HUMAN RIGHT OR COMMODITY: MIDDLE-CLASS PERCEPTIONS AND EXPERIENCES OF THE MIX OF PUBLIC AND PRIVATE HEALTH CARE IN SAN JOSÉ, COSTA RICA

By

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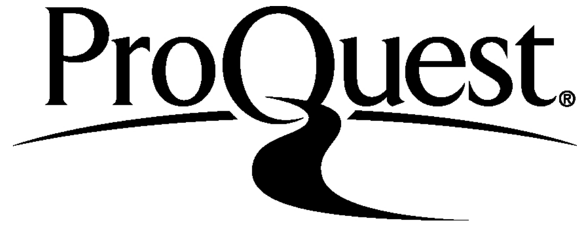

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ABSTRACT

HUMAN RIGHT OR COMMODITY:
MIDDLE-CLASS PERCEPTIONS AND EXPERIENCES
OF THE MIX OF PUBLIC AND PRIVATE HEALTH CARE IN SAN JOSÉ, COSTA RICA

By

Lynnette Zahrn King

This dissertation examines middle-class health care professionals', providers', and patients' perceptions and experiences of the ideologies and practices of health care in San José, Costa Rica. More specifically, this study examines health care as a human right and health care as a commodity, as experienced in public and private health care and their mixing. Furthermore, it examines how Costa Ricans mix these ideologies and systems of care. Costa Rica is particularly important for the study of a mixed health care system because it not only has a successful public health care system that is facing important challenges but also a private sector that is intensifying and mixing with the public health care system in significant ways. In addition, it is well documented that the population holds strong beliefs about publically provided health care, but little is known about what happens to those beliefs when individuals use a mix of public and private health care.

To date, although globally most health care systems commonly mix public and private health care, there is a paucity of research on experiences and perceptions of this mix. In order to examine this phenomenon, I conducted participant observation, focus groups, along with interviews with 74 health care professionals, providers, and patients who use a mix of public and private health care for their work and health care needs. This study found five key strategies for resolving the public–private health care tension in San José:

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1. Individuals struggled with problems of public health care, primarily long waits for care.
2. In response, individuals found ways to manipulate the public health care system to make it work for them.
3. Individuals also used informal networks of family and friends to address health issues without waiting.
4. Individuals chose to use only the private health care system.
5. Finally, some individuals used a mix of public and private health care.

In sum, the perceptions and experiences of how individuals engage in these strategies indicate that as individuals in this study used a mix of public and private health care, they came to view health care, doctors, and the clinical experience as a commercial marketplace. Flexible medical citizenship is proposed as a means to understand the uncertainties, vulnerabilities, and inequalities that emerge as the ideologies and practices of public and private health care are mixed in daily life. Taken together, these findings illustrate the impact of neoliberal ideologies on health care, and how the once taboo topic of health care privatization has become more tenable.

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CHAPTER 1: INTRODUCTION, CONTRASTS AND TENSIONS

Victor Morales, a 28-year-old public nurse, talks easily about his experiences with the mix of public and private health care in San José, Costa Rica. He works as a public nurse, teaches at the public nursing school, uses the public health care system for his own health care, but uses the private system for his daughter's health care. He says that he uses the private health care system for his daughter because he feels that health care in private is "more organized." He clarifies what he means by "more organized" by adding that in the private sector he doesn't have to wait in line for hours when his baby is sick. Then he seems to step back from his personal experiences and make a general observation. "There are two perspectives, right?" he says. "In public you have 'Class A' hospitals and the idea that health care is a human right, but in the private system health care is a commodity." Not only does Victor use a mix of public and private health care for himself and his family, but in his four years working at a top public hospital some of his patients also use a mix of public and private health care. He tells me that some of his public patients just can't wait so long to for surgery in the public system. He explains that in these cases the public hospital arranges for the patient to get diagnostic exams in the private sector and then come back to public for the surgery. Victor tells me that this mix of public and private health care is "typical." He explains how the public and private systems coordinate with each other, passing patient files back and forth, including results of exams, and discussing what should be done next. In fact, he says that it is often the same doctor who works in both public and private sectors, which, Victor says, "contributes to the commercialization of medicine."

—Victor Morales, 28-year-old public nurse, interviewed November 19, 2013

Like Victor Morales,[1] many people in Costa Rica use a mix of public and private health care. Both individuals and institutions strategize among the public and private health care options available to make health care work. It is striking that Victor, like many of the participants in this study, explicitly refers to the contrasting values of health care as a human right and health care as a commodity as he talks about these two health care systems.[2] This raises the question of whether individuals such as Victor see a tension between these two ideologies and how people manage these contrasts. The public health sector in Costa Rica is underpinned by beliefs in solidarity, equality, democracy, human rights, and universal access (Godoy 2013; Salas 2011). In

[1] All institutional and personal names and professional details have been changed throughout this dissertation to preserve anonymity.

[2] By health care system I mean a system that includes all the organizations, people, resources, and actions to deliver health care services and promote, restore, or maintain health (Chartered Technofunctional Institute 2012; WHO 2016). Health care systems are classified broadly as public, private, and mixed.

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contrast, the private health care sector is organized around ideas of individualism, profit, competition, and choice without an official design or particular interest in the promotion of rights (Chamberlain 2007). Yet, as seen in the interview with Victor Morales, public and private health care mix in complex ways. Indeed, in the wake of neoliberal reform in Latin America, there is a great deal of mixing between public and private health care ideologies, strategies, and systems, and Costa Rica is an example of how this occurs.

Costa Rica is particularly important for the study of real experiences of the mix of public and private health care not only because it has a successful public health care system that is facing important challenges, but also because it is well documented that the population continues to hold strong beliefs in publically provided health care and health care as a human right, even as many individuals turn to the expanding private health care sector for work and health care (Bowman 1999; Chamberlain 2007; Godoy 2013; PAHO 2012). Yet despite strong beliefs in publically delivered health care, private health care appears to be an irresistible option for patients who can afford it. This presents an ideological problem in a country that has been at the forefront of promoting health care as a human right: Should health care be considered a human right or a commodity? For these reasons, this study asks: How do Costa Rican health care professionals and patients who are part of a culture that embraces the idea of the state provision of universal health care comply with, ignore, resist, embrace, or rework the contrasting ideologies of public and private health care?

In order to answer this question, this study draws on interviews, focus groups, and observations with primarily middle-class individuals who work in or access health care in a climate where the ideologies and practices of health care as a human right and health care as a for-profit enterprise intersect. Although many social scientists have examined public and private

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health care in Costa Rica, there is little research on how the mix of public and private health care and their ideologies are understood and experienced by the people who use this mix. Most previous research on the Costa Rican health care system has been survey based and does not include detailed ethnographic analysis. Much quantitative research relies upon assumptions regarding individuals' perspectives and experiences, which may reify a dichotomy between public and private health care. Other research describes some of the ways that public and private are mixed without examining the experiences and perspectives of individuals themselves (Flood, Stabile, and Tuohy 2002; Flood and Thomas 2010; Schmid et al. 2010). Although anthropologists have made significant contributions to how neoliberalism may or may not influence the welfare state (Keshavjee 2014; McKenna 2012; Navarro, Schmitt, and Astudillo 2004; Noy and McManus 2015), the specific case of the experiences and understandings of the mix of public and private health care in Costa Rica is underexamined. This dissertation addresses the theoretical gap in the literature by exploring the ways that public and private mix, as well as the ways that individuals negotiate the seemingly contradictory imperatives of health care as a human right and health care as a commodity.

I heard about the strategies of mixing of public and private health care time and time again during fieldwork from July 2013 to May 2014 in San José, Costa Rica. For the Costa Ricans I interviewed, public health care is both a way to deliver health care goods and services at low cost and a set ideological beliefs about what it means to be Costa Rican. This set of ideological beliefs includes ideas about fundamental human rights, solidarity, equality, democracy, public well-being, and national exceptionalism (Biesanz, Biesanz, and Biesanz 1999; Lee 2012; Rayner 2014). Yet despite these strong beliefs, many participants struggle to get the health care they need in the public health care system.

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Accounts of the struggle for health care are set in the context of tensions in the Costa Rican Public Health Care system. According to literature on the Costa Rican health care system (mostly from history, sociology, and economics), Costa Rica is both regarded globally as an example of the success of national health care[3] and facing serious problems of high patient volume, rising costs, debilitating debt, crumbling infrastructure, management issues, and long waiting lists for care (Clark 2005, 2011; 2014; Torres 2013). These limitations lead many patients and health care providers with the financial means and social capital to turn toward private care for work or to meet their health care needs (PAHO 2012; Torres 2013).

Although public and private health care have coexisted in Costa Rica since the emergence of the national health care system in 1941, the private sector has increased significantly since the 1980s (Chamberlain 2007). The intensification of the private health care sector is not only a result of the problems in public health care but also related to economic, political, and global interests such as the passing of the Central American Free Trade Agreement, the implementation of structural adjustment policies, and networking between physicians, politicians, and health care officials (Lee 2012; Chamberlain 2007; Clark 2011; Ormond, Khoon, and Verghis, forthcoming; Rayner 2014).

The expansion of the private health care sector alongside the problems in the public sector has created a climate where private health care is an option for many individuals (Torres 2013). For instance, even though it is reported that currently 91% of the population uses national health care insurance to access public health care, in 2008 out-of-pocket health care expenditures accounted for 29% of total health care expenditure (McIntyre 2011; McIntyre et al. 2013; PAHO 2012; Zúñiga-Brenes, Vargas, and Vindas 2012). In the health care climate of the mixed use of

[3] The United Nations World Health Report in 2000 ranked Costa Rica within the top 20 worldwide and first in Latin America (WHO 2000).

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public and private health care, the neoliberal ideologies of profit, efficiency, competition, and choice intersect with the ideologies of solidarity, democracy, public health, and universalism that underpin public health care.

In this study, I examine the ideologies of public and private health care, and their contrasting practices, not as competing but as mixing in the everyday lives of the people who move between public and private health care. This examination enables a closer view of how public and private health care are dependent on each other, thus shaping local ideas of how health care entitlement, individual responsibility, and human rights are being understood and acted upon.

Current theoretical models address these ideological conflicts in a variety of ways, considering how governmental health care institutions regulate individuals in different ways (Foucault 1991), how citizenship rights are tied to health care rights and patient demands (Goldade 2009; Nichter 2008; Orsini 2006; Petryna 2002; Wailoo, Livingston, and Guarnaccia 2006), how citizenship rights create categories of people who can be included or excluded from access to health care (Rose and Novas 2005), and how consumption of health care has become part of a global marketplace that is disconnected from national policies (Rose and Novas 2005). These approaches add significantly to the understanding of the qualities, demands, and rights of public and private health care as separate systems but do not directly address the mixing of the practices and ideologies of public and private health care. I argue that the examination of the mix of public and private health can add to our understanding of different kinds of citizenship (such as membership in public and private health care), as well as the entitlements and vulnerabilities that emerge as individuals engage in this mix. In addition, the ability to flexibly move between

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public and private health care can be seen as a strategy with its own benefits and vulnerabilities that remain to be examined.

According to scholars of health care in Costa Rica, historically health care rights have been not only considered citizenship rights but also constructed as constitutional and fundamental human rights (Gutiérrez 2009; Salas 2011). In contrast, the ideology of neoliberalism defines human rights as the right of choice and the right to consume any (public, private, or mixed) health care services and products (WBI 2013). The mixing of public and private health care includes the mixing of these contrasting ideas of health care rights and entitlements. The study of the mixing of public and private health care in Costa Rica is timely not only because most health care systems in the world are mixed systems but also because the World Health Organization (WHO 2012) has in recent years urged countries like Costa Rica to continue to ensure universal access to quality health care services at the same time that global and local interests in corporatizing health care institutions have intensified (Chamberlain 2007; Chartered Technofunctional Institute 2012; Drechsler and Jütting 2007; Hernández and Salgado 2014; Hidalgo 2014; Unger et al. 2008; Zúñiga-Brenes, Vargas, and Vindas 2012).

In this dissertation, I propose the framework of flexible medical citizenship as an analytical lens to address the limitations of previous ways to understand the public and private health care and their mixing, as well as to explain how the contrasting ideologies and practices of public and private health care are experienced and understood as they are mixed. I define flexible medical citizenship as the flexible movement of health care workers, patients, ideologies, and practices back and forth between public and private health care settings and the qualities of the particular mix of ideologies, practices, uncertainties, and entitlements that result from this flexibility. I posit that the term flexible medical citizenship can be useful for identifying how

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ideas of health care rights, responsibilities, and claims to state and private resources are shaped by one's participation in public, private, and mixed health care systems. Therefore the flexibility to move between contrasting health care settings and ideologies of care is central to understanding the way medical culture is constructed, understood, and strategized. This analysis enables an examination of how illness and health shape relationships to state and corporate health care institutions, as well as how illness and health care are defined and complicated with the mixing of public and private health care. The examination of the perceptions and experiences that emerge as individuals maneuver between public and private health care can reveal a nuanced picture of the contrasts and tensions of the current health care climate.

The concept of flexible medical citizenship follows the work of Nguyen (2005) and Kleinman (1980), who have examined health care systems as cultural systems. For instance, Nguyen's (2005) research examines policies for the distribution of antiretroviral drugs by focusing on state responsibility alongside the rights and responsibilities of what he calls "patient-citizens." He describes his idea of medical citizenship as including "a heterogeneous and uneven congeries of practices and techniques, present and active in daily life to produce particular kinds of subjects and forms of life—AIDS activists, resistant viruses, and therapeutic citizens" (Nguyen 2005, 126).

In other words, Nguyen (2005, 126) views medical citizenship as an assemblage of the practices and techniques found in the daily use of health care systems. The way that Nguyen includes ideologies, practices, and norms is important for understanding the medical culture of the flexible strategizing between public and private health care. In this study, I expand on Nguyen's idea of citizen to include not only a member of a state but also more specifically a member of a health care system—public, private, or mixed. For instance, in public health care

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medical citizens claim the right to health as mandated in the national constitution, national health insurance, and international health declarations. In private health care, however, medical citizens claim the right to health care as a personal private right supported by private property rights, ability to pay, and the neoliberal idea of the right to consumption. Both public and private health care have sets of ideologies, rituals of membership, and normative practices that, when mixed, shape clinical interactions as well as identities as a doctor, nurse, or patient, thereby making up a flexible medical citizenship in public and private health care.

A deeper understanding of how the mix of public and private health care is understood and experienced is important, since public and private health care establishments confer different sets of rights and entitlements; those rights are being challenged as the private health care sector expands (see also Ormund, Khoon, and Verghis, forthcoming). For instance, Horton et al. (2014) argue that the idea of health as a right, which is enshrined in many constitutions (such as Costa Rica's), is being challenged by the conversion of health into a privately purchased commodity. Horton et al. argue that neoliberalism transforms the concept of governance itself as well as the responsibilities of the individual, corporations, and the state. Similarly, this dissertation investigates important qualities and tensions of flexible medical citizenship in public and private care in the era of health care after the 1980s, when neoliberal policies expanded in Costa Rica.

How This Study Was Conducted

In order to accomplish the goals set forth in this dissertation, I conducted ethnographic, qualitative research in San José, Costa Rica, from July 2013 to May 2014, including semistructured and open-ended interviews, participant observation, focus groups, archival research, and reviews of popular media. I lived in two suburbs just outside of the city of San José, giving me access to the entire city in addition to resources and colleagues at the University

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of Costa Rica, the National University, and the Free Law School. This research design allowed me to contrast what people say they do (ideologies of health care) and what they actually do (experiences of health care).

Through the narratives and experiences of the health care professionals, health care providers, and patients,[4] this dissertation offers insight into the contrasts and tensions between the ideologies of public and private health care, as well as the practices, rights, and vulnerabilities of flexible medical citizenship. The research sample was designed to focus on the middle class in Costa Rica, since these individuals move back and forth between public and private health care, enabling a view of the mix of public and private health care. In addition, the middle class has been historically linked to social movements such as policy making in health care, facilitating the examination of narratives of how health care policy is interpreted and perceived (Cordero 2005). According to Cordero (2005, 157), a Costa Rican social scientist of the class system in Costa Rica, the Costa Rican social structure is "characterized by important participation of the middle classes" who defend, resist, celebrate, or find dangerous the movement toward the privatization of health care. Therefore, the experiences of health care professionals, doctors, and nurses, both as health care workers and as patients, are an important beginning point for understanding the experiences and perceptions of tensions between health care as a human right and health care as a commodity that emerge as public and private health care are mixed.

[4] All of the participants in this study are patients who use a range of public, private, and mixed health care options available to them. However, of the 74 semistructured and open-ended interviews, 28 were health care professionals (lawyers who work in health care, health care administrators, professors, pharmaceutical sales representatives, and pharmacists), 16 were doctors, 15 were nurses, and 15 were patients who were referred by doctors and nurses interviewed in this study. See Chapter 3 for more details.

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Social scientists of the middle class in Latin America argue that class is best understood in terms of education, household size, location of residence, and participation in the labor force (or occupation), not solely income (Birdsall 2013). Furthermore, according to Birdsall (2013) the middle class is known to fluctuate significantly with economic change such as global recession and economic restructuring. For instance, Portes and Hoffman (2003) note that fluctuations in the economy such as the contraction of public sector employment can lead to a series of adaptive solutions by the middle class. Therefore, the middle class serves as a window into the strategic uses of public and private health care and their mixing. I argue that as individuals move between public and private health care, they also engage the ideologies and practices of public and private health care; the mixing of these ideologies and practices can inform us about the medical culture of mixed health care systems. I take a critically interpretive medical anthropological approach that allows the examination of how participants understand health care as a human right, health care as a commodity, and their health care experiences within the larger context of the mixing of public and private health care.

Overview of Dissertation

In this dissertation I show how middle-class participants understand and experience the contrasting ideologies of public and private health care within the context of the mixing of these health care systems. I argue that the medical culture of these individuals comes with complex sets of ideologies, norms, practices, rights, and vulnerabilities and that an examination of these can inform us about the ongoing relations between individuals and states, bureaucracies, and corporations. I draw specific attention to the contrasts between ideology and real lived lives, public and private, state and neoliberal capitalistic.

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In Chapter 2, “The Mix of Public and Private Health Care in Context,” I situate the dissertation question by describing the emergence of public (state) and private (neoliberal, capitalist) care in Costa Rica, including their histories, ideologies, successes, and challenges. This chapter provides the context for my research question and develops the ongoing problems the public system faces alongside the factors that contribute to the growth of the private sector. I first focus on the historical context of the Costa Rican health care system, paying particular attention to the emergence of the current mix of public and private health care. I define and introduce characteristics of the current mix of public and private health care and some of the tensions between health care as a human right and health care as a commodity based on profit. This enables me to interrogate the literature on public and private health care in a novel way that interconnects with the data uncovered in my fieldwork, in order to deepen our understanding of the mix of public and private care and their ideologies.

In Chapter 3, “Setting and Methods,” I describe how I came to identify this topic, the specific places where research took place, why San José, Costa Rica, is an ideal place to do this research, my research design, and methodology. I describe the research locations and techniques that are specific to investigating the perspectives and experiences of people in two types of health care systems. I give a brief summary of my team of research assistants and how we organized fieldwork for the particularities of San José.

In Chapter 4, “Ideologies and Lived Realities of Public Health Care,” I ask: What are the ideologies, practices, and norms that underpin public health care and reinforce beliefs in health care as a human right and government as responsible for health and well-being? And what medical culture emerges as individuals comply with the norms of publically delivered health care? To answer these questions, I examine the perspectives of the health care professionals,

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health care providers, and patients interviewed in this research. I describe the ideological views and experiences that some participants have about the value of publically delivered health and health care as a human right. Their narratives shed light on the ideologies, promises, and limitations of publically delivered health care.

In Chapter 5, "Discourses on Managing Public Health Care and Its Problems," I examine the struggles, limitations, and vulnerabilities of public health care, using narratives of waiting for health care appointments and procedures. This chapter addresses two questions. First, what are some of the major problems facing public health care, and how do people deal with those problems when they experience them? Second, how do some of these individuals rework, ignore, or resist public health care and its ideologies in important and novel ways?

In Chapter 6, "Strategies of Negotiating Private Health Care and Mixed Health Care," I examine how some health care professionals and patients improvise on the public health care system by either using only private care or by mixing public and private health care. In this chapter I address the question: How do people understand and experience the mixing of public and private health care? In examining this question, I develop the idea that the culture of medicine in San José includes the blurring of the boundaries between public and private health care, as well as how some of the ideologies of private care enter into everyday talk and understanding of public health care.

Finally, Chapter 7, "Conclusion," revisits the ideas set forth in the introduction by looking at the contrasting ideologies and practices of public and private health care and their mixing. I consider how this study serves as an example of what the mix of public and private health care is like for middle-class health care professionals and patients. I explore how this topic is timely and global. I discuss the limitations of this study and call for additional studies on the

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perceptions and experiences of the blurring of the boundaries between public and private health care and how the ideologies of health care as a human right and health care as a commodity are platforms for understanding the entitlements, vulnerabilities, and ideologies of participation in public and private health care and their mixing. I propose the concept of flexible medical citizenship as a framework for understanding the mix of public and private health care. I then highlight the role of anthropology in guiding us through the terrain of complicated health care systems, and how this study advances anthropological theory on mixed health care systems.

In summary, this dissertation examines the contrasts and tensions of the mix of public and private health care and the work it takes individuals to comply with, ignore, resist, embrace, or rework those contrasts. I argue that the experiences and perceptions of the mixing of health care ideologies and practices is informative about shifts in relations to state power, bureaucracies, and corporations. Contrasts between public and private health care ideologies and practices reveal the personal costs of membership in a mixed health care system, such as waiting for care, lack of resources, or paying out of pocket. I examine how the expansion of private health care leads to a paradox where private care both undermines existing health care configurations and at the same time serves to fill in the gap of the limitations of public care. Throughout the following chapters, I examine the entitlements and vulnerabilities of flexible medical citizenship in public and private health care—a category I use to further analyze encounters between the ideologies in contrasting health care systems and individuals themselves—how they shape each other and the unintended consequences of those encounters. The concept of flexible medical citizenship can illuminate how some of the participants in this study endure the problems of public health care, some work within the public system to manage its problems, some reject the public system altogether, and others use a mix of public and private

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health care options available to them. The health care system of Costa Rica provides a key site to examine how individuals move between public and private health care and the contrasting ideologies and practices of health care as a human right and health care as a for-profit enterprise, thus illuminating the cultural dynamics of the mixing of public and private health care health care.

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CHAPTER 2: THE MIX OF PUBLIC AND PRIVATE HEALTH CARE IN CONTEXT

Introduction

When the middle-class Costa Ricans in this study access health care, they are choosing from a range of public and private health care options. This challenges the idea that Costa Rica has a single, unitary health care system. As individuals flexibly move between public and private, they also confront the challenges of public and private health care alongside the mixing of their contrasting ideologies. The challenges and ideologies of public and private health care in Costa Rica are complicated because they have emerged within a historical context where health care policies have moved back and forth between a focus on universal, primary health care and neoliberal impulses to privatize health care and promote it as a commodity (Chamberlain 2007). This chapter explores the context of the current health care climate by examining how public and private health care emerged historically, their theoretical underpinnings, and their mixing in a place that has been at the crossroads between the promotion of health care as a human right and health care as a commodity.

Since the emergence of the public health care system between 1940 and 1944, there has always been a mix of public and private health care in Costa Rica; however, in the 1980s and 1990s the private sector intensified (Ministerio de Salud 2002; Muiser, Herring, and Vargas 2008). Consequently, the ideologies and practices of public and private health care mix in emergent and complex ways. In other words, at the same time the state is promoting universal health care and health care as a human right, neoliberalism and corporate medicine are also influencing the health care climate. These factors may affect how some Costa Ricans interpret the meaning of health care and the paths they can take for health care or work in health care fields. There is a paucity of research on how the mix of public and private health care is

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perceived and experienced by the individuals who work in and use this mix of health care options (Rylko-Bauer and Farmer 2002). The history of public and private health care in Costa Rica adds to the understanding of the context of the contrasting ideologies, tensions, and practices that arise as public and private health care are mixed, and sets the stage for the chapters that follow.

The Caja Costarricense de Seguro Social (*Caja*)

Between 1940 and 1944, President Rafael Angel Calderón created the Costa Rican Public Health Care system (in Spanish, the Caja Costarricense de Seguro Social, or *Caja* for short) to cover health care of workers (Clark 2014; McIntyre et al. 2013; Palmer 2003; Sáenz, Acosta, and Bermúdez 2010). The *Caja* is an autonomous governmental institution, enabled and legitimized by the Costa Rican Political Constitution with the explicit goal to "universalize social security services in favor of the workers who reside in the national territory and responsibly pay for social security" (República de Costa Rica 1949, CPCR, Art 73, 74, and 177; Sáenz, Acosta, and Bermúdez 2010, 4). Historically, the *Caja* has provided national health insurance, public health care, physician education, and public health care for state citizens, residents, and permanent foreigner residents.

Motivations behind the Creation of the *Caja*

Palmer (2003) and Chamberlain (2007), historians of Costa Rica, describe competing perspectives on the creation of the *Caja.* One perspective states that the *Caja* was created to calm the provocations of the working class during a period of industrialization (Salas Picado 1995). According to this perspective, politicians such as Calderón Guardia calmed workers by claiming that social security would better their living conditions. In contrast, leftist scholars such as Salas Picado (1995) argue that Calderón Guardia used his position as physician and president not

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primarily to help workers but instead to gain the support of the Catholic Church and the Communist Party and consolidate his political power. From this perspective, the rights of workers were co-opted to promote Calderón Guardia's political interests.

Another perspective, put forth by Rosenberg (1983) and Mesa-Lago (2008), is that Costa Rica's system of social security is related to the diffusion of European ideas of universalism, solidarity, and equal treatment to Costa Rica. Rosenberg (1983) and Mesa-Lago (2008) suggest that Calderón Guardia thought these ideas would inevitably influence Costa Rica, so he followed suit. These ideas can be traced to international recommendations to provide laws for protection of workers, such as those proposed by Bismarck in 1879, the encyclical *Rerum Novarum* issued by Pope Leo XIII in 1891, and the International Labor Organization in the 1920s (Rosenberg 1983).

Palmer (2003) adds a perspective focused on internal debates in the medical community. Palmer describes how many members of the medical professions (primarily physicians) originally opposed the creation of social security because they thought it would end their medical monopoly. Therefore, the movement toward social security required a charismatic physician–politician such as Calderón Guardia to popularize and persuade the medical class that their professions could profit by state involvement. Calderón Guardia was successful in popularizing social security. However, the development of social security was also made possible by the abolition of the military in 1949, which made more capital available for social services (see also Palmer 2003). It is the combination of these forces, along with a large number of allied health care workers who could staff a public health care system, that made it possible for Costa Rica to develop a public health care system. One legacy of the forces that influenced the emergence of public health care is that the ideologies of public health care arose and gained credibility—

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namely, belief in universalism, solidarity, equality, government responsibility for health care, and human rights.

The *Caja* and Its Basic Services

Before 1941, health care was provided by a combination of private and charitable organizations and was not centrally organized (Lee 2012; Palmer 2003). When the *Caja* was created, social security was based on labor and territoriality rather than citizenship, making the *Caja* the unitary provider of social insurance in the country (Clark 2014; Sáenz, Acosta, and Bermúdez 2010). Then in 1961 the government universalized and centralized the *Caja* as part of a government commitment to universal health coverage that would cover all individuals residing within the country, not only workers (Muiser, Herring, and Vargas 2008). This was done through the Universal Coverage Act of 1961 (Ley de Cobertura Universal). Management was transferred to the Social Protection Board (Junta de Protección Social) in 1973, and 20 years later to the Ministry of Health and the *Caja* (CCSS 2006, 2007; Martínez Franzoni 2012; Ministerio de Salud 2002; Muiser, Herring, and Vargas 2008).

