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Alicia Mason
Pittsburg State University, amason@pittstate.edu

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Overcoming the "dual-delivery" stigma: A review of patient-centeredness in the Costa Rica medical tourism industry

Alicia M. Mason
Ph.D., Associate Professor, Department of Communication
Pittsburg State University
amason@pittstate.edu

Abstract

Due to the growing globalization of health care and an increase in access to technology many consumers are utilizing the World Wide Web for securing medical services abroad, a phenomena commonly known as medical tourism. The current investigation employs an emic cultural approach for analyzing the Western concept of patient-centeredness within several public and private medical facilities within Costa Rica. Through a detailed field investigation and personal interviews with directors of Costa Rica's largest accrediting institutions (AAAAF and ProMed), hospital organizations, and private health clinics an interpretative framework for evaluating patient-centeredness and quality of care is offered. Discussion, implications, and future directions are provided.

Key words: Medical Tourism, Patient-Centered Care, Costa Rica

Introduction

The globalization of healthcare and increase in access to technology has led to a greater number of consumers using the World Wide Web for the purpose of accessing health related information and medical services that transcends international borders (Kangas, 2010; Lunt, Minion, &Epworth, 2012; Macready, 2007; Snyder, Crooks, Adams, Kingsbury, & Johnston, 2011). Web-based health resources are often utilized not only as educational material, but also as a means of trading health-related products including accessing health services from a foreign country. The medical tourism marketplace consists of a growing number of countries competing for patients by offering these services as well as access to restricted procedures (e.g. stem cell surgery) or products (e.g. restricted pharmaceuticals) at prices that are often considerably lower than in the U.S (Snyder et al., 2011; Turner, 2011). These types of consumer activities have been labeled "medical tourism," and this consumer-driven health trend has attracted the attention of a number of researchers in recent years, including health communication scholars (Mason & Wright, 2011; Mason, Wright, &Bogard, 2011; Lunt et al., 2007).

A large amount of the communication research has focused on artifacts such as websites (Turner, 2011; Penney, Snyder, Crooks & Johnson, 2011), e-promotional materials (Muthana & Omoush, 2013), and patterns of service distributions (Gan & Frederick, 2011) to provide explanatory insight into the global medical tourism industry; there are however alternative approaches toward knowledge generation. American linguistic anthropologist Kenneth Pike (1954) introduced the terms 'emic' and 'etic' to distinguish between two approaches to studying cultural systems, just as the terms 'phonemic' and 'phonetic' distinguish two approaches to the study of a language's sound system. In both cases, the analyst can take the point of view of either an insider or an outsider.

Etic approaches involve analyzing cultural phenomena from the perspective of one who does not participate in the culture being studied. To date, this has been the dominant approach by many health communication scholars when analyzing medical tourism artifacts such as websites, news reports, and publicity materials used to promote medical tourism services (Mason & Wright, 2011, Penney, Snyder, Crooks & Johnson, 2011; Turner, 2011). In contrast, emic approaches involve investigating and explaining cultural patterns from the standpoint of one immersed within a culture.Gobo (2008) contends that "Emic knowledge is essential for the intuitive and empathic understanding of a culture, and …is often a valuable source of etic hypotheses." Etic knowledge is argued to be vital for cross-cultural comparisons, because such comparison requires both unitization and categorization. Given that much of the medical tourism research to date has employed an etic approach, this investigation is novel in that it employs an emic framework toward understanding how patient-centeredness is reflected through the cultural system of medical tourism within one specific country, Costa Rica.

Overview of Costa Rican Medical Tourism

The Council for the International Promotion of Costa Rica Medicine (ProMed) is a private non-profit organization that coordinates medical tourism efforts to ensure the quality of services provided by the private health industry in Costa Rica, as well as their international promotion. ProMed was strategically designed to consolidate the country as a center for global medicine and

a major destination for medical tourism. In 2011, Massimo Manzi, director at ProMed in Costa Rica estimated that medical tourism brought in $196 million to Costa Rica's health industry, with patients spending an additional $84 million in hotels, meals, travel and shopping. Rommel (2012) estimated $280 million was spent on medical tourism in 2011, an increase from$252 million in 2010, this trend is expected to continually rise. A majority of the Costa Rican medical tourism market is comprised of American patients.

