

THE MAKING OF MEDICAL SUBJECTS: MEDICAL TOURISM AND ITS ADHERENCE TO  
NEOLIBERAL IDEOLOGIES

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By  
Kristen E. Allen  
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Dr. Sydney White, Thesis Advisor, Anthropology

## ABSTRACT

Medical tourism is not a new phenomenon but in its current form, medical tourism or health travel is a practice that stems from the structures of the healthcare system. For citizens of countries with primarily private healthcare and citizens of countries with socialized healthcare the forces behind seeking international healthcare are economic (cheaper prices) and temporal (long queues), respectively. The foreign nation-state/patient relationship is an integral part in facilitating the medical tourist/hospital relationship and is also a way to discern discrepancies in welcomed versus unwelcomed visitors. On the one hand, medical tourists are welcomed visitors while other types of "tourists" are not. During my fieldwork as a volunteer at a private Costa Rican hospital, I was quickly made aware of the popular discourse that denigrated Nicaraguans entering Costa Rica while simultaneously catering to Euro-American tourists. This is a clear example of the discrepancy between neoliberal doctrine and neoliberal practices in that the free market promotes the transnational flow of capital while slowing or stopping altogether the flow of (certain) bodies. The United States and South Korea both issue special medical visas to medical tourists and these practices have thus far made international borders even more penetrable by the global elite and/or those with the capital to afford medical care in another country; thus graying the distinction between citizen and non-citizen.

The means by which the medical tourism industry, from a marketing standpoint, attracts this global elite is through the accreditation process, which is the act of an accrediting body legitimizing a business, medical facility or school through an intense, expensive, and lengthy process. Within the medical tourism industry, hospitals located in developing nation-states are clamoring for accreditation from agencies based in the U.S.

and Europe. Many in this industry believe that such accreditation will increase the number of foreign, primarily Western, patients. I argue that accreditation is a form of subjectification, because many international hospitals that cater to Western patients want to legitimize themselves through an American and/or European body even though their healthcare systems rank higher than the U.S. Accreditation makes international hospitals "qualified" to provide medical services in the eyes of Western medical tourists and the medical tourism industry as a whole, which underscores the quality and superiority of many healthcare systems in the developing world. The problems that I have undertaken is the discrepancy between neoliberalism and the flow of (certain) bodies and capital vis medical tourism and public policy as well as how accreditation is used as a form of surveillance, gaze, and subject making that renders hospitals nearly powerless to the standards set by accrediting bodies.

## TABLE OF CONTENTS

	Page
ABSTRACT .....	ii
ACKNOWLEDGMENTS .....	v
LIST OF TABLES .....	vi
LIST OF FIGURES .....	vii
CHAPTER	
1. INTRODUCTION .....	1
2. FRIENDS OF THE WEST: HOW COSTA RICA BECAME FERTILE GROUND FOR THE MEDICAL TOURISM INDUSTRY .....	6
3. MEDICAL TOURISM: NEOLIBERAL IDEOLOGIES AND REALITIES .....	35
4. DASHED LINES: THE IMPENETRABILITY OF INTERNATIONAL BORDERS AND HEALTH TRAVEL .....	60
5. MEDICAL TOURISM AND ACCREDITATION: THE SUBJECT MAKING OF INTERNATIONAL HOSPITALS .....	84
6. CONCLUSION .....	102
REFERENCES CITED .....	105

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## LIST OF TABLES

TABLE 1: Price list for procedures at <i>Hopital Croix</i> .....	17-22
TABLE 2: Timeliness based on culture.....	45

## LIST OF FIGURES

FIGURE 1: Examples of medical tourism advertisements.....	68
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## 1. INTRODUCTION

Medical tourism is a term initially coined by travel agencies and the mass media to describe the practice of traveling across international borders to obtain health care. This practice is not a new phenomenon, but what is new is the involvement of nation states and the amount of marketing that goes into promoting hospitals, clinics, nation states, travel agencies, accrediting bodies, and associations. It is estimated that in 2008 there were more than 200,000 Americans who travelled abroad for medical procedures. The problem that I will discuss in this thesis is how this new niche for investors and entrepreneurs is molding the industry to abide by Western ideals that privilege neoliberalism and dominant cultural hierarchies.

Medical tourism is also known as health tourism. Beth Kangas (2010) notes that these two terms for describing patients who travel abroad for medical care “...refers to a deliberate marketing strategy; patients are potential consumers” (352). Medical tourism entrepreneur, Bill Cook (2007) argues for the use of ‘medical tourism’ because patients are involved in “soft tourism” and are interacting with a different culture and environment. Cook notes that some procedures such as dental, cosmetic, orthopedic, and bariatric procedures benefits from pre and post procedural excursions. Another argument comes from the medical tourism industry as a business, which upholds Kangas’ assertion. For the purposes of marketing, businesses prefer to use ‘medical tourism’ because of the familiarity of the term in popular media. One businessman told me that potential patients/consumers are more likely to type “medical tourism” in search engines than health tourism or health travel.

According to Tourism Research and Marketing (2006), medical tourism falls into

four categories:

1. Illness
  - a. Medical checkup
  - b. Health screening
  - c. Surgery
  - d. Cancer treatment
  - e. Transplants
2. Wellness
  - a. Acupuncture
  - b. Spa treatments
  - c. Beauty care
  - d. Homeotherapy
3. Enhancement
  - a. Cosmetic surgery (including cosmetic dental procedures)
  - b. Non surgical cosmetic procedures
  - c. Liposuction
4. Reproduction
  - a. Fertility treatments
  - b. Birth tourism (including surrogacy)

There is an enhanced marketing strategy within the medical tourism industry to promote wellness tourism because it is seen as a profitable niche that will attract more bodies than illness tourism due to the fact that one does not have to be sick in order to seek wellness.

The four most popular types of medical tourists are: (1) Citizens of wealthy countries who travel to developing countries, (2) Wealthy citizens of developing countries who travel to the West (also known as reverse medical tourism), (3) Citizens of developing countries who travel to nearby developing countries, and (4) Patients who travel to a different city within their country of citizenship (also known as domestic medical tourism).

My research is based on multi-sited ethnographic fieldwork. I spent two months volunteering in the international department of a major private hospital in Costa Rica

named *Hopital Croix*<sup>1</sup> and I also volunteered at the 2<sup>nd</sup> Annual World Medical Tourism & Global Healthcare Congress (also known as the MTA Congress), which was held in Los Angeles, California in 2009. During my ethnographic fieldwork, I did preliminary interviews with hospital and conference staff, Costa Rican entrepreneurs involved in the medical tourism industry, my host family in Costa Rica, and attendees of the conference.

Aside from fieldwork and preliminary interviews, I performed a literary review that focused on three key concepts: neoliberalism, subjectification, and citizenship. Based on my fieldwork and literary review, I will answer the following research questions: how and why do those involved in the industry adhere to neoliberal doctrine? How will this effect socialized healthcare? How will this effect subaltern (i.e. the poor and middle-middle class) populations? How has the medical tourism industry changed the parameters of citizenship? What influence does it have on public policy? How do those involved in the medical tourism industry, who are citizens of developing countries, make subjects of themselves vis Western notions of a quality medical infrastructure?

The significance of my project is to give a critical analysis of this industry and to give a voice to those who have been excluded. The membership fee for the Medical Tourism Association is at least \$500 USD and membership to Promed (a Costa Rican medical tourism association with representatives from both the private and the public sector) costs \$2,500 USD for a corporation. The hospitals that attract medical tourists are, according to the woman I stayed with during my fieldwork in Costa Rica, “only for the rich.” The average monthly income for Costa Ricans is \$350 USD, thus the average Costa Rican cannot

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<sup>1</sup> The names of all persons, hospitals, and hotels are pseudonyms.

afford to join medical tourism associations or benefit from the private healthcare industry. Essentially, they are excluded from medical tourism citizenship.

It is critical that anthropologists deconstruct and analyze arguments used to promote private industry. For example, the Costa Rican government argues that the investment of public funds into the private medical tourism industry will yield high returns to the country as a whole through revenue from tourism. The basis of this argument stems from the belief (stated as a fact) that medical tourists spend an average of four times more money than “normal” tourists.

My main argument is that if the medical tourism industry stays on the same trajectory as the neoliberal ideology and practices that the industry is based on, then the industry will not be the impetus for the redistribution of wealth and opportunities that the industry giants adamantly proclaim. Also, inequalities of citizenship and the free flow of bodies will be amplified. Countries including South Korea and the United States have recently begun to offer medical visas to persons and their companions who are getting medical treatment in the aforementioned countries. These visas are good for up to one year and can be renewed. The presence of medical visas is another avenue that can be used by those with the economic capital to obtain healthcare abroad to easily traverse the globe. Sponsorship by a government or a business has been used to ease international travel and now, with the rise of the medical tourism industry, sponsorship by a hospital or clinic will suffice in making international borders legally permeable to the global elite regardless of country of origin.

How do nation states attract medical tourists? One way is through the accreditation process, which I will argue is a form of subjectification. Subjectification is the process of

training oneself or another person into certain ways of behaving. In this case, accreditation trains hospitals, recovery hotels, and clinics to accept and use Western-based biomedical practices. The Costa Rican healthcare system is ranked higher than the United States; however, Costa Rican private hospitals are clamoring for accreditation by U.S. and European-based accrediting bodies. Are neoliberal models that privilege finance and capital at play here? Or is it subjectification based on racial and national hierarchies? The former question refers to subjectification based on economics, i.e. if hospitals in developing countries are not accredited by the United States or Europe then citizens of wealthy countries (with financial capital) will not come and spend money. The latter question is based on historical hierarchies of culture, race and issues of self-culturalist interpretations. I argue that both models are dialectically represented in the medical tourism industry.

In chapter two, I will give a general overview of Costa Rica and why it is a popular destination for medical tourism and other forms of tourism such as ecotourism. I will discuss the contingencies of race, space, and politics that create an image of Costa Rica as a fertile ground for the medical tourism industry. In chapter three, I will discuss how the medical tourism industry has adopted neoliberal doctrine and what the social ramifications of using neoliberal models are for citizens of developing countries and how it modifies “regimes of citizenship.” In chapter four, I will discuss how medical tourism perpetuates inequalities based on various types of citizenship. I argue that these inequalities are an extension of the hegemonic privileging of the West and financial capital. In chapter five, I will discuss how the accreditation process is a form of subjectification that creates a medical tourism ‘gaze’ and solidifies a hierarchy that places the developing world in a subordinate position to the West.

## **2. FRIENDS OF THE WEST: HOW COSTA RICA BECAME FERTILE GROUND FOR THE MEDICAL TOURISM INDUSTRY**

A former Spanish Colony, Costa Rica is located in Central America and has historically been a popular tourist destination, especially amongst eco-tourists. The Costa Rica Health Tourism Corporation estimates that 150,000 medical tourists travel to Costa Rica annually (Tourism Research and Marketing 2006). What draws tourists to Costa Rica is that, compared to neighboring countries such as Guatemala, El Salvador, and Nicaragua, Costa Rica has a history of political stability. In this chapter, I will historicize the current state of Costa Rica and how its history (amongst other things) promotes Costa Rica as a popular medical tourism destination. Also, I will give a detailed account of my fieldwork in Costa Rica volunteering at *Hopital Croix*. The problems that I will discuss are based on the juxtaposition of my observations and experiences as a temporary citizen of the medical tourism industry in Costa Rica and at the Medical Tourism Congress to issues of neoliberalism and race.

Costa Rica is part of the 22 older democracies, a list that is rife with European countries. Costa Rica prides itself on being devoid of a dictatorship and is a relatively peaceful country. It abolished its army in 1949 and 25% of its terrain are either national parks or protected land, which are the primary reasons why Costa Rica is a popular destination for tourists, particularly eco-tourists. John A. Booth (2008) refers to Costa Rica's democratic transition and its survival as deviant vis its regional setting, but normal considering its social structure. In terms of the latter, Costa Rica in many respects is a socialist country. Booth argues that the spread of power resources in the country, its growing economy, and class configuration created fertile ground for democracy to thrive

even during the turbulent 1950's and 1960's, which saw many nearby countries that were center-left being toppled (with the help of the U.S.) by anti-communist groups. During the 1948 civil war, the communist-led labor left was defeated and subsequently marginalized and contained, thus the U.S. saw no threat brewing in Costa Rica and did not intervene militarily nor covertly encourage an internal coup or civil war.

Political stability, I argue, not only created a tropical safe space for Western tourists, but it also encouraged Western missionaries to stay and raise their families. Three of the employees who I worked with at *Hopital Croix* are children of American missionaries. While missionaries from surrounding countries either fled or chose not to relocate their families to, for example, Nicaragua for safety reasons, many missionaries chose to stay in Costa Rica. In a capillary effect, more Americans decided to relocate to this politically stable, Western friendly tropical paradise. So with the influx of Americans, many Costa Ricans were exposed to American culture and English language, which are both beneficial in terms of being a citizen of the medical tourism industry.

Another aspect that cultivated the medical tourism industry in Costa Rica is the role of the media and to a lesser extent the comparative Whiteness of the country. Hailed as the 'Switzerland of Central America', this description evokes a subliminal, racialized hierarchy that ascends Costa Rica above its surrounding countries. Even the word 'hailed', which is used in multiple literature about Costa Rice is a congratulatory phrase that privileges being aligned with the West over being aligned with Central America. Because of Costa Rica's historic democracy and lack of any major internal strife, the media and medical tourism literature paints the country as the jewel of Central America, both in terms of Europeanness and political stability. In more of a business sense, the literature brags about

the amount Western multi-national corporations as well as the fact that former President, Dr. Oscar Arias Sanchez was awarded a Nobel Peace Prize in which both forms of bragging rights are very reminiscent of being legitimized through the West (see chapter 5). Also, many Costa Ricans relish the fact that they have more Spanish blood than surrounding Central American countries. Similar to how the communist left was marginalized and contained, Afro-Costa Ricans, many of whom were migrant workers from the West Indies, were and still are relegated to the Limon province, which is located on the Atlantic Coast. These migrant workers were denied citizenship until 1949 when a new constitution declared that anyone born in Costa Rica is considered a citizen.

The issue of Whiteness only surfaced one time when my host mother, who is from Limon, told me that her maternal grandmother would treat her poorly because she is part Black. Her father is Black and Chinese and her mother is White Costa Rican. She said that there is a lot of discrimination against Afro-Costa Ricans and especially Indigenous populations. She noted that there have been occasions when Indigenous men were murdered simply for being Indigenous.

Nicola Foote (2004) discusses the efforts of the Black elite in Limon to attain citizenship, but at the expense of poor Black women. She writes that: "The black population of Limon Province on the Atlantic Coast has been largely excluded from Costa Rican historiography, due to racism and regionalism compounded by the tendency to work within the paradigm of Cost Rican 'exceptionalism'" (198). Elite Blacks in Costa Rica sought citizenship through assimilation, but as Foote argues, their plight was undermined by intra-racial class tensions. By denigrated poor Blacks to White society they were by default projecting negative images of themselves. Similar to the U.S., Black culture is not divided

into poor, uneducated Blacks and wealthy, educated Blacks; all Blacks are stereotyped as criminals, uneducated, unqualified, and poor. In many ways, Costa Rican society mirrors the racism that exists in the world where Africanness and Blackness are denigrated while Europeanness and Whiteness are seen as superior. As mentioned previously, the issue of race and racism surfaced only once, but I did get a sense of racial polarization just below the surface.

When I asked my supervisor if I could take a Friday off to meet a friend of a friend in Limon, the staff expressed concern for my safety and warned me to not drink the water. In fairness, Limon is not the safest part of Costa Rica (the friend of a friend who I was visiting was robbed of his cell phone and shot in the foot a week prior to my visit), but similar to the United States, the city and its racialized inhabitants get a lot of press for being violent; even though *Quatro Reinas* which is located in San Jose, according to my host mother, is the most violent place in all of Costa Rica. I argue that by virtue of being the area where most Afro-Costa Ricans live, the media focuses on its violence because of Limon's Blackness. In his article, T.L. Dixon (2006) concludes that Blacks are overrepresented as criminals because Whites own the media and prefer to see the "other" depicted poorly, and ratings do increase when Blacks are portrayed in a negative light. For example, *The Real Housewives of Atlanta*, which has an almost all Black cast is the highest rated of the Housewives TV shows.

Historically, Blacks were segregated to the Atlantic Coast and thus the region became shunned by the rest of Costa Rica for its Blackness. In contemporary times, with the rise of consumerism and the commodification of culture, the Limon region has been part of a tourism campaign. During my stay in Costa Rica, my host mother, her daughter,

and an American staying with us went to a cultural tourist attraction. We were greeted by bilingual staff dressed in traditional Costa Rican *campesino* (country side) garb, complete with a *campesino* accent. The show consisted of regional forms of dress and dance. There was also a video with English subtitles discussing the history of Limon and the immigration of Blacks from the West Indies who worked for the United Fruit Company. The video showed smiling Afro-Costa Ricans in bright clothing, usually holding a basket of fresh fruits. The video, like many tourism videos, fails to go deeper than the superficial and controlled historiography that sugar coats history and fails to discuss how Blacks were systematically isolated and denied citizenship in Costa Rica. The point of the video is to paint a positive picture of Limon and Black culture to tourists in order to invite tourism, which is different from the image that is displayed in popular media to Costa Ricans.

Tourism, whether it is medical or travel to Limon, is seen as a cash cow. Tourists spend money, tourists are consumers, and tourists want to consume culture at a distance and at their own discretion. Thus, Limon and the Blacks that live there are essentially only valuable for tourism. Their negative portrayal in the media to Costa Ricans juxtaposed to the positive portrayal to tourists reduces Afro-Costa Ricans to pawns in the tourism game, to be used by the owners of transportation services and hotels for their own monetary benefit while being disregarded as unwanted in the non-consumerist context.

The focus of the Limon tourism video adheres to one of the main tenets of neoliberalism, which is a profit-centric ideology that promotes, among other things, consumerism. Even though Costa Rica is, for the most part, a socialized country there are tenets of neoliberalism that run throughout its institutions. The Ministry of Competitiveness is a governmental body that works directly with private hospitals in order

to make them more competitive compared to hospitals in other countries. Another governmental body, referred to as the Tourism Board of Costa Rica gave the cluster of private hospitals \$200,000 for marketing. Both government agencies provide legislative support and/or funding for the medical tourism industry.