These reforms included the creation the primary health care scheme of small community-based health care centers called EBAIS (Equipos Básicos de Atención Integral a la Salud [Basic Integral Health Attention Teams]) throughout the country.[5] EBAIS community-based health care centers are typically composed of one doctor, one nurse's aide, and one technical assistant in primary health care. The EBAIS system enabled health care services to reach into the most remote areas of the country and "contributed to diminishing the urban-rural gap and to creating a nearly universal sense of belonging and shared national identity among the citizenry"

[5] The EBAIS system has its roots in programs of rural and community health that were implemented between 1973 and 1976 (L. Morgan 1993; Salas 2011). The EBAIS were implemented as the entire first level of care in 1994.

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(Sandbrook et al. 2007, quoted in Seligson and Martínez Franzoni 2005, 2–3). Financially, the health care system is made possible by tripartite contributions of mandatory income-related payments by employers, workers, and the state. The development of the national health care system has helped to make the state one of the largest employers in the country; the *Caja* is the largest "firm" in Latin America, employing close to 55,000 people, 10% of whom are medical professionals (Ávila-Agüero 2013; Muiser, Herring, and Vargas 2008).

Currently, Costa Ricans access health coverage through a network of first, second, and third levels of care according to their legal residence (Sáenz, Acosta, and Bermúdez 2010). The first level of health care includes the EBAIS clinics, each of which serves 3,500–4,500 residents. This is where residents go first for health education, and primary, preventative, and chronic health care. The second level of care includes a network of 11 major clinics, 13 peripheral hospitals, and seven regional hospitals that provide emergency, diagnostic, specialized, and simple surgical care. The third level of care includes four specialized and three national hospitals that provide high-technology, specialized, and complicated surgeries and transplants.

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Table 1. First, Second, and Third Levels of Attention of the *Caja,* Costa Rica

Levels	First	Second	Third
Type of health care center	EBAIS Peripheral clinics	Major clinics Peripheral hospitals Regional hospitals	National hospitals Specialized hospitals
Services	1. Basic health care for children 2. Basic health care for teenagers 3. Basic health care for women 4. Basic health care for adults 5. Basic health care for senior citizens	1. Emergencies 2. Diagnosis 3. Specialized outpatient consultation 4. Minor surgeries	1. Patient admissions 2. Surgeries 3. High-technology treatments

Source: Adapted from Sáenz, Acosta, and Bermúdez 2010.

In addition to the large number of patients who use the *Caja,* most doctors and nurses receive their education, necessary supplies, medical residencies, and in-service training through public universities financed by the state and *Caja* clinics and hospitals (Clark 2005; Lee 2012; Unger et al. 2008). It is reported that 90% of doctors work for the state, although it is estimated that one-third of these also have private practices (Clark 2005). After training, physicians whose education was subsidized by the state are required to work for the *Caja* as part of their contract for receiving medical school education (Clark 2005; Lee 2012). According to historian Steven Palmer (2003), physician prestige and success are first made in the public system; after attaining a reputation in the public sector, some expand into private practice (Clark 2005; Palmer 2003). Traditionally, physicians have a high level of prestige and influence in Costa Rica based on their skills, competence, quantity of experience working in the public sector, and public education, but this spills over into political influence. For example, several physicians have held key political offices as presidents or ministers. Therefore, the national socialized health care system remains

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the primary means of educating physicians, distributing health care, and influencing politics, even as privatization enters the system.

Ideologies of Public Health Care, Health Care as a Human Right, and Universalism

Ideologies of public health care, including health care as a human right and universalism, play an integral role in policy making and thinking about health care in Costa Rica (Salas 2011; Seligson 2001). For instance, according to Salas (2011), the principles that underpin the *Caja* are solidarity, equality, universalism, obligation, and social participation. Historians of health care in Costa Rica such as Miranda (2008) and Mesa-Lago (2008) argue that these ideological values are consequences of the Beveridge Report in 1942, a document that influenced the development of many welfare states. The Beveridge Report called for social security systems, underscored by health care as a human right, as well as other rights for workers (Miranda 2008). Indeed, in Costa Rica, international treaties such as the Beveridge Report enjoy constitutional rank (Hogerzeil et al. 2013).

The ideology that the public health care is a system of solidarity, income redistribution, government responsibility, social participation, universalism, and freedom from political influence also stem from the Beveridge Report (Mesa-Lago 2008). The ideology of public health care and health care as a human right was further elaborated with the 1948 United Nations Universal Declaration of Human Rights, which set the standard for universal health care as a human right that was not legally binding, yet left each nation to its own interpretation of how to best protect and enforce a right to health (Kinney 2001; Kinney and Clark 2004; L. Rodríguez and Lombaerde 2014). The right to health was then reinforced with the emergence of the World Health Organization, in particular the 1978 Alma Ata Declaration of "Health for All by 2000" (WHO 1978). Alma Ata influenced Costa Rica to focus on primary health care and improving

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health indicators as two concrete strategies to put the declaration into effect (Miranda 2008; L. Morgan 1993).

Universal access to health care is more than a belief, since it is also mandated by the Costa Rican constitution. Although the constitution contains no explicit right to health, the Constitutional Court has interpreted Article 21 on the right to life as a guarantee of the fundamental right to health, health services, and social welfare (Hogerzeil et al. 2013; Sáenz et al. 2011). The Court declared that life is the most important public good that can be protected by the state, and that health is a key aspect of life (IJSA 2013; *República de* Costa Rica 1949; Sáenz, Acosta, and Bermúdez 2010). This mandate by the court has been very influential in Costa Rican health care policy and public life (Lee 2012). According to Sáenz, Acosta, and Bermúdez (2010), Costa Rica is one of the few countries in Latin America that has almost achieved the goal of universal health care. A report by the Pan American Health Organization documents that in 2011 more than 90% of the population had access to national health insurance and public health care (Clark 2014; PAHO 2012). Costa Rica continues to participate in coalitions in Latin America to set priorities for realizing health care as a human right in collaboration with the World Bank Institute (WBI 2013).

The dominant way that scholars of health care have examined the right to health is to trace the flow of ideas from the international/transnational level to the local level (Engel 2012; Godoy 2013). Clearly policy makers in Costa Rica consider international and transnational laws, declarations, and policy seriously. This vertical view of international relations posits that human rights policies are an agent of change coming from outside developing countries like Costa Rica and have profound influence on local governments and policies. This perspective leaves out the way that Costa Rican policy makers and individuals select, reject, and adjust those policies to fit

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the local cultural, social, economic, and political context. In contrast, Engel (2012) argues for a horizontal rather than a vertical view, which enables a perspective that examines the multiplicity of ways local communities conceptualize policies such as international treaties on human rights. Shore and Wright (1997) argue that international policies do not move in a linear way from one country to another but are more complex and nuanced. This horizontal view of health care policy is closer to the reality of health care in Costa Rica and useful in understanding the perspectives and experiences of the individuals in this study.

It is reported in the literature on the Costa Rican health care system that most individuals in Costa Rica strongly believe that the government should be responsible for health care (Lee 2012; PAHO 2012; Rayner 2014; Torres 2013). Scholars of Costa Rica argue that belief in public health care forms part of the national narrative of exceptionalism—defined as a collective pride that Costa Rica is exceptionally egalitarian, homogeneous, peaceful, and democratic, in contrast to its neighbors (Hedeyat 2014). In the national imagery of exceptionalism, the public health care system is seen by Costa Ricans as one example of how Costa Rica's democracy is exceptional. These views are substantiated by WHO, which considers the *Caja* to be one of the best examples of universal health care coverage and social medicine in Latin America (along with Cuba; Clark 2011, 2014; Godoy 2015; Martínez Franzoni, Sánchez-Ancochea, and Solano 2012; OMS 2012; Sáenz, Acosta, and Bermúdez 2010; WHO 2000). According to WHO, Costa Rica's public health care system is a star performer because it covers the maximum number of people with health indicators as good as those in the United States, at less governmental expense (Clark 2014; Lee 2012; Martínez Franzoni, Sánchez-Ancochea, and Solano 2012; L. Morgan 1987, 1993; OMS 2012; WHO 2000). In addition, infant mortality and life expectancy rates are comparable to those of Western developed countries. Scholars of the Costa Rican health care

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system attribute these successes to prioritization and investments in primary health care, public health, and health promotion for all people, including the poor, unemployed, and recent immigrants in one all-inclusive health care system (Clark 2014; Martínez Franzoni, Sánchez-Ancochea, and Solano 2012; Muiser, Herring, and Vargas 2008; Torres 2013). For these reasons the *Caja* is often referred to as one aspect of Costa Rican exceptionalism by scholars, observers, and Costa Ricans themselves (Lee 2012).

Problems of the *Caja*

Problems in Costa Rica's public health care system since 1980s created a space for the growth of the private health care sector as one response to these problems. Despite 70 years of successes in the delivery of public health care, the aging of the population alongside the global financial crises of the 1980s, and 2009–2010 have led to profound challenges to the delivery of public health care. The system has faced problems of efficiency, equity, shortfalls in the number of available medical specialists and rural health workers, high levels of corruption and tax evasion, questions of financial sustainability, increasing public demands for health care, rising health care costs, and public criticism (Ávila-Agüero 2013; Godoy 2013; Hidalgo 2014; Kinney and Clark 2004; Madies, Chiarvetti, and Chorny 2000; Muiser, Herring, and Vargas 2008; Noy 2013; Rayner 2014; Rodriguez-Garcia and Akter 2000; Unger et al. 2008). Long-term economic crises, an aging population, and the large number of noncontributors to the system—such as immigrants, the poor, and workers in the informal economy—limit the successes of publically delivered care and pose problems for the delivery of timely, quality health care (Torres 2013).

In what follows, specific problems facing public health care are addressed. These include demographic changes, financial stresses, rising inequality, and managerial, infrastructural, and political problems (Ávila-Agüero 2013; Lee 2012; Torres 2013). These problems have led to the

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overcrowding of clinics and hospitals, long waits for appointments and care, deteriorating conditions in hospitals and medical equipment, and demoralization of doctors (Clark 2005; L. Morgan 1987). The Pan American Health Organization reports that financial stability and long waiting lists are the main challenges to the Costa Rican Public Health Care system (PAHO 2012). These limitations and problems inspire public and academic dialogue questioning the sustainability of the *Caja* (Torres 2013).

Demographic Changes and Financial Stresses

Declining fertility rates and rising life expectancy lead to an aging population, which consequently leads to financial imbalances, since less money is coming into the system through mandatory insurance contributions and more money is going out for high-technology and chronic health care. For example, according to Torres (2013, 1–2), "the decline in fertility rate has kept the total fertility rate lower than the replacement rate since 2005 . . . and this trend is expected continue for the next 10 to 15 years."

Other demographic factors that influence the finances and infrastructure of the public health care system are the increase in migration from rural to urban areas, along with immigration from other Central American and South American countries, both of which put stress on urban clinics and hospitals. In 2011 the CCSS had meetings to review financial issues and came up with a final report with a list of 81 recommendations for changes; however, the implementation and the success of these measures remain unclear (Carrillo et al. 2011; Torres 2013).

Rising Inequalities

Despite that idea that universal health coverage underpinned by the principles of equity and solidarity would overcome social inequalities, inequality in Costa Rica has increased in the

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last 20 years. This is striking because Costa Rica historically has had the lowest levels of inequality in Central American; inequality has been low even when compared to the United States and Europe (Hidalgo 2014; Programa Estado de la Nacíon 2014; Torres 2013). The State of the Nation report (the annual statistical assessment of social, economic, and environmental issues in Costa Rica) has reported that Costa Rica is one of the only three Latin American countries where inequality increased since 2000 (Hidalgo 2014; Programa Estado de la Nacíon 2014). The United Nations Economic Commission for Latin America and the Caribbean reported that Costa Rica's Gini Index, a measure of inequality, went up from 0.47 in 2000 to 0.50 in 2011 (Torres 2013). The documents of the *Caja* that claim that it is philosophically grounded in principles of universality, solidarity, unity, equality, obligation, and equity stand in contrast to these reports of growing inequalities (CCSS 2007; UNDP 2014). Not only are there growing economic inequities—wealthier patients bypass waiting lists by purchasing health care in private clinics, while poorer patients wait for care in deteriorating facilities with medical equipment that is often in disrepair (Programa Estado de la Nacíon 2014; Clark 2005).

Rising inequality has been attributed to rising inflation; high tariffs on imported agricultural products consumed by the poor such as milk (65%), rice (35%), and chicken (40%–150%); tax incentives for multinational corporations; high taxes for local corporations; and a widening gap in workers' skills and education (Hidalgo 2014). According to Torres (2013), the services the *Caja* is able to provide are negatively influenced by these economic factors. For instance, there are reports of inequality between the poor who primarily use the public health care system and the wealthy who have more access to the private health care system; there are also reports of inequalities of access in rural areas compared to urban areas, and less access to

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health care for undocumented immigrants and seasonal agricultural workers (Dos Santos 2015; Goldade 2009; 2011; Noy and Voorend 2015; Torres 2013).

Managerial, Infrastructural, and Political Problems

According to Ávila-Agüero (2013), financial problems are not the only issues facing the *Caja.* Research on the Costa Rican health care system has found that there are profound managerial deficiencies, as well as bureaucratic gridlock and infrastructural problems. For instance, the EBAIS system of local clinics spread throughout the country is particularly costly in terms of infrastructure. Many of the top national hospitals were built in the 1970s and need costly repairs and modifications to be modernized. These problems have reportedly led to the inability of the public health care system to meet the needs of the population (Ávila-Agüero 2013). In addition, these problems lead to questions of efficiency, quality of health care, and patient dissatisfaction, motivating patients to seek out private health care options (Torres 2013).

Conflicts of interest between stakeholders in public and private health care and political struggles over power have also been attributed to some of the problems facing publically delivered health care in Costa Rica (Gifford and Rodríguez 2011; Lehouoq and Molina 2002). In addition, government corruption is often one of the main topics in news, media, and political debates, where individuals are accused of diverting public funds to their own political or personal interests (Lee 2012). Forms of corruption such as tax evasion, employers and employees sub-declaring salaries, and late payments are costly to the *Caja* (Muiser, Herring, and Vargas 2008). The incidence of corruption is high enough that in 2013 the government made transparency and anticorruption a goal as part of the 2015–2018 National Development Plan (Transparency International 2015; Villarreal 2015).

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Waiting Lists and Long Wait Times for Care

Universal access to health care is also impeded by long waiting lists and waiting times for care (Torres 2013). Cercone and Jiménez (2008) note that the demand for health care due the large number of aging patients places demands on the public health care system that challenge its ability to meet the population's needs. This has led to a serious problem with waiting times and waiting lists (Torres 2013).

One way the patients deal with the contradiction between health care as a fundamental human right and their lack of timely access due to waiting lists is to make legal claims against the *Caja* in court (Torres 2013). Since the 1990s, there has been a significant increase in lawsuits against the *Caja* for access to medications, provision of services, supply of new and expensive technologies, and movement up waiting lists (WBI 2013). The *Caja* provides medications on its *Lista Oficial de Medicamentos* (Official Drug List) for free to people who pay their monthly fee (and to the poor through subsidies), yet many doctors and patients desire or need expensive, brand-name medications not on the official list. To get these medications, patients can either purchase them privately out of pocket or file a lawsuit against the *Caja* with the Fourth Constitutional Court. Therefore medications are free but also not exactly free. However, some have suggested that these lawsuits are an example of inequities in access, since not everyone has the same ability or influence to file them (WBI 2013).

Rising Patient Dissatisfaction

Scholars of the Costa Rican health care system note that citizens long accustomed to the entitlements and ideologies of public care are feeling the effects of the problems with publically delivered health care (Marq 2006; Torres 2013; PAHO 2012). However, reports and surveys of public satisfaction with the *Caja* offer contradictory conclusions. Some studies report that the

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Caja has been widely perceived among Costa Ricans as an example of democracy and social welfare and is supported by much of the population (Biesanz, Biesanz, and Biesanz 1999; Edelman and Kenen 1989; Palmer and Molina 2004; Rayner 2014). For example, the Latin American Public Opinion Project (see Hernández and Salgado 2014) asked questions about perceptions and satisfaction with public hospitals and quality of care; it found that 67.5% of Costa Ricans thought the government and not the private sector should be in charge of health care (Hernández and Salgado 2014). In addition, the *Latinobarómetro* 2011 survey found that 63% of Costa Ricans surveyed were satisfied with the way public hospitals work (Corporación Latinobarómetro 2013).

In contrast, other studies show that Costa Ricans are turning to private health care or using a mix of public and private health care. For example, the National Health Survey of Costa Rica used household surveys of 7,522 individuals and census data to document that 56% of the population surveyed paid for a private doctor in 2006 (Muiser, Herring and Vargas 2008).[6] According to a 2009 survey by the Institute of Population Control, 60% of respondents preferred private services to public because of better service, quality, and speed (Gutiérrez 2009). Local newspapers regularly post articles about dissatisfaction, waiting lists, and failing infrastructure in the public health care system (see, e.g., Ávalos 2014a, 2014c; Ávalos 2015a, 2015b; Herrera 2015; Sánchez 2014). Increases in the uses of the court system to file appeals against the *Caja* to get off waiting lists, get medications not on the official list supplied by the *Caja,* or to get therapies that are nonexistent in the public health care system may also signify patient dissatisfaction (Sáenz, Acosta, and Bermúdez 2010; WBI 2013). These studies use census data

[6] The 2006 National Health Survey (ENSA 2006) is a random proportional study of households and census segments with a 95% response rate. (Muiser, Herring, and Vargas 2008).

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and survey data, giving little voice to individuals themselves or how these contrasts make sense within wider social and political phenomena, which this dissertation will address.

Health Care Reforms and Intensification of the Private Health Care Sector

Challenges to the national health care system and the emergence of international and local pressures to privatize health care can be traced to the worldwide recession of the 1980s. Recession led to a decrease in salaries, an increase in unemployment, and thereby a decrease in the number of employers and employees contributing to the national health insurance fund. At the same time, demands for high-technology medicine were increasing the cost of health care (Fiedler 1996; Torres 2013). This was seen as a crisis for public health care (Fiedler 1996). In response, there have been public, governmental, and international demands for health care reform and interest in health care privatization.

Although not always called "privatization," reforms to privatize aspects of *Caja* existed from the beginning (Chamberlain 2007; Salas Picado 1995). What was new about the 1980s and 1990s was that the severe economic crisis arose alongside financial burdens created by the rise in life expectancy, which stemmed from successfully decreasing deaths from infectious diseases and cancer, heart disease, and hypertension (Chamberlain 2007). Reforms throughout the 1980s and 1990s included austerity measures of the state and pressures from the World Bank, International Monetary Fund, and World Trade Organization to reduce outlays for state-organized health care (Jasso-Aguilar, Waitzkin, and Landwehr 2004; Nichter 2008; Mulligan 2012). Reductions included limiting overtime for health care workers, as well as limiting the distribution of materials such as soap, towels, paper, and pencils (Chamberlain 2007; Salas Picado 1995).

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In 1993 Costa Rica accepted a World Bank health sector loan of $22 million to reorganize the health care system for more efficiency, access, and quality of care (Clark 2011). Structural adjustment programs attached to these loans required that Costa Rica cut back on public sector spending (such as health care) while privatizing some government industries to stimulate growth and pay back debts (Clark 2011; Stoker, Waitzkin, and Iriart 1999). For example, the government was allowed to divert public health care funds to other projects (Marq 2006; Sáenz et al. 2011). Another part of the negotiation of the World Bank loan was the Ministry of Health and the *Caja* were reorganized so that "the Ministry of Health became the steward of the health care sector, and the social security fund [*Caja*] introduced a quasi-market model to organize its duties as financier, purchaser, and provider of most of the health care services in the country" (Muiser, Herring, and Vargas 2008, 53).

These policies also permitted the entrance of multinational foreign capital into publically financed institutions, a process that was occurring throughout Latin America (Iriart and Waitzkin 2006). It is notable that at the same time that some in the United States were debating the need for more equitable access to health insurance and public health care, neoliberal global interests were expanding in Latin America and Costa Rica (Stoker, Waitzkin, and Iriart 1999).

In addition, international and local government policies toward growing the private health care sector coincided with long waiting lists (such as inpatient care and treatment by specialists), deteriorating infrastructure, high debt, management problems, and patient dissatisfaction with public health care. These factors contributed to a health care climate of increased uses of private health care (Ávalos 2014a, 2014c; Clark 2011; Torres 2013).

Due to these policies and problems, physicians as well as patients have incentives to turn to the private health care sector. For instance, it is estimated that 30% of physicians work in a

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mix of public and private health care (Clark 2005; Lee 2012). Doctors also face problems of attaining medical residencies in the public sector, which sometimes moves them toward private health care. Lee's (2012) ethnographic study of medical tourism in Costa Rica found that although all doctors' residencies are provided by the *Caja,* only a limited number of residencies are allotted to each specialization. According to her interviews, doctors who do not get a residency position must keep applying, work as a general physician, or change careers (Lee 2012, 67). Due to the growth of the private sector and expansion of medical tourism, physicians have more options to work in the private sector.

In 2009, after much public debate, 85 years of public monopoly over national health insurance ended with the ratification of the Central American Free Trade Agreement (CAFTA) (Clark 2011; Rayner 2014). Health care figured prominently in public debates over CAFTA. In particular, some argued that trade liberalization conflicted with Costa Rica's constitutional values of state provision of public health care; others argued that CAFTA would lead to economic growth and market stability (Clark 2011; Fernandez 2007; Pearson 2013; Rayner 2014). Since the implementation of CAFTA, the Costa Rican government now allows international health insurance providers to offer local coverage for the first time (Sáenz et al. 2011). Although the use of voluntary private health insurance is only a fraction of the total private health expenditures, according to Torres (2013, 4), the use of this type of insurance is increasing. Therefore some Costa Ricans can now take advantage of the option to buy international private health insurance. This option increases competition between the public and private health care sectors, possibly decreases the reliance on public health insurance for some

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individuals, and threatens the sustainability of public health care (Clark 2014; Torres 2013).[7]

Movement toward liberalizing health care is not linear. For instance, between 2006 and 2011, the Costa Rica Ministry of Health was reorganized with the goals of health promotion, health prevention, and social well-being (PAHO 2012). Yet interest in making the health care market internationally competitive continued. In 2009, President Oscar Arias proclaimed that the government was making medical tourism a national priority in order to push forward goals to diversify the economy and create a medical marketplace niche (Lee 2012; Warf 2010). In other words, health care policy has moved back and forth between a focus on public health care and centralization and a focus on liberalizing health care and decentralization.[8]

There is a gap in research on how the everyday lives of people and institutions are caught up in these trends. For instance, there is little accurate data regarding how many people are buying private insurance and how it may structure health care choices and access (Clark 2011; Hernández, Ortiz, and Salgado 2014; Torres 2013). In addition, there is a paucity of research on how individuals perceive and experience the growth of the private health care sector. In 2006 the Encuesta Nacional de Salud (National Health Survey) found that 31.3% of all households reported that they had seen a private health care provider in a three-month period (ENSA 2006;

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[7] According to data from the Ministry of Health (Ministerio de Salud 2002) and Muiser, Herring, and Vargas (2008), between 1991 and 2001 public health sector expenditures as a percentage of gross domestic product (GDP) decreased as private health sector expenditures increased. Muiser, Herring, and Vargas (2008, 67) note that "the relative increase from 6.9 to 7.4% in GDP can be translated in a relative decrease in public sector expenditure from 76.8 to 71.0% of the total health expenditure and a relative increase from 23.2 to 29.0% in private expenditure. . . . In other words, the relation between public to private health expenditure changed from 77/22 to 71/29 between 1991 and 2001."

[8] Goodale and Postero (2013) note that in Latin America there has been a tradition of resisting neoliberalism (liberalizing trade and reducing public spending) and interrupting neoliberalism by refocusing on state public services and limiting trade liberalization. The result is a contradictory landscape where parts of the market are aligned with trade liberalization and the ideologies of profit and other parts are aligned with the social contract of the state.

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Muiser, Herring, and Vargas 2008). A 2007 study by the University of Costa Rica found that only 44.0% of the population reported not paying for a private doctor, while 56% did (Muiser, Herring, and Vargas 2008; Poltronieri 2007). Other research found that in 2008, out-of-pocket expenditure for health care was 29% of the total health expenditure (McIntyre 2011; McIntyre et al. 2013; Torres 2013; Zúñiga-Brenes, Vargas, and Vindas 2012). McIntyre (2011) also reports that in 2011 about 10% of the population used the private sector. These numbers are striking in a society that relies on and believes strongly in inexpensive, quality, publically delivered health care. Finally, there is a paucity of research on the experience of mixing public and private health care as an adaptive strategy to survive instability in the public health care system or as a creative alternative to the assumed hegemony of neoliberalism.

This study focuses on how the paradox of the contrast between health care as a human right and health care as a commodity articulated by these trends is not resolved but continues to influence how public health care and private health care are experienced and perceived. Even though the majority of patients use the public health care system, payments for private health care products, medications, health care services, and office visits account for a significant portion of health care spending (Clark 2002; PAHO 2012). Therefore, although the *Caja* has endured in spite of pressures to privatize and problems of publically delivered health care, the private sector makes up a significant part of the health care climate of Costa Rica (Hernández and Salgado 2014; Torres 2013).

The Mix of Public and Private Health Care in Costa Rica

Currently the Costa Rican health care system is a mix of public health care and private health care (Muiser, Herring, and Vargas 2008; Noy 2013). Starting in the 1980s and 1990s, due to international pressures to liberalize the economy and an ongoing financial crisis, the health

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care reforms put forth by the Costa Rican government have permitted aspects of privatized health care to increase nationally and intersect in various ways with the public sector (Clark 2010; Homedes and Ugalde 2002; Muiser, Herring, and Vargas 2008; Sáenz et al. 2011). Examples of this mixing as described by Muiser, Herring, and Vargas (2008) are mixed medicine, public health care sector contracts with the private health care sector, health care cooperatives, private ambulatory services used for getting to public hospitals, and company doctors.

Some scholars of comparative health care systems note that the mix of public and private health care blurs the boundaries between public and private (Flood and Thomas 2010). For example, the *Caja* purchases services from the private health care sector, and the government is allowed to divert public health care funds into other projects (Marq 2006; Sáenz et al. 2011).

International development scholars and anthropologists define the ways the boundaries between public and private health care are further blurred in the use of private health care insurance, government reliance on public–private cooperatives, the corporatization of hospitals, and medical tourism (Clark 2010; Flood and Thomas 2010; Lee 2012; Sáenz, Acosta, and Bermúdez 2010; Sáenz et al. 2011). In all of these cases, public and private health care mix resources, infrastructure, personnel, patients, and services. This creates a context in which public and private health care are not independent but instead are interdependent and contingent on each other. An oversimplified view of the Costa Rican health care system is that it is a unitary, purely public health care system. However, Lee (2012) shows how in many ways the successes of the private sector are built upon the successes of the public system, such as the public sector providing the education for physicians who work in the private sector. Therefore, the public health care system is both interconnected to and supports the growth of the private health market.

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There are two seemingly conflicting trends: to expand universal health care coverage and to experiment with mixed models of medicine (Noy 2013).

Willis and Khan (2009, 1003) argue that policies of the interlinking between public and private may contribute to the growing role of the market in public health care. They argue that the mixing of public and private health care sectors make the health care climate more complex than a simple government–market dichotomy, since the public and private health care sectors are interdependent. It is important to understand the background of how these various schemes mix public and private health care to understand the context for how individuals experience and perceive the mix of public and private health care in Costa Rica.