When faced with the high cost of health care or limited treatment options in the U.S., more and more Americans are looking to developing countries to obtain a wide-variety of health-related services, including cosmetic surgery, dentistry, diagnostic testing, fertility treatment, and major surgeries such as heart valve operations and organ transplants (Dalstrom, 2012; Snyder et al., 2011; Sobo, Herlihy, & Bicker, 2011). The number of people buying health-related products and accessing health information and medical services via the Internet is increasing (Lunt, Hardey, & Mannion, 2010).

According to Turner (2010) the popularization of medical tourism in the U.S.is related to social inequalities, loss of employer-provided health insurance, rising premiums for health insurance, limited public funding of health care, and lack of access to affordable health care. Turner (2010) also contends that the U.S., due to its growing population of uninsured, underinsured, and people struggling to pay rising health insurance premiums, has become a leading target market for foreign medical facilities seeking international customers.

A key driver of medical tourism is consumer use of the Internet for gaining access to healthcare information, including exposure to medical tourism advertising. While advertising certainly exposes potential consumers to medical tourism services and facilities, medical tourism tends to be driven by the consumer, especially in cases where medical tourism facilities offer cheaper or more convenient access to health-related products or services coupled with low cost travel packages, featuring discounted airfare and lodging. In some cases, health services are offered in conjunction with travel packages to major tourist attractions within the country offering the services (Turner, 2010).

HuliHealth.com (2013), a medical booking service dedicated to transparency in worldwide medical care, reports the specialties most sought by medical tourists to Costa Rica are: dentistry (42%), gynecology (22%), preventive medicine (16%), plastic surgery (10%), orthopedics, and bariatrics, although other specialties include general surgery and dermatology. While eco-tourism is a draw for many Costa Rican tourists, a dominant portion of the Costa Rica's medical tourism sector attracts U.S. and Canadian patients for a specialized form of medical tourism referred to as "dental tourism." The recently launched U.S. health insurance program known as the Affordable Care Act requires Americans to purchase health insurance by 2014 in order to avoid being fined; however, this requirement does not extend specific vision or dental coverage. It is currently estimated that 108 million Americans do not have dental insurance (Reuters, 2010) and individuals who struggle to afford oral health care may find even more problems down the line, as gum disease is a known contributor to ailments like diabetes and heart disease in aging populations (Kim, 2012).

Patient-Centeredness

The author holds that insight from "patient-centered" marketing of health care services within the U.S. can serve as a useful framework for interpreting the quality of medical tourism infrastructures. Currently patient-centeredness has been integrated into the strategic and organizational planning of many health care organizations in the U.S., yet to date no medical tourism related communication research has been found which utilizes a patient-centeredness framework for understanding the nuanced differences of international medical tourism systems. Patient-centeredness is an important concept to the U.S. health industry as it often communicates the perceived quality of care that patients receive.

Bookman and Bookman (2007) have argued that medical tourism creates a dual delivery health care system within these specialized health regions: one that caters to rich foreigners and one to poor locals. In a bulletin published by the World Health Organization (WHO) NaRanong & NaRanong (2011) confirmed this effect of medical tourism in Thailand. Hospitals and other health-related facilities, particularly those located in low and middle income countries, often offer a more comprehensive range of surgical and diagnostic procedures at lower prices than in higher income countries (such as the United States), and these organizations are increasingly active in their marketing efforts to attract international patients (Dalstrom, 2012; Snyder et al., 2011). However as Mason and Wright (2014) have argued "each region tends to differ in terms of the services and products that are offered," (p. 7).

