

Dojemanje oskrbe, osredotočene na pacienta, v treh klinikah za zdravljenje neplodnosti: vpliv zdravljenja v domačem okolju ali tujini in povračila stroškov

Perception Of Patient-Centered Care in Three Fertility Clinics: Influence Of Domestic Or Cross-Border Treatment And Reimbursement Policy

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Izvleček

Uvod: Namen te študije je bil oceniti izkušnje bolnikov z oskrbo, osredotočeno na bolnika (PCC), na treh klinikah za zdravljenje neplodnosti glede na kritje stroškov zdravljenja in kraj, kjer so bili zdravljeni.

Metode: Pari, ki so se zdravili z oploditvijo z biomedicinsko pomočjo (OBMP), so bili razdeljeni v tri skupine: (I) slovenski pacienti v zavarovalniškem programu, (II) tujci s samoplačniškim zdravljenjem v kliniki v tujini in (III) tujci s samoplačniškim zdravljenjem v kliniki v Mariboru. Izvirni vprašalnik Radboud University Patient Centredness Questionnaire on Infertility Treatment (PCQ-Infertility), preveden v jezike bolnikov, je bil posredovan 400 parom, izpolnilo ga je 78 % parov. Za vsako od treh skupin bolnikov so izračunani povprečni rezultati za področja in kazalnike

Abstract

Introduction: This study aimed to evaluate the experience of patients undergoing patient-centered care (PCC) at three fertility clinics in Southeastern Europe in terms of the treatment cost coverage and quality of care provided.

Methods: Couples who underwent assisted reproductive technology (ART) were divided into three groups: (i) Slovenian patients covered under the national insurance programme; (ii) self-pay patients receiving treatment in their country of origin/a clinic abroad; and (iii) cross-border self-pay patients receiving treatment in Maribor, Slovenia.

A standardized questionnaire, the "Patient Centredness Questionnaire on Infertility Treatment (PCQ-Infertility)", was translated into each patient's native language

na pacienta osredotočene obravnave (PCC). Ti podatki so nato uporabljeni pri analizi razlik v ocenah.

Rezultati: Na splošno je ocena v zvezi s kompetenca-mi osebja pokazala najvišjo točkovno vrzel v rezultatih (SDG) v skupini čezmejnih samoplačniških pacientov, medtem ko je imela najnižjo oceno domena organizacije zdravstvene oskrbe v skupini domačih pacientov iz zavarovalniškega programa. V celotni raziskavi je kazalnik o informacijah o morebitnih stranskih učinkih predpisanih zdravil pokazal najnižjo točkovno vrzel kazalnika (SDG), medtem ko se je najvišja SDG nanašala na stalnega terapevta, ki je vodil postopek in je lahko pacient kadar koli v stiku z njim.

Zaključek: Rezultati niso pokazali, da način financiranja zdravljenja z OBMP vpliva na izkušnje bolnikov s PCC. Čeprav je bila usposobljenost članov tima visoko ocenjena, domači pacienti iz zavarovalniškega programa OBMP še vedno nimajo več pozitivnih izkušenj s PCC, povezanih z organizacijo zdravljenja.

and administered to 400 couples, of whom 78% completed it. For each of the three patient groups, the mean scores of the PCC domains and indicators were calculated. These data were then used for the score gap analysis.

Results: Overall, the domain assessing the competence level of medical staff produced the biggest score domain gap (SDG) in the group of cross-border, self-pay patients, while the smallest score was observed for the health organization domain in the group of domestic patients with reimbursed cycles. In our research, the indicator corresponding to information about any possible side-effects of the prescribed medication produced the smallest score indicator gap (SIG), while the biggest SIG was observed for staff members assigned to be contacted for questions at any time.

Conclusion: The results did not show that the financing method of ART treatment affected patient experiences of PCC. Although the competence of the medical staff is rated highly, domestic patients with reimbursed ART cycles continue to experience a lack of PCC in the health organization domain.