Mixed Medicine

One example of the blurring of the boundaries between public and private health care is mixed medicine. Mixed medicine (*medicina mixta*) was introduced in Costa Rica in 1989 (Muiser, Herring, and Vargas 2008). Mixed medicine is defined as a scheme where patients who are insured by the *Caja* purchase medical consultations and acquire prescriptions from private providers at their own expense, but the *Caja* covers the costs of medications, laboratory tests, and exams ordered by the private physician (Knaul, Gustavo, and Zúñiga 2002). According to Willis and Khan (2009), mixed medicine is one of the ways the state uses the private health care sector to meet some public health care needs. Flood and Thomas (2010) argue that mixed medicine blurs the separation between public and private health care because it gives a greater role to public–private partnerships within a publically funded health care system.

Public Contracts with the Private Health Care Sector

Health care reforms of the 1990s included increases in public health care contracts with the private health care sector, such as purchasing diagnostic and treatment services from selected

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clinics and hospitals (Muiser, Herring, and Vargas 2008), or contracting agreements for the management of some EBAIS. However, these expenditures are officially counted as public expenses, thus showing another way that public and private are mixed. Unger et al. (2008) reviewed trends of mixing public and private health care and found that public contracts with the private sector for diagnostic and treatment procedures have led to more patients using private health care.

Health Care Cooperatives

Since 1988, health care cooperatives have been used as an innovative scheme to "combine the advantages of public and private approaches to health care service provision" (Gauri, Cercone, and Briceño 2004, 292). Health care cooperatives are autonomous clinics that are managed by private corporations at a health care facilities leased from the *Caja* (Gauri, Cercone, and Briceño 2004). In other words, health cooperatives are nongovernmental organizations that work to provide health care through a scheme of utilizing a mix of public and private financing and provision. Cooperatives are an example of how the Costa Rican government instituted health care reforms to increase market participation in public health care. Cooperatives make private profits for their shareholders but must also make detailed legal agreements with the *Caja* and serve public health care interests defined by the *Caja.*

Ambulance Services and the Company Doctor

According to Muiser, Herring, and Vargas (2008) one of the biggest trends in using the private health care sector is the individual purchase of private ambulance services to get to public and/or private hospitals, although there is not much written about this trend. In 1974 a mixed system called *medico de empresa* (the company doctor) became popular: employers hire a

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private health care provider to provide health care services to employees on site, yet the *Caja* covers medications, exams, and laboratory tests.

Ideologies of Private Health Care

This dissertation is situated within the framework of the global flow of neoliberal ideas from Northern developed countries to Costa Rica, arguing that the market is the most efficient and profitable way to deliver health care. The ideologies of private health care include an assemblage of discourses and practices emphasizing that health care is best organized by principals of efficiency, competition, entrepreneurialism, and individual autonomy (Comaroff & Comaroff 2009; Ganti 2014; Quan 2005). Although scholars and policy makers have defined neoliberalism in diverse ways, in general neoliberalism is both a system of ideas promoted by a network of right-wing intellectuals and policy makers and an economic system that promotes more profitability in capitalism by reducing the role of the state in the economy (Connell and Dados 2014; Wilson 1994). Proponents of neoliberalism argue that these policies can remove distortions of the overbearing state and improve the economy. Therefore, neoliberalism is both a set of ideologies that shape ideas of what is ethical about markets and a practice of governing that prioritizes competition, self-interest, efficiency, and the unregulated free market (Ganti 2014). Both the ideological and structural aspects of neoliberalism shape local health care understanding and experience. For instance, the main features of this school of economic thought include balanced budgets, productive investment in place of social expenditures, tax reform, incentives for foreign investment, privatization of state enterprises, extreme emphasis on individual responsibility, and liberalization of exchange rates and trade; these features shape both ideas and behavior (Ganti 2014; Hilgers 2010; Kadia 2015; Wilson 1994).

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Since the 1970s, the global spread of the objectives of neoliberalism has extended to Costa Rica and led to local debates and decisions about how much of these policies to permit in the Costa Rica health care climate (Chamberlain 2007). Since then, Costa Rica has gone through periods of alignment with the neoliberal principles and practices of economic competition, individualism, profit, and efficiency, and periods of resistance to those ideas (see also Chamberlain 2007; Ganti 2014). In part, the privatization of segments of the public health care system in Costa Rica can be attributed to the domestic deployment of ideas that the market can work by an "invisible hand" to add more efficiency to health care, even though these steps may be destabilizing to the existing public health care system (Chamberlain 2007; Wacquant 2012).

Therefore, neoliberalism is more than a set of economic policies and practices; it is also set of ideas about how to imagine the state and health care, and these ideas shape the cultural practices of individuals and institutions (Cruikshank 1994; Ganti 2014; Hilgers 2010; Lyon-Callo 2004; Rose 1999). It is these cultural and ideological aspects that are important to the present study because they show that neoliberalism is tied to culture; neoliberalism shapes how to think about and put into practice ideas of the state, citizenship, social insurance, and individual freedom (see also Rose 1999). Scholars are concerned that neoliberalism will impact health care negatively by moving the focus of health care from well-being toward profit (Ganti 2014).

However, scholars also argue that the state authority is not diminished in the neoliberal era but is instead reconfigured. For instance, in thinking about the state, Wacquant (2012, 66) notes that what is *neo* about neoliberalism is not the freedom of the market from the state but the "redeployment of the state as the core agency that sets the rules and fabricates the subjectivities, social relations, and collective representations suited to realising markets." Wacquant (2012) argues that rather than being a free market where state power is lessened, the neoliberal state

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gains power and authority in its role of regulating markets and access to its services. Scholars argue that the interplay between the authority of the market and the state creates new definitions of personhood, patients, health, and bodies (Rose and Novas 2005). Therefore the social state that provides universal health care in Costa Rica—alongside private medical corporations, hospitals and clinics that promote private care, together with the individuals who work in and use them—are all caught up in the processes of neoliberalism and state making. The mix of public and private health care creates a climate of the mixing of ideologies, rather than a linear shift in ideologies (from one to the other) that challenges entrenched ideas about the meaning of health care, as well as who is entitled to and responsible for health care.

A theoretical overview of neoliberalism is important to consider for two reasons. First, ideologies of neoliberalism underpin the intensification of the private health care sector and organize the way that health care is practiced and conceptualized, contributing to a medical culture where public and private health care are mixed. Second, the way that individuals do or do not subscribe to the idea that health care is most efficiently delivered in the form of a commercial marketplace needs to be examined.

Anthropologists who examine neoliberalism have developed various approaches with corresponding contributions and limitations to examine the perceptions and experiences of the mix of public and private health care. For instance, Marxist scholarship pays attention to the material and historical conditions that contribute to the global spread of neoliberalism (Comaroff and Comaroff 2000; Harvey 2005). In this conception, neoliberalism is seen as a direct imposition of neoclassical economics on social democratic governments through the hegemony of international financial institutions. Governments accept the imposition of neoliberal ideas of organizing the state and markets because they need access to international loans, and they must

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focus on paying back debts and economically restructuring state institutions as a condition of those loans (Escobar 1995; Wilson 1994). Marxist scholars argue that the policies of neoliberalism are hegemonic, especially in limiting the role of the state in the economy by forcing the state to balance budgets, reduce public expenditures, reform taxes, give incentives to forcing investors, privatize state enterprises, and promote private property rights and trade liberalization (Wilson 1994). For these reasons, they further argue that social protections of the state are threatened by the forces of neoliberalism (Noy 2013).

However these conceptions of neoliberalism examine the impact of global policy on local governments as monolithic, thus undertheorizing the role of institutions and local actors who pick and choose among neoliberal ideas (Wacquant 2012; Wilson 1994). For example, according to Wilson (1994), the Costa Rican state often does not follow the conditions of international loans, thereby making its own policy choices. Consequently, policy choices in Costa Rica have fluctuated between embracing neoliberalism and resisting it (Goodale and Postero 2013; Noy 2013). In addition, local political actors within competing political parties have promoted neoliberal agendas, so that the state is not the only or primary actor (Wilson 1994). Noy (2013, 265) argues that in the neoliberal era there is both "more market *and* more state involvement in the health sector in Latin American countries." This reveals that neoliberalism is more flexible by examining how notions of neoliberalism shape the perceptions and experiences of people and populations through various technologies and that strategies employed by the government and other political actors are not always monolithic (Noy 2013; Wacquant 2012). Similar to Wacquant's argument, this dissertation considers how neoliberalism is culturally constructed. More specifically, I examine how Costa Rica national policy makers decide what aspects of neoliberal policies to include and exclude, as well as what is regulated and what is not regulated,

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the shaping the environment in which individuals secure their work and their health care. For example, individuals themselves pick and choose among the contrasting ideas of health care as a social, state project and health care as a neoliberal project.

Similarly, Ong (2006, 1) examines how Asian governments “have selectively adopted neoliberal forms in creating economic zones and imposing market criteria on citizenship.” In Ong’s ethnography of neoliberalism in East and Southeast Asia, she shows how neoliberalism is malleable and how market-driven programs shape various conceptualizations of citizenship and sovereignty. Following Giorgio Agamaben, Ong is concerned with what the interplay between the social state and neoliberal market reforms can tell us about who is included and who is excluded in policy decisions. This interplay organizes people and their rights and benefits. Like Ong, this dissertation is concerned with how rights, benefits, and vulnerabilities are constructed and practices as policies of the state and the market mix.

Vinh-Kim Nguyen (2009) also argues that the state is linked to global political processes that can be used to secure government interventions and validate who can be included and excluded from claims to human rights. Nguyen uses the example of enrolment in HIV treatment programs in Africa; his points highlight questions about who has the right to basic health services and who should provide them as states, NGOs, juridical systems, and international financial institutions mix. According to these scholars, the mix of public and private, health care as a human right and health care as a commercial enterprise, is a significant context in which health professionals and patients work in and access health care.

Conclusion

Traditionally, the aims of health care as a human right have been achieved in Costa Rica through the national health care system. However, the neoliberal model of human rights includes

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other ideas concerning the right to health such as: the right to choose public or private health care, thus redefining the meaning of health care as a human right (WBI 2013). The combination of policy, problems with public health care, and the intensification of the private health care sector has created a medical health care context where public and private health care mix in complex ways. I follow Godoy (2013), who argues that what often gets lost in the literature about the continuous strategizing about health care rights and privatization are the everyday understandings and experiences of the health care professionals and patients who work in and use public and private health care. This rest of this dissertation examines how the mix of public and private is put into practice. This illustrates how the idealization of public care alongside experiences of its destabilizing problems to beliefs that private care is better, makes further privatization thinkable. In addition, the mix of public and private health care can lead to new rules, practices, and conceptualizations of health care.

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CHAPTER 3: SETTING AND METHODS: CONDUCTING FIELDWORK ON THE MIX OF PUBLIC AND PRIVATE HEALTH CARE

Introduction: Fieldwork on the Mix of Public and Private Health Care

Health care in San José, Costa Rica, consists of a mix of publically provided national health care alongside a range of private health care options. San José serves as an example of a trend that is taking place in Latin America, where national health care systems are facing pressures to privatize (Hernández and Salgado 2014; Homedes and Ugalde 2005; Mesa-Lago 2008; C. Williams and Maruthappu 2013). Costa Rica has not privatized and currently has no plans to privatize its national health care system. However, financial stresses such as government debt, rising health care costs, and the high volume of patients, as well as health care reforms and international neoliberal pressures, have led to the expansion of the private health care sector (Torres 2013). For these reasons, many Costa Ricans use a mix of public and private health care (Lee 2012; Noy 2013; Torres 2013). For instance, although participation in national health insurance is mandatory, it is also reported that about 25% of the total health expenditure is on private, out-of-pocket health care (Knaul, Gustavo, and Zúñiga 2002). Yet, little is known about how this mixture of public and private health care is experienced and understood by the people who work in it or use it to meet their needs. Therefore, this dissertation asks: How do Costa Rican health care professionals and patients, who are part of a culture that embraces the idea of the state provision of universal health care, comply with, ignore, resist, embrace, or rework the contrasting practices and ideologies of public and private health care?

In order to answer this question, this study was designed as an urban ethnography of a wide range of research sites including public and private hospitals, local public clinics, public regional hospitals, and private hospitals and clinics. Qualitative research methods were employed

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in this study, such as semistructured open-ended interviews, observations, and focus groups with health care professionals, physicians, nurses, and patients. This type of methodology is effective for examining the ideologies, practices, and norms that emerge with the mixing of public and private health care as well as illuminating the medical culture that emerges as individuals participate in a flexible medical citizenship in public and private health care.

This chapter provides a description of the settings of this research, followed by an overview of how data was collected and analyzed. Together these sections demonstrate the research approach I employed to examine the complex environment of public and private health care in San José.

Field Sites

Costa Rica is located between Panama, Nicaragua, the Caribbean and the Pacific; it is slightly smaller than West Virginia and is defined as an upper-middle-income country according to World Bank criteria (World Bank 2015). According to the 2014 census, Costa Rica has a population of 4.7 million, with more than one-third living in the San José metropolitan area (CIA 2015). Both citizens and scholars have long considered Costa Rica to be a leader in the Central American region for its democracy, for its health indices similar to those in developed countries, and for being a country without a military (Biesanz, Biesanz, and Biesanz 1999; PAHO/WHO 2008). Costa Rica is also known for its national health care system, which has promoted social and educational policies throughout its history (Biesanz, Biesanz, and Biesanz 1999). Yet this image of Costa Rica as the so-called "Switzerland of Central America" is being challenged by current events.

Since the 2009–2010 economic recession, Costa Rica now faces rising gaps between the rich and the poor, a decrease in voter turnout, corruption, national debt, and crumbling

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infrastructure of public hospitals and clinics (Programa Estado de la Nación 2014; Seligson and Martínez Franzoni 2005). These factors are related to financial stress and concerns about the sustainability of the public health care system. In addition, according to research on the Costa Rican health care system and news coverage, many patients are dissatisfied with public care and some are turning to the private health care system (Torres 2013; Arias 2015).

Figure 1. Map of Costa Rica. *Source:* https://www.lib.utexas.edu/maps/costa_rica.html

The city of San José, Costa Rica serves as a useful research site because it is the capital of Costa Rica; the seat of the offices of the Ministry of Health and the Costa Rican Department of Social Security (*Caja Costarricense de Seguro Social,* or *Caja* for short); the location of 29 public hospitals and six private hospitals; and a center for biotechnology research institutions and

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pharmaceutical companies. Therefore, the city of San José provides access to the range of public and private health care settings used by doctors, nurses, and patients.

Research sites in the public sector in this study were one national public hospital, one regional public hospital, and three local public clinics. Research sites in the private sector were five private hospitals and two private clinics. The names of these clinics and hospitals have been changed to ensure anonymity. These contrasting public and private health care settings represent different degrees of reliance on socialized and privatized medicine pertinent to this study. In addition, these two kinds of research sites offer variances in how the ideologies, entitlements, and vulnerabilities of public and private health care are constructed, understood, and experienced.

Public Hospitals and Clinics

The public system is divided into three levels of care. The first level includes more than 1,000 local clinics called EBAIS,[9] each covering about 4,500 inhabitants, which provide preventative and primary health care services (Clark 2014; Knaul, Gustavo, and Zúñiga 2002; PAHO/WHO 2008). The second level offers clinical and hospital services provided by 7 regional hospitals and larger clinics. The third level includes 3 national general hospitals, 6 specialized hospitals, and 10 specialized centers and laboratories in San José that provide hospitalization, specialist, pharmaceutical, and diagnostic care. Patients are assigned to clinics and hospitals according to their place of residence.

One main public hospital, one regional public hospital, and two local public clinics were selected for this study as examples of the range of public care in the city: Hospital Central Valle (a main national hospital), Colinas Azules Hospital Regional (a regional hospital), EBAIS del

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[9] Local clinics are called *Equipos Básicos de Atención Integral de Salud* (EBAIS) in Spanish, or Basic Integral Health Attention Teams in English.

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Oeste and EBAIS Universitaria (two local clinics). Hospital Central Valle is one of the top three public hospitals in San José, serving approximately 56% of the residents of the city. It is known for having the best specialists in the country, providing heart transplants, surgeries, and cancer care as well as all the primary hospital services. Colinas Azules Hospital Regional is one of the most highly regarded regional public hospitals serving only one residential area of the city. EBAIS Universitaria is an example of a local clinic within the city, and EBAIS del Oeste is an example of a rural clinic lying just outside the city limits.

Private Hospitals and Clinics

Five private hospitals and two private clinics were selected as research sites in this study: Hospital de Nuestra Señora de Los Ángeles, Hospital Contemporáneo, Hospital Metodista Central, Hospital Urbano, Clinica Norte, and Clinica Nueva. These hospitals and clinics serve a cross section of the class, gender, age, and ethnic differences in Costa Rica, but cater to upper- and middle-class Costa Ricans as well as medical tourists. They offer a range of specialty medical services, outpatient care, plastic surgery, and emergency care. In addition, these hospitals and clinics either have hotels attached or arrange for hotel and rehabilitation accommodations for patients.

Ethnographic Qualitative Research

The research question in this dissertation was developed after five weeks of preliminary research in San José, Costa Rica, in 2010. During preliminary research it became clear that the public health care system was facing serious challenges and pressures to privatize parts of the system. Preliminary interviews showed that doctors, patients, and nurses were caught in the middle of these challenges and pressures as they strategized to make careers in the health care field, deliver health care services, or secure health care for themselves. Additionally, in

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preliminary interviews I found that while nearly all participants felt strongly that the public health care system is an important element of the Costa Rican state and being Costa Rican, many used the private health care system for employment and health care.

I chose qualitative ethnographic research methods for this study because they gather information on "understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell et al. 2007, 4). Many previous studies of health care in Costa Rica have relied heavily on policy maker and administrator interviews, surveys, and economic data, which cannot completely account for the complexity of the daily perceptions and experiences of public and private health care. In contrast, ethnographic qualitative research is used to describe and analyze the underlying meaning that informs people's behavior alongside actual behavior. Thus, the anthropological contributions of this project rely on its ability to (a) offer insight into the phenomenological experiences and understandings of health care professionals, physicians, nurses, and patients; and (b) examine the medical culture that emerges when health care professionals, physicians, nurses, and patients move among and between public and private health care settings where the degree of reliance on socialized and privatized medicine varies.

Research Methods

In order to answer the proposed question, this study uses standard ethnographic tools: semistructured and open-ended interviews, participant observations, focus groups, library research, and reviews of local media reports. The bulk of the primary data was semistructured interviews with urban, middle-class individuals who work in and access a range of public, private, and mixed health care. An innovative aspect of this study is to explore and analyze how different health care practices and ideologies are manifested in different public and private health care settings.

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Interview data focused on how a wide range of patients, some working in fields related to public and private health care or a mix of public and private health care and some who are not related to the health care industry at all, talk about their health care understandings and experiences. Interviews were useful for eliciting narratives from individuals whose voices would not usually be heard (Hill 2005, 183; Quinn 2005, 9). A challenge in conducting qualitative research is to have a sample large enough to exhibit a sufficient range of perspectives to discern patterns and relationships pertinent to the research question, yet small enough to obtain the depth of information necessary to fully explore the phenomenon in question. According to literature on qualitative sampling strategies, a sample of 10 per subject group is sufficient for open-ended interviews and observations (Bernard 2006; Creswell 2007).

Interviews alone cannot capture the complexities that spontaneously arise when people interact (Quinn 2005). For this reason, observations of daily life, hospital waiting rooms, and clinical encounters added depth to the data from interviews by illuminating the structure of interactions between people and triangulating the data collected. However, participant observation also presents a theoretical problem since it is possible to miss the implications of structures of power and historical context because these forces are not immediately visible in everyday observations of individuals (Brotherton 2003). This is why multiple methods were useful in this study. For example, in addition to interviews and observations, I conducted two focus groups with nursing students enrolled in courses at a public university in order to gather understandings about public and private health care that emerged as individuals interact with each other; these insights might not emerge in interviews or observations alone (D. Morgan 1997). Focus groups allow for rich ethnographic data about collective human interactions and group beliefs (Bernard 2006; Madriz 2000). Finally, archival and media research formed the

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background for this study and enabled an understanding of the current debates and ideological frameworks surrounding public and private health care.

Participant Recruitment

Interviewees were a purposive convenience sampling of individuals who work in or get their care in a mix of public and private health care settings. Research participants were first recruited from contacts made during preliminary research. Additional contacts were made through my research assistants and referrals during interviews.

At the end of each interview participants were asked for referrals for health care professionals, doctors, nurses, and patients for interviews, focus groups, and observations. Nearly all participants showed great interest in the project and provided between one and three referrals. My criteria for selection were only that participants be between the ages of 19 and 99, and that they either have worked in and around public and/or private health care, or have been patients in public, private or mixed health care settings. Participants were chosen from lists of referrals a cross section of the public, private, or mixed uses of health care common to San José.

Semistructured and Open-Ended Interviewing

The study consisted of a purposive convenience sample of 74 semistructured, open-ended interviews of individuals who use a range of public, private, and mixed public and private health care. All of these 74 individuals were patients since they use public, private, and/or a mix of public and private health care for their own health care, as well as that of their families. Of the 74 interviewees in this study, 28 were professionals with careers related to health care (lawyers, health care administrators, academics, pharmaceutical sales representatives), 16 were doctors, 16 were nurses, and 15 were patients whose work was not related to the health care professions and who were referred by doctors and nurses in this study.

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Table 2 summarizes selected characteristics of all the interview participants in this study. In all, there were 28 males and 48 females, ranging in age from 19 to 88 years of age, with a mean age of 47 years. Most were married, and all spoke Spanish as their primary language. The majority were born and live in the San José metropolitan area and attended college or had college degrees. Most had professional careers; however it should be noted that 11% were retirees, students, or homemakers. The majority identified as Costa Rican; one identified as Cuban, one as Afro-Caribbean, and two were of Asian descent.

Questions about work in public, private, or varied experiences in both public and private settings revealed that 26 (35%) have worked only in the public sector, 22 (30%) only in the private sector, and 20 (27%) have worked in both during their careers. Questions about whether they use public, private, or mixed public and private health care revealed that 23 (31%) use public only, 16 (22%) use private only, and 35 (47%) use a mix of public and private. Although I did not seek a representative sample, it is interesting to note how this sample compares to census figures. According to the World Bank (2015), in 2014 48% of high school graduates were enrolled in some tertiary educational program (education past secondary education). The research institution Consejo Nacional de Rectores in 2008 reported that 9.3% of the population had a college degree, compared to a 28% average for countries in the Organisation for Economic Cooperation and Development (Castro 2010; Organisation for Economic Cooperation and Development 2009). This study included people of higher educational background than the average for Costa Rica, yet still many of these individuals had to work hard to get their health care.

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Table 2. Selected Characteristics of Interviewees ($N = 74$)

Characteristic	Number	%
Gender		
Male	28	38
Female	46	62
Age range		
18–24	2	3
25–34	14	19
35–44	20	27
45–54	14	19
55–65	17	23
>65	7	9
Highest level of education		
Some high school	1	1.4
Some trade school	1	1.4
High school	1	1.4
Some college	4	5.4
Bachelor's degree	29	39.2
Master's degree	11	14.8
MD	21	28.3
PhD	2	2.7
Law degree	4	5.4
Profession		
Academic	8	10.8
Lawyer/judge	3	4.1
Health care administrator	10	13.5
Physician	16	21.6
Nurse	15	20.2
Medical technician	2	2.7
Physical therapist	1	1.35
Pharmaceutical industry	3	4.1
Health care marketing	1	1.35
Social work	1	1.35
Supervisor/office manager	2	2.7
Secretarial	2	2.7
Teacher	1	1.35
Travel agent	1	1.35
Homemaker	3	4.1
Student	1	1.35
Retired	4	5.4
Works in:		
Public health care only	26	35
Private health care only	22	30
Both public and private	20	27
Student/homemaker/retired	6	8
Personally uses:		
Public health care only	23	31
Private health care only	16	22
Both public and private	35	47

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Semistructured/Open-Ended Interview Procedures

Participants took part in this study voluntarily. Interviews were arranged by telephone and e-mail to be conducted at locations comfortable and convenient for participants (homes, offices, cafes, and a conference room at my apartment set up for meetings). Of the 74 interviews, 72 were conducted in Spanish and two in English at the request of the interviewees. The study received ethical approval from the Human Subject Institutional Review Board at Michigan State University. Following Institutional Review Board regulations and standard ethical practices, participants were given a consent form at the beginning of each interview. They gave their written informed consent to be interviewed and/or tape-recorded. All names and identifying characteristics have been changed to protect anonymity. In addition to obtaining written consent, I verbally reiterated to participants that all data collected would be anonymous and that they could choose whether to have their interview tape-recorded or not.

Interview Schedule

Interviews were the primary source of data to learn about the understandings and experiences of public and private health care and their mixing in Costa Rica and how public and private health care are negotiated and managed. Interviews were piloted and revised in the first months of research. I began with an interview schedule that reflected themes from preliminary research. The interview schedule included semistructured interview questions, open-ended questions, and probes to solicit answers on appropriate topics. Using both semistructured and open-ended questions allowed me to follow the same set of topics for each interview for later comparative analysis while permitting participants to answer in the way they chose (Bernard 2006). The strength of this method is that it is thorough and can be used to make comparisons, while still allowing for unexpected data to emerge.

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Participants who took part in this study were asked to provide an account of their work in and personal and familial use of public, private, or a mix of public and private health care. They were asked to describe their perceptions of the current health care situation in Costa Rica. The interview schedule questions reflected the following key themes that emerged in preliminary research:

1. **Experiences of the health care system**. Participants were asked about their experiences in work or getting health care in public and private settings to orient them to the interview process, as well as to gather health care narratives.
2. **Perceptions of public care, government responsibility, and health care as a human right.** Participants were asked to talk about the current public health care system, its characteristics, changes, values, and challenges.
3. **Experiences with private care, privatization, private insurance, and using bank loans and credit cards for health care.** These questions gathered health care narratives about private care and private forms of paying for health care.
4. **Contrasts and tensions between public and private care.** Questions covered whether they saw a tension and if so, in what ways; how they make decisions about choosing public or private health care; and comparisons between clinical relationships, types of patients, types of illnesses, and finally types of authority/autonomy in public and private.
5. **Demographics.**

Each interview lasted between 50 and 60 minutes and allowed time for gathering referrals for more interviews, observations, and focus groups. During the interviews, my research assistant

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and I took hand-written notes and the interviews were recorded for transcription; of the 74 interviewees, eight declined to be tape-recorded.

Participant Observation

Interviews were complemented with ethnographic observations in waiting areas of public and private hospitals and clinics. Observations described aspects of health-care-seeking activity in contrasting public and private health care settings. One main public hospital, one regional public hospital, and two local public clinics were selected for this study as examples of the range of public care in the city: Hospital Central Valle, Colinas Azules Hospital Regional, EBIAS del Oeste and EBIAS Universitaria. Five private hospitals and two private clinics were also observed: Hospital de Nuestra Señora de Los Ángeles, Hospital Contemporáneo, Hospital Metodista Central, Hospital Urbano, Clinica Norte, and Clinica Nueva. Twice a week for six months, I rotated observations at each of these locations, averaging two morning or afternoon observations at each. I observed routine activities in the waiting areas, including waiting in line to register, sitting for appointments, waiting in line at the pharmacies, and interactions between people, staff, nurses, and doctors in waiting areas. Waiting rooms were important for this research because waiting for health care emerged as a main theme in interviews.

In addition, during my 10 months of ethnographic research I participated in Costa Rican daily life, giving me many opportunities to talk to people about health care. I also attended one conference on health care at the University of Costa Rica and a ceremony dedicating new dialysis equipment at one of the top national public hospitals. I also observed several strikes of public employees in the city. Detailed, descriptive field notes were taken in each setting either during observations or immediately afterwards.