Zill, Scholl, Harter, and Dirmaier (2013) contend that while the idea of patient-centeredness has gained importance over the last two decades, there remains a lack of theoretical clarity regarding the term. Extant literature indicates patient-centeredness generally: increases the emphasis on the participation and self-determination of patients in their health care choices (Maizes, Rakel, & Niemiec, 2012); increases the quality and efficiency of care thus potentially reducing health care costs (Coulter& Ellins 2006; 2007); and has been found to be associated with other positive outcomes (e.g., higher patient satisfaction, enhanced adherence, improved illness-related knowledge and health behavior, and decreased health care utilization) (Michie, Miles, & Weinman, 2003; Robinson, Callister, Berry, & Dearing, 2008).

Patient-centered care is a philosophical approach toward the planning, delivery, and evaluation of health care, grounded in mutually beneficial partnerships among health care providers, patients, and families. As such, it redefines relationships in health care. In this analysis the term *patient-centeredness* is conceptualized as a support system of healthcare professionals, patients, the medical

center, and family used to ensure that the patients' wishes including their wants, needs, and values are followed and that all patients are educated with the necessary medical terminology and understanding to make decisions best for them. This conceptualization is in alignment with consumeristic patient orientations currently documented in Western healthcare literature (Wright, Sparks, & O'Hair, 2013).

After conducting research with numerous focus groups and interviews Planetree® an organization dedicated to researching patient-centeredness in the healthcare industry has developed eleven standards for evaluation and measurement of patient-centeredness which include:(1) structures and functions necessary for implementation, development, and maintenance of patient-centered concepts, (2) human interactions/independence, dignity, and choice (3) promotion patient/resident education, choice and responsibility, (4) family involvement, (5) dining, food, and nutrition, (6) healing environment: architecture and design, (7) art programs/meaningful activities and entertainment, (8) spirituality and diversity, (9) integrative therapies/paths to well-being, (10) healthy communities, and (11) measurement (Guastello, 2012).

These categories of consideration will serve as the framework for analyzing the Costa Rican medical tourism infrastructure in order to answer the central research question presented below.

RQ1: How are patient-centered concepts represented within the Costa Rican medical tourism industry?

Medical tourism is a complex process which involves many agents that have been defined differently in extant literature. For example, Penney, Crooks, Snyder & Johnson (2011) defined a *medical tourism broker* as "third parties who connect patients to hospitals or doctors in another country," (pg. 2) while Wagle (2013) uses the term *medical tourism facilitator* (MTF) to define agents which "act as intermediaries between patients and medical services,"(pg. 28). For the purpose of this analysis the term medical tourism facilitator (MTF) will be used, as it is in alignment with the governmental accreditation and certification institutions within Costa Rica. Wagle (2013) further characterized MTFs as generally having a presence in the host/destination country, in order to assist foreign patients to locate a suitable destination within their budgets; who frequently advertise and reach a larger audience through the medium of the internet; wh ohave emerged as the most common source of information that influences a patient's choice of destination country.

Method

In the summer of 2013, the author travelled through the medical tourism facilitator (MTF) Costa Rica Med Travel Agency to Costa Rica. Within eight weeks of planning the facilitators arranged meetings with six contacts representing both the public and private health sectors, others including post-operative care personnel, medical tourism facilitators, and hotel/hospitality providers were interviewed throughout the process. The research participants represented the public and private sectors and included directors from Costa Rica's largest accrediting institution, physicians and nurses within the country's JCI accredited hospital organizations and owners of private health clinics. Creswell (2005) holds that in qualitative research, "the intent is not to generalize to a population, but to develop an in-depth exploration of a central phenomenon," which is best achieved by using purposeful sampling strategies (p. 203). In total, twelve interviews were conducted with members of Costa Rican healthcare system.

The data were gathered using in-depth qualitative interviewing techniques (Taylor & Bogdan, 1984). Interviews followed a semi-structured format. An interview guide with open-ended questions provided a list of topics to be covered, and probing questions were utilized to clarify meanings. Using a semi-structured approach provided participants ample time to express their diverse views and elicit narratives about their personal experiences.

