and performance measurement in the healthcare system. These studies demonstrate that social responsibility is increasingly recognised as a key factor shaping the quality and sustainability of healthcare systems.

Quality of care refers to a set of characteristics that reflect the ability of healthcare services to meet patients' needs in accordance with professional and regulatory standards (Madraimov et al., 2025). Hospitals must comply with the principles of social responsibility, which include ethical norms (such as respect for patients and professional integrity), legal requirements (including compliance with medical standards, privacy, and confidentiality), and broader societal obligations related to equity, transparency, and accountability. These principles collectively shape the institutional responsibility of hospitals and other medical facilities in delivering quality medical services.

A study by Wu et al. (2022) confirmed the theory that social responsibility materially impacts the quality of medical care. Accessibility of care ensures equitable access to healthcare services regardless of a person's status in society, wealth and residence. Researchers argue that healthcare institutions with a stronger commitment to social responsibility tend to demonstrate higher levels of service quality, transparency, and patient-centred practices. Concurrently, empirical evidence indicates that implementing social responsibility remains uneven across healthcare systems and institutional contexts.

Fonken et al. (2020) argued that several issues in healthcare remain, principally the financial barrier. Their analysis of healthcare in Kyrgyzstan concluded that the material and technical support of medical institutions does not fully permit the principle of social responsibility to be applied in medicine. There are, for example, differences in the provision of medical care between urban and rural populations, as well as disparities in the quality and accessibility of services among healthcare institutions financed through the state budget and those operated by individual government departments.

Peabody et al. (2020), in a sociological survey on the adequacy of medical care for residents of the Osh region, identified an overall average level of healthcare quality in the region. Their nationwide evaluation showed that, although clinical outcomes may be improved through standardised quality interventions, patients' assessments of healthcare quality largely depended on organisational conditions, communication with medical staff, and the perceived social responsibility of healthcare professionals. The study emphasised that sustainable improvements in care quality depend not only on clinical training and adherence to protocols, but also on patient-centred practices, transparency, and institutional accountability, particularly at the level of regional

hospitals. The theoretical analysis and sociological study by Japarova and Sayakbaeva (2020) indicate that the extent to which social responsibility is implemented in practice is shaped by institutional conditions within healthcare organisations, which in turn are influenced by broader social and regulatory frameworks. These findings highlight the need for an integrated conceptualisation of social responsibility that links institutional, legal, and sociological dimensions of healthcare. The state establishes regulatory frameworks and ensures equitable access to healthcare; healthcare institutions organise and deliver services; insurance funds provide financial coverage; and medical professionals bear direct responsibility for clinical decisions and ethical conduct.

Legal concepts such as standards of care, negligence, harm, and causality define formal criteria of accountability in healthcare. Social responsibility extends these notions by integrating ethical and institutional dimensions, thereby linking formal legal standards with organisational practices and patient perceptions.

Social responsibility in healthcare integrates ethical, legal, and institutional dimensions. Ethical principles include respect for patient autonomy, beneficence, non-maleficence, and justice, while legal and institutional principles relate to compliance with healthcare legislation, accountability, accessibility, transparency, and public trust.

Previous studies have examined the ethical and societal dimensions of social responsibility in healthcare (Banahene et al., 2021; Janeway et al., 2022). These works highlight the role of social responsibility in linking medical practice with broader social processes and reducing inequalities in healthcare. Moreover, organisational and economic aspects of social responsibility have been shown to influence institutional performance and service quality (Layman et al., 2023).

Although a growing body of research addresses social responsibility in healthcare, existing studies often are deficient because they fail to systematically integrate ethical, legal, and institutional dimensions with empirical assessments of healthcare quality, particularly in transitional healthcare systems. This gap is especially evident at the level of regional healthcare institutions. Moreover, existing research has not sufficiently examined how healthcare institutions apply principles of social responsibility in practice. Notably, the analysis of social responsibility often involves

ambiguities and divergent interpretations, reflecting the differing perspectives of various stakeholders.

Based on this conceptual framework, we analyse the case of Kyrgyzstan to illustrate empirically how principles of social responsibility operate in practice and to examine how they interact with legal norms, institutional arrangements, and patient assessments. This approach enables a transition from theoretical principles to their practical realisation within a specific national healthcare system.

Thus, the study aimed to theoretically substantiate and analyse approaches to how the principles of social responsibility in healthcare, involving medical professionals, healthcare institutions, and regulatory frameworks, can be practically implemented to better ensure delivery of quality medical care. The goal determined the following tasks:

- to define social responsibility;
- to identify the peculiarities of how social responsibility is manifested in healthcare professionals' activities;
- to study the factors that affect the quality of medical services;
- to study the negative phenomena that hinder successfully implementing social responsibility principles;
- to analyse the level of medical care provided to patients of the Osh City Clinical Hospital of Kyrgyzstan.

2 Materials and Methods

In 2023, we conducted a sociological survey on the provision of medical care at the Osh City Clinical Hospital in Kyrgyzstan. 251 respondents participated in our study. We gathered our data over a three-month period. At the first stage, we used the general sample (n=251) to identify the healthcare institutions patients most frequently visited. During the analytical stage, we selected a focused subsample consisting of 103 respondents who reported seeking care at the Osh City Clinical Hospital for in-depth analysis. Our cohort consisted of 60 women and 43 men residing in the Osh region. 38 of the participants resided in rural areas while 65 resided in urban areas. The patients' ages ranged from 19 to 64 years. We chose the Osh City Clinical Hospital for our study because it represents a typical regional

healthcare facility and allows analysis of social responsibility at both professional and institutional levels.

We applied both inclusion and exclusion criteria to ensure the validity of the sample. Participants were eligible if they were aged 18 years or older, resided in the Osh region, had received medical care at the Osh City Clinical Hospital within the preceding 12 months, and provided voluntary informed consent to participate in the survey. Respondents were excluded if they submitted incomplete questionnaires, had no experience of receiving medical care at the specified hospital, or refused to participate or withdrew from the survey.

The questionnaire method was designed to capture key problems and needs in the provision of medical care to the residents of the district. The survey was conducted following ethical principles: the respondents gave their voluntary consent and were informed of the purpose of the study. The personal information of the participants was not disclosed. The questionnaires were distributed using online links and the patients' personal contacts. We applied this mixed distribution approach in order to increase response rates and ensure that both urban and rural respondents were represented.

The questions for the questionnaire were created on the Google Forms platform in 7 blocks (Table 1).