During my fieldwork, I did notice that there were not a lot of Blacks in San Jose and was told on multiple occasions that I, as an African-American, would most likely be mistaken for a woman from Limon. I did not see any Blacks (except for the one medical tourist from the U.S.) at *Hopital Croix* and I definitely noticed a color gradient in terms of the doctors/nurses and the janitorial staff as well as the staff in the international department where I worked. The janitors tended to be a little darker while the doctors, nurses, and international department staff were White. Three of the international department staff are dual citizens with the United States and are children of missionaries. As noted in chapters 4 and 5, within the realm of the medical tourism industry it is believed that Western medical tourists will be drawn to hospitals that are legitimized by the West and consist of staff that mirrors the stereotypical image of a qualified doctor. In contemporary times, Asians are seen as the “model minority” and are also seen as excelling in the realms of math and science. Thus, much of the medical tourism literature reflects that image: an Asian or a slightly tanned doctor, which is also discernable at *Hopital Croix*.

The tropical terrain, political stability and democratic status of Costa Rica make it a popular residence for Western expatriates. The laws that exist in Costa Rica privilege the influx of financial capital bearing Westerners. For example, it is fairly easy for a Canadian or American with a pension, business, or investments that can be cashed in to receive legal residency status, which is in stark contrast to the hoops that racialized migrants from

Nicaragua must jump over in order to receive legal status. If a Westerner does not have a criminal background and all documents are in order then residency is almost guaranteed. The most common types of residencies are: *pensionados* (people receiving a lifetime pension), *rentistas* (other retired people with no pension, but investments to provide income), and *inversionistas* (investors who want to go into business or invest in certain sectors). All of the above residencies can claim a spouse and children under 18 years of age. As of 2009, a minimum of \$600 USD per month was needed in order to gain residency status, but there were talks to increase that number to \$3,000. However, some believe that it will only be increased to \$1,000.

Expatriates cannot vote; however, the Association of Residents of Costa Rica (ARCR) has a lot of clout. It exists to serve foreign residents in Costa Rica and those wanting to move to the country. One must be over 20 years old in order to be a member. Also, the ARCR offers discounts on private insurance to members. The group is currently at the forefront of the movement to remove taxes from importing cars. The same car in the U.S. would cost thousands of dollars more in Costa Rica due to high import taxes, which is why Costa Ricans tend to buy used cars from other Costa Ricans.

Tourists can own property, businesses, and cars, and can generate income from self-employment. Costa Rica does not tax income from overseas, which makes it attractive to foreigners. The aforementioned laws that are in place to facilitate the privileged living conditions of Western expatriates encompass a neoliberal model that favors entrepreneurship, private property and lower taxes. Many countries, including countries that have historically been socialist, have internalized a Western neoliberal model while

unsuccessfully trying to maintain a socialist country, which is discernable in the dismal state of public healthcare in Costa Rica compared to its private hospitals.

Proximity to the U.S., as well as political stability, Whiteness, and favorable residency laws for Westerners play key roles in the popularity of Costa Rica as a medical tourism destination. For certain ailments, it is dangerous to travel by plane for a long period of time. Also, the thought of 30+ travel hours to Bangkok or Singapore is daunting for many people. On the other hand, Miami is only 2.5 hours from San Jose while Houston is a little under 4 hours, and it is possible to get a non-stop from both cities.

What also makes Latin America attractive to American medical tourists is that there is a greater familiarity with Latin American culture as opposed to Asian culture. I noticed that in the discourse of medical tourism blogs, there is less of a sense of culture shock amongst American bloggers who travel to Latin America as opposed to Asia. The mass immigration of Cubans, Puerto Ricans, Dominicans, and Mexicans into the U.S. juxtaposed to Latin Americans' visibility in the media through the *Telemundo* television station (which is the second largest Spanish language station in the world) and T.V. show such as *Ugly Betty* and *The George Lopez Show* as well as musical acts such as Jennifer Lopez, Selena, Ricky Martin, Celia Cruz, and Gloria Estefan, just to name a few, have saturated American media and created a familiarity of Latin America within U.S. culture. I am not by any means discounted the permeability of Asian culture into American society nor the visibility of Asians in the U.S. media; however, Cancun, Mexico remains a popular spring break destination for American students more so than India, Bangkok, and Singapore. Also, according to the U.S. census of 2000, Hispanics make up 15.8% of the U.S. population while Asians comprise only 4.6%. It is argued that the number of Hispanics that were counted in

the U.S. census is low because of the large number of undocumented Hispanics in the U.S. Furthermore, when I visited Tijuana, I noticed a lot of American youth enjoying the clubs as well as American adults enjoying the cheaper prices. I believe that proximity is the culprit as well as space. Chinatowns tend to be located on the West Coast and in the Northeast while *Telemundo* and the Latin Grammy Awards are broadcast in most major U.S. and Canadian cities including Oklahoma City and Boise, Idaho; both of which have been characterized as “White, middle America” with not a lot of diversity. Thus, the saturation of Latin American culture and its proximity to the U.S. makes Latin America, particularly Costa Rica, an attractive medical tourism destination.

As mentioned previously, Costa Rica’s comparative Whiteness, its proximity to the U.S., lack of culture shock and its historic political stability and reputation created fertile ground for medical tourism to flourish. In the remaining chapter, I will give an overview of the medical tourism industry in Costa Rica based on my fieldwork at *Hopital Croix* and at the 2<sup>nd</sup> Annual Medical Tourism (MTA) Congress in Los Angeles, CA. What I perceived and documented during my fieldwork, which included visual observations and preliminary interviews, intertwines with broader issues of color, class, and many forms of capital.

En route from Miami, Florida to San Jose, Costa Rica where I would begin my fieldwork studying medical tourism, it was a major coincidence that I happened to sit next to a lawyer representing a major accrediting body who was vying for a contract to train Costa Ricans to accredit themselves. Also on the flight was the CEO of the accrediting body that the lawyer was representing. The lawyer, upon being informed that I was studying the medical tourism industry in Costa Rica, proceeded to walk to first class in order to ask the CEO to talk with me. Mark, the CEO, gave me an overview of his company: the cost, what

types of facilities his company accredits, etc. Once we were finished talking, Mark bid me farewell and went back to first class. I continued my conversation with Richard, the lawyer, and he told me that I should, “ditch anthropology, become a lawyer and make some real money.” I replied that I was happy being an anthropologist but will keep his suggestion in mind vis a JD on top of my PhD in anthropology.

Richard’s comment is very indicative of the value placed on financial capital within the realm of the growing neoliberal world and the medical tourism industry. My mannerisms and enthusiasm for my research was apparent, but happiness, enthusiasm, and passion take a back seat to money. Clearly, Richard is a corporate lawyer and his suggestion was most likely not an encouragement to practice humanitarian law.

### **Promed**

Promed was started in 2008 and its sole purpose is to promote medical tourism in Costa Rica as a whole. It was birthed by the Ministry of Competitiveness, which is a governmental body that works with private hospitals. It has five committees that include rules and regulations and marketing. It has loose admission standards and a sliding fee scale based on the type of entity that wants to be part of Promed. For example, membership costs \$5,000 USD for hospitals and \$2,500 USD for companies. The group is made up of representative from the Ministry of Health (a governmental body), hospitals, businesses, and universities. During my fieldwork at *Hopital Croix*, I attended a rules and regulations committee meeting. I spoke with one of the members after the meeting and he expressed that the general ideology of the group is to mitigate undo regulations.

### ***Hopital Croix***

There are three private hospitals in San Jose and there are plans to build more in the Guanacaste region, which is rife with expatriates, mostly from the U.S. and Canada. I chose *Hopital Croix* because it has a department that specifically handles international tourists and when I contacted them, they were extremely helpful in terms of giving me contact information for a host family and arranging interviews with the medical director of *Hopital Croix* and others involved in the medical tourism industry. *Hopital Croix* is a large private hospital with 120 beds and consists of two buildings that are attached by an elevated walkway. What struck me most about the hospital was that it was unlike any American hospital that I had experienced. It did not look like a hospital. The colors were not the stale white and pastel pink that we are commonly used to in the U.S., but instead were various shades of blue. There was always somebody cleaning and the hospital seemed to be overstaffed, which considerably reduced wait times. Two to three times per week, there was even a piano player who would play on the first floor of the building where the international department is located. The hospital has two food courts, one of which has a waterfall with trees and ornate décor that reminded me an upscale European café. The rooms were also impressive. Each room had a flat screen TV, contemporary sinks, and a futon for a guest (guests stay free of charge during the patient's stay at the hospital).

The hospital was built in the early 20<sup>th</sup> century by protestant missionaries as a community hospital and is now one the most renowned *private* hospitals in the country. 1/3 of its profits go to the community and 1/3 go to infrastructural improvements. There was also a fund for the poor to get treatment at *Hopital Croix* free of charge, but I was informed by my host mother that that fund usually is reserved for single mothers and their children. 25% of hospital patients are foreign (including expatriates) and there are

approximately 25 surgeries per month on foreign patients. Medical tourists (excluding expatriates) only account for 10% of *Hopital Croix's* patients. Jack, the president of the international department, is trying to convince the hospital's management team to decrease the price of procedures because they are losing business to Mexico who has lowered the price of lap band surgery and the head of the international department attributes this to the economic law of supply and demand: a growing number of Mexican surgeons are becoming proficient in the procedure.

Much to the dismay of Jack, *Hopital Croix* continuously increases the price of medical procedures. Table 1 shows the 2009 price list for *Hopital Croix*:

<b>PROCEDURE</b>	<b>COST</b>	<b>HOSPITAL NIGHTS</b>	<b>RECOVERY NIGHTS</b>	<b>ESTIMATED SURGERY TIME (Hours)</b>
<b>Orthopedic</b>				
Total Knee Replacement (single)	\$11,500	2	10	2
Total Knee Replacement (double)	\$20,900	3	15	3
Total Hip Replacement (single)	\$12,500	2	10	2
Total Hip Replacement (double)	\$23,000	3	15	3
Hip Resurfacing (single)	\$12,500	2	10	2
Hip Resurfacing (double)	\$22,500	3	15	3
Shoulder Joint Replacement	\$9,700	1	7	2
Meniscal Repair	\$4,000	0	7	1.5
Rotator Cuff Repair	\$4,900	0	7	1.5

ACL Repair (anterior curiae ligament)	\$4,200	0	7	1.5
Burse Sack Removal	\$2,800	0	5	1
Carpel Tunnel Release (one hand)	\$1,900	0	2	1
Carpel Tunnel Release (two hands)	\$2,800	0	2	1
Knee Arthroscopy	\$2,800	0	5	1
<b>General Surgery</b>				2
Sleeve Mastectomy	\$10,500	1	5	3
Laparoscopic Gastric Bypass (RNY)	\$12,500	2	7	3
Mini Gastric Bypass (MGB)	\$12,000	1	7	1.5
Lap Band (ambulatory)	\$8,400	0	3	2
Lap Inguinal Hernia Repair (unilateral)	\$5,800	1	7	2.5
Lap Inguinal Hernia Repair (bilateral)	\$6,800	1	7	1.5
Umbilical Hernia Repair	\$5,000	0	3	1
Leoma Removal	\$2,500	0	3	2
Gall Bladder Removal	\$5,900	1	7	
<b>Cardiac Surgery</b>				
Heart Angioplasty with 1 Med Stint	\$13,000			
Heart Bypass Graft (CABG)	\$25,000			
Single Valve Replacement	\$30,000			

<b>Cosmetic Surgery</b>				
Facelift (including neck)	\$6,000	1	8	3.5
Facelift (including eyes and neck)	\$6,500	1	8	3.5
Forehead Lift	\$4,000	0	8	2
Gynecomasty	\$3,800	0	8	2
Mini Facelift	\$4,900	0	7	3
Blepharoplasty	\$2,800	0	7	1
Rhinoplasty	\$4,500	0	7	3
Breast Augmentation	\$3,750	0	8	1.5
Breast Reduction	\$4,600	0	8	2
Breast Lift	\$4,600	0	8	2
Liposuction	\$3,600	0	5	2
Tummy Tuck (includes stomach lipo)	\$5,300	1	10	3
Buttock Implant	\$5,700	1	8	2
Buttock Lipo Injection	\$3,900	0	8	1.5
Calf Implant	\$3,900	0	8	2
<b>Combination Cosmetic Procedures</b>				
Breast Lift/Breast Augmentation	\$5,900	1	8	3
Breast Lift/Arm Lift	\$8,000	1	8	3

Breast Augmentation/Arm Lift	\$7,000	1	8	3
Breast Lift/aug/Arm Lift	\$8,800	1	8	3
Face Lift/Breast Augmentation	\$8,700	1	8	5
Face Lift/Breast Lift	\$9,600	1	8	5
Face Lift/Breast Lift/Augmentation	\$10,200	1	8	6
Breast Lift/Rhinoplasty	\$7,900	1	8	4
Face Lift/Tummy Tuck	\$9,800	1	12	5
Breast Augmentation/Lipo	\$5,700	0	8	3
Breast Lift/Lipo	\$7,000	1	8	3.5
Breast Lif/Augmentation/Lipo	\$7,400	1	8	3.5
Lipo 2 Areas	\$4,900	0	8	2
Lipo 3 Areas	\$5,900	0	8	3
Lower Body Lift (Tummy Tuck, Butt Lift)	\$8,000	1	12	6
Tummy Tuck/Breast Augmentation	\$7,900	1	10	4
Tummy Tuck/Breast Augmentation/Lift	\$9,400	1	10	5
Tummy Tuck/Breast Lift	\$8,700	1	10	5
Tummy Tuck/Thigh Lift	\$8,300	1	10	4
Tummy Tuck/Breast Lift/Arm Lift	\$10,200	1	12	6
Tummy Tuck/Breast Lift/Augmentation/Thigh Lift	\$10,200	1	12	6
Tummy Tuck/Breast Lift/Arm	\$10,600	1	14	4

Lift/Thigh Lift				
Tummy Tuck/Lipo (1 area)	\$6,700	1	10	4
Tummy Tuck/Lipo (2 areas)	\$8,500	1	10	4
Tummy Tuck/Lipo (3-4 areas)	\$9,500	1	10	4
<b>Ophthalmology</b>				
Cataract (one eye)	\$2,400	0	1	
Cataract (two eyes)	\$4,200	0	3	
LASIK (two eyes)	\$2,000	0	2	
<b>Gyn/OB Surgery</b>				
Hysterectomy	\$5,680	1	7	2
Myomectomy	\$5,680	1	7	2
Reverse Tubal Ligation	\$4,900	1	7	1.5
<b>Diagnostic (transport not included)</b>				
Colonoscopy/with Dr's Consultation	\$350	0	0	0
Gastroscopy/with Dr's Consultation	\$155	0	0	0
Electrocardiogram	\$70	0	0	0
Echocardiogram	\$150	0	0	0
Stress Test Echocardiogram	\$285	0	0	0

Thorax X-Ray	\$60	0	0	0
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Clearly these prices are substantially cheaper than the U.S., which makes medical tourism attractive to those with little or no health insurance, high deductible health insurance, and/or those who have to wait a substantial amount of time for medical treatment. In the U.S., heart bypass surgery usually costs \$100,000 and a heart valve replacement can cost as much as \$200,000. In 2008, the prices at *Hopital Croix* were slightly less and there were rumors that the hospital board of directors was going to approve another price hike for 2010. Also, the hospital is more aggressive in terms of marketing major procedures such as single valve, hip, and knee replacements, because these procedures generate more revenue for the hospital than smaller ambulatory procedures.

In terms of efficiency and patient care, there did not appear to be long wait times in the emergency room and I did not witness a wait time to check in of no more than five minutes. I have limited experience at American hospitals but the few times that I've had to go to the emergency room, I generally had to wait more than an hour to be seen. After check-in, the international patient rarely waited more than 10 minutes before being called to see the doctor at *Hopital Croix*. The nurse to patient ratio is 1:4 and in the ICU it is 1:2. I met a former American nurse touring *Hopital Croix* who was astounded by the nurse to patient ratio because sometimes he would have as many as 15 patients under his care. During my fieldwork at *Hopital Croix*, I witnessed three nurses checking in on a patient at one time and one day I expressed to Maria (an international department staff member) that

I wanted to make an appointment to have an eye exam. She called the eye doctor at 9am and I was seen at 10am.

I argue that, based on my experience at *Hopital Croix*, the American hospitals that I had been to were understaffed. Even though many of the American doctors and nurses were pleasant, they always appeared to be rushed. I accompanied three patients to their doctors' consultation and I got a sense that the doctors at *Hopital Croix* were not rushed and did not recommend unnecessary treatments. Insurance companies constantly complain that American doctors order unnecessary tests, but because we live in a litigious society, doctors are essentially covering themselves in case of a lawsuit. Also, it appeared that doctors were not under any pressure to recruit as many patients as possible. For example, a patient from South Florida contacted a surgeon at *Hopital Croix* because he wanted laparoscopic hernia surgery. The doctor informed him that due to the condition of the area where the surgery would take place, he could not perform it laparoscopically. The patient decided to travel to *Hopital Croix* and have the more invasive and traditional form of the surgery. Upon an in person consultation, the doctor determined that laparoscopic surgery might be possible. The surgeon said that he would initially perform the surgery laparoscopically, but may have to switch to the traditional form. The surgeon could have easily assured the patient that his hernia repair could be performed laparoscopically just to get him into the hospital, and because the patient spent money on a plane ticket and made lodging arrangements, it is highly improbable that the patient would refuse treatment and return to the U.S. Thus, this deceitful practice would almost guarantee a patient and revenue for the doctor. However, this particular surgeon did not appear to be under

pressure to fill a quota. In the U.S., doctors have quotas and are many times penalized (taking away vacation days and docking pay) if they do not meet said quota.

The doctors at *Hopital Croix* are similar to independent contractors. They are required to pay a fee to use the hospital's facilities. For example, about half of the cost of each procedure is paid to the hospital and if the doctor needs ancillary personnel, such as an anesthesiologist, the doctor must pay for these services him or herself. The doctor must also pay for supplies such as surgical equipment and gauze. Considering that the average Costa Rican earns \$350 USD per month and if a surgeon at *Hopital Croix* performs one double knee replacement, he or she will earn \$10,000 USD. Private physicians can live a very comfortable lifestyle, which mitigates financially based pressure to garner as many patients and procedures as possible. Also, doctors at *Hopital Croix* do not have assistants, which further mitigates financial responsibilities and increases take home pay. I was shocked when I saw a doctor drop off paperwork to the international department himself.

### **International Department: *Hopital Croix***

Jack who, at that time, was an employee of Hopital Croix and worked as an insurance claims collector for the hospital started the international department in 2006. The previous person who worked in that position could not speak English and many claims were not fulfilled. The hospital was so impressed that Jack had a 100% success rate that they aided him financially in creating the international department (for example the hospital initially paid some of Jack's employees' salaries), which is a separate entity from the hospital. I worked two months in the international department of *Hopital Croix*. I was a patient assistant and my job duties included translating, escorting patients to and from appointments, answering email inquiries, and writing medical tourism travel guides for

various countries. The staff of ten consisted of four women and six men. Most of the staff had lived in the U.S. and all are bilingual. Three of the staff members are dual citizens with the U.S. and three are insurance claims collectors.