Field notes were transcribed, and 215 photos were collected. These are the units of analysis used to inform the findings and analysis of the Costa Rican medical tourism infrastructure. Interview content was reviewed; the content of the transcripts was then segmented into topics or themes. When topics or themes were noted repeatedly, they were designated as "categories," and the sections of interview data that related to that topic were labeled and indexed accordingly. Finally, the groupings of interview data were separated in relation to the Planetree categories. The interview data were analyzed by category in an effort to understand the essence of the experience offered by participants.

Findings and Analysis

In order to answer *RQ1* regarding how patient-centered concepts are reflected through the medical tourism industry of Costa Rica a one week field investigation was conducted. Utilizing the patient-centered framework developed through Planetree and reported by Guastello (2012) a variety of sources were used to inform this analysis including: facility tours, personal interviews, photographs, and supplemental promotional literature. The findings and analysis is detailed below.

Structures and Functions

As a category of patient-centeredness the structures and functions are conceptualized as those components necessary for implementation, development, and maintenance of patient-centered concepts. Patient-centeredness is not defined based on the identity of a patient as medical tourist or non-, but rather the quality of care provided by a health system. It is within this cultural context that several academics have argued medical tourism creates dual delivery environments (Bookman & Bookman, 2007; Rudra, 2011). For example, in India specialized medical tourism facilities have reportedly been built on land given at concessional rates with an understanding the facility will reserve a certain percentage of in-patient and out-patient services for locals, thus providing care to those living close but who cannot afford

health care. Rudra (2011) found certain locations in India were denying access to health care to those in-need. These types of events perpetuate the "dual-delivery" stigma associated with the medical tourism industry, but are generally not differentiated between differing cultural systems.

Beyond patient access to health care systems of delivery, additional structure and function considerations include the internal mechanisms designed to ensure high-quality of care outcomes. The safety and quality of care available in many international health care settings is no longer a dominant concern given international organizations, such as the Joint Commission International (JCI) a collaborator with the World Health Organization (WHO) amongst others, are accrediting private medical tourism healthcare facilities. Established in 1980, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the largest non-profit accrediting organization in the United States, was designed to develop a standardized accreditation program to improve the quality of medical and surgical care at ambulatory surgery facilities. AAAASF takes a lead role in the accreditation of medical tourism facilities throughout the WHO Region of the Americas, including North, Central and South America. Oscar Molina, AAAASF program director rejects the "dual-delivery" stereotype associated with medical tourism noting instead that the standardization and accreditation processes are applied to both government and private care clinics thus protecting the well-being of all patients, both domestic and international. "There is no difference," Molina stated. "We take pride in providing high-quality health care to our citizens and our guests."

To further assist in regulating the private care system the non-profit organization ProMed offers training and certification programs for medical tourism facilitators (MTFs).The ProMed organization is guided by a board of directors, and six specialized committees who are responsible for implementing specific actions: *promotion, regulation, ethics, legal, admission,* and *education*.

Recent media reports that feature "victims" of medical tourism fraud have created a skeptical U.S. consumer market. Beyond providing certificate programs for facilitators, a contract-system of reimbursement between health care providers and MTFs allows international patients to avoid the potential pitfalls of advanced payments. The process of sending advanced payments to facilitators, which may or may not provide services, is overcome through Costa Rica's contract-system payment by which facilitators are reimbursed a certain percentage of the procedural cost by the health providers. Health care organizations reimburse the contracted facilitators after the patient has received treatment, thereby removing the need for facilitators to act as payment processers. Hilty (2013) noted, in contrast to countries offering patient-centered care, within physician-centered countries such as Korea, foreign credit cards are not allowed, and private insurance is forbidden hence limiting the potential health care and treatment offerings.