Table 1: Questions for the Questionnaire in 7 Blocks

Block 1	Quality of medical care. The questions concerned satisfaction with the services provided in the facility, the professionalism of doctors and nurses, the effectiveness of treatment and the availability of medical resources.	<ol style="list-style-type: none"> 1. How would you assess the quality of medical care provided during emergency treatment, hospitalisation, or outpatient visits? 2. How would you assess the performance of nursing staff in terms of professional competence, efficiency, and interpersonal qualities? 3. How would you assess the effectiveness of the prescribed treatment and diagnostic procedures?
Block 2	Availability of services. Residents' assessment of medical care: language of service, geographical accessibility, waiting time.	<ol style="list-style-type: none"> 1. How would you rate the waiting time for appointments, consultations, and medical procedures? 2. How would you assess the geographical accessibility of the hospital? 3. How important is the language used in patient care for you?
Block 3	Communication and feedback. Evaluation of the information provided to patients, patients'	<ol style="list-style-type: none"> 1. How would you rate the clarity and completeness of information provided by healthcare professionals regarding your treatment?

	understanding of diagnoses, as well as the accessibility of medical staff for communication.	2. Are your diagnoses and treatment plan clear to you? 3. How accessible are healthcare staff for communication and consultation?
Block 4	Ethics of medical personnel. It consisted of questions about the respect and ethical behaviour of medical staff and their attitude to patients' characteristics.	1. How would you assess the personal qualities of medical staff? 2. How would you assess the level of respect and ethical behaviour demonstrated by nursing staff? 3. How would you assess the level of trust between you and medical staff?
Block 5	Material and technical resources. Assessment of the hospital's infrastructure, compliance with sanitary standards, and availability of necessary equipment.	1. How satisfied are you with the quality of the hospital's equipment and medical supplies? 2. Does the hospital have sufficient medicines for emergency medical care? 3. Do the conditions of hospital wards and facilities meet sanitary and hygiene standards (cleanliness, maintenance, and infrastructure)?
Block 6	Financial aspects, insurance system. Included questions about the cost of services, transparency of pricing and access to health insurance.	1. How would you assess the transparency and clarity of pricing in the hospital? 2. How satisfied are you with the balance between the cost and quality of medical services? 3. Does your health insurance adequately cover your medical expenses?
Block 7	Suggestions and wishes. How to improve the level of patient care, what aspects of the staff's work need to be changed, and patients' recommendations. Answers to this set of questions were to be recorded in the "own option" column.	1. In your opinion, what aspects of medical staff performance require improvement? 2. In your opinion, does the hospital have a sufficient number of medical staff? If not, which categories of staff are lacking? 3. Would you recommend this hospital to your relatives or friends?

Source: compiled by the authors.

There were 21 questions, with answer options divided into high level, medium level, low level, and own option. Responses were measured using an ordinal scale, and the results were presented as percentages.

The study's methodological framework was grounded in an integrated conception of social responsibility encompassing ethical, legal, and institutional dimensions. The ethical dimension was operationalised through indicators related to patient-doctor communication, the attentiveness of medical staff, respect for patients' rights, and the perceived quality of interaction. The legal dimension was assessed on the basis of respondents' perceptions of compliance with standards of medical care, transparency of medical procedures, and adherence to professional obligations. The institutional dimension was examined through indicators of access to medical services, quality of infrastructure, organisational effectiveness, and availability of

medical resources. This approach enabled us to empirically assess social responsibility across professional, legal, and institutional levels of healthcare.

3 Results

3.1 Social Responsibility, its Peculiarities in Healthcare

Social responsibility is a framework that requires organisations and individuals to act in the interests of society beyond formal legal requirements. It encompasses ethical standards, respect for human rights, environmental considerations, and voluntary commitments, alongside compliance with laws. Thus, social responsibility integrates legal, ethical, and societal dimensions of organisational and professional activity.

In healthcare, social responsibility is closely linked to the quality of medical services and the patient-centred approach. This relationship reflects the interaction of professional, institutional, and social factors shaping healthcare practices (Chen, 2022). Although many international organisations and national policies emphasise access to quality and affordable healthcare as a normative goal, the extent to which this principle is formally recognised and practically implemented varies across countries and depends on how ethical, legal, and institutional principles are embedded in national healthcare systems.

We can empirically assess how ethical, legal, and institutional principles of social responsibility are implemented in practice through indicators of healthcare quality, which translate abstract normative principles into measurable empirical parameters. According to the World Health Organisation (WHO) (2024), the quality of healthcare services is determined by factors such as system coherence, competent personnel, adequate funding, effective management, and access to medicines and modern equipment.

Table 2 summarises key indicators of healthcare quality relevant to assessing social responsibility in medical practice.

Table 2: Medical Care Quality Indicators

Metric	Implementation and basis of the indicator
Availability	Standardisation is a method used to implement the right to accessibility. Ensuring timely and affordable access to healthcare services. Healthcare facilities should be located in such a way that residents can easily access them, regardless of where they live. Healthcare facilities' infrastructure should be convenient for all patients, including those with disabilities. The cost of medical services should be affordable for all segments of the population. Availability of insurance policies and government assistance programmes. Minimal waiting time to see a doctor and undergo necessary procedures. Rapid response to medical emergencies.
Continuity of care	This is an indicator of the regulation of actions during patient care by different specialists. This regulation of healthcare professionals' actions ensures the stability of treatment and its subsequent outcome.
Treatment effectiveness	The correspondence of the care provided to the outcome is acceptable in a particular case. An effective indicator is the provision of optimal, rather than maximum, medical care by the healthcare system. Efficiency should correlate with quality norms and standards.
Patient-centred approach	The ability for patients to participate in decision-making during healthcare. This indicator reflects patients' rights to quality medical care and to be treated with respect by healthcare professionals. It also includes the ability to give informed consent to any manipulations and medical interventions.
Safety	Ensuring patient safety, addressing sanitary and epidemiological safety. Eliminating or minimising risks and errors that could lead to harm. Safety depends both on the totality of information provided by the attending physician and on compliance with treatment protocols and standards.
Promptness	Providing timely care to prevent the patient's condition from deteriorating. Timeliness complements the accessibility indicator and is provided by effective diagnostic procedures allowing for timely treatment. It depends on the level of the doctor's qualification and the standardisation of the process. Timeliness has a significant impact on treatment outcomes and overall patient satisfaction and helps prevent additional complications and costs.
Adequacy	This is an indicator of the compliance of the method of medical care with the needs of the population within the limits of the acceptable quality of life for the patient. Adequacy consists of timeliness and accessibility of medical care, which is defined as a means for a patient to receive care at a convenient time, in full and at minimal cost.
Lack of errors in treatment protocols	The indicator depends on the professional qualifications of the doctor, the use of modern diagnostic equipment and treatment technologies.
Scientific degree	An indicator of the quality of medical care is the scientific and technical level of prevention, diagnosis and treatment methods. This indicator complements the adequacy indicator.