On the business side of the international department, the department has 40-50 contracts with medical tourism travel agencies (referred to as facilitators), but 5-7 send patients regularly. The contracts are free and before the contract is initiated, usually a facilitator will send representatives to tour the hospital. Contracts last for one year and the international department gives a commission to the facilitator in the amount of 10% of the cost of treatment. Patients Without Borders is probably the most well known facilitator and the organization also has contracts with insurance companies.

Patients must pay for the procedure in full and sometimes pay an additional deposit. The international department will only accept as forms of payment: cash, wire transfer, visa, American Express, or MasterCard. There is a discount given to patients who pay cash because credit card companies charge a fee based on a certain percentage of the charge. Patients must sign a release form, which states that the insurance company will pay the hospital and not the patient. I was told that at a different hospital an inexperienced international department employee did not have the American patient sign the release form. The insurance company then sent a \$100,000 check to the patient and the patient kept the money. The hospital had no recourse because the patient had no assets in Costa Rica and the U.S. Embassy will not aid with collections.

As mentioned previously, three employees exclusively handle insurance claims and there are some insurance companies that international department will not work with because of previous problems and/or the company does not put things in writing. The

department does not take a major insurance carrier in Canada because claims in the past have not been fulfilled. The insurance companies that they usually work with include: Blue Cross/Blue Shield, Cigna International, Aetna Global, United Health Care, Prudential, Bupa, International Medical Group, and Secure Horizons. The employees who handle insurance claims were the busiest of all the employees. They were constantly on the phone with a firm tone in their voice. I did a preliminary interview with the head of the insurance claims leg of the international department who had worked at *Hopital Croix* for nine years. He noted that sometimes it can take up to one year for the insurance company to send payment. He also noted that one has to be firm with them. He said, "Sometimes you have to be mean with the insurance companies. If you are too nice then they walk all over you. Well, not mean but firm."

I was designated as a patient assistant, which entailed that I answer emails, translate (if needed), and escort patients to and from appointments. If a potential patient contacts the department, they get an immediate automated reply that states that an international department staff member will respond shortly. Then I would send a price estimate of the procedure that he or she inquires about and two follow up emails (one per week for 2-3 weeks). There are templates for the most common procedures, which include breast augmentation, liposuction, ACL repair, gastric sleeve surgery, hip replacement, knee replacement, lap band surgery, and rhinoplasty. The initial email response from a staff member includes the price of the procedure, name of the bilingual doctor who performs the procedure, the doctor's CV (available in English and Spanish), a disclaimer that if complications arise the procedure may cost more, a medical questionnaire that is forwarded to the doctor, hotel recommendations, what is included in the price (such as

transportation and it is also noted that transportation has air conditioning), a statement that the prices do not include airfare or the cost of accommodation outside of the hospital, a statement that guests can stay in the hospital with the patient for free, number of days to recuperate in a hotel before flying home, doctor referrals, size of the scar, surgical approach (i.e. laparoscopic, etc.), and number of days notice needed to schedule the surgery.

Once the patient arrives he or she receives blood work, x-rays, and (if over 45) an EKG. Two hours later the test results are ready. An international department patient assistant will retrieve the results and give them to the doctor of the foreign patient. The assistant will escort the patient to his or her doctor (results in hand) and then will either stay with the patient during the consultation or leave and then return at the end of the consultation to escort the patient to his or her next appointment or to awaiting transportation. The surgery will usually occur the day after the consultation and patient assistants will routinely visit patients in order to make sure that they are comfortable and to see if they need anything. On one occasion, a patient's companion needed a case for her contact lenses, so the patient assistant went to the first floor of the hospital where the pharmacy is located. The pharmacy did not have any contact lense cases and the patient assistant knew the assistant to one of the eye doctors and retrieved one free of charge. The patient's companion was very impressed with the customer service.

### **Recovery Hotels**

*Hopital Croix* recommends a handful of recovery hotels. The most inexpensive hotel that the department recommends is *Hotel San Jose*, which costs \$39 USD/night. The hotel itself is aesthetically pleasing, but is not located in the most upscale neighborhood. The next tier hotel is *El Castillo*, which is located in the city and costs just under \$100 USD per

night (depending on the room). I visited this hotel and like *Hotel San Jose, El Castillo* is enclosed in terms of space; however, unlike *Hotel San Jose*, which only has a gated door, *El Castillo* has a completely enclosed compound with security guards at the entrance and walking about the premises. The wall that separates the hotel from the city is decorated like the Costa Rican countryside. The grounds include a sauna, shoe buffer machines, a pool, a hot tub, indoor/outdoor restaurant (with tasty food) and some of the rooms have a washer/dryer, full kitchen, and a bathtub. Some rooms are handicapped accessible, which is suitable for patients recovering from orthopedic surgery and require a wheelchair. Jack usually doesn't use *El Castillo* because there is no nurse on site; however, the staff at the hotel informed me that there were plans to hire a nurse and devote one floor to medical tourists. For hotels that do not have an on-site nurse, the international department will send a nurse from Homewatch International to the patient's hotel. The final hotel, named *El Rancho Bellatierra*, is located outside of San Jose, approximately 30 minutes from *Hopital Croix* by car, and sits on many acres. I met the proprietors who are both Latin American, but have lived in the U.S. in the past. *El Rancho Bellatierra*, costs \$100 USD per night for a single person and \$150 USD for two people. It offers a lot of amenities including free transportation to and from the hospital, and free phone calls to the U.S. and Canada. There is a 24-hour nurse and the nursing staff consists of one nurse and two assistants. The hotel will provide gauze, tape, aspirin, and dressings for free.

All three hotels have spatial separation in common, but the means of separation is different. *El Rancho Bellatierra* uses distance and barriers are used at *Hotel San Jose* and *El Castillo*. On the surface, safety is cited as the key reason for this separation; however, there is a deeper subliminal reason that is mired in xenophobia and class. Within the medical

tourism discourse, there is a consensus that Westerners feel more comfortable and safe in developing countries if there are visible security personnel, safes in the rooms, and barriers to keep outsiders out. Most hotels in the U.S. lack safes and barriers to enter the premises, which equates to a distrust of those living in developing countries; reducing its inhabitants to criminals. I am not discounting the prevalence of theft against tourists in developing countries; however, I am arguing that safety is not the sole reason for such security measures. In her book *City of Walls: Crime, Segregation, and Citizenship in Sao Paulo* (2000), Teresa Caldeira notes that: "Closed condominiums, the new type of fortified elite housing, are not places people walk to or even simply pass by. They are meant to be distant, to be approached only by car and then only by their residents, a few visitors, and of course the servants, who must be kept under control and are usually directed to a special entrance" (257). Considering that the average monthly wage for a Costa Rican is \$350 USD, a night at one of the *Hopital Croix* approved hotels is out of the question for many Costa Ricans. These fortified elite hotels serves as a means of spatial segregation that mirrors social and economic segregation between the Whitened, Westernized elites and the darkened, Central American natives. Caldeira argues that fortified enclaves send a message of fear, segregation, and suspicion. "These elements, together with the valorization of isolation and enclosure and the new practices of classification and exclusion, are creating a city in which separateness comes to the forefront and in which the quality of public space and the possibility of social encounters have already changed considerably" (296).

Those who are included within the hotel space are Western and elite guests and employees. The employees who interact with guests are required to know English. The majority of Costa Ricans who are fluent in English are already privileged. Thus, the hotel is

a mingling ground for Westerners and elite and semi-elite Costa Ricans while non-elite Costa Ricans are excluded from this “safe space” for medical tourists.

In regards to Caldeira’s assertion that the quality of public space has changed, I argue that the privatization of space, which is the result of xenophobia and classism, is creating a dichotomy between public and private healthcare facilities. *Hopital Croix* was never overcrowded while I was doing my fieldwork, wait times were very short, and the hospital seemed overstaffed. According to Tourism Research and Marketing (2006), one of the ethical dilemmas of the medical tourism industry is that it drains resources and personnel from the public hospitals. In his article in the *New York Times*, Joshua Kurlantzick (2007) provides a narrative of his experience falling ill in Bangkok, Thailand. During his first bout with what he thought was dengue, he went to a major private hospital that is popular amongst medical tourists and was “[s]urrounded by a gaggle of nurses ready to care for [his] every complaint at any time of day...” When Kurlantzick felt the fever reemerging, he decided to go to a Thai hospital that is not part of the elite medical tourism network. He sat on an uncomfortable bench for over an hour in a waiting room with trash on the floor before a nurse informed him that a doctor wouldn’t be around for hours.

The private medical sector is more profitable for doctors and hospital personnel than local, public hospitals. According to a doctor at *Hopital Croix*, doctors at public hospitals are overworked and make less than their counterparts at private hospitals. Also, public physicians cannot make their own hours. Thus, the medical tourism industry and the privatization of hospitals are siphoning medical personnel away from public, local hospitals. I witnessed this practice in Costa Rica. I did not physically go to a public

hospital but my host mother told me that her experiences with public hospitals in Costa Rica were rife with long wait times, understaffing, rude personnel, and patient overcrowding. According to my Costa Rican co-worker in the international department, public hospitals have no air conditioning, use old equipment, have rooms with as many as 15 beds, set visiting hours that allow only two visitors at a time, 20 spots per day for appointments (appointments are same day with no call ahead and one must stand in line as early as 4:00 am in order to be seen that day), and up to three years wait time for surgery, which is in direct contrast with my observations at *Hopital Croix* considering that I was able to get an appointment within hours of calling ahead for an eye exam.

### **The Medical Tourism Association and Its Subsidiaries**

The Medical Tourism Association (MTA) is a non-profit organization started by an American husband and wife team that acts as an aggregate for the medical tourism industry. It is based in Palm Beach, Florida and membership costs \$3,000 for a hospital. The organization does act as a referral service for patients who are interested in travelling overseas for healthcare. The who's who of the industry are members of the MTA. It acts as an umbrella organization over the *Medical Tourism Magazine* and the World Medical Tourism and Global Healthcare Congress. The former is a monthly publication that started in December of 2007. Jack noted that being in the magazine, particularly writing an article, is like establishing oneself within the business. The latter is a yearly conference that brings together representatives of the medical tourism industry from around the world. I was able to attend the Congress in October of 2009 in Los Angeles, California. The cost of attendance for facilitators, technology providers, hospitals and 'other' (I fell under the 'other' category) was \$1,500 for early registration and \$2,500 for late registration. MTA

members receive a 20% discount off registration. Full conference registration includes: three days of workshops, general sessions, prescheduled one on one networking meetings, coffee, tea, lunch, and cocktail receptions each night with entertainment. I was able to have the registration fee waived in exchange for volunteering to help the MTA staff during the congress. Also, Jack was accompanied by one of his female employees and we shared a room, which further mitigated my costs.

The cost of attendance for insurance companies is substantially cheaper. Early registration was \$1,200 and late registration was \$1,600. There was even a fee waiver application for insurance companies, or as they are known in the business: 'buyers'. Buyers received VIP incentives, which will give discounts or free registration, free hotel nights, and/or free flights. Some companies will also pay the insurers to attend the congress. Insurance companies are considered gold because they are seen as revenue generating. If an insurance company will cover procedures at a particular international hospital then that hospital will see an influx of Western, capital bearing patients. I expressed to Jack that the fee for the MTA congress was expensive and his reply was that buyers have expensive tastes. They want expensive food and fancy venues. In fact, the MTA congress of 2009 was not really *in* Los Angeles, it was held in Beverly Hills.

Major companies, hospitals, and countries will usually have a booth at the congress, which costs \$10,000. Other costs that the participants of the MTA congress will incur are lodging, visas (many attendees were from overseas), food, and transportation. There are also six tiers of sponsorship: Diamond Corporate (\$100,000), Platinum Corporate (\$75,000), Gold Corporate (\$40,000), Silver Corporate (\$15,000), Bronze Corporate (\$7,500), and Exhibitor (\$5,000). South Korea was the Platinum sponsor of the 2009

Congress and Dubai was the Diamond sponsor of the 2010 MTA congress. Because countries are represented at the congress, public funds are being used to cover the costs of attendance. Essentially, conferences are one of the many venues that are siphoning public funds into a private industry. Privatization and the use of public funds to support a private entity are two of the major tenets of neoliberalism.

Prior to going to MTA Congress, Jack encouraged me to be a presenter and I responded with a few topics based on my fieldwork. His response was that I needed to present on a topic that will interest congress participants. In other words, it had to be a topic pertaining to business. There was only one presentation about the social aspects of the medical tourism industry entitled: "Social Entrepreneurship" and it was dismally attended. Most of the topics covered during the 2010 MTA congress pertained to insurance companies implementing international coverage, which coincides with the VIP status of insurance companies who are seen as the harbingers of profits and wealth for international hospitals and clinics. Other major topics include wellness tourism (spas), marketing, and patient safety, all of which tie into business interests.

The MTA congress is the most popular medical tourism conference, but there are many break out conferences that are regional. The Latin American Medical Tourism Congress started in 2009 and was located in Monterrey, Mexico. Jack planned on attending but it was cancelled due to the swine flu scare. The International Medical Tourism Conference of 2010 was held in Costa Rica. There is also an Asia Medical Tourism Congress and congresses that were held in Kuwait and South Korea.

## **Conclusion**

I argue that Costa Rica became fertile ground for medical tourism to flourish because of its history of democracy and political stability. While missionaries and other Westerners were fleeing neighboring Central American countries, Costa Rica saw an influx of expatriates and missionaries, especially after the 1948 Civil War. Also, its label as the 'Switzerland of Central America' adheres to the dominant hierarchy that privileges the West, thereby discursively whitening Costa Rica. The dominant discourse among Costa Ricans prides itself on being more White than neighboring countries. I personally witnessed Costa Ricans of many different class distinctions denigrate Nicaraguans and blame them for many of the country's problems. I asked my host mother how one can tell who is from Nicaragua and she said that they are darker and have more indigenous features. Also, Black Costa Ricans were systematically segregated to regions on the Atlantic coast, particularly the Limon Province. Nicaraguans, Indigenous people, and Afro-Costa Ricans have historically been excluded from many forms of citizenship and segregated from the Whiter Costa Rican community. The images presented in the medical tourism media are that of fair-skinned and exotic doctors and nurses, and Costa Rica's reputation of being more European and democratic than most other countries in Latin America (especially Central America), adheres to the ideals privileged in the West. Whiteness and democracy coupled with proximity to the U.S. make Costa Rica an ideal destination for Westerners seeking comparatively inexpensive medical treatment with minimal culture shock.

### **3. MEDICAL TOURISM: NEOLIBERAL IDEOLOGIES AND REALITIES**

Traveling across international borders for healthcare is not a new phenomenon. During the colonial period, colonists from Europe would travel to their colonies near the equator because it was believed that a tropical climate would help to relieve certain ailments. A contemporary example that has not received as much attention as patients travelling to developing countries is King Khalid of Saudi Arabia who practices what is referred to as 'reverse medical tourism' by travelling to the U.S. in order to be a patient at the Cleveland Clinic. Although medical tourism is not a new practice, the foundation that it is built on is. The amount of marketing and the heavy involvement of extraneous bodies such as governments, insurance companies and associations add a contemporary element to the practice. What is also new is the ideology on which the industry is based.

In this chapter, the problems that I will discuss are the ways in which the medical tourism industry has adopted neoliberal ideology and how the use of this ideology by the medical tourism industry, like neoliberalism as a whole, is having a negative impact on poor and middle-class Costa Ricans with little or no ties to North America and/or a low proficiency of the English language. Neoliberalism is an ideology that has penetrated ideas and practices throughout the world. It lies at the heart of how we view the optimal self and how we view the optimal society by valorizing the hardworking successful individual, entrepreneurial freedoms, private property rights, free markets, and minimal government oversight.

In the description of the optimal neoliberal individual and how he/she is formed, Thomas Lemke (2001) discusses a particular form of human capital that encompasses two conditions:

...[A]n inborn physical-genetic predisposition and the entirety of skills that have been acquired as the result of “investments” in the corresponding stimuli: nutrition, education, training, and also love, affection, etc. In this model, the wage laborers are no longer the employees dependent on a company, but are autonomous entrepreneurs with full responsibility for their own investment decisions and endeavoring to produce surplus value, they are the entrepreneurs of themselves. (199)

My critique of the neoliberal description of what entails optimal human capital is the hereditarianist ideology that it advances. Although “physical predispositions” such as Down Syndrome can play a role in cognitive and physical abilities that can affect educational opportunities and employment, I do caution the use of “genetic predispositions” because of its possible essentialist applications. By labeling a person as genetically predisposed to falling short of the neoliberal ideal places that person (and those like him/her) in a permanent sub-category. Genetic arguments imply unmalleability and fixed predispositions that promote racist ideologies. For example, Canadian psychologist John Philippe Rushton’s “experiments” that concluded that intelligence is passed down genetically through parents were used to discredit the use and, especially, funding of social educational programs such as Head Start because, as some have argued, if a person or groups of people lack intellect due to a genetic predisposition then no amount of aid and education will rectify it. In his book, *The Debt: What America Owes to Blacks* (2001), Randall Robinson argues that studies on the correlation between race and intelligence tend to compare students of color in underfunded and failing inner city schools with their White and Asian counterparts in high performing suburban public and private schools. If “scientists” like Rushton would compare Black, Latino, and White students from the same socio-economic background then there would be little difference in standardized test scores.

Similar to hereditarianist arguments, neoliberalism and liberalism do not take into account structural violence and societal systems and practices that act to maintain a permanent underclass. Drawing on the works of Sidney Mintz, Paul Farmer (2001) applies physical ailments to the linkage of "...the interpretive project of modern anthropology to a historical understanding of the large-scale social and economic structures in which [medical] affliction is embedded" (305). Farmer is noting the importance of historicity and social structures in negative medical outcomes such as AIDS, tuberculosis, and infant mortality. For example, in *AIDS and Accusation: Haiti and the Geography of Blame* (1993), Farmer gives historicity to the AIDS epidemic in Haiti. The blackballing of Haiti and reparation payments to France after the Haitian Revolution resulted in abject poverty which led to an increase in sex workers, particularly men engaging in transactional sex with gay Western men, which exposed them to HIV. A lot of these male sex workers were displaced from their rural villages due to the building of a dam that flooded fertile lands and when they returned to their home village they then spread HIV to their wives and girlfriends. The structural violence that began with an economic embargo became the catalyst in creating a system that had deadly consequences. The structural violence that occurs, particularly in the U.S., are longer jail sentences for using and/or distributing drugs that tend to be used by African-Americans as opposed to Caucasians, underfunding poor, Black and Latino schools, discouraging educational excellence in Black schools while promoting athletics, and taking away social programs and aid from married couples which causes and maintains single-parent households in poor communities are a few of the many systemic practices that keep certain groups in a permanent underclass.