Structural and functional considerations of a system also seek to understand the factors which create ideal states of homeostasis, or balance. In order to continue to provide patient-centered health services care Costa Rica has its own internationally recognized medical schools, demonstrating there is an educational infrastructure in place designed to ensure the adequacy and availability of highly trained human resources to meet the growing demands on the public system resulting from increased migration and immigration from residents of nearby countries (Otterstrom, 2008; Sandoval-Garcia, 2004).

Beyond promoting and adhering to formalized practices of training MTFs and recruiting patients, in Costa Rica patient-centered care begins at the point of entry. The expedited processing through customs and immigration for inbound medical tourists indicates patient-care and accommodation begins upon arrival.

Human interactions/independence, dignity, and choice

The second variable of patient-centeredness includes providing personalized care for patients, residents, and their families as well as creating organizational cultures that support and nurture staff. Human interaction is dependent upon communication. Medical tourism staff and personnel are often bi- & tri- lingual. The linguistic structure and functions of some nationalized systems undermine the potential for medical tourism to become an economic driver. For example, Hilty (2013) documented that patients receive on average three minutes of a physician's time under the physician-centered Korean national health care system. The author further noted that a medical tourism infrastructure is not yet in place because, "Communication skills are a primary concern as there is a perceived lack of foreign language facility among health providers," (n.p.). All representatives from the Costa Rican government, private and public health facilities physicians, staff and MTFs spoke fluent English.

Medical tourism facilitators (MTFs) serve a pivotal role in personalizing the heath care experience.In Costa Rica's medical tourism facilitator certification training programs, facilitators are trained to provide a minimum of three referrals for doctors specializing in the form and type of care the patient is seeking. This Costa Rican model allows patients to retain a sense of empowerment, control and agency over their healthcare decisions.

Facility directors from both the public and private health care industry repeatedly mentioned the value of intra-organizational, interdisciplinary communications and interactions. Most commonly these sessions occur during daily planning meetings among physicians and support staff, to ensure effective, high-quality healthcare services to patients.

Promotion of patient education, choice and responsibility

The worldwide medical tourism industry has been criticized for not disclosing proper risk information and total costs prior to their departures **(**Brown, 2012; Hall, 2011; Tompkins, 2010**).**As a concept of patient-centeredness collaborative care conferences, patient pathways, and a

variety of educational resources provide patients and residents with the information and skills to actively participate in their care prior to departure, as well as maximize their physical and psychological well-being while abroad. MTFs often serve as intermediaries between patients and physicians, and other health care support staff. In addition to facilitating the patient-provider interactions noted above, facilitators often play a vital communicative role in providing "local knowledge" of medical facilities, after care treatment options and tourism opportunities for patients and their families/guests.

Family Involvement

Social support is vital to good health without regard to the setting. While the "tourism" part of the medical travel process provides opportunities for family involvement, so does the health care process for patients. Participants, specifically physicians and nurses within the private sector, noted the involvement at multiple stages of decision-making relating to the medical tourism process including: the selection of a medical tourism facilitator and/or physician, the selection of procedure(s), and the selection and format of the travel experience. As noted above there is a distinction between patient-focused family involvement that is related to the health care elements of the medical tourism process, and the social engagement and family entertainment opportunities related to the tourism element of the medical tourism process. The latter are further described below in the "arts and meaningful activities" section of the manuscript.

Dining, Food, and Nutrition

Deloitte (2008) stated in order to enhance healthcare access and delivery "providers need to understand social and cultural differences among international medical travelers" (p. 21). For example, Islamic travelers would be provided with *halal,* Muslim kosher requirements, as well as non-pork or vegetarian meals, however during the month of Ramadan fasting requirements may interfere with proper medical care. Sensitivity to the socio-culture, religious, and gender expectations helps providers to communicate and provide treatment to patients of diverse cultural backgrounds. All facilities directors and personnel indicated flexibility and sensitivity to the nutrition and dietary needs of patients.