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Clinical Observations

I also conducted 20 clinical observations in one private hospital and one private clinic that consisted of shadowing two private physicians—one radiologist and one general practitioner—during their daily clinical meetings with patients. Participants were recruited through referrals during interviews and contacts acquired through collaboration with my research assistants, as well as from contacts made during preliminary research.

In each clinical setting I obtained written informed consent from the physicians and oral consent from each patient for observation. Clinical observations included shadowing the doctor during his or her routine day and observing interactions between the doctor and patient. During observations the doctor conducted and discussed with patients diagnostic tests, patient histories, treatments, diagnosis, the next course of action, and paying for care. Detailed, descriptive field notes were taken at the time of the observations.

Focus Groups

Two focus groups were conducted consisting of 11 nurses (one group with five nurses and the other with six) who were studying or working in a public university but had worked in a mix of public and private health care settings. Nurses were recruited through a key contact who was a director of nurse education at the nursing school and through referrals during interviews. Six of the nurses from focus groups were recruited for interviews.

Focus groups are another way to hear voices not usually heard as well as the perspectives that emerge as participants interact with each other (D. Morgan 1997). In many ways, group interaction may approximate real life more than interviews alone, since the way in which one understands a concept is often reflected in discourse (Álvarez 2014, 4). This follows D. Morgan (1997, 20), who says that focus groups "reveal aspects of experiences and perspectives that

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would not be accessible without the group's interaction." However, focus groups go beyond individuals talking about topics of interest to the researcher; during the focus group individuals learn from each other (D. Morgan 1997, 20). Relevant perspectives and understandings of topics emerged through the process of focus groups.

Focus groups lasted 90 minutes with a break in the middle and were organized using a discussion outline with a brainstorming icebreaker and trigger questions. The focus groups were group conversations concerning topics of public and private health care that are important to these nurses. The focus group guide included an ice-breaking exercise asking for key phrases to describe public and private health care and then four discussion probes on (a) work experience in public and private health care; (b) problems encountered (if any) in public and private health care; (c) the best and the most difficult things that had happened during work in public and/or private health care; and (d) future work plans and goals. The specific goal of the focus groups was to gather data on the everyday experiences and perceptions nurses have in working in public and private health care settings, and to listen to them talk about the knowledge, attitudes, and practices that influence the practice of nursing in public and private health care settings.

At the beginning of each session, consent was discussed and each participant signed a consent form. The first focus group of five nurses was conducted in a meeting area at my apartment. The second focus group of seven nurses took place at a large picnic table under an umbrella outside the public nursing school, where students gather.

Archival and Media Research

Local newspapers and written reports of legal cases by patients against the *Caja* provided an invaluable resource in this study of how the mix of the ideologies and practices of public and private health care are experienced and understood. I also examined websites of the *Caja,* World

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Bank, International Monetary Fund, Pan American Health Organization and SaluDerecho, which is an organization to promote dialogue about issues of health equity, efficiency, design, implementation, and law in Latin America. Finally, I examined videos of television broadcasts, YouTube videos of conferences on health care, and documentaries produced in Costa Rica about health care. These sources usefully provide background information as well as illustrate the dynamics of the mix of public and private health care, the contrasts between the ideologies of health care as human right and health care as a commodity, the nature of the problems in the *Caja,* the routine use of private health care, and culture that emerges around the mixing of public and private health care.

Research Assistants and Research Team: Collaboration as a Research Method

My position as an outsider gave me the opportunity to be in the role of a learner, while the people I met and worked with were in the role of advocates in figuring out the health care system. In this study, I approached ethnographic research as a relationship between people. Costa Rican Spanish has an abundance of colloquialisms, truisms, and clichés specific to Costa Rica, making it sometimes difficult to uncover the deeper meaning of what was being said. Fortunately, I developed a team of three research assistants (two male and one female) who assisted in making phone calls, joining me on interviews, taking interview notes, and transcribing interviews. I am indebted to them for their generosity, insight, and professionalism. After interviews we would debrief about the interview, and they would patiently answer my endless questions.

Through networking with my assistants, I worked with five translators who helped me with translations and the interpretation of difficult passages of transcripts, media reports, and articles. With this group of engaged and talented research assistants and translators, I formed a

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team approach to the project that included two team meetings to discuss changes in the interview schedule, parts of the research design, and preliminary interpretations of data. I had not anticipated that I would develop a team of such extraordinary, insightful individuals and good friends for this work. It was invaluable to have a sounding board for the ideas that I saw emerging from the project while in the field.

Qualitative Data Analysis

The study included the constant evaluation of data and analysis of interviews and field notes in order to allow for continual revision and honing of research questions and interviewing techniques (Bernard 2006). Initial data analysis began in the first weeks of data collection, as I reviewed early interviews and observations in order to refine interview guides and observational strategies. My research team helped immensely in this process with items that were added, reworded, refocused, or deleted as appropriate.

The data analysis involved a multistepped process. I first carefully reviewed all transcripts and translations and generated a codebook of more than 80 variables, reflecting as much detail as possible. Based on close readings of transcribed and translated interviews and field notes, I constructed summaries using a summary template. Then I conducted more detailed coding using NVivo 10 (Qualitative Solutions and Research International 2010), a text management software package designed for anthropological research. During the coding process, I constructed detailed codes and hierarchical classification of codes based on interview questions, themes that emerged in team meetings, preliminary analysis, and categories from field notes and interview notes (Bernard 2006).

In addition, I recoded pertinent sections in more detail as new themes emerged. This iterative process was valuable to my analysis and interpretation. During this process I referred

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back to field notes and consulted with my research team by e-mail to clarify pertinent points. I also sent follow-up e-mails to correspond with some research participants, always discussing with them their informed consent, reaffirming that they had no obligation to reply, and thanking them for their participation. I used Microsoft Excel to create tables of demographic and personal characteristics for comparative analysis. Finally, I constructed cases out of key participants' experiences and then closely analyzed them for main themes and comparisons between cases. To protect the privacy of the participants in this study, all names and identifying characteristics have been changed throughout.

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CHAPTER 4: IDEOLOGIES AND LIVED REALITIES OF PUBLIC HEALTH CARE

When I was a little girl, I had good health care through the public system but I didn't contribute to it myself. Now I do contribute, and I hope that my part—my contributions from my salary—will help a person having an emergency. Now that I am a doctor myself I think about these things. You see, we don't say to the person without insurance, "No, we cannot attend to you." I can as a doctor attend to that person. All of us deserve the same quality of care because health is a human right.

Listen. Three years ago when my father had prostate cancer, I took out a personal bank loan and set him up for surgery in private care. I told my father, "Look dad, if I take you to the Caja[10] *you will die waiting for surgery, right?" So I got the loan and I brought him to the private doctor and I said, "Here is the money, now operate on him." Everything went well. If we waited, I am sure it would have been two years.*

Now I work in this private hospital because there are so few jobs in the public sector. I see the problems with the Caja *everyday with my patients. The other day a patient came to me with high blood pressure that was not getting better using the prescribed medications from the* Caja*. So, I prescribed another medication not on the official list and the patient got better!*

So you see, the Caja is not fair or optimal right now. Many people who need care are not being treated [due to long waits for care]. People are dying. That's why there are a lot of private clinics now—it's like a fashion. It is fashionable because many people think that the Caja gives poor service, so they go out and buy private health insurance, and then they have options. But it should not be this way!

—Dr. Mena Salazar, 31-year-old family doctor at a prestigious private hospital in San José, March 25, 2014

Introduction

Dr. Mena Salazar is a 31-year-old family doctor, trained in a public university, who has been practicing in a prestigious private hospital for three years. Like many participants in this study, she spoke to me about the ideologies that underpin public health care as a way to explain what she sees as valuable about public health care and to frame her experiences of its problems, such as patients waiting for care or not getting the medications she thinks are best. Dr. Salazar talks about how she values the public health care system for making health care available to everyone as a human right, even people without insurance. In her narrative she keeps her faith in public health care, even as she recounts the story of using private health care for her father's

[10] Participants in this study call the Costa Rican public health care system (*Costarricense de Seguro Social*) the *Caja* for short.

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cancer surgery because the wait was too long for public health care. She adds that it should not be this way, implying that people should not have to resort to private health care to get the care they need. Dr. Salazar believes in the system of state-organized health care even though she works in the private sector and has the financial means to use private health care and does so. Like many of the participants in this study, Dr. Mena Salazar negotiates the contrasts and ambiguities between her belief in the ideologies that underpin public health care and the realities she observes by letting these seemingly stark contrasts lie there side by side, finding both the positive and the negative at the same time. The object of this chapter—the contrasts between culturally held ideals and their lived realities—are part of what anthropologist Julie Livingstone and others call an "anthropology of value," defined as the investigation of how the ethical and political are conjoined with human medicine, and offer one slice of the life of national health care in Costa Rica (Livingstone 2012, 6–7).

This chapter presents specific discourses about experiences and perceptions of public health care from transcripts and field notes in order to examine and explain the public health care system as a medical culture and what that culture is like. In other words, health care is a place where people contemplate meanings, practices, and politics of care (see Livingstone 2012, 8). More specifically, in this chapter I examine how contrasts between public health care as a cultural ideal and real experiences of its problems are managed, thus revealing how participants respond to the ongoing crisis in public health care and the unbridled growth of private care.

Medical anthropologists argue that the best way to deal with contrasts and tensions uncovered in fieldwork is to consider them as part of a "complex negotiation of reality" (Crapanzano 1997, quoted in Ong 1988, 28). For example, Ong shows how female rural workers in Singapore, who come to the city to work in multinational industrial factories, confront

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profound differences in culture, morality, gender relations, and social values between those two worlds, and how they negotiate those two realities in emergent and important ways. Following Ong, I examine the ways health care professionals, doctors, nurses, and patients who are primarily middle class negotiate the contrasting ideologies and promises of public health care with the realities of their practical struggles for health care.

In addition, the work individuals do to negotiate the contrasts between what public health care is to them ideally and what they actually experience may disguise or resolve social tensions (see also Ong 1988). For instance, ideological talk in the narratives of these participants can reveal how ideologies work to maintain the status quo. Ideologies that the *Caja* is an exceptional health care system may work to disguise its discordant problems and discriminatory practices. Or ideological imagery such as framing good health care as "luck" may resolve tensions that individuals experience when the health care they receive from paternalistic state institutions doesn't match up to state guarantees of "good health care for all." According to Gay Becker (2004, 260), who studies struggles for health care in the United States, narratives of health embody how individuals view and reflect on cultural values and ideologies, and these ideologies in turn help individuals make sense of the world. Following Becker, I examine how ideologies can reveal some of the meanings attached to public health care, such as the connection between ideologies of public health care and ideas of exceptionalism, the connection of ideals of familial care and public health care, rituals of defending the public health care system despite its problems, and the emergent ambiguity of meanings individuals attach to public health care, found in contrasts between universalism and exclusion, equality and inequality, and security and insecurity.

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Medical anthropologists also examine how ideologies are instrumental to the policies and practices of the state and its institutions, thereby shaping human bodies, notions of citizenship, and access to health care as forms of bureaucratic and/or neoliberal governance (Rose and Novas 2005; Waitzkin 1991). This suggests that institutions convey ideologies "from above" and in response individuals do little negotiating. Instead, it is argued that the behavior and discourse of individuals support the current social order (Waitzkin 1989). These analytical perspectives show how bureaucratic and neoliberal institutions regulate individuals but say little about how individuals respond, resist, or comply with institutional norms (Ong 1995). In contrast, other researchers examine individual responses to institutional governance "from below"—or how individuals sometimes strategize to negotiate, contest, or resist, thus defining their own definitions of reality (see also Brotherton 2003).

The perceptions and experiences of the individuals in this study demonstrate that a synthesis of these perspectives is necessary, given that individuals are both passive and active; at times being shaped by larger institutional, bureaucratic, and neoliberal social forces and at other times deliberatively taking control over their decisions and interpretations (Bacchi and Beasley 2002; Brotherton 2003; Ong 1995; Montemayor 2014). For instance, most of the individuals in this study talk about a deep faith in a public health care that is focused on universalism and solidarity, while also talking about how paternalistic, bureaucratic, and highly regulating the state can be. Some individuals seek control over their public health care by working out other options, such as using the private sector, while others stay within public health care despite its challenges. Individuals without the financial means to choose private care talk about their support of public health care alongside discourses of complaint and dissatisfaction.

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Although both upper-middle-class and lower-middle-class participants in this study talk about the importance of public health care, it is important to note that half of these participants have the financial means to believe in state-organized health care while choosing private health care options. In contrast, individuals without the financial means do not necessarily have the luxury of choosing private health care. In the narratives in this chapter, both groups maintain belief in public health care even though they may have different reasons for keeping those beliefs. In this study, I focus on primarily middle-class individuals who flexibly move between public and private health care as a beginning point in examining how the contrast between ideals and lived realities is negotiated; this group of patients experiences both the contrasting ideologies of health care and their lived realities as well as the contrasting ideologies of public and private health care.[11]

It is within this framework that I examine the contrasts and tensions between the ideals of health care and real lived experiences, thus, illuminating some of the insecurities with the provision of public health care. As discussed in Chapter 2, these tensions can be traced to a financial, infrastructural, and managerial crisis in public health care alongside the passing of the Central American Free Trade Act, which opened up medical markets leading to the intensification of private health care. This chapter examines how these tensions are interpreted, perceived, and experienced by real people. I argue that these tensions reveal a paradox between growing insecurities and inequalities in public health care in a culture where this care is ideally about security, universalism, equity, and accessibility.

[11] In the conclusion to this dissertation I will discuss the advantages and limitations of this focus.

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Ideologies of Public Health Care

In this section, I will examine perceived beliefs, truths, and rationales about public health care that emerge in many of my interviews and conversations in this study in order to examine these individuals' understandings of the nature of public health care, its ideologies, and their contradictions. I will show how interviewees commonly talk about beliefs in public health care and how these in many ways mirror beliefs about the Costa Rican state. Overall, public belief in the Costa Rican health care system or *Caja* appears to legitimize the idea of state-organized health care, but clearly, the individuals who give this support can also withhold their legitimation. The fact that many of the participants in this study support the *Caja* even when its ideals do not match reality will be explored later in this chapter.

Narratives of Embracing Ideologies of Public Health Care

When I asked Dr. José Araya, a 69-year-old medical doctor who has been a *Caja* administrator for nine years, to tell me about the *Caja,* he replied by listing its core values and then connecting them to development, democracy, and the importance of the health guarantees of the constitution. He said, "The health care system is a big part of the development of Costa Rica. It is universal, equitable, unitary, and guaranteed by the constitution. The most important part of democracy is access to health care."

Dr. Araya grew up and received his master's degree and medical license in a culture that has socialized every generation for the past 70 years to believe that the state is the best deliverer of health care and that universal health care is a key symbol of democracy. He is also an example of a middle-class health care professional with a career that aligns with his beliefs in the *Caja.* I found that the narratives in Dr. Araya's interview suggest that the social contract between the

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Caja and individuals, includes defining health care as a public good that lies at the heart of individual ideas of Costa Rican democracy.

Dr. Araya has internalized the formal model of what the *Caja* and health care are, but it is also meaningful to him personally. He is able to recall some of the core values of universality, equality, and solidarity that are written and promoted in every public and historical document about the *Caja*, but he also told me that he and his family use only the public health care system for all their health care needs (Miranda 2008; L. Morgan 1993; Salas 2011).

Juan Rolando, a 35-year-old intensive care nurse in a public hospital, also told me the *Caja* is important in Costa Rica. As Juan explains, "The *Caja* is the best. It is excellent. It has an excellent range of services, remedies, and procedures." This type of commentary praising the *Caja* became so commonplace in my daily conversations and interviews that it is best viewed as a ritual form of talking about belief, nostalgia, and pride in the *Caja*—or, one could say, an idealized talk that describes what some individuals see as the natural order of things.

Participants had varied ways of explaining their beliefs in the good of the *Caja.* Some participants told me that the *Caja* is "best" by comparing it to other countries. This was often done by reciting the commonly heard truism that the *Caja* "offers health care as good as that in the United States for less cost." For instance, when Juan Rolando talked about the *Caja* being best he added, "considering the size of Costa Rica, it is better than most Latin American countries in health care reaching the majority of the population." For Juan there is a cultural idea that both the *Caja* and the state are superior to other health care systems and other states. Such examples from my interviews begin to reveal something about the ideologies of public health care. Participants believe in public health care and its successes. Discourses of pride in the *Caja*

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are more than repeating a set of health indices and statistics—they are part of everyday conversation and define some of the central qualities of public health care for these individuals.

Ideologies of Exceptionalism and Nationalism

One of the underlying truths beneath these ritualized beliefs in the *Caja* is that they represent ideas of exceptionalism and nationalism. Costa Rican ideas of exceptionalism and nationalism are well reported in the literature on Costa Rican culture and health care (Booth 1998; Bowman 2014; Rayner 2014). These scholars of Costa Rican social history define exceptionalism as the shared ideology that Costa Rica is unique among other Central American countries, especially for its stable democracy, human rights, and high human development scores (Biesanz, Biesanz, and Biesanz 1999; Booth 1998; Bowman 1999; Hedayat 2014; Rayner 2014; Robinson 2003). For instance, Harry Li, a 47-year-old nurse with 25 years of experience in both public and private health care, said, "The *Caja* is the only health care system in the world set up to enable a peaceful democratic society."

Another way exceptionalism is talked about appears in my interview with Melissa Valverde, a 34-year-old nurse educator in a private university. She connects exceptionalism to both universal health care coverage and the technical successes of the *Caja*: "The *Caja* is one of the best health care systems in the world. It is very advanced. People get expensive medications and transplants, all covered by their national health insurance."

Melissa teaches nursing at a private university but idealizes public health care. Yet, the story she told me about her experience in a *Caja* emergency room contrasts markedly with these ideals:

> One day I had to go to the emergency room directly from work so I was still wearing my nurse's uniform. There was a man there getting an IV but the line was disconnected. I knew it was a medication that should not be stopped because stopping it could stop his heart. So I fixed the line myself, because the nurse on duty was helping other patients.

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But the nurse didn't even notice! I wondered how this nurse could work there and not even know who she is working with or not notice what I was doing with her patient?

Melissa Valverde saw the poor staffing conditions and overcrowding in the public emergency room; since she was a nurse, she chose to help this patient, possibly saving his life. Yet the poor working atmosphere and life-threatening conditions of the public emergency room did not change her support of the *Caja*; indeed, she told me later that when she herself has a medical emergency, she still goes to *Caja.* Melissa Valverde is able to find both the negative and the positive meaningful at the same time. In addition, she believes in the *ideal* that the *Caja* is exceptional due to its universal access and advanced medical technology, even though she experiences the *reality* that no one noticed that the IV of this patient was disconnected.

Like Melissa Valverde, many of the participants in this study referred to medical technology to explain the exceptionalism of the both the *Caja* and Costa Rica. Pedro Morán, a 34-year-old public nurse, proclaimed, "The *Caja* has state of the art technology!" Others I spoke to—like David Campos, a 54-year-old lawyer who has worked with legal cases regarding health care, and Dr. Araya (above)—state that access to quality medications is a measure of the *Caja*'s success. In addition, I often heard people cite health care statistics including life expectancy and successes over infectious diseases as they talked about the *Caja.* For example, 34-year-old nurse Harry Li, who is currently working as a health educator in a public university, sums up points made by many of these participants:

> The *Caja* is not the best in the world, but it is one of the best. Life expectancy has improved. We have the lowest infant mortality rate in Latin America. Costa Rica is one of the few Central American and Caribbean countries that guarantee access to medications. It is the best place for transplants in all of Latin America.

Another way exceptionalism is described can be seen in my interview with Victor Morales, a 28-year-old public health care nurse. Victor refers to the hospitals, doctors and specialists of the *Caja* to explain its exceptionalism. For example, Victor calls the *Caja* hospitals

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“Class A” and then adds that they are good for everything from chronic care to transplants. Victor is not alone in sharing his ideas of the quality of public hospitals; lawyer David Campos is confident that the public hospital in his district is “elite.” “It has the best doctors in the country,” he says, “That is where the specialists are.” Cristina Echeverría, a 55-year-old nurse administrator in the *Caja,* proclaims, “Doctors are the ‘Olympian Gods.’” These individuals described how much they value public hospitals, which since the origin of the *Caja* have been where most doctors and nurses gain training, prestige, experience, and professionalization (Clark 2005; Palmer 2003). According to Palmer (2003), there is a tradition of idealizing doctors, many of whom have become presidents of the state, so it makes sense that public hospitals, medical technology, and doctors’ expertise would become connected to an overall ideology of the exceptionalism of public health care.

Ana Vásquez, a 50-year-old nurse, has been working for nine years in marketing at a prestigious private clinic that provides services to both Costa Ricans and medical tourists. She also attributes the exceptionalism to both the *Caja* and to the greatness of the Costa Rican state and democracy. For example, although she has dedicated nine years to promoting private health care services, she talked in detail about the exceptionalism of the *Caja,* especially its importance in promoting peace and democracy. According to Ana, “The *Caja* is extremely valuable. It is the cornerstone of the democracy. It is important to the country because it is important for sustaining peace.” For Ana, the *Caja* is synonymous with democracy and maintaining a peaceful society.

The way these individuals talk about the *Caja* depicts an image of the Costa Rican health care system that extends beyond treating health and illness; it also shapes ideas of the state and defines some qualities of democracy. These examples are consistent with research on the Costa Rican health care system that the *Caja* has come to symbolically represent the state of Costa Rica

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in general (Ávila-Agüero 2013; Biesanz, Biesanz, and Biesanz 1999; L. Morgan 1993; Rayner 2014). In this sense, the *Caja* is a mirror for a broader set of ideologies that underpin the state, democracy, and Costa Rican identity (see also Brotherton 2003).

In contrast to these ideas that both the *Caja* and the Costa Rican state represent values of universalism, solidarity, democracy and equality, scholars note that the idea of exceptionalism also includes exclusion, xenophobia, and racism (Dos Santos 2015; Hedayat 2014). For example, according to Hedayat (2014, 10), Costa Ricans portray themselves as "a predominantly white, homogeneous, egalitarian, peaceful and innately democratic society, while portraying their neighbors as predominantly indigenous, hierarchical, violence-prone and autocratic/dictatorial societies." These scholars sometimes refer exceptionalism as a myth because, in reality, Costa Rica has experienced a civil war and rising inequality; it is not homogeneous due to its colonial history. Costa Rica also has an indigenous population and one of the highest immigration rates in all of Central American (Hedayat 2014; Pizarro, Christiny, and Contrucci 2014). The archeological record shows continuity between Costa Rica and its neighbors to the north and south, rather than uniqueness.[12] Although this ideology of exceptionalism creates a sense of identity and solidarity that may reinforce beliefs in the *Caja* and democracy, it can also submerge the visibility of discriminatory practices discussed later in this chapter.

Care as a Key Motif of the *Caja*

Narratives in this study also depict set of ideals of what health care means socially and culturally. For example, when Karla Madriz, a 30-year-old graduate student with diabetes, told me about the *Caja*, she emphasized the relationship between the health of an individual to work and the rest of Costa Rica, by saying, "Health is central to life. You need health in order to work.

[12] I am indebted to Jane Wankmiller for emphasizing this point.

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So if there are many sick people then the rest of us Costa Ricans will suffer, because those people cannot work."

For Karla, health is central to life because work is central to life. She also views health as a social responsibility, since others may suffer if people are so unhealthy they cannot work. Karla expresses solidarity with the suffering of other Costa Ricans who may be impacted by fewer people doing their jobs in her community.

Other participants I interviewed made similar connections between solidarity with workers and public health care. According to research on Costa Rican health care history, the idea of care that underpins ideologies of public health care is rooted in ideas of care for the worker (Biesanz, Biesanz, and Biesanz 1999). Universal health care in Costa Rica emerged from a "workerist" model of social security for public workers (covering 5% of the population in 1940) that was later expanded into a universalized health care system that covers about 91% of the population (PAHO 2012; Sáenz, Acosta, and Bermúdez 2010; Vargas and Muiser 2013). Universal health insurance provided by the state is seen by participants like Karla as a public good for all people including the poor, immigrants, and unemployed (Clark 2014). Karla's observations are part of an ideology about the worker, the state, and health care that connects the health of the worker to the health of everyone.

Karla's narrative demonstrates a point made in much of the literature on health care in Latin America—that in Latin America health is social and health care is a social product (see, e.g., Ávila-Agüero 2013). For instance, Édgar Flores, a 38-year-old lawyer, talks about the social and public aspect of health care. Although Édgar told me that the *Caja* is overrun with mistreatment, violations of human rights, and overcrowding and that he only uses the private sector for himself, he says, "In Costa Rica health is a public issue and has a public meaning to

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people." He told me that he sees only advantages in having a public, state-run health care system, because "if it were private it would be too expensive and not everyone would have access to it." Édgar's narrative shows that he notes the stark contrast between the ideal that it is meaningful to people that public health care exists and the realities he observes of human rights violations within the system. The way Édgar manages this contrast is to use private health care while maintaining his belief that public health care as a system should persist. The idea of care is caught in a conundrum between its social and human rights values and the serious problems in the delivery of public health care.

Expanding on the idea of the meaning of care, community, and health, other individuals in this study told me that health is a focus of the entire family, community, and schools. For example, Sileny Salazar is a 64-year-old retired nurse who worked in the public health care system. She says, "I grew up in a family where health came first. If we had to, we would go without something or borrow money for a family member to have health care. It was something we had to do."

In Sileny Salazar's family, health is very important. My research assistants told me the same thing, adding that a good, healthy Costa Rican family is one that has good hygiene. For example, they told me that a student would be sent home from school if teachers discovered that he or she had not had their daily morning shower. In her ethnography on the Costa Rican health care system, Setha Low (1985, 4) noted, "Costa Ricans worry more about their health than their economic state." The focus on health as central and vital in these accounts also follows observations made by L. Morgan (1993, 9) that health in Costa Rica is "imbued with the highest moral connotations—altruism, purity, self-control, charity, goodness"—values that are rooted in personal and family life as well as a way to judge the behavior of others.

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During the course of living and conducting fieldwork in San José, I found that many of the people I met also connected health to ideas of community. The community-centered approach to health care harkens back to policies of the 1970s that focused on primary health care, prevention, and health promotion and are still the aims of community health care via the vital network of local clinics called Equipo Básico de Atención Integral de Salud (EBAIS)[13] (L. Morgan 1993). These are clinics usually within walking distance that provide basic outpatient care. Many participants mentioned these three foci of public health care: primary care, prevention, and promotion; they sounded like slogans for a campaign. Yet, underneath the rhetoric is the idea that one thing that makes the *Caja* good is its community-oriented focus on primary health care. For example, nurse administrator Cristina Echeverría (who talked about doctors as having godlike qualities, above) says, "What makes the health care system a good model is that it includes not only health care but health care promotion." This focus was a main point made by Allan Torres, a 55-year-old state administrator. Allan says, "The *Caja* is universal and focused on primary care. The strategy is completely different than making money from health care." And then he adds, "The main thing is to protect the health of the people." The ideology of care that underpins that *Caja* is contradictory in these accounts—it is valued socially, culturally, and historically, but in reality care is compromised due to problems in the *Caja.* One way that individuals in this study manage this contrast is to engage in discourses of defending the *Caja.*

Ideologies of Social Responsibility and Identity

I found that the ideals of "solidarity, equity, universality, obligation, and social participation" used to describe the *Caja* not only reinforce the ideals of the state, democracy, and

[13] EBAIS are explained in Chapter 2.

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public health care, but also delineate what is it to be human for these individuals. For instance, in the narratives discussed in this section, the ideology of the state and the *Caja* includes ideologies of social responsibility and identity. Juan Rolando, the intensive care nurse who talked enthusiastically about the *Caja* above, explained his ideas of social responsibility and care this way:

> The health care system enables people unlimited access to the health care they need just by paying for their national insurance plan, and some people don't even pay at all. Transplants and complicated surgeries are possible for everybody who needs them.