Neoliberal doctrine places the responsibility on the individual to obtain “nutrition, education, training, and also love, affection, etc.” (Lemke 2001: 199) and structural violence is not taken into account. People who are not successful are blamed for their own demise, not society, racism, sexism, poverty, nor the criminalization of actions that tend to be used by the poor and minorities. At first glance the ideas of (neo)liberalism that promotes merit based on hard work as opposed to birth is definitely a progressive and positive stance that acts to distribute wealth and opportunities for success; however, Stuart Hall (1986) notes that liberalism’s idealist interpretations of society privileges nature over nurture and collapses the spiritual and social factors that act to constrain individuals and groups. Hall also notes that:

Equality [in liberal doctrine] is a subordinate value to [liberty] and means primarily that all individuals are equal because they are born with the same rights. None therefore should have prior status as a consequence of birth or inherited position. Everyone must have an equal chance to enter the competitive struggle-there must be no barriers to entry (41).

In theory, innate congenital ability (unless one is born with a congenital disease) is equal, but in practice there are socially produced prejudicial barriers in place to restrict the upward mobility of certain groups. For example, ex-talk show host and radio personality Larry Elders had a discussion with employers on his talk show, including Black employers, who admitted that they would not grant an interview to someone who submits his/her resume and has a “ghetto-sounding name.” “Ghetto-sounding names” created a pejorative image of the person behind the name. Behavioral traits such as ill-behaved, loud, obnoxious, bad attitude, and tardiness were linked to people with “ghetto-sounding names.” According to liberal doctrine everyone is born with the same rights but this theory

collapses onto itself when societal prejudices act upon certain bodies to create unequal opportunities and access to resources, which perpetuates inequality.

Later in the article, Hall (1986) points out that the liberal argument of equality does not equate to “quality of condition”, but only to quality of human ability. Thus, liberal doctrine does not promote giving positive advantages to those born into poor circumstances. Under liberalism, similar to the hereditarianist position, social programs that help the poor are unnecessary because of people’s innate potential as human beings to attain success. To an extent, this statement is true, for example self-made millionaire and entrepreneur Chris Gardner (the movie *The Pursuit of Happyness* (2006) is a biography of his life) went from homeless to über success. The advantage that Gardner had was social capital. Prior to his success, he had already been a salesman (albeit unsuccessful) and he had post-secondary training and discipline as a Naval officer and later as a clinical researcher. But for those with little or no social capital such as inadequate education, few opportunities for advancement, and limited access to the outside world; success (under the neoliberal and liberal definition of success) is much harder if not nearly impossible to attain. For example, I argue that those who are successful in the medical tourism industry are people who speak English (especially doctors and nurses), entrepreneurs, and those with the financial capital to invest in the industry.

Another contradiction within the notion of equality under liberal doctrine is the ascension of certain people to the position of lawmakers and law appliers. It has little to say about the unequal status of the judges and the people who come before them. For example, the judge is free to go home to his/her comfortable and safe home while the vagrant who is criminalized for simply being homeless (via anti-loitering, anti-panhandling,

and anti-vagrancy laws) has nowhere else to go unless there are homeless shelters, which are usually overcrowded or non-existent. Hall (1986) asserts that: "...this contrast between formal and substantive equality is another source of ambiguity in liberalism" (42).

Similar to liberalism, neoliberalism also valorizes individual freedoms; however, individual freedoms are based on and guaranteed by the freedom of the market. On the contrary, and as seen in the movie *Enron: The Smartest Guys in the Room* (2005), freedom of the market does not equate to freedom of the individual. The free market and the lack of checks and balances caused the bankruptcy of Enron which subsequently limited the freedom of individual shareholders who lost their lifesavings and did not have the individual freedom to retire as planned, to take that trip around the world, or to start a small business with their savings.

Now I will transition from an explanation of liberal and neoliberal doctrine to applying liberal/neoliberal ideologies to the medical tourism industry. Below is an outline of neoliberal applications to the industry both in practice and in discourse. The following explanation is based on multi-sited fieldwork at the aforementioned 2<sup>nd</sup> Annual World Medical Tourism and Global Health Congress that took place in Los Angeles, California in 2009 and at *Hopital Croix* during the summer of 2009. The methodologies used during my fieldwork were preliminary interviews, literature reviews, and popular discourse in the media and amongst my co-workers at the hospital and the people attending the congress (which included my co-workers at the hospital).

According to David Harvey: "Neoliberalism is...a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework

characterized by strong private property rights, free markets, and free trade” (2005: 2). Harvey’s description differs from Lemke’s in that the former incorporates the importance of an institutional framework that ensures that people can be neoliberal citizens while the latter privileges investments made by individuals themselves, not institutions. Those involved in the medical tourism industry uses both Lemke’s and Harvey’s descriptions of neoliberalism. On the one hand, government institutions are lobbied by the industry to ease visa/entry requirements for medical tourists and to invest in the industry. There were government representatives at the meetings of groups that promote medical tourism and also at the Medical Tourism Association’s Annual Congress. On the other hand, the rhetoric amongst those in the medical tourism industry valorizes the individual, autonomous medical investment of deciding to research international hospitals, and travel overseas for medical treatment as well as the investment to learn English and be a medical tourism entrepreneur.

Neoliberal systems that privilege the free international flow of capital and bodies are at work in easing the travel of citizens of developing countries that attended the congress or are traveling overseas for medical treatment. Because the people involved in the medical tourism industry represent a capital-bearing market enterprise and are sponsored by businesses and governments with links to businesses, the presence of these “3<sup>rd</sup> World” citizens goes against popular culturalist interpretations of a “3<sup>rd</sup> World” visitor to the United States. This contradiction is especially noticeable in the aftermath of Arizona legislators passing SB 1070, which makes it a crime to live and travel through Arizona if one is in the country illegally and gives police the right to search anybody that they *suspect* as being illegal immigrants. The passing of this bill has opened the flood gates of debates

concerning racism against Hispanics and negative culturalist rhetoric that paints Hispanics (especially males) as tied to the drug trade, involved in other forms of criminal activity (not including the criminalization of being in the U.S. illegally), alcoholics, devoid of English language skills, and bogging down social programs that are meant to help American citizens. The Hispanic “visitors” that some Arizona residents want deported are not sponsored by a government or business, are not bringing in massive amounts of capital and are not part of the overly consuming global elite. Thus, the flow of capital and (certain) bodies are welcomed into developed nation-states while those (racialized) bodies bearing little or no capital or capital-bearing potential are excluded, which goes against the neoliberal ideology that promotes the free flow of the market; including laborers.

Another contradiction in neoliberal doctrine is the separate dichotomy that it purports should exist between public and private sphere. In other words, the government should assert little influence and oversight within the private sphere. However, the medical tourism industry constantly looks to the government to, for instance, tweak public policy (i.e. visa laws) to allow for easy entrance into the country by foreign patients. For example, South Africa, the United States, South Korea, and India offer medical visas to foreigners and companions who are getting medical treatment at hospitals in these countries. Also, associations have been formed with members coming from both the public and private sectors. Two such associations are Promed (Costa Rica) and Proexport (Colombia) and the mission statement of both associations include promoting medical tourism in their countries as a whole; not a particular hospital or clinic. The same neoliberal practitioners that denigrate government involvement in the private sector also turn to the government for financial support and legislation that promotes the medical

tourism industry. For example, public funds in Costa Rica are being used to build private hospitals and to host and send representatives to conferences.

The argument that the Costa Rican government uses in order to justify investing large amounts of capital into the medical tourism industry is that the industry will create jobs and promote entrepreneurship vis this privatized industry. The Costa Rican government is in alignment with Harvey's argument about one of the main tenets of neoliberalism, which is the promotion of private enterprise via a favorable institutional framework that includes using public funds in order to support a private industry. Costa Rica is what Harvey (2005) refers to as a neoliberal state, which is a state that valorizes private property owners, financial capital, businesses, and multinational corporations. For example, the Costa Rican government is siphoning public funds to train doctors and nurses for this private industry as well as to build new private hospitals in wealthy expatriate neighborhoods in the Guanacaste region. The government even partially funded an international airport in Guanacaste so that expatriates and tourists do not have to fly into San Jose.

Job creation is one of the justifications used by the Costa Rican government to divert public funds to the medical tourism industry. This justification is problematic because the people filling those jobs are generally highly educated, have ties to the West, and speak English. Thus, those benefitting from the industry are already in the upper echelons of Costa Rican society. At this moment, there is minimal trickling down of opportunities and the industry is not distributing wealth across class lines, but is giving employment and entrepreneurial opportunities to the middle and upper classes. When asked if the medical tourism industry would help the Costa Rican poor, one of my co-workers stated that the

poor will stay the same because they would not even know about the industry. I did not ask her to elaborate. Did she mean “know about” in terms of access? Benefit? Or knowledge of the industry? I can only guess that it was a combination of all three. The poor have yet to benefit from the claims made by the government that the industry will generate dollars from medical tourism that would be invested in the public healthcare system. The statistics state that medical tourists will spend four times more than traditional tourists and the government anticipates an increase in revenue for the country from medical tourism. So far, the government is heavily investing in the private healthcare industry, which results in diminished funding in the public sector. Also, the poor cannot benefit from job creation because many of them do not know how to speak English and/or do not have the education to attend medical or nursing school. In terms of access, the poor are excluded from the industry and its jobs because they cannot afford private healthcare and they generally do not know how to speak English. Chauffeurs, hotel staff, doctors, nurses and other hospital staff as well as recovery spa staff all need to know English in order to work in the medical tourism industry. This exclusionary practice was occurring at *Hopital Croix* where I did my fieldwork. The hospital was systematically firing employees, even janitors, who could not speak English.

At first glance it seems as if the medical tourism industry is intentionally excluding people who do not speak English and generally those people are poor, uneducated, and are of a mature age. The Costa Rican school system requires that all students take a foreign language-usually French or English. Thus, English proficiency varies along age, level of education, and class lines. Medical tourism is believed and stated to provide riches to all; however, in practice those riches only come to those who “master...the technologies” of the

West, which are based on neoliberal business models, Western mannerisms and styles of dress, and English proficiency while at the same time “...threaten[ing] the very existence of those who do not” (Comaroff 2008: 180).

Citing Richard Sennett, Comaroff and Comaroff (2008) note that with the rise of capitalism and globalization, production (in the case of medical tourism, providing medical services to Westerners) is only a perceived source of national wealth. “...a stable local context [is] no longer [a] prime site for the creation of value or identity” (178).

“Traditional” Costa Rican identity based on an amalgamation of indigenous culture, Spanish Colonialists, and Afro-Caribbean immigrants is slowly being usurped by foreign investors and expatriates, primarily from English speaking countries. Instead of embracing the Spanish language, the medical tourism industry privileges English, Western medicine, and behavior and mannerisms that mirror the stereotypical Westerner. For example, during a seminar for Westerners who are considering moving to Costa Rica, one of the presenters noted the difference between American time and “Tico”<sup>2</sup> time. I have reproduced his table below (table 2):

	<b>Late Excused</b>	<b>Tension</b>	<b>Hostility</b>
<b>Pacific Islands</b>	2 hours	3 hours	4 hours
<b>Latin America</b>	30 minutes	1 hour	2 hours
<b>U.S. &amp; Canada</b>	5 minutes	15 minutes	30 minutes

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<sup>2</sup> Tico is another word for Costa Rican.

Many Costa Ricans, primarily those who associate with Westerners, have internalized this essentialist table. For those who work in the medical tourism industry, local identity and value (both in terms human worth and financial capital) is based on Western ideals such as English proficiency, biomedicine, and knowledge of Western practices through ties to the West (everyone who I worked with at *Hopital Croix* had lived in the United States at some point). It is believed by many in the industry that Westerners will not seek services from hospitals that are not like the ones in the West. As a result, traditional Costa Rican ways of living are being usurped not completely by the West, but by Costa Ricans who seek to mirror the West in the name of profits and business ventures. The government is also creating a Petri dish for business and foreign financial capital vis a vis public policy (low taxes) that is very much modeled on a neoliberal foundation.

As an extension of David Harvey's definition of neoliberalism, Aihwa Ong (2006) applies neoliberal doctrine to public policy and the State:

Neoliberalism interacts with regimes of ruling and regimes of citizenship to produce conditions that change administrative strategies and citizenship practices. It follows that the infiltration of market logic into politics conceptually unsettles the notion of citizenship as a legal status rooted in a nation-state, and in stark opposition to a condition of statelessness. Furthermore, the neoliberal exception articulates citizenship elements in political spaces that may be less than the national territory in some cases, or exceed national borders in others (6).

The practices that are engaged in the medical tourism industry are forms of neoliberalism: the industry promotes private hospitals, it uses public and private funds to invest in this private infrastructure, and it interacts with "regimes of citizenship." For example, the annual medical tourism congress hosted over 1,000 people, mostly from countries where, historically, their citizens were not welcomed in the United States (Latin America and Asia),

and with the backing of this new industry, the borders that were at one time so rigid for citizens of these countries are now disintegrating, but only when the visitors are capital-bearing. On the other end of the spectrum are those who may be (legally) restricted to “less than the national territory.” As we have seen in the contentious debate concerning Mexicans crossing the border illegally and the aforementioned law in Arizona, those in the lower classes and those who are not backed by a government, a business entity, a school, or cannot afford medical treatment overseas and get a medical visa are unwelcomed citizens confined to the spaces of their national borders and are not extended the “privilege” of deterritoriality that the global elite can obtain.

Western-based neoliberal medical ideologies have been transported to countries that have been historically socialist. Costa Rica has socialized healthcare for all citizens and even if someone is not a citizen a hospital/clinic cannot deny him/her care due to inability to pay. Costa Rica, according to José Itzigsohn (2000), is a paternalistic-protective State with strong social services compared to other Latin American countries. For example, Costa Rica has strict regulatory labor policies including minimum salaries *that are enforced*, and underemployment and unemployment are low compared to other Caribbean and Central American countries. Another way that Costa Rica ensures a higher standard of living for its populace is the mandatory registering of businesses with the Social Security Institute. Businesses must pay taxes for each worker and in return workers receive free health services, and pensions for disabilities because of work injuries and retirement. Due to Costa Rica’s strict regulatory oversight, workers have the option to complain to the Ministry of Labor about violations of labor regulations, which can cause employers to have

to pay back-taxes and heavy fines. This, in turn, ensures (though not completely) that employers will comply with labor laws in order to avoid being reported.

In terms of healthcare or “overall health system performance” (Evans et al. 2000), Costa Rica actually ranks higher than the United States according to the World Health Organization in which the former ranks 36 while the latter ranks 37. Despite being socialized and available to all Costa Ricans regardless of socio-economic status, there were many complaints leveled at the system by the Costa Ricans whom I stayed with and worked with during my fieldwork. For example, Costa Rican citizens have access to universal healthcare; however, these facilities are not adequate to fulfill the demand. In a bare minimum sense, every Costa Rican citizen can go to a hospital or clinic for free; however, there are not enough clinics considering the demand and those who live in rural areas must travel a great distance. If one is lucky enough to live close to a hospital or clinic, appointments are same day, in person and on a first come first serve basis, and you must stand in line at times starting at 4:30 am in order to be seen that day. Also, the hospital experience is not a quality one. My host mother has a heart condition and she has to wait a year for an appointment with a heart specialist. One night while I was asleep, she had to go to the hospital because she was having heart problems. Later, she told me that there were no available beds or rooms and she had to sit in the cramped waiting room next to moaning patients with IV drips. Also, she noted that some of the doctors were sleeping in hospital beds and that the staff was very rude. She told me that she had had enough with public Costa Rican hospitals and decided to purchase private insurance, which she said cost \$50 USD per month for a family.

I am for public hospitals, but I am not a supporter of a lack of resources for essential functioning and the fact that the already scarce public funds (public meaning everyone, not just the wealthy) are being siphoned to this private industry that only benefits expatriates and already privileged Costa Ricans, which is contradictory to the claims of the government that the profits from the medical tourism industry will return to the people. Neoliberalism promotes privatization and in turn medical tourism associations promote the use of public funds for private good (another neoliberal practice) because, they argue, medical tourists spend four times more money than regular tourists and that investing in the private medical infrastructure will create jobs and entrepreneurial opportunities. This practice of funneling public funds to the private sector is actually limiting the (medical) freedoms of Costa Ricans. Instead of using public funds to build new private hospitals for expatriates, medical tourists, and wealthy Costa Ricans located near expatriate neighborhoods and major cities, the State should use those funds to hire more specialists, general doctors and nurses, and build new and bigger facilities. More public facilities and a broader range of medical procedures does equate to more choice; however, more private hospitals and the defunding of public hospitals limit the choice of those without the financial capital to afford private insurance or pay out of pocket for care at a private hospital.

A final example of transnational market penetration and neoliberal doctrine in practice is the push to create a free trade zone (FTZ) in Costa Rica. One of the people who I worked with at the hospital told me during the medical tourism conference that he hoped that the Costa Rican government would create a FTZ for medical tourists and American doctors. In a free trade zone, doctors can work outside of the restrictions of American and Costa Rican laws, primarily to perform controversial procedures and to be free of paying

taxes. Other countries, including The Daegu-Gyeongbuk Free Economic Zone located “in” South Korea, already have medical tourism facilities and Jack, my supervisor at *Hopital Croix*, is hoping that Costa Rica will shortly follow suit. FTZ’s/FEZ’s are the epitome of neoliberalism, they have no government oversight and they are completely privatized.

FTZ’s/FEZ’s are the brainchildren of what Comaroff and Comaroff (2008) refer to as the “transnational capitalist elite” (182) and many involved in the medical tourism industry are part of this class. Every year since 2008, the Medical Tourism Association has held a Medical Tourism Annual Congress in Los Angeles, California and representatives from Asian and Latin American governments, businesses, and private hospitals are in attendance. For these transnational capitalist elites, obtaining a visa is as easy as printing a form from the Medical Tourism Association’s website and sending it along with pertinent documents to the United States Embassy. The transnational capitalist elite “...seek to disengage from parochial loyalties and jurisdictions, thus to minimize the effect of legal regulations, environmental constraints, taxation, and labor demands” (182).

Getting back to my earlier point that the medical tourism industry only benefits those who master the technologies of the West (for example, by “disengaging from parochial loyalties and jurisdictions”); if an FTZ is created in Costa Rica those who have not mastered these technologies will suffer because there will be no labor regulations, similar the *maquiladoras* of Mexico, and there will be no taxes collected. Thus, there will be no increase in public funds through the collection of taxes from the businesses located in the free trade zone and the claims made by the elite within the medical tourism industry and government that investment of public funds into this private industry will be beneficial to all is false.