Healing Environment

When speaking with private facility directors the expectancy violation reported by patients most frequently results from the expectancies of infrastructure specifically related to architecture and design. Dr. Arig Ibrahim practices private care in Costa Rica, and currently serves as the facility director of Clinica Zahha. Ibrahim, explained that "many times international patients come expecting a large hospital, not a private clinic." Dr. Ibrahim strategically designed Clinica Zahha, *zahha* being Arabic for health, an AAAASF certified private clinic which offers an array of elective and specialized services for treatment of patients with diverse cultural backgrounds. Ibrahim noted that small things like having two clocks in the recovery rooms or access to iPad technology for patients to connect with families post-operatively are important accommodations offered to international patients.

Ibrahim identified two important ways MTFs assist with patient care for Clinic Zahha (1) they help set expectations of international patients and (2) are often the first contact in the relational development stages of medical tourists. Ibrahim noted the importance of facilitators in setting expectations of care and procedures recalling one patient who arrived with money, without a facilitator for an operation but no plans and no money for the after-care recovery stay, which Clinica Zahha does not provide. Ibrahim also noted the pre-screening tactics facilitators use to match patients with physicians as a benefit. Referencing one patient who traveled without a facilitator for an operation during which time the patient did not disclose a pre-existing medical condition that may have resulted in a complication. Ibrahim noted that MTFs develop a personal relationship with patients early on the planning process thus serving a critical role in obtaining and disseminating relevant and important patient information.

Agencies such as the World Institute for Surgical Excellence (WISE) certified recovery centers require a full-time registered nurse to care for each patient, personalized meals are provided, and doctors and surgeons make trips to the recovery centers to check on their patients regularly, but also when requested or required. Other private, family-owned after care facilities such as the CheTica Ranch Wellness and Recovery Center, serve as a transitional facilitators, in that once patients arrive the support staff remain in constant communication with the doctors' administrative offices, while resident nurses attend to wounds, stitches, medicines, hygiene, and act as a liaison with physicians. Many offer transportation services to physicians' offices for follow-up care, if needed.

Medical tourists receiving care through private clinics still face the need to secure prescriptions following procedures. The speed and efficiency of the health care system for public and private patients was demonstrated particularly in the area of pharmaceutical services. Several MTFs indicated that they provided the service so patients do not face additional wait times between the surgical care and convalescent stays at wellness centers. While prescriptions drugs are regulated, larger facilities are using technology to speed the process by offering patients on-line prescription requests which are processed for home-delivery through the public health system. Weekly and monthly home deliveries of prescriptions to patients facing chronic disease management are available for as little as $10 U.S. per month.

Art programs/meaningful activities and entertainment

Because most medical tourism patients are not often staying in hospitals long-term, but rather at wellness care and recovery facilities an evaluation of the arts programs and activities available to patients was not possible. Interviews with facilitators and tour directors indicated access to Costa Rica's rich cultural and art heritage is available year-round at the *Teatro de Nacional*,

and the national parks eco-systems. The "tour before" philosophy was expressed by many MTFs in relation to patients; however tourism opportunities for family members are accommodated throughout the experience. Note the aforementioned word "accommodated" not sales-pressured. Greivin Quiros, served as the author's MTF in Costa Rica. Quiros stated that initially facilitators form the relationships with patients, and those relationships grow through physicians and medical staff during the treatment process; however, the relationships with patients are matured during the after-care treatment process. The relational development process was reflected through Quiros' statement "We begin as strangers and depart as friends, Pura Vida!"

Facilitators view the social support systems of patients, accompanying friends and family members, as in-need themselves. Generally MTFs do not receive compensation for non-health related travel/tourism planning but many facilitators offer these services to increase the satisfaction of patients and their social support systems with the medical tourism experience.