INTRODUCTION

Patient-centered care (PCC) has emerged as an important component of high-quality healthcare (1). From a conceptual viewpoint, PCC emphasizes more than patient satisfaction. First, it focuses on understanding patients' experiences of illness and disease, but it also adopts a holistic approach to patient care (2). Second, PCC describes the quality of personal, professional, and organizational relationships and interactions (3) among the actors in healthcare arena. Patients should be encouraged to be rightly placed in the core of their healthcare needs, given advanced understanding of infertility, how to use communication media, and technology (4,5). These arguments highlight the complexity of PCC, particularly in the communication with medical staff, information available during treatment, and explanation domains – string of questions that identifies a realm of their needs and expectations

during treatment. Apart from the existing objective quality standards, we need to consider the patient's subjective perspective as a more accurate indicator of the quality of patient health care (6). However, these measurements should be considered as a complement (7) to enhancing the quality of care.

With the growing number of people undergoing infertility treatment, PCC has become an important pillar of this type of care. Research reveals that the level of patient-centeredness in fertility care is associated with patients' quality of life and their levels of anxiety and depression (8). Other studies have shown that PCC is directly and indirectly associated with the patient's acceptance of treatment and adherence to treatment, as well as their well-being and the improvement of care quality (9,10,11). The quality of fertility care has become a prominent issue in many countries, while patients' experiences have been recognized as a key factor for patient-centeredness assessment (12). In a

qualitative study carried out in Austria, Spain, the UK, and Belgium, Dancet et al. argued that patients across Europe value the same elements of infertility care (13). Nevertheless, the evidence shows that certain differences exist. The results from a study examining patients' experiences in the Netherlands and Slovakia showed differences, particularly with regards to the provision of information, explanation of medical results, and staff communication skills (14). The differences in healthcare experiences can be explained by organizational characteristics (healthcare systems), the socio-cultural context, and patients' personal preferences and expectations (14,15).

As in other healthcare areas, patients with infertility problems can seek treatment outside of their country of origin and, in the case of EU citizens, they may receive a full or partial reimbursement for the treatment (16). The most common drivers of patient decisions to seek cross-border treatment include the following: the cost of the treatment, waiting time, trust (in the healthcare system, the source of information), language preferences, and willingness to pay more for treatment abroad (17). In addition, a proportion of infertility healthcare treatment received abroad can be attributed to certain legal barriers that prevent patients from undergoing treatment in their country of origin (18,19). A study of Dutch and Belgian hospitals showed that Dutch couples often travel to Belgium to receive infertility treatment as they report better quality of care, since Belgian hospitals are more patient-centered than "protocol oriented" (20). Drivers of patients' willingness to pay more for these services include the following: good staff attitudes, continuity of physicians, shorter waiting times, and follow-up support (21). Moreover, the level of PCC care has been found to significantly influence the patient's choice of fertility clinic (12). Greater emphasis on tailored care could promote a more positive experience for patients, enhance patient-centeredness (8), and increase the effectiveness of healthcare (12,22).

All domestic patients in Slovenia have the right receive six fully reimbursed cycles. All cross-border Serbian and Croatian patients treated in Slovenia are obliged to pay for the treatment and it is not possible for them to be reimbursed by the health insurance

companies in their own country. All patients treated at fertility clinics in Serbia and Croatia (DPSC) reported that no cycles were reimbursed. The domestic patients in Slovenia (DPS) treated under the insurance programme were managed by a team of doctors who rotated administration of folliculometry, follicle puncture, and embryo transfer procedures. They communicated with several embryologists at the time of embryo transfer. The foreign patients in Slovenia (cross-border patients, CBPs) were managed by only one doctor and one embryologist. Both groups of patients received written instructions for the medically assisted reproduction (MAR) programme and stimulation protocol prior to the commencement of stimulation. The same written instructions and protocols for treatment were provided by the same team to patients treated at fertility clinics in Serbia and Croatia, and CBPs treated in Slovenia.