Juan emphasizes what is important for him about the *Caja*—its availability to everyone. He went on to tell me that part of being a public nurse is "serving the indigent, foreigners, and people with mental problems." Juan told me it is his social responsibility to pay his national insurance for the health of others.

The ideology of care for others can be seen in the ideas of solidarity, such as in 53-year-old lawyer Julio Cerdas's comment: "All the time that you are not sick but still paying the *Caja* there is solidarity, because you are part of the system of caring for people." Caring for others is a value found in personal, family, and community life that diffuses into ideas about health care. For example, it is common for people to help an elderly or disabled person on or off buses, or keep an orderly line waiting for buses or prescriptions. It may be that familial and social ideas of care are co-opted into a rationale for participating in public health care.

In addition, many Costa Ricans I met, interviewed, worked with, or developed friendships with connected the values of *Caja,* care, and social responsibility to their identity as Costa Rican, or "being *Tico."* The Costa Ricans I met often affectionately refer to themselves, the state, and the *Caja* as "*Tico*"—their shorthand for "Costa Rican." *Tico* is a title that includes identity, a set of values, and a particular way of life (Biesanz, Biesanz, and Biesanz 1999). For example, based on a decade of fieldwork in Costa Rica, Biesanz, Biesanz, and Biesanz (1999, 6)

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show that being *Tico* includes the idea that individual and state decisions must be made "*a la tica*" or in ways that do not violate normative ideas of family, democracy, peace, and education. Beliefs in the *Caja,* exceptionalism, and identity could help explain the hesitancy of some participants to talk negatively about the *Caja* and the staying power of beliefs in public health care despite negative experiences.

Discourses of Defending the *Caja*

Interviewees not only label the *Caja* as exceptional and centered on ideologies of care for the worker, community and individual, they also commonly defended the *Caja* or told me that they needed to defend it. This is the case for 56-year-old Alex Diaz, a professor of public health who instructs the next generation of public health care workers. For instance, Alex Diaz says:

> The *Caja* is something that Costa Ricans defend and perceive as necessary. They feel like that even though they complain a lot about it. They wait in long lines for services and the system is inefficient and has to improve, but people think the system is really important.

According to Alex, his fellow Costa Ricans defend the *Caja* even though they complain, wait in long lines, and observe its inefficiencies.

Clearly, many of the Costa Ricans I met and interviewed strongly support the *Caja* for pragmatic reasons: it provides inexpensive, high-quality care to everyone—in theory. Another reason individuals speak defensively about the *Caja* is in response to the everyday barrage of negativity about the *Caja* in the media from politicians, critics, concerned individuals, and stakeholders in the private health care sector. Participants like José Araya, a *Caja* administrator, make their own observations of this phenomenon: "The public is being manipulated by these messages. Politicians and other people use the media such as *La Nación* [a national newspaper] and Channel 7 [a televised news channel] to create public opinion against the *Caja* for private medicine." In response to this negativity, Morena Shum, a health care administrator, refuses to talk about the *Caja's* problems: "There is no problem with the system as a model. I don't talk

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about its problems or anything about that." Pedro Morán, the nurse who talked positively about the *Caja* above, also talks about the commonality of discourses of defending the *Caja,* saying, "Costa Ricans are always defending the *Caja* because without it many would not have access to health care."

All of the participants above are patients themselves, whether they are professionals in the *Caja,* nurses, doctors, educators, or retired shopkeepers. This means that their health care is completely covered by the national health insurance through a mandatory payroll tax of 15% (Torres 2013).[14] National health insurance covers all essential and emergency health care services and medication on the *Caja*'s official list, from care for traffic accident victims to transplants and chronic care. Pamela Jirón, a 35-year-old secretary, knows this well, since she suffered a serious car accident. The *Caja* covered her surgery, 20 days in the hospital, and two and half years of rehabilitation. She said, "Without the *Caja* I would not have been able to get medical care because I cannot afford private. In general the *Caja* is good, and it has benefitted me greatly." This coverage for low personal cost can partly explain the esteem that these individuals have for the *Caja,* but it does not completely explain how individuals maintain those beliefs when they face problems, or why individuals who live modestly or near poverty save to use the private system.

Pedro Morán, the public nurse who sees the *Caja* as exceptional (above) due to its advanced medical technology and has 10 years of experience in both the public and private sectors, makes a similar point. When I asked Pedro to tell me about the *Caja*, he hesitated and said, "I do not want to demonize [*satanizar*] the *Caja* for any mistakes or problems it has because it is a great blessing for many people." What Pedro means by "not demonizing" is not

[14] Retired patients like Patricia Corella contribute 14% of their pension income (Torres 2013).

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"giving any misinformation or altering the facts."[15] Pedro stressed the importance of what he was saying by using religiously related words such as "demonize" and "great blessing." He wanted me to know that "it is a great system. When the *Caja* is working well they give good care that is better than any private hospital." It appears that the ideology of the *Caja* as exceptional and representative of the values of the state is very powerful, leading many to talk highly of the *Caja* and others to hesitate to talk about the *Caja's* problems.

Take for example the case of Patricia Corella, a 58-year-old single mother with two grown children still living at home, who suffers from high blood pressure, fibromyalgia, and fatigue. Patricia is a retired shopkeeper who lives modestly, using her pension to pay for her children's continuing education; her children work to help support the household while going to school. Patricia defended the *Caja* even though she has had problems getting the care she needs. She told me that she has to go back and forth to the *Caja* often, spending hours waiting for her appointments. Sometimes after a long wait she is not given care but instead referred to a specialist, so she has to make another appointment and endure another long wait. When I talked to her, she was taking nine pills a day and was not getting better. Patricia finally decided to save for several months so she could go to a private doctor. Yet, she insisted that "the *Caja* is not wrong. . . . It has been good for me. The *Caja* is right for all citizens, they care about citizens."

I analyzed 74 interviews with health care professionals, doctors, nurses, and patients. All but two of the participants I interviewed were nostalgic and positive about the *Caja.* The majority of participants support the *Caja*, even though some have struggled to get health care or have received poor health care services. The way these participants invoke the ideologies of the *Caja* defensively seems to show evidence of shared, stable understandings of belief in public

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[15] I am indebted to my research assistant R. M. for clarifying this.

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health care, even though there are differences in how they illustrate their talk and the way they frame their experiences (see also Quinn 2005).

Narratives about the *Caja* show strong belief in the *Caja*'s ideals while at the same time many patients do not get the care they need. These individuals are able to hold this ambiguity or seemingly ignore it. In doing so they also downplay the problems they experience or observe, thus reinforcing and legitimizing the *Caja.* According to Howard Waitzkin (1991), a distinguished researcher of health care and professor emeritus of sociology and clinical practice, ideologies (such as the ideologies of the *Caja* discussed by these individuals) both reinforce social control and maintain existing norms. I argue that the way these individuals talk about the *Caja* is a form of patterned or ritualized talk that forms part of their citizenship in public health care. This talk can help explain how they negotiate the meaningful contrasts between ideologies and their lived realities. In other words, one of the rituals of membership in public health care is idealizing the *Caja* despite the costs of long waits for care, shortage of supplies, lack of staff, and crowding; thus, belief along with financial status legitimizes the choice to stay in public health care.

Universalism versus Inequality and Certainty versus Uncertainty

In the narratives in this study, I found that differences between ideals about health care and their lived realities include contrasts between the value of universalism that promises equal health care for the entire population and the reality that health care access is not always equal. In addition, some individuals talk about their reliance on the idea that the *Caja* provides certainty that they will get the health they need without being financially devastated, yet they also talk about their experiences of uncertainty.

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Evita Díaz, a 29-year-old nurse who has worked three years in a private hospital, had strong beliefs in universalism, saying for example, “Health is vital for the country, and access to health resources is vital.” Universalism is one of the main promises and ideologies of public health care, and suggests that residents have access to health care that is equally accessible and reliable. It emerges as a key theme in interviews with retirees, administrators, health care professionals, students, and struggling single mothers. However, my ethnographic research demonstrates that although all residents ideologically have universal access by law, the reality of universal health care is not the same for everyone. For instance some have to wait and others do not.

Consider the example of Maria Montealegre, a 60-year-old retiree. Maria gave me this account of the inequality of access she observed in the emergency room in a public hospital when she broke her leg:

> I kept waiting with the other 50 people in the emergency room. The whole time my leg was getting worse. It was turning black from a broken blood vessel and the nurse told me the tissue wasn’t getting enough blood supply. They gave me heparin for blood clots and morphine for pain. The nurse told me, “Be patient. We will see the most severe cases and the elderly first.” At that time I had been already waiting four days on a gurney in the hallway because all the emergency room beds were taken. I told them, “But I am elderly, I am 60 years old, and this is a serious injury!”
>
> Then an ex-minister of one of the government branches came in with his mother, and his mother got care immediately. Nurses rushed around catering to the ex-minister and his mother. Why is it that every Tom, Dick or Harry [*cualquiere “hijo de vecino”*] is not treated like that? We all feel the same, and we are all human beings!

Maria experienced the inequalities of access in a system that proclaims universality and equality. Yet later she told me that she is thankful for the *Caja,* saying, “Thank God we have the *Caja!*” Although Maria noticed the contradiction that she had to wait while the wife of this public official did not, she still praises the *Caja.* Access to health care is ideologically universal, but access to timely, quality, safe health care is not necessarily universal.

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Vania Oreamuno, a 50-year-old graduate student with four children, also talks about access to health care and the idea of universalism: "Universality is important to *Ticos.* They believe it is an exceptional thing that even people who do not pay can get health care. It would not be social security if it were not for everyone."

The "health care for everyone" that Vania talks about includes emergency and maternal health care, regardless of citizenship, insurance status, or employment status, as a fundamental human right (Clark 2014; Dos Santos 2015; Goldade 2009). Dr. Ronald Quiros, a general practitioner at a local EBAIS, connected the idea of universal health care to a sense of security: "The social security provides coverage for everyone within the national territory; no matter your socioeconomic status, or your place of residency, you are ALWAYS going to get medical care."

Victor Morales, a 27-year-old nurse and nurse educator who has worked in both public and private health care, talks about how important it is that everyone has access to public health care:

> The Costa Rican health care system is a system of social solidarity [*el sistema de la solidaridad social*]. The worker pays his monthly insurance bill, but the health insurance is not for him. It is for all of society that needs it. Look at the patients with multiple trauma [*politraumatizadas*] from car accidents, they get care and often they are uninsured.

According to Victor, he shares in a "system of social solidarity" with the people "who do not even pay at all"—even the uninsured.

However, some interviewees' narratives show contrasts and tensions between a health care system based on solidarity and universalism and their perceptions and experiences of inequality and loss of control regarding health care. For instance, in practice, Victors Morales's model of solidarity as "sharing in the health of others" does not work for many immigrants, who face difficulties getting health care; some undocumented immigrants are turned away. That there is tension between Costa Rican citizens and immigrants is not surprising (see also Dos Santos

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2015; Goldade 2009; Noy 2015). But this tension is also critical in the sense that it challenges notions of solidarity and universalism. Dos Santos (2015) found this in her interviews about health care for immigrants in Costa Rica. In her study, Costa Rican citizens talked about solidarity as unity with the "people who contribute; thus, solidarity is with the system —as opposed to with the people" (Dos Santos 2015, 193). According to Noy and Voorend (2015, 1), "Immigration poses a significant challenge to states' existing social protections systems. . . . Immigration produces a tension between citizenship rights—those extended to only citizens, and social rights—rights extended by the state to others within their national territory." In these cases, there is more than one way that solidarity and universalism are understood. For some solidarity is unity with the health of workers, for others it is unity with all people regardless of whether they pay into the system or not, whereas for still others, solidarity is unity with those who pay into the system.

Like Noy and Voorend (2015), participants in this study reframed the meaning of solidarity and universality, thus demonstrating the flexibility of these ideologies. For example, some participants talked about care for Nicaraguans or "everyone within the national territory" as proof of universalism, while others talked about Nicaraguans as undeserving or the cause of the financial crisis in the *Caja.* In addition, some of the same individuals who said that "health is for all" later talked about the Nicaraguan use of the health care system as a lamentable expense and stress on the system.

Discord between Nicaragua and Costa Rica enters into public debates about health care, immigration, and daily life (Lee 2012; Dos Santos 2015; Noy and Voorend 2015; Sandoval 2002). For instance, many of the Costa Ricans I interviewed commonly use the derogatory *Nica* for Nicaraguan identity as they contrast racial and cultural distinctions between themselves and

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the Nicaraguans who live and work in Costa Rica (Dos Santos 2015). For example, nurse Sileny Salazar one day looked out at the patients waiting to see her and noticed that half were immigrants. According to Sileny, "Many immigrants use the system and get the same care. They have less education, get sick from poor hygiene and social habits, and they do not practice family planning, but they get the same care."

Sileny Salazar seems to be questioning the idea of universality of care and the deservingness of her immigrant patients because, in her view, immigrants are not practicing the same cultural behaviors as Costa Ricans. The immigrants Sileny talks about are not Costa Rican enough and they can never be "pure Costa Rican" (*puro tico*). In other words, according to Sileny and others, Nicaraguans cannot follow what Costa Ricans consider to be the hygienic, family, work, cultural, and linguistic norms that make one a true Costa Rican and would allow them access to the same rights as Costa Ricans. Although there is a long history of contention between Costa Rica and Nicaragua, this reframing of deservingness is also related to the financial stress on the public health care system due to financial crisis and the high expense of repairing crumbling infrastructure, purchasing advanced medical technologies, and demographic changes bringing more people into the system, such as immigrants and the elderly.

For example, the financial crisis in the *Caja* and governmental concerns about security and crime has led to a (re)accounting of policies regarding social services for immigrants—in particular for Nicaraguans, who make up 9% of the Costa Rican population (Clark 2014; Noy and Voorend 2015). Before 2010, immigrants could easily access health care in the *Caja* without having social insurance or regular migratory status (Dos Santos 2015; Noy and Voorend 2015). In 2010 a new General Migration Law (*Ley General de Migración Extranjería* No. 8764) came into effect that aims to integrate immigrants while retaining their human rights. However, this

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law also gave more authority to Migration Police and required immigrants to contribute to national health insurance to obtain regular migratory status (Clark 2014; Dos Santos 2015; Noy and Voorend 2015).

This law redefined citizenship, rights, surveillance, responsibilities, and the meaning of solidarity. For instance, since the national health insurance became a prerequisite for migratory status, the *Caja* had a new regulatory role (Noy and Voorend 2015). Anthropologist Dos Santos (2015) has noted how this new law reshapes health care at the local level. For example, the Nicaraguans in her study now need to present their *Caja* card (*carnet*) and migration identification at the EBAIS for care. If they are uninsured, they will be asked to pay a fee and may be refused care—a condition not placed on Costa Rican nationals (Noy and Voorend 2015). Dos Santos's (2015) interviews reveal that the 2010 law changed the role of the EBAIS from a focus on the delivery of primary care to a filter for protecting the system from overuse by uninsured and undocumented immigrants. Noy and Voorend (2015) note that the law is vague and does not include a defined instrument for regulation and implementation. For example, none of the participants in this study talked about seeing the *Caja* follow through and collect such payments or seeing someone get turned down. Some said that such a thing "would be odd." However, Dos Santos (2015) talked to immigrants who faced these obstacles; some immigrants used their illness to qualify for the emergency and maternal health care that the *Caja* still covers, regardless of immigrant status. These examples show that new laws create new barriers for immigrants to get health care, thus challenging notions of universalism and solidarity.

According to anthropologists Goldade (2009) and Dos Santos (2015), immigrants threaten Costa Rican ideas of universality, identity, and exceptionalism because including immigrants in state social services challenges the idea of a pure Costa Rica; excluding them

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challenges foundational ideas of universalism and human rights that lie at the heart of the *Caja*'s exceptionalism. In other words, discourses of the otherness of immigrants rationalize changing norms of exclusion and inclusion, even though Costa Rica has incorporated a human rights framework for making decisions about immigration policy and access to health care. In addition, official ideas regarding solidarity and universalism can impact local understandings and practices regarding access to health care.

I often heard Costa Rican taxi drivers, shopkeepers, and housewives define immigrants as people who drain the *Caja* by using it too much without paying. This creates a stereotype of the immigrant as someone who is more sick, pays less (or does not pay at all), but uses the system more than a typical Costa Rican. This complaint discourse about immigrants was usually the first way people told me about the problems in the *Caja.* For example, Julio Cerdas, the lawyer who prizes the *Caja* for caring for all people, also observes, "We have large number of foreigners, mostly Nicaraguans who do manual labor and service work. They have low salaries so their pay into the *Caja* is low, but they get the same care as rich people."

Julio Cerdas and others commonly view immigrants, particularly Nicaraguans, as taking advantage of the generosity of the *Caja.* According to research on health care and immigration policy in Costa Rica, immigrants are viewed as receivers, not contributors, whereas the poor and unemployed are not viewed this way (see also Noy and Voorend 2015; Dos Santos 2015). This contradiction appears to be hidden in rhetoric that Nicaraguans are one reason why the *Caja* has problems. However, Carlos Sandoval (2004), a social scientist who studies Nicaraguan immigration in Costa Rica, notes that the *Caja*'s ability to give good health care is weakened more by reduced investment in equipment and infrastructure and problems with employers and individuals not paying their contributions than immigration in general.

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Noy and Voorend (2015, 4) note that the focus on differences in identity that emerges in the context of popular discourses about immigrants "can wear down the normative consensus about welfare distribution," thereby questioning the social legitimacy of solidarity and universalism. According to L. Morgan and Roberts (2012), the tension in contrasting perspectives on immigrant rights to health care produces new moral regimes and new subject positions. In other words, universalism and solidarity are emergent and contested projects that are shaped and reshaped by forces such as changing demographics, immigration, immigration law, and social rights. In turn, these forces can shape the meaning of health and human rights.

For instance, the model of health that emerges in interviews and observations in this study includes ideas of a social contract between individuals, society, and the state. I was able to understand how individuals view the relationship between the state, health care, and themselves because many talked about the responsibilities of the state to citizens and citizens' obligation to pay their monthly national insurance fee to the state, with the hope of getting good care in return. Here, I take the state to mean a continuously shifting set of practices involving individuals rather than a unitary, static entity (see also Foucault 1991; L. Morgan and Roberts 2012, 139).

In many ways the relationship between the state (or government) and individuals described by participants in this study includes a model of reciprocity and mutual responsibility. For example, Vanessa Calderón, a 46-year-old patient with a chronic immune disease, said:

> Health is the responsibility of the state. Health is holistic. The state is responsible for every aspect of health including nutrition, emotional well-being, and physical health. Also the population has the obligation to buy the national health insurance. At a minimum people should have health. This is not a socialist system but a social state. As a social state it should look after people who have access to state goods since health care is a good.

Vanessa relies on the "social state" to take on the role of health expert and guarantor in exchange for her obligatory fees. She sees health care as belonging to those who have access by

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paying. In other words, according to Vanessa, she has solidarity with the people *within* the system. For example, she says that the "social state should look after people who have access to state goods," but she does not talk about what happens to the people who do not have access. The meaning of solidarity is shifted by Vanessa to capture her experiences and perspectives in the midst of recent contentious debates about immigration and health care.

Even though Vanessa talks in some detail about the system being responsible for her health, in her own experience the system offers no sure guarantee. She says, "The system is worn out and does not satisfy the needs of the population." This is personally very real to her because when her husband Nilhs recently became unemployed and decided to start his own business, he also became uninsured. Vanessa went to the government offices to get him insured by the *Caja* indirectly under her insurance. The government officials did not understand why Nilhs was not working and didn't want to cover him. She told me, "A husband can insure a wife forever but the reverse is difficult." In the end the government officials agreed to insure Nilhs for one year. Vanessa's experience of being the wage earner and having trouble insuring her unemployed husband shows the power of existing gender norms. Mannon (2006) examined how neoliberal restructuring has led to an increase in women's economic activity and a decline in men's income-earning power, yet gender inequality still made it difficult for Vanessa to insure Nihls.

Vanessa's experiences in trying to insure her husband led her to say, "Sometimes the state does not fulfill its obligations." Even though she responsibly paid her obligatory monthly fee, the state employees argued with her about following through on the state's part of the social contract. Vanessa, like many of the participants in this study, is trying to make sense of the fact that although they do pay their obligation to the state, they are not always getting good health care or health care coverage at all.

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One way some participants have come to talk about health care from the state is as a form of luck—perhaps not only because life chances are unpredictable (that some get sick or well and some do not) but also as a response to the randomness or inequalities in how some people get good care from the state and some do not. Take for example Yancy, a 30-year-old single mother who takes care of the health care for her 4-year-old son Jeremías and her 60-year-old mother Marlen Chavez. Her mother's health care story is a long series of struggles for care, misdiagnoses, extended periods of time on waiting lists, and switching doctors. Her son Jeremías's story is different. Even though Jeremías has had acute episodes with asthma and is chronically asthmatic, he has received high-quality and timely care. When Yancy contrasts her mother's story with her son's, she calls herself and her son lucky. "We have been very lucky with my son," she says. It is striking that Yancy frames good care as luck. It appears that good care is not guaranteed. According to Yancy, she was lucky to acquire good care for her son in the midst of the struggles her mother faced, and she was lucky to acquire care on time while her mother endured long waits.

The state guarantees good health care for all as a policy, yet some have mixed experiences like Yancy. In addition, as can be seen by the discourses so far, many of these individuals talk about their strong beliefs in public health care, yet Yancy frames good care as luck. Yancy uses luck to negotiate the difference between her mother's and son's health care. By making good or bad care a matter of chance, Yancy is expressing a lack of control over her mother's bad health care. Yancy may critique the system or give an exasperated shrug, but what can she do if good care is framed as luck? In this kind of framing, luck is a palliative for the harsh realities her mother faced; it is not the system that has failed her mother, it is simple chance.

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Ideologies of Ownership

Some participants talk about themselves as owners of the *Caja* and thereby may gain a feeling of security and control over their health care as owners. In contrast, others talk about insecurity that the *Caja* will fulfill its obligations, and talk about not having control over their health care outcomes in public health care. For example, I talked at length with Sileny Salazar, the retired nurse who has interesting ideas that connect health to family and care (above), but also talked about how she feels about paying for others who do not pay or pay less than her:

> In the end, I pay for you. That I pay for you means that I am more owner than you [*es que yo le pago a usted, yo soy más dueña que usted*] [laughs]. Yeah, that expression exists because we have been led to believe that I am also the owner of the system, yes it is true, because I pay for it.

In contrast to others who say that "the *Caja* belongs to everyone because everyone pays," Sileny feels like she is the more the owner than the person who pays less than her. The idea of ownership appears to be connected to the reciprocal nature of the social contract and its legitimation. For example, when Sileny pays her part she becomes the owner; ideally, in return she receives equality of access to good care. Sileny also appears to think she has the moral high ground over those who do not pay their part. It appears that public health care is a moral regime that defines a set of expected behaviors and rights.

Karla Madriz, who suffers from chronic disease, also talks about ownership of the *Caja.* Karla says, "Everyone pays in, so everyone has ownership of the *Caja.*" She adds that "it is an essential quality of the system that no matter how much money you have, you can access health care." Together these accounts suggest a security and access to rights in being owners of a dependable health care system.

Caja administrator José Araya, who said interesting things about the health guarantees in the current interpretation of the national constitution, gives this example: "A hemophilia

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patient's medication costs the *Caja* $40,000 per patient per year. No one can pay that, only a system where everyone pays in can support that." In other words, the monthly payment to social security is the cost of membership in public health care, while ownership, equality of access, and some semblance of security are the rights granted as part of that membership. Not one person in this study complained about paying into the system, although some of those who used both public and private health care did complain about "paying twice." Like Dos Santos (2015), I did not find people talk about health care as "free." They may say, "And then I got free medications," but they always qualify that by adding, "You know it is not really free because I paid my fee, right?" In discourses about the *Caja* I did not hear expressions of entitlement to health care services or products; rather, the way that they framed their understanding of health care was as part of a reciprocal social contract, ownership, and solidarity.

Many participants talked about public health care in this study as a source of security because it would be there for them if they were in a car accident or got cancer. Through this system they knew that they would get the health care they needed without financial suffering. In other words, as part of their ownership they receive "health security."[16] For example, Dr. Randal Villalobos, a 37-year-old general practitioner who works in a rural EBAIS seeing 30–35 patients a day, calls the *Caja* a "shelter that protects people from diseases and maintains health." According to Dr. Villalobos, the *Caja* provides a shelter "because it is a way for people without money to get health care."

Evita Díaz, a nurse educator, also talks about security as access to health care. She says, "It gives me peace of mind that I have access and that everyone has access." In contrast, when

[16] Health security is defined ambiguously and inconsistently in the literature. In developing countries, health security is often understood in a broader public health context (Aldis 2008). Here, I refer to the security of having health insurance and protection from the effects of rising health care costs.

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Dr. Mario Jiménez, a privately practicing family doctor and homeotherapist, talked to me about his feelings of insecurity. He says, "I am afraid the *Caja* may stop. There are too many chronic patients and not enough money." Dr. Jiménez feels a lack of security because he doubts that the health care system as it is right now is sustainable financially. Édgar Flores, a 38-year-old lawyer, is one of the two participants who has little good to say about the *Caja.* Although he feels that public care is "a state issue and should remain that way," he only goes to private care, and he thinks the national health care system will collapse. He has no confidence in the sustainability of the system or in its ability to meet his own health care needs. In fact, Édgar says that private health care can save his life and public care will threaten it. Dr. Laura Zúñiga, a 36-year-old biologist, agrees that the system is not secure, but she does not think the financial and managerial crisis in the *Caja* is responsible; instead, she says, "This level of growth in the private system creates a situation where the public system may fall apart and the private will remain."

Ana Manuela Steward, a 39-year-old mother of two and teacher, also described her lack of security with public health care. She says, "In an emergency it does not feel safe to be waiting." In fact, she told me that she feels the *Caja* is not safe, adding that in public health care "insecurity comes before health." Now Ana uses only the private sector for her health care. Contrasts between ownership and deservingness and between security and insecurity appear to be part of the discourse about public health care for these participants. These contrasts describe what some interviewees see as features of public health care and point to areas of tension between public and private health care.

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Conclusion: Dissonance between Narratives of the Ideologies of Public Health Care and Their Lived Realities

Through these narratives, public health care in Costa Rica serves as a place where contrasts between ideologies of public health care and their lived realities can be observed, offering insights about how beliefs in public health care are negotiated or maintained despite its serious problems for patients, doctors, and nurses. Although participants often do not talk about the dissonance between narratives of the ideologies of public health care and their lived realities, these contrasts do form part of complaint discourse. For instance, complaint discourse expresses experiences of insecurity and inequality that contradict the *Caja*'s official mission of universalism, solidarity, democracy, and equality. Other contrasts such as those between: beliefs that the *Caja* offers security but experiences of insecurity; beliefs in equality of access but experiences of inequality; and beliefs that health care is universal but experiences of ambivalence about universality for all also emerge in narratives. When there is a dissonance between the rhetoric of the ideologies of public care and real lived experiences with health care problems, all the individuals in this study but two continue to believe in publically provided health care. Coherence and continuity of belief is perhaps more reliable, secure, and comfortable than experience.

Exceptionalism acts as an imaginary and symbolic identity that serves to both maintain a peaceful society and to privilege some Costa Ricans and also legitimatizes state-organized health care (see also Álvarez 2014; Booth 1998). Ong (1995, 1243) notes that scholars influenced by Michel Foucault "claim that while biomedicine attends to the health of bodies, it is also constitutive of the social and bureaucratic practices that socialize subjects of the modern welfare state." These narratives show that part of membership in the public health care system includes

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socialization into the beliefs in public health care and health care as a human right. This chapter shows that health care is a cultural system—a site of the normalization and continuous negotiation of ideologies and the practices of health care.