There are already 3,000 FTZ's in 135 countries. The United Arab Emirates has 36 free-trade zones, most of which are located in Dubai (Shah 2010) and many of these FTZ's house hospitals. There are already plans for medical tourism FTZ's in South Korea and Taiwan. According to the *Medical Tourism Magazine* (2010), an official from the Taiwanese Department of Health stated, "...the *government* is planning a special zone for foreigners near Taiwan Taoyuan International Airport to tap into the growing health tourism market" (italics added) and the site near the airport was chosen for its easy access for tourists flying in from various locales. According to the *International Medical Travel Journal* (2010), the Organic Laws and Statutes Bureau, which is a legislative body that advises the Taiwanese government, suggested that only hospitals located in the medical tourism zone should be allowed to treat international patients.

North of Taiwan on a man-made island off of the coast of South Korea, New Jersey developer, Stanley Gale, envisions a corporate hub in a free economic zone named Songdo where foreigners can "...own lands, run schools and hospitals and where companies can get relief from Korean taxes and bureaucracy" (Brooke 2004). The site is planned to have a privately owned American managed hospital (opened in December of 2007), a 17% income tax on employees and foreign executives, no import fees on the import of capital goods, and financial capital grants for foreign high technology investments. Thus far, the city of Incheon and the Korean government have invested \$10 billion on "infrastructure projects" in Songdo including a seven-mile bridge linking Songdo to Incheon. The Joint Commission International, which is an American-based accrediting body has accredited one hospital (Inha Hospital) and one medical center in the free economic zone of Incheon, South Korea. Inha Hospital also has a clinical trial center, which espouses to follow the Korea Guidelines

for Good Clinical Practice and the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceutical for Human use by the Korean FDA. In this FEZ, corporate income tax, tariffs, and corporation taxes are exempt at 100% for the first three years and 50% for the following two years. Also, property taxes, registration, and acquisition are 100% exempt for the first ten years and 50% for the subsequent three years (Ministry of Finance and Economy 2003). The former groupings of taxes are national taxes while the latter are local taxes, and these exemptions are for foreign investment companies located in the FEZ. James Brooke (2004) cites that: "Government planners freely admit that one strategy behind Incheon and two other coastal economic zones is to set an example for what economic liberalism and reduction of red tape can do, creating support for the adoption of such measures on a national scale." In Kuala Lumpur, the China-Asean free trade area is the third largest free trade area in the world. Liz Gooch (2009) notes that 90% of goods traversing this zone will have no tariffs and that manufacturers in Southeast Asia are worried that, similar to what happened in Jamaica, cheaper foreign goods will put a lot of local manufacturers out of business.

Aside from the negative economic results of FTZ's, there are also negative health and criminal consequences. I try to steer clear of comparisons because each socio-cultural-national-political space has its own historicity, contingencies, and nuances that act to create the current state of affairs. However, I will draw comparisons that are common between multiple FTZ/FEZ's in order to problematize the creation of medical facilities that are left solely to the regulations of multinational corporations. In a *New York Times* article, Angela Shah (2010) links free trade zones and criminal activity. Quoting U.S. Treasury financial attaché, Stuart Jones, Shah notes that: "Organized crime and counterfeiters are

very resourceful and creative...[t]hey are also interested in free-trade zones to exploit the very ecosystem government created to contribute to economic development”, which includes weak regulations and the rapid movement of goods.

The negative cultural costs of FTZ's include criminal activity (money laundering, counterfeit goods, and organized crime) and the negative effect on workers whose rights are not regulated by a body minimally concerned with profits (i.e. the government, unions, and NGO's). Also, Williams and Homedes (2001) discuss the negative byproducts of *maquiladoras* on health and the environment. *Maquiladoras* are generally U.S. operations or subsidiaries located close to the U.S. border in Mexico and in 1998; U.S. corporations invested 67% of the \$5.98 billion dollars total direct foreign investments in the *maquiladora* industry. Due to relaxed environmental regulations and enforcement, the areas close to these factories are rife with water and air pollution as well as water shortages and waste management problems. Levels of lead, chromium, and cadmium well above the EPA standard were discovered in drainage ditches close to residential areas and although the *maquiladoras* have actively suppressed information on worker's exposure to hazardous materials and subsequent illnesses there have been noted injuries due to fire and smoke inhalations and workers' exposure to methylene chloride, xylene, ethylbenzene, toluene, and acetone. For example, prolonged exposure to methylene chloride can result in skin irritation and chemical burns. The U.S. Department of Health and Human Services (2000) released a paper linking methylene chloride to cancers of the lungs, liver and pancreas. Quoting a labor activist who used to work for a plant located in the border town of Rio Bravo, Mexico, David Bacon (2001) stated that: “In terms of safety [in the

*maquiladoras*], well, there just wasn't any" (338). Workers were given dust masks but they were ineffective in filtering out chemical toxins such as methylene chloride.

Clearly, FTZ's in the developing world benefit the global capitalist elite who benefits from cheap labor and not the average worker. Will this dichotomy between those who benefit and those who do not extend to the medical tourism industry in Costa Rica? Only time will tell, but in the above examples, the relaxed economic, environmental, and health regulations in FTZ's had negative consequences for the local populations.

The medical tourism industry, at this point and time, only benefits the privileged class and is providing a framework for entrance of non-Western people into the category of transnational capitalist elites. In order to be a part of this class, one must have English language proficiency and knowledge of Western customs, which is a clear example of 'cultural imperialism.' Quoting Herber Schiller, Julia Galeota (2004) notes that cultural imperialism is:

...the sum of the processes by which a society is brought into the modern world system, and how its dominating stratum is attracted, pressured, forced, and sometimes bribed into shaping social institutions to correspond to, or even to promote, the values and structures of the dominant center of the system (1).

In theory, the medical tourism industry promises new found riches and opportunities for all, but in practice only those with the 'technologies of the West' have benefitted from the industry; i.e. those who were "bribed" by the riches that the industry promised, absorbed Western hegemony, and upheld "...values and structures of the dominant center", which includes neoliberal ideology.

In the movie *Life and Debt* (2001), former Jamaican Prime Minister Michael Manley stated in reference to the creation of the International Monetary Fund (IMF) after WWII:

“You ask whose interest? I ask the question who set it up?” Manley is referring to whose interests are promoted in such global banking institutions and in order to discern whose interests are being promoted, one must look to who set up these banking institutions and their policies. The IMF and the World Bank have adopted neoliberal policies and as an extension of Manley’s declaration that global banking institutions only benefit those who set it up, I argue that the policies and ideologies of these institutions only benefit those who set up and are part of the institutions, which include the transnational capitalist elite. The policies and ideologies that I am referring to are those that promote neoliberal practices. *Life and Debt* also discusses the neoliberal policies set up by global banking institutions that have caused developing countries such as Jamaica to spiral into deeper and deeper debt. In order to obtain a loan from the IMF and the World Bank, countries must agree to the terms outlined by these banking institutions, which include currency devaluation, the weakening of trade barriers, and decreased spending on social services and these terms have decimated the local Jamaican economy. Jamaican farmers are going bankrupt because it is cheaper to purchase foreign produce, other foreign goods (which Jamaica relies heavily on) are more expensive, schools and public hospitals are underfunded, and FTZ’s were created to exploit the working poor by paying egregiously low wages to factory workers. This systemic practice of creating a new form of imperialism gives merit to Michael Manley’s claim that those who create the system are the ones who benefit from it. Thus far, Jamaica has sunk deeper and deeper into debt and are now slaves to the whims of the Western banking industry in which the latter continues to draw up terms for borrowing money that are impossible to meet. So the questions are: who set up the medical tourism industry in Costa Rica and who’s benefitting?

Costa Rica has a long history of contact with Euro-Americans. Missionaries (who arguably were imperialists) were very prominent in the early part of the 1900's and established schools and hospitals for both Native Costa Ricans and expatriates. Many of these schools and hospitals still exist and by virtue of them being started by Euro-Americans, these institutions have credibility with many Westerners who want to travel overseas for healthcare. At their genesis, these institutions were community based but now they are exclusive and private, and only wealthy Costa Ricans and Westerners can afford to patronize them. The now private and exclusive hospitals that are encompassed in the medical tourism industry stemmed from the attraction of Western financial capital; a new money making venture for native and foreign (including many with dual United States and Costa Rican citizenship) entrepreneurs and investors. The ideology adopted by those in this new industry happened to be neoliberalism. Those who set up the medical tourism industry and its accompanying neoliberal ideologies are the interests that are being served.

Neoliberalism is an extension of imperialism and exists to maintain already existing class distinctions. If neoliberalism was not the prevalent ideology amongst the transnational capitalist elites then another ideology would exist to maintain class stratification. As mentioned previously, many in the medical tourism industry selectively use neoliberal ideologies in order to benefit their interests, which are usually the interest of the transnational capitalist elite. Catherine Kingfisher and Jeff Maskovsky (2008) argue that anthropologists need to "...treat neoliberalism as a process rather than a *fait accompli*, and to emphasize that its rise to global prominence has been fraught with contradiction and partiality and subject to limitation" (115). The starkest contradiction of neoliberalism as it pertains to the medical tourism industry is the membership of the Ministry of Health

in Promed and the private industry's request for public funds to subsidize the cost of building new private hospitals and attending expensive conferences. I discerned that the presence of Ministry of Health officials at Promed meetings had little to do with public good and more to do with business interests. For example, the topic of the Promed regulations committee meeting that I attended revolved around bids by U.S. based accrediting bodies to receive a contract to train Costa Ricans to accredit their medical services. The committee concerns itself with meeting U.S. market demands and wants to mitigate regulations that are deemed unnecessary. In this case, the market demand is the need for inexpensive, but quality healthcare. In general, Promed does not want undue regulations and many members expressed to me that the government should not be a part of private healthcare. But as mentioned previously, the government is a part of the private industry through funding; and that, according to many Promed members, is acceptable.

Another limitation of using neoliberalism as a grand theory to describe industrial practices is the discrepancy between issues of citizenship. For example, in popular media and discourse the influx of Nicaraguan migrant workers is denigrated; however, neoliberal doctrine privileges the free flow of bodies to benefit the market. Many Nicaraguans work as construction workers and maids, and since there is a market in need of bodies to fill those roles then those transnational capitalist elites (many of whom employ Nicaraguan women as maids) who embrace the needs of the market, in theory, should not be opposed to Nicaraguan migrants who fulfill the needs of the market. However, many of those who adopt neoliberal ideologies that privilege market freedoms and seek to mitigate undo governmental regulation want to curb Nicaraguan migration into Costa Rica. Some of the pejorative phrases used by those who embrace neoliberalism to express distaste for

Nicaraguans in Costa Rica include: “they bog down the healthcare system” “they are costing Costa Rica a lot of money” “they commit crimes” and “Nicaraguan men beat their wives”, but at the same time their cheap labor is welcomed and unfortunately some of the same people who expressed prejudice against Nicaraguans employ them as maids. On the other hand, there are illegal Western immigrants, including a person who gave a presentation at *Hopital Croix* to Westerners interested in moving to Costa Rica. However, in popular discourse the number of illegal Canadian, European, and American immigrants was not addressed. The focus was clearly on Nicaraguan illegal immigrants. If the market privileges the free flow of bodies and currency, then those neoliberals should not have issues with the influx of Nicaraguan workers who fulfill the needs of the market; however, on many occasions in Costa Rica as well as at the medical tourism congress in Los Angeles, people expressed to me disdain for Nicaraguan and Mexican immigrants, respectively.

In conclusion, neoliberalism and liberalism are doctrines based on a certain understanding of freedom; however, there are many contradictions. Despite the U.S. and other countries adopting many neoliberal/liberal practices, the gap between rich and poor has widened in the last 40 years and practices that limit the free flow of bodies from developing and underdeveloped countries are increasing. Will the failures of neoliberal/liberal practices be transported to medical care? In his article for the *New York Times*, Joshua Kurlantzick (2007) notes that the downside of medical tourism (in Thailand) is that doctors and resources are being taken away from the public sector because the private sector is more lucrative, which may lead to a public backlash. As mentioned previously, Costa Rica is investing public funds into the medical tourism industry, which they argue will yield high returns to the population. If this will be the case has yet to be

determined. Thus far, the industry has created jobs and entrepreneurial opportunities, but the key question is who has access to and who benefits from these jobs? Generally, those in the industry must at least be bilingual (i.e. speak their native tongue and English or another “elite” European language), must have a certain amount of social capital to know how to start a business and know enough “important” people for networking purposes with in order to obtain a job. Thus, most of the people that I met at *Hopital Croix* and at the Medical Tourism Congress were middle and upper class. If public healthcare is getting worse due to doctors and government funds enjoying the *freedom* to move from the public sector to the private sector then neoliberalism has failed again by limiting the freedom to obtain healthcare by those without the socio-economic capital to have other choices.

#### **4. DASHED LINES: THE IMPENETRABILITY OF INTERNATIONAL BORDERS AND HEALTH TRAVEL**

I will begin this chapter by explaining the title. My theory of parallel citizenship purports that elites (based on nationality, financial capital, and education) have the freedom to travel globally and thus national boundaries are becoming, for them, weakened. For the global elite, the line representing their travel around the global is continuous, with minimal barriers. However, below (i.e. perceived as inferior) and running parallel to the top line is a dashed line, with each dash representing a space, in this case, a nation state; with no bridge to the other. This is a metaphor for rigid international boundaries in which non-elites and those without financial capital cannot cross. I will offer an analysis of the uneven permeability of international boundaries as it pertains to health travel or, as it is popularly known, medical tourism. The problem that I will discuss is how the categorization of a person as a medical tourist creates a parallel citizenship, which allows those in the medical tourism sector to reside in the top parallel line and have the ability to bypass visa laws regardless of nationality while those without capital or medical tourism citizenship remain in the subordinated dashed line. The medical tourism industry is an avenue for differential immigrant/visitor status (legal vs. illegal) that is based more so on the potential for high profits than access to healthcare. Also, the category of medical tourist is still based on economic capital and does not challenge the notion that bodies without this perceived capital are restricted to certain territories.

Americans, Canadians, and Western Europeans have what I call a “golden passport.” We are able to travel easily, and for the most part, do not need a visa in order to cross international borders legally. In contrast, citizens of developing countries such as

Colombia and Costa Rica must go through an intense and costly process in order to obtain a visa to visit developed countries. For example, in order to obtain a tourist visa to the United States, a Costa Rican citizen must go to the U.S. Embassy located in San Jose in person and submit to an interview. He/she must purchase a personal information number (PIN) from *Banco Nacional*, must have a valid Costa Rican passport, and pay a non-refundable interview fee of at least \$140. An interview appointment is not necessary if a Costa Rican is applying for a student, work, or official visa, which affirms my theory (discussed later) that capital bearing bodies that are backed by governments, businesses and/or academic institutions are given a higher status and can traverse the globe with minimal constraints; meaning that they are part of the continuous parallel line. During the interview,

...each applicant must demonstrate that he or she has a permanent residence outside of the U.S. that he or she does not intend to abandon. The burden of proof is on the applicant to show that he or she qualifies for the visa. Proof may come in many forms, but when considered together, it must be strong enough for the interviewing officer to conclude that the applicant's ties to Costa Rica (or other country of residence) will compel him or her to return at the end of a temporary stay in the United States" (U.S. Embassy of Costa Rica website).

The burden of proof usually comes in the form of bank statements and business/home/property ownership, thus the privilege of visiting the United States is usually extended to financial capital bearing bodies. In contrast, Americans, Canadians, and Western Europeans do not have to go through such a strenuous process in order to travel internationally.

Despite historic and racist exclusionary policies in the United States, American policy makers have created a way to circumvent tourist visa restrictions and ease entry

into the U.S. for people obtaining medical care. In an article in the online *Medical Tourism Magazine*, Elizabeth Ziemba (2009) outlines the procedures for obtaining a medical or B-2 visa. In order to obtain a medical visa, one must prove that: (1) “The purpose of the trip is to obtain medical treatment” (2) “The stay in the United States will be of a limited and defined period” (3) “The [a]pplicant has *sufficient funds* to cover all expenses including the cost of medical care while in the U.S.” (italics added by author) (4) “Evidence of *financial and social ties to home country*” (italics added by author) (5) “Evidence of a residence outside the U.S. to which the applicant will return once the purpose of the trip is concluded.” The fact that finances are mentioned in two of the five guidelines and that home ownership is mentioned once means that economic capital carries a lot of weight in terms of receiving the privilege to obtain medical care in the U.S. Ziemba also notes that the U.S. government is concerned with people obtaining medical care for free, so documentation of finances is a must. Obtaining a medical visa or a tourist visa are similar processes except that the former requires letters from doctors and/or the hospital. In both cases, finances play a key role in determining who has the privilege of entering the United States legally.

A visa is a certification that a person can legally enter a country. It is controlled by the government with authority given to governmental agents with their own personal biases. For example, Muslim women in France have the ability to evoke sympathy from some civil servants who, as a result, grant them illness visas. However, Muslim males are less likely to receive sympathy and illness visas because Algerian men are stereotyped as deceitful, sexist, and violent (Ticktin 2006). Thus, the deterritoriality of international borders is not a right, but a privilege given to a select few with, depending on the context,

certain forms of social capital. In the case of medical visas, the ability to obtain medical treatment equates to financial capital. This is the key difference between France and the United States. Although in popular discourse both countries have adopted neoliberal policies that privilege free markets, the U.S. is more extreme in that the very thought of socialism of any kind evokes a negative response in “popular” media. The privilege of healthcare in the U.S. as well as the privilege to enter the U.S. as a tourist is given to those foreigners with financial capital, which is discernable in the guidelines for obtaining a visa.

Such exclusionary practices have been in place for a long time. Xenophobia in the United States is currently more clouded and euphemized, and racist discourse is usually shrouded in terms of crime, economics, and a “drain on society.” But 100 years ago, racial discrimination was more overt. For example, in 1882, U.S. President Chester Arthur signed the *Chinese Exclusion Act*, which suspended the immigration of Chinese citizens. Canada enacted a similar law in 1923. Immigration and citizenship rights are an extension of prejudices that privileges certain racialized bodies over another. Susanne Wessendorf (2008) discusses the Swiss citizenship debate vis a vis “culturalist discourses” that focus on assimilation and certain migrants perceived contribution to Swiss Society. The discourse has remained the same, but the group that the discourse is focused on has changed over time. Wessendorf notes that the Swiss majority currently denigrates Middle Eastern and immigrants from the former Yugoslavia while privileging Italian immigrants; however, until the 1970’s, Italian immigrants were highly discriminated against. Italians were seen as threatening to the culture and moral fabric of Switzerland. Currently, Italians in Switzerland are seen as model minorities and this change in the perception of Italians occurred during a time of *economic* growth. As mentioned previously, a little over 100

years ago Asians were unwelcomed immigrants into the United States and Canada, and now they are seen as beneficial to our society through their essentialized role as scientists and mathematicians. Both science and math are highly valorized and funded disciplines, and the ascension of certain groups through this educational and professional venue creates an economic justification of moving certain groups from unwanted and denigrated immigrants to valued or model immigrants. The juxtaposition of model minorities and economics is making it easier for immigrants who have been historically discriminated against through the mediums of medical tourism and business/educational/governmental-backed sponsorship (which are tied into economics) to have access to countries that make it difficult for racialized minorities to enter.