There is a need for fertility clinics to focus on management quality and patient centeredness (10). The level of patient-centeredness is an important measure of a clinic's performance. It can promote tailored quality improvement plans, as well as international benchmarking and cross-country comparison of infertility care from the perspective of patients (23). Our study aimed to assess PCC by evaluating the experiences of domestic patients undergoing infertility treatment covered under the Slovenian insurance policy, cross border patients in Slovenia and patients treated in their own country (Croatia and Serbia) undergoing infertility treatment where cost for treatment was not reimbursed.

To our knowledge, no similar research has been carried out to date to examine this issue.

METHOD

Aim of the study

This study aimed to assess how the choice of therapist, number of therapists involved, change in clinic location, staff support, and infertility treatment cost influence patients' perceptions of procedures.

Study design

We designed a prospective, cross-sectional study and

included randomly selected couples undergoing MAR treatment at three fertility clinics based in Slovenia, Serbia, and Croatia. The data were collected over a 12-week period.

Participants/materials, setting, and methods

Depending on the reimbursement policy for MAR treatment and the location of the treatment center, the participants were divided into three groups: 1) Domestic patients (DPS) with health insurance cover (insured patients in Slovenia, n=106); 2) Domestic patients in foreign centers (DPSC), (patients treated in their own countries in Serbia and Croatia as self-pay patients, n=137); and 3) Cross-border patients (CBPs), self-pay treatment (self-pay foreign patients treated in Slovenia, n=69).

Self-pay patients were treated by the same gynecologist and embryologist in all three countries. Patients in the public programme were cared for by a team, with different care-team members from the same specialties taking turns to perform the treatment interventions. Different reproductive nurses worked in all three centers.

To measure patient-centeredness, this study followed one of the recommended national standards for surveying the level of patient-centeredness in fertility care and administered a standardized questionnaire known as the “Patient-centeredness Questionnaire-Infertility (PCQ-Infertility)”, developed by Radboud University, Holland (24). Patients completed the questionnaire, which was translated into their native languages (Slovenian, Serbian and Croatian). The translation was carried out at the Research Department of the University Hospital Maribor. The questionnaire had 55 questions. First part covered sociodemographic data, number of previous IVF treatments, pregnancy status, and financial coverage. Second part consisted of three assessment levels: eight domains (accessibility, information and explanation, staff’s communication skills, involvement in treatment, respect for values and needs, continuity and transition during treatment, staff competence and care organization) and 46 single indicators, measured according to the scale ranking from 0 to 3. The number of items used to assess

each domain differed. Minimal number (2 items) has domain “accessibility” and highest number (11 items) domain “information and explanation”. The questionnaire finished with analogue scale of 0 to 10 to assess satisfaction with overall treatment at the institution where treatment was received.

Microsoft Office Excel 2016 was used to perform a basic descriptive analysis and obtain mean score results for PCC domains and indicators for each group of patients (scale range 0-3). These score results were further analyzed by performing a gap analysis. A gap analysis is a strategic management method used to assess existing differences between expected and observed performance (25). In our research, a gap analysis was performed to calculate the differences between the scores on domain or indicator levels, where a gap refers to the “space” between patients’ perceptions of PCC among different groups. The group of domestic (Slovenian) insured patients served as a reference group for the gap scoring. A correlation analysis and linear regression model were used to determine a possible significant association between the different indicators in each group. Based on the indicators analysis, the score gap established which domains of the PCC processes have been neglected or insufficiently developed by healthcare organizations.

RESULTS

Our results are divided into two segments. The first level of analysis was based on the eight PCC domains among the three groups of patients. We observed the highest and the lowest domain scores, and the score domain gap (SDG). The second level of analysis examined the level of indicators with regards to the highest and the lowest indicator score, the score indicator gaps (SIG) between insured and self-pay patients, and any possible existing correlations between the indicators.