Before 2010, the rights to health care were social, human rights, since any person residing in the territory of Costa Rica had the right to emergency care or maternity care, regardless of nationality or immigration status. Individuals, regardless of national citizenship, could not be denied health care by law. In Costa Rica, health care was not tied to national citizenship but was a human, social membership. The new 2010 immigration law on one level reinforces the human rights of immigrants, while at another level it creates stricter regulations that require monthly payments and proper identification in order to get health care. Culturally, Nicaraguans have become the representative group for the "people who do not pay" and challenge notions of exceptionalism, universalism, and solidarity.

These narratives show how ideologies of solidarity, universalism, and equality are continuously being reframed and at times are ambiguous. For example, solidarity is defined by some as "solidarity with people" and redefined by others as "solidarity with people who have access to the system," thus reinforcing existing racism and xenophobic ideas. Interviews show that ideologies of universalism, democracy, solidarity, and exceptionalism have continuously shifting meanings according to policy, laws, and the life experiences of individuals. For example, some participants define solidarity as a shared membership with others in the system rather than solidarity with all people. The constant redefining of these ideologies also redefines citizenship and its entitlements, legitimizing the government's right to include some and exclude others.

Equality is an ideology of the *Caja* that is defined by some participants as equality of access, yet this equality contrasts significantly with real experiences of inequality. As seen in

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many of the narratives in this chapter, one way this contrast is negotiated is by rituals of complaining and storytelling about a lack of equality, lack of security, lack of access, or luck. Complaint discourse and storytelling reveal actual experiences of gender, age, class, and ethnic inequalities. It appears that individuals desire or need to air grievances against the *Caja*, while at the same time expressing concerns about defending the *Caja.* Complaint discourse is popular and common; for example, one participant said, “We make a national sport of complaining.” There is an assumed common-sense understanding in stories about health care problems, suggesting that everyone knows about waiting lists, problems getting a relative insured, or bad experiences, leading to an acceptance of these practices as a normal part of the health care system. In other words, the acceptance of the dissonance of beliefs and reality appears to legitimize the *Caja* in spite of its problems. These participants’ ideological investment in public health care can help explain the persistence of public health care despite its problems or the intensification of the private health care sector. Such an analysis has the potential to show how public health care systems are maintained despite opposition.

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CHAPTER 5: DISCOURSES ON MANAGING PUBLIC HEALTH CARE AND ITS PROBLEMS

Introduction

Given the culture of strong beliefs in public health care in Costa Rica, how do individuals manage the problems they experience with publically delivered health care? Scholars have conceptualized these beliefs in terms of ideologies of solidarity, human rights, and government responsibility for providing universal health care, which have normalizing and legitimizing functions (Becker 2004; R. Williams 1977). Indeed, according to Becker (2004), the success of policies for universal health care may be interconnected to strong public beliefs that such systems are morally and practically valuable.[17] Yet, the *Caja*[18] presents challenging problems to patients, sometimes making health care hard for them (Goldade 2009).

All the individuals in this study discussed their serious concerns with the problems of the *Caja.* For instance, during interviews, many participants developed verbal lists of the problems they encountered.[19] According to literature on the Costa Rican health care system, some of the main problems of publically delivered health care are lack of efficiency, high debt, poor management, high patient volume, and crumbling infrastructure, all of which are interconnected to patient experiences of long waits for appointments, exams, and health care procedures (Ávila-

[17] In contrast, Becker (2004) observes that Americans demonstrate ambivalence about trust in the government to solve problems of health care national health care, which may be connected to conflict over policies of national health insurance (see also Jacobs 1993; Starr 2013).

[18] The Costa Rican Social Security System is called the *Caja Costarricense de Seguridad Social* or the *Caja* for short in Spanish.

[19] Most of the individuals I talked to agree on the following challenges, summarized in Appendix B: (a) demographic changes of more seniors, more expensive care, and fewer young working people paying in; (b) the *Caja* is having a financial, and managerial crisis; (c) quality issues and dehumanization; (d) waiting lists; (e) infrastructure issues such as buildings needing repair, crowding, lack of space, lack of supplies, a shortage of nurses; (f) too many generic medications; and (g) corruption.

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Agüero 2013; Torres 2013). According to a Pan American Health Organization (PAHO 2012) report, waiting for appointments and health care is the most serious problem facing the *Caja.*[20]

This chapter examines narratives of participants who continue to believe in public health care while staying within the system despite its problems. More specifically, waiting lists are examined as a key example of how individuals frame their understanding of the problems and strategize problems in the *Caja.* This chapter examines the ways that some individuals in this study continue to embrace public health care despite its problems, as well as how some individuals work within the system to manage their health care without resorting to the option of private health care. These patients cope or actively strategize to make public health care work despite rumors and experiences of public health care going badly.

This chapter explores two ways that Costa Ricans in this study stay within the public health care system despite the problem of long waits for appointments, results, and care. One way that the middle-class participants in this study deal with the problem of waiting is to stay within the public health care system despite its problems. In other words, commitment to public health care as an inexpensive system of attaining health care and supported by strong ideological beliefs enables some individuals to endure its problems. The other ways that these middle-class participants manage problems of waiting is to improvise by developing strategies to make public health care work better for them.

[20] For example, a news report stated that one of the top national hospitals had 464 patients waiting to see a specialist, nine of whom have been waiting since 2010 (Ávalos 2015b). It was also reported that patients could wait four to five years for lung or heart surgery at another top-tier national public hospital (ibid.). According to Zúñiga-Brenes, Vargas, and Vindas (2012), waiting is endemic at all levels of the Costa Rican health care system. Previous studies also show that although waiting lists can be attributed to factors such as lack of resources and capital or an aging population leading to large numbers of elderly using the health care system, waiting lists are also forms of rationing health care (Sáenz, Acosta, and Bermúdez 2010; Torres 2013; Zúñiga-Brenes, Vargas, and Vindas 2012).

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Narratives of what participants do or do not do about long waits for appointments and/or health care present one example of how individuals think about the problems of public health care. In her ethnography of the experiences of patients, relatives, and staff in a cancer ward in Botswana, Wendland (2010) observes that health care narratives reflect on lived experiences and inform us about how individuals think about medicine and health care. Similarly, narratives of individuals who stay within public health care or make public health care work without resorting to private health care are informative about the current health care climate.

Narratives of staying within public health care are significant since these individuals strategize problems in public health care without resorting to private health care. Specifically, the diffusion of the principles of neoliberalism has led to the intensification of the variety of private health care options available to many Costa Ricans. Yet, in the interviews examined in this chapter, individuals do not accept the problems of public health care by resorting to private health care options, but instead develop their own ways to manage public health care such as enduring problems, using a doctor in the family before going to the *Caja*, or taking the *Caja* to court.

This chapter includes two subsections. The first subsection examines participants who decide to wait for public health care appointments and services even though many feel uncertain about their health as they wait. In particular, these interviews show how individuals endure the problems of long waiting times and lack of resources, often working hard to get the health care they need. Some continue to wait despite the worst-case scenario of waiting for care—dying while on a waiting list. In contrast, the second subsection examines narratives of individuals who rework the public health care system by seeing a family member who is a doctor or nurse first or taking the *Caja* to court to get the health care they need. These participants are able to maneuver

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within the public health care system without resorting to private health care, thus showing their continuing financial reliance on and/or belief in publically delivered health care in spite of its problems. Together these two subsections examine how public health care is managed without resorting to private health care, even though private health care is an option.

Section 1: Staying in the Public Health Care System While Waiting

The Waiting Routine

Waiting for care was talked about often in interviews, demonstrating that waiting is accepted as a routine part of the public health care system. Pedro Morán a 34-year-old nurse who works in a national public hospital, has been waiting for two years for his son's surgery. When he described his son's situation, Pedro appeared to be both frustrated and compliant with the public health care system. Pedro's son needs surgery for a vascular abnormality, yet Pedro is still waiting for the phone call to schedule his son's surgery. While Pedro waits he faces uncertainty about his son's health care, yet he told me, "When the *Caja* is working well they can give good care, even better than in private." Pedro appears to embrace the promises of low-cost and effective public health care while enduring the long wait for his son's treatment, even though he also said that if he went to a private clinic his son would get surgery right away. For families like Pedro's, waiting is one part of the promise of universal health care. Economists consider nurses like Pedro to be a part of the middle class in Costa Rica (Birdsall 2013). Yet living expenses in the city cost more than one-half of a nurse's salary. Pedro's salary is well above the minimum base salary set by the government and enables him to choose private services at his own expense without becoming impoverished (Knaul, Gustavo, and Zúñiga 2002; Zúñiga-Brenes, Vargas, and Vindas 2012). Yet Pedro stands by his son while he waits in the gray area between hope and uncertainty.

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In contrast, Karla, a 28-year-old public nurse, has not had to wait for care at the local public clinic to manage her chronic hypertension and diabetes. According to Karla, local clinics are very good at providing care for chronic conditions like hers. Yet, her father waited two years for treatment for a hernia. Like Pedro, Karla says, "Waiting is seen as normal, as part of the *Caja.*" Universal access to public health care alongside long waits for health care intersect in complex ways, leading to a phenomenon where waiting is a normal part of publically delivered health care, at times adding to the uncertainty of health care outcomes. Indeed, Karla expressed concern that people may die while waiting. The uncertainty that emerges from waiting adds another layer to the realities of public health care.

Consider the case of Victor Morales, a 28-year-old nurse at a national public hospital. He told me that at his hospital there is always a high volume of people waiting, and waiting can make their health conditions worse. Victor takes care of patients who wait months for the results of cancer biopsies, leaving them to wonder if they have cancer or if it is getting worse. According to Victor, there are not enough specialists at his hospital to analyze all the biopsies in sufficient time. Victor also said that at his hospital there are 4,000 people on the waiting list for gallbladder surgery. Similarly, Pamela Jirón, a 35-year-old patient, gave this account of waiting:

> So a patient goes to the doctor with gallstones and a lot of pain. Of course, first they go to their regular public doctor. The doctor says that they need surgery right away but there is no room. So the doctor prescribes some pills and says, "We don't even know if these pills will cause you more pain." The doctor then says, "Look dear, you have gallstones. You will need an operation, so we are going to set up the date." So let's say the patient came in on March 20, 2014, with all that pain—well, they set up the appointment for the operation for October 20, 2015. You may just die from pain!

In addition, Pamela discussed her observation that some patients have to take more pills, or pills that are not solving their problems, in order to endure long waits. According to Pamela, long waits for care add to the work and personal costs of getting health care in the public health care system, even though the constitution guarantees a "right to health."

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Lower-class patients cannot afford private health care without accruing debt or selling property. For example, Karla's father cannot afford private health care, so he stays on the waiting list for his surgery. This creates the appearance of an unofficial two-tiered system in which patients with more access to cash can escape waiting lists and wait times by going to private care, and others cannot. Yet experiences with waiting are varied. For instance, Yancy Chavez is a 30-year-old single mother and secretary and cannot afford private care. According to Yancy, she usually has to wait to get care for her son. She says, "If I have an appointment at 1 p.m., I won't leave the hospital with medications and everything until 4:30 or 5:00 p.m." On another occasion her son was referred to a pediatric specialist and got the appointment within one month.

Waiting has also become a routine part of health care for Dinorah Ahrens, a 56-year-old public nurse with a lot of nursing experience. She told me she has learned to handle the waits well because she knows the system and is more patient. Dinorah's patience with the system is indicative of one way that many participants deal with waiting. For instance, Dinorah can handle these waits with little stress, she told me, because she is "used to it." Dr. Vilma Garcia is very familiar with the conditions of the public health care system, since she is an obstetrician who divides her time between a national hospital and her own private practice. Yet personally, Vilma and her family only use the public health care system. Although she told me that she chose to work in the public health care system because it means a lot to her and her country, she also told me that the "public health care does not have all the resources needed." She explained that waits for care, waits for appointments, and the misallocation of resources were common in many local public clinics.

Uncertainty and waiting are especially difficult in the case of emergencies. For instance, when Dinorah Ahrens's son needed emergency surgery for a severe urinary tract infection, there

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was no room in the operating rooms; he had to wait 24 hours on a bench. Likewise, Maria Montealegre, a 60-year-old retired school teacher, had to wait nearly two weeks on a gurney in the hallway of the emergency room for surgery for her severely broken femur. All the while her leg worsened and she had to endure pain, lack of privacy, constant lights, noise, and fear. Patients like Dinorah and Maria talk about waiting as a problem, yet they endure it, sometimes because they have no other financial options. Uncertainty about health outcomes while waiting also appear in other stories, such as accounts of people dying while waiting.

Dying for a Cause: Staying in Public Health Care Even Though It Can Threaten Care

The ultimate fear discussed by many participants in this study is that they will die while waiting, and this fear emerges strongly in the rumors participants often repeated. In interviews, I collected many narratives of second-hand, anonymous accounts of people who died while waiting for care. I am not concerned as to whether these accounts are true or false (although that is important) but rather, how these stories are told and retold, how they circulate, and what they reveal about the culture surrounding public health care. Certainly, the outcome that participants hope for is good care—a remedy, a cure, or a diagnostic exam completed on time. Their health care narratives often speak to this hope, but that is not the only possible ending to enduring a public health care system that is struggling that they discussed. Narratives of the "friend of a friend" who died while waiting on a list for health care reveal the worst fear and the highest cost for believing and staying in public health care.

Narratives of dying while waiting suggest that waiting is a serious issue. Consider the case of Karla Madriz, the 30-year-old patient with hypertension and diabetes. Karla lost her grandmother in 2010. Karla gave her grandmother as an example of "people dying while waiting": the *Caja* called her house in 2011 to see if her grandmother was coming to her

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appointment, even though she had passed away a year earlier. Karla expressed to me her personal pain in having to tell the secretary that her grandmother has already passed away, as well as her horror regarding the inefficiencies of the public health care system. Similarly, Marta Vega, a 69-year-old retired office worker and mother of five, lost her husband to cancer. One year after he passed away, a receptionist at the public clinic called to schedule an appointment for him. Rumors of dying while waiting are not only real because they are written in news articles and do happen but also because they express actual concerns and problems in the public health care system.

For instance, when I asked participants about the problems of the *Caja,* participants often talked about waiting, adding, "and people die while on waiting lists!" These rumors were repeated so often that they appeared to be a normal public expression of real underlying fears and uncertainties. Rumors and friend-of-a-friend accounts seem to represent people's worst fears, or the worst outcomes of waiting. According to Wendland (2010, 7) these kinds of stories "do significant work" because they are spaces to reflect on lived experiences and reveal how people think about health care.

Anthropologists who conduct ethnographic research on rumors argue that rumors can both reveal data about the sociopolitical context and affect the lives of the tellers by illuminating real social and political anxieties or real losses (Masquelier 2000; Samuels 2015; Scheper-Hughes 1996). For example, the public health care system in Costa Rica inspires hope and trust that health problems will be solved, whereas waiting years for tests or surgeries can be frightening. Rumors may be an expression of people's awareness of the problems in public health care and/or their experiences of the inconsistencies between the aims and promises of publically delivered health care and patients' lived realities. In addition, anthropologists note that

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the value of examining rumors is not as much about whether they are true or not but rather what they tell us about social truths (Samuels 2015). For instance, Samuels (2015), who examined rumors of child trafficking in post-tsunami Aceh, Indonesia, argues that rumors are powerful because they express emotion and voice the possible. It is the possibility of the worst outcome of waiting that is being expressed in rumors of dying while waiting. In other words, the accounts I heard in Costa Rica about people who died while waiting for a phone call from the *Caja* to schedule a surgery may be expressions of the possibility and cultural fear that the worst can happen. Living with fear and wondering whether the outcome might have been different in private health care are elements of the current health care climate for these patients, yet they stay in the public system. Another way the patients stay in public health care is not to endure waits but instead to strategize ways to make public health care work better for them.

Section 2: Road to Certainty

While these patients endure the problems and uncertainties of public health care in order to get the care they need, other patients try to find ways to solve their long waits for care within the public health care system by improvising official pathways to public health care. Ricardo Jiménez Miranda, a 60-year-old administrator at the University of Costa Rica, described the official view of how to access the public health care system to me. He drew a pyramid in the air with his hands. Then he explained the three levels of health care (local community, regional, national) and how patients are expected to use the public health care system in the right order. Later, after more interviews, I found that many participants would draw the same pyramid in the air as they described their health care system.

Yet, even though it was common to hear this official story of the public health care system, the same participants explained how they did not follow the official pyramid structure.

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Officially they should access public health care in a hierarchical way by first going to the local public health care clinic, then regional public health care clinics and hospitals, and finally to the top public hospitals and specialists. Instead, on the ground individuals improvise on this model by finding ways to circumvent waiting, such as seeing a doctor in the family or taking the *Caja* to court.

Improvising Official Pathways to Public Health Care: A Doctor in the Family

Karla Madriz, whose father had to wait for surgery, has several doctors in her family. She told me that if something happens to her she first goes to a family member who is a doctor, who tells her what to do and may give her a referral to a public or private doctor or specialist. For example, Karla explained that when she was in a car accident, a doctor in the family referred her to a private heart specialist. Karla explained to me that it is "good" and prestigious for a family to have at least one doctor or nurse to call. For Karla, family is the first level of care, not the local public clinic (called EBAIS).[21] Karla's situation is far from unique. Other participants reported to me that they get advice over the phone from the nurse or doctor in the family; that often the doctor will call in the prescription to a local pharmacy, and another relative will pick it up and deliver it to their home. These informal networks are an important way for Karla to arrange timely care.

Knowing someone who works in the *Caja* appears to be another form of networking as well as a strategic advantage for some of the participants in this study. For instance, Alex Diaz, who now works in public health, has many friends who are doctors. Alex explained that he gets the care he needs because he knows well-regarded doctors at one of the top public hospitals. "I have so many friends who are doctors, so I see them first when I am sick. Then if I have

[21] EBAIS are explained in Chapter 2.

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something serious, I call my friend who works in the *Caja*." Throughout my interviews, I found that knowing someone in a specific *Caja* hospital can be an advantage to getting timely care or care from a well-regarded specialist. Individuals in this study described their discomfort with the crowds at their local EBAIS and the lack of resources, as well as long waits to make appointments and receive care. Yet they also discussed using the court system as another way to get public health care without waiting.

Resiliency by Taking the *Caja* to Court

Some patients tried to do more than endure the problems of the *Caja;* instead, they took specific actions to get the health care they needed within the public health care system by filing lawsuits in public court against the *Caja.* For instance, Yancy, the young mother of a child with asthma, is also responsible for the health care for her mother, Marlen Chavez. When Marlen was 52 she became very ill; her face, arms, legs, and stomach swelled up, and the local EBAIS could not diagnose it. The doctors at the EBAIS sent Marla to the emergency room at the regional hospital, but the doctors there could not find anything wrong, so they sent Marlen home. In this case, Yancy and Marlen tried to follow the usual routes to care, but nothing was working. At this point Yancy and her family had to improvise ways to get Marlen the care she needed.

First, Yancy's family improvised by using a sister's address to get a new health care card that gave Marlen access to a different public hospital.[22] At that hospital they were able to get an appointment with a specialist. Yet when Marlen finally got to see the specialist, he set the appointment for two years later. The second approach that Yancy and her family took to get an

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[22] Several patients in this study talked about switching hospitals as a method of solving problems within the public health care system. The social security system is set up so that access to public hospitals and clinics is controlled by the registered place of residence. Families like Yancy and Marlen are able to use a relative's address to switch residency and get access to a hospital where they believe they can get the care they need.

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earlier appointment was to file a case against the *Caja* with the Fourth Constitutional Court (also called *la Sala*, *Sala Cuarta*, or *Sala Constitutional*). Yancy told me how she was able to use the legal system to make an appeal to get her mother an earlier appointment. She argued to the court that a two-year wait violated her mother's right to universal health care. These types of court cases are possible because the Supreme Court has interpreted the constitution as mandating a right to health, and the Supreme Court plays an active role in guaranteeing those rights (Lunes, Cubillos-Turriago, and Escobar 2012; Norheim and Wilson 2014). Health care litigation has become a route to health care rights when those rights are ambiguous or delayed by long waits.

Lawsuits against the *Caja* hold the state accountable to protecting the fundamental right to health and life as interpreted and mandated by the Constitution (WBI 2013). This step is an acceptable and increasingly common route to care (Reveiz et al. 2013; WBI 2013). According to David Campos, a lawyer I interviewed who works at the Fourth Constitutional Court, cases related to health care currently make up the majority of lawsuits in the court. By using the legal system, a patient can petition for the court to demand the *Caja* to take them off a waiting list for surgery, get an appointment with the specialist, or get a brand-name medication paid for by the *Caja.* This follows current research reporting that the primary types of cases brought to the courts in recent years concern patients on waiting lists, especially for appointments for surgery or to see a specialist, patients who want access to a new medical technology, and patients who want medications not on the official list (Hogerzeil 2006; Lunes, Cubillos-Turriago, and Escobar 2012).[23]

For example, David Campos gave an example of the type of cases he works on weekly:

[23] Some of the recent cases have concerned high-cost cancer treatments, multiple sclerosis, kidney failure, waiting times for surgeries, and in vitro fertilization (Norheim and Wilson 2014).

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> The court can demand that the *Caja* do things. For example, if a person is number 2,000 on a waiting list for surgery and the hospital is doing two of those surgeries each week, then really there is no set date for the surgery. Then the court demands that the *Caja* set a specific date. If it is urgent, the date will be within two months. They do this because a fundamental right to health is being violated.

Lawsuits against the *Caja* (called *amparo* in Costa Rica) are one way that problems with public health care are solved within the public health care system. Similar to living with fear and uncertainty, lawsuits appear to be another way to manage public health care and its problems.

Litigation is one way to patients can strategize to get access to public health care with shorter wait times. Since the 1980s, these lawsuits have increased dramatically (Lunes, Cubillos-Turriago, and Escobar 2012; Norheim and Wilson 2014; WBI 2013). For example, in one study it was estimated that there had been 4,000 lawsuits focused on health issues up to 1989 (Lunes, Cubillos-Turriago, and Escobar 2012).[24] Between 1989 and 1998 there were 179 *amparo* cases against the *Caja* (Lunes, Cubillos-Turriago, and Escobar 2012; Zamora 2010). Strikingly, between 1999 and 2008 the number of cases increased to 2,524. The large number of cases filed against the *Caja* shows that health care litigation is an accepted and increasingly common route to the right to health.

As these high numbers demonstrate, health care litigation is a path to care for patients with knowledge and access to lawyers in San José. In addition, among the middle and upper classes, court cases related to health rights have increased dramatically because of public demands for timely, high-quality health care (Lunes, Cubillos-Turriago, and Escobar 2012). According to Lunes, Cubillos-Turriago, and Escobar (2012, 3), "public demands have changed from [a focus on] the solution of public health issues to the delivery of timely, high quality, and service-oriented health care." Lunes, Cubillos-Turriago, and Escobar (2012) further argue that

[24] Most of the earliest cases concerned HIV/AIDS medications not on the official list (Norheim and Wilson 2014).

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these sets of demands align well with the values and goals promoted in neoliberalism and private health care. Not only has the demographic and epidemiological structure of society placed more demands on public health care but also, as Lunes, Cubillos-Turriago, and Escobar (2012) show, patients themselves want fast care without waiting. The desire for individualistic, timely, high-quality care may place more demands on publically delivered health care as well as demonstrate that the neoliberal values of efficiency, speed, and individualism in health care are diffusing into daily clinical care and patient perspectives. For instance, many participants in this study spoke candidly about how slow the process of health care is in the *Caja* and discussed their desire for fast, high-technology care.

Conclusion

In this chapter I have discussed several ways that individuals remain in public health care despite its problems. I have painted a picture of how the problem of waiting for health care is and is not dealt with in San José. Although some patients continue to see public health care as valuable ideologically and practically despite its problems, others strategize ways to make public health care work for them within the system. Public health care for these patients is at once problematic, ideological, and valuable. In addition, the uncertainty and fear of waiting structures these individuals' understandings of publically delivered health care.

Narratives of staying in public health care despite its problems or working within the public health care system to get off a waiting list without resorting to private health care demonstrate that as these participants encounter real problems in their public health care system some do not resist or rebel but rather embrace it. How patients struggle to access public health due to long waits for appointments, diagnostic tests, results, or treatment while maintaining a belief in public health care in general is a lens for examining experiences and understandings of

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the current health care climate. Some of these patients were able to maneuver within the public health care system without resorting to private care, thus showing their continuing reliance on and/or belief in publically delivered health care in spite of its problems. The next chapter will examine narratives of patients who turn to private health care and mix of public and private as another way to strategize their health care.

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CHAPTER 6: STRATEGIES OF NEGOTIATING PRIVATE HEALTH CARE AND MIXED HEALTH CARE

Introduction

In this chapter I examine the strategies that individuals in this study used to negotiate the problems of the public health care system by using only the private health care sector or mixing public and private. More specifically, I examine how these individuals participate in the private health care system and mixed health care systems, and how these individuals talk about these systems. For instance, the health care professionals, doctors, nurses, and patients I interviewed developed their own strategies for dealing with the problems they found in publically delivered health care. In addition, as they engaged in private health care practices, some individuals' beliefs in the ideologies of public health care shifted so that they began to consider health care as a competitive marketplace. In doing so, they experienced the contrasts between the underlying ideologies of those two systems.

In trying to understand how these participants manage the public and private health care options available to them and their contrasting ideologies, the concepts of cultural work (Townsend 2009) and moral economies (Wendland 2010) shed light on how individuals interpret their health care arrangements and develop their own understanding of health care in the context of mixing public and private health care.[25] Wendland (2010, 196) has observed that contrasting ideological systems make up a *moral economy*, defined as sets of "emotionally charged values used to negotiate changing economic and social relations" and that these values "*are themselves* open to negotiation and change." In this sense, individuals who move between public and

[25] I am indebted to Townsend (2009), who made the point that when people face competing norms they engage in cultural work to interpret them. For instance, Townsend (2009, 115) proposes that "when people's lives diverge from cultural norms they have to do the cultural work to deny, explain, or reinterpret this divergence."

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private health care and the meanings or values that underpin health care are flexible. The ideologies of public and private health care are at once local, flexible, and fluid. How the meaning of health care is worked out in practice—such as how values are tried out, abandoned, reformulated, or preserved—can influence how much support these participants give or do not give to publically delivered health care.

This chapter examines strategies for negotiating the problems of publically delivered health care, such as using only private health care and using a mix of public and private health care, in order to investigate the ways in which the private health care system has become interdependent with the public. As these systems mix, their boundaries become blurred, creating an environment where privatization is thinkable.

The Unofficial Two-Tiered System: Strategies of Using Only Private Health Care

Narratives of how middle-class participants use only private health care not only show how they negotiate and manage their options but also serve as a window into how they manage the meanings that underpin public and private health care. Take, for example, the case of Édgar Flores, a 38-year-old health care lawyer. I met Édgar in an empty classroom at a private university where he was teaching a class on health care law. He explained that "there are only advantages to having a public health care system, since private is too expensive and not everyone has access to it." Yet when I asked him what he does when he needs health care, he admitted that he only uses private health care. Édgar talked about his decision in the following way:

> I only go to private when I need medical care because I can get better attention there that may save my life. I cannot get that kind of care in the *Caja.* In the *Caja* there is mistreatment, violations of patient rights, overcrowding, and unhealthy conditions. For example, some public hospitals do have enough beds or proper linens, test results do not come in on time, and people are not treated on time.