Spirituality and Diversity

Mason and Wright (2014) report that "accessible contemporary international communication systems coupled with skilled medical experts in state-of-the-art facilities are catalysts for the expected growth of medical tourism worldwide" (p. 69). As a result healthcare providers are compelled to adjust to more frequently providing care to patients from diverse backgrounds with vast cultural worldviews. Patient-centered care holds that the development and implementation of innovative models of healthcare should focus on the healing and nurturing of the body, mind and spirit are vital to patient satisfaction. The country of Costa Rica is dominantly Catholic, and has seen an influx of immigration from surrounding countries such as Nicaragua and Panama. Research on the social inequalities of Costa Rican immigrants have been widely studied by a variety of scholars, therefore a detailed examination of this potential patient-base is beyond the scope of this analysis (Campo-Engelstein, 2011; Herring, Bonilla-Carrion, Borland, &Hill, 2010; Sandoval-Garcia, 2010). The impact of non-resident immigrant labor forces on the healthcare system infrastructure was mentioned; however, only in relation to the public health system, the private system which most medical tourists find themselves engaging was not documented as being affected.

Sensitivity to the diverse spiritual and religious needs of international patients was further documented through the offering of specialized services such as Eucharistic adoration, for Catholics, a prayer practice in which Holy Communion is brought directly to the patient.

The concept of diversity in health care was noted in relation to female reproductive treatments. Clinica Biblica, a renowned, private hospital facility guided by faith-based principles offers advanced medical care such as pediatric cardiology, radiology, urology, neurosurgery, amongst others. As a faith-based private facility Clinica Biblica offers procedures such as "tubal ligations," which many patients in the U.S. are denied access to because of the service restrictions by private hospital systems with faith-based orientations (e.g., Via Christie Hospital Network).

Integrative Therapies

While striving to continually improve and promote Costa Rica as a medical tourist destination through organizations such as JCI, ProMed and AAAASF, the Costa Rican government has continued to find ways to improve the quality of care provided to domestic patients through the public system. By developing strategic partnerships with HomeWatch Caregivers Costa Rica has expanded its health care infrastructure. Follow up carefor medical tourists is uniquely challenging as [patients] will be returning to their home country and may have difficulty contacting the physician or surgical team abroad should complications or questions arise post-operatively which can pose as a post-operative health risk," (Penney, Snyder, Crooks, & Johnson, 2011, p. 3).

HomeWatch® was the first company to offer at-home care services in Costa Rica and focuses on treating patients with a variety of disease-specific needs. These services are available to citizens in need of care resulting from Alzheimer's, dementia, out-patient treatment, palliative care, and basic elderly care.

As an international organization HomeWatch Caregivers also operates in many of the countries of origin medical tourism patients derive from within the WHO Region of Americas, therefore should aftercare be required these programs and services are available to medical tourists. This innovative option extends the relationship with medical tourism patients from health care provided in a foreign land, to health care received in the homes of medical tourists. These programs help fill a gap in the care cycle, as many U.S. doctors remain reluctant to accept the insurance liability for after care of medical tourists.

Dominant managed-care health models have placed an emphasis on access to biomedical treatment options, therefore the concept of integrative care is not as widely known among many U.S. patients. Clinica Biblica promotes the concept of integrative care in its organizational tag line "your integral health…"and currently provides 40 specialized health services such as integrative biologic medicine, interventional cardiology, and intra-operative radio therapy, from multi-lingual highly trained physicians; however as mentioned, "integral" is not a dominant marketing term that U.S. consumers comprehend and understand. Initially formalized in 1996, the American Board of Integrative Holistic Medicine (ABIHM) notes that "integrative medicine" is an "emerging specialty," in the U.S. for practitioners, and further notes that holistic approaches to health are not fully understood by American health providers, aside from health seekers.

Integrative therapy was demonstrated by the added emphasis on the non-verbal communicative role of haptics, human touch, and was noted throughout the facilities. Touch has been found to reduce anxiety, pain and stress benefiting patients, residents, families and

caregivers. This concept was most notably demonstrated in the neonatal area of Clinica Biblica. While new mothers are resting or recovering, new fathers are provided with education and instructional training on the role of touch early in the life cycle. New fathers were observed holding their newborn child skin-to-skin in the nursery areas. Private clinics such as Zahha offer private healing and therapeutic rooms. Furthermore, many private health facilities utilize a bio-medical surgical model for patient-treatment, as well as alternative, holistic, and integrative health care treatments.