Patient-related characteristics

Completed PCQ-Infertility questionnaires were collected from 312 infertile couples in total, with a response rate of 78%. The average age of the women

Table 1. Summary of patients' related characteristics for the three patient groups

	Woman age Mean	Number Of ART treatments	Level of education *	Pregnancy status**
	(Range) ± SD	(Range) ± SD	(Range) ± SD	(Range) ± SD
Domestic patients, reimbursed treatment (DPS)	34.00 (25-43) ±4.28	2.00 (0-7) ±1.78	3.00 (1-5) ±.96	1.00 (1-2) ±.49
Domestic patients in foreign centers, self-pay treatment (DPSC)	36.92 (26-45) ± 4.28	2.91 (0-11) ± 2.33	3.96 (3-5) ± .711	1.20 (1-2) ± .40
Cross-border patients, self- payed treatment (CBP)	35.94 (24-45) ± 4.505	3.103 (0-15) ±2.722	3.696 (3-5) ±.602	1.015 (1-2) ± .122

*1-pregnant, 2- not pregnant

** 1-elementary, 2-grammar, 3- high, 4- university, 5-other

who responded to the questionnaire was 34 ± 4.3 years (24–45 years), and most had a secondary-level education or higher. They were undergoing their second or third MAR treatment. At the time of completing the questionnaire, the majority of these women were not pregnant and were part of the group treated with IVF/ICSI (in vitro fertilization/intracytoplasmic sperm injection) (Table 1).

Domain levels

Overall, the highest score was observed for the Staff Competences domain ($2.791 \pm .278$) in the group of cross-border, self-pay patients, while the lowest score was observed for the Healthcare Organization domain ($1.473 \pm .036$) in the group of domestic insured patients (Table 2).

The results revealed that the difference between perception for most components of service quality among groups differ was negative. This means that cross-border patients in Slovenia rated their experiences more positively than self-pay patients in their own countries. SDG values were the smallest between the CBP and DBPSC groups in almost all domains, implying comparable scores in both patient groups. They were positive for the Accessibility and Care Organization domains, with higher scores

assigned by CBP patients.

The biggest score domain gap (SDG) between the insured and self-pay group of patients occurred in the Healthcare Organization domain (-1.106) and the Continuity and Transition During Treatment domain (-0.99). The smallest SDG was observed for Accessibility (-0.092) and Staff Communication Skills (-0.104) in the group of cross-border, self-pay patients. Comparing the SDG ratings of couples coming from the same environment to different clinics showed different values. The biggest SDG between both groups of self-pay patients was observed for Accessibility (0.536), with the highest score among patients treated in their countries of origin ($2.591, \pm .031$) and the smallest among cross-border patients ($2.055, \pm .365$). The smallest SDG for this comparative pair was observed for the Patients' Values and Needs domain (0.047).

Indicator levels

In the group of insured domestic patients, the highest indicator score was observed for the question "whether caregivers contradict each other in policy" (Q37) (2.837 ± 0.372). This means that they received contradictory information or answers to the same

Table 2. Domains scores and score domain gap (SDG) for domestic and cross-border patients with reimbursed or self-pay treatment