Although Édgar says that "health [care] is a public and state issue and should remain public," he says that he chooses private care over public care because of the overcrowding and

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lack of quality care in public hospitals. Since Édgar is a middle-class professional, he can afford this option. He has the ability to pay out of pocket for private care while still paying his mandatory fees to the national social security fund. Édgar does not see a contradiction between his belief in public health care and his use of the private sector. He is able simultaneously keep his belief yet negotiate care for himself outside the *Caja.*

Like Édgar Flores, Ana Manuela Steward, a 39-year-old mother of two and public high school teacher, strategically tries to use only private care for tests and emergencies for herself and her daughter's asthma and allergies. As she stated, "The *Caja* is failing people so they have to go to private." Instead of the long waits she experiences in the *Caja,* Ana says that in private care she can get prompt, personal care and the newest nonsteroidal anti-inflammatory medications to treat her severe allergies. She says in the public system she feels like a number and that the generic medications she received in public care gave her allergic reactions and side effects. Ana tried to use the public system when her daughter had an acute asthma attack, because the tests were too expensive in private care, but she had to wait five months for important tests. As we talked in her modest home in an upper-middle-class neighborhood, Ana told me she now sees Dr. Mario Jiménez, a private general practitioner who combines home visits and phone consultations with office consultations and alternative medicine.

Ana described security (*seguridad*) as very important to her health care, which led her to choose Dr. Jiménez as her private family doctor. Ana told me that for her, security means "not having to wait when there is an emergency." Security is so important to Ana that she also purchases emergency services from a private company (Emergencias Médicas), which she calls "extra security" (*seguro extra*). They provide her with 24-hour, 365-days-a-year coverage for private ambulance services. She is able to do this because she is a married middle-class mother

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of one. She is a teacher, and her husband is owns a profitable small business. Ana says that she buys this private emergency policy so that if her daughter has an asthma attack, fall, or accident at school, the emergency company can go straight to the school, treat her daughter immediately, and then decide whether or not to move her to the hospital. The desire for security, problems with the *Caja* such as waiting and poor infrastructure, and the ability to pay out of pocket for health care shape Édgar and Ana's health care decisions.

The participants I talked to frequently spoke about strategizing their health care by using the private pharmacy before going to the *Caja.* For example, Allan Torres, a 55-year-old state administrator, called the pharmacy "a first level of care." He said, "Patients will simply go there first to see if they can fix their problem." This is the case for Patricia Corella, a 58-year-old retired shopkeeper who suffers from hypertension, fibromyalgia, and fatigue. Unlike Allan, Patricia lives on a fixed income in a lower-class neighborhood. Yet Patricia is able to afford both public and private health care. She uses the public system for her high blood pressure, emergencies, and things like the flu, and she sees a private rheumatologist to diagnose and manage her fibromyalgia and fatigue. Although Patricia takes nine pills a day, the only medications she gets from the *Caja* are her high blood pressure pills and acetaminophen; everything else she pays out of pocket at the private pharmacy because, she says, the *Caja* does not have the medications she needs. Patricia is an example of the affordability of medications at private clinics as well as how private pharmacies are part of a strategy to get needed health care.

According to Mossialos et al. (2015), community pharmacists in Australia, Canada, England, the Netherlands, Scotland, and the United States are the third largest group of health care professionals after physicians and nurses. The use of pharmacists as a first level of care was also reported in interviews in this study. Many of the participants I interviewed reported that they

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often go to the pharmacy for medical information and medications. They told me that some pharmacies have a doctor on staff and a small room for medical consultations and injections. The individuals I talked to know the cheapest pharmacies, and I often observed a long line of people waiting to see the pharmacist. For example, Stephany Gutiérrez, a 50-year-old nurse administrator, told me when she has flu symptoms she goes to the private pharmacy near her home on her way to work; she quickly gets an injection that lessens her flu symptoms and still gets to work on time. Like Stephany, Vanessa Calderón, a 46-year-old patient who suffers from a chronic immune disease, told me that when she is sick she goes to the pharmacy first. She said that this way she does not have to spend all morning at the *Caja.*

Even with these options, some patients I interviewed told me they prefer to first go the *Caja* but then run into problems when the clinic runs out of the medication they need. In this case, the pharmacy is not only another form of networking health care but also fills in the gaps for some of the problems in public health care. For instance, Oscar Ulloa, a 61-year-old CAT scan technician, explained that he first tries to get his medications at the *Caja,* but sometimes the *Caja* pharmacy does not have them, so he buys his medications from a private pharmacy. Oscar has to use the private pharmacy to get his prescription filled, showing the interdependence between the public and private health care systems.

Karla Madriz, who was mentioned above in the discussion of using family member who are doctors, talks about the same situation as Oscar. Karla explains that people use the pharmacy to avoid some of the problems in her local EBAIS:

> Sometimes the EBAIS does not have the needed medication so the person takes the prescription from the public [health system] and uses it to buy medicine in private. This kind of mixing is normal, especially if people want things fast. But the people who are using private [health care] for part of their care can easily migrate over into other private services.

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According to Karla, using the private pharmacy to fill in the gaps of the public health care system is a common strategy, especially when she wants things fast. Karla also comments that in the process of using a mix of public and private, it may become easy for people to turn to private health care altogether. She expresses the idea that the habitual use of private health care not only fills in the gaps of public health care but also can become the first strategy for accessing health care.

For these middle-class patients, private pharmacies and the private health care sector are an available health care strategy. However, this strategy can also culturally create an unofficial two-tiered model where the poor use only public health care and the wealthy strategize private health care options, even though officially Costa Rica is classified as a single-payer state health care system.

Using the private pharmacy as a first level of care can be problematic. For instance, in my interview with Karla Madriz she also said, "Costa Ricans love to self-medicate, and they often use medications from each other's prescriptions." Similarly, nurse Dinorah Ahrens talked about her patients who use a medication prescribed for something else and then complain to her that it does not work. She says:

> People know that folic acid is important for pregnant women, so they are now using it to try to get pregnant. Now is used by *raymundo y todo el mundo* [everyone and their brother]. People are using Vitamin C pills like breath mints. They use the anti-inflammatory drug *indocid* for migraines, headaches and any other kind of pain.[26] People stockpile medications and then use them incorrectly.

Dinorah's patients and Karla are examples of middle-class patients using the private pharmacy to get their medications, even though they are covered fully under the national insurance of the state. The use of the private pharmacy as a first level of care is similar to the

[26] *Indocid* is a nonsteroidal anti-inflammatory drug commonly used for fever, pain, or stiffness.

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findings of van der Geest, Whyte, and Hardon (1996) and Cooper (2013). However, van der Geest, Whyte, and Hardon (1996) and Cooper (2013) are also concerned that using the pharmacy as a first level of care often leads to overuse or misuse of medications, adverse side effects, and unnecessary use of medications.[27] The movement of patients between public clinics and private pharmacies is one example of how the boundaries between public and private become blurred.

Blurring the Boundaries: Strategies of Alternating between Public and Private Care

Half of the middle-class participants in this study navigate between public and private health care, strategizing the networks needed to maneuver between them. For example, David Campos, a 56-year-old lawyer who writes academically about health care as a human right, understands the mix or public and private health care in the following way:

> Using the private health care system is an option—a possibility for people. The private sector actually lightens the load of the public health care system. It is a market opportunity. So I think there is not a tension between public and private. The market is like an exhaust valve for the tensions and the actual suffering of people in the public system. This is because if all these people were to go to public, the system would collapse.

David Campos talks about private health care as a system of care for people who can afford it. Such patients use private health care opportunistically to fill in the gaps for some of the problems in public health care. David does not see a tension between public and private health care; instead, it appears that he sees them as interdependent and interconnected. For instance, David says that in his view, the movement of some people to private care not only lightens the load on the public health care system but also may keep the public health care system from collapse.

[27] For these reasons, in Costa Rica the unregulated use and overuse of pharmacies was evaluated in 2014 (Guerrero 2013). In this case the *Caja* negotiates the relationship between public and private health care, showing how the state is involved in the private health care sector. Contrary to the state having less authority, the state has an authoritative role in the surveillance of the relationship between public and private health care.

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Sileny Salazar, a nurse who is currently working in the public sector, also talked about how the private sector may fill in the gap for what is lacking in public health care. For instance, she said that she primarily uses public health care, but when it does not work well she goes to a private doctor. She told me that recently she met with her public cardiologist, but after the consultation she still felt bad. She immediately went to her private cardiologist. She told me that she can get an appointment with her private cardiologist on the same day she calls him and get an electrocardiogram right away. Sileny said that she is happy with the public health care system but "by the grace of God" she can go the private doctor and not have to stand in line all day.

These participants strategize waiting lists and inefficiencies in public health care by moving back and forth between public and private health care. Instead of the distinct bifurcation of public and private, the interviews in this study show various ways to strategize between these systems. In a study on public–private partnerships, Nutavoot Pongsiri (2002) made a similar observation that a traditional model of autonomous public and private sectors does not match the reality of the phenomena of the mix of public and private. Rather than the private sector acting in pursuit of its immediate goals and a distinct public sector with its own objectives, in reality there is a dynamic interdependence between public and private health care. This intermixing is the context in which these participants construct their understandings of health care and strategize their options.

Mixed Medicine

One strategy that many participants used to access both public and private health care is a system called "mixed medicine" (*medicina mixta*). Mixed medicine in Costa Rica is defined as a system where the patient pays out of pocket for a medical consultation with a private doctor, but the *Caja* pays for the medications and support services (Knaul, Gustavo, and Zúñiga 2002). As I

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traveled around San José, mixed medicine was visible in advertisements on billboards throughout the city as well as on placards above private clinics, saying, “We do mixed medicine here” (see Figure 2). These signs show the popularity of mixed medicine as a health care strategy as well as a way for doctors to develop their private practices. In writing about health care in Canada, Flood and Thomas (2010) argue that mixed medicine is one example of the blurring between public and private health care because it includes a greater role for public–private partnerships within a publically funded health care system. Mixed medicine is also an example of a well-organized way to use a mix of public and private health care in order to get some of the benefits of both.

Figure 2. Photos of clinics using mixed medicine to advertise their services.

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Consider Camilla Masis, a 70-year-old widowed mother of three children, who talks about mixed medicine:

> Mixed medicine (*medicina mixta*) is when you pay the private doctor for the consultations and some of the care and then you go to *Caja* to fill prescriptions for "free." I used it for my thyroid problem. I first saw the private endocrinologist but got the tests and the medications from the *Caja.* But the first time around I lost my prescription and had to go get it again. I think mixed medicine works well.

As we talked over afternoon tea, Camilla explained that she uses mixed medicine to get timely care without waiting. For example, Camilla told me that she strategically chose a gynecologist-oncologist who works in both public and private health care in order to get what she called "the benefit of both." Both public and private benefitted her, as she arranged timely care through her private doctor and got her prescriptions for free through the *Caja.*

Camilla also used mixed medicine when she was having a leakage of her bladder after the birth of her first baby. She went to the doctor's private clinic, and then he sent her to the public hospital for surgery. By doing so Camilla got the appointment right away with the specialist by paying out of pocket, but the *Caja* paid for her surgery. This mixing of public and private health care enabled Camilla to get surgery immediately. Camilla described her desire to be able to choose her doctor, something that she explains can only be done in the private sector. According to Camilla, being able to choose her doctor and have timely care is associated with private health care, whereas low cost and uncertainty about how long waits will be is associated with public health care.

These patients strategized their health care by choosing a doctor who works in both public and private care. This way they could get timely care in the doctor's private practice and use of public health care facilities covered by their national health insurance in his or her public practice. Since physicians are not required to commit to contracts of exclusivity with the *Caja*, many work in the public sector in the mornings and in their own private clinics in the afternoons

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(Gifford and Rodríguez 2011). For example, Dr. Roxana Granados, a general practitioner, worked seven years with part of the day working in public care and part of the day running her private practice.

However, Laura Zúñiga, a 36-year-old biologist, talks about public doctors who refer their patients to their private practice as an example of "kidnapping patients." She says that some of these doctors give poor care in the public sector and good care in private. For example, Laura Zúñiga notes:

> There are conflicts of interest because doctors who work in both public and private want their public patients to move over to their private practice. This way they can make more money. There is no legislation about this but we are working on it, but doctors want to keep control over their private practices.

When the doctor who works in both public and private health care gets patients off of waiting lists or patients pay privately for some of the services of the *Caja,* it is often referred to as an illegal practice colloquially called *biombos*, or "behind the screen care" (Gifford and Rodríguez 2011; Lehoucq and Molina 2002). *Biombos* are one form of corruption, generally known as *chorizos*;[28] it is reported that bribes, payoffs, kickbacks, and *biombos* are very prominent in government and business in Costa Rica (Howard 2014). For example, nurse Harry Li said he has observed doctors getting their wives cosmetic surgery using the *Caja*'s funds, hiring friends, keeping employees in the *Caja* who do not work, and not controlling public hospital expenses. Nurse Pedro Morán summarizes the commonality of these practices of corruption this way:

> Maybe with privatization, quality of care and better service would be an advantage. But theoretically the advantage would be that everyone has access to the same service. However, that doesn't happen. Right now it depends on the friends you have and

[28] The word *chorizo* usually means a kind of sausage, but colloquially in Costa Rica it also refers to forms of corruption found at all levels of society.

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biombos. Biombos is where you let your friend who is 61st on the waiting list move up to the top.

According to Dinorah Ahrens, a 56-year-old nurse, one health care strategy of many patients is to look for a prestigious doctor who works in both public and private health care. Similarly, Vanessa Calderón, a 46-year-old patient with a chronic immune disease, said this is how "people use the private system to get the benefits of the public."

When I talked to Dr. Alex Diaz, who works in public health care, about *biombos,* he said that this practice results in a double standard where doctors give one level of care in public and another in private. Indeed, according to Homedes and Ugalde (2002), some doctors take advantage of their position between public and private and may even benefit from long waiting lists for care or poor care in the public sector, leading to further deterioration of public health care services. A. Rodríguez (2009, 136) notes that some doctors also collaborate with health policy makers to evade guidelines of the *Caja* or contribute to the poor management of some EBAIS, poor allocation of resources, evasion of fees, underreporting of salaries, and failure to make schedules for care.

In fact, corruption or *chorizos* (of which *biombos* is one example) are so common that they figured into President Solis's 2014 presidential campaign when he said, "There will be no *chorizos* in a PAC [*Partido Acción Ciudadana,* or Citizens' Action Party] government" (González 2013). By running on an anti-*chorizo* ticket, Solis and his political party expressed the disgust of the public with corruption (González 2013; Howard 2014). Such accounts show how the strategies of mixed medicine and corruption are ways to negotiate health care for these participants.

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Health Care Cooperatives

Another way public and private health care are blurred can be seen in health care cooperatives. Health care cooperatives are a public–private partnership where the *Caja* is the owner, financier, and administrator of the clinic or hospital, but a private company manages the daily provision of health care. The boundaries between public and private are blurred as both public and private sectors mix to arrange, finance, and manage these clinics and hospitals, and private health care is used within the public health care system. In other words, when patients go to health care cooperatives they are using a mix of public and private health care.

Participants in this study had their own views of health care cooperatives. David Campos, a lawyer who works with health care legal issues, talks about health care cooperatives as a form of privatization that exists within the national health care system. Nurse administrator Stephany Gutiérrez says what is happening is that the cooperative sells its services to the *Caja*, making the *Caja* into a purchaser and consumer of private care (see also Lee 2012). In interviews, I asked participants if they had observed any aspects of health care privatization occurring in Costa Rica. Many refused to use the word, and some dismissed it as not taking place. When I asked why, they replied that the word "privatization" is politically loaded and controversial, so they do not like to use it. Yet lawyer David Campos and nurse administrator Stephany Gutiérrez talk about health care cooperatives as examples of how aspects of privatization are entering into public health care.

These contrasts appear in the literature on health care privatization in Latin America. Some researchers call the mix of public and private health care in Costa Rica an example of "passive privatization" in order to describe the informal, tacit, even covert ways that privatization is entering into the health care system (Gifford and Rodríguez 2011; Homedes and

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Ugalde 2005; Lee 2012). For example, Homedes and Ugalde (2002) argue that health care cooperatives are examples of how aspects of health care privatization have entered into the public health care system. In contrast, Gauri, Cercone, and Briceño (2004) argue that cooperatives are not privatization but rather a compromise between the state provision of health care and the private sector, which brings forms of privatization into the public system without officially privatizing. When I talked to patients about their experiences in health care cooperatives, they expressed confusion about whether they were public or private. The ambiguity of this mixing suggests to me that individuals may go to the *Caja's* health cooperative and then receive care from a private firm without giving it much thought, thereby making privatization subtle and integrating patients into private health care.

Public–Private Contracts

Public–private contracts, such as the *Caja* commissioning a private hospital or clinic to provide services not available in the *Caja* or to lessen long waits for care, also integrate patients into a mix of public and private health care. According to Lee (2012), these contracts are an example of how the *Caja* has become the largest customer of some of the private hospitals in San José. For example, when I conducted observations of the radiology wing at a private hospital, several *Caja* patients were being treated at the private hospital. The radiologist, Dr. Gerardo Arias, told me that the *Caja* sends patients to him because some of the equipment in the private hospital is superior in quality to those in the *Caja* and there are more people waiting for treatments than space available in the *Caja.* Nurse Victor Morales talked about the same thing happening at the public hospital where he has practiced nursing for four years. He said that his hospital sometimes purchases diagnostic services from a private health care clinic or hospital and sends the public patient there in order for the patient to get the exams done in time for surgery.

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In these cases, the *Caja* itself manages how to mix public and private to meet its goals and make health care work. Consider. for example, Dr. Aarón Tejada. He is a plastic surgeon who worked for 15 years devoting half his time to a *Caja* burn unit and half to a private hospital. For the last seven years he has worked only in his own private clinic. As he told me about his work experiences in public and private health care, he said that in the public hospital the equipment in the *Caja* was often not taken care of and therefore not functioning properly or not working at all. According to Dr. Tejada, this creates a need for the *Caja* to purchase services from the private sector. He said, "The public equipment was destroyed by lack of maintenance. You know? If it belongs to everyone then it belongs to no one." In Dr. Tejada's experience a pattern of reliance on private care has developed due to the failure of bureaucratic decision making about how to care for equipment and the notion that maintenance was someone else's job. He said these failures influenced his decision to work only in private health care. Dr. Tejada's strategy of working in both public and private sectors easily led to his choice to work only in the private sector as a strategy to avoid problems he saw in his public hospital.

The way that some participants talked about public contracts with the private sector can be informative about what people may think about the mixing of public and private health care. For instance, nurse administrator Cristina Echeverría said that contracts between the public health care system and private establishments are movements toward privatization. She added that in her experience privatizing services in the *Caja* has led to a decline in the social model of medicine, so that now private health care is seen as more efficient than public health care.

Similarly, lawyer David Campos talks about public–private contracts this way:

> There are many versions of privatization. One version is the denial of services by the public system and those people going to private. We don't have that. Another version is the *Caja* contracting with the private hospital to deliver some services, as a last resort.

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For example, the *Caja* has arranged for the cooperatives and some EBAIS to be administered by the private sector.

According to David Campos, the *Caja* contracts with the private sector "as a last resort" to help solve health care delivery problems in the public health care system. Like Cristina Echeverría, he sees these contracts as a form of privatization. It is striking that in a culture that embraces publically delivered health care and its ideologies, these participants accept privatization as part of the public health care system.

David Campos talked about a recent change in management of several EBAIS*,* which at the time was a big topic in the media as well as in many interviews. In 2014, the *Caja* arranged for several EBAIS to change management from a public university to a private one (Ávalos 2014b). I interviewed several patients who used the EBAIS that changed management, and they talked about their concern with this mix of public and private. Some were concerned about the continuity of care, and others were concerned about the jobs of the people who were working in public health care before this change and would be working for a private company after the change. These participants said that it is more prestigious to work in public than private. When patients go to the health care cooperatives or the EBAIS that are now managed by a private firm, they are engaged in a mix of public and private sectors in order to get their care.

Patterns of Negotiating the Mix of Public and Private Health Care

I found that patients strategize different pathways of when to use public and private health care services and for what conditions. These strategies show a multiplicity of ways to maneuver between public and private, thus demonstrating mobility and flexibility in strategizing health care. For instance, David Campos, the lawyer who talked about health care privatization, has developed a specific strategy for accessing a mix of public and private health care. For minor things he and his family go to a private doctor, but for serious things they go to the public health

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care system. This way, he says, he can get fast care for minor things but not have to pay large fees for major surgeries. He also says that he gets the best of each system this way. For instance, when his wife had surgery for kidney stones, she went to one of the top public hospitals in the country. He told me that he feels secure about this strategy because the hospital they use is the most elite in the country with the best specialists.

Other patients talked about starting in a private health care hospital, but then, when the condition required longer, more expensive care, they were moved to a public health care facility. Other reasons participants talked about for moving from private health care to public health care were "the money running out," or needing a particular specialist or equipment only available at a top public health care hospital. For instance, nurse Victor Morales, who now works in a top public hospital, has cared for patients who came to his public hospital after first going to a private doctor. He told an account of his patient who had abdominal pain and went to his private doctor and then found out that he had a serious stomach ulcer that required surgery. The patient was transferred to the public hospital because the surgery was complicated and the intensive care was too costly in the private sector.

Nurse Christina Echeverría strategizes how to use both public and private in the same way as David Campos. For example, when she had thyroid cancer she did all the tests in a private clinic and the surgery in a top public hospital. She says that she has less confidence in the private health care sector for the treatment of cancer. According to Christina, the private sector has less experience and technology for cancer care. Yet she uses the private sector for medical tests because it is faster. This strategy of diagnostic tests in private and surgery in public was a common theme in interviews. For instance, Ana Vasquéz, a private health care nurse, told me

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that many of her patients use the public health care sector for all their health care needs but come to her private clinic for mammograms because it is faster.

A pattern of using public and private health care that emerges in interviews is to use public care for costly surgeries, cancer care, and end-of-life care. In interviews, public health care is associated with high levels of experience, high technology, and low cost. According to research, these types of care are costly to the public health care system, which is experiencing high levels of debt (Ávila-Agüero 2013; Torres 2013). This strategy works well for private health care providers, who cater to outpatient surgeries, non-urgent surgeries, and diagnostic exams, all of which are quick, relatively simple, and highly profitable.

Handling Emergencies

Some participants talk about using private care only in the case of very serious emergencies where they feel that they have no other option. Evita Díaz, a 29-year-old nurse educator, says that she and her family only go to the private hospital if it is "life or death."

According to Zúñiga-Brenes, Vargas, and Vindas (2012), few Costa Ricans pay out of pocket for hospitalization. This appears to be the case for most of the participants in this study. Some participants talked about paying out of pocket as a painful or unnecessary experience. For instance, Morena Shum, a 56-year-old health care administrator, said that when she used private care it was very painful to pay for it. "People are not used to that," she says. Indeed, the Costa Rican social security system fund purchases hospital care for the entire population, even those who do not make contributions to the system (McIntyre et al. 2013). In accordance with this literature, many participants in this study use private care for consultations and diagnostic exams, and public health care for hospitalizations.

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Chronic Care Is Public

Another strategy used by some participants in this study is to rely on public care for the treatment and maintenance of chronic health care conditions such as diabetes and hypertension. Karla Madriz, who has high blood pressure and diabetes, uses her local public clinic (EBAIS) for her regular check-ups and the management of her disease. She says that she has had only positive experiences with her health care. Several participants talked about the success of the EBIAS in treating chronic disease because, they told me, the state has made obesity, diabetes, and hypertension part of public policy and the EBAIS has a focus on health promotion, prevention and primary care. They often told me that "the *Caja* is good for chronic care," and this appears to be a common observation. Participants also told me the care of chronic conditions is seen as costly to the *Caja*, perhaps due to the amount of time spent in appointments and the aging of the population, which has added to the number of patients requiring chronic disease care (see also Torres 2013).

Some patients who themselves use private care have family members with chronic diseases who use public care. For example, Irene Segura, a historian, told me she goes to private care when she is sick, but her mother, sister, and father go to public care for their diabetes and hypertension. Similarly, nurse Victor Morales uses a private pediatrician for his baby's care, but both his parents go to the EBAIS for their chronic care. The number of appointments these patients have in public care may make private care cost prohibitive for them, and so far they have told their family that they have received effective chronic care in the public system.

Culturally Private Care: Pregnancy, Childbirth, and Personalized Care

During the course of this study I found that there were frustrations with the lack of privacy in public health care, and alternatives were sought in order to have more personalized

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private care. For example, several participants in this study report that they chose private care because they did not want to be observed by medical residents. According to Clark (2005) and Lee (2012), it is common for residents to be present in public hospitals in Costa Rica as part of their state-funded medical training. Dr. Mena Salazar, a general practitioner who works in a prestigious private hospital and clinic, told me that privacy is one of the things that her patients seek when they choose her as their private doctor. This is how she explained the lack of privacy in public hospitals:

> In the public hospital everyone, including students, checks on the patient. This is how students learn. The patient will be in bed with eight students standing around the bed and the doctor at the end of the bed. They each check the patient, touch the patient, and talk to him. Even a woman who is about to have a baby will have everyone check to see if she is dilated. The patient has to endure it because they have no choice. If they say no, it would be very bad [*feo*].

Another common preference is to have all prenatal and childbirth care done in private hospitals. The lack of privacy and poor care for pregnant women in public hospitals has recently gained the attention of policy makers in the *Caja* (Ávalos 2015a). According to these reports, the administrators of the *Caja* are currently making the improvement of quality of care a priority (ibid.). For example, the current executive president of the *Caja*, Marie de Rocío Saenz Madrigal, said publically that health care as a human right includes the "right to quality treatment, dignity, and respect" (Ávalos 2015a [my translation]).

Strategies of Nurses for Employment

Desire for more personalized care not only influenced some patients in this study to choose private health care but also some of the nurses; they explained their preference was to work in private care in order to be able to offer their patients more humane and personalized care. Some of these nurses told me that they strategized ways to avoid working in the public sector because they viewed the conditions as less personalized. Take for example the case of

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Pedro Morán, a 34-year-old nurse currently working in public health. Pedro told me in detail that although he is now working in public health care, he would prefer to work in the private sector. He says, "Care in private is more personal and humane because you get care faster without lines, and in public you see people dying and you have to smell bad smells." According to Pedro, the conditions in private are more personal and therefore better for both nurses and patients, and he told me that if he could he would work in private health care.

I observed discussions some of the values that nurses attach to public and private health care in two focus groups with nurses who work in a mix of public and private health care settings. Nurses were asked whether they would prefer to work in public or private health care settings and then were asked to explain their answers. In the two focus groups, nurses discussed their ideas of the main qualities of their work in public and private health care. The groups showed a consensus that although they liked the respect, career opportunities, and social values in public health care, they actually preferred private health care for the ability to work around their family responsibilities, power to make decisions, and ability to give more personal attention to patients. Even nurses who are trained in public universities and talk about how much they value public health care find the private health care sector alluring because it can fit into their life choices and their values of personalized care.

In contrast, nurse Juan Rolando talked negatively about work in private health care. Juan Rolando is a 35-year-old nurse who worked for one year in a private health care clinic and then the spent the next 13 years in a public hospital. Juan explained his observations of private nursing this way:

> Sometimes the private nurse is no longer seen as a nurse, but as a professional. Nurses in private care are there to tend to the whims of patients because they are paying. They are not going to serve the poor, immigrants, or people with mental illnesses unless it profits

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> the private hospital. Of course we give the same kind of care in public and private but it is true that deferential treatment goes to the patient who is paying.

According to Juan, personalized care is not always better care since, in his view, nurses in private care are expected to be health care professionals who serve the whims of paying patients rather than focus on health care.

Negotiating the Meaning of the Mix of Public and Private Health Care

Some of the participants in this study learned to use the public health care system for some arenas of health care and work, developing particular strategies and demands of public health care; likewise they developed particular strategies for navigating the private health care system. For instance, the strategy of going to the pharmacy for advice or using mixed medicine can result in a quick answer or the ability to purchase a medication or injection right away.