Economics cannot solely explain why certain immigrant groups are privileged over another. Sarah Horton (2004) goes in depth in explaining the American healthcare system's "...differential construction of Mexican and Cuban immigrants" (472). Issues of deservingness, individual responsibility, self-discipline, and citizenship status creates a culturalist discourse that discourages Mexicans from making demands on American social institutions, including hospitals and clinics. Through the Cuban Refugee Program, Cubans upon setting foot on American soil are granted legal citizenship status, provided English classes, and welfare benefits, while Mexicans must go through a strenuous, expensive, and long bureaucratic process in order to obtain legal status in the U.S. Legal status creates unalienable rights including access to social services and a sense of deservingness. Rarely does mainstream society touch below the surface of this discriminatory and systemic exclusionary practice, but blame the victims instead. As a result, the differential privileging of Cubans over Mexicans in terms of access to citizenship and public rhetoric creates a

double standard. Quoting Silvia Pedraza-Bailey, Horton notes that the Cuban Refugee Program:

...shows that [it] has assisted Cuban refugees in translating the initial class advantage into a “cumulative advantage” in their integration into the United States, although Mexican immigrants are allowed no such helping hand. [Bailey]...points out that the states’ policies have, in turn, led to each group’s divergent status within the popular imagination; Cuban refugees are viewed as deserving immigrants and Mexican immigrants are portrayed as a “silent invasion” (474).

The institutionalization of differential treatment of Cubans and Mexicans permeates into public discourse that turns a blind eye to Cubans who “bog down” the system, which is similar to the popular discourse in Costa Rica that focuses on illegal Nicaraguans while ignoring the fact that there are a substantial number of illegal Canadians and Americans.

In an article in the English language Costa Rican newspaper, *The Tico Times*, delegates representing Costa Rica in the International Court of Justice in the Hague were “surprised” that the delegate from Nicaragua gave such a “brilliant” presentation. Later, in the article it is noted that “[Costa Ricans] have the concept that...in Nicaragua everyone is stupid” (Rogers 2011). During my time in Costa Rica, I heard a lot pejorative comments about Nicaraguans. Over and over, Nicaraguans were blamed for causing long queues at public hospitals and for costing the country money because public health facilities have to treat a person no matter what, and if they do not pay, the country has no recourse if the person owns no property in the country and/or is not working in the formal sector.

The border between Costa Rica and Nicaragua is fairly permeable (the two countries are separated by the San Juan River) and Nicaraguans frequently come to Costa Rica to work. Women generally work as domestics while the men generally work in construction. Some Nicaraguans are in Costa Rica legally but most are not and it is hard for them to

become legal. They face a lot of hoops, discrimination, and harassment. On the contrary, citizens from developed nations have a much easier time going to Costa Rica and obtaining legal immigration status. For example, I did not need a visa to enter the country, all I needed was a passport and I was allowed to stay for up to 90 days. If I wanted to stay longer than that, I would have to leave the country for 48 hours and then return, and my 90 days would be renewed. The process of becoming a permanent resident, as a citizen of a developed nation, is comparatively easy.

While I was working at *Hopital Croix*, I was told that once a month the hospital hosts informational seminars for people (primarily Canadian and American retirees) who want to live (legally) in Costa Rica. They also give tours of the hospital to the participants of the seminar because they *are* potential customers. The seminar covered a variety of topics pertaining to foreigners living in Costa Rica. How to obtain a phone, shipping cars from U.S., health insurance, how to fill out and what is needed for the immigration/residency paperwork, how to sign up for expatriate residence associations, banking, how to learn Spanish (the person who gave this presentation mentioned how it is important to know Spanish so that you can communicate with your native girlfriend and that Costa Rican women don't care about age), how to do your (American) taxes, and the Costa Rican "culture" were covered by various Costa Rican, American, and Canadian presenters. Based on my experience at the seminar (transportation, lunch, and beverages were provided), I deduce that Americans and Canadians are wanted immigrants while Nicaraguans are unwanted immigrants. The ease with which Americans and Canadians can obtain legal residency is in sharp contrast to Nicaraguans. I would also like to note that there are many Americans and Canadians who are in Costa Rica illegally (one of the American presenters

admitted that he was in the country illegally and no one, including the Costa Ricans, seemed to care) and at this point in my research, I am not sure if they bog down the health care system or any other social services, but based on what I've heard in the media and in public discourse, little, if any, attention is paid to illegal American and Canadian "aliens."

I argue that Americans and Canadians are wanted visitors due to racial, ethnic and economic privilege. North Americans<sup>3</sup> are essentialized as White and wealthy, and economic terms such as market value are generally used to describe medical tourists from North America. Similar to many Latin American countries, Whiteness is a source of privilege and some Costa Ricans embrace the fact that Costa Rica is a whiter country than other Central American nation-states. Historically, Indigenous and Black populations were relegated to certain territories and faced immense amounts of discrimination in Costa Rica. There were many Afro-Caribbeans (primarily from Jamaica) who migrated to the Atlantic Coast of Costa Rica in order to work for British-owned plantations. When the plantation industry ended, Afro-Caribbean migrants were relegated to Atlantic Coast territories such as Limon, which to this day has large numbers of the descendants of Jamaican worker-immigrants. Currently, through the commodification of culture, Limon is advertised as a tourist destination because of its distinction of being unique and straddling two cultures: Afro-Caribbean and Costa Rican. Similar to Black culture in the United States, Blackness is embraced but only at a distance and as a tourist commodity to be purchased.

All of the employees in the international department of *Hopital Croix* were phenotypically White and fluent in English. Three were dual U.S. and Costa Rican citizens

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<sup>3</sup> By North Americans I am referring to citizens of the United States and Canada.

and many had lived in the United States at some point. All of the medical tourists were White, middle-aged, and upper-middle class except for one African-American woman who, at the time of her visit to Costa Rica, was 28 years old. So the image at this particular hospital of medical tourists is that of White and economically privileged individuals, which similar to the image of Cubans being deserving of healthcare in the U.S., privileges certain bodies as deserving and welcomed visitors.

This stereotypical image is projected in medical tourism literature because it is believed that North Americans want to feel a sense of camaraderie and similarity to those who are providing services to them, thus the images projected on medical tourism websites and brochures are an extension of already existing racial and gender stereotypes of the West. Usually the image is that of a fair-skinned “other” treating a White middle-aged patient. If the “other” is a doctor or surgeon, the image is usually of a youthful-looking, but mature-aged male, while assistants and nurses are usually depicted as young, attractive, fair-skinned and exotic women. Below (figure 1) are a few examples of images from medical tourism and international hospital websites:



These images interact with each other in a subliminal dialectical relationship between those who generate the images and those who view the images, which adheres to and perpetuates the view of who is a medical tourism provider, who is a recipient of services and who is worthy, deserving and qualified to be in the medical tourism industry, i.e. who has medical tourism citizenship. Also the rhetoric within the medical tourism industry is very sympathetic towards North Americans, which is the market that those in the business are clamoring to tap into. Americans and Canadians are seen as deserving of inexpensive healthcare overseas because of the exorbitant cost of healthcare/health insurance and long queues, respectively. However, Nicaraguans in Costa Rica are constantly denigrated for bogging down the system.

The fact that North Americans who visit Costa Rica have the ability to pay for private healthcare, while many Nicaraguans must use the public healthcare system (which is free to Costa Rican citizens who pay a relatively small tax) creates a dichotomy between those perceived as bringing in wealth to the nation (if wealth is measured solely in monetary terms) and those who are bogging down the system. Even if a person has the inability to pay, the law states that he or she must be medically treated. This inability to pay for many Nicaraguans who are generally maids and unskilled laborers creates tension because many Costa Ricans possess the view that they are siphoning resources away from deserving citizens. Long queues and financial strain on the public health sector are commonly blamed on Nicaraguans. Popular discourse in Costa Rica cites that Nicaraguans do not pay taxes because they are illegally in the country and have “under the table” jobs, thus they are not contributing economically to Costa Rica and are draining social services from “deserving” tax paying Costa Rican citizens. The focus is on economic contribution, but

with economic contribution emerges a culturalist discourse that paints Nicaraguans negatively and North Americans positively. In the broader spectrum of the medical tourism industry, the deservingness of certain groups extends to public policy and not only are certain groups deserving of medical treatment, but certain groups are deserving of being part of a nation state, not necessarily as citizens but as a tourists or even as permanent residents. These images and notions of deservingness become juxtaposed to issues of citizenship and ease of international travel.

Moving away from Costa Rica, there have been recent newspaper articles about various countries modifying visa laws in order to make it easier for “deserving” medical tourists to enter the country as well as hiring airport staff to help medical tourists once they arrive. For example, a World Health Organization bulletin noted that India has introduced an “M” or medical visa. These visas are valid for one year and are also issued to companions. According to the article, despite the availability of medical visas, medical tourists from developed countries still choose to use regular visas because they don’t have to register with regional authorities within two weeks of arrival (Chinai 2007). Clearly, it is easy for citizens of wealthy countries to obtain a regular visa but for those from poor “undeserving” countries, a medical visa may be an easier route<sup>4</sup>. A recent *New York Times* article discusses the introduction of medical visas in South Korea, which allows patients and their families to obtain long-term visas for medical treatment (Sang-Hun 2008). Other countries that have medical visas are the United States and South Africa.

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<sup>4</sup> More research is needed.

Another example of the penetrability of national boundaries by “deserving” individuals is the ease with which one can obtain a visa if one is sponsored by a government, business, and/or is attending a conference, which aligns with my earlier argument that economics as well as Whiteness plays a role in deservingness. For instance, on the website for the 2009 Medical Tourism Congress there is a link where a person can print a form to send to the U.S. Embassy in order to obtain a visa to attend the conference. When I asked my co-workers from Costa Rica at the conference if obtaining their visa was easy they replied that their boss did all of the paperwork for them and that it appeared to be a smooth process.

It is clear that medical tourists and those tied to businesses are being welcomed with open arms and that the circumferential line of travel around the globe is continuous and permeable to those with the resources to get medical procedures or are citizens of a country in which global travel is made easy. However, for working-class Nicaraguans and others without the economic means to be medical tourists, the circumferential line is dashed with no bridge to connect them.

Aihwa Ong has written extensively about the permeability and impermeability of citizenship. She states that citizenship is no longer “...rooted in a nation-state” and is contradictory because political spaces can both extend past national borders and be restrictive to less than the national territory (2006: 6). As discussed in chapter 3, neoliberal ideologies that are adopted in the medical tourism industry also extend to issues of citizenship. Neoliberal ideals that place value and deservingness on hardworking individuals who are entrepreneurs and essentially part of the business elite extend to who is deserving of citizenship. This deservingness is discernable in the fact that nation-states,

private hospitals, and those in the medical tourism industry actively ease travel restrictions to medical tourists who are usually Americans or Canadians in Costa Rica and Western Europeans and Japanese and Chinese business elites in South Korea, Bangkok, Singapore and India.

Aihwa Ong (1996) decouples the binary theory of cultural citizenship that purports that racial minorities in the U.S. are regarded as inferior. She:

...argues that hierarchical schemes of racial and cultural difference intersect in a complex, contingent way to locate minorities of color from different class backgrounds. Comparing the experience of rich and poor Asian immigrants to the United States, I discuss institutional practices whereby nonwhite immigrants in the First World are simultaneously, though unevenly, subject to two processes of normalization: an ideological whitening or blackening that reflects dominant racial oppositions and an assessment of cultural competence based on imputed human capital and consumer power in the minority subject (737).

In other countries and within the medical tourism industry, cultural citizenship and a general welcoming are extended to Westerners. As an *African-American* woman, I was treated with the upmost respect and everyone was very hospitable towards me. During my fieldwork in Colombia, a friend warned me that people in Medellin are “very racist.” He stated that I would experience this racism, but when I visited the homes of many White-Colombians, some of who would not hire a Black maid, they were very hospitable. Also, during my time at a private hospital in Colombia, a man stated that the Colombians that I worked with were nice to me because they think that I am rich and have a “blond wife”; he also attested to the racism in Colombia. I was confused about what my friend had said juxtaposed to how I was treated and he replied, “You are American.” He noted that if I were Afro-Colombia, I would have been treated very differently. By virtue of being American, I

was essentially Whiteness. As mentioned earlier, economics is a factor of deservingness and Americans are stereotyped as having a lot of money and consumer power, which are valorized in this growing neoliberal world. Those in the medical tourism industry who are not from the West, value consumer power regardless of race. Those who can afford medical treatment are essentially Whiteness. The Whiteness of Western medical tourists is an extension of the stereotype that Westerners have consumer power. Even though there is a gap between the status of Americans of color and White-Americans within the boundaries of the West, the gap is not as wide when Westerners of color are transposed into the developing world.

Andrew Kipnis (2004) argues that citizenship must be theorized on “...an independent axis [from] social inequality” (257). Kipnis believes that anthropologists tend to use Marxian understandings of inequality juxtaposed to class, race, and gender while not analyzing inequality vis a vis citizenship. As mentioned earlier, my status as an American whiteness me in certain contexts, mostly in developing countries. Despite being of African ancestry, my status as an American citizen superseded my status as a woman of African descent. I argue that citizenship does play a role in certain contexts; however, race, class and gender also play a role. Being an American citizen clearly Whiteness me; however, there are still negative stereotypes about African-Americans that have permeated throughout the world through popular media. For example, an acquaintance of mine from India told me that her father warned her to not associate with African-Americans because “they kill people” and a Caucasian friend of mine who travelled to Africa was repeatedly asked by Black Africans if she was scared because American media portrays Blacks as being violent. I argue that because I was the only American studying medical tourism, I was contextually

allotted a higher status; however, in a different context, I might not have been given such a superior status. For example, if I were in a developing country with a room full of Americans and “natives” would I still have the same status or would the hierarchies within the U.S. emerge? If I were in a room full of American White males, would I have the same status as if I were the only American in the room? I argue that I would not have the same status; status is contextual and does not circumvent dominant racial and gender discourses. Similar to Aihwa Ong’s argument (1996) that: “Global citizenship thus confers citizenship privileges in Western democracies to a degree that may help the immigrant to scale racial and cultural heights but not to circumvent status hierarchy based on racial difference” (737); over time, the racial difference may change, but as of now certain groups are still viewed as inferior.

I argue that even though racism exists within the medical tourism industry, there is an “ideological whitening” of those in the industry because traits are valorized that are stereotypically associated with White Westerners, such as wealth and entrepreneurial prowess. For example, South Korea was a platinum sponsor at the 2009 Medical Tourism Congress in Los Angeles, which carries a price tag of \$75,000 and \$75,000 bought these “others” VIP status. Representatives from South Korea were invited to VIP parties, given a front row dinner table with the president and CEO of the Medical Tourism Association, and a special performance by South Korean dancers at one of the major dinner parties. As discussed earlier, Asians have historically been excluded from Western cultural and national citizenship, but now Asians, primarily Chinese, South Koreans, and the Japanese have been Whitened through the image of them as being industrious, businessmen, and

intelligent, similar to the dominant image of Europeans and Euro-Americans. Through economics and education Asians were able to purchase Whiteness.

In the case of the medical tourism industry, there were not many African descent people attending the conference, many attendees were Asian, Euro-American, or fair-skinned Latin Americans; however, I observed for the sake of business ventures and marketing, people set aside nationalistic and racial alliances. One of the VIP's was an African-American man and as an African-American woman I did not feel that people were shunning me. As a graduate student, my consumer power and economic potential is really low; however, I was able to "purchase" Whiteness by virtue of being a PhD student, which is understood to equate to future consumer power. At the Medical Tourism Congress and during my research at *Hopital Croix*, I never encountered a person who was rude or dismissive of me. Through my status of being an American and a PhD student, not only was I able to purchase Whiteness, I am also able to purchase different forms of citizenship. I was a citizen of the Medical Tourism Congress, a citizen of *Hopital Croix*, and a temporary citizen of Costa Rica. My citizenship came very easily.

Westerners and those with the backing of an institution of higher learning or business have the ability to traverse the globe fairly easily; however, those with little economic or consumer power are not afforded the same privilege. This prejudice is discernable within popular discourse in Costa Rica and the U.S. that denigrates Nicaraguans and Mexicans, respectively because they are seen as a drain on resources. Thus, personal value is measured in terms of economics and education.

Westerners with perceived consumer and economic power regardless of race have the privilege of what Aihwa Ong refers to as 'latitudinal citizenship', which is "both the

spatialities of market rights and deterritorialized ethnic power to constitute labor relations across national borders” (2006: 122). This is reminiscent of John Gledhill’s (2005) discussion of the cosmopolitan elite and 3<sup>rd</sup> way theorists who are adverse to claims of nationalistic solidarity. Ong’s latitudinal citizenship refers to the penetration of the free market across national borders while Gledhill’s argument refers to (elite) individuals traversing the globe without restrictions and indulging in commodified forms “otherness.” The current President of Costa Rica, Laura Chinchilla, is actively tweaking immigration laws in order to promote foreign investments and economic opportunities. According to President Chinchilla, the new immigration law: “is a flexible instrument that will allow us to shape a proactive immigration policy based on selective criteria” (Long 2011).

It is clear that this “selective criteria” creates parallel lines, one continuous and the other dashed, that restricts the flow of certain bodies based on issues of deservingness that are grounded in consumer power and economics. Foreign investment, economic opportunities, and national security are addressed in the new immigration law as well as a new requirement that foreigners who want to become residents must pay into the social security system because it is believed that immigrants are bankrupting the system. Based on my observations in Costa Rica, the immigration law uses euphemistic language that welcomes a certain kind of visitor with financial capital. The only groups, based on what I observed, who were blamed for bogging down the system are Nicaraguans and many Nicaraguans are underpaid, so the question is: is it financially feasible for them to pay into the social security system? Also, if economics and security are the issues addressed in the immigration law then which groups fit into those two categories? Based on my fieldwork in Costa Rica, Westerners are welcomed visitors and are viewed as a source of financial

capital, while Nicaraguans, especially males, are placed in the category of criminals and wife-beaters. So once we deconstruct the law, it becomes apparent that the new immigration law essentially creates a path to citizenship and legal residency for those bringing in financial capital while under the guise of “national security”, the law creates barriers for certain groups, primarily Nicaraguans, that play into already existing stereotypes. Simply, Westerners and groups viewed as having financial capital are welcomed.