PCC domains	Group of patients Mean (SD)								
	Domestic patients, reimbursed treatment (DPS)	Domestic patients in foreign centers, self-pay treatment (DPSC)	Score domain gap (SDG)	Domestic patients, reimbursed treatment (DPS)	Cross-border patients, self-pay treatment (CBP)	Score domain gap (SDG)	Domestic patients in foreign centers, self-pay treatment (DPSC)	Cross-border patients, self-pay treatment (CBP)	Score domain gap (SDG)
1. Accessibility	1.963 (0.031)	2.591 (0.031)	-0.628	1.963 (0.031)	2.055 (0.365)	-0.092 (min)	2.591 (0.031)	2.055 (0.365)	(0.536) (max)
2. Information and explanation	2.052 (0.777)	2.218 (0.777)	-0.166	2.052 (0.777)	2.312 (0.710)	-0.26	2.218 (0.777)	2.312 (0.710)	-0.094
3. Staff's communication skills	1.997 (0.887)	2.101 (0.887)	-0.104 (min)	1.997 (0.887)	2.271 (1.015)	-0.274	2.101 (0.887)	2.271 (1.015)	-0.17
4. Involvement in treatment	2.004 (0.180)	2.581 (0.180)	-0.577	2.004 (0.180)	2.735 (0.055)	-0.731	2.581 (0.180)	2.735 (0.055)	-0.154
5. Respect for values and needs	2.031 (0.429)	2.199 (0.429)	-0.168	2.031 (0.429)	2.246 (0.700)	-0.215	2.199 (0.429)	2.246 (0.700)	-0.047 (min)
6. Continuity & transition during treatment	1.767 (0.245)	2.554 (0.245)	-0.787	1.767 (0.245)	2.757 (0.095)	-0.99 (max)	2.554 (0.245)	2.757 (0.095)	-0.203
7. Staff's competence	2.335 (0.187)	2.588 (0.187)	-0.253	2.335 (0.187)	2.791 (0.278)	-0.456	2.588 (0.187)	2.791 (0.278)	-0.203
8. Care Organization	1.473 (0.036)	2.579 (0.036)	-1.106 (max)	1.473 (0.036)	2.309 (0.427)	-0.836	2.579 (0.036)	2.309 (0.427)	0.27

question. The lowest score value was observed to the provision of information by staff about how to obtain support from a social worker or a psychologist (Q11) (0.295 ± 0.854). Furthermore, in both of the self-pay groups (i.e., cross-border and domestic patients), the question relating to the provision of information by staff about how to obtain support from a social worker or a psychologist (Q11) was scored the lowest (0.938 ± 0.265 and 0.343 ± 0.943 , respectively). The highest score for both groups of self-pay patients was observed for question relating to "having received a treatment plan with a time schedule" (Q8). Among the cross-border self-pay patients, this question (Q8) produced the highest indicator scores in our research (3.00 ± 0.0).

The highest indicator score among domestic patients eligible for treatment reimbursement (DPS) was observed for question Q37, "Did caregivers contradict each other in policy (one says one thing, the other says something else)?" ($2.837 \pm .372$), while the lowest score was observed for question Q11, "Did the staff inform you about how to get support from a social worker or a psychologist?" ($0.295 \pm .854$). This information (Q11) was ranked equally low by foreign patients treated in Slovenia ($0.343 \pm .943$) (CBP) and by those treated domestically in their own countries ($0.938 \pm .265$) in Croatia or Serbia (DPSC). Both groups assigned the highest score to questions about preparations for their procedures (8): "Did you receive an overview of your treatment plan with a time schedule?" ($2.978 \pm .256$,

Table 3. The highest indicators score gap (SIG) between patients with reimbursed and self-pay treatment

PCC Dimensions (number of indicator)	Group of patients Mean score for indicator±SD		(SIG)
	Patients with reimbursed treatment	Patients with self- payed treatment	
Q31 Was one staff member assigned to you to contact any time you had any questions or problems (e.g. a nurse)?	0.495± .867	2.631± .993	-2.136
Q32 How many different physicians are or were involved in your treatment at your present hospital	1.150± .967	2.768± .629	-1.618
Q34 How often did you have an appointment with the same physician?	1.231± .779	2.667± .634	-1.436

Table 4. The lowest indicators' score gap (SIG) between patients with reimbursed and self-pay treatment

PCC Dimensions (number of indicator)	Group of patients Mean score for indicator±SD		(SIG)
	Patients with reimbursed treatment	Patients with self- payed treatment	
Q9 Were you informed of any possible side-effects of the medication prescribed to you?	1.423±1.334	1.424± .895	- 0.001
Q2 Was it a problem for you to contact staff (by telephone or e-mail) if you had any questions?	1.783± .516	1.797± .472	- 0.014
Q42 How often were logistics smooth at the Fertility Department?	2.457± .476	2.485± .760	-0.028

DPSC; 3.00 ± .0, CBP).