As some of the participants in this study strategically navigate through a mix of public and private health care, they also navigate the meanings of bureaucratically organized medicine in public health care clinics and hospitals at the same time that they maneuver their way through the meanings of corporatized health care services in the private sector. Consider Vania Oreamuno, a 50-year-old mother of four who is working on an advanced degree in health administration. She told me that privatization has now become thinkable in Costa Rica. She said, “Five or six years ago it would have been unheard of to overhear people talking about privatization. It was unthinkable. Now it is in the media so much that it is thinkable.” Vania’s comments are one window into how she frames her understanding of the current health care climate. Similarly, Ana Manuela Steward, who strategically tries to use only private care, also talked about the use of private care as a reason for some people to think of health care as a commodity. She explained that people pay out of pocket for private care because they do not

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want to wait on a list in the *Caja* and that for this reason, "health care has become more of a commodity."

The use of the mix of public and private health care described by these participants is set in the context of 30 years of policies alternating between neoliberal and primary care health care reforms that have led to a growth of the private health care sector (Chamberlain 2007). According to recent literature on neoliberalism, the intensification of private health care in Costa Rica is part of a global diffusion of neoliberal notions that health care is most efficient and profitable when it is organized around the principles of individualism, private property rights, and competition rather than the collective notions of state-organized social welfare or human rights (Chamberlain 2007; Godoy 2013; Hilgers 2010; Wacquant 2012). Similarly, participants in this study talked about public and private health care in ways that show how the rationalities of the private health care sector shape their ideas of health and what makes a doctor reputable.

For instance, Camilla Masis, a 70-year-old widowed mother who uses mixed medicine, said that doctors are "good doctors" because they can arrange her care in public and private facilities without long waits for care. For Camilla a good doctor is a doctor who works in both public and private health care and can negotiate shorter wait times for her.

Nurse Pedro Morán also has ideas of what a good private doctor is. Pedro is the public nurse who discussed his preference for working in private care. According to Pedro, a "good private doctor" is

> the private doctor who is most recognized or the one who gets the most applauded is the doctor who admits as many patients as possible into the hospital and gets patients to purchase things and pay for diagnostic tests, because that is where private hospitals are making the most profit.

For Pedro, a good private doctor helps the private hospital to make profit. Dr. Irene Segura, a 46-year-old historian of public health, told me, "For some doctors medicine is not a

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vocation but a business. Some do it for prestige and social promotion and others as a service." Dr. Dinorah Ahrens, a 56-year-old nurse, also had views of the role of the private doctor. She noted, "For some doctors medicine is not a vocation but a business. Some do it for prestige and social promotion and others as a service."

Not only doctors but also patients are influenced by the rationalities of private care. For example, Dinorah Ahrens noted that "people go to the private dermatologist because he has a laser. It is the laser they want and the laser that sells the private doctor's business to the people."

Like the perception of "good" doctors, views of nurses are also shaped by private care. Nurse Juan M. told me, "Sometimes in the private the nurse is no longer seen as a nurse, but as a professional." He went on:

> Nurses in private are there to serve the whims of the patient because the patient is paying. They are not going to serve the indigent, foreigner, or people with mental problems unless it can generate financial gain. Of course the nurse gives the same kind of care in public and private but they give deferential treatment to the patient who is paying.

Dr. Mario Jiménez, a general practitioner who runs his own private practice, articulates the influence of neoliberal rationalities on discourses of public care clearly:

> From a private administrator's point of view, the doctor is starting to become a health entrepreneur. This completely changes the picture. Just like any employer, administrators in private care about money, nothing more, and the patient becomes a commodity. Of course health is a human right. But now even the *Caja* sees the patient as a customer, this is becoming instilled in people. They do not understand that the patient is not a commodity, but a person. Or that the patient is paying to be served by the *Caja.*

In my interview with Dr. Jiménez he notes that patients have become consumers—even to people working in the public health care system. It appears that some of the rationalities of private care, such as the idea that health care is a marketplace based on profit, may be entering into Pedro and Dr. Segura's notions and observations of the roles of doctors, nurses, and patients, as well as their understandings of the goals of a health care system.

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Krause and De Zordo (2012, 137), who study changing rationalities with expansion of neoliberalism from the North to the South, note that as rationalities change, "new tactics, truths, and moral regimes emerge." It appears that some of the rationalities of public and private health care mix when people use them in complex ways. For example, when Dr. Randall Villalobos, a public general practitioner, explained his views of how the *Caja* has changed during his career as a medical doctor, he said, "The *Caja* has become a company, it seems to me. It is an organization, a corporation really. But in the process it has left behind what social security really is."

It is striking that for Dr. Villalobos the public health care system is likened to a corporation. Similarly, Irene Segura, an academic who now only goes to private care since her grandmother's bad experience in public care, says, "We have been having the commercialization of medicine since the 1990s." This is one reason why Melissa Valverde, a nurse educator at a private university, says that in some ways health has already privatized. Melissa reasons that this is so "because the market is now more open and people view the role of patients differently." According to Pongsiri (2002), one development out of the global free-market economy is the diffusion of neoliberalism into Costa Rica, influencing the respective roles of the state and the private sector. The participants in this study who use both public and private health care respond flexibly to problems, needs, and health care opportunities. As these participants move back and forth between public and private health care, they also learn how to manipulate and make sense of the contrasting meanings and ideologies of public and private health care.

Conclusion

In the case of the middle-class participants in this study, one possible way to manage the problems of public health care is to use private health care or a mix of public and private health

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care. The mixing of public and private health care is also a strategy of the public health care system to make health care work at an institutional level, thus blurring the boundaries between public and private health care. Not only is the use of private health care a strategy, it also reinforces neoliberal ideas of privatization. The health care experiences and understandings of middle-class individuals who negotiate the practices and meanings of public and private health care serve as a window not only into how health care is managed but also into how health care privatization in a country that relies on publically delivered health care is thinkable.

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CHAPTER 7: CONCLUSION

In this dissertation, I set out to learn more about how middle class Costa Ricans perceive and experience the mix of public and private health care in San José in order to add to our understanding of the phenomenon of the privatization of national health care systems in Latin America. Through ethnographic research methods of interviews, focus groups, and observations, I sought to explore the mixing of public and private health care practices and ideologies as a cultural system following the work of Kleinman (1980) and Nguyen (2005). I found that the contrast between the ideals and practices of public and private health care as well as how individuals culturally manage these contrasts is especially important in Costa Rica. Indeed, the mix of public and private health care is a significant reality for the individuals in this study, and demonstrates how privatization is becoming thinkable in a place where the national health care system has had success and ideological support.

This dissertation shows that a significant kind of medical citizenship is taking place as public and private health care are mixed. I call this “flexible medical citizenship.” This perspective is useful, to the extent that it puts into focus how individuals, practices of medicine, and ideologies of health care are mobile as public and private health care are mixed. Therefore, as a result of this research, I propose the framework of “flexible medical citizenship” as an analytical lens to describe and explain how the lived realities of the contrasting ideologies and practices of public and private health care are experienced and understood as they are mixed. Meanings of health care such as the meanings of human rights and health care as a commodity are flexible and shape and/or are shaped by the providers and patients who move between public and private health care settings. Flexible medical citizenship can highlight some of the uncertainties, inequalities, and vulnerabilities that emerge in this climate of mixed health care.

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Flexible Medical Citizenship

Many events and forces shape the mixing of public and private health care and the emergence of flexible medical citizenship. Even though the Costa Rican public health care system is a globally recognized successful system, it is also caught in a conundrum between the state provision of health care for the entire population, limits to that access due to factors such as long waits for care, and an increasing reliance on the private sector to fill in the gaps of public health care. In addition, in the decades since the 1980s due to the global diffusion of ideas of neoliberalism, the private health care sector has intensified and become more accessible to residents of urban San José.

Since most heath care systems in the world are a mix of public and private health care, a framework that can investigate how the ideologies and practices of mixed health care are constructed and experienced is necessary to contribute to our understanding of this phenomena[29]. Yet, most previous studies of health care systems describe the public and private health care sectors separately. A focus on describing health care systems as public or private without addressing the mixing of the practices and ideologies of health care delivery and access is limiting. Also, by directly addressing the culture, practices, and ideologies of the mixing of public and private health care, important questions about the sustainability of public health care, the meanings of health rights and the commodification of health care become clearer.

Flexible medical citizenship is defined as the movement of health care workers, patients, ideologies, and practices back and forth between public/state and private/corporate health care settings and the particular medical culture of ideologies, practices, uncertainties, and entitlements

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[29] For instance, according to research on public, private, and mixed health care systems in the world, most health care systems are a mix of public and private health care (Chartered Technofunctional Institute 2012; WHO 2016).

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that result from this flexibility. The term flexible medical citizenship can be useful for understanding the complex mix of public and private health in Costa Rica and how the ideas of health care rights, responsibilities, and claims to state and private resources are shaped by and/or shape providers and patients who work in and use this mix. Therefore, I argue that all the individuals in this study are flexible medical citizens moving between the institutional arrangements, ideologies, and expectations of public and private health care. In this process they become caught up in forms of public/bureaucratic and private/corporate control, and therefore use their flexible medical citizenship to get the health care and health careers they need.

In summary, the framework of flexible medical citizenship focuses on the movement between public/bureaucratic and private/corporate relationships of health that shape and are shaped by doctors, nurses, and patients on a daily basis. For example, providers and patients in this context must flexibly utilize their knowledge of these two systems to navigate them, and thusly, a medical culture of mixed health care emerges.

Flexible medical citizenship builds on previous work of anthropologists on biopolitics, biological citizenship, and medical citizenship and extends those perspectives to the specific case of the mixing of public and private health care. *First*, it builds on the perspective of biopolitics employed by Foucault and other scholars to understand how institutions, bureaucracies, and scientific technologies shape, regulate, and organize the lives of individuals and populations (Foucault 1991, 2008; Horton et al. 2014; Lemke 2011; Smith-Nonini 2012). According to Foucault (2008) biopolitics examines the processes by which human life is managed by regimes of authority such as institutions of health care. Flexible medical citizenship applies the contributions of Foucault’s concept of biopolitics to the specific case of the mixing of public and private health care, thus, enabling a focus on both how individuals are caught up in

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public/bureaucratic and private/corporate attempts to regulate ideas and practices of health care as well as how individuals regulate themselves in order to access a mix of public and private health care.

In other words, flexible medical citizenship, as used here, illuminates the understandings and practices that individuals engage in as they comply with, ignore, rework, or reject powerful discourses of public and private health care and their mixing. In this way, we can examine what Ian Hacking describes as "the public life of concepts and the ways in which they gain authority" (Hacking 1990: 7, cited in Krause and De Zordo 2012: 138). This is especially useful in attempting to understand how emergent types of control such as privatization in Costa Rica enter into the culture of publically delivered health care as well as to identify some of the consequences of the mixing of the ideologies, practices, and norms of this mixing. This can bring to light how individuals are exposed to contrasting ideologies and practices of public and private health care and document the emergent practices and meanings of real individuals as public and private health care are mixed.

Secondly, flexible medical citizenship builds upon the work of Petryna (2002), and Rose and Novas (2005) who outlined the concept of biological citizenship in order to examine how the biology of individuals is harnessed as a resource to gain access to or be excluded from state benefits. They consider how biological aspects of individuals have become resources utilized by authorities to create who is or is not a citizen, and what citizenship includes and excludes. This includes how individual access to state resources is shaped by the enactment or cessation of policies, access to special resources, and demands for certain protections (Rose and Novas 2005:441). It also includes claims by authorities over citizens as well as claims by patients and patient groups for access to health care resources. By applying this concept to the mix of public

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and private health care, flexible medical citizenship considers how membership in both state and corporate health care systems includes sets of entitlements and resources. For instance, flexible medical citizenship is more that citizenship in a state, since it is also membership in privatized health care. Therefore, it can illuminate how mixed health care systems work and are experienced by providers and patients.

Thirdly, flexible medical citizenship builds upon the concept of medical citizenship developed by Goldade (2009), Nichter (2008), and Wailoo, Livingston, and Guarnaccia (2006). Scholarship on medical citizenship narrows the object of investigation to health care systems and critically interrogates how health care providers and patients, as biological actors are part of *medical citizenship projects* where situated individuals are shaped by as well as shape larger medical institutional structures (Goldade 2009; Nichter 2008; Orsini 2006; Rose and Novas 2005; Wailoo, Livingston, and Guarnaccia 2006). Although various researchers have used the concepts *embodied, health, medical, reproductive, therapeutic,* and *pharmaceutical citizenship* to examine the politics of health care, entitlement and deservedness, flexible medical citizenship captures how health care for most people involves moving between public health care services, and private outpatient, private pharmacies, and private clinics and hospitals. Similar to these researchers, flexible medical citizenship examines how one's relationship to the science of medicine such as "doctor," "nurse," or "patient" or one's health status as diseased or healthy become resources for claims by individuals to rights for health care goods and services, as well as claims of the health care institutions over individuals (with power to define inclusion and exclusion as well as behavior and norms). Yet flexible medical citizenship adds a more specific focus on the crossing back and forth, among and between public and private health care systems, in order to conceptualize the current mixed health care climate where the ideologies and

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practices of socialized and corporatized health care meet. By defining flexible medical citizenship as the totality of ideologies, norms, and practices that shape access to and participation in public and private health care, I can illuminate the contrasts and tensions of this current health care climate.

Finally, research on the mixing of health care systems aligns with recent directions in global health. For instance, according to a Bulletin of the World Health Organization (Nishtar 2010) global health interests have turned toward understanding health care systems. Nishtar (2010) states that the focus on health care systems for understanding global health is important since the global financial crisis adds another layer of stress on governments to maintain publically delivered health care. This dissertation shows that a focus on mixed health care systems is useful in understanding the Costa Rican case, and that an approach that can examine health care systems as mixed systems would add to our understanding of the factors and characteristics of other mixed health care systems.

Flexible Medical Citizenship in the Costa Rican Context

The Costa Rican health care system is a good example of the phenomena of mixing public and private health care. For instance, Costa Rica has the appearance of a unitary, solitary national health care system underpinned by ideologies of universal health care, equality, solidarity, and community. Yet, the urban middle class participants in this study strategize their health care among the options of public, private or a mix of public and private health care. One of the rituals of flexible medical citizenship in Costa Rica is idealizing public health care despite the costs of long waits for care, shortage of supplies, lack of staff, and crowding, thus, legitimizing the choice to stay in public health care. Another ritual of flexible medical citizenship is to wonder if and when the private option should be used. While the patients in this study wait

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for care in the public health care system, they gave accounts of how they continually wonder if they should get a loan or mortgage their home to move to private care even as they remain in public for practical, financial, or emotional reasons. Uncertainty about health care emerged in this research as a significant quality of the current health care climate, even though the state officially guarantees universal coverage and access to health care. Flexible medical citizenship includes the process of selecting public health care among the options of public, private or a mix of public and private health care.

Another quality of flexible medical citizenship in public care is the maintenance of strong beliefs that publically provided health care is the best form of health care delivery despite knowledge of and experiences with its problems and the use of private health care. Providers and patients who move between public and private health care in this study do the cultural work to comply with, manage, justify, ignore, or rework public and private health care and their corresponding uncertainties and inequalities. Narratives in this study demonstrate how a health care climate has emerged where health care professionals and patients are expected to be flexible, mobile, and responsible and points to some of the unintended consequences of those requirements.

Official entitlements and obligations set up by the Costa Rican public health care system as well as the lived experiences of participation in public care such as long waits, hope, and uncertainty are all qualities of public health care. Some patients manage waiting simply by enduring those waits with mixed experiences of uncertainly and belief. The telling and retelling of rumors of patients dying while waiting underscores the depth of these fears. However, some patients do not passively endure waiting but rather demonstrate agency by filing cases in the court with the hopes that the court will force the *Caja* to move them up a waiting list. The culture

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of medicine in Costa Rica includes a particular array of meanings and practices of entitlement, uncertainty, universalism, and patient agency that make up the fabric of flexible medical citizenship.

Flexible medical citizenship also includes inconsistencies, tensions, and contrasts. for example, the patients in this study experience the inconsistencies, between the right to health and universal health care as mandated by the constitution and their actual access and experiences within the health care system. An example of these contrasts is also discussed by Rodríguez (2009), who points out that the combination of the right to health and universality stands in stark contrast to the limitations of the public health care system. Similarly, the inconsistencies found in this study inspire and contribute to a sense of fear and uncertainty leading to the use of the private health care sector. In other words, fear and uncertainty are real material consequences of larger structural forces of the problems within public health care and the intensification of private health care.

In addition, the flexible use of public and private health care can highlight some of the inequalities of access of the public health care system that is promoted as a system of equality, solidarity, and universalism. The stark contrast between the ideals of equality and real experiences of inequality of access between those who know someone in the public health care system and those who don't, or between national citizens and Nicaraguan immigrants emerge not only as lived realities but also as defining qualities of how health care is working in Costa Rica. However, rather than critique the public health care system, many individuals endure these inequities or explain them by luck or national exceptionalism. Although health care is considered to be a fundamental human right in Costa Rica, questions of who has more or less access to that right remain to be addressed.

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My fieldwork illuminated a reframing of the meaning of solidarity and universality, thus, demonstrating how flexible these meanings can be as public and private health care are mixed. For example, some participants talked about care for Nicaraguans, or "everyone within the national territory" as proof of universalism of the public health care system, while others talked about Nicaraguans as undeserving or the cause of the financial crisis in the *Caja.* In addition, some of the same individuals that talked to me about "health is for all" later talked about the Nicaraguan use of the health care system as a lamentable expense and stress on the system. In these examples, solidarity and universalism has flexible and contradictory meanings.

Ideas of individualism and individual responsibility also emerge in interviews. Horton et al. (2014) note that societies that embrace national health insurance also embrace the idea that individual responsibility for health is tied to responsible citizenship. Part of the social contract of citizenship in public health care in Costa Rica is to wait in line, complain about it, but still believe in the *Caja.* In addition, these patients are governable medical citizens, responsibly playing their roles and supporting the system ideologically (see also: Ong 1995; Peterson and Lupton 1996). Similarly, Brotherton (2003:7) shows that the intensification of neoliberal forms of delivering and accessing health care occurs in tandem with the "production of a community of autonomous individuals." In this study, these individuals autonomously make decisions about how to mix public and private health care, and how to advocate for their care in the face of long waiting lists. The public health care system therefore works in part as a result of these patients' struggles to make it work.

Ways that individuals make the public health care system work for them is to appeal to the juridical system to gain access to health care or move into the private health care sector. For example, one participant explained how in his legal practice, both the patient and doctor worked

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within the public health care system and public court system to get a medication by taking the *Caja* to court. The result of the lawsuit was is that the *Caja* was required to purchase a medication from a private source. This example demonstrates how even when individuals attempt to solve problems of waiting within the public health care system and the public court system, ultimately a mix of public and private was used. The public court ordered the *Caja* to use state funds to purchase a private medication for the patient. Clearly, public and private health care are not dichotomous, but rather mixed and interdependent and even patients who try to work within the public health care system are participating in a flexible medical citizenship in public and private health care.

In summary, I propose flexible medical citizenship as a conceptual lens that enables an examination of two key themes. First, flexible medical citizenship is the mobility among and between public and private health care each with its own kinds of belief, authority, practices of membership, rights and vulnerabilities. Both the public health care system and the private health care system impose normative ideological values, rights of citizenship, and vulnerabilities that become complicated as they are mixed.

Second, flexible membership in public and private health care creates a paradox of participation where ideologies of public and private at times clash, mix, or lead to unintended consequences. The health care system of Costa Rica provides a key site to examine how individuals move among and between the contrasting ideologies and practices of health care as a human right and health care as a for-profit enterprise thus revealing how health care is lived and put into practice and how flexible medical citizenship is negotiated by individuals. In the Costa Rican context, with the phenomenon of the mixing of these ideologies, what I am referring to as

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flexible medical citizenship, question remains: do middle class Costa Ricans view their health care as a human right or as a commodity?

Human Right or Commodity?

The Costa Rican case serves as an example of the lived experiences of contrasts between health care as a human right and health care as a commodity role. More specifically, with the global expansion of the idea of neoliberal approaches to health care, I see a recasting of the relationship between public and private health care.

Interviews and observations with the individuals in this study cast light on the difficulties of public health care provision and the subtle ways that the public health care system is mixing with the ideologies and services of the private sector in order to overcome these difficulties. Accounts of uncertainty about waiting for health care services and health care inequities in the public health care system reveal the difficulties these individuals encounter even though health care is an expressed human right guaranteed by the state. Many of these individuals rely on their own financial, cultural, and social resources to manage the public health care system enabling them to achieve some control over their health care outcomes. As they do so these individual see health care as a commercial enterprise, even calling the public health care system a big business. I argue that the mix of public and private health care is a significant reality for these individuals that demonstrates how privatization is becoming thinkable in a place where the word privatization is sometimes taboo.

The case material presented throughout this dissertation has shown that in the case of the contrasting ideologies between health care as a government responsibility and human right and health care as a commodity, people are able to hold both ideologies simultaneously without talking about them as contradictions or trying to resolve their contrasts. More specifically,

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individuals actively interpret the health care in their country as a human right while at the same they talk about how health care for them is becoming more and more a marketplace based on the goal of profit instead of preventive and primary health care. Some also likened their public health care system to a corporation suggesting that the public health care system is not different from the private sector in the way it is organized, works, or its ultimate aims. This can be seen as consistent with Harvey's (2005) work that suggests that neoliberal principles are monolithic and powerful. However, I hesitate to draw such conclusions. The participants in this study do not passively accept neoliberalism and its profit motive, rather they strategize their public and private health care options while ideologically supporting the ideal of publically delivered health care. Within the group of individuals I interviewed and observed in San José, a more nuanced and complex view of the conundrum of the mixing of these ideologies emerges. On one hand, interviews show concern with the expansion of neoliberalism through their questions about the sustainability of public health care while on the other hand they defend health care as a human right.

Limitations to This Study

This study draws the accounts of these 74 interviews, two focus groups, and 20 clinical observations with two private clinicians, and observations in public and private hospitals and clinics. It is the story of the realities of public and private health care of this group of individuals in one city at one point of time. This sample size is large enough to examine a range of middle class perspectives and experiences with public and private health care. However, this sample is not intended to completely represent Costa Rica as a whole, although it does offer an important part of the story of public and private health care. In other words, I am cognizant and careful about generalizing the experience of health care in San José as a general experience of all Costa

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Ricans. However, I have traveled extensively throughout Costa Rica and although this research is situated in San José, many Costa Ricans from other provinces come to the city for medical care and many physicians from the city work in or have worked in other districts.

Another limitation in this study was the imbalance of male and female respondents. Although the goal was to have a balance of male and female participants, my position as a single female researcher limited my access to men. In addition, there are fewer male nurses than female, and female patients were more likely to agree to an interview than males. For instance, when talking about intimate health issues women responded and talked to me more than men. It helped to have male research assistants and often health care narratives emerged in interviews with health care professionals, doctors and nurses in the course of talking about public and private care. Thus, while the data has more of focus on female perspectives than male, in the Costa Rican family context, health care decisions tend to be primarily the wife and mother's responsibility (Knaul, Nigenda, and Zuñiga 2002), and are not likely to have a serious impact on my conclusions.

While the focus on the middle class is both insightful for advancing our understanding of the contrasts between health care as a human right and health care as a commodity and a limitation, the focus on the middle class leaves out perspectives of other classes that could add significantly to our understanding of the perspectives and understanding of the mix of public and private health care.

I chose to interview doctors, nurses, administrators, academics, and health care policy makers, since they are the class of people who make decisions about how to deal with the problems of public health care, the growth of the private health care sector, and how to mix public and private. Middle class practices and aspirations are central to the continuation of public

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health care. I see these health professionals as a starting point for examining the contrasts of public and private health care and some of the conundrums of their mixing. These participants not only work in and access public and private health care but they also have a strong voice in the direction of the public and private health care sectors. This follows the work of anthropologists who study the middle class in Latin America such as Rachel Heiman, Mark Liechty, and Carla Freeman (2012:4). These authors' view the middle class as a critical site for considering the implications of the current global economic crisis.

While the narratives in this study are not representative of all of San José, or all of Costa Rica, they do offer important insights into how the some Costa Ricans manage this historical moment. Consequently, many of the examples I have given in this dissertation relate to practices of the individuals who have the social capital and financial means to choose private health care. However, this leaves out the voices of less fortunate Costa Ricans who do not have this social capital and financial advantage. These narratives show how this group of Costa Ricans view public health care, even as they face its limitations or turn to private health care. Further research is necessary to expand this study to other segments of Costa Rican society.

Recommendations

This dissertation has considered the blurring of the boundaries between public and private health care and the perceptions and experiences of public, private, and mixed health care in that context. This research contributes to anthropological theory of health care systems by proposing a framework of flexible medical citizenship. I call these situated health care professionals and patients "flexible medical citizens" to describe their resiliency as well as their cultural strategies of maneuvering between both public and private health care. In other words, one quality of flexible medical citizenship is the ability to negotiate public and private health care spaces,

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ideologies and cultural worlds. I also argue that as some of these individuals strategize their private health care options they may also engage in local understandings of neoliberal discourses. According to Bustamente and Méndez (2014) economic liberalization (neoliberalism) in Latin America beginning in the 1980s, and a growing middle class during the 1990s have increased individual demand for private health care. Therefore, theories of neoliberalism and the welfare state need further refinement in face of this evidence.

This research has important implications for theories of development, neoliberalism, globalization, welfare states, and health care reform. My research clarifies how an allegedly national health care system is maintained through persistent ideological support and its ability to fill in the gaps with private health care services. Bustamente and Mendez (2014) call this "demand-driven privatization" and examine how medical industries create this demand among patients (Bustamente and Mendez 2014). According to their research, the neoliberal model of health care works by creating a consumer demand for private health care. The used of mixed public and private health care can culturally create a two-tiered model where the poor use public care and the wealthy use private care even though officially Costa Rica is classified as a single-payer state health care system. Even though Costa Rica has been able to prevent large neoliberal reforms to its health care system, the mix of public and private health care in this study demonstrates that mixed systems include interdependency between public and private that make privatization thinkable for some providers and patients. Further research into this process can add to our understanding of the problems of publically delivered health care and its sustainability in this context.

Anthropologists can advance the understanding of the ideological underpinnings of the mix of public and private health care such as health care as a human right and health care as

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commodity and how relations of inequality, health care insecurity and the neoliberal concepts of individual responsibility and health care as a marketplace often modify patients' beliefs and realities of universal health care access and the right to health. Further research on how the mix of public and private health care are perceived and understood by poor patients would reveal a more general view regarding if and how the mix of public and private health care are utilized and understood. My research does not indicate a major shift toward neoliberalism, but rather a subtle, passive acceptance of its strategies and ideologies. Future work should consider a closer look at the inequalities, fears, and uncertainties regarding publically delivered health care.

Finally, I argue that this research, methodology, and framework can be applied to other mixed health care systems. Questions to be explored include: Is belief necessary to sustain publically delivered health care? What kinds of benefits and vulnerabilities emerge in the mix of public and private health care? What can this analysis tell us about the justification of bureaucracies, the creation of consumer-patients, the creation of an informal two-tiered health care system, and the continuity of care? How are human rights redefined in the context of mixed health care and is access to that right equally accessible? Given the financial, managerial, infrastructural and demographic struggles of public health care in Costa Rica, understanding these dynamics are central to our understanding of health care systems. Finally, I propose using the concept of flexible medical citizenship to illuminate these questions since the conceptual framework of flexible medical citizenship can highlight the mobility of health care professionals and patients between public and private health care as well as the mobility of health care meanings and practices.

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