The medical tourism industry encompasses both the unrestricted flow of the market and (certain) people penetrating national borders. The penetrability of national borders vis a vis persons can be discerned from the fact that medical tourism agencies are rallying successfully for the modification of visa requirements. From the market side of it, foreign hospitals are creating ties with sister hospitals in the U.S. and clinical trials from American-based companies are being outsourced overseas. For example, *Hopital Croix* has affiliations with two major U.S. hospitals. In order to lay claim to legitimacy almost all hospitals that market to international patients boast affiliations with top American hospitals (see chapter 5). For example, *Hospital Punta Pacifica* located in Panama boasts an affiliation with Johns Hopkins Medical Center, and St. Lukes Medical Center has a hospital in the Philippines.

Another example of transnational market penetration is the push to create an FTZ in Costa Rica, which I discuss in chapter 3. One of my coworkers at *Hopital Croix* told me during the Medical Tourism Congress that he hoped that the Costa Rican government would create a FTZ for medical tourists and American doctors. Within a FTZ, doctors work outside of the restrictions of American and Costa Rican laws, primarily to perform controversial procedures and to be free of paying taxes.

John Gledhill (2005) discusses the rise of the cosmopolitan elite (who generally promote FTZ's) and the disintegration of nationalistic solidarity. In juxtapositioning his argument to the medical tourism industry, I agree that international alliances are formed, which are free from a strong nationalist solidarity. This medical tourism solidarity is based on economics and consumer power. Anyone, regardless of where he or she is from and what his or her background is was treated with the upmost respect and care by the staff of *Hopital Croix* during my time at the hospital. All of the patients who came while I was there were from the United States and the majority of the patients were men receiving orthopedic surgery while most of the women were undergoing cosmetic surgery. Also, at the Medical Tourism Congress, many countries were represented, primarily Latin America, Asia, and the United States. At this conference there were many business alliances made and I observed many handshakes that crossed national, religious, and ethnic lines. However, I will argue that despite the emergence of the cosmopolitan elite, legitimacy is obtained through quasi-nationalistic ties to the United States and Europe.

In certain contexts, Gledhill's (2005) argument is on the mark. There is an emergence of a global elite, which transcends national borders and denigrates nationalistic ties as a threat to progress and capitalism; however, within the realm of the medical tourism industry, national solidarity to American bodies (hospitals, universities, accrediting bodies, etc.) is perceived as the key to a successful marketing venture. The rationale behind this is that Western patients believe that the apex of medical care is in Western countries and thus are more likely to go to a hospital that aligns itself with Western-based infrastructure, training, rules, and regulations. This form of legitimization breaks down the idea of the cosmopolitan elite who denigrates national ties, because there

are medical and economic nationalistic ties to legitimacy vis a vis Western countries and Western medical and economic doctrine.

These nationalistic ties are being broken down via passports and citizenship. Three of my co-workers and one of the members of the Promed Rules and Regulations Committee have dual citizenship (U.S. and Costa Rica). At the Rules and Regulations Committee meeting that I attended, I did not get a sense of any nationalism in terms of discussion about what would benefit the country *as a whole*. It was all about business, probably due to the nature of the committee; however, by virtue of wanting an American accrediting body to train Costa Ricans is a subject making process that disintegrates the very core of nationalism (see chapter 5). It is accepting the American model of accrediting and acknowledging that Costa Ricans are not adequate enough to accredit their own facilities without American instruction. On the other hand, if the accrediting body wanted to promote nationalism in the U.S. vis medical interests then they would not want to promote an industry that is taking patients and revenue away from American hospitals. It is similar to sharing American secrets that would siphon expertise and economic opportunities away from American businesses.

At this time period, there is tension between those who want to preserve nationalism and those who feel that nationalism is a barrier to individual freedoms and personal growth. In terms of my fieldwork in Costa Rica and within the medical tourism industry, nationalism crosses international borders; creating a global citizenship for those who can afford medical treatment overseas. However, citizenship via medical treatment does not always apply to elites of the developing world and Westerners. Miriam Ticktin (2006) writes about the drive to “...turn to illness for papers...in the wake of the limited

success of the social movements by and for undocumented immigrants in France to secure basic human rights” (33). In France, there is an “illness clause” that allows people regardless of citizenship status the right to stay in France in a luminal citizenship category if they have a serious illness. As a result, “...people end up trading in biological integrity for political recognition” (33). Generally the people who take advantage of this clause are from impoverished regions of the African continent. The illness clause is used to mitigate the abuses (poverty, exclusion, and exploitation) that being an undocumented visitors entails.

Historically, the migratory aspects of humanity have created a gray area in terms of citizenship. Currently, the realm of medicine is creating a politically recognized form of citizenship, visitation privileges, and legal residency status vis a vis visa laws and illness clauses that redefines what it means to be a legal resident of a nation state. No longer is citizenship based on birthright, but citizenship can be purchased via money, Whiteness, and/or health status. The ability to obtain healthcare overseas, being sick in France, and being part of a Whitened demographic can “purchase” legal residency status. As mentioned previously, the focus in Costa Rica is not on illegal Western immigrants, it is on illegal Nicaraguans who have been Blackened because of their limited consumer and economic power.

Simultaneously straddling multiple nation states and cultural identities is not a new phenomenon. Recognition as a member of a particular nation state is mired in bureaucratic policies that mask already existing prejudices. For example, African-Americans were not considered citizens of the U.S. or even full humans until 1865 when the 14<sup>th</sup> amendment was passed. Currently, there are people who want to repeal the law granting citizenship to those born in the U.S. and the anti-Mexican sentiment is very

apparent in this discourse. According to the State Department, none of the top 10 countries with the longest wait list for citizenship are from Europe. Mexico, the Dominican Republic, and the Philippines are the top three. Also, there are caps in terms of obtaining an immigrant visa based on how the person is sponsored (sponsorship by a U.S. citizen speeds up the process more so than sponsorship by a person with a green card) and country of origin. Section 201 of the *Immigration and Nationality Act* (INA) puts a 7% cap on the total number of family sponsored and employment-based green cards. The economic situation and social safety nets of many European countries are mitigating factors to the number of citizenship applicants from Western Europe, but masked in these U.S. laws, similar to the law that banned the immigration of Asians, is racial prejudice. The fact that persons holding a European Union passport do not need a visa to enter the U.S. speaks volumes to the hierarchy based on country of origin and level of Whiteness. Americans and EU citizens can travel to most foreign countries without a visa, because Americans and Western Europeans are seen as having a lot of consumer power and are not seen as a drain of the system. Economic capital in terms of citizenship and visa requirements is given the upmost importance.

The issue of (economic) preference vis the privilege of legally entering a particular nation state is reflected in dual citizenship. Dual citizenship tends to be granted to those with financial capital. According to Aihwa Ong (1999): "The multiple passport holder is an apt contemporary figure; he or she embodies the split between state-imposed identity and personal identity caused by political upheaval, migration, and changing global markets. In this world of high modernity, as one scholar notes, national and ethnic identities "become distinctly different entities, while at the same, international frontiers become increasingly

insignificant as such” (2). The key words to note in this passage are “changing global markets”, i.e. economics. In terms of the U.S., political upheaval is a lower priority than economics. For example, Cubans are granted automatic green cards if they touch American soil; however, Haitians immigrants are not granted this privilege even though the political situation and living conditions of Haiti are very tumultuous. There are many protests by Haitian Americans, especially in Miami that challenge the privileging of Cubans over Haitians. Haitians who are discovered to be in the U.S. illegally are sent back to Haiti while Cubans are given green cards and the benefits of being in the U.S. legally. Cubans in the U.S. tend to be fairer-skinned, while Haitians are clearly Black. The anti-Castro tendencies of U.S. politicians tend to fuel such discrepancy but I argue that issues of Whiteness also play a role. Ex-Haitian President, Jean-Bertrand Aristide, was rumored to have been exiled by the U.S. government. So if the U.S. deemed Aristide as unfit to rule and a dictator (similar to Castro) then why aren't Haitians granted the same political asylum privileges as Cubans? If the Cubans who migrated to the United States had been dark-skinned would we have the same immigration laws for them? I argue no. I argue that Aihwa Ong's theory of the Whitening and Blackening of certain groups play a role in obtaining legal immigrant status. The U.S. has a history of discrimination based on immigration and citizenship laws that privileges groups that are seen as White. As mentioned earlier Whiteness can be obtained through economic capital as well as skin color, in which the latter is also tied to perceptions of economic capital.

It is much easier for a fair-skinned person to “pass” than someone with dark skin. Many African-Americans adopted the names of their White masters but are still seen as “others.” However, groups who are fair-skinned can change their name to the name that is

common in the dominant culture and can essentially pass. A White childhood friend of mine who I thought was German based on his last name admitted to me that he is Jewish and his grandfather dropped the “-berg” from their last name because of the anti-Jewish sentiment in his community.

As mentioned previously, Hospitals outside of the United States market themselves by boasting affiliations with American hospitals, which is their means of obtaining Whiteness. Also, they boast English/French/German speaking staff, doctors who are members of medical associations in the United States and/or Europe, facilities “on par” with Western countries, and most of all they boast accreditation by an American body, primarily the Joint Commission International.

In conclusion, the medical tourism industry creates a new way for people to become cosmopolitan, deserving, and Whitened global elites. Those in the medical tourism sector (entrepreneurs, doctors, government representatives, nurses, hospital administrators, etc.) can now travel to countries that have historically and legally excluded them. They are now backed by a new industry that legitimizes them as global elites; as essentially Whitened. Also, this new industry is not only breaking national barriers for people within the industry, it is also breaking down barriers for those with the means to obtain healthcare in a foreign country. Modifying visa laws and allowing visas for conferences are ways in which politics, nationhood, and business are merging. On the other hand, national borders are becoming more rigid for the poor and those not tied to business, governments or conferences. As the divide between rich and poor increases, i.e. the distance between the parallel lines, so will the divide between those who can travel globally and those who cannot.

## **5. MEDICAL TOURISM AND ACCREDITATION: THE SUBJECT MAKING OF INTERNATIONAL HOSPITALS**

Accreditation is the act of an accrediting body legitimizing a business, hospital/medical center or school through an intense, expensive, and lengthy process. To be accredited means that a separate body with vested authority has determined the credibility, competency, and authority of a particular entity. The accredittee must abide by official standards set by the accrediting body in order to obtain accreditation. In the case of the medical tourism industry, international hospitals are clamoring for accreditation from agencies based in the U.S. and Europe. Many in the medical tourism industry believe that such accreditation will increase the number of foreign, primarily Western, patients. I argue that accreditation is a form of subjectification, because Costa Rican hospitals (and international hospitals that cater to foreign patients) want to legitimize themselves through an American and/or European body even though, according to the World Health Organization (Evans et al 2000), the Costa Rican healthcare system ranks higher than the U.S. Thus, accreditation is a subject making process that forces hospitals to abide by the standards set by the accrediting body, i.e. the West.

Many countries have long ago adopted the Western biomedical model, but in terms of the medical tourism industry, adopting Western medicine is not enough, the biomedical entity must be recognized and legitimized by the West. The problems that I will discuss in this chapter are the subjectification of international hospitals to Western entities and how subjectification legitimizes, via accreditation by a Western body, international hospitals. Accreditation makes international hospitals qualified to provide medical services in the eyes of Western medical tourists and the medical tourism industry as a whole, which

underscores the quality and superiority of many healthcare systems in the developing world.

There are two major Western accrediting bodies: the Joint Commission International (JCI) and the International Organization for Standardizing (ISO). The former is based in the U.S. while the latter is based in Europe. There are also other accrediting bodies, including the Accreditation Association for Ambulatory Health Care (AAAHC), which is based in the U.S. The difference between the JCI and the AAAHC is that the latter accredits medical facilities with no overnight capabilities while the former accredits hospitals with overnight care. Also, both companies are not-for-profit. JCI accreditation can cost as much as \$100,000 with the average being \$46,000 and AAAHC accreditation usually cost \$4,000-\$7,000. The JCI also requires that, on top of the cost of the survey, hospitals must pay for the food, lodging, and transportation of the survey team. Each company's accreditation must be renewed every 3 years and the initial accreditation process usually spans three years. In order for an international hospital to receive accreditation from a Western-based accrediting body, signs must be bilingual (English and the native language), infrastructure must be updated (which costs money), and there must be a certain amount of bilingual doctors. According to the JCI website, the benefits of accreditation are:

- Improve public trust that the organization is concerned for patient safety and the quality of care;
- Provide a safe and efficient work environment that contributes to worker satisfaction;
- Negotiate with sources of payment for care with data on the quality of care;
- Listen to patients and their families, respect their rights, and involve them in the care process as partners;
- Create a culture that is open to learning from the timely reporting of adverse events and safety concerns; and

- Establish collaborative leadership that sets priorities for and continuous leadership for quality and patient safety at all levels.

It is important to note the emphasis on public trust and quality that run through accreditation literature. The discourse in the medical tourism industry reflects the belief that Western public trust is tied into being legitimized by a Western accrediting body, which inherently delegitimizes the qualification of the State in the developing world to provide oversight of its own healthcare facilities.

During my research in Colombia, a group of American representatives from an insurance company toured the private hospital where I was doing my fieldwork and was given a presentation (in English) of the hospital by its staff. One of the American insurance representatives asked if the hospital used medical equipment from the United States and Europe. The hospital staff was very quick to say, “Yes” and then go on to discuss the number of doctors who were trained in the U.S. or were members of Western medical associations. As discussed in the chapters pertaining to neoliberalism and citizenship, economics seem to trump nationalistic solidarity. International hospitals are clamoring for Western accreditation because accreditation makes it more likely that a Western-based insurance company will put said hospital in its network of approved and covered healthcare providers, which will increase the hospital’s number of patients and revenue.

The insured American is a market that international hospitals want to tap into in order to increase profits and expand job opportunities for the local population. Also, the medical tourism industry is lobbying the U.S. government to expand Medicare/Medicaid benefits to cover procedures at international hospitals, which would increase their market share. Medicare/Medicaid will not even cover medical treatment domestically if the

hospital is not accredited. As of now, only a few Western insurance companies cover non-emergency care at international hospitals. For now, most Westerners must pay out of pocket and for many it doesn't make financial sense to pay \$10,000 for knee surgery in Costa Rica if their insurance will cover the surgery in the U.S.

As mentioned earlier, the potential for increased profits produces a form of subjectification by privileging Western medical standards over local standards. Michel Foucault has written extensively on the subject and the subject making process. He defines the word subject as: "...subject to someone else by control and dependence; and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to" (1982: 781). In the case of the medical tourism industry, the international hospital is the subject to the Western-based accrediting body "by control and dependence." The accrediting body *controls* the hospital by requiring that it adhere to the guidelines set by the members of the accrediting body and the hospital is *dependent* on the accrediting body to tap into the Western medical market.

Why does the medical tourism industry require multi-lingual signage in international hospitals but not require medical tourists to learn the language of the country that they are receiving medical treatment? This is a clear example of the privileging of the West. This phenomenon cannot simply be explained in compartmentalized terms of Whiteness, culture, and economics. I argue that each of these three (of many) elements that creates privilege act in a dialectical relationship that is contextual. The subject making process privileges Whiteness, Western culture, and economics; however, an African-American who is economically advantaged, in certain contexts, would be privileged over, for example, a White-Russian who is economically disadvantaged. Another example, based

on my fieldwork, occurred during the presentation discussed earlier at a private hospital in Colombia. One of the insurance representatives was an African-American male and the representatives from the private hospital treated him like a VIP in order to increase its chances of being part of the insurance coverage network. Another example from my fieldwork occurred during the Medical Tourism Annual Congress of 2009. The platinum sponsor and VIP was South Korea and in 2010 the Diamond sponsor and VIP was Dubai. These examples of VIP's are clearly not White and two of the examples are not Western. So by virtue of being a representative of a financial capital bearing body one is able to purchase VIP status/Whiteness regardless of one's race or nationality.

In chapter 4, I discuss the process of Whitening. Whiteness can be purchased with currency, citizenship, membership in a certain group or organization, and education. Once someone is a member of a privileged group and is thus Whitened then he or she is more likely to have the ability to make subjects. Subjectivities are contextual and are based on many different nuances including race, gender, class, skin color, country of origin, linguistic dialect, education level, etc. A subject in one context may be a subject creator in another context. For example, Dubai and South Korea were able to purchase VIP status and make subjects of the Medical Tourism Congress, but outside of the congress both regions are subjects to Western accrediting bodies and feel the need to cater to the West in order to attract medical tourists. Quoting Habermas, Kevin Heller summarizes Foucault's theory of subjectivity:

Because subjects are created by power-relations they do not consciously control, the creation of subjectivity is a homogenous process in which subjects are little more than "individual copies that are mechanically punched out" ...subjectivity that is opposed to the interests of power—cannot exist (1996: 78).

So what is power? Power is not a monolithic entity and comes in many forms, but in the medical tourism industry, which is not a monolithic entity either, power comes in the form of the neoliberal model that privileges economic success. International hospitals seek power in the form of legitimacy, which will allow them to attract foreign patients and obtain increased revenue. If a member of the industry is opposed to the source of power: money via Western patients, then he or she will fall from grace. Private international hospitals are very interested in attracting Western patients and if an employee is in any way a deterrent to attracting patients then he or she is systematically removed from the international hospitals; i.e. their medical tourism citizenship is revoked. For example, at *Hopital Croix*, employees, including janitors, are being fired if they do not speak English and preference is given to job applicants who are fluent in a Western language, preferably English. English proficiency is seen as a necessity in attracting Western patients and obtaining Western accreditation. Since English is a *lingua franca*, especially amongst the global elite (a target market), and is the native language of North Americans (another target market), it is required in the industry. No sane person will willingly submit to medical care if he or she cannot communicate with the healthcare provider.

The accrediting bodies place grand importance on bilingual signs and employees, and as part of the accrediting process representatives of the accrediting body are deployed in order to assess and survey the international hospitals. For example, JCI accreditation is an intensive process that can sometimes require at least one year to prepare. At first, representatives (usually a doctor, nurse and an administrator) make announced visits to the hospital; however, that may later evolve into unannounced visits (Timmons 2007).

Foucault has written extensively on the medical gaze and surveillance in which the latter “... is based on a system of permanent registration” (1995: 196). Although Foucault is referring to the prison industry, he often likens this industry to schools and other institutions. Accreditation lasts for three years, thus it is not permanent per se, but there are systemic pressures based on economics and legitimacy that renders accreditation, i.e. *registration* with a Western accrediting body, and continual renewal as a necessity and not an option.

The Western accrediting bodies place international hospitals under their strict surveillance, which is supported by a statement given to me by a high level executive of a major accrediting body who referred to the rival accrediting body as a “gotcha company”; meaning that the other accrediting body is looking for deviations from set regulatory parameters; i.e. an excuse not to accredit. This form of surveillance, similar to the magistrates’ surveillance of prisoners, is a form of control. The hospitals must adhere to all guidelines, otherwise they will not be accredited and therefore will lose legitimacy in the eyes of the West, which is seen as a prerequisite to snowballing into a loss of financial capital and the revocation of medical tourism citizenship.