The SIG analysis of the insured and self-pay patient groups revealed the biggest gap for the indicators used to assess whether a staff member was assigned to be contacted for questions at any time (Q31) (-2.136). The result was negative and this question produced the biggest gap among domestic insured patients (Table 3). The results of the overall analysis revealed that the biggest SIG between these two groups was found for the question relating to “information about possible side effects” (-0.001), although the scores for this question in both groups were below average (Table 4). In the SIG analysis of the group of cross-border and domestic self-pay patients, the smallest score gap was observed for the question relating to “discussion with patients about the results of the investigations” (Q15) (0.007), which was rated slightly higher by cross-border patients. Whereas the biggest SIG for self-pay cross-border patients was observed for the indicators

used to assess “access to their own medical records during the treatment period” (Q24) (-1.019).

Correlation

In the group of domestic insured patients, pregnancy status before treatment was positively correlated with comprehensive information about the treatment (Q7) ($p \leq 0.001$) and patients' perceptions of the physician(s) as being competent (Q40) ($p \leq 0.006$). Patients who had higher levels of education felt that the care-team did not discuss the results of the investigations with them (Q15) ($p \leq 0.003$).

Moreover, patients in both groups (domestic insured patients and cross-border patients) with higher levels of education had expected the staff to pay greater attention to the possible emotional impact of fertility problems on them (Q30) ($p \leq 0.001$ and $p \leq 0.022$). In the group of self-pay patients, a positive correlation was found between pregnancy status

and the information provided about any possible side-effects of the prescribed medication ($p \leq 0.002$). However, all our patients tend to experience problems with accessing staff in Slovenia; they were unable to reach the staff immediately (Q1) ($p \leq 0.019$) and had difficulty contacting them by telephone or e-mail (Q2) ($p \leq 0.028$) during the treatment period. This question influenced their overall satisfaction and experience of PCC ($p \leq 0.030$) and was also correlated with the patients' level of education ($p \leq 0.009$). Cross-border patients in Slovenia reported that they encountered greater difficulty in being able to speak promptly with a care-team member with the low number of received treatments in past (Q1) ($p \leq 0.020$). No significant correlation was found between the indicators and the method of financing the treatment in any of these three groups of patients.

DISCUSSION

Patients' perceptions of the competence levels of their care-team proved to be an important factor for their decisions to seek treatment abroad. Other factors that influenced patients' decisions to avail of cross-border fertility treatment included familiarity, availability, cost, quality, and bioethical legislation. Among these five key drivers responsible for the increased demand of fertility treatment abroad, this study found that familiarity with the context (e.g., staff who speak the patient's native language) and quality (i.e., staff's competence) were the most important key drivers for the group of cross-border couples who underwent fertility treatment. The competence of the clinic and medical staff, together with information and attitudes, and the patients' relationships with staff, were one of the three dimensions that were assigned the highest priority by the respondents (9).

Domestic insured patients sometimes experienced problems related to the following domains: Healthcare Organization, Continuity and Transition During the Treatment. The patients reported that their healthcare providers never contradicted each other in clinical practice, as the patients never received contradictory information or advice (Continuity and transition domain). The patients also found that the care-team

members were well-organized (Staff Competences). In this study, the majority of domestic patients who underwent treatment reported difficulties in being able to contact a care-team member involved in the treatment intervention, and that there was a failure to assign one staff member who could be contacted to address any questions or problems should the need arise. This was not the case with foreign CBPs. Similar results were obtained from another national research conducted in Slovakia, where problems contacting care-team staff were reported by two out of three patients on average (14). On the contrary, most CBPs in the Slovenian fertility center had a staff member assigned to them. The patients reported that the physicians were competent and the staff were well-organized. These results fall under the Staff Competences domain. The ability to contact a staff member (by telephone or e-mail) in the event that the patient had any questions was positively correlated with overall patient satisfaction. Contacting the patients after they are discharged from the hospital can have an impact on the quality of transitional care with no effect on hospitalization.