Source: compiled by the authors based on Wu et al., 2022.

While quality indicators reflect the outcomes and characteristics of medical care, the factors influencing quality explain the structural, organisational, and social conditions that shape these outcomes. The choice of indicators determines how these conditions are identified and interpreted in empirical analysis (Table 3). Together, these factors shape the organisational and institutional foundations of healthcare quality.

Table 3: Factors That Affect the Quality of Care

Factor	Factor display	Characteristic
Qualifications of medical personnel	Education and training	Characterised by the quality of training of doctors, nurses and other healthcare professionals, and their participation in programmes, seminars and conferences for professional development.
	Experience and skills	Ability to effectively apply knowledge and technology in practice.
	Ethics and professionalism	Adherence to medical ethics, respect for patient rights and adherence to service standards.
Organisation of medical institutions	The level of material and technical equipment.	Availability of modern equipment, access to medicines and technologies, and the arrangement of medical facilities.
	Process management	Coordination of medical staff, optimisation of waiting times, efficient planning and resource allocation.
	Existence of standards and protocols	Compliance of the facility with the established standards and protocols of medical care.
Funding and resource availability	Public or private funding	Level of funding for healthcare, availability of health insurance, subsidy programmes.
	Availability of medicines and technologies	The ability to provide patients with modern diagnostic and treatment methods.
Quality control and patient safety	Monitoring and control system	Regular compliance audits, and analysis of medical errors and incidents.
	Patient feedback system	Collection of feedback, complaints and suggestions from patients to improve the quality of services.
Social and demographic factors	Socio-economic status	Access to medical services may depend on income and education.
	Geographic location	Residents of remote regions may face limited access to quality medical care.
	Cultural and language barriers	Language and culture can affect the quality of communication and understanding between patients and healthcare staff.
Patient factors	Timely assistance	The earlier a patient seeks medical attention, the more effective and better-quality care can be provided.
	Patient participation in the treatment process	Patient awareness and willingness to follow doctors' recommendations

Source: compiled by the authors based on Febres-Ramos & Mercado-Rey, 2020.

Assessing healthcare quality should be based on a clear and conceptually grounded definition of quality. However, defining quality of care remains methodologically complex due to the diversity of indicators and assessment criteria.

The outcomes of medical care, particularly in terms of patient recovery and restoration of basic functions, are widely considered key indicators of healthcare quality. However, the use of outcomes as quality indicators remains subject to debate, as they may not always fully reflect the complexity of medical processes (Lokshin et al., 2024). Nevertheless, outcomes remain an important criterion for assessing healthcare effectiveness, as they are relatively measurable compared to other dimensions of care. However, several factors impede the use of outcomes as reliable indicators of quality medical care, including the influence of patients' baseline health status and comorbidities, time lags between care delivery and observable outcomes, and the limited ability of outcome measures to capture organisational and communicative aspects of care. Moreover, outcomes do not always reflect broader dimensions of healthcare quality. In some cases, clinical outcomes may appear less significant in terms of mortality but still have substantial implications for patients' health and quality of life (Sakaguchi et al., 2024).

Healthcare quality is influenced not only by clinical outcomes but also by organisational, preventive, and systemic factors that shape the conditions of care delivery. Beyond institutional and legal dimensions, social responsibility within healthcare systems also involves addressing broader socio-cultural tensions that shape medical practice. Technological development enhances clinical effectiveness but may simultaneously reduce the emphasis on interpersonal aspects of care. This shift affects doctor-patient interaction and perceptions of care quality.

Therefore, the balance between technological development and human-centred values constitutes a core analytical dimension of social responsibility within healthcare systems and provides a conceptual basis for the empirical analysis presented in this study.

3.2 Healthcare System in Kyrgyzstan

The functioning of the healthcare system provides the institutional context in which social responsibility is distributed among key actors, including the state, healthcare institutions, and medical professionals. Each of these actors bears specific

responsibilities related to financing, organisation, accessibility, and quality of medical services. Therefore, analysing the healthcare system in Kyrgyzstan is essential for understanding how social responsibility is implemented in practice.

Issues and tasks to improve the quality of the health care system are central to any civilised country. Financing the health care system in Kyrgyzstan and the formation of a market for medical services are important aspects of improving public health and ensuring access to quality services. Healthcare institutions are financed through the single-payer system of the Compulsory Medical Insurance Fund (CMIF) (which also covers part of the costs), which makes it possible to distribute funds in a targeted manner by a single management body, thus ensuring control over the quality of medical services provided. However, despite these efforts, the health care system in Kyrgyzstan still faces several challenges: lack of qualified medical personnel, and the need to modernise medical equipment and management. The Kyrgyz government is taking action to increase funding for health care by allocating more funds to improve infrastructure, increasing the salaries of health workers and improving access to health services for all institutions (Kyrgyzstan: Strengthening Primary..., 2023).

Financing is central in determining the types of free and paid medical services. Financial issues affect the accessibility and quality of medical care and its fair distribution among the population. The state budget is used to maintain a network of medical facilities, purchase equipment, and medicines and pay medical staff. The state budget and the CMIF are used to determine the list of free medical services provided to citizens under the State Guaranteed Programme (SGP). This includes emergency medical care, treatment of certain chronic diseases, vaccinations, perinatal and obstetric services, and treatment of diseases under national programmes.

Kyrgyzstan has a compulsory health insurance program. The insurance policy covers certain outpatient services, diagnostics, and basic inpatient services. The type of free medical services provided depends on the priorities set by the government, the country's financial capacity and contributions to the CMIF. State programmes may be revised over time depending on changes in the economic situation, population needs, demographic factors and medical priorities (e.g., increased costs for cancer programmes or fighting epidemics).

Paid services are partially provided outside of the SGP and include:

- treatment services in private medical institutions in excess of quotas or benefits;
- specialised services not included in the SGP;
- services with improved conditions of stay (comfortable rooms, consultations with private specialists).

Private clinics and medical centres provide an alternative to public services. However, the cost of services in private institutions is often higher, and they are not covered by the state insurance system (Dakhno et al., 2022; 2023). The private sector partially offloads state institutions but poses issues of accessibility of medicine for the poor. Funding from international sources also exists, with Kyrgyzstan receiving significant health care support from international organisations and donors (e.g., World Bank, World Health Organisation, Global Fund). This support is aimed at combating certain diseases (TB, malaria, HIV), developing infrastructure and improving health services (Kyrgyzstan: Strengthening Primary..., 2023).

Lack of funding often results in public hospitals not being able to offer a wide-range of quality free services. Since the quality of medical care is one of the most common issues discussed in society, in our study we surveyed patients to assess the quality of medical care provided. Factors influencing care quality include institutional conditions, the use of technology, patient safety, the social status of physicians, and social security mechanisms (Picone et al., 2023).

Our survey yielded the following results concerning the most common places in the Osh region where people seek medical help: 41% (103 people) mentioned the Osh City Clinical Hospital; 32% (80 people) identified the Osh Interregional United Clinical Hospital; 16% (40 people) identified the Osh Children's Regional Hospital; 2% (5 people) listed the Kurmanzhan-Datka City Hospital; 1% (2 residents) listed the Nookat District Hospital. Private clinics were chosen by 8% of respondents: 3% (8 residents) are treated at the Nur Multidisciplinary Clinic; 4% (10 people) visit the Kyrgyz-Turkish International Clinic Beman and 1% (3 people) visit the Baiken+Baby Medical Centre.

Because 41% of respondents mentioned Osh City Clinical Hospital, which is one of the leading hospitals in Osh City, our survey assessed the quality of medical care in this hospital. The hospital provides qualified and specialised medical care to

residents of Osh City, Batken, Osh and Jalal-Abad regions. The institution provides both inpatient treatment and daycare. It also has a 24-hour emergency department.

As can be seen from the patients' responses below, residents are not fully satisfied with the quality of medical care, as it is sometimes too formalistic or generalized and does not always address individual patient wishes and preferences. In general, the effectiveness of care was evaluated at a sufficient level.

Figure 1 presents respondents' assessments of the quality of services provided by medical staff at Osh City Clinical Hospital.

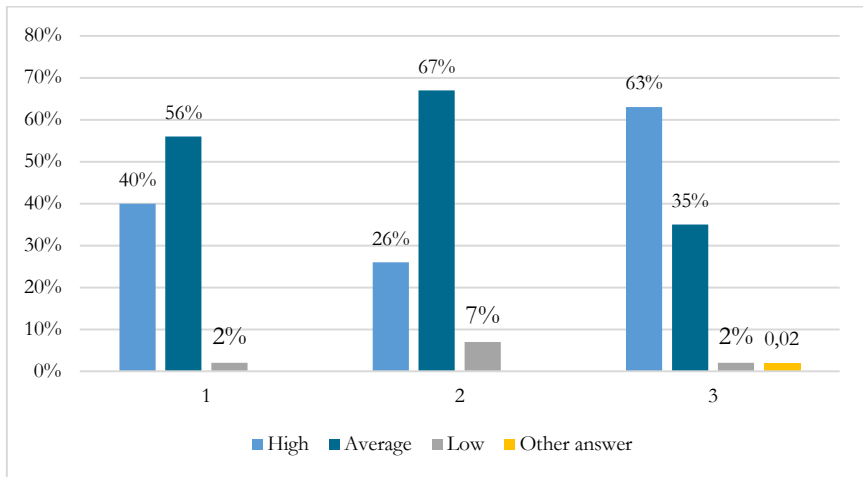


Figure 1: Assessment of the Quality of Services Provided by Medical Staff at Osh City Clinical Hospital

Source: compiled by the authors.

The results presented in Figure 1 demonstrate a differentiated assessment of the quality of medical services provided by hospital staff. Physicians' professional competence and the effectiveness of prescribed treatment were evaluated more positively than the performance of nursing staff. In particular, respondents tended to rate treatment effectiveness highest, while assessments of nursing staff performance were comparatively lower, indicating an asymmetry in perceived professional responsibility among staff categories.

Overall, the results suggest that the professional dimension of social responsibility is more strongly manifested among physicians than among nursing staff, indicating an uneven distribution of responsibility across professional groups within the healthcare institution.

Figure 2 presents respondents' assessments of the accessibility of healthcare services at Osh City Clinical Hospital.

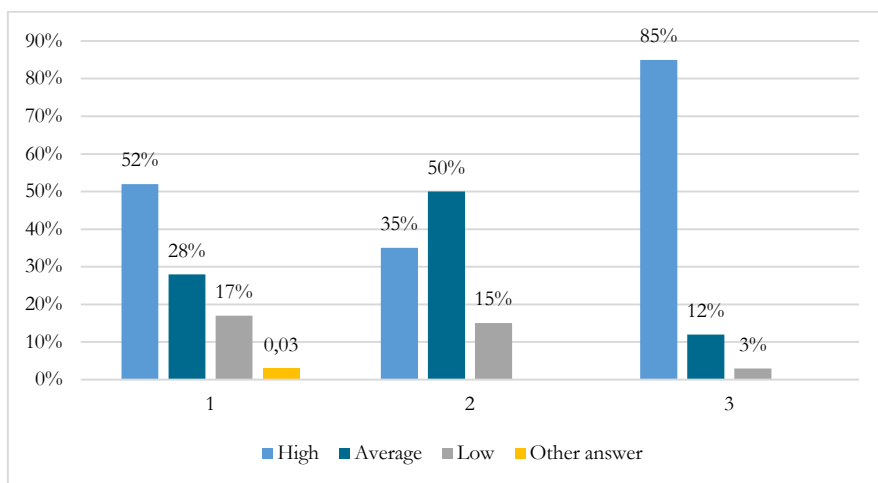


Figure 2: Assessment of Accessibility of Services Provided at Osh City Clinical Hospital

Source: compiled by the authors.

Figure 2 shows a heterogeneous pattern of healthcare accessibility at Osh City Clinical Hospital. General accessibility was viewed more positively than waiting times, while linguistic accessibility emerged as a particularly salient factor. Organisational and geographical barriers, including long waiting times and difficulties in reaching the hospital for non-urban residents, were identified as key constraints shaping patients' perceptions of access to care.

Thus, these findings suggest that accessibility constitutes a key institutional dimension of social responsibility in healthcare. The results also demonstrate that organisational efficiency, geographical availability, and linguistic inclusivity jointly determine the level of access to medical services, thereby influencing the extent to which healthcare institutions fulfil their social responsibility.

Figure 3 illustrates respondents' assessments of feedback and communication between patients and medical staff at Osh City Clinical Hospital.

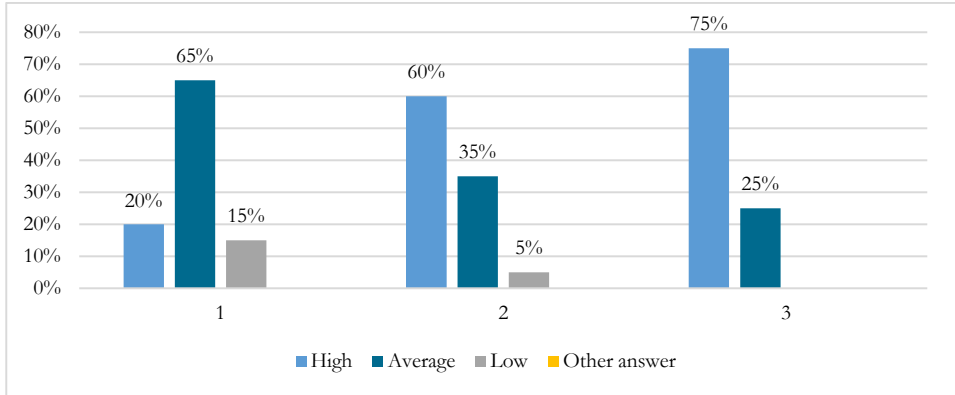


Figure 3: Level of Feedback and Communication from Medical Staff at Osh City Clinical Hospital

Source: compiled by the authors.

As illustrated in Figure 3, respondents generally evaluated the accessibility of medical staff for communication positively; however, assessments of information clarity and understanding of diagnoses were less consistent. These findings indicate that, despite relatively favourable interpersonal interaction, gaps in medical communication persist, particularly in the explanation of diagnoses and treatment protocols.

Consequently, the results suggest that the ethical and communicative dimensions of social responsibility within healthcare systems are realised unevenly. While respectful attitudes and openness of medical staff are largely ensured, insufficient clarity of medical explanations may undermine patients' understanding, trust, and active participation in the treatment process. Thus, effective communication emerges as a critical component of social responsibility in healthcare practice.

Figure 4 presents respondents' assessments of the ethical behaviour of medical staff at the Osh City Clinical Hospital.

Figure 4 indicates generally positive evaluations of ethical behaviour among medical staff, particularly in terms of trust. At the same time, variability in assessments of personal qualities and attentiveness suggests that ethical responsibility is realised unevenly in everyday clinical practice.

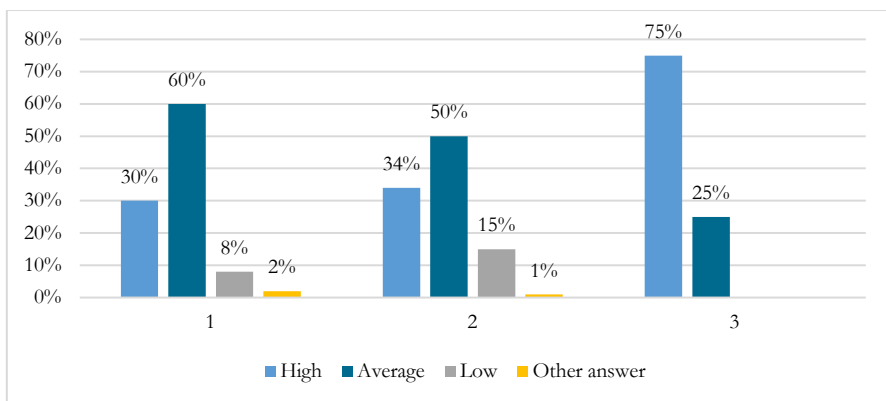


Figure 4: Level of Definition of Medical Staff Ethics at the Osh City Clinical Hospital
Source: compiled by the authors.

Therefore, the results demonstrate that the ethical dimension of social responsibility within healthcare systems is predominantly realised but remains uneven in practice. The presence of negative patient experiences indicates that ethical responsibility is shaped not only by individual professional behaviour but also by institutional culture and organisational conditions that structure everyday medical interactions.

Figure 5 presents respondents' assessments of Osh City Clinical Hospital's material and technical resources.

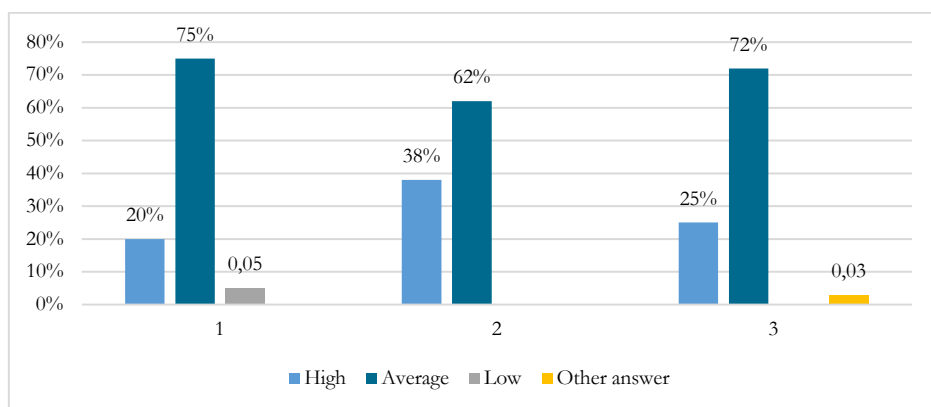


Figure 5: Level of Material and Technical Equipment of Osh City Clinical Hospital
Source: compiled by the authors.

As shown in Figure 5, respondents predominantly assessed the hospital’s material and technical resources at an average level. These findings point to infrastructural constraints that may limit the institutional capacity of the hospital to fully meet patients’ expectations regarding service quality.

Overall, the results demonstrate that the institutional dimension of social responsibility in healthcare is shaped not only by professional performance but also by the adequacy of material and technical resources, which directly influence patients’ perceptions of service quality and organisational reliability.

Figure 6 reflects respondents’ evaluations of the financial aspects of healthcare services at the Osh City Clinical Hospital.

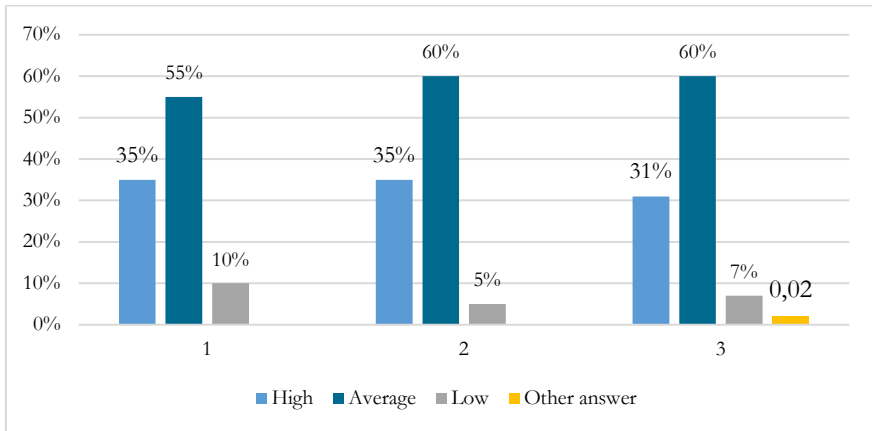


Figure 6: Level of Satisfaction with the Price and Quality of Healthcare Services at Osh City Clinical Hospital

Source: compiled by the authors.

Figure 6 demonstrates that financial aspects of healthcare services were most often evaluated at an average level. Issues related to insurance coverage and pricing transparency remain salient factors influencing patients’ perceptions of fairness and accessibility within the healthcare system.

Consequently, the financial dimension of social responsibility appears insufficiently institutionalised, indicative of potential structural gaps in insurance mechanisms and pricing transparency. This suggests that social responsibility within healthcare

systems extends beyond clinical and ethical domains and requires systemic financial and policy-level solutions.

The last set of questions about patients' suggestions and recommendations received the following answers: it is necessary to improve the patient care system (attentiveness of the nursing staff, quality of care, professional development of hospital staff, modern equipment); the hospital needs experienced qualified staff, namely, there is a lack of therapists, cardiologists and nurses. In response to question 3 from the block, 80 people would recommend this hospital to friends and acquaintances, 3 people wrote "depending on which doctor will conduct the treatment", and 1 person admitted "no possibility to be treated elsewhere".

Thus, the survey results indicate a sufficient level of medical care at Osh City Clinical Hospital, while also revealing structural and organisational factors that shape how social responsibility is implemented. These findings underscore that social responsibility in hospital settings depends not only on professional conduct but also on institutional conditions, resource availability, and effective management practices.

5 Discussion

The results obtained in this survey describe the social responsibility of medical staff at the Osh City Clinical Hospital of Kyrgyzstan in providing quality medical care. When interpreted in relation to international empirical research, these findings highlight both convergences and context-specific differences in how socially responsible healthcare practices are implemented. The study clarifies key dimensions of social responsibility and underscores the relevance of a value-based approach to healthcare quality. Overall, the findings indicate that the institution's level of social responsibility can be assessed as sufficient, although further improvements remain necessary to enhance the quality of medical care. The following discussion situates these findings within international empirical research by specifying the settings, research designs, and principal conclusions of selected studies and by comparing them directly with the present results, with particular attention to institutional, managerial, and professional dimensions.

The study's empirical findings demonstrate that the principles of social responsibility are manifested at different levels of the healthcare system. In particular, issues of accessibility and infrastructure reflect institutional responsibility, patient assessments

of communication and attentiveness relate to ethical responsibility, while compliance with standards of medical care illustrates the legal dimension of social responsibility.

Social responsibility in healthcare encompasses not only clinical care but also environmental and organisational practices that influence population health. In their conceptual analysis of medical professionalism and ethics, Desai & Kapadia (2022) argued that healthcare institutions hold ethical obligations that extend to minimising environmental harm through responsible organisational decision-making. Luo et al. (2020), in a study conducted in China, showed that institutional social responsibility shapes environmentally responsible behaviour by influencing awareness and normative expectations, despite the study not being limited to healthcare settings. Likewise, Hadj (2020), analysing organisations across multiple sectors, found that sustained commitment to social responsibility and environmental management supports responsible innovation and long-term competitiveness. These insights inform the interpretation of the present study, as infrastructural conditions, resource management, and organisational responsibility were among the aspects most frequently evaluated as average by respondents at Osh City Clinical Hospital. This indicates that environmental and institutional factors constitute integral, though often underdeveloped, components of socially responsible healthcare practice.

Limbu et al. (2020) conducted an empirical survey of hospital patients to examine how corporate social responsibility initiatives influence patient trust, patient-hospital identification, and brand advocacy. Using questionnaire data analysed through structural equation modelling, the authors assessed relationships between perceived social responsibility, trust in the hospital, and patient behavioural intentions. The study demonstrated that organisational commitment to social responsibility significantly strengthens patient trust and identification with healthcare institutions, which in turn enhances perceived service quality, institutional credibility, and willingness to recommend the hospital. These findings are comparable to the present study, in which transparency, communication practices, and organisational responsibility were also identified as key factors shaping patients' assessments of healthcare quality. However, whereas Limbu et al. focused primarily on trust formation and advocacy within a competitive healthcare environment, the present study highlights similar mechanisms within a public regional hospital context characterised by different institutional and resource conditions.

Azhdari et al. (2020) analysed urban public and private hospitals in Iran with a focus on the relationship between managerial decision-making, financial performance, and social responsibility strategies. Their study examined how hospital leadership integrates social responsibility into strategic planning, stakeholder engagement, and financial management. The authors found that senior management plays a decisive role in institutionalising social responsibility through coordinated policy implementation and resource allocation. They also emphasised that in order to effectively implement social responsibility there needs to be coordinated managerial action rather than isolated initiatives. These conclusions correspond with the present findings, as patients' assessments of transparency, organisational efficiency, and staff support at Osh City Clinical Hospital likewise reflect the influence of managerial decision-making on everyday healthcare practice. At the same time, the present study places greater emphasis on patient-perceived outcomes rather than financial performance indicators.

Lubis et al. (2017) examined the formation of a value-based approach to healthcare from the perspective of patients' perceptions of the medical services they received in hospitals in Medan, Indonesia. The authors analysed how patients evaluated service quality and concluded that medical staff play a central role in delivering high-quality care and shaping patients' perceptions of value. They further demonstrated that the perceived value of a healthcare institution increases when high-quality services are provided and a positive institutional image is maintained. Similarly, Efremov (2026) noted that social responsibility contributes to enhancing a hospital's status and overall institutional value. These findings are consistent with the present study, in which patients' evaluations of medical staff performance and institutional organisation were closely associated with their overall assessments of healthcare quality.

The quality of medical care in healthcare facilities in Kyrgyzstan remains one of the most pressing issues for the state. Quality management constitutes a key component of effective healthcare governance. Previous research indicates that a range of practical and theoretical challenges have emerged following socio-economic reforms (Moffa et al., 2021; Tulewicz-Marti et al., 2023). In a comprehensive perspective, the quality of medical care encompasses the scope of services provided by healthcare institutions, the organisation of patient care, the efficiency and effectiveness of service delivery, and adherence to clinical protocols and safety standards (Latka et al., 2024). The findings of the present study indicate that adherence to principles of

public health and well-being supports medical staff in achieving a high level of professional performance. These contextual factors provide an important framework for interpreting the present findings, as they help explain structural constraints influencing how social responsibility is implemented at the level of regional hospitals.

Muke et al. (2022) conducted a study of emergency departments in public hospitals in Kenya, focusing on organisational and clinical determinants of care quality in resource-constrained settings. Using observational and survey-based data from emergency units, the authors analysed staffing practices, service organisation, and allocation of limited medical resources. The authors demonstrated that access to quality medical care can be improved by differentiating between mandatory emergency services, optional interventions provided when clinically indicated, and high-cost specialised procedures. Concurrently, they found that an excessive reliance on high-technology healthcare services may undermine accessibility by concentrating limited resources on costly interventions, thereby reducing equitable access for patients with basic emergency needs. These findings are directly relevant to the present study, as respondents at Osh City Clinical Hospital similarly reported challenges related to accessibility and waiting times. Both studies therefore indicate a structural tension between technological intensity and equitable access within public hospital systems, although the Kenyan study emphasised emergency care settings, whereas the present research reflects patient perceptions across a broader range of services.

Assessment of healthcare quality requires a conceptually grounded approach that links organisational structures to clinical outcomes. Kim et al. (2024), in a nationwide study of medical institutions in South Korea, examined the effects of intensive care unit (ICU) quality assessment programmes on staffing changes and in-hospital mortality. Their findings demonstrated that systematic quality evaluation was associated with improvements in staff stability and reductions in in-hospital mortality, highlighting the importance of retaining qualified medical personnel and monitoring structural indicators over time. This evidence is relevant to the present study, as respondents' assessments of staff performance and institutional support at Osh City Clinical Hospital similarly point to the role of organisational conditions in shaping healthcare quality.

Ghate and Ahmed (2024) conducted a study of healthcare management and service quality in hospitals in India, examining how leadership structures and professional roles influence perceived social responsibility and care quality. Their analysis focused on the distribution of professional responsibilities between physicians, nursing staff, and institutional leadership. The authors found that physicians were perceived as demonstrating higher levels of social responsibility due to their greater involvement in clinical decision-making, treatment planning, and communication with patients. They explained this difference by physicians' broader institutional responsibilities within hospital settings and by their central role in coordinating treatment processes. The authors further concluded that stronger involvement of national health leadership in hospital governance enhances accountability and organisational coherence, thereby contributing to more consistent standards of care delivery. These conclusions are comparable to the present findings, in which residents of the Osh region likewise perceived physicians as demonstrating higher levels of social responsibility than nursing staff. However, while Ghate and Ahmed emphasised governance and leadership structures at the national level, the present study highlights organisational and communicative factors at the institutional level.

By contrast, Alqasmi & Ahmed (2025) demonstrated that nursing staff can play a substantial role in improving the quality of healthcare delivery through patient-centred care, attentiveness, and continuity of support. Their findings indicate that nurses' contributions to care quality are strongly shaped by organisational conditions and professional support structures. The present study similarly suggests that hospital management and physicians indirectly influence healthcare quality by shaping nurses' working conditions, professional roles, and capacity to deliver effective patient care.

The results from our study demonstrate that while most respondents highly appreciated the efficiency of doctors' work, there was a significant percentage of respondents who were not satisfied with nurses' work. Additionally, although patients did not always understand the attending physician's diagnoses and treatment protocols, medical staff tried to explain and justify the prescription scheme. These results are consistent with those of Shah et al. (2023). The quality of care is based on the safety and effectiveness of the treatment provided, people-centredness, equity, rationality and integration, which will further influence the treatment outcomes and patient safety.

The study by Jagodic et al. (2023) utilised a patient satisfaction survey similar to the one applied in the present research to examine the quality of medical care in public healthcare institutions in Bosnia and Herzegovina. Their study was conducted in four public health institutions within Tuzla Canton and involved 200 adult patients receiving primary healthcare services. The authors analysed patients' evaluations of doctor-patient interaction, nursing care, access to healthcare facilities, and the institutional environment. The findings indicated that 54.17% of respondents reported satisfaction with the medical advice provided and the course of treatment, highlighting the importance of communication, professional conduct, and organisational conditions in shaping patient satisfaction. Several of these findings are consistent with the results of the present study, particularly regarding the central role of medical staff behaviour in patients' assessments of care quality.

The financing of medical facilities plays a crucial role in the delivery of medical services and in shaping overall patient satisfaction. Stronger financial capacity is generally associated with improved healthcare delivery, as adequate funding enables institutions to offer competitive remuneration, attract and retain qualified medical personnel, and invest in infrastructure and medical equipment. Private hospitals are for-profit or non-profit healthcare organisations financed from private resources. Kalaja et al. (2023) conducted a patient satisfaction study in private healthcare institutions in Albania involving approximately 400 patients. Using the SERVQUAL framework, the authors assessed multiple dimensions of service quality, including responsiveness, reliability, safety, tangibles, and empathy. Their analysis showed significant associations between specific quality dimensions and overall patient satisfaction, indicating that higher perceived service quality in private hospitals correlates with increased satisfaction levels. These findings partly correspond with the present study, as respondents likewise associated infrastructure quality, staff professionalism, and organisational efficiency with overall satisfaction. However, whereas Kalaja et al. examined private healthcare institutions operating under competitive market conditions, the present research focuses on a public regional hospital, where resource constraints and institutional responsibilities shape patient perceptions differently.