Healthy Communities

Planetree holds that patient-centeredness is expressed by health care organizations that work with schools, senior citizen centers, churches and other community partners, hospitals are redefining healthcare to include the health and wellness of the larger community. Opposed to countries such as India which have deemed "health" a commodity available for exportthus resulting in massive health care metropolises, Costa Rica's historical and cultural philosophy has placed value on three important contexts: *health, education* and the *environment*. In 1948 Costa Rica redirected military funding into the health and education infrastructure and as a result created a nationalized system of health care, available to all citizens.

There are many native populations living in the Costa Rican rural areas, many government and private hospitals engage in community outreach programs for vaccination and hygiene. By creating relationships with members in rural communities some private facilities are able to harvest the natural resources and are currently marketing lotions and creams which sustain rural vaccination and treatment programs. These practices indicate a high level of community and social responsibility on the part of those working in Costa Rica's medical sector.

Measurement

Assessing patient-centeredness in a quantitative way is challenging given that each facility keeps its own internal records and these records generally focus on procedural quality of care outcomes (e.g., procedure effectiveness, complication or infection rates, and recovery time) opposed to the psycho-social perceptions of patients, thus the lack of standardization makes comparability and generalizability difficult at best.

Discussion, Limitations and Future Directions

It is evident the concept of *health* is deeply engrained into the minds and hearts of those working within Costa Rica's health industry, and has furthermore been woven into the fabric of the government, political, educational and economic components of its cultural system. Private clinics, hospital facilities, and medical personnel working within the system all conveyed a sense of national pride for the quality of health care available to the citizens of Costa Rica, as well as international medical tourists.

Perhaps the most important finding was that all parties involved in the Costa Rican medical tourism system including: government-run, privately-owned, and community-based centers rejected the "dual delivery" system concerns, which extant literature has associated with the industry (Bookman & Bookman, 2007).

Jingfeng (2013) noted that *emic* and *etic* are sometimes regarded as inherently in conflict, and one may be preferred to the exclusion of the other, yet the complementarity of emic and etic approaches to research has been widely recognized, especially in the areas of interest concerning the characteristics of human nature as well as the form and function of human social systems (p.78). Moving forward as research explores the nature of medical tourism as an indicator of the globalization of health, we should carefully consider the value of the knowledge in relationship to the approach.Emic knowledge may result in in-depth knowledge of how medical tourism functions within the larger cultural system and can inform future efforts of analysis that employ an etic standpoint of evaluation for comparability. At this time, there remains a lack of standardized assessment tools to validate how patient-centered concepts are manifested in international medical tourism health systems.

Communication by nature is a reciprocal process of interaction, designed to create mutual understanding. The promotion of medical tourism to the U.S. market would benefit greatly by assimilating into the marketing vernacular that audiences are accustomed to. While ideas such as *holistic, affordable,* and *integral*e ffectively describe the nature of the health care services commonly offered, the term patient-centered connotes the expectation of high-quality care outcomes in relation to patient-satisfaction to which Western patients have grown accustomed.

Medical tourism, a bi-product of the globalization of health, is a fertile ground for future explanation, understanding, and theory-building. The complexity of medical tourism is reflected through the political, social, economic, technological, educational, medical and communication infrastructures. Clearly further research into the nuanced variations of international health care delivery systems offering medical tourism services is needed.

Given the increase in utilization of the term "patient-centered" in the marketing and promotion of domestic U.S. healthcare services, a primary consumer market for Costa Rica medical tourism services, additional research which utilizes the patient-centered framework toward analyzing the organizational, political and social systems that provide medical tourism services can provide new academic insight. This form of knowledge may be useful in developing categories for assessing patient's perceptions of the medical tourism processes and provide data that may distinguish the features of certain providers, thus in the future informing the decision making of consumer-oriented patients seeking services abroad.

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