The hospital, over the last 100 years, has gone from being a source of community service to a profit-making entity devoid of its initial humanitarian aspect. Many hospitals in Latin American and other developing nations began as missionary hospitals, which gave access to healthcare to community members regardless of income or ability to pay. Now these same hospitals, which have Christian-based names are private and can only be afforded by wealthy citizens of developing nations and Westerners. During my fieldwork in Costa Rica at *Hopital Croix*, I received an eye exam, which costs me \$8 USD. In err, I

returned to my host family and raved about how cheap my eye exam was. My host mom replied in Spanish: “That’s expensive! Only the rich can go to that hospital. You could’ve gotten an eye exam in the neighborhood for 2,200 *colones* [\$4 USD].” This incident grounded me in terms of access and the increasing dichotomy between healthcare spatialities for the local elite and Westerners and healthcare spatialities for the majority of Costa Ricans. Bragging about how cheap the eye exam was definitely a *faux pas*; I took for granted my privilege and I will never forget that encounter.

In regards to the transformation of the hospital from a humanitarian effort to a source of profits, Foucault states:

In a regime of economic freedom, the hospital had found a way of interesting the rich; the clinic constitutes the progressive reversal of the other contractual part; it is the *interest* paid by the poor on the capital that the rich have consented to invest in the hospital; an interest that must be understood in its heavy surcharge, since it is a compensation that is of the order of *objective interest* for science and of *vital interest* for the rich. The hospital became viable for private initiative from the moment that sickness, which had come to seek a cure, was turned into a spectacle. Helping ended up by paying, thanks to the virtues of the clinical gaze (1994: 85).

Because medical tourism and hospitals are seen as a source of profits, investments are encouraged and seen as a way to make more money and increase economic power. On the medical tourism listserv that I subscribe to there are many discussions about investment opportunities and in an article in the *Medical Tourism Magazine*, Cayla Lambier (2010) cites investment opportunities in both Dubai and Saudi Arabia; however, other emerging economies such as South Korea, India, and Bangkok are also cited as fertile ground for investments.

The hospital became both a source of health and a source of wealth, and the humanity aspect of healthcare is increasingly being swept under the rug in favor of

economic capital. For Foucault (1994), the clinical gaze is learned expertise and perception by doctors that raises them to a higher status. Because medical experts are legitimized through this gaze their theories become truth and cannot be legitimately challenged by lay people. The gaze renders sick lay people as helpless to the medical whims of medical practitioners and thus practitioners can exploit their enhanced power. One of the main ways that the gaze creates an environment that is a Petri dish for exploitative practices is the compartmentalization of expertise and legitimacy to a select few. For example, some U.S. States have laws that make it illegal for pregnant women to have a midwife. Women must give birth in hospitals, which takes away a woman's right to choose which professional she will entrust to birth her child. In this era of late capitalism where money is king, the gaze became an avenue for attaining financial capital and turned the medical profession into a profit making entity and away from its humanitarian roots. Bodies are subjected to the apathetic gaze of medical professionals who want to concentrate money and power within the institution of the hospital.

The hospital/clinic is the institution in which the gaze is concentrated and therefore in conjunction with the gaze being an economic asset, by default the hospital also became a source of economic capital. *Hopital Croix* does have a fund for patients who cannot afford treatment, but my host mother informed me that she and her family do not qualify for that fund because it is usually reserved for single mothers and their children who are destitute. Similar to the U.S., the poor has some safety nets that include Medicaid and the wealthy can afford adequate insurance while the middle class usually falls through the cracks. As mentioned earlier, my host mother stated that *Hopital Croix* is "for the rich." Although I did not interview Costa Rican patients, I did discern "proper" Spanish being spoken in the

waiting room as well as people with fashionable and expensive-looking clothing. There is private insurance available but it costs the equivalent of \$50 USD per month for a family, which is out of reach for the average Costa Rican who makes around \$350 USD per month. Also, keeping in mind what the average Costa Rican makes, if one does not have medical insurance, the cost in 2009 for an MRI at *Hopital Croix* is \$600 USD and a colonoscopy is \$350 USD. Major and life sustaining surgeries such as a heart angioplasty with one med stent costs \$13,000 USD and a bilateral hernia repair costs \$6,800 USD. Quality of life surgeries such as a double knee replacement costs \$20,900 and a double hip replacement costs \$23,000 USD. Clearly, these prices are out of reach for the average Costa Rican and many Westerners. But because of the gaze and the compartmentalization of expertise, the ascension of economics and the descension of socialized health care and humanitarian efforts became possible.

Financial capital in the hospital is a priority that is placed before health. Before a patient receives treatment he or she must pay in full prior to being treated (unless it is an emergency). This is especially the case for international patients because *Hopital Croix* has no recourse if the patient leaves the country without paying unless he or she has property in Costa Rica. Also, if the international department does not receive payment it is liable and must pay the hospital because the international department is a separate entity from the *Hopital Croix*. The hospital makes it easy to pay because there is a bank in the hospital, which attests to the amalgamation of finance and medicine. Prior to treatment an international department representative will escort (sometimes roll via a wheel chair) the foreign patient to the hospital bank in order to withdraw funds or initiate a wire transfer. There was one instance when an American patient claimed to have been robbed the night

before of \$1,500 USD. Her procedure costs \$3,500 and she had \$1,900 in cash and \$1,100 on a debit card. \$3,000 covers hospital costs and doctor's fees and the facilitator (the middleman who paired her with *Hopital Croix*) agreed to temporarily waive their \$500 fee. If the facilitator had not agreed to collect the fee when she returned to the U.S., the procedure would not have been done. The facilitator was U.S. based and had legal recourse if this patient failed to pay; however, the international department of *Hopital Croix* did not and would have denied service because of the liability that it would have had to the hospital.

Getting back to Foucault's discussion of the clinical gaze, which not only applies to medical care and its institutions, but it also applies to accreditation; I argue that the accrediting gaze, also compartmentalizes expertise, which gives a small number of groups the authority to deem hospitals worthy of providing quality and safe medical care. Dr. Lissette Chavarria (2008) states that JCI accreditation is "the maximum international recognition [that can] be achieved." The JCI is the apex of the accreditation gaze and the gaze, according to Foucault, transitioned medicine from a humanitarian-focus to a financial capital-focus. I argue that despite the fact that accreditation does try to ensure quality and safety, and the JCI is a non-*profit* organization, accreditation costs as much as \$100,000 for a hospital and thus the business of accreditation is very profitable for employees. Also, non-profit can be a very misleading term because obscenely high salaries can be established for employees and high level executives, which drives up the cost of service.

The accreditation gaze siphons expertise and legitimacy to a select group of Westerners. I attended a Promed meeting in which the topic was accreditation. Two major accrediting bodies were bidding to get a contract to train Costa Ricans how to accredit

ancillary services such as recovery hotels and transportation. This is a clear example of Western hegemony. Why is it that the medical tourism industry in developing countries looks to the West for instruction on how to ensure quality and safety in their own country? Are Costa Ricans incapable of ensuring quality and safety of their medical facilities? Of course they are capable. According to the World Health Organization (Evans et al 2000), the Costa Rican healthcare system is ranked higher than the U.S. Japan, Singapore, Chile, Israel, the United Arab Emirates, Saudi Arabia, and Colombia also have healthcare systems that are ranked higher than the U.S. but have hospitals that are accredited by the JCI. The rationale behind Western accreditation is that it is believed that Westerners feel more comfortable if international hospitals are held to the same standards as Western hospitals. In his article, "Accreditation of Overseas Hospitals-JCI or Isqua", Dr. Edward Watson (2007) puts forth the question: "Will I receive the same quality of care I would receive in an American hospital?" His answer is that accreditation from the JCI would ensure this quality. But indirectly stated just below the surface of the question is that all American hospitals (which all have to be accredited) provide quality care, which I beg to differ. There have been many cases of negligent hospital incidents that have resulted in major injury or even death. One of the most notorious cases was the 1995 incident at a Tampa, FL hospital where a surgeon amputated the wrong leg of a patient. I interviewed a former American nurse who was astonished (in a good way) that the nurse to patient ratio at *Hopital Croix* is 4 to 1, because at his former place of employment, he would sometimes have as many as 15 patients. Many Americans think that American-based entities by default are legitimate and quality, while questioning the legitimacy and quality of the "other." Many Westerners and those in the medical tourism industry have internalized the superiority of the West without

question and are willing to trade nationalistic solidarity for economic capital. In the current era that privileges fast money and short-term gains, the long-term discursive countering of Western hegemony in the medical tourism industry is almost non-existent. International hospitals are clamoring for Western accreditation and are willing to be subservient to the accrediting gaze.

Drawing on Gramsci, Edward Said (1979) wrote that knowledge is power and knowledge is used to control others. I argue that the accrediting gaze is a form of control and a way to make international medical facilities conform to Western beliefs pertaining to quality, safety, and methods regardless of whether or not the “old” and “native” way of doing things is more efficient and works best in that particular context. As discussed previously, the accrediting gaze is the compartmentalization of knowledge and that knowledge creates power in the form of strict and uniform guidelines for accreditation.

Anthropologists have critiqued blueprint applications of policies that do not take into account history, culture, space, and context, and thus fail time and time again. Emery M. Roe (2008) critiques the use of blueprint development, which is the uniform application of development projects, particularly in rural areas. He argues that blueprint development should be abandoned and replaced with a “learning process approach” (313). The latter approach is adaptable and flexible, and failures are part of a larger learning curve that seeks development policies that better serve the community to which these policies are applied. He also argues that blueprint development schemes are part of a nepotistic web that creates well-paying jobs for the friends of agents involved in development schemes. For example, as of 2009, there were talks of The Medical Tourism Association (MTA) having their own seal of accreditation and some medical facilities have multiple

accreditations. For example *Hopital Croix* is accredited by the JCI and ISO. In fairness, such overkill is a means to market the hospital's quality to the U.S. and Europe, respectively, but the MTA wants to be an accrediting body and employees of *Hopital Croix* welcome their accreditation. So when will all of this stop? Is there a such thing as too much accreditation? I argue that there is a hierarchy of accreditation, with the JCI being at the apex; however, based on my fieldwork it appears that the more hierarchically superior accreditations that are received, the more legitimate *Hopital Croix* becomes in the eyes of the West.

Roe (2008) concludes that: "...the argument here has not been that blueprint development that suits one country should suit them all, but rather a more modest claim. Blueprint development narratives are to be evaluated solely on the grounds of how well learning introduces a measure of realism into them" (319). But what throws a monkey wrench into the equation in terms of the medical tourism industry is that many in the industry are straddling two different cultures: one Western and the other their native land in the developing world in which they have internalized an economic hierarchy that privileges financial capital over nationalistic ties within the spatialities of the medical tourism industry. Money, especially money from the West, mitigates any desire for international hospitals that cater to the West to maintain native cultural practices. The realism is the fact that these international hospitals that are catering to primarily Western medical tourists are trying to mirror the West by adhering to Euro-American biomedical standards. So the context is not the developing country; that is simply the backdrop. International hospitals are trying to attract two kinds of patients: the global elite and Westerners with financial capital. Thus, blueprint accreditation, in the eyes of the medical

tourism industry, should work regardless of the national context of the location of the hospital. If the hospital conforms to Western ideals then it should be able to build its desired market. The spatial context of the hospital takes a back seat to the cultural hierarchy that exists in the industry. Westernisms and the financial capital that comes with it trump nationalism in the developing world.

The international hospital becomes similar to the U.S. embassy in that within the confines of the hospital one is immersed in Euro-American culture. Most employees speak English, many doctors were trained in the U.S. and the hospital adheres to the standards of Euro-American accrediting bodies. In order to be an employee and a patient one must submit to Western standards of medicine and culture.

Blueprint accreditation, similar to blueprint development policies, applies uniform standards to all international hospitals regardless of whether one hospital is located in South Korea, India, Costa Rica, or South Africa. Roe (2008) argues that: "Plausible assertions are those development narratives that can be justified as applicable to a site on the basis of long experience and observation" (320). International hospitals that cater to Western patients are setting up new policies, which trumps established, local experience. Even though *Hopital Croix* is trying to attract Westerners, only 25% of its patients are foreign; the rest are Costa Ricans. So how will blueprint accreditation affect them? How will it affect the wealthy local elite (who can afford these private hospital) in Bangkok? Saudi Arabia? Colombia? Brazil? Since many patients at these elite hospitals are local, how will blueprint accreditation affect them and the doctors who have been working at these hospitals for many years? If the latter speak English, they should be fine; however, if not, they will be fired. Also, Dr. Lissette Chavarria (2008) writes that Mexican doctors resisted

documenting their activities with patients, which is a requirement for Hospital Certification by the Mexican General Health Authority. The guidelines set by the health authority are based on the premise that: “that which is not written down and is not done does not exist, and that which is done but is not written down is not known.” Even though the *Mexican Health Authority* set these guidelines, it is very reminiscent of the practices pertaining to paperwork and documentation of the West, primarily in England as outlined by Ilana Feldman in her book *Governing Gaza: Bureaucracy, Authority, and the Work of Rule, 1917-1967*. The British are notorious for their extensive filing and documentation practices, which were absorbed by their colonies. Even though Mexico was a Spanish colony, it is very close to the U.S., which was a former British colony and has historically been influenced by U.S. practices through migration, tourism, diplomatic dialogue, and multinational corporations.

It is clear that many countries have absorbed the practices of the West and it is not a surprise that the Mexican government has guidelines for certification that is very similar to the West. Previously, I mentioned that a few U.S. based accrediting bodies were vying for a contract to train Costa Ricans to accredit their own facilities. There seems to be a commonality amongst the global elite regardless of country of origin and country of citizenship in that they are willingly making subjects of themselves in order to legitimize their medical facilities in the eyes of the West, which they believe will increase the number of medical tourists and profits. Also, this standardization creates a global uniformity that seeks to subjectify international hospitals to adhere to Western biomedical standards and privilege employees who speak English and were trained in Western schools, which create a clear dichotomy between those with medical tourism citizenship and those without.

In an article in the online *Medical Tourism Magazine*, Karen Timmons (2007) notes that the JCI does take into account cultural difference, but the bottom line is that the core Western standards will be followed. For example, Timmons states that: "...informed consent by patients is a JCI requirement, but different cultures handle this in different ways. In some cultures patients fill out a form in front of a witness, while in others a family member may be the only one allowed to give consent. JCI accreditation allows for these differences." The means to get to the end result may be different, but the end result is the same and is set by a Western accrediting body. The JCI also works with countries' ministries of health to established guidelines, but the key point is that this U.S. accrediting body has the final say in accreditation and thus wields a lot of subject making power if the bottom line is increasing Western medical tourists and being an approved healthcare provider by insurance companies and Medicare/Medicaid.

In conclusion, the common theme throughout this essay is that in this neoliberal world, nationalism is seen as a threat to progress and progress is measured in terms of financial capital. The medical tourism industry, primarily in the developing world, is making themselves subjects to the West and the clear medium of subject making is the process of accreditation. Accreditation is a means of surveillance, gaze, and subject making that renders hospitals nearly powerless to accrediting bodies. International hospitals can choose to not be accredited by a Western accrediting body, but in the medical tourism industry that is considered financial suicide. There are systemic practices that make Western accreditation a requirement for medical tourism citizenship. There is so much propaganda in the Western media that stresses the importance of JCI accreditation and routinely prints headlines about botched cosmetic surgeries in unlicensed and

unaccredited 3<sup>rd</sup> world hospitals, and coupled with the fact that Western insurance companies will not approve medical facilities that are not accredited by Western accrediting bodies gives international hospitals that want to tap into this money making arena no choice in the matter. To put it simply: “if you accredit it, they will come.”

## 6. CONCLUSION

Medical tourism, like many other practices, is beneficial to some while stagnating or decimating the opportunities for others. The primary literature within the industry focuses on investment opportunities, the potential for profits, and marketing. As mentioned previously, there was one presentation at the 2009 MTA Congress entitled: “Social Entrepreneurship” that was sparsely attended. The different facets of the medical tourism industry internalize Western hegemony in that fair skin, English language, and Western education are valorized over dark skin, local education, and proficiency in a non-Western language. Also, interwoven within hierarchical regimes are citizenship and neoliberalism. All three are in a dialectical relationship that stems from Western hegemony and the privileging of economic and financial capital. Neoliberalism privileges private property, free markets, and the free flow of (certain) bodies for labor. It also interacts with regimes of citizenship to override State parameters regarding citizenship for the purposes of business interests. Members of the global elite who have been “whitened” through education, English language proficiency, financial capital, and/or with support from a business or nation-state are given legal access to countries that are not their own.

The medical tourism industry creates an avenue for the global elite to easily traverse the globe by lobbying for the easing of visa requirements for medical tourists. During my fieldwork in Cost Rica and at the MTA Congress, I overheard a few conversations in which the consensus called for the strengthening of international borders to keep Mexicans out of the U.S. and Nicaraguans out of Costa Rica; specifically, those foreign citizens without global elite status.

Citizens of the medical tourism industry privilege neoliberal doctrine. They want to promote the free flow of (certain) bodies, create FTZ's, and lobby local governments to invest public funds into the private industry. Also, non-Western hospitals are willing to make subjects of themselves via the Western accrediting gaze. Neoliberalism and subjectification within the confines of the medical tourism industry are adhered to for the purposes of increased financial capital. Like many other industries that enact blanket policies and privilege neoliberal ideology, there are negative social consequences.

As more top international hospitals become accredited by Western accrediting bodies local medical practices and procedures are being overtaken by Western biomedicine. Also, the private medical tourism industry is very lucrative for doctors in developing countries and, as a result, many are moving out of the already strained public health sector. Another negative social consequence is that issues of cultural hierarchy are not being addressed and in fact ethnic, gender, and racial stereotypes are being upheld in discursive elements and in the media. In the medical tourism marketing literature, women are usually pictured as attractive nurses or assistants while men are shown as doctors. Most medical personnel who are pictured in this literature are fair-skinned, but exotic while the patients tend to be middle-aged and White. Medical tourism citizenship in marketing literature is generally afforded to those who are *perceived* as having financial capital and the qualifications to work in the medical field, which adheres to racial stereotypes. Despite the social ramifications of the medical tourism industry, it does provide entrepreneurial opportunities and healthcare for Americans who do not have health insurance or have inadequate insurance, Canadians and Western Europeans who have long wait times for certain procedures, and citizens of developing countries who do

not have access to certain specialized treatments. However, the industry is siphoning public funds to private hospitals that the average local resident of a developing country cannot afford. The rationale for this practice is that increased tourism will create new jobs and increase profits for the local economy that will be reinvested into the public sector. Only time will tell whether or not this claim is the truth or a smokescreen to hide the siphoning of financial capital away from local taxpayers and into the pockets of the global elite.

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