Jeurissen et al. (2021), in a multi-country comparative study of public and private hospitals across several European healthcare systems, analysed differences in care provision under varying reimbursement and ownership models. The authors concluded that urban public hospitals often provide a level of care comparable to

that of private hospitals, particularly in terms of professional expertise and service range, while rural public facilities tend to face greater structural and resource-related constraints. Their findings indicate that hospital location and institutional context substantially influence care quality, in some cases more strongly than ownership status.

Evidence from Central and Eastern Europe further supports the role of urban public hospitals within national healthcare systems. In Slovakia, Dobrovanov (2021) and Dobrovanov & Kráľinský (2018) demonstrated that city hospitals provide effective and affordable diagnostic services, particularly in specialised fields such as prenatal and postnatal ultrasound screening. These studies showed that professional experience and clinical competence in public urban hospitals are often comparable to those observed in private medical institutions.

Similarly, Niyazbekova et al. (2025), in a study focusing on oncology diagnostics in urban healthcare centres in Central Asia and Eastern Europe, reported that investments in advanced medical technologies, including genetic testing and liquid biopsy, are associated with improved diagnostic accuracy and treatment quality. Their results indicate that technological innovation within urban hospitals contributes to higher service quality irrespective of ownership structure.

Overall, evidence from these international studies supports the findings of the present research, indicating that urban hospitals – particularly public institutions – can serve as central components of healthcare systems when supported by professional expertise, organisational capacity, and targeted investment.

The findings of the present study, together with evidence from research conducted in Europe and Central Asia, indicate that social responsibility constitutes an important determinant of healthcare quality. International experience suggests that strengthening organisational practices, professional accountability, and targeted investment is essential in order to better develop socially responsible healthcare systems. These principles support medical personnel in delivering effective, equitable, and patient-oriented services, thereby contributing to public health and societal well-being. This comparative analysis demonstrates that the findings of the present study are broadly consistent with international empirical research, while also reflecting the specific institutional and resource conditions of regional public hospitals in transitional healthcare systems.

5 Conclusions

This study analysed the concepts of “social responsibility” and “quality of medical care”. Social responsibility in medicine covers a wide range of principles aimed at ensuring the health and well-being of society, such as professional ethics, accessibility and equality, education and prevention, social engagement, environmental responsibility, and employee support. The empirical findings demonstrate that these principles are manifested unevenly across professional, institutional, and organisational dimensions of healthcare, indicating that social responsibility in healthcare is a multi-level phenomenon rather than a uniform ethical or legal obligation.

The findings highlight the interdependence between the quality of medical care and institutional, professional, and financial factors. They demonstrate that the quality of medical care is shaped by the interaction of professional competence, organisational efficiency, and institutional resources, confirming the structural nature of social responsibility in healthcare systems.

The results of the sociological survey we conducted to identify the problems and needs of Osh region residents in the provision of medical care at the Osh City Clinical Hospital show that not all respondents are satisfied with the quality of medical care. Most patients appreciated the professional dimension of care: 40% rated physicians’ professional competence as high (with 56% assessing it as average), whereas only 26% expressed high satisfaction with nursing staff (with 67% assessing it as average), revealing an asymmetry in professional responsibility. The effectiveness of prescribed treatment was evaluated most positively, with 63% reporting high satisfaction (35% average; 2% low). Moreover, while overall accessibility of healthcare services was judged as high by 52% of respondents, satisfaction with waiting times was considerably lower (35% high satisfaction), indicating persistent organisational barriers. Language accessibility emerged as a salient dimension of institutional responsibility: 85% of respondents emphasised the importance of receiving services in the Kyrgyz language.

These findings reveal key challenges faced by healthcare institutions, including workload imbalance, limitations of material and technical resources, and insufficient institutional support for medical staff. These factors significantly affect the quality of medical care and how social responsibility is implemented in healthcare practice,

demonstrating that social responsibility is conditioned not only by individual professional behaviour but also by institutional and systemic constraints.

The empirical evidence derived from our study leads us to conclude that there are several steps that can be taken to improve social responsibility in healthcare. The following five measures are priority items: (1) strengthening nursing staff capacity and support, given the gap between high ratings for physicians (40%) and nursing staff (26%); (2) optimising institutional procedures and patient flow management, as waiting-time satisfaction remained low (35%) despite relatively high overall accessibility (52%); (3) improving patient-oriented communication, because only 20% of respondents highly rated the clarity of information provided by medical staff; (4) addressing infrastructural constraints, as hospital equipment, medicines, and facility conditions were predominantly assessed as average (e.g., 62-75% average evaluations across infrastructure indicators); and (5) strengthening transparency and insurance and financial mechanisms, since 55-60% of respondents rated pricing transparency, cost-quality balance, and insurance coverage as average. Implementing these measures would contribute not only to strengthening social responsibility but also to improving the overall quality of medical care through enhanced organisational performance, communication, and resource management.

The limitations of the study were the relatively small and regionally limited sample, which restricted the generalisability of the findings. Future research may expand the empirical base and further explore the interaction between ethical, institutional, and financial dimensions of social responsibility in healthcare.

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Povzetek v slovenskem jeziku

Študija je bila izvedena z namenom ugotoviti raven družbene odgovornosti medicinskega osebja Klinične bolnišnice mesta Oš v Kirgizistanu. V ta namen je bila med prebivalci regije Oš izvedena anketa o zagotavljanju kakovostne zdravstvene oskrbe, v kateri je sodelovalo 251 anketirancev. Rezultati so pokazali, da je 55–60 % anketirancev raven družbene odgovornosti bolnišnice ocenilo kot povprečno. Bolniki so visoko ocenili učinkovitost zdravljenja (63 % visokih ocen), medtem ko je delo negovalnega osebja visoko ocenilo le 26 % anketirancev, kar kaže na asimetrijo v poklicni odgovornosti. Poleg tega je 52 % anketirancev dostopnost zdravstvenih storitev ocenilo kot visoko, medtem ko

institucionalne in finančne ovire še vedno ostajajo precejšnje. Ugotovitve kažejo, da socialno odgovornost v zdravstvu oblikuje neenakomerna porazdelitev strokovnih, institucionalnih in organizacijskih virov, kar se odraža v različnih ocenah uspešnosti medicinskega osebja, dostopnosti storitev in finančnega kritja.