Both groups of DPSC and CBPs reported similar experiences with respect to their values and needs during the treatment process. The communication skills of staff were assessed, with small differences observed in both groups. A small gap in this domain shows high levels of communication competence among care-teams in Slovenia, especially language-based competence which allows healthcare staff to speak with patients in their native language. In order to achieve effective healthcare delivery, we need to recognize that healthcare providers and patients bring their own cultural perspectives to the encounter.

A common characteristic of all patient groups was their perception that information was lacking with regards to how patients can obtain the support of a social worker or a psychologist. Medical providers should pay greater attention to this indicator because of an existing association among the level of patient-centeredness in fertility care, patients' quality of life, levels of anxiety and depression (8), and the equal emotional burden experienced by women and men in their process of undergoing treatment.

Both insured and self-pay patients were dissatisfied with the level of consideration given to the emotional impact of fertility problems. Older, higher educated women who underwent several IVF/ICSI treatments tended to experience problems with accessibility to staff, and the amount of information and explanation provided, regardless of the method of financing the treatment.

Moreover, the existing information gap in respect to the possible side-effects of the prescribed medication indicates that medical professionals provide insufficient information and explanation about the treatment interventions. The provision of more information increases patient safety and reduces adverse events.

From the patients' perspectives, there were differences in PCC. For example, domestic patients reported experiencing some problems in Continuity and Transition, largely due to not having a staff member assigned to them. They also reported that they were unable to access their own medical records during the treatment. Nevertheless, patients agreed that the staff were competent and well-organized with good communication skills. They were also satisfied with explanations of the results of their treatment. However, some patients with higher levels of education reported that the results of the investigations were not discussed sufficiently with them.

Strengths and limitations of the study

Our research has some limitations. We did not include questions about how patients perceive the importance of certain domains and indicators, which could offer greater insight into patient-centeredness in infertility care. Although sufficient response rates were achieved, a larger sample of participants would increase the reliability of the findings. Since we only included foreign couples from three Southern European countries, we cannot conclude that these results are universally applicable to all foreign couples.

CONCLUSIONS

According to our results, we can conclude that the method of financing IVF/ICSI treatment does not influence couples' experiences with patient-centered infertility care. Our results indicate that differences in PCC arise from existing differences in the organizational level of clinics, rather than differences between countries (26).

Both groups of patients, namely those in the fully-reimbursed treatment group and self-pay patients, were dissatisfied with the attention paid by staff to the impact of infertility on their emotional well-being. They felt that insufficient attention was paid to warnings about the side effects of medication and found that there was a lack of information about the availability of supports from a psychologist and social worker.

Domestic couples whose procedures were fully covered by insurance, rated the communication skills of the staff lower than the CBP group. The absence of individual contact with only one gynaecologist was the biggest drawback reported by this group. This was not reported by patients treated in Croatia or Serbia where there is individual contact throughout the whole intervention. The accessibility of the intervention was rated as very high by the self-pay group in all three countries, in contrast to the reimbursed group of patients.

PCQ-Infertility might be used as a benchmarking instrument to measure performance and provide feedback for quality improvements (27).

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CONFLICT OF INTEREST

All authors declare that no conflict of interest exist.

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ETHICAL APPROVAL

The questionnaire is one of the documents used to monitor individual treatment success and to collect an anonymised assessment of patient satisfaction after treatment. The questionnaire is part of the internal quality control system of the clinics. The informed consent that the couple accepts before the start of the treatment includes information and consent for written contacts after the treatment